Kent Community Health
NHS Foundation Trust

Agenda and Papers

for the

Formal meeting of the

Kent Community Health NHS Foundation Trust Board

In Public

to be held at 10am on

Thursday 26 July 2018

in

Rooms 6 and 7
Kent Community Health NHS Foundation Trust offices
Trinity House, 110 – 120 Upper Pemberton
Eureka Business 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 26 July 2018
Rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 - 120 Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN25 4AZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Interim Chair	Interim Chair	
1.2	To receive any Apologies for Absence	Interim Chair	
1.3	To receive any Declarations of Interest	Interim Chair	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 24 May 2018	Interim Chair	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 24 May 2018	Interim Chair	
1.6	To receive the Interim Chair's Report	Interim Chair	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	Chair of Quality Committee	

2.3	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	
2.4	To receive the Charitable Funds Committee Chair's Assurance Report	Deputy Chair of Charitable Funds Committee	Verbal
2.5	To receive the Integrated Performance Report	Chief Operating Officer/ Deputy Chief Executive Deputy Director of Finance	
2.6	To approve the Six Monthly Community Hospitals Safer Staffing Review	Chief Nurse	
3.	**REPORTS TO THE BOARD**		
3.1	To receive the Quarterly Infection Prevention and Control Report	Chief Nurse	
3.2	To receive the Annual Infection Prevention and Control (DIPC) Report	Chief Nurse	
3.3	To receive the Quarterly Mortality and Learning from Deaths Report	Medical Director	
3.4	To receive the Annual Safeguarding Report including Safeguarding Declaration	Chief Nurse	
3.5	To receive the Annual Medicines Optimisation Report	Medical Director	
3.6	To receive the Annual Patient Experience and Complaints Report	Chief Nurse	
4.	**ANY OTHER BUSINESS**		
	To consider any other items of business previously notified to the Interim Chair	Interim Chair	
5.	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA**		

Kent Community Health
NHS Foundation Trust

6. DATE AND VENUE OF NEXT MEETING

Thursday 27 September 2018
Motivation Room, Village Hotel, Castle View, Forstal Road, Sandling, Maidstone ME14 3AQ

Kent Community Health NHS Foundation Trust

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10am on Thursday 24 May 2018
in The Committee Room, Tonbridge and Malling Council Chamber,
Gibson Drive, Kings Hill ME19 4LZ

Meeting held in Public

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

24/05/1 **Introduction by Chair**

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

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

24/05/2 **Apologies for Absence**

Apologies were received from Jen Tippin, Non-Executive Director.

The meeting was quorate.

24/05/3 **Declarations of Interest**

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

24/05/4 **Minutes of the Meeting of 29 March 2018**

The Board **AGREED** the minutes.

24/05/5 **Matters Arising from the Meeting of 29 March 2018**

The Board **RECEIVED** the Matters Arising.

24/05/6 **Chairman's Report**

Mr Griffiths had attended the Chair and Chief Executive Board for Kent and Medway earlier in the month. The Trust had been formally invited to become a member of the forum.

24/05/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board for assurance.

With regards to Exercise Shakespeare, staff members had been led by the Head of Resilience and not the Medical Director as stated in the report.

In response to a question from Mr Field regarding the recent comments made by the Chief Executive of NHS Providers around the slow flow of money into the community, Mr Bentley commented that there was an ambition for more money to be invested in the community. He suggested that the Community Network would be a helpful lobby group to accelerate this.

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

24/05/08 **Patient Story**

Ms Strowman presented the video to the Board for assurance.

In response to a question from Ms Skelton regarding how the wound clinics were promoted, Ms Strowman explained that referrals came from community nursing and GPs. In response to a further question regarding whether there were more patients in the community that could be treated at the clinics, Ms Strowman confirmed that there were and that the clinics had the capacity to accept them. Some patients were unable to attend due to a lack of available transport and the Trust continued to work with the voluntary sector to help alleviate this problem. The clinics were also accepting patients referred by practice nurses.

In response to a comment from Mr Griffiths regarding whether the shortcomings of the Community Information System (CIS) as identified in the video indicated that there was a quality issue around care planning with the patient, Ms Strowman confirmed that the CIS tablet did not allow for documenting care planning in the home. She regarded it not as a quality issue but rather one of best practice. Once the nurse had carried out the care planning with the patient in their home, the documentation would be

uploaded to the system back at the base.

In response to a comment from Mr Conway that there was still an outstanding issue that clinicians were unable to access an extant plan in the community, Dr Phillips suggested that the issues relating to data availability and connectivity would be considered as part of the new CIS system which the Trust was now contemplating. Ms Strong added that the Trust had recognised early on that data availability would be an issue for CIS and had taken effective steps to develop a work around. Personalised care plans were held on CIS, printed off and kept in the home.

The Board **RECEIVED** the Patient Story.

24/05/9 **Quality Committee Chair's Assurance Report**

Mr Howe presented the report to the Board for assurance.

The Committee had met earlier in the month and scrutinised a number of reports that the Board would be receiving at that day's meeting. With regards to the Dental Service Never Event, the Committee had viewed a new training video which gave them confidence that the service had identified and learned lessons from the incident which it was sharing with all staff. The Trust had done well on addressing the issues and the Committee suggested that the Board no longer needed to monitor the implementation of learning from this incident.

There had been a number of vacancies that had endured for a considerable period of time in west Kent, Ashford and Canterbury. Although there had been some recruitment and the triangulation of data indicated that there were no quality issues at this time, the Committee was concerned that the vacancies were being tolerated. Ms Strong confirmed that new members of staff were expected to be in place in September 2018 and in the meantime, some bank staff had been put onto short term contracts to provide additional capacity. The outcomes from the Meridian productivity work was also helping teams to work together to match capacity with demand. Ms Strong and Ms Norris would be visiting the Ashford community teams imminently to support them. In response to a question from Mr Griffiths regarding when the Board could expect to receive greater assurance, it was agreed that update reports would be provided at the Patient Safety and Clinical Risk Group (PSCRG) over the following months. The Quality Committee would monitor the situation through the PSCRG Chair's Assurance Report with a view to the Board receiving greater assurance in September 2018.
Action – Ms Strong

With regards to the 2018/19 Quality Priorities, Mr Griffiths confirmed that these had been discussed and supported at the April 2018 Informal Board meeting.

The Board **APPROVED** the 2018/19 Quality Priorities.

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

24/05/10 **Audit and Risk Committee Chair's Assurance Report**

Mr Conway presented the report to the Board for assurance.

The Committee had scrutinised the 2017/18 Annual Accounts and the Annual Governance Statement. There had been some minor changes made by the External Auditors. The Remuneration Report and Annual Report had not been scrutinised but were included in the Board papers that day.

The Board **RECEIVED** the Audit and Risk Committee Chair's Assurance Report.

24/05/11 **Charitable Funds Committee Chair's Assurance Report and Annual Report**

In response to a question from Mr Bentley regarding clarity around the period of reporting relating to the Charitable Funds Committee Annual Report and the Charitable Funds Report and Accounts, it was agreed that this would be clarified.
Action – Ms Tippin

The Board **RECEIVED** the Charitable Funds Committee Chair's Assurance Report, subject to the clarification point.

24/05/12 **Strategic Workforce Committee Chair's Assurance Report**

Ms Skelton presented the report to the Board for assurance.

A summary of the topics that the May 2018 meeting had discussed was presented. This included staff retention and the introduction of new retention targets for services, further reflections on the Meridian productivity exercise and the development of the apprentice nurse pathway model. It had been agreed that a report on the model would be presented to the Board in July 2018.
Action – Ms Norris

The Committee had agreed that it would like to invite services to future meetings to present their recruitment initiatives that had been successful.

In response to a question from Dr Phillips regarding whether within the Sustainability and Transformation Partnership (STP) the Trust was leading in developing an apprentice nurse pathway, Ms Norris indicated that other organisations were considering it; but with a target date of September 2018, the Trust was ahead in developing more concrete plans.

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

24/05/13 2017/18 Annual Report and Accounts

Mr Flack presented the report to the Board for approval.

The 2018/19 Quality Priorities were set out in the report. With regards to performance, the Trust had hit most of its targets. The relevant certificates and statutory components were included. The Annual Governance Statement had highlighted that the Trust recognised that workforce was the significant issue for the organisation. With regards to the 2017/18 Annual Accounts, these reflected the reporting that had been made at Month 12 to the Board. The Quality Report had been scrutinised by the Quality Committee and the Annual Accounts had been scrutinised by the Audit and Risk Committee.

The Board **APPROVED** the 2017/18 Annual Report and Accounts.

Self-Certification with NHS Providers Licence

Ms Davies presented the report to the Board for approval.

The Audit and Risk Committee had reviewed the conditions of the licence and the supporting evidence in February 2018.

In response to a question from Mr Griffiths regarding the Board assessing the Trust's compliance with all the conditions, Ms Davies confirmed that the evidence to support compliance for the majority of the conditions was clear. However, there were six conditions that she suggested were more of a judged assessment. These related to integration of care, Fit and Proper Persons, patient eligibility for treatment, restrictions on disposal of assets, Going Concern and governance arrangements. Ms Davies provided evidence of what the Trust had in place for each of these conditions and the Board was assured.

In response to a question from Mr Conway regarding the scrutiny process in the future, it was agreed that the Audit and Risk Committee would carry out a scrutiny of the conditions each year and provide a report to the Board on its conclusions.
Action – Ms Davies

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

24/05/14 Workforce Report

Ms Norris presented the report to the Board for assurance.

The Strategic Workforce Committee had discussed the recommendation to change the Key Performance Indicators (KPI) for turnover, vacancies and sickness (stress and anxiety) and had supported it.
In response to a question from Mr Field regarding whether the Nursing and Quality Team could operate effectively while it carried its current vacancy rate, Ms Strowman confirmed that recruitment was in place to bring the

team back to full capacity.

In response to a question from Mr Bentley regarding the recent spike in the metric relating to agency shifts and compliance with the price cap, Ms Norris commented that this related to the availability of nurses through framework agencies. The Trust's compliance with this metric was normally good and it was disappointing that there had been an increase in the reporting period. As to when the Trust would be compliant, this was not clear. It was likely that the Minor Injury Units where specialist and medical staff were difficult to recruit to from framework agencies had impacted on the figures but it was agreed that this would be clarified.
Action – Ms Norris

In response to a question from Mr Griffiths regarding why training compliance in August 2017 had been over 100 per cent, Ms Norris explained that this related to a long term dementia training objective. She acknowledged that it might have the potential to skew the figures that were reported suggesting a false assurance. However, the Trust was ahead of the trajectory for achieving compliance with dementia training of all staff in the Trust. With regards to whether the figures could impact on the Trust's 85 per cent compliance level with mandatory training, Mr Flack highlighted that there was a full breakdown of training compliance in the Integrated Performance Report each month. Ms Norris confirmed that the Strategic Workforce Committee also scrutinised mandatory training compliance regularly.

In response to a question from Mr Field regarding the trend in sickness absence relating to stress, anxiety and depression, Ms Skelton confirmed that the Strategic Workforce Committee had received good feedback on the Trust's Musculoskeletal Physiotherapy Fast Track service and mental health support for staff earlier in the week. The Trust's investment in supporting staff's mental and physical health was helping them to remain at work. Ms Norris confirmed that the Trust would be focussing on staff mental health wellbeing over the coming year.

The Board **APPROVED** the changed Key Performance Indicator (for turnover, vacancies and sickness (stress and anxiety).

The Board **RECEIVED** the Workforce Report.

24/05/15 **Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

In response to a question from Mr Field regarding the School Health – Reception Children Screened for Height and Weight Key Performance Indicator (KPI), Mr Flack explained that the KPI had not been rated and the timing fitted with the academic year. This had led to a lack of comparability in the numbers. A trajectory was in place for the service to meet its target by the end of the school year and the service was confident that it would reach it. Its performance was being published weekly in the Flash Report

and the Trust and Kent County Council (KCC) was monitoring it. In response to a further question as to whether there was enough resource to deliver the target, Ms Strong confirmed that there was a plan in place and the service was working in conjunction with the schools.

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

24/05/16 **Monthly Quality Report**

Ms Strowman and Dr Phillips presented the report to the Board for assurance.

In response to a comment from Ms Barber regarding the up take in responding to patients' comments through the 'You Said, We Did' approach, it was agreed that this would continue to be actively encouraged at a local level.
Action – Ms Strowman

In response to a question from Ms Barber regarding whether there was any learning that could come from the themes identified in the reopened complaints, Ms Strowman explained that the reopened complaints related to low level complaints that had been handled at a local service level without the input of the Patient Experience Team. The team was now working with the clinical teams to improve the quality of the clinical teams' response to reduce the number of complaints that were re-opened.

Further to a comment from Mr Griffiths and a question from Dr Phillips regarding why a fall that was sustained by a child in the waiting area of a Trust clinic was reported in the Quality Report, it was agreed that an explanation as to why it was Datixed would be sought.
Action – Ms Strowman

Mr Bentley suggested that in the Falls work programme for the year ahead, there might be tighter classification around falls to avoid over reporting or over-stating the Trust's position.

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

24/05/17 **Finance Report (Month 1)**

Mr Flack presented the report to the Board for assurance.

The Trust was in a good financial position, although this was due in part to having received considerable Sustainability and Transformation Fund (STF) funding recently. Overall, the current surplus was slim. The Trust was behind its Cost Improvement Programme (CIP) target but it was anticipated that this would be made up over the coming months. The Capital Plan was in the same position. There was variance in income and pay which was driven by the vacancy factor. The challenge would be to bring them into alignment.

The Board **RECEIVED** the Finance Report.

24/05/18 **Committees Terms Of Reference**

Ms Davies presented the report to the Board for approval.

Each of the committees had reviewed and approved their Terms of Reference.

In response to a question from Mr Bentley regarding whether the Chair of the Audit and Risk Committee was appointed by the Chair of the Trust or the Board, it was agreed that clarification would be sought.
Action – Ms Davies

The Board **APPROVED** the Committees' Terms of Reference.

24/05/19 **Interim Appointments following the Chair's Retirement Report**

Ms Davies presented the report to the Board for approval.

It was anticipated that the interim arrangements would be in place until the new Chair of the Trust had been appointed. It was agreed that, if required, a review would take place at the end of September 2018. It was confirmed that Ms Skelton's appointment as Chair of the Finance, Business and Investment Committee was interim.

The Board **APPROVED** the Interim Appointments following the Chair's Retirement Report

24/05/20 **Minutes of the Charitable Funds Committee meeting of 25 January 2018**

The Board considered the Minutes of the meeting.

The Board **RECEIVED** the Minutes of the Charitable Funds Committee meeting of 25 January 2018.

24/05/21 **Quarterly Infection Prevention and Control Report**

Ms Strowman presented the report to the Board for assurance.

The Board **RECEIVED** the Quarterly Infection Prevention and Control Report.

24/05/22 **Quarterly Patient Experience and Complaints Report**

Ms Strowman presented the report to the Board for assurance.

The Board **RECEIVED** the Quarterly Patient Experience and Complaints Report.

24/05/23 **Quarterly Mortality and Learning from Deaths Report**

Dr Phillips presented the report to the Board for assurance.

It was agreed that the mortality data would be received by the Board prior to publication on the Trust's public website.

The Board **RECEIVED** the Quarterly Mortality and Learning from Deaths Report

24/05/24 **Six Monthly Freedom to Speak Up Report**

Ms Norris presented the report to the Board for assurance.

The Board **RECEIVED** the Six Monthly Freedom to Speak Up Report

24/05/25 **Comprehensive Information Governance Report**

Ms Davies presented to the Board for assurance.

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

24/05/26 **Emergency Planning and Business Continuity Annual Report**

Ms Davies presented the report to the Board for assurance.

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

24/05/27 **Staff Survey Report**

Ms Norris presented the report to the Board for assurance.

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

24/05/28 **Any Other Business**

There was no further business to discuss.

24/05/30 **Questions from members of the public relating to the agenda**

There were no questions from the public.
The meeting closed at 11.45am.

24/05/31 **Date and Venue of the Next Meeting**

Thursday 26 July 2018, Rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 -120 Upper Pemberton, Eureka Business Park, Kennington, Ashford, Kent TN25 4AZ

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 24 MAY 2018 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Quality Committee Chair's Assurance Report	To bring a regular update report regarding the recruitment position in the west Kent, Ashford and Canterbury community teams to the Patient Safety and Clinical Risk Group.	Ms Strong	Although Ms Strong does not attend the Patient Safety and Clinical Risk Group, she has confirmed that the Heads of Nursing and Quality will be asked to report to the group. The Chief Nurse as chair of the group will include on the agenda.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Charitable Funds Committee Chair's Assurance Report and Annual Report	To clarify the period of reporting relating to the Charitable Funds Committee Annual Report and the Charitable Funds Report and Accounts.	Ms Tippin	The 2016/17 accounts were prepared and signed off by the Committee in January 2018; and the details submitted to the Charities Commission in line with the 31 January 2018 deadline (please note that we are legally obliged to submit an annual return no later than 10 months after the end of the relevant Financial Year). Financial information relating to the year in question (i.e. in this case 2017/18) is routinely updated to the Committee at meetings throughout the year and the indicative draft position for 2017/18 was advised at the April Committee. The 2017/18 accounts will be prepared, audited and signed off by the Committee in time for 31 January 2019, with the 2018/19 position being advised at Committee meetings accordingly.
Strategic Workforce Committee Chair's Assurance Report	To present a report on the Apprentice Nurse Pathway Model to the Board in July 2018.	Ms Norris	Agenda item.
2017/18 Annual Report and Accounts – Self-Certification with NHS Providers Licence	To provide a report from the Audit and Risk Committee to the Board on annual basis regarding the Trust's self-certification with NHS Providers Licence.	Mr Conway	The Committee will undertake its annual review in February 2019.
Workforce Report	To clarify why there had been an increase in the use of non-framework agency staff that month.	Ms Norris	The increase is minimal and due to a couple of long tem bookings to ensure continuity of staff.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Monthly Quality Report	To ensure that 'You Said, We Did' communication with patients was taking place at a local level.	Ms Strowman	This is with the Communications Team and Patient Experience Team to ensure this is included in ward boards.
Monthly Quality Report	To investigate why a fall sustained by a child in the waiting area of a Trust clinic had been Datixed.	Ms Strowman	This was reviewed and changed to unavoidable and low harm.
Committee Terms of Reference	To clarify whether the Chair of the Audit and Risk Committee was appointed by the Chair of the Trust or the Board.	Ms Davies	Section C3.1in the Code of Governance states "the Board of directors should establish an Audit Committee." This will include the appointment of a chairperson.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 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 decision required.

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

Kent Community Health
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
July 2018

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

Staff

1. Agenda for Change Pay Award

The NHS Staff Council meeting on 27 June, employer and staff side representatives formally agreed, with the exception of the GMB trade union, to ratify the agreement on a 3 year pay deal and contractual reforms for staff on Agenda for Change terms and conditions. The new pay rates will be paid in July with arrears expected to be paid in August.

The new pay structure will:

- increase starting salaries
- reduce the number of pay points
- shorten the amount of time it takes to reach the top of the pay band for most staff.

Everyone on the Agenda for Change contract (not doctors and dentists) will receive a pay rise of at least 6.5 per cent over the next three years. About half of staff will receive much more than this. From 2018/2019, funding for the pay deal will apply to existing and new staff on the NHS Terms and Conditions of Service (Agenda for Change) employment contract employed in both NHS bodies and non-statutory non-NHS organisations that provide NHS services. Moving forward, this funding forms part of the additional investment announced by the Prime Minister for the NHS.

2. NHS 70

We've launched our NHS 70 celebrations in style, with our annual staff awards event on Friday, 22 June. Around 300 colleagues came together to celebrate another year of achievements and support the winners of our six awards.

Fifty colleagues received their long service award for 25 years' continuous NHS service, Jo Sherrington, Commercial Manager was judged by the panel as non-clinical colleague of the year, Aileen Whatley, Sexual Health Nurse was our clinical colleague of the year, the OneYou Smokefree Pregnancy Home Visits Team won non-clinical team of the year and The East Sussex Children's Equipment and Adaptations Service won clinical team of the year. Health improvement specialists Beverley Crossland and Tracey Tomkinson were awarded the David Griffiths' Outstanding Achievement Award for the launch and development of the Ashford OneYou shop. Our KCHFT choir performed for only the second time to a delighted audience and the prize draw raised more than £1,200 for our charity i care.

We also launched our Humans of KCHFT campaign, where we photographed and interviewed 70 colleagues from across the trust to find out more about the people behind the uniforms and name badges. These ran on our social media channels. The response to this campaign has been incredibly positive with thousands of comments, likes and new followers to our profiles on Facebook and Twitter. The stories have been recreated in a commemorative book.

As part of the celebration of the anniversary of the NHS the Chair and I were invited to attend a service of commemoration for the NHS at Westminster Abbey, our award winners Aileen and Jo were also invited. The service was an uplifting reminder of the day in day out remarkable work which the service delivers.

A number of NHS7Tea parties were also held across the trust the week of the anniversary and we have issued 3,000 NHS70 badges for staff.

Congratulations to Consultant Community Geriatrician Dr Shelagh O'Riordan who is the winner for south east England in the NHS70 Parliamentary Awards. Dr O'Riordan won the south east person-centred care champion award category after being nominated by MP for Faversham and Mid-Kent Helen Whatley. The NHS70 Parliamentary Awards asked MPs to find and nominate individuals or teams they thought have made the biggest improvements to health services in their constituencies.

3. The Big Listen

As part of our work to improve retention, on Friday, 1 June we invited colleagues to take part in The BIG Listen to tell us in their own words what they like about working for KCHFT and what changes they would like.

We had an excellent response from more than 1,300 people. We also offered people the opportunity to attend a Chatwich - where we gave colleagues the chance for a lunchtime chat to Chief Nurse Ali Strowman, Deputy Chief Nurse Ruth Herron and Director of Workforce, Organisational Development and Communications Louise Norris.

We have identified a number of key themes, which have been discussed by our management team and we are now defining the programme of work to build on the good practice and make the changes needed. We have been working with NHS Improvement on this project. It will require a transformational approach, not just transactional, but when delivered will make significant improvements or our workforce team.

4. Quality Improvement

Our work to implement a quality improvement (QI) approach across the Trust continues. 7 colleagues are currently undertaking their NHSE QSIR (Quality, Service Improvement and Redesign) College course to enable us to provide QI training, in-house throughout the Trust from the end of 2018, into 2019 and beyond. There will be varying levels of training available to staff, patients and carers interested in leading or participating in QI projects and further information will be forthcoming in the next few months.

There are currently 74 users signed up to the Life QI system on-line where all of our KCHFT QI projects will sit. The system has the ability to provide tools and documents for most phases of a QI project and over 25 projects are currently active, 10 added in the last month alone. The QI team are working with our communications colleagues to individualise the KCHFT approach to QI. We are also working hard to create a QI area on our website and Flo, and a dedicated QI email address will be coming soon.

Partnerships

1. CQC Relationship Manager Visit

The Trust CQC Relationship Manager, Emma Bond and her manager Louise Thatcher, Inspection Manager met with the Children's Specialist Services on 5th July. The session was held at our East Sussex, Polegate clinic which provided the opportunity to celebrate our transformation of East Sussex Children's Integrated Therapy and Equipment (CITES) services since we acquired them 5 years ago and the recent re-award following tender of the services. Children's Therapies, Bladder and Bowel and Looked After Children (LAC) Services all presented case studies illustrating:

- how they work in collaboration with other providers, families and children to provide more person centred services such as physiotherapy sessions

for babies and parents in local swimming pools and training within special schools

- innovations that have been adopted such as bladder and bowel scanners which provide ability to deliver local diagnostics and earlier intervention without need to attend acute or tertiary centres
- Service transformation with LAC that has allowed the clinicians to have more time to deliver packages of care, support groups and increased clinical autonomy to improve outcomes for very vulnerable children and young adults

There was a common theme that services have adapted to meet local needs that support on-going independence through using community infrastructure and helping parents to have the confidence and skills to manage/support their child's specific needs. The message that managers have been enablers and facilitated teams and services to be innovative, responsive and be autonomous was delivered passionately by our clinicians.

The CQC inspectors were impressed by the clinicians, case studies and mentioned how we are clearly proud of the services and their achievements that make a real difference.

2. KCHFT Operating Plan

The Trust has received support for its operational plan from NHS Improvement (NHSI). In a letter sent to the Trust, NHSI confirmed their support for the financial plan and encouraged the Trust to continue its whole system approach to Winter Planning. These plans are underway with a focus on preventing admissions to acute trusts and ensuring that the right services that will make the most positive impact to patients are established, both in the community and fully integrated between partners. The plan will be ready by September 2018.

3. Cyber Savvy

We have been awarded the Cyber Essentials first tier certification. Cyber Essentials is a Government-backed scheme which is re-assessed on a yearly basis to make sure the standards are being maintained. Our IT team is now working towards Cyber Essentials Plus certification.

Patients

1. Edenbridge – combined hospital and GP surgery

I am pleased to be able to update you on progress in developing the new combined hospital and GP surgery for Edenbridge.

Since the Edenbridge project programme board was established late last year to oversee the work, we have been working closely with West Kent Clinical Commissioning Group and Edenbridge Medical Practice.

Two potential sites for the development have been shortlisted. Before making a final decision, we are assessing the sites to check they comply with the design principles previously.

We are working closely with Sevenoaks District Council and the town council who are very supportive of the project. It is possible to bid for national money through our local Sustainability and Transformation Partnership (STP). We are pleased to say the Edenbridge project has been shortlisted by the Kent and Medway STP as a priority for central government funding, and a bid has been submitted by the STP on our behalf on 29 June 2018. While very encouraging, there will be bids from across the country for the national money so the programme board is continuing to explore other sources of funding.

The clinical model for the services to be delivered from the new combined hospital and GP surgery is being developed. There will also be an opportunity for patients, public and our partners to contribute ideas, and get involved in the next few months. The model fits with the wider local care plan, which describes how we want to provide better access to joined-up care and support in people's own communities across west Kent.

Paul Bentley
Chief Executive
July 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 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 meeting held on 15 May, 19 June and 17 July 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

This report covers the Quality Committee meetings held on 15 May, 19 June and 17 July 2018 setting out the Non-Executive Director challenges made and the assurances received, residual concerns and/or gaps in assurance, with work outstanding.

Item	Key points Level of Assurance	Remarks / Challenges	Next steps to address residual issues, gaps in controls or assurance; work outstanding; who is accountable and when the work will be completed
Standing Agenda Items	At each meeting the Committee receives assurance reports from: • **Chief Nurse** (Quality Report, Patient Safety & Clinical Risk Group, Serious Incidents (SI)) • **Medical Director** (Clinical Effectiveness Group, Patient Outcomes, Clinical Audit and Research, Mortality Rates) • **Deputy Chief Nurse (**Patient Experience Group, clinical commissioning group (CCG) clinical concerns and relationship management)	Principal areas for the Board's attention are discussed further in this report.	

Item	Key points Level of Assurance	Remarks / Challenges	Next steps to address residual issues, gaps in controls or assurance; work outstanding; who is accountable and when the work will be completed
Board Assurance Reports	The Committee reviewed the following reports over the course of the three meetings: Annual Caldicott Report Annual Quality Strategy Annual and Quarterly Patient Experience and Complaints Reports Annual Flu Report Annual and Quarterly Infection Prevention and Control Reports Annual Medicines Optimisation Report Learning from Mortality Review	Each report received challenge and areas of high achievement or need for improvement were recorded within the Quality Committee minutes (to be approved by the Board). There were no serious concerns highlighted.	It is recommended that the Board accepts and notes these reports.
Policies Ratified	Safe Staffing Assessment and Escalation Procedure for Withholding Care Orthopedic Diagnostic Examination Requests	Staffing of inpatient wards. Management of risk to safety of staff from violent or abusive behavior. Policy for non-medical staff working within the Community Orthopedic Service	
'we care' Visits	The 'we care' programme is progressing well and on track to have reviewed all services by September 2018.		The consolidation of reports will give the Board an evidenced-based overview of current strengths and weakness within the Trust's services.

Item	Key points Level of Assurance	Remarks / Challenges	Next steps to address residual issues, gaps in controls or assurance; work outstanding; who is accountable and when the work will be completed
Falls – Deep Dive Report	The Committee requested a review of patient falls that occurred during the financial year 2017/18. In 2016/17, the average number of falls within the Trust per 1000 occupied bed days was 6.32 with the national average being 6.63. The Trust average for 2017/18 is 7.13. The national average not yet available.	A total of 625 falls incidents were reported during this period of which 42 were classified as avoidable. The report identified a number of areas for improvement, including: • Falls Assessments to be completed in a timely manner • Assessment and management of patients with cognitive decline • Pharmacy review on admission. Within the Trust, falls prevention training compliance was a low at times (52.9% in March) and this training is currently not classed as essential to role for bank staff.	The Falls Prevention and Improvement Group to review and drive the action plan, reporting progress through the Patient Safety and Clinical Risk Group to the Quality Committee. Who will review trends and lessons to be learned from Serious Incidents? Ongoing.
Pressure Ulcers (PU) – Deep Dive Report	During 2017/18, the Trust saw a significant reduction in all levels of avoidable PU. • 41% Category 2 • 31% Serious Harms	The reduction in PU harms remains a high priority for the Trust. Category 3 and 4 harms occurred in the following locations: • West Kent Intermediate Care Team (ICT) 3 • Ashford Long Term Condition (LTC) 8	Service action plans have been implemented in the Ashford and Canterbury localities and a review of root cause analysis (RCA) has been conducted ensuring common themes and lessons are highlighted. The Quality Committee will continue to monitor and review.

Item	Key points Level of Assurance	Remarks / Challenges	Next steps to address residual issues, gaps in controls or assurance; work outstanding; who is accountable and when the work will be completed
Pressure Ulcers (PU) – Deep Dive Report		• Canterbury LTC/ITC 5 • Thanet 2 The result of this review provided assurance confirming that a: • robust operational process is in place • management Strategic Action Plan is in place; • audit of x5 Category 3 PU had found that appropriate action had been taken by Trust to prevent reoccurrence.	
Review of the Trust's escalation process during times of manning pressures	The Board is aware that a number of recent SI/RCA and deep dives (see above) have attributed manning pressures as one of the causative factors to harm. The Quality Committee has requested further analysis of the impact of manning pressures and also a review of the Trust's escalation process to provide the Board assurance that all appropriate mitigation actions are in place and lessons have been identified and learned from recent events.	Recent recruitment initiatives and the introduction of the Meridian software tool have impacted in a positive way on these 'stressed' areas.	The Quality Committee Chair and the Chief Nurse to discuss the next steps.

Item	Key points Level of Assurance	Remarks / Challenges	Next steps to address residual issues, gaps in controls or assurance; work outstanding; who is accountable and when the work will be completed
Health Visiting Service	During the June meeting, the Chief Operating Officer identified her concerns over retention and morale within the Health Visiting Service. Although quality metrics were not highlighting issues Staff Side and the Freedom To Speak Up Guardian were drawing management's attention to staff concerns. The Community Services Director provided a detailed report to the July meeting outlining the issues and the mitigations that had been put in place. This included a leadership review, improvement in communications and the recruitment of 21 band 5 nurses (new initiative) to support the Health Visiting Service.		The Chief Operating Officer will update each Quality Committee meeting on progress. The Community Services Director is to be invited to report progress to the Quality Committee in late Quarter Three. In due course the Non-Executive Directors from the Quality Committee will conduct an assurance visit to the service.

SC Howe CBE
Chair, Quality Committee
18 July 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	2.3
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 21 May 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.

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 21 May 2018 setting out the Non-Executive Director challenges made and the assurances received, residual concerns and/or gaps in assurance, with work outstanding.

Item	Key points Level of assurance	Challenges	Next Steps to address residual issues, gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
Workforce Report	The Committee discussed issues behind the data presented in the Workforce Report with turnover, absence, vacancies still in red, albeit showing a smaller gap between starters and leavers. It was good to note 14 staff returning to the Trust and the Hawkhurst Community Hospital at full establishment.	Moving and Handling training had dropped out of compliance. Plans are in place to be compliant by July latest. To what extent was pressure accumulating and contributing to the level of sickness with indicators clearly showing stress/anxiety levels worsening.	Change has been a contributor factor to stress; lessons to be learnt from Meridian work to embed new ways of approaching change. Initiative underway to encourage managers to contact staff during their first week of absence. New retention Key Performance Indicators (KPIs) - see below
People Strategy Action Plan	The Committee received a monthly update on progress against the People Strategy plan.	How is the ownership/accountability of actions shared between HR and operations? Mixed teams have been put together to design the solution to ensure engagement from operations. Are there too many actions to allow focus? Should we simplify and do fewer well?	The Quality Management meetings pick up workforce issues each week to ensure they are being progressed. All actions are tested by linking back to the strategy and are work in progress. Specific attention is given to priority items like mental health. This initiative is providing a lot of useful information to inform a plan to focus on key problem areas. We are also involved in 'The

Item	Key points Level of assurance	Challenges	Next Steps to address residual issues, gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
			Time to change' initiative.
Staff Survey Action Plan	Further work on engagement is a priority following staff survey findings. Each service has a local action plan to take local ownership. The engagement work is linked closely to the Quality Strategy and the Health and Wellbeing plans.	Are key questions from the survey being asked of all staff?	Impact is being measured quarterly asking questions as part of the Staff and Friends Test.
Enabling BME Nurse Programme Progression Update Report	The Committee received an update confirming that the action plan is complete. Future progress will be tracked and overseen by the Trust Workforce Equality Group, with communication and engagement key to raising awareness.		
Retention Report	The Trust has been invited to be part of an NHS Improvement (NHSI) retention support programme of work for nursing staff. KCHFT is looking at a Trust wide initiative. Last year we lost 320 nurses equating to 27 a month. We lost 56 members of staff in their first year. NHSI recommend a 2% reduction in target. Every leaver is being contacted to learn more about why they left and what might have changed their mind.	What would a stretch Trust target look like, wanting stretch and realism? What insights do we have that would allow us to aggressively attack these numbers and retain more staff?	The HR team is looking at a 4% target which we wish to exceed. Work is being done at a local level with local team targets. These require support and discussion instead of just 'being distributed" The NHSI work using focus groups and team discussions will provide insights to know further where the problems are, what the issues are and suggest ways of tackling them. A paper setting out the findings, insights and actions is coming back to the Workforce Committee in July. The Trust goal is to "make this the best place to come and stay".

Item	Key points Level of assurance	Challenges	Next Steps to address residual issues, gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
Quality Strategy and Innovation	The Committee received a short update describing the development of processes to promote innovation and the work started by a small team looking at a simple pathway to gather ideas from staff for both Quality Improvement (QI) proposals and other innovation proposals. Delivery of this is being tracked as part of the Quality Strategy implementation programme of work which feeds into Quality Committee.		
Meridian Productivity Project	The Meridian report summarised the workforce benefits of this work including productivity and efficiency, cultural change, leadership opportunities, better e-rostering, developmental opportunities as well as prospects to work more effectively with our skills mix. Looking to extend next into clinic-based children and adults.	The work has successfully been taken from West to East Kent where else can we take it and at what speed realistically? What lessons can we learn from the Meridian Team who has minimised stress and anxiety as they introduced change to the teams?	A short paper mapping out immediate opportunities and longer term areas to be presented at the next Workforce Committee meeting. Operations and HR to meet and distil lesson for change in terms of approach, behaviour and tone not process that could help us with other change initiatives across the Trust.
Leadership Development Framework	The Leadership offer was presented to the Trust and identified a gap for Bank 7 – 8 which is being addressed.	How does the talent management work dovetail with leadership development?	All individuals who score outstanding will be picked up and their development prioritised. In September a paper will come to the Committee setting out the number of outstanding's, where they are in the Trust and how we best retain, develop and value them.
Musculoskeletal Physiotherapy (MSK) Staff Fast	Data collected from the internal service is limited but at the same time useful.	Is there any further data we can collect to help us support the staff?	Data to collect from both MSK Service and Counselling Service is being looked at, to ensure it is both sensitive for the individual and

Item	Key points Level of assurance	Challenges	Next Steps to address residual issues, gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
Track Service	454 referrals last year, 10% off sick with 91% saving time off work.		useful for us.
Apprentice Nurse Pathways	A lot of background work completed by HR and Operations to look at future staffing levels, models of nursing, vacancy rates as well as routes into nursing. Plan to recruit and train 50 nurses over 4 years at a cost of £6m. New nursing models looked at the needs from Band 4 and 5 and nurse associates. A number of key questions still need to be answered including payment levels, and the impact on the organisation creating a different type of workforce. Outstanding issue include: - impact on the STP - pay levels - investment case - infrastructure requirement - cultural change - reassurance to staff that they get cover on the days that nurses are training - ensuring staff are invested at a local level. The wider benefit will ultimately demonstrate how we are embracing the new medical school. There are many Trusts looking at this route to secure nurse numbers.	What is the value for money case? Is there anyone we can share the investment with? Are we clear about all the risk to mitigate them? Are we clear about the immediate and wider benefits to the Trust?	A more in-depth financial piece of work is going to the Executive Team setting out the business case clearly articulating the assumptions being made. A paper setting out the immediate and longer term benefits is being drafted. In tandem to this, a plan is being drawn up as to how we would implement the pathway setting out the activities to support the individual nurse, the infrastructure, and the cultural wide change piece.

Item	Key points Level of assurance	Challenges	Next Steps to address residual issues, gaps in controls or assurance - work outstanding – who is accountable and when the work will be completed
Non-Medical Prescribers Report	Update on work received.	How involved were operations in the decisions on who and how many local prescribers we have?	Discussion with Medical, Nursing and Operations to clarify needs to ensure mutual commitment, to satisfy the needs of the Trust as we encourage further empowerment at a local level.
NHS Pay Deal	Unions balloting no decision yet. Due May – June.		
Any Other Business	Committee effectiveness was discussed.	Q: How can we sharpen up the meetings? Q: Do we need to meet monthly?	Quicker through assurance papers and more time for deep dive into key areas. Introduce service presentations to highlight or illustrate good working practice that could be shared across the Trust. Papers to be shorter and focus on insight, analysis, and action rather than delivering data. Meeting to continue bi-monthly to respect amount of time spent in meetings and ensure actions are taken and progress made on key issues between meetings. A balance of Non-Executive Directors with clinical background and financial background would be advantageous.

Items for the Board to specifically note:	Areas of focus for next period include retention, sickness (mental health) and the Apprentice Nurse Pathway work.
Recommendations for the Board:	**None**
Policies Ratified	**None**

Bridget Skelton
Chair, Strategic Workforce Committee
21 May 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	2.5
Subject:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context)

The Integrated Performance Report has been revised for the 2018/19 financial year, taking on board learning from East London NHS Foundation Trust (ELFT) in the way that the report is presented. The use of run charts has been presented and agreed through the Executive Team, as well as further integration of Quality, Workforce, Finance and Operational Performance reports. It should be noted that the full Finance, Workforce and Quality reports will still be presented at their respective committees. The report has been produced in collaboration with the Executive Team and their support teams.

This report contains the following sections:

- Corporate Scorecard and Summary
- Quality Report
- Workforce Report
- Finance Report
- Operational Report

Historic data has been provided to show trends, however, the availability of trend data varies between indicators as can be seen from the charts presented. The charts are designed to show a rolling view of performance for each indicator, but as stated this does depend on data availability. Upper and Lower control limits are used to indicate a shift in performance over a sustained period and to highlight where performance deviates from these expected ranges.

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 decision required.

Nick Plummer, Assistant Director of Performance and Business Intelligence	Tel: 01233 667722
	Email: nick.plummer@nhs.net

Kent Community Health
NHS Foundation Trust

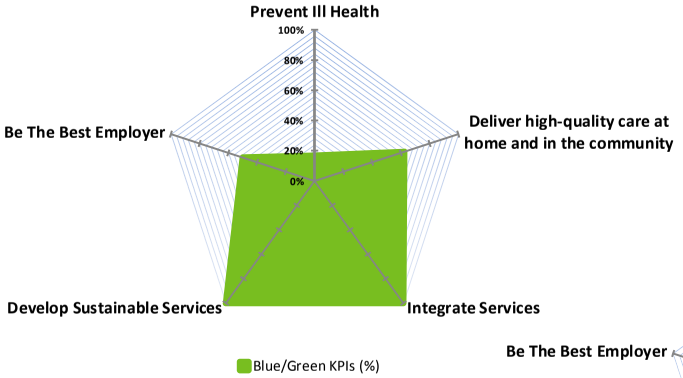
Integrated Performance Report 2018/19

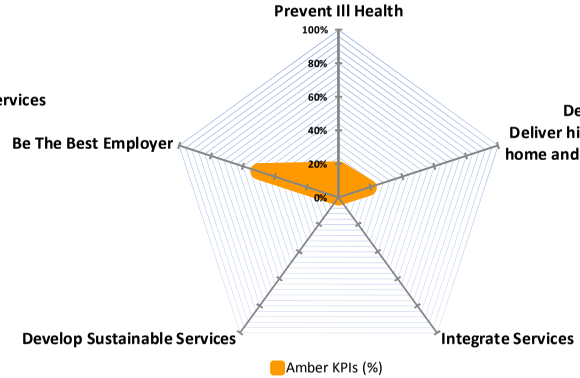
July 2018 report

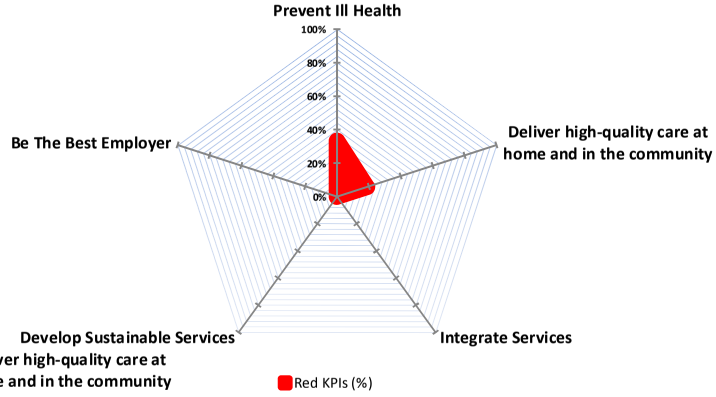
Part One

we care

1.0 Assurance on Strategic Goals







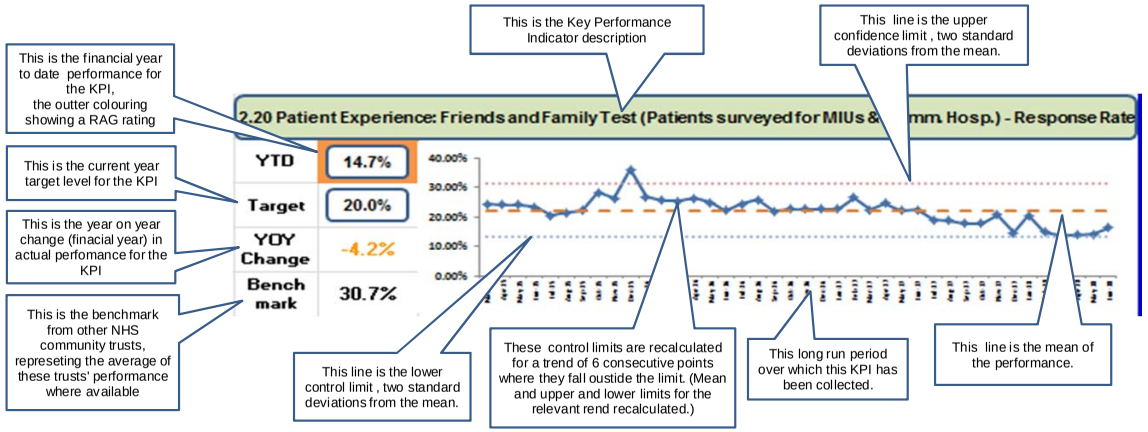
Integration of Services and Developing Sustainable Services were the best performing strategic goals with 100% of KPIs performing at either blue (achieving aspiration) or green (achieving target). However its worth noting that there are currently only 1 goal for each and therefore not fully represenative of the aspiration of the Trust RE: Integration.

33.3% of the "Prevent Ill Health" indicators are red currently.

Overall, of the 28 indicators, 64.3% are blue/green, 17.9% are amber and 17.9% are red.

Of the red indicators, 2 are improving, none are static and 3 have worsened since last month's report.

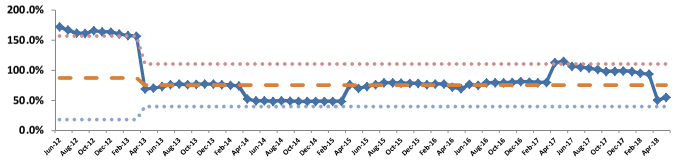
Run Charts explained



1. Prevent Ill Health

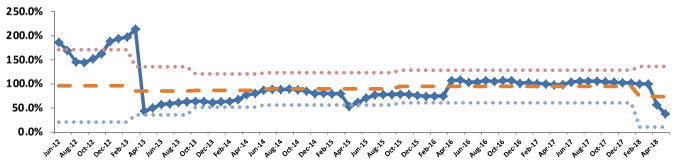
KPI 1.1 Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%)

YTD	55.4%
Target	100.0%
YOY Change	-38.4%
Bench mark	N/A



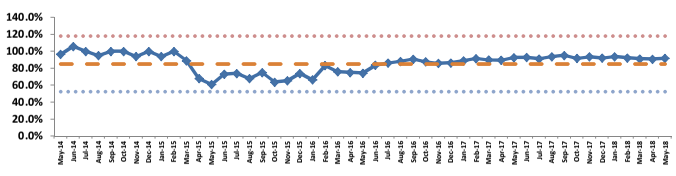
KPI 1.2 Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%)

YTD	37.8%
Target	100.0%
YOY Change	-62.3%
Bench mark	N/A



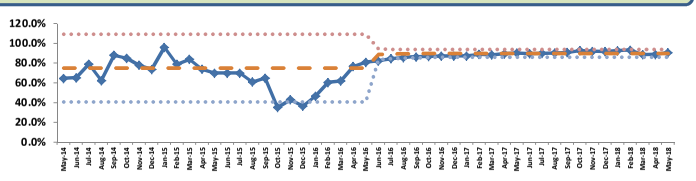
KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days

YTD	91.3%
Target	90.0%
YOY Change	-1.2%
Bench mark	N/A



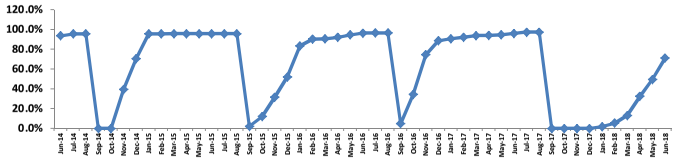
KPI 1.4 Health Visiting - 6-8 week assessment undertaken by 8 weeks

YTD	89.8%
Target	85.0%
YOY Change	-1.2%
Bench mark	N/A



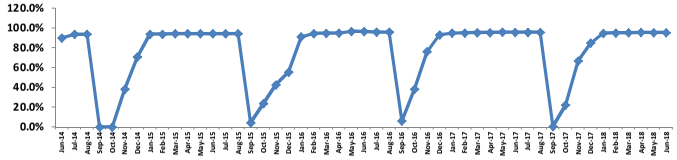
KPI 1.5 School Health - Reception Children Screened for Height and Weight

YTD	71.0%
Target	90.0%
YOY Change	57.8%
Bench mark	N/A



KPI 1.6 School Health - Year 6 Children Screened for Height and Weight

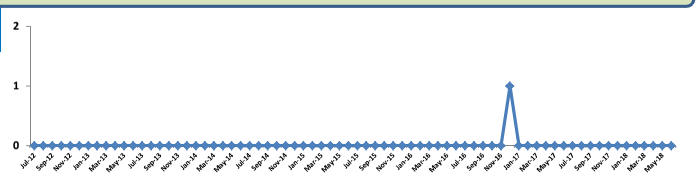
YTD	95.5%
Target	90.0%
YOY Change	0.3%
Bench mark	N/A



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

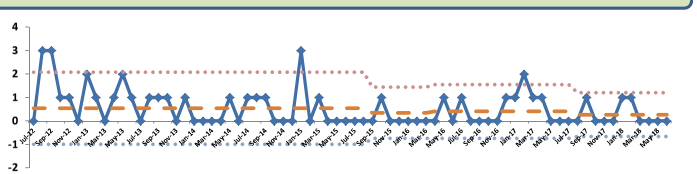
KPI 2.2 Never Events: Number

YTD	0
Target	0
YOY Change	0
Bench mark	N/A



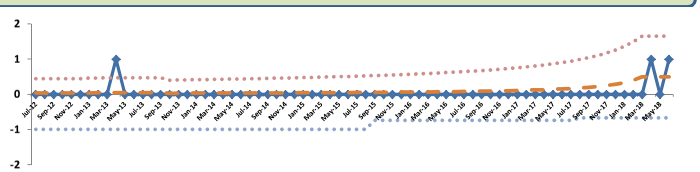
KPI 2.3 Infection Control: C.Diff (Target <6 cases in year) (Target YTD)

YTD	0
Target	0
YOY Change	-4
Bench mark	N/A



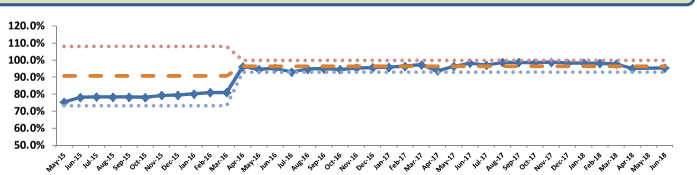
KPI 2.4 Infection Control: MRSA cases where KCHFT provided care (Target 0 cases)

YTD	2
Target	0
YOY Change	2
Bench mark	N/A



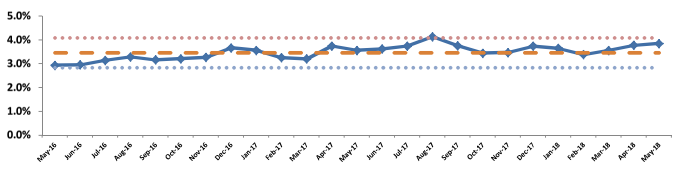
2.8 Contractual Activity: YTD as % of YTD Target

YTD	97.8%
Target	100.0%
YOY Change	0.4%
Bench mark	N/A



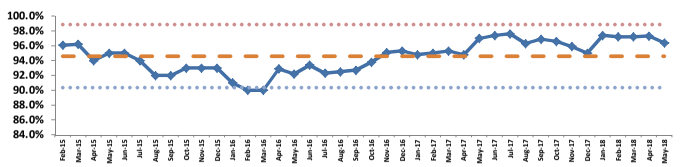
2.9 Trustwide Did Not Attend Rate: DNAs as a % of total activity.

YTD	3.8%
Target	4.0%
YOY Change	0.2%
Bench mark	4.0%



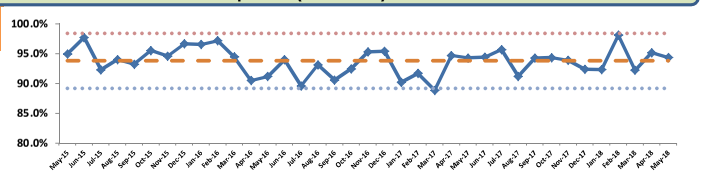
2.10 LTC/ICT Response Times Met (%)

YTD	96.9%
Target	95.0%
YOY Change	0.2%
Bench mark	N/A



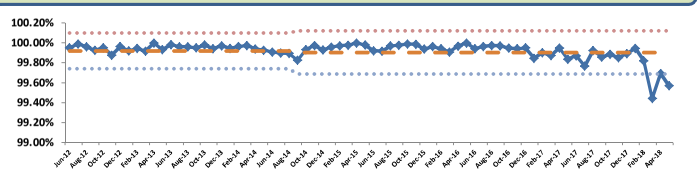
2.11 Rapid Response - Percentage of Consultations started within 2hrs of referral acceptance (Trustwide)

YTD	94.8%
Target	95.0%
YOY Change	0.8%
Bench mark	93.7%



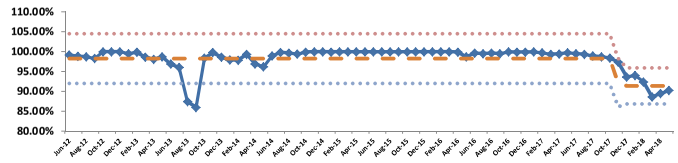
2.12 Total Time in MIUs: Less than 4 hours

YTD	99.63%
Target	95.0%
YOY Change	-0.2%
Bench mark	99.4%



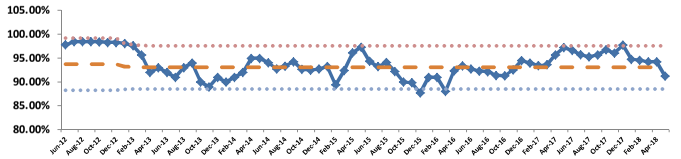
2.13 Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways

YTD	89.9%
Target	95.0%
YOY Change	-6.8%
Bench mark	98.0%



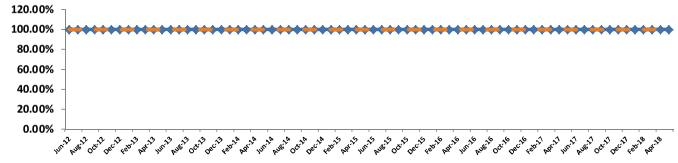
2.14 Allied Health Professionals Referral to Treatment Times (RTT)

YTD	92.8%
Target	95.0%
YOY Change	-3.1%
Bench mark	97.6%



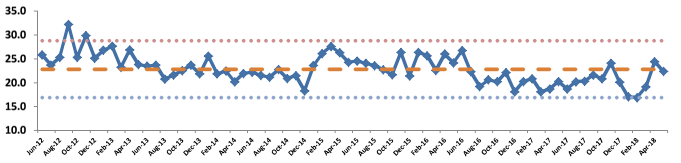
2.15 Access to GUM: within 48 hours (Monthly Target 100%)

YTD	100.0%
Target	100.0%
YOY Change	0.0%
Bench mark	N/A



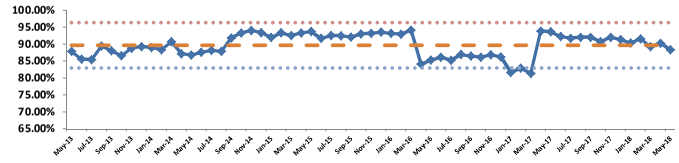
2.16 Length of Stay (Median Average)

YTD	23.4
Target	21.0
YOY Change	3.6
Bench mark	25.6



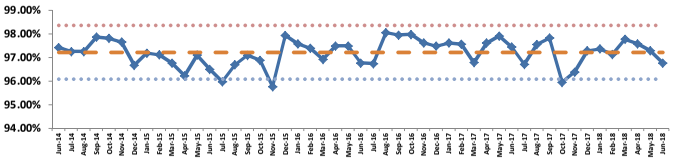
2.18 Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services.

YTD	89.4%
Target	80.0%
YOY Change	-2.4%
Bench mark	N/A



2.19 Patient Experience: Friends and Family - Percentage of Patients who would Recommend KCHFT.

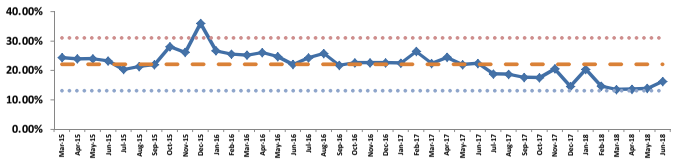
YTD	97.2%
Target	95.0%
YOY Change	0.0%
Bench mark	95.8%



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

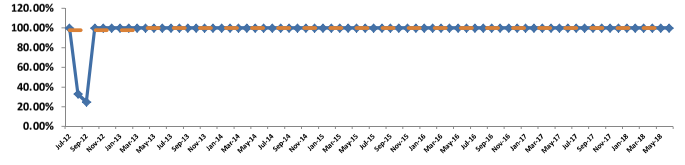
2.20 Patient Experience: Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp.) - Response Rate

YTD	14.7%
Target	20.0%
YOY Change	-4.2%
Bench mark	30.7%



2.22 NICE guidance: New NICE Guidance reviewed within required timescales following review of publication.

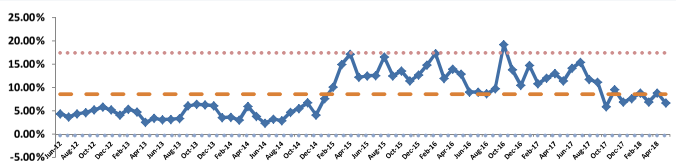
YTD	100.0%
Target	100.0%
YOY Change	0.0%
Bench mark	0%



3. Integrate Services

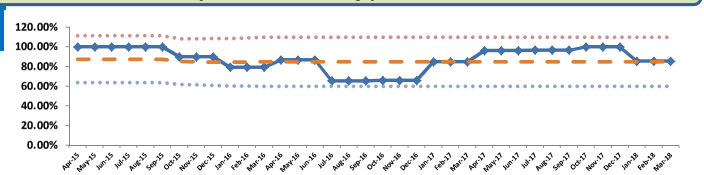
3.1 Delayed Transfers of Care as a % of Occupied Bed Days

YTD	7.8%
Target	9.5%
YOY Change	-2.5%
Bench mark	12.5%



3.3 CQUINs: combined measure of CQUIN performance (% of CQUIN money achieved to 17/18 Q4)

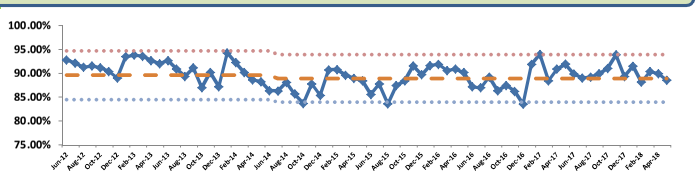
YTD	DCU
Target	85.0%
YOY Change	N/A
Bench mark	N/A



4. Develop sustainable services

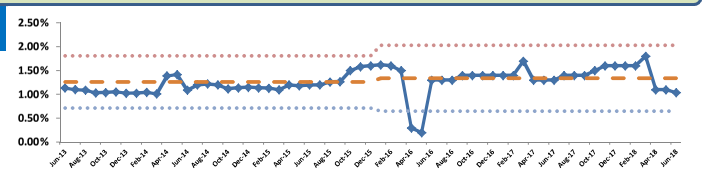
4.2 Bed Occupancy: OBDs as a % of available bed days

YTD	89.3%
Target	87.0%
YOY Change	-1.2%
Bench mark	90%



4.3 Income & Expenditure - Surplus (%)

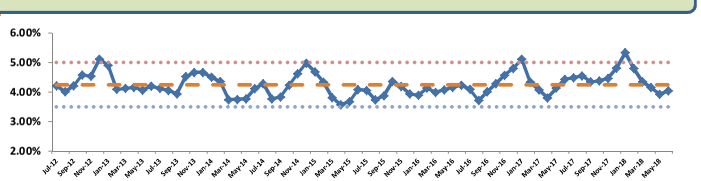
YTD	1.0%
Target	1.0%
YOY Change	-0.8%
Bench mark	1%



Be The Best Employer

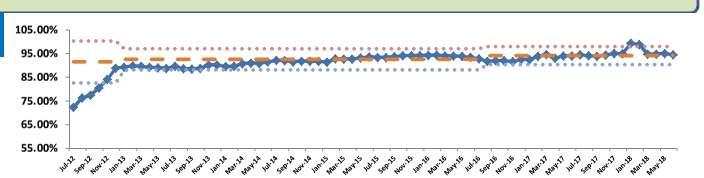
5.1 Sickness Rate

YTD	4.05%
Target	3.90%
YOY Change	-0.40%
Bench mark	4.40%



5.4 Mandatory Training: Combined Compliance Rate

YTD	94.6%
Target	85.0%
YOY Change	-0.19%
Bench mark	86.80%

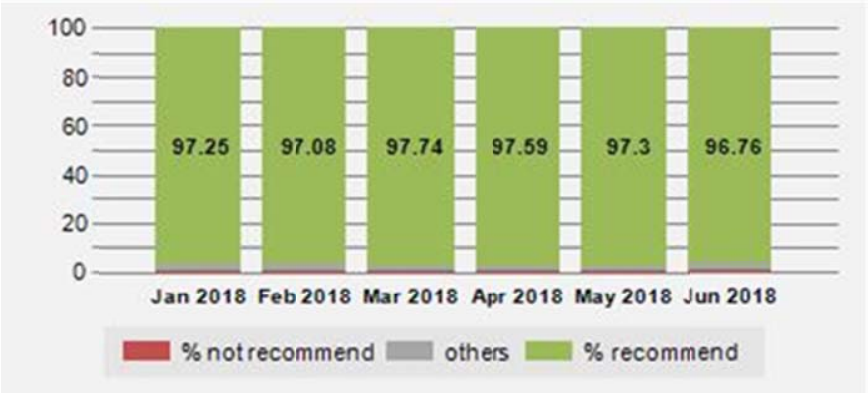


2.0 Quality Report

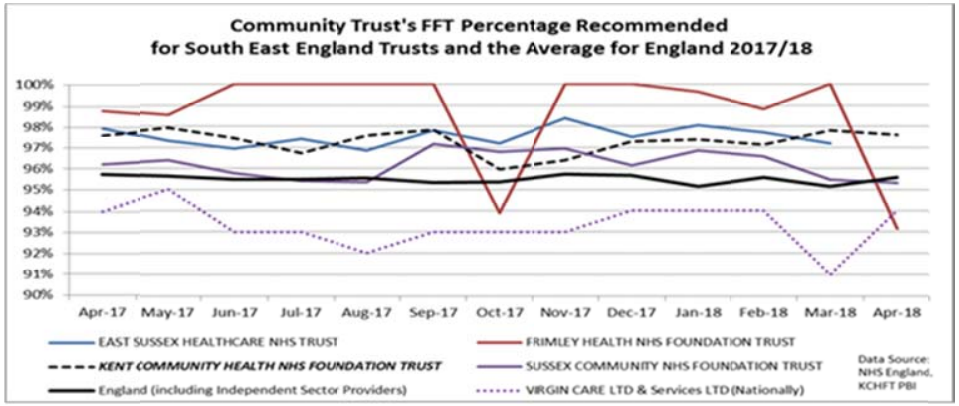
2.1 Assurance on Patient Experience

2.1.1 The NHS Friends and Family Test (FFT)

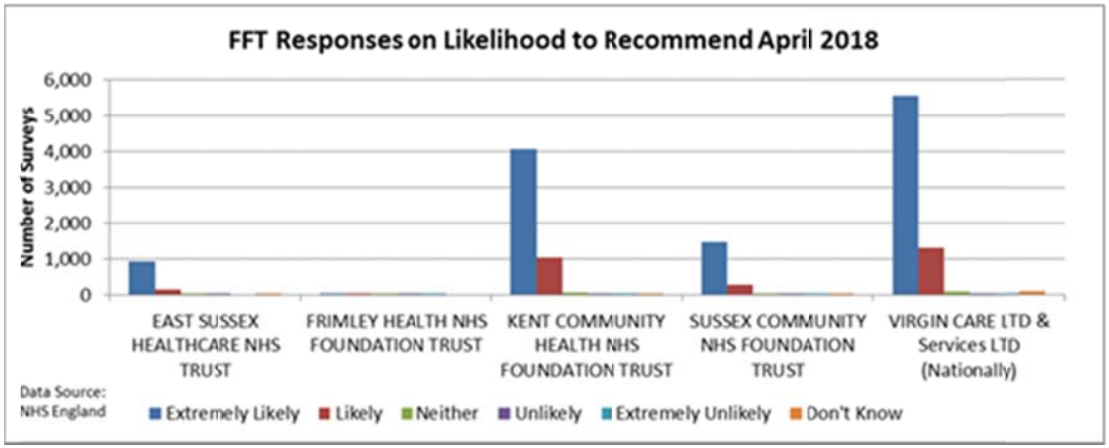
Score response comparison is shown below and satisfaction levels remain consistently high.



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



The following table benchmarks KCHFT in terms of numbers of surveys and outcomes (April 2018 data). This demonstrates that survey numbers are high and score outcomes are similar.



2.1.2 National Institute for Clinical Excellence (NICE)

The number of NICE guidance/ standards that were issued in June 2018 was fifteen.

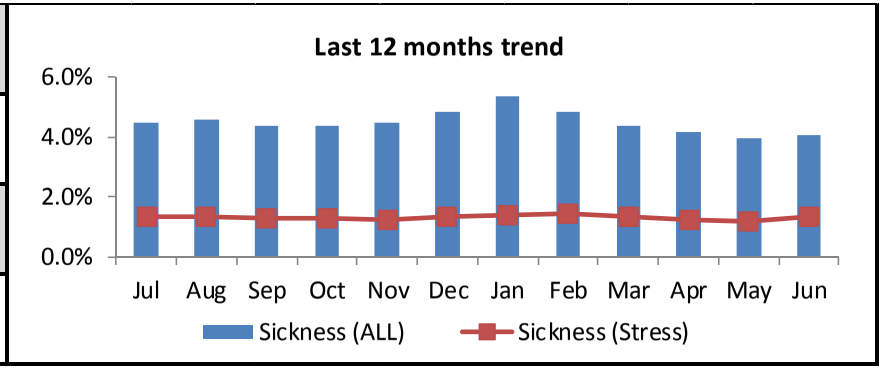
The number of guidance/standards issued in February 2018 that were due for assessment in June 2018 was twenty-two. Eight of the guidance/ standards issued were deemed applicable to at least one service throughout the Trust.

3.0 Workforce Report:

3.1 Assurance on Sickness

3.1.1 Sickness Absence

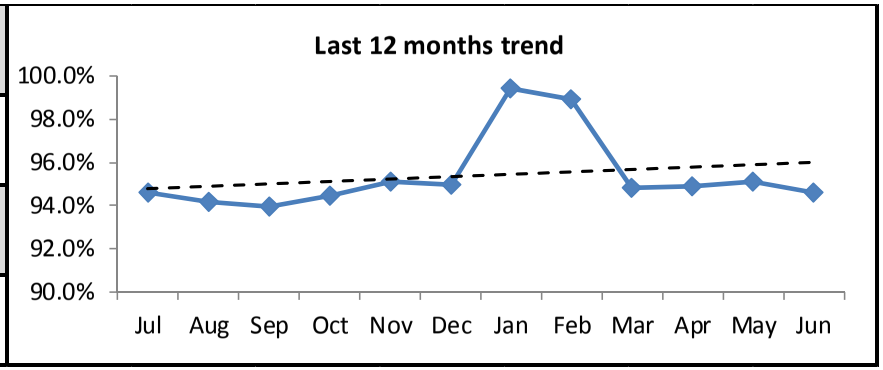
Current Month	**4.05%**
18/19 YTD	**4.05%**
17/18	**4.45%**
Annual Target	**3.90%**



Sickness remains above the Trust target at 4.47% (target 3.90%). However, June saw a decrease in the from May (4.47%). Nationally Community Service providers average a sickness rate of 4.68%.

3.2 Assurance on Training Compliance

Current Month	**94.6%**
18/19 YTD	**94.6%**
17/18	**94.8%**
Annual Target	**85.0%**



Mandatory training decreased from 95.1% in May to 94.6% in June, whilst appraisals increased to 99.4%.

4.0 Finance Report:

4.1 Assurance on Financial Sustainability

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	619	539	80
Year End Forecast £k	3,128	3,128	0

The Trust achieved a surplus of £620k to the end of June.

Pay and depreciation/interest have underspent by £2,966k and £29k respectively and non-pay has overspent by £2,094k.
Income has under-recovered by £820k.

The forecast is to deliver a surplus of £3,128k which is in line with the plan for the year.

Use of Resource Rating — Rag rating: Green

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

The Trust has scored the maximum '1' rating against the Use of Resource rating metrics for M3 2018-19.

CIP — Rag rating: Amber

	Actual	Plan	Variance
Year to Date £k	744	1,047	-303
Year End Forecast £k	4,080	4,080	0

The Trust achieved CIPs of £744k to the end of June against a plan of £1,047k, which is £303k behind target.

71% of the total annual CIP target has been removed from budgets at month three.

The Trust is forecasting to achieve the full plan of £4,080k by the end of the year.

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	21,829	23,176	-1,347
Year End Forecast £k		26,357	

Cash and Cash Equivalents as at M3 close stands at £21,829k, equivalent to 37 days operating expenditure.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	484	1,176	692
Year End Forecast £k	3,485	3,485	0

Capital Expenditure year to date is £484k, representing 41% of the YTD plan.
The full year plan is £3.5m and the Trust expects to utilise this in full.

Agency Trajectories — Rag rating: Green

	M3			YTD		
	Actual £	Trajectory £	Variance £	Actual £	Trajectory £	Variance £
External Agency Expenditure (inc. Locums) £k	375	628	253	1,011	1,884	873
Locum Expenditure £k	59	106	48	152	319	167

External Agency Expenditure (Inc. Locums) was £375k against £628k trajectory in June.
(YTD £1,011k against £1,884k trajectory).
Locum Expenditure in June was £59k against £106k trajectory.
(YTD £152k against £319k trajectory).

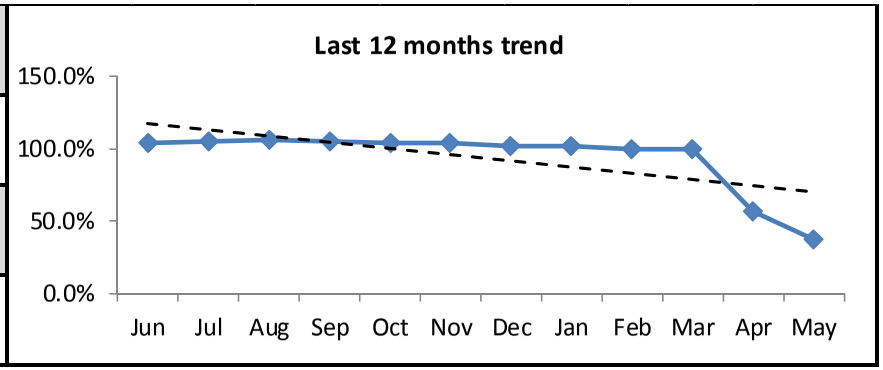
5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits

Health Checks

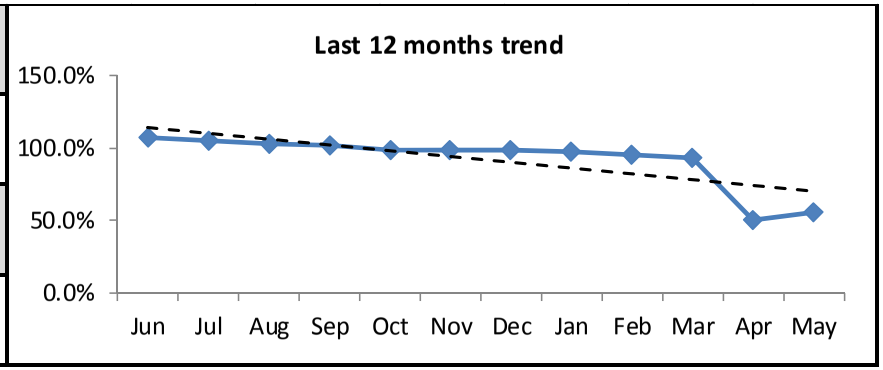
Current Month	**37.8%**
18/19 YTD	**37.8%**
17/18	**100.2%**
Annual Target	**100.0%**



The NHS Health Checks IT infrastructure changed on the 1st April 2018. This is a new IT system procured by KCC. There have been some problems with loading software on the new system and consequently the practices have been unable to invite their population for 18/19. This has delayed some practices by 2.5 months.

Stop Smoking Quits

Current Month	**55.4%**
18/19 YTD	**55.4%**
17/18	**93.8%**
Annual Target	**100.0%**



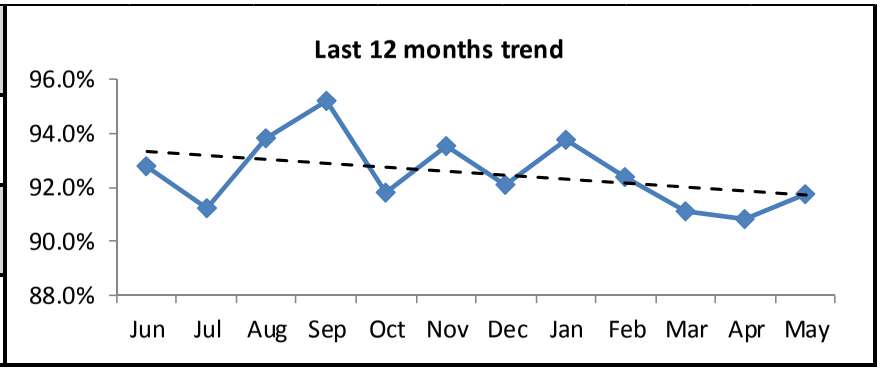
The ONE YOU Services has implemented a new IT system combining three client pathways into one as per the new contractual agreement with KCC. The focus for the ONE YOU Smoke Free service has been to work with the third party providers to update their outcome data for quarter 4 and DOH

report was sent on 14th June 2018. There have been some issues with the new IT system and the service now has a focus on supporting the third party providers so that they can update the data management system with new clients entering the service from 1st April 2018. The numbers are lower and the service will work hard to get the IT system up to date. May has seen some recovery improvements following the action plans in place.

5.1.2 Health Visiting

New Birth Visits

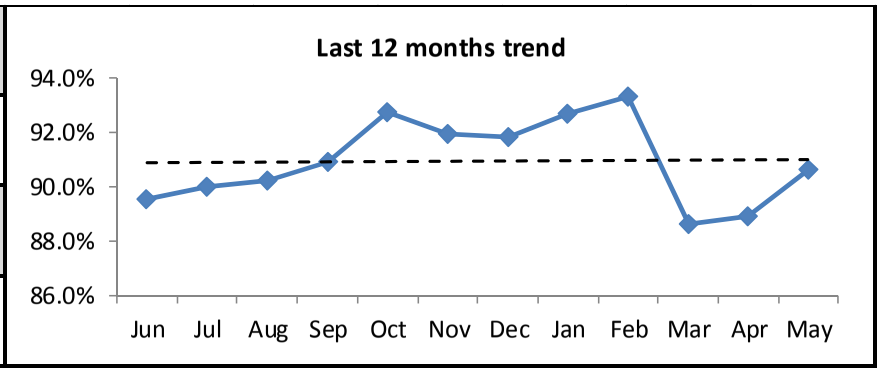
Current Month	**91.8%**
18/19 YTD	**91.3%**
17/18	**92.5%**
Target	**90.0%**



Performance steadily increased during 17/18 with a year-end performance of 92.5%. A slight downward trend had started to occur but has improved to 91.8% in month 2, with the target of 90% being consistently achieved.

6-8 Week Checks

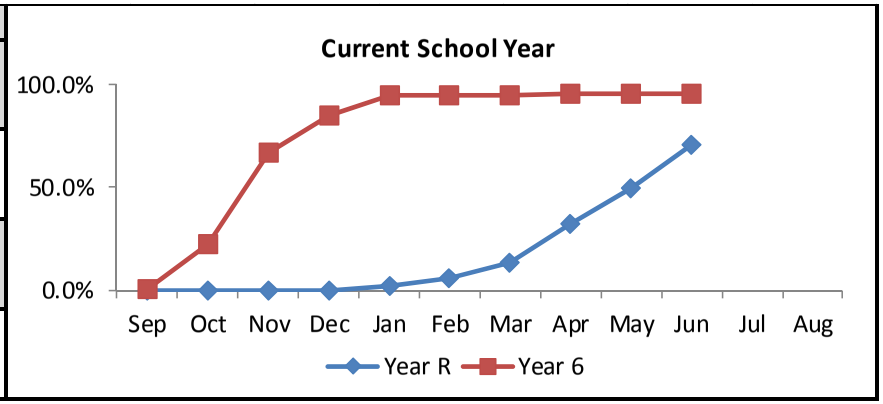
Current Month	**90.7%**
18/19 YTD	**89.8%**
17/18	**91.0%**
Target	**85.0%**



While March and April performance dipped to around 88-89%, the general trend is upwards slightly and beyond the target level of 85%, with May performance improving to 90.7%. Monthly processes continue to be in place for localities to drill down into any reasons for not meeting the targets and ensure accurate data reporting.

5.1.3 National Child Measurement Programme (NCMP)

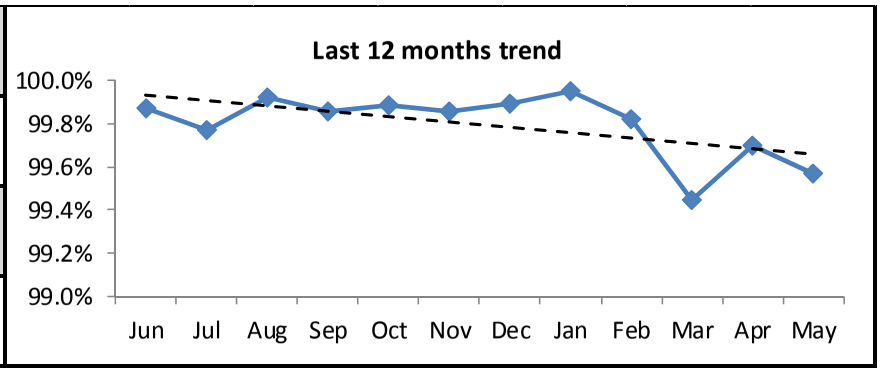
	Year R	Year 6
Current Month	**71.0%**	**95.5%**
17/18 School Year YTD	**71.0%**	**95.5%**
16/17 School Year	**97.3%**	**95.7%**
Annual Target	**90%**	**90%**



The measurement programme for Year 6 pupils has been completed for the 2017/18 school year, with a 95.5% completion rate, slightly down on last year. At the end of June the reception year measurement programme had reached 71%, with the programme expected to have been completed by the end of July 2018

5.1.4 Minor Injury Units (MIU) 4 Hour Wait Target

Current Month	**99.6%**
18/19 YTD	**99.6%**
17/18	**99.8%**
Target	**95.0%**



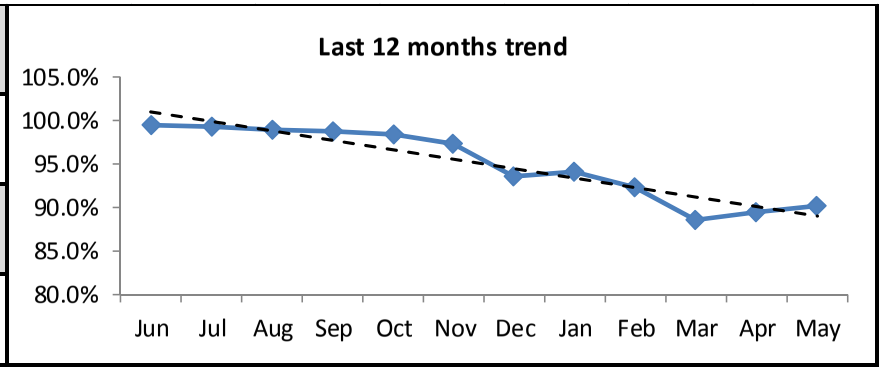
KCHFT's achievement of the 4 hour wait target for Minor Injuries Units has consistently been high, with 99.8% seen within 4 hours in 2017/18. However, there has been a slight increase in the number of breaches in the last couple of months, although this has still been a small proportion of attendances, with March performance the lowest at 99.4%.

5.1.5 GUM 48hr

Access to GUM clinics within 48hrs has been consistently 100%, with no reported breaches

5.1.6 Consultant-Led RTT Incomplete Waits Over 18 weeks

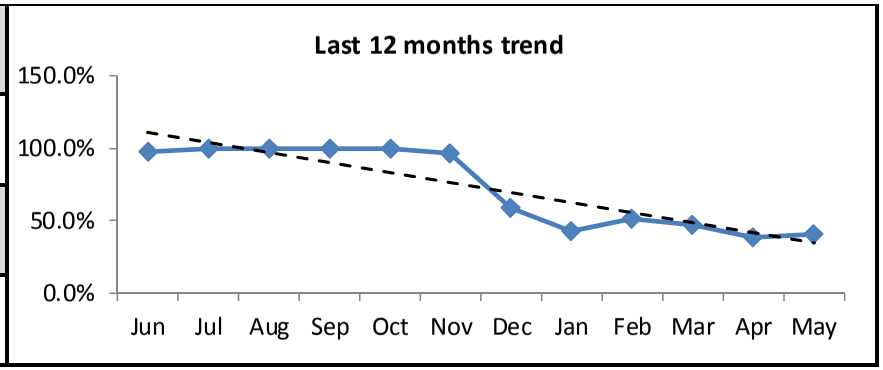
Current Month	**90.3%**
18/19 YTD	**89.9%**
17/18	**96.7%**
Target	**92.0%**



The proportion of patients on a consultant-led Referral to Treatment (RTT) pathway at month end who are waiting less than 18 weeks has slowly worsened since August 2017. The vast majority of our incomplete pathways over 18 weeks are within our Adult Chronic Pain service. There has been a marginal improvement in the last 2 months, which is expected to continue over the summer.

5.1.7 6 Week Diagnostics (Audiology)

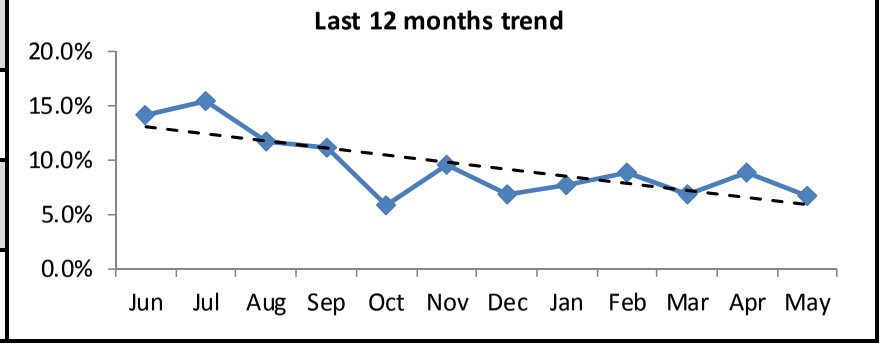
Current Month	**40.4%**
18/19 YTD	**39.7%**
17/18	**82.6%**
Annual Target	**95.0%**



There has been a downward trend since October 2017, prior to this KCHFT were consistently achieving 100%, with very occasional breaches. However, due to reduced capacity (vacancies), a backlog has grown causing a number of breaches. While the May performance has only marginally improved to 40.4%, the number of existing breaches on the caseload had significantly improved, with June performance onwards expected to show a more positive outlook.

5.1.8 Delayed Transfers of Care (DTOCs)

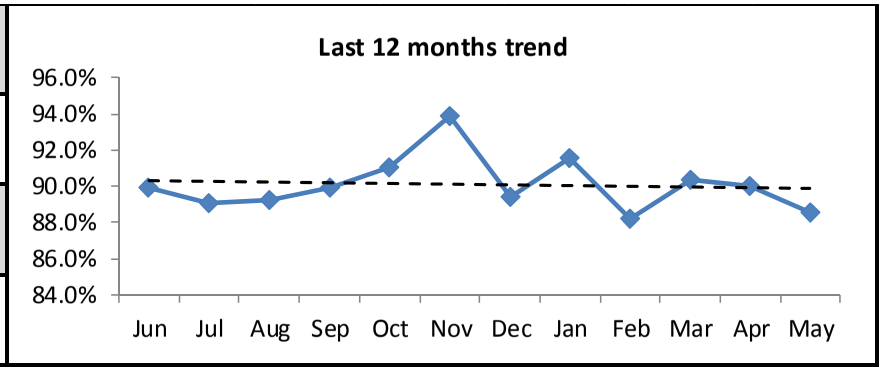
Current Month	**6.7%**
18/19 YTD	**7.8%**
17/18	**10.2%**
Annual Target	**9.5%**



KCHFT's target for delayed transfers is to reduce to an average of 7 per day in both east Kent and west Kent, which equates to around 9.5% as a rate of occupied bed days. While the 17/18 achievement was higher than this at 10.2%, there has been a reducing trend with Month 2 at 6.7% (7.8% YTD)

5.1.9 Bed Occupancy

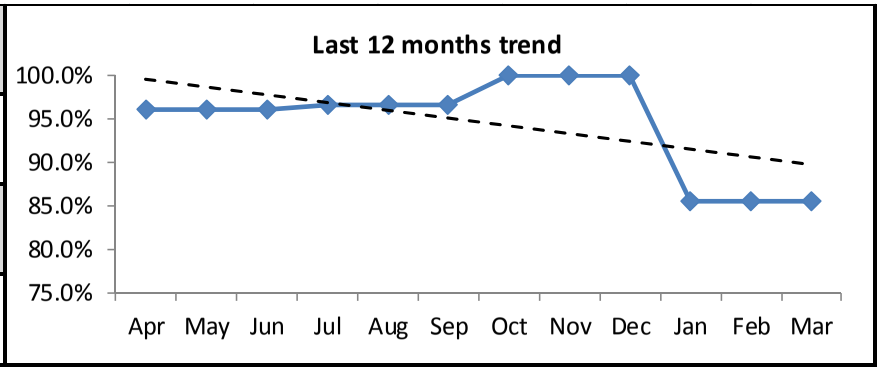
Current Month	**88.6%**
18/19 YTD	**89.3%**
17/18	**90.5%**
Target	**88-92%**



Bed Occupancy has shown a relatively static trend across the last 12 month, although month 2 is slightly below the 17/18 performance at 88.6%. However, this is still within the ideal threshold of 88-92%

5.1.10 CQUIN

Current Quarter	85.6%
18/19 YTD	Not Yet Available
17/18	94.6%
Annual Target	100.0%



Estimated final outturn for CQUIN for 17/18 was placed at 94.6%, with the Q4 achievement estimated to be 85.6%. CQUINs are now in place for 18/19 and the estimated Q1 achievement will be reported to the August board.

5.2 Assurance on activity and productivity

5.2.1 Activity

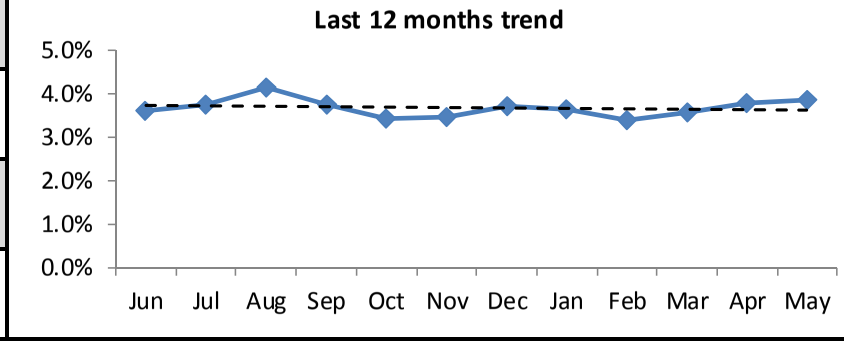
Service Type	M2 Actual	YTD Actual	YTD Target	YTD Variance	Movement	Contract BRG
Long Term Conditions	54,113	104,783	111,731	-6.2%	Positive	
Intermediate Care	19,763	38,736	42,093	-8.0%	Positive	
MIU Attendances	11,441	22,010	19,012	15.8%	Positive	
Community Hospital Admissions	213	499	303	64.5%	Negative	
Community Hospital Occupied Bed Days (WK)	2,192	4,315	4,369	-1.2%	Positive	
Specialist and Elective Services	27,772	54,407	56,844	-4.3%	Positive	
Children's Specialist Services	14,732	27,156	25,533	6.4%	Positive	
Dental Service - All currencies	8,320	16,474	20,923	-21.3%	Positive	
Health Trainers	DCU	DCU	484	DCU	Static	
All Services (contractual)	**138,546**	**268,380**	**281,293**	**-4.6%**	Positive	

Contract
>+10%
>-10%
<+/- 10%

During May 2018 KCHFT carried out 202,298 (138,546 for services with a target) clinical contacts, of which 11,441 were MIU attendances. For the year to May 2018 KCHFT are 4.6% below target for services that have contractual activity targets in place, an improvement on the April position. The largest variances are within Long Term Conditions (-6.2%), Intermediate Care Services (-8%), Specialist and Elective Services (-4.3%) and Dental Services (-21.3%).

5.2.2 DNA rates

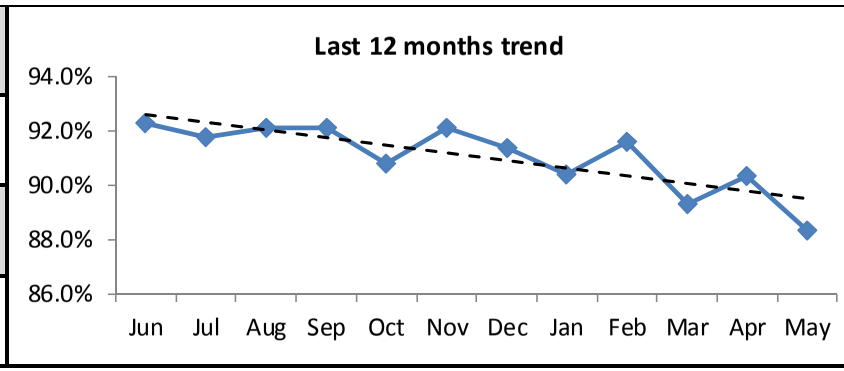
Current Month	**3.8%**
18/19 YTD	**3.8%**
17/18	**3.7%**
Annual Target	**5.0%**



DNA rates continue to fall below the target of 5%, although are significantly higher within some services, particularly children's therapies. The general trend over the last 12 months is slightly downward, although the last 3 months have shown a small increase in DNA rates.

5.3 Outcomes

Current Month	**88.4%**
18/19 YTD	**89.4%**
17/18	**91.8%**
Annual Target	**80.0%**



Aggregate outcomes are currently reported for Adult Specialist and Children's Therapy services, with patients receiving a favourable outcome in the vast majority of cases on a consistent basis, although they have marginally reduced in the last couple of months. It is hoped to start included outcomes for further services throughout 18/19 due to the introduction of Personalised Care Plans (PCPs) and goal achievement on CIS.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	2.6
Subject:	Six Monthly Community Hospitals Safer Staffing Review
Presenting Officer:	Ali Carruth, Chief Nurse

Action - this paper is for:	Decision	X	Assurance	☐

Report Summary (including purpose and context)

This paper provides a full review of the staffing levels required to provide safe care in inpatient wards of community hospitals. The review involved an audit of patient acuity and dependency, assessment of quality metrics and the professional opinion of the ward matron.

It was demonstrated that the acuity and dependency of patients is stable on the majority of wards and the patient safety and experience profile remains positive.

The recommendation is that there are no changes required to staffing over the next six months.

Proposals and /or Recommendations

The Board is asked to review the information in the Safer Staffing Report and to agree the proposal that there are no changes required to the staffing profile at this time.

Relevant Legislation and Source Documents

Care Quality Commission (CQC) fundamental standards

Has an Equality Analysis (EA) been completed?

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

Ali Carruth, Chief Nurse	Tel: 01622 211920
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Kent Community Health NHS Foundation Trust

COMMUNITY HOSPITALS SAFER STAFFING REVIEW

1. Introduction

1.1. Patients have the right to be cared for by appropriately qualified, and experienced clinical staff. The National Quality Board (2016) expects the Trust to ensure safe, effective, caring, responsive and well-led care on a sustainable basis, and that the Trust will employ the right staff with the right skills in the right place and at the right time. It is expected that safe staffing reviews will be reported to a Public Board twice a year, and the Board last received a review in January 2018 with data relating to May to November 2017.

1.2. To demonstrate the Trusts commitment to the above requirement, a twice yearly assessment and evaluation is undertaken in all community hospital wards. In addition to this, staffing levels are monitored daily with the option to request additional short term resource, should the acuity and dependency of patients on the ward increase. Fill rates are reported to Board monthly.

1.3. KCHFT Board is committed to ensuring safe staffing in all services. As the Community Hospitals are essentially nurse led, and are isolated units, the Board has committed to ensuring the safety of patients by having no less than 2 Registered Nurses (RN) on any given shift. In recognition that rehabilitation patients require a higher level of the key fundamentals of care, it is considered appropriate to have a higher skill mix of Health Care Assistants (HCA) to registered nurses than would be the case in an acute ward. This is monitored and reported to Board monthly by the Chief Nurse.

1.4. The Ward Matron is not included in the staffing numbers and is supervisory, allowing time for management and leadership duties to be undertaken, as well as mentoring and supporting of staff.

2. Background

2.1. An accurate calculation of staffing levels to provide safe care is a crucial part of the planning of clinical care; however there is an absence of national guidance for undertaking reviews on smaller wards. Therefore the Trust has developed a robust methodology for undertaking the assessment that reflects the principles of work undertaken nationally related to calculating safer staffing levels (Safer Nursing Care Tool 2013, NICE SG1, July 2014, Nurse Staffing Levels, Wales 2016). The principles remain the same in that the three elements of patient acuity, quality indicators, and professional judgement, as pictured in the below diagram, are considered independently and form the basis on which to make an informed judgement regarding safe staffing levels.

2.2. KCHFT is commissioned to provide rehabilitation inpatient care and the wards predominantly care for older patients. It is well recognised that older patients often have complex care needs and may have significant levels of dependency, and wards therefore require a workforce with time to deliver appropriate care in a dignified manner.

2.3. The current review process takes account of nursing staff, registered nurses, assistant practitioners and health care assistants. It is anticipated that the next audit in 6 months will include the ward based physiotherapists and occupational therapists.

2.4. The last review in November 2017 found that acuity and dependency of patients had reduced slightly since the previous audit. Key safety and quality metrics for each hospital had remained stable over the 6 month period, indicating that there had been adequate staff numbers to provide safe care for patients. It was evident that the quality of care had generally improved and patient experience was very positive.

3. Methodology of review

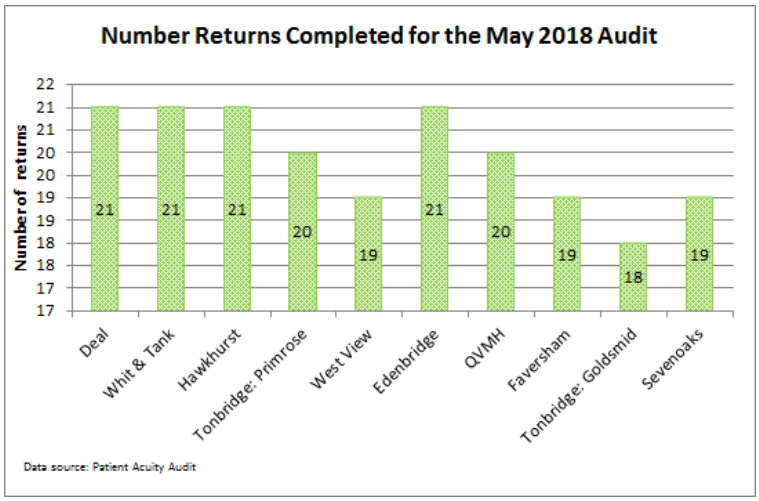
3.1. Findings of a 21 day audit undertaken during May/June 2018 were analysed. The audit focused on the acuity/dependency of the patients with an allocation of a Red/Amber/Green rating to each bed, as described in appendix 2.

3.2. A review meeting was held with the ward matrons and the Assistant Director of Patient Safety and Experience. The review included analysis of six months of quality data for the period of December 2017 to May 2018.
The data focused on:

- The quality indicators of avoidable falls, medication incidents, avoidable pressure harms and serious incidents
- Patient experience feedback and complaints
- Professional opinion of the Matron, including any relevant information regarding the ward layout.

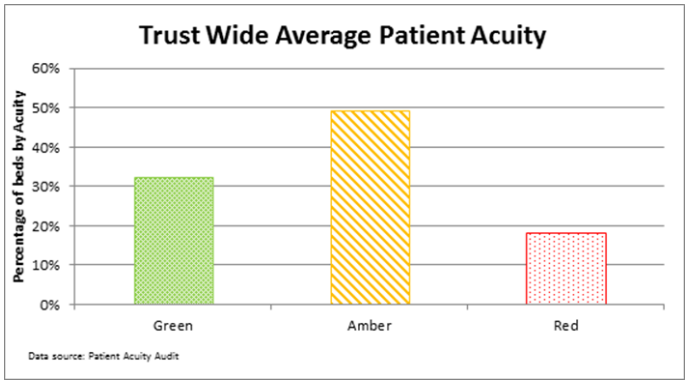
4. Summary of findings

4.1. Whist wards were requested to submit data for a 21 day period, and where data was incomplete or there were empty beds data was generated by taking an average of the other days. The number of returns is detailed by ward in the graph below.

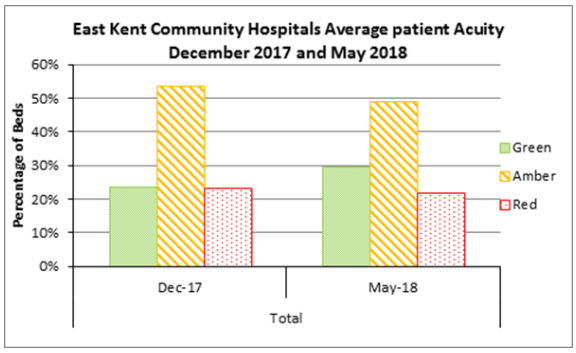


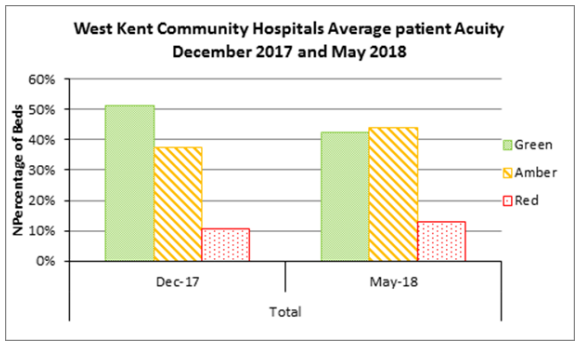
4.2. **Trust wide acuity and dependency**

The data demonstrates that over period December 2017 to May 2018, 50% of the patients cared for in KCHFT wards had moderate care needs, which is to be expected in patients who are rehabilitating and just over 30% were fairly self caring as they prepare for discharge. It is of note that almost 20% of patients were significantly dependant requiring high levels of support and nursing care.

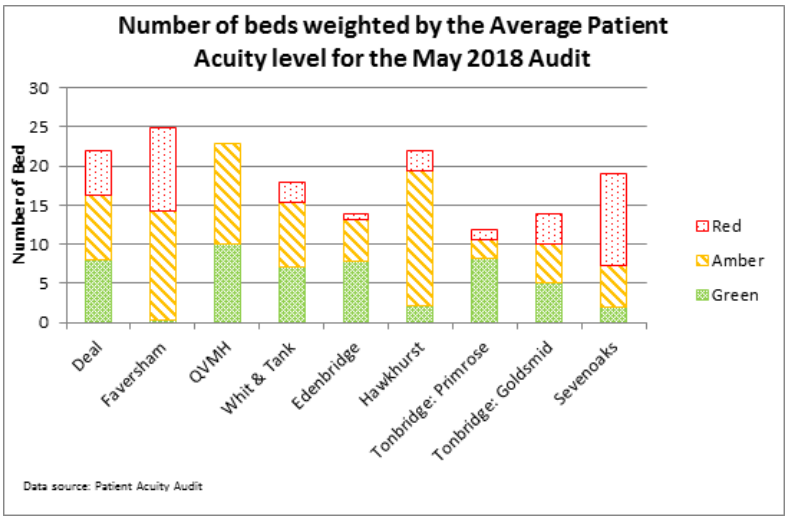


4.3. When the data is split by east/west it is evident from the below tables that the acuity/dependency of patients in the east had slightly decreased, and in the west it has slightly increased, mainly influenced by the changes at Sevenoaks and Hawkhurst.

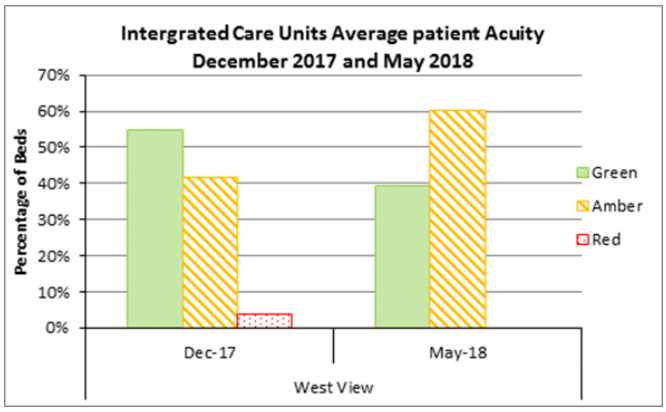




4.4. The below table demonstrates that the wards with the highest dependency are Sevenoaks and Faversham. Most wards have at least one third of patients who are in the green category and would be fairly self caring, the exceptions to this are Faversham, Hawkhurst and Sevenoaks. A data comparison chart of audit data from November and May is detailed at Appendix 1.



The integrated unit has been separated from the other wards as this is contracted differently, and is registered to Kent County Council. The ward has 15 health beds and 10 social care beds but had a number of empty beds during the audit due to a change in the admission process. It is staffed by a mix of NHS staff and KCC staff. Data suggests that acuity has slightly increased.



5. Patient safety metrics

5.1. Key safety and quality metrics for each hospital have remained stable between December 2017 and May 2018 indicating that there have been adequate staff numbers to provide safe care for patients. The safety profile on the wards continues to be good, there have been are no pressure ulcers and on most wards medication incidents have reduced. There has been a slight increase in falls with fracture, one at Deal, one at Edenbridge, and two at Westbrook, each have been raised as serious incidents, thoroughly investigated and the learning shared. When compared with the previous six months in the chart below, it is evident that in most areas, the quality of care has improved. No ward is demonstrating a trend of metrics to cause concern. Importantly, patient experience remains especially positive with the Friends and Family Test at 100% at Deal, QVMH and Tonbridge Goldsmid.

Comparison of quality metrics for December 2018 to May 18

Hospital	Avoidable Falls with Fracture		Avoidable Medication Incidents		Avoidable Pressure Ulcers		Serious incidents		Patient Complaints		FFT scores		Overall satisfaction scores	
	05/17-11/17	12/17-05/18	05/17-11/17	12/17-05/18	05/17-11/17	12/17-05/18	05/17-11/17	12/17-05/18	05/17-11/17	12/17-05/18	05/17-11/17	12/17-05/18	05/17-11/17	12/17-05/18
Deal	0	1	9	5	0	0	0	1	1	2	100.00%	100.00%	96.31%	93.44%
Faversham	1	0	11	4	0	0	1	0	3	3	98.55%	98.33%	98.61%	97.88%
QVMH	0	0	20	6	0	0	0	0	2	1	91.89%	100.00%	84.74%	87.58%
Whit and Tank	0	0	5	10	0	0	0	0	1	0	100.00%	97.22%	97.74%	94.67%
Hawkhurst	0	0	4	9	0	0	0	0	0	1	100.00%	98.25%	93.80%	91.09%
Sevenoaks	0	0	8	10	0	0	0	0	3	1	97.94%	93.65%	91.88%	90.54%
Edenbridge	0	1	15	3	0	0	0	1	0	1	97.47%	98.11%	93.32%	97.68%
Tonbridge Goldsmid	0	0	10	12	0	0	0	0	0	2	97.62%	100.00%	95.69%	95.61%
Tonbridge Primrose & Sommerhill	0	0	2	10	0	0	0	0	0	0	98.11%	96.08%	89.25%	89.44%

Westview	0	2	1	0	0	0	0	2	0	0	n/a	n/a	n/a	n/a
Total	**1**	**4**	**85**	**69**	**0**	**0**	**1**	**4**	**10**	**11**	**97.72%**	**97.95%**	**93.48%**	**93.10%**

6. The professional opinion of the Ward Matrons

East Kent: (Deal, Faversham, Herne Bay and Whitstable and Tankerton)

- Matrons stated that they were generally satisfied with the staffing numbers and the skill mix.
- Faversham has a higher turnover of patients than other wards, with more non- weight bearing patients. There is no identifiable reason why this is the case. The Matron plans to skill mix her team to increase the staff on the ward at peak admission times and consultant rounds, the ward will continue to have 2 registered nurses on each shift. There have been 3 complaints and there are no common themes to these.
- The wards are in various stages of recruitment for appointment of a therapeutic worker post for each ward. QVMH has a full time staff member in post and this has made a significant impact on reducing the demands on clinical staff, Deal has temporary cover as the post holder is on maternity leave and Whitstable & Tankerton and Faversham are still recruiting.
- Matrons confirmed that they are able to request additional temporary staff when acuity was higher, or when they had more dependent patients.
- All the wards have volunteers to support activities for patients, Faversham has the most at 8 hours, QVMH, Deal and Whitstable and Tankerton have 1-2 hours of support.

West Kent (Tonbridge, Edenbridge, Hawkhurst and Sevenoaks)

- The ward Matrons felt the audit was an accurate reflection of the ward.
- Sevenoaks Matron confirmed that the audit reflected the ward accurately. She reported that there are more dependent patients on the ward and this is due to patients with cognitive impairment. The additional HCA at night, which was added following safety concerns in the last safer staffing review (10pm-6am), is working well. The ward has approximately 8 hours of volunteer help a week which is well used to provide activities for patients.
- Summerhill & Primrose, the therapy ward, has had an additional RN on each shift to provide a level of registered nurse input to the patients with a higher level of acuity. There has been a slight increase in medication incidents but this is being managed. There has been a number of agency staff on the wards, especially registered nurses.
- Tonbridge has had some challenges in terms of staffing, especially registered nurses and then supervisory nurse then converts her shift to clinical. They have volunteers supporting ward work for approximately 8 hours a week.
- The audit demonstrates that Edenbridge have the least dependant patients, however they have had a number of vacancies and have not always been able to fill shifts. They also have an additional HCA at night, added to the substantive staffing following safety concerns in the last safer staffing review and this is working well. This ward has 6 volunteers who work on the ward equating to about 15 hours.
- Hawkhurst has shown an increase in patients with a higher level of dependency and acuity, and the Matron reports that this is due to patients with cognitive impairment. Following a period of high vacancies there has been some successful recruitment, but there continue to be vacancies. The Matron reported that morale is high, and staff are resilient.

- Matrons confirmed that they are able to request additional temporary staff when acuity was higher, or when they had more dependent patients.

Westview

- An Advanced Clinical Practitioner (ACP) is now working on the ward and has trained staff to enable them to accommodate more complex patients. She confirmed that the audit results were reflective of the ward cohort and that the current staffing is satisfactory. The acuity and dependency has increased since Westbrook unit closed. They currently have 25 beds open and were not at full capacity over the audit period.

7. Recommendations

7.1. Overall, the acuity of the patients has reduced slightly in the east and has increased in the west. This is mainly due to the number of patients being admitted with cognitive impairment. Comparison data is set out in Appendix 1 with the staffing levels by ward.

The therapeutic workers, where in place are working very well. Some wards are maximising the support of volunteers with good effect. Quality and safety metrics remain very positive with an improving picture in reduction of harms for patients and very positive patient experience.

The Chief Nurse therefore is not recommending any additional staffing in the community hospitals.

8. Conclusion

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

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

The Board is asked to note the information in the Safer Staffing review and to agree that the staffing establishment should remain the same.

Ruth Herron
Deputy Chief Nurse
July 2018

Appendix 1 Audit Results May 2018

Staffing Calulations June 18					
Ward	**Beds**	**Audit results Nov 17**	**Audit results May 18**	**Supervisory time B7**	**Actual staffing**
Deal	22	4	8		2RN +2AP+3 HCA
		14	9	1	2RN+1AP+2HCA
		4	5		2RN 2HCA
Faversham	25	8	0		2RN +2AP+3 HCA
		13	14	1	2RN+1AP+2HCA
		4	11		2RN 2HCA
QVMH	23	5	10		2RN+4 AP/HCA
		14	13	1	2RN+1AP+2HCA
		4	0		2RN 2HCA
Whit & Tank	18	4	7		2RN+1AP+2HCA
		6	8	1	2RN+1AP+2HCA
		8	3		2RN 2HCA
Hawkhurst	22	7	2		2RN+1AP+3HCA
		12	17	1	2RN+1AP+2HCA
		3	3		2RN 2HCA
Sevenoaks	18	11	2		2RN+1AP+3HCA
		7	5	1	2RN+3HCA
		1	11		2RN 3HCA
Edenbridge	14	7	7		2RN+1AP+2HCA
		5	6	1	2RN+2HCA
		2	1		2RN+2HCA
Tonbridge: Goldsmid	14	8	5		2RN+1AP+2HCA
		5	5	0.6	2RN+2HCA
		1	4		2RN+1HCA
Primrose and Sommerhill		9	8		1AP+2HCA
	12	1	3	1	1AP+2HCA
		2	1		2HCA
Westview	Based on 20 beds, 15 Health, 5 Social Care	11	8		2RN+3HCA+3CARERS
		8	12	1	2RN+2HCA+2CARERS
		1	0		2RN+2HCA+2CARERS

Appendix 2

Green

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

Amber

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

Red

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

References

Nurse Staffing Levels (Wales) Act 2016 (2016) Statutory Guidance Welsh Government

Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time: Safe sustainable and productive staffing (July 2016) National Quality Board

Five Year Forward View (2014) NHSE

Health and Social Care Act (2012) UK Parliament

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

NHS Constitution for England (2013) Department of Health

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

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

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

Kent Community Health NHS
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	3.1
Subject:	Quarterly Infection Prevention and Control Report
Presenting Officer:	Ali Carruth, Chief Nurse and Director of Infection Prevention and Control

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

Report Summary (including purpose and context):

This paper provides a summary of infection prevention and control activity since the previous report presented May 2018.

- There were no *Clostridium difficile* Infections in May or June.
- There was one MRSA bacteraemia in June where KCHFT staff provided care, the PIR identified no learning for KCHFT.
- MRSA screening compliance for podiatry was 98% in May –pertaining to one patient who was not screened prior to surgery, and 100% in June.MRSA screening compliance for the community hospitals was 92% in May and 67% in June. This relates to 3 missed screens, one in QVMH in May and June, and one in Deal in June.
- In April there were 108 Ecoli bacteraemias reported in Kent, KCHFT staff provided care in 19 cases, 28 Kentwide Klebsiella bacteraemias, where KCHFT staff provided care in 7 cases, and 3 pseudomonas bacteraemias, with no KCHFT involvement.
- In May there were 126 Ecoli bacteraemias reported in Kent, KCHFT staff provided care in 12 cases, 36 Kentwide Klebsiella bacteraemias, where KCHFT staff provided care in 2 cases, and 12 pseudomonas, with 2 cases where KCHFT staff provided care. Of the E-coli cases 2 developed their bacteraemias in Whit and Tank hospital whilst inpatients, these are being investigated currently.
- In 2018/19 KCHFT have implemented a CAUTI/UTI reduction campaign, which will run concurrently with the wound management projects and WIRE project, to tackle the areas where our patients are most at risk of developing gram negative bacteraemias.
- The NHSI East Kent collaborative for reduction of Gram negative bacteraemias has commenced, and the Trust AD for Infection Prevention and Control is representing KCHFT.

- Across May and June the Trust are on trajectory to achieve the planned reduction for CAUTI's and UTI's – although there has been an increase in June of UTI's.

- Cleaning reports for April and May indicate compliance with national standards in all wards except Sevenoaks, where the standard has not been achieved for the preceding 2 months- The Head of facilities has put actions in place at this locality.

- Trust Compliance with hand hygiene training was reported as 90%, and mandatory training 96% in May. Compliance amongst clinical staff was 88.1% for hand hygiene, and 95.5% for mandatory training.

- The actions to close the enforcement notice from the Health and Safety Executive have been completed, and the notice has been lifted. Work is continuing to roll out the actions across the organisation for wider learning.

- There were 2 outbreaks in May, one confirmed norovirus, one diarrhoea and vomiting but with no pathogens found, and none in June. Nationally Measles continues to be reported at increased rates, and KCHFT have continues to raise awareness and work with Occupational Health to reduce the impact on KCHFT staff and patients.

- The Water Safety Committee continues to meet to highlight gaps in assurance, and evidence risk reduction actions.

- The Antimicrobial Stewardship committee continues to meet, currently focus remains upon collaborative working across Kent through CCG lead Antimicrobial stewardship groups.

Proposals and /or Recommendations:
For assurance only

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

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QUARTERLY INFECTION PREVENTION AND CONTROL REPORT

1. Introduction

The full content of this report was presented and discussed at the Quality Committee on 17 July 2018.

2. Clostridium difficile

Aim: The Trust aims to have no more than 4 cases of *Clostridium difficile* infections with no level 3 lapses in care. There have been no *Clostridium difficile* toxin positive infections cases in this time frame

3. MRSA

From 1 April 2018 MRSA bacteraemia cases are allocated as 'Pre 48 hour onset or Post 48 hour onset, and lessons learned identified for organisations and healthcare economies, therefore changing the way these cases are reported internally. Investigations continue into all cases where we have provided care, and the clinical commissioning group (CCG) or acute trust manage these investigations, with a co-ordinated response to any learning identified through organisational Infection Prevention and Control committees, and CCG quality meetings.

There was one MRSA bacteraemia in June where Kent Community Health NHS Foundation Trust (KCHFT) staff provided care, and following the PIR there was no identified learning for KCHFT.

In both May and June staff in Queen Victoria Memorial Hospital (QVMH) missed a patient screen, the Infection Prevention and Control (IPC) Team is working with the ward to address this, and have escalated this to the Matron and Head of Service. Deal missed one patient screen, and the IPC Team is working alongside the staff to address this. Separately, the IPC Team is also reviewing screening requirements for Trust patients admitted to community hospitals. In Podiatry in May, one patient was admitted for surgery who had not been MRSA screened, owing to the timeframe from referral to surgery. The Podiatric Team has a protocol in place for this – and the patient screened on arrival for surgery, operated on last on the list, and was provided with Octenisan washes for the postoperative phase, as per protocol.

4. Gram negative bacteraemias

There is no specific objective for KCHFT in relation to Gram negative bacteraemias, as currently cases are not attributed, however there is a national focus to reduce cases by 50% by 2021 –with a year on year plan to reduce by 10% in order to achieve that aim.

An amendment to the previous report – in 2017/18 South Kent Coast CCG did achieve its objective to reduce by 10% in 2017/18.

	April E-coli	May E-coli	April Pseudomonas	May pseudomonas	April Klebsiella	May Klebsiella
Kent total	108	126	3	12	28	36
KCHFT involvement	19	12	0	2	7	2

3 bacteraemias developed in a community hospital – 1 in Tonbridge and two in Whitstable and Tankerton. The Tonbridge case and one case from Whitstable and Tankerton identified lessons relating to documentation of observations following abnormal results, and this is being addressed as part of a wider project in recognition of the deteriorating patient training. All community cases are also investigated, and themes of lessons identified relate to specimen collection and result checks, complex patients with long term catheters, and no pathway or plan in place. The IPC Team is working with operational teams, and the wider health economy to address these issues.

The Assistant Director of IPC is part of an East Kent collaborative to reduce gram negative bacteraemias, and four projects are planned. The Assistant Director of IPC is taking over Chairship of the Kent wide HCAI reduction group from September 2018

5. CAUTI/UTI reduction

The aim for 2018/19 is to reduce CAUTI's to no more than 12 healthcare associated cases, and no more than 82 UTI's in the Trust's community hospitals.

The Trust is on trajectory to achieve this.

6. Cleaning

Standards in Sevenoaks have dropped in April and May predominantly due to staffing. This has resolved and the June results are above national standards.

7. Training

The Learning and Development Department collect and collate all training figures on behalf of the IPC Team – target - 85% compliance for all infection prevention and control training.

May training figures demonstrate Trust compliance with hand hygiene training at 90% and mandatory training 96% in May. Compliance amongst clinical staff was 88.1% for hand hygiene and 95.5% for mandatory training (June data was not available at time of reporting)

8. Health and Safety improvement notice

The Trust was served an improvement notice relating to a staff member with contact dermatitis associated with glove use and hand washing. All local actions have been completed, and the notice has been lifted, and KCHFT are currently rolling out training across the organisation to ensure learning is shared and actions are implemented Trust wide.

9**. Outbreaks and incidents**

There were two outbreaks in May; one norovirus and one Diarrhoea with no pathogens isolated. The wards remained open, and the affected patients were isolated in cohort bays. Nationally there continue to be norovirus outbreaks.

9.1 Measles

Nationally, measles continues to be identified in clusters, and in Kent there have been localised clusters. KCHFT has raised awareness through information on the Intranet, and informing staff face to face where possible. The Occupational Health Team has also undertaken an exercise to ensure they are aware of any staff who require vaccination. This process has also identified some staff who do not wish to be vaccinated, and the Occupational Health Policy has been revised accordingly, outlining actions to take if staff who are not vaccinated are exposed to viruses. The actions include temporarily moving staff to non-clinical situations, or, if required, staff to take leave (paid or unpaid) until the period of communicability has passed.

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. Currently the Trust has received 97% of data required for full assurance on water quality, safety and maintenance.

11. Antimicrobial Stewardship

The Antimicrobial Stewardship Committee continues to meet and implement actions from the 5 year plan. The group is already planning activity and awareness raising for the forthcoming months.

Lisa White
Assistant Director of Infection Prevention and Control
17 July 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	3.2
Subject:	Annual Infection Prevention and Control (DIPC) Report
Presenting Officer:	Ali Carruth, Chief Nurse and Director of Infection Prevention and Control (DIPC)

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)

This paper is the Annual DIPC Report 1 April 2017 – 31 March 2018.

- The Trust achieved the target of Zero attributable MRSA bacteraemias
- The Trust achieved its aim of having no more than five attributable *Clostridium difficile* infections, with a total of four reported cases
- MRSA screening targets were not fully met, achieving 99% compliance pertaining to one patient throughout the year not being screened as per policy
- Catheter associated urinary tract infections and urinary tract infection reduction targets were not achieved
- Gram negative bacteraemia surveillance was completed throughout the year
- Compliance with Infection Prevention and Control training was achieved strategically
- National guidance was analysed and incorporated into the annual work plan and policies
- Kent Community Health NHS Foundation Trust (KCHFT) continues to work collaboratively with the Kent-wide HCAI reduction group
- There were 13 outbreaks of infection throughout the year, closing inpatient beds
- The Trust remains strategically compliant with all aspects of the Hygiene Code.

Proposals and /or Recommendations

To note the report.

Relevant Legislation and Source Documents

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

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

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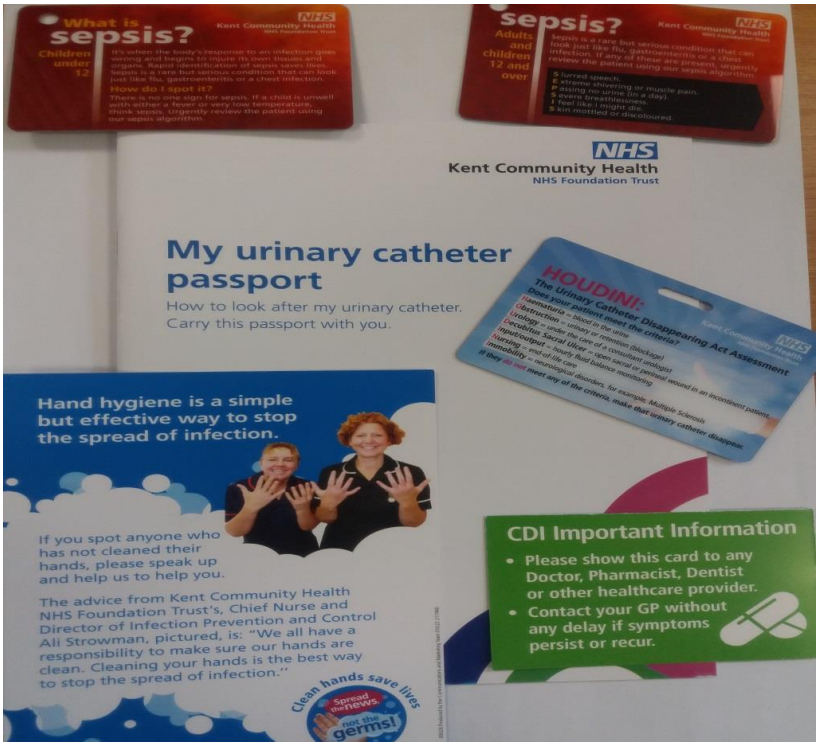
NHS Foundation Trust

Infection Prevention and Control Annual Report 2017/18



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

Executive Summary

Over the last year the Infection Prevention and Control (IPC) Team has supported the operational teams to deliver further improvements in infection prevention and control. This annual report provides a full account of this activity. In addition, new guidance and evidence has been reviewed and incorporated into policies, practice, education and guidance.

1.1 Director of Infection Prevention and Control (DIPC) assurance

The DIPC gives the following assurances on behalf of Kent Community Health NHS Foundation Trust (The Trust):

- The Trust is strategically compliant with the Hygiene Code
- 100% of patients presenting for elective surgery are MRSA screened at pre-assessment
- Every case of *Clostridium difficile* infection is investigated and a Root Cause Analysis completed to ensure lessons are learned and actions taken for non-compliance
- The Trust participates in the Post Infection Review process for all MRSA bacteraemia's as part of the whole systems approach to healthcare
- The Trust is undertaking surveillance on bacteraemias caused by Gram negative bacteria
- The IPC Team carries out an annual programme of audit as required by the Hygiene Code
- The Trust uses national cleaning specifications to determine cleaning frequencies and methodology within the healthcare environment and audit against these
- The Trust undertakes decontamination audits which report through the Infection Prevention and Control sub-committee
- The Trust sources Occupational Health provision from an external provider. Screening is carried out on all staff at pre-employment checks and further surveillance and screening is carried out at agreed intervals and as necessary
- The Trust has the required infection prevention and control arrangements in place.

2.0 Healthcare Associated Infection Surveillance

Indicator Description	Aim	Year Total
MRSA bacteraemia	0	0
MRSA screens for podiatric surgery % compliance	100	100
MRSA screens in Community Hospitals % compliance	100	99
Clostridium difficile infections	≤ 5 cases, 0 Level 3 lapses in Care	4 cases, no level 3 lapse in care
Hospital acquired UTI's (rate per 100,000 OBD's)	158	174
Hospital acquired CAUTI's (rate per 100,000 OBD's)	19	32.5

Gram negative bacteraemias	Kent total	KCHFT involvement
E-coli	1514	201
Klebsiella	359	58
Pseudomonas	143	34

2.1 *Clostridium difficile* 2017/18

The Trust achieved its target of no more than five cases of *Clostridium difficile* and no level three lapses in care, by reporting four attributable cases, with no level three lapse in care. A full Root Cause Analysis was undertaken on all cases, and all were deemed to be unavoidable and due to appropriate antimicrobial prescribing in the acute setting.

2.2 Meticillin Resistant *Staphylococcus aureus* (MRSA) Bacteraemias

For the fourth year running, there were no MRSA blood stream infections attributed to the Trust in 2017/18, although five cases where Trust staff were providing care were investigated – five less than last year. All were reviewed by a PIR panel, and communication systems improved between healthcare providers as a result.

2.3 MRSA Screening

The Trust continues to screen high risk patients admitted to its inpatient units and all patients undergoing podiatric surgery. 91 patients were admitted to the inpatient units who fitted the 'high risk' category and 90 were screened. Actions were implemented in the hospital where the omission occurred and this has not recurred in this or any other hospital.

2.4 Gram negative bacteraemia surveillance.

The Trust implemented gram negative surveillance from 1 April 2017 on all E-coli, Klebsiella and Pseudomonas bacteraemias. The Trust was not able to identify if the cases where they provided care had reduced by 10% (as per the national target to reduce E-coli bacteraemias) as there had been no previous surveillance. However, the Trust identified that the key interventions potentially associated with the bacteraemias were urinary tract infections / catheter associated urinary tract infections, and wounds. The Trust has a wound infection risk assessment tool (WIRE) currently piloted and launching, and a Trust -wide CAUTI/UTI reduction action plan, incorporating an awareness campaign, and implementing the 'HOUDINI' protocol, which assess the need for a catheter, and advises removal where identified.

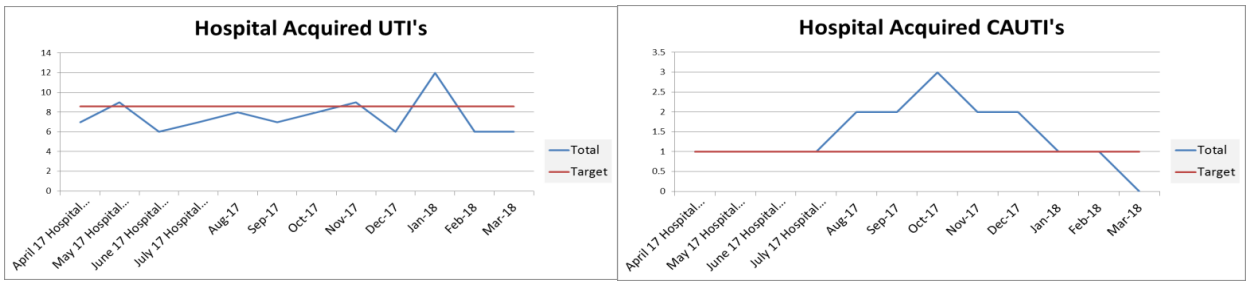
The Trust has also effectively worked collaboratively with all health and social care partners implementing a revised Catheter Passport, participating in a review of Kent-wide guidelines and pathways; and in East Kent, participating in training programmes in care homes. South Kent Coast CCG did achieve the planned 10% reduction in E-Coli bacteraemias.

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

The target for 2017/18 was to reduce CAUTI's by 15% and UTI's by 10% which the Trust failed to achieve, with a 1% reduction in UTI rates (per 100,000 OBD's) and a 33% increase in rates per 100,000 OBD's in CAUTI's. However, since the implementation of training and the reduction campaign, there were only two cases of CAUTI reported between January 2018 and April 2018.

Over the preceding four years the Trust had succeeded in reducing CAUTI's by over 40% and the Assistant Director for Infection Prevention and Control, Lisa White was invited to speak at a national conference about the Trust's success in reducing these infections, and presented at multiple national conferences throughout the timeframe, and highlighted how collaborative working impacted most.

Figure 3: Community Hospital acquired UTIs and CAUTI's



4.0 Outbreaks

In 2017/18 there were a total of 23 outbreaks, nine Confirmed influenza / respiratory, four confirmed norovirus, 10 Diarrhoea / vomiting unknown cause. Of these, whole wards were closed for seven outbreaks. For the remaining outbreaks, they remained contained within individual bays. In April there was one norovirus outbreak.

Of these, whole wards were closed for seven of the outbreaks. In all others, the outbreaks remained contained, and individual bays were closed, with the wards remaining open for admissions. This change in practice does not appear to have affected the length of outbreaks and has allowed the whole health care economy to continue using beds in affected areas.

5.0 Seasonal Flu Campaign

During 2017/18 flu season, staff were given the opportunity to be vaccinated against influenza in line with the Department of Health Staff Flu Programme. An in-house vaccination programme was run and 57% of patient facing staff were vaccinated, which is a 4% increase from the previous year.

Kent Community Health NHS Foundation Trust

6.0 Decontamination of medical devices

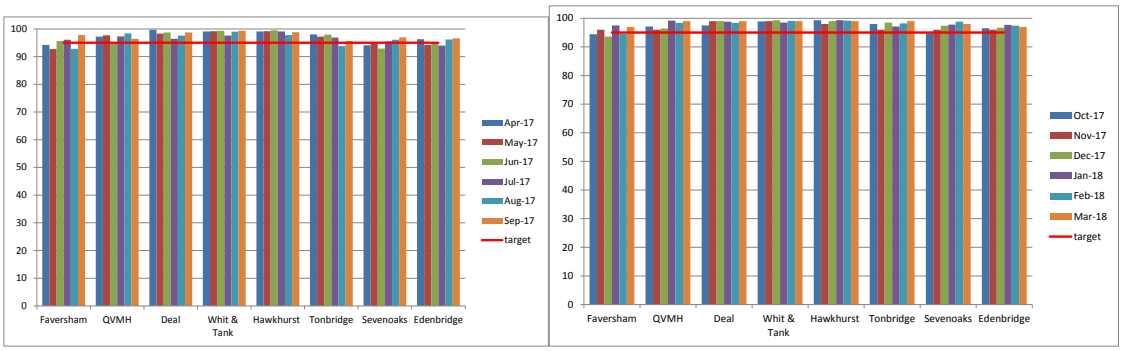
The Trust recognises the risks to patients, staff and others created by the use of medical devices. There is an operational system in place which manages the procurement, usage, maintenance and disposal of medical equipment, to meet the requirements of national legislation and NHS guidance and to make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

Decontamination processes are jointly managed and reported through the Trust. The IPC sub-committee receives exception reports and provides assurance for the Trust on all aspects of decontamination. The IPC Team undertakes audits in areas that utilise re-usable instruments; and in all outpatient departments and Dental services found full compliance with decontamination processes. The Trust Independent Authorised Engineer for Decontamination also verified the compliance of the Central Sterilisation Services that the Trust utilises, and continues to support the Dental Service in its centre where local reprocessing is undertaken.

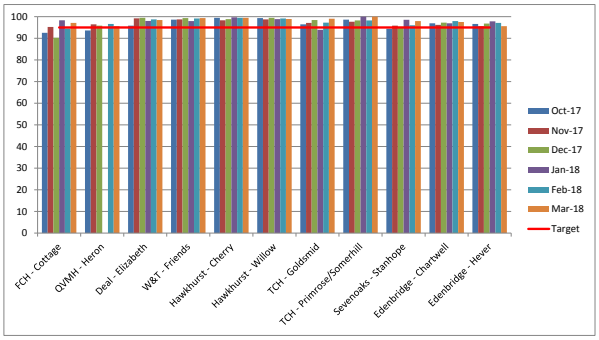
7.0 Cleaning Services

All Trust sites are monitored for cleanliness against NHS Standards Of Cleanliness 2007. The inpatient sites are in the high risk category with a compliance target for monitoring of 95%. Performance reports are provided to the IPC Team monthly.

The charts below show cleanliness monitoring results for the inpatient sites between April 2017 and March 2018.



The scores per ward are shown in the below chart for October 2017 – March 2018.



Cleaning scores continue to be presented six times a year to the IPC Committee. In 2017 changes were made to the report to include overall soft facilities management (FM) performance, including training compliance. In the last year, Gravesham, Sittingbourne and Sheppey hospitals inpatient units have transferred to Virgin Care and are no longer cleaned or monitored by the Soft FM Team.

The Trust has a loyal and hardworking Facilities Team and changes that have taken place in the last 12 months have served to support both the Facilities Team, clinical staff and improve infection control on the wards.

- New cleaning schedules have been produced and displayed on the wards for patients and visitors to see
- There has also been the introduction of independent quarterly monitoring by the Soft FM Team where audits are completed at a management level in conjunction with a senior clinical staff member. The results of these audits are published in the performance report to IPC
- Investment has been made on equipment, including floor machines and steamers
- Staff have received additional training on SOP's and COSHH
- A new induction booklet has been created and is being given to all new staff members. This contains useful information on training and also contains evidence pages for sign off of training
- All staff have been retrained on deep cleaning of clinical areas
- From February 2017 there has been a change to the management structure and the inpatient units have moved to different managers. This allows for a fresh pair of eyes to review process and performance.

7.1 Site Review

Throughout 2017/18, most sites continue to achieve an excellent standard of cleaning performance. A small number of sites require support and monitoring to ensure they are meeting the set standards. The below sites are being monitored and have had a management structure change to support this.

- Faversham – Continues to be challenged by senior staff sickness although in later months there has been a consistent improvement in the cleaning monitoring percentage
- QVMH – remains consistently around the 95% mark. A new supervision structure was introduced but was unfortunately faced with sickness within the structure; this has now been resolved and looks to have settled
- Sevenoaks – Challenges with sickness and recruitment continue with absence in supervision continuing due to maternity and sickness. This is being resolved with the support of the catering lead on site to provide on-site support to the staff and charge hand.

Plans for 2018 include the following

- Review of chemicals used to establish if better value and quality chemicals can be sourced
- The review of cleaning time and supervision will continue
- To increase the amount of independent monitoring that is completed
- Continued review of cleaning equipment on the market with trials where appropriate
- The planned increase in NHS pay scales (to be approved) will mean that the current Band One staff will increase in banding and pay bringing them to the national living wage range.

7.2 Patient Led Assessment of the Care Environment (PLACE) 2017

	Cleanliness	Food & Hydration	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
National	98.4%	89.7%	83.7%	94%	76.7%	82.6%
Community	98.6%	91.8%	83.7%	92.7%	80.6%	86.1%
KCHFT	96.93%	88.28%	73.47%	84.55%	66.86%	74.8%
Edenbridge	91.88%	92.41%	75.93%	81.21%	41.87%	52.61%
Hawkhurst	97.31%	85.24%	86.49%	95.7%	85.97%	89.22%
Sevenoaks	96.82%	93.7%	68.15%	75.44%	51.41%	68.06%
Tonbridge	100%	93.58%	79.49%	94.51%	81.94%	82.51%
Deal	96.43%	87.2%	72.45%	85.1%	66.47%	73.48%
Faversham	95.93%	83.16%	63.51%	72.02%	64.35%	70.19%
QVMH	96.92%	87.13%	66.86%	87.61%	66.74%	79.67%
Whit & Tank	98.75%	87.73%	77.98%	84.59%	64.66%	74.36%

The results from 2017 were below the levels the Trust requires and expects to see for its patients and service users.

Following the release of the results an action plan was created and a multi discipline working group including Estates, Facilities, IPC, NHS Property Services (NHSPS) and a patient representative met on a fortnightly basis to review actions and log progress.

Target times were issued to each action with some being able to be achieved prior to the start of the 2018 assessments. All reactive maintenance tasks were completed within the set timescale. Water coolers were installed into each ward to ensure patients and visitors had access to chilled water at all times (This is in addition to the ongoing water jug system still in place). It has been agreed that a decoration program will commence during the summer of 2018 to ensure compliance with condition and appearance criteria and the dementia criteria.

7.3 Preparation for 2018

On release of the questionnaires the Facilities Management Team will meet to discuss the organisational questions and complete the questionnaire for each site to ensure consistency across the organisation. Throughout each assessment on site the assessors will be prompted to refer back to the PLACE assessor training to achieve the answer appropriate for each element of the assessment. The Estates Management Team continues to work with the property landlords towards resolving any ongoing issues with the condition and appearance of the premises.

8.0 Estates

The IPC Team continues to work closely with the Trust's Estates Team in order to ensure the environment is conducive to the prevention and control of infections with continued interaction between teams. Information flow has improved and working relationships are excellent. The IPC Team continues to be involved at an early planning stage in refurbishments, new builds and projects which involve patient areas. Incident management processes have also been significantly improved and developed this year.

Estates project managers and operational estates managers continue to seek professional advice from infection prevention and control colleagues. Typical examples of this would be the interaction on the capital plan and site specific remedial actions required at community hospitals. Estates work very collaboratively on resolution of IPC related issues; in particular, the involvement in ward improvements in Herne Bay this year.

The IPC Team continues to risk assess any maintenance or construction activity to ensure the presence of construction workers does not pose a risk to the patients within the adjoining areas – including the removal of waste, reduction of dust within the environment and avoidance of contamination of the air supply and extract systems. The operational Estates Team has also undertaken further training within the last year to enhance and further improve its knowledge.

The Trust also has maintenance arrangements in place with NHSPS which have seen significant improvement in compliance responses and compliance remedial actions this year with the compliance trend being above the required threshold. This was informally audited this year and proved successful.

Significant work has been undertaken with regard to the commercial estate maintenance which was formerly managed by a partner trust. This has now been outsourced to a private provider and compliance control has significantly improved this year. The Trust now has direct control over its commercial estate and its contractors rather than through a third party. This will further improve information flow and timely receipt of information over the next 12 months.

The Trust's Water Quality and Safety Committee has been working with all partners to ensure the assurance is received by the Trust, in a timely manner, to enable any issues to be identified and rectified. The Trust's Water Safety Policy has been ratified and agreed by the Trust this year along with further improvements to incident control SOP's. The group has attendance from all partners and has made good progress this year, with regular reporting to clinical commissioning groups (CCGs) and the IPC Committee on water safety issues. The Trust has also improved formal training in water safety matters for key staff.

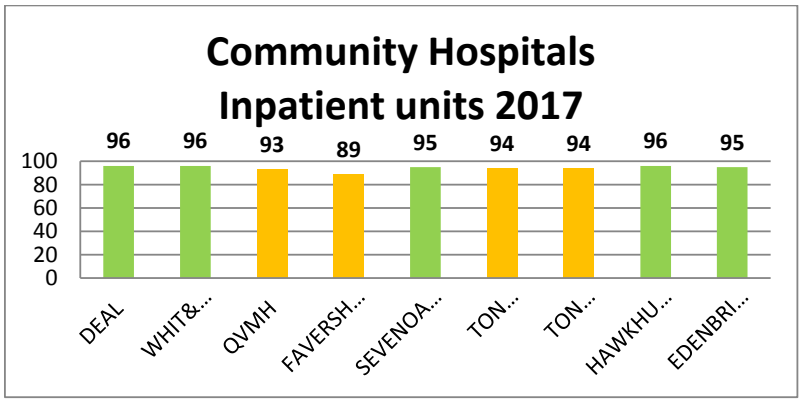
Last year's improvements to the estates on-call and incident processes have yielded a reduction in incident numbers over the year. This has improved interaction between the Estates Team to respond to issues where the IPC Team require estates involvement and action. A robust 24 hour on-call estates incident process is now well embedded into the organisation responding to IPC Team and Trust-wide issues, ensuring a robust system is in place to respond 365 days of the year. Staff had also benefitted from further training and mentoring in incident management and responses.

Last year's improvements to see more interaction between Estates and the Soft FM Team have also been actioned. The teams have been relocated together and a new Head of Soft FM appointed. The management team has also been aligned, further enhancing and improving the service provision within the Trust. Dashboard reporting is also now in place on a monthly basis providing key trend and Key Performance Indicator (KPI) information to the Trust.

9.0 Audit and Monitoring

The Essential Steps programme of self-assessment is in use in all community hospitals and appropriate clinical teams. This monitoring tool incorporates hand hygiene, urinary catheter care, IV devices care and enteral feeding. Results of this monitoring are managed and stored locally, and the results are reported to the IPC sub-committee twice annually.

During 2017, the IPC Team audited eight community hospitals against standards of infection prevention and control, laid out in the Hygiene Code (four hospitals previously audited changed provider within the year, therefore were not audited by the Trust).



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

Three hospitals received an AMBER rating: 89-94% compliance.

Two hospitals improved their scores from the previous year (Deal 96% previously 94%; Sevenoaks 95% previously 94%).
Six hospitals scored lower than 2016 (Faversham 89%, previously 95%; QVMH 93%, previously 97%; Whitstable and Tankerton 96%, previously 99%; Edenbridge 95%, previously 98%; Tonbridge 94%, previously 97% and Hawkhurst 96%, previously 98%).
Tonbridge - Summerhill/Primrose wards were not operational last year so comparisons cannot be drawn.

The three main areas for improvement this year were :

- The catheter care bundle documentation is not being comprehensively completed
- Cleaning schedules were not being comprehensively completed. A new cleaning schedule has been devised by the IPC Team and shared with Matrons who have agreed to implement this and provide standardisation in this area. The ward staff are in the process of introducing this schedule
- Some areas remain cluttered in the clinical environment. This should be constantly assessed as prevents effective cleaning from occurring.

All services are given a full report regarding their audit and produce action plans for any highlighted non compliances.

10.0 Antimicrobial Stewardship

The Antimicrobial Stewardship Group meets quarterly to review the Antibiotic Strategy within the Trust. The group encourages Trust-wide participation in the national Annual Antibiotic Awareness Week. Plans are being developed for the 2018 campaign. Regular audits on antimicrobial prescribing are conducted in community hospitals, dental and sexual health services. Audits of compliance with patient group directions (PGD's) in minor injury units are performed. All audits have demonstrated improving compliance to PGDs, formulary and national guidelines. The Antimicrobial e learning package has been updated

and is available to all staff. The Trust participates in the East and West Kent CCG Antimicrobial Stewardship groups.

11.0 Waste

The waste and environmental management service is provided to the Trust by NHSPS. As part of the service, NHSPS provides contract management, audits, training, technical advice and policy writing to the Trust and its staff. The Waste Policy was revised this year to incorporate national changes. The Trust hosts a 'waste' group, and minutes and exceptions are reported through the Infection Prevention and Control sub-committee.

12.0 Infection Prevention and Control Training and Education

Infection Prevention and Control training is mandatory for all staff and compliance is monitored centrally and reported to the Board. In March 2018 Trust compliance with hand hygiene training was 90% and mandatory training 95%. Compliance amongst clinical staff was 88.5% for hand hygiene and 93.8% for mandatory training. Bespoke training is provided for services at their request and external organisations have also contracted the Trust to undertake training in different settings such as nursing and residential homes.

13.0 Link Workers Education

The Trust continues to support and facilitate an education programme for IPC Link Workers.

These staff are given time within their service to complete the aspects of their role that improve patient services, and are released to attend educational updates and meetings with the IPC Team twice a year. This is an extension to their existing role and provides their colleagues with a point of contact for additional advice on infection prevention. Over 200 link workers are in post across the Trust and in 2017/18, the team put on 42 link worker meetings, which provide continued professional education, audit assurance and sharing of innovations and ideas.

14.0 Campaigns

Throughout the year the IPC Team has launched and implemented a number of campaigns designed to raise awareness of specific issues. These include SEPSIS awareness, HOUDINI (urinary catheter assessment tool) and a hand hygiene campaign. All have been well received and act as an effective reminder of good infection prevention and control practices.

15.0 Review and update of policies, procedures and guidance

The review and update of the IPC policies has continued throughout 2017/18. All policies and protocols are based on national guidance and are updated as new evidence is available and all Infection Prevention and Control policies are up to date.

16.0 Staff Health

The Trust provides an occupational health service for staff via a contract with PAM Occupational Health department. This contract has been in place since June 2016 and is working well. All sharps injuries are presented at the Infection Prevention and Control sub-committee to identify any potential themes and trends, and potential actions.

17.0 Conclusion

The actions put in place to reduce the incidence of health care associated infection on the whole have been effective in 2017/18. However, the failure to achieve the planned reduction in UTI's and CAUTI's was disappointing, but the actions implemented appear to be having the desired impact.

Going forward the focus on collaborative working is essential in order to achieve the national target for reduction in Gram negative bacteraemias. CCGs and providers are all enthusiastic and fully engaged in this, and the ongoing collaborative work will produce improved care for patients.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	3.3
Subject:	Quarterly Mortality and Learning from Deaths Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary (including purpose and context)

National guidance on learning from deaths requires Kent Community Health NHS Foundation Trust (KCHFT) to collect and publish mortality data and learning points quarterly via a paper to Quality Committee and Public Board. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard included has been based on national suggested format.

As the Board is aware, the KCHFT Mortality Review Policy was developed following the recommendations made by the National Guidance on Learning from Deaths (2017). Other national publications were also used to guide the content of the policy. The scope of reviews includes all community hospital inpatient deaths, all deaths in the community under the care of KCHFT's 'Home Treatment Service', any patients who die under our care with serious mental health needs, all children and all patients with learning disability.

The Mortality Review policy and process underwent a change in May as the result of a planned review 6 months after implementing the original policy. Reviews are now carried out at two central review meetings each month made up of doctors, quality leads and a senior member of ward staff, along with centralised administrative support. Members rotate on a monthly basis to maintain a degree of independence and this replaces the previous process of hospital MDT teams being allocated deaths from another hospital for review. The new process allows for a more efficient way of reviewing deaths, feeding back learning to teams responsible for patient care and monitoring actions.

As defined in the Policy, the Trust Board has overall responsibility for ensuring compliance with all legal and statutory duties, along with best practice including having an overview of the mortality review process and knowledge of the learning that emerges from the reviews that drive improvements in care. The focus of trust mortality review is intended to be on meaningful learning and sharing ways to improve care.

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 decision required.

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Kent Community Health NHS Foundation Trust

SUMMARY OF LEARNING FROM MORTALITY REVIEWS (APRIL TO JUNE 2018)

1. Introduction

National guidance on learning from deaths requires Kent Community Health NHS Foundation Trust (KCHFT) to collect and publish mortality data quarterly via a paper to the Quality Committee and Public Board. The quarterly report must include mortality data and learning points. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

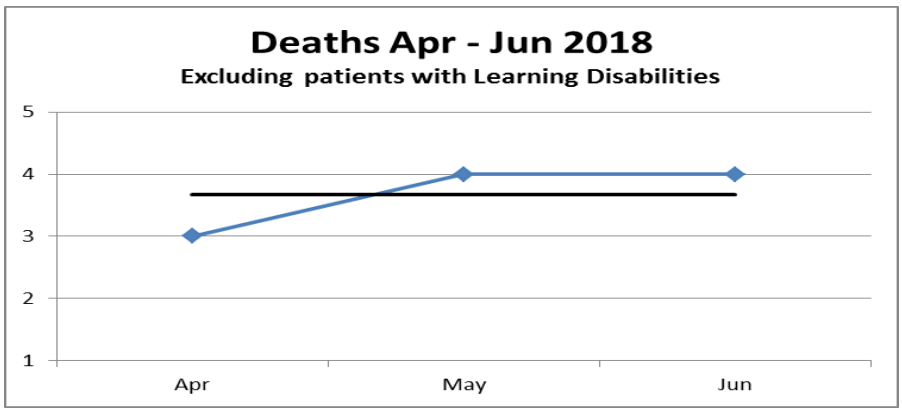
2. June Dashboard

2.1 The dashboard below has been based on national suggested format.

Total Number of Deaths in Scope			Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month		**Last Month**	**This Month**		**Last Month**	**This Month**	**Last Month**
4		4	8*		1	0	0
This Quarter (QTD)		**Last Quarter**	**This Quarter (QTD)**		**Last Quarter**	**This Quarter (QTD)**	**Last Quarter**
11		27	9		22	0	0
This Year (YTD)		**Last Year**	**This Year (YTD)**		**Last Year**	**This Year (YTD)**	**Last Year**
38		22	31		22	0	0

**Deaths reviewed in a given calendar month can exceed the number of deaths reported that month because the figure includes deaths which took place in the previous month, but have fallen into the next month for review.*

2.2 The graph below shows the number of deaths per month this quarter along with the average.



3. Learning from Mortality Reviews

3.1 The table below outlines key areas of learning identified in reviews completed this quarter, along with the actions taken. These are also reviewed in the monthly Mortality Surveillance Group (MSG).

Learning from Reviews	Comments/Actions
6CIT assessment conducted as part of pre-admission checklist but lack of evidence of handover of information once admitted to community hospital. The confusion identified was not referenced again so it is unclear if this was investigated further.	Feedback sent to ward matron at Sevenoaks and will be added to the agenda for the next monthly Matrons' Meeting in the West. Minutes of this meeting will be requested and noted by the MSG as confirmation that ward staff have been made aware of the importance of following up observations of confusion with evidence and actions in the notes.
Although there is evidence of supportive conversations with families/carers at End of Life and after death, there is a lack of specific evidence to state that bereavement leaflets are being given, and whether families are being explicitly asked if they had any concerns about their relative's care.	This reflects wider Trust issues around documentation and consistency. A meeting will be taking place on 24th July for the Deputy Chief Nurse, Nurse Consultant for End of Life Care and a senior Geriatrician to discuss existing documentation around End of Life and mortality, with a view to standardising paperwork to make data recording more robust, allowing for better capture of actions such as giving out the bereavement leaflet.

There were several record-keeping deficiencies identified: •There was no name or patient identifier on the checklist for after death and no evidence of who completed it • There were two instances of documents relating to a different patient being misfiled in another patient's notes • There was overuse of unclear abbreviations • DNA CPR form was mentioned but not physically present in notes • Some documentation was left with blank boxes rather than being completed with "N/A" if not applicable.	Feedback sent to ward matron at Herne Bay and will be added to the agenda for the next monthly Matrons' Meeting in the East. Minutes of this meeting will be requested and noted by the MSG as confirmation that ward staff have been made aware. Documentation deficiencies partly reflect wider Trust issues. The Clinical Director of Quality and Governance will be attending the CIS Working Group on 28th July to feed back the concerns noted by the MSG to ensure that mortality and End of Life care are taken into consideration when any decisions are made regarding electronic patient record systems.

Sarah Phillips
Medical Director
25 June 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	3.4
Subject:	Annual Safeguarding Report including Safeguarding Declaration
Presenting Officer:	Ali Carruth, Chief Nurse

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

Report Summary

The Board of Kent Community Health NHS Foundation Trust (KCHFT) is assured that, during 2017/18, the following arrangements were in place to safeguard and protect our service users/patients, whether they were children, young people or adults at risk.

- We had lead safeguarding professionals, who fulfilled the statutory requirements of Working Together to Safeguard Children (2015), and who ensured the requirements of the Mental Capacity Act 2005, the Care Act 2014 and Prevent Duty Guidance: for England and Wales (2015) were delivered.
- The Board level Executive Lead with the responsibility for safeguarding was the Chief Nurse, who is a standing member of the Kent Safeguarding Children Board and the Kent and Medway Safeguarding Adults Board, she chairs the Safeguarding Assurance Group which provides assurance to the Board
- The Board regularly received and responded to information about safeguarding incidents and investigations, including monthly reports via the Patient Safety Clinical Risk Group.
- We were actively involved in the Local Safeguarding Boards, which has helped us set our organisation's priorities and ability to protect vulnerable people from harm and abuse. We were continually concerned about the safety of vulnerable adults and children under our care and demonstrated that interventions to identify and protect vulnerable people are in place, to reduce the risk of harm and abuse.
- The level of Adult Safeguarding referrals implicating the Trust during 2017/18 saw a slight increase against last year (51 in 2017/18 compared to 49 in 2016/17), work with our frontline services to reinforce the importance of the holistic, compassionate care that our service users need and should expect to receive from all of our practitioners remains a priority, particularly work within the Community hospitals.
- Decisions being made by professionals were in the best interests of the service users/patients, including robust application of Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS) legislation. All Case Reviews and Domestic Homicide Reviews were investigated, lessons were identified and improvements implemented in a timely way. We routinely shared the lessons identified nationally and locally through safeguarding supervision, training and assurance reporting, to strengthen embedding of learning into frontline practice.
- All eligible staff groups had access to regular safeguarding supervision, with additional arrangements in place to support staff seeking ad hoc advice or guidance on specific issues or cases.

• All eligible staff within Kent Community Health NHS Foundation Trust were supported in accessing their mandatory and essential-to-role safeguarding training. Compliance with training across the trust was over 85%. • Our internal safeguarding systems, processes and procedures to provide controls for identifying and responding to vulnerability and risk were in place. We met our statutory requirements in relation to pre-employment clearance of all new staff, including enhanced Disclosure and Barring Service checks. • We continually questioned the extent to which Safeguarding is embedded into our organisation, including access to training; internal assurance visits and audits.

Proposals and /or Recommendations
That in receiving this report, the Board notes the successes for 2017/18 and the key actions for 2017/18.

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

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Kent Community Health NHS Foundation Trust

ANNUAL SAFEGUARDING REPORT 2017/18

1. Introduction

Kent Community Health NHS Foundation Trust (KCHFT) is committed to working in partnership with key stakeholders, to ensure that the children and adults at risk within our care are identified early and protected from harm.

The purpose of this report is to:

- Provide an overview of the Trust's safeguarding (SG) activity during 2017/18,
- Provide assurance that the organisation is compliant with its safeguarding duties and,
- Outline the safeguarding priorities for the forthcoming year.

The Trust's SG service worked closely with local provider services throughout the Kent health and social care community to drive forward the standards and quality of safeguarding.

Whilst the report focuses mainly on the activities of Kent Local Children and Adult Safeguarding Boards (LSCB and LSAB), the Trust is mindful that its services based outside Kent are required to work to the safeguarding frameworks of their local LSCB and LSABs. For 2018/19 there is a Work Plan in place for the Safeguarding service.

2 Safeguarding Infrastructure

The skill mix of SG services was routinely reviewed to provide the required capacity across the service and its (3) locality based teams. The internal SG duty rota continued to provide timely advice and support to frontline practitioners. Support to practitioners also includes provision of SG training and supervision.

2.1 Strategic Context

The Children Act 1989 (Updated 2004) provides the core legislative framework for safeguarding children, which is supported by the statutory duty on agencies to co-operate in making arrangements to safeguard and promote the welfare of children.

During 2017/18, *Working Together to Safeguard Children* (2015) remained the key, statutory safeguarding children guidance that drove local policy and procedure, in accordance with the Children Act 1989 (Updated 2004). The KCHFT's Safeguarding Operational Manual is available on the Intranet and also provides a link to the Kent Safeguarding Children Board (KSCB) multi agency procedures.

At local level, the KSCB is the key statutory mechanism for agreeing how organisations/ agencies within its geographical location will co-operate to safeguard and promote the welfare of children and for ensuring the effectiveness of what they do.

Lead officers within the Trust were identified for each KSCB sub-group, where the organisation had standing membership. The Named Nurses for Safeguarding Children (SGC) have statutory

responsibilities, as laid out in *Working Together to Safeguard Children* (2015), to support other professionals in their agency to recognise the needs of children, including responding to possible abuse or neglect. Their key roles and competencies are outlined in the Royal College of Paediatricians and Child Health Intercollegiate document, *Safeguarding children and young people: roles and competencies for health care staff* (2014). The Named Nurses for SGC work closely with the Trust's Named Doctors for SGC.

2.2 Child Protection

Throughout 2017/18, the Trust's frontline practitioners made child protection work a high priority within their case management, with attendance at child protection case conferences (CPCC) reaching 93.6% for Health Visitors and 98.5% for School Nurses. Frontline practitioners made 253 referrals into Children's Social Care.

Key Achievements in 2017/18

- The SG service continues to support frontline professionals to carry out their duties in focusing on the 'voice of the child' and working in partnership to safeguard the welfare of children and young people. This is through support and advice offered during the 'duty' processes, during safeguarding supervision and at SGC training sessions and workshops.
- The SG service has reviewed and updated all SGC training packages to incorporate learning from local Serious Case reviews (SCR's).

Impact on child/young person/adult

- Frontline professionals' attendance at CP case conferences ensures that appropriate planning and interventions are incorporated to meet best outcomes for children and young people.
- The assessments completed by CYP staff capture the "Voice of the Child", ensuring that care planning is child focussed and child led.

2.3 Kent Corporate Parenting Group (KCPG)

The KCPG has statutory responsibility for the development and delivery of services to Kent Looked After Children (LAC). The Trust had standing membership of the KCPG, where the Trust is represented by the Named Nurse for LAC.

2.4 Governance and Assurance Arrangements

Whilst the Chief Executive of KCHFT is the accountable officer for safeguarding, the Chief Nurse is the Executive lead for both safeguarding children and adults. As a sub-group of the Patient Safety Clinical Risk Group, the Safeguarding Assurance Group took a strategic overview of the SG arrangements within the Trust. Local Commissioners (within Kent) representatives attended this meeting, to provide external scrutiny and feedback assurance to their respective organisations.

2.5 The Kent (and beyond) Picture

As at 31 March 2018, there were approximately 333,045 children and young people residing within Kent (excluding Medway), with 1,461 subject to a Child Protection Plan (Source: KCC Management Information Department, March 2018). Within East Sussex there were approximately 101,367 children who were eligible to access our School Nursing and Children's Integrated Therapy services.

Kent County Council had 1,366 looked after children and young people placed within the county and 238 placed out of Kent (March 2017) with 51 at a confidential address, with a further 1,274 looked after children and young people from other authorities placed within Kent (Source: KCC Management information Department, March 2018).

2.6 Safeguarding Children Significant Incidents (SGC SIs)

During 2017/2018 there were two serious incidents relating to the safeguarding of children/young people.

Through the Trust's SI investigation framework it was established that safeguarding action, seeking advice and timely referral to children's social services was not made. The robust investigations have ensured that thorough analysis, action and learning has been implemented. Recommendations include robust assessment and review, record keeping concerns, timely referral when there is a safeguarding concern, appropriate support and escalation when needed.

2.7 Case Reviews (CRs) and Serious Case Reviews (SCRs)

The Safeguarding Team have contributed to 18 reviews during 2017-2018. KCHFT Safeguarding Team have developed action plans with the relevant services to build and develop safe systems of working and to support staff to recognise and respond to their role in Safeguarding children and young people. Numbers of SCR/Case Review /Summary of involvement undertaken in 2017/18 - Serious Case Reviews (SCRs) – 4; Local Case Reviews – 5; Summaries of Involvement – 8; Thematic Case Reviews (teenage suicides) – 1.

For 2017-2018, the main themes identified (note: some themes multifactorial across the reviews) were neglect, Non Accidental Injury (NAI), private fostering, sexual abuse, teenage suicide, concealed pregnancy.

2.8 Child Sexual Exploitation (CSE)

Child sexual exploitation (CSE) is a form of sexual abuse that involves the manipulation and/or coercion of young people under the age of 18 into sexual activity.

CSE as a work stream continues to evolve and the provision of robust training programmes to key services has resulted in staff proactively risk assessing using the current CSE toolkits and referring into the appropriate agencies working with CSE victims.

Close interagency working by the safeguarding team with the Strategic CSE Team and other key partners has led to timely information sharing in identifying and supporting victims/potential victims of CSE.

Over the last quarter there has been a development of a wider strategy to include information sharing on Missing children, and the role of Gangs with training being funded by NHS England for staff to attend.

<u>Key Achievements in 2017/18</u>

- Completion of CSE training in current Risk assessment tool to key frontline services, particularly LAC & Sexual Health Services.
- LAC team assessing all LAC Children for CSE Risk when attending for Health Assessments

<u>Impact on child/young person/adult</u>

- Increase by 50% in the number of intelligence reports submitted in respect of young people at risk/victims of CSE to the Children Sexual Exploitation Team
- Young people are being assessed and safeguarded earlier by the appropriate services.

2.9 Female Genital Mutilation (FGM)

Emerging areas of safeguarding children, including FGM, required the timely development of robust training programmes, guidance and risk assessments, to support and develop staff awareness, knowledge and delivery of care to young people and adults at risk.

<u>Key Achievements in 2017/18</u>

- The Trust has been working on a "routine enquiry" question for FGM to be embedded into patients' first contact records or risk/vulnerability assessments.

An FGM Workshop has been developed for Operational staff to attend as part of their Safeguarding Children Level 3 training.

Impact on the child/young person

- Operational staff are able to respond appropriately to any service user that discloses that they have undergone FGM.
- Operational staff are able to provide support and guidance for those at risk of potential FGM.

3 Safeguarding Adults

The Trust has standing membership of the KMSAB Board, where the Trust is represented by the Executive Lead for Safeguarding. Lead officers within the Trust were identified for each KMSAB sub-group, where the organisation has standing membership. KCHFT's *Safeguarding Operational Manual*, which is on the intranet, provides a link to relevant LSAB policies and procedures. Together, these resources underpin the *Care and Support Statutory Guidance* and provide explicit instructions for all Trust staff in undertaking work that is associated with adults' protection from harm and neglect.

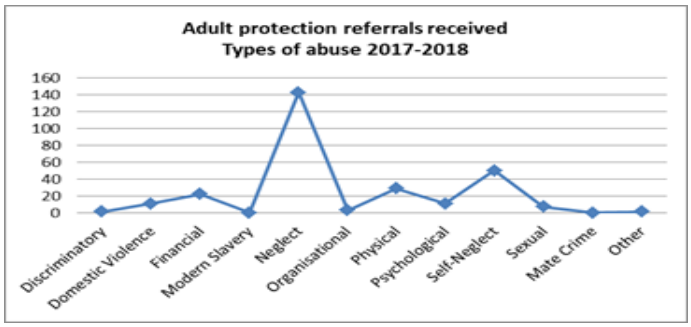
Significant work continued within KMSAB, to understand and further develop local arrangements around safeguarding adults and to align them with the legislative changes introduced by the Care Act 2014. The number of referrals made in 2017/18 into the local safeguarding process was lower than 2016/17, triangulation of supporting activity and incidents (reduction in falls and pressure ulcers) and opportunities to learn lessons from local cases of potential or significant harm have been embedded across the Trust and contributed to this improved position.

Publication of NHS England's *Safeguarding Adults: roles and competencies for health care staff – Intercollegiate Document* which will describe the key roles and competencies of safeguarding adult practitioners continued to be delayed throughout 2016/17. The document is currently in a draft form. However, once this is finalised, it will provide a more structured guidance in terms of expected staff roles and competencies.

The following took place in 2017/18:

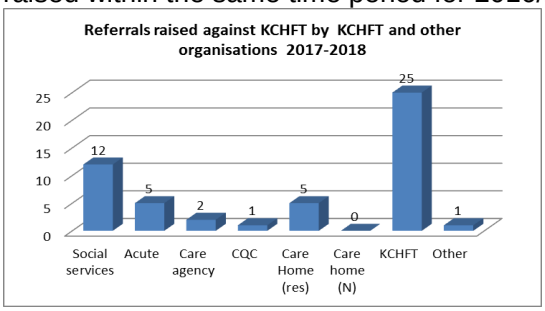
- The Adult Safeguarding team reviewed their systems and processes to improve on productivity and efficiency.
- In January 2018, The Department of Health published "Safeguarding Adults Protocol: Pressure Ulcers and the interface with a Safeguarding Enquiry". This document provides guidance on when a patient with a deteriorating pressure ulcer should be considered as a safeguarding concern. This has been incorporated into relevant policy and process to support understanding and implementation by operational staff.
- A new category of abuse was incorporated to the existing 10 categories, called Mate Crime. The term is generally understood to refer to the befriending of vulnerable people for the purposes of taking advantage of, exploiting and/or abusing them. The Safeguarding team continues to raise awareness of this category of abuse.
- The KMSAB Self-Neglect Policy and Procedure has been revised and currently is at its final draft. A Self-Neglect and Hoarding Initial Risk Assessment Tool is being introduced as a result of feedback from KCHFT staff, for use by staff.

Prevention, early identification/intervention and promoting the welfare of adults accessing our services are fundamental factors in safeguarding. The Trust's ultimate goal is to ensure that all patients receive care that reflects and responds to their specific needs and wishes, which includes keeping them safe from harm at all times, particularly when they may not be able to make decisions for themselves.



Neglect is the most common category of abuse that occurred during 2017/18.

During 2017/18, a total of 301 adult protection referrals were received by the Trust's SG service. 250 referrals were raised by KCHFT against other organisations, compared to 201 for the same time period for 2016/17. Of these 51 were raised against KCHFT (of which 25 were raised by KCHFT staff against KCHFT and 26 by other organisations against KCHFT), compared to 49 raised within the same time period for 2016/2017.



Referrals raised against KCHFT by KCHFT and other organisations

Of the KASAFs raised against KCHFT, 8 were upheld that implicated the Trust within 2017/18, of which 4 were partially substantiated and 4 were fully substantiated. Themes from these KASAFs were in relation to 4 neglect/failures to act, and 4 relating to tissue viability. These cases were investigated by the Trust and were viewed when appropriate through the SI process. Staff were offered support from their managers, safeguarding supervision and through the Serious Incident action plan process as appropriate.

Key Achievements in 2017/18

- The Trust participated in the KMSAB self-assessment framework, to evidence that it met its statutory obligations to safeguarding adults accessing its services.

Key Actions for 2018/19

- To continue to promote the Making Safeguarding Personal agenda and ensure that staff consider patients' views and wishes, and promote the voice of the adult when supporting them through the safeguarding process.

Impact on service users

- The "Voice of the Adult" is routinely heard, which means that service users' needs are being taken into account, and are central and paramount in the delivery of their care.
- Partnership working with KMSAB and a host of other agencies continues to strengthen, enabling joint working and decision-making to meet the wider needs to the service users.

3.2 Mental Capacity Act (MCA) including Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act (MCA) 2005 provides the legal framework for acting and making decisions on behalf of people who lack capacity. The Trust sought to provide assurance that they comply with the Act and have patients' best interests at the heart of decision-making processes, through a dedicated MCA Co-ordinator, who supported further embedding of MCA/DoLS in

frontline practice. The strategic overview for MCA is led by a number of senior positions within the organisation

KCHFT safeguarding team have continued to support staff to ensure service user's remain in the centre of decision making, are treated in best interests and that staff routinely explore any advanced decisions or Designated Powers in place under the Act. The move to electronic patient records posed some challenges in ensuring consistent evidence of compliance with MCA and the safeguarding team have worked with systems to reflect MCA questions in line with MCA principles and to capture reporting data in relation to DoLS and IMCA.

Key Achievements in 2017/18

- MCA and DoLS training compliance exceeded the Trust target of 85% for the third year running.
- Maintaining a robust monitoring system for patients meeting the threshold for Deprivation of Liberty Safeguards to ensure no service user is unlawfully deprived of their liberty

Impact on service users

- MCA and DoLS legislation was set up to protect those most vulnerable in our society. Compliance with this law enables services users' past and present views and wishes to be at the centre of decision making. Greater emphasis is being given to psychological wellbeing and service users' happiness while maintaining their safety.

3.3 Modern Day Slavery and Human Trafficking

In 2017/2018 KCHFT Safeguarding service continued to be committed to raising the profile of Modern Slavery as part of the safeguarding agenda. The Slavery and Human Trafficking Statement on the Trust public website was reviewed in line with section 54 of the Modern Slavery Act 2015.

Key Achievements in 2017/18

- The SG service supported the review of Multiagency adult protection procedures and contributed to its section on Modern Slavery.
- A Modern Slavery workspace was set up to support staff in identifying potential victims of this crime and support available and includes an eLearning package for staff to access

Impact on service users

- Awareness of this crime and early identification of victims and support available is a key aspect in protecting those most vulnerable. Having robust multiagency safeguarding procedures will enable staff to be consistent with their response and thereby increase a victim's protection.

3.4 Safeguarding Adults Significant Incidents (SGA Sis)

The Trust's SG service reviewed all reported serious incidents of a safeguarding nature and was routinely involved in supporting Root Cause Analysis (RCA) investigations.

In total, 18 serious incidents were reported in 2017/18 (fig 6 below). Of the 18 cases, 6 remained open, 4 were awaiting an outcome from the respective commissioner and the rest were closed. Although this indicates an increase of 3 SIs from last year, in comparison, there was a reduction in the number of neglect related themes.

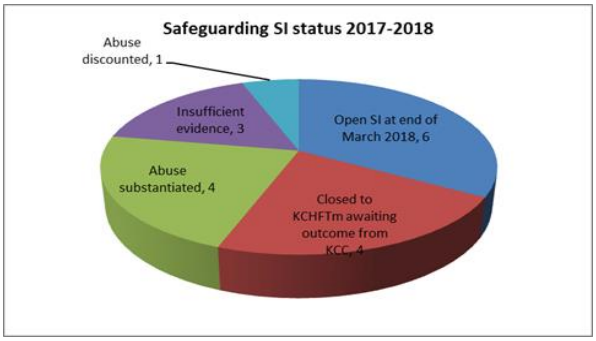


Figure 6 – Safeguarding SI status 2017-18

3.5 Domestic Homicide Reviews (DHRs)

Kent and Medway's DHR Protocol was published in May 2015 and has been followed by the Trust when overseeing any newly commissioned Domestic Homicide Reviews. During 2017/18 there were 2 DHRs commissioned by the Kent Community Safety Partnership (CSP) Key learning includes, staff to exercise professional curiosity, appropriate review of holistic assessments, sharing information and working with professionals, raising staff awareness of DA and stress on carers, raising awareness of staff of Lasting Power of Attorney (LPA).

Key achievements in 2017/18

- A co-ordinated approach for the delivery of Domestic Violence and Abuse (DVA) training which reflects NICE guidance.
- Raising awareness of DVA to staff during the safeguarding awareness week and the Safeguarding conference

Impact on service user

With robust systems, processes, tools and policy in place that increase staff knowledge and ability to support their client groups, support early identification and interventions, service users can be confident that their safety and wellbeing will be considered at all stages of the health care provided by KCHFT.

3.6 Serious Adult Reviews (SARs)

During 2017/18, there was 1 SAR commissioned by the Kent and Medway Safeguarding Adults Board.

Key learning for the Trust from this case includes the need to obtain consent, clear documentation, MCA assessment, hearing the voice of the adult, taking appropriate action on deterioration of observations and completion/review of assessments.

4 Partnership working – Kent County Council Central Referral Unit

KCHFT also provides on-site, specialist health knowledge and skills to the Kent County Council (KCC) Central Referral Unit, (CRU) and forms part of a multi-agency team with KCC Social Care and Kent Police co-located in one office. The model offers an integrated, co-ordinated and timely multi-agency response to individual situations.

Key Achievements in 2017/18

- The CRU health team has maintained a safe and effective service by prioritising, utilising alternative sources of information and services, and by being flexible in their working arrangements.
- CRU health has contributed to multi-agency initiatives including the ongoing development of the 'one front door'.

Impact on child/young person/adult

- Risks are identified in a timely and effective way leading to improved outcomes for children, young people and vulnerable adults
- Vulnerable children and adults are protected and kept safe, by ensuring that effective safeguarding practice, in line with statutory, national and local guidance.

5 Inter-Agency Collaboration

The Trust's SG service worked closely with local provider services throughout the Kent health and social care community, to drive forward the standards and quality of safeguarding. Examples of work with local provider services include:

- Influencing and contributing to multi-agency SG policies and procedures
- Development and delivery of multi-agency training
- Support to individual complex cases, including attendance at multi-agency complex case planning/strategy meetings
- Involvement in and contributing to multi-agency audit, case reviews and domestic homicide reviews

6 Prevent

The *Prevent* Duty Guidance for England and Wales was published in the summer of 2015. This document gives clear statutory guidance on what specified authorities, such the Local Authority and the NHS need to do to prevent people (including patients, service users, communities and colleagues) from being drawn into terrorism. In terms of the Trust, we have a responsibility to:

- Embed *Prevent* into our Policies and Procedures
- Deliver *Prevent* training to identified staff groups within the organisation. The staff groups were identified with reference to the *NHS England Training and Competencies Framework* (2015). This Framework is also linked in to NHS England's draft *Safeguarding Adults: Roles and competencies for health care staff – Intercollegiate Document (draft)*
- Ensure staff are aware of how to recognise and refer those considered at risk of being drawn into terrorism to the Trust's SG service, who may then advise an onward referral to Channel[1]

Key Achievements in 2017/18

- Prevent training compliance 97%, WRAP training compliance 94% achieved by 31st March 2018.
- New WRAP Train the Trainers delivered WRAP training to volunteers in KCHFT.

Impact on children/young people/ adults

- Early identification and timely Channel referrals enables the child, young person or adult to receive timely intervention and support, which could prevent them from being caught up in the subsequent criminal stage of the counter-terrorism process.

7 Domestic Violence and Abuse

Health services have a pivotal role to play in the identification, assessment and response to domestic violence and abuse (DVA) not only because of the impact of domestic abuse on health, but more importantly victims may access KCHFT services.

Key Achievements in 2017/18

- Multi Agency Risk Assessment Conference (MARAC) attendance is now provided by the SG team. A MARAC process has been created to ensure safety and risk to staff is addressed and

[1] Channel is a programme that uses a multi-agency approach that focuses on the provision of support to people who are identified as being vulnerable to being drawn into terrorism.

that appropriate/relevant feedback is sent to staff working with the children within the household.

- It has been an essential part of KCHFT safeguarding work to ensure practitioners embed 'Think Family' as part of any Domestic Abuse situation or disclosure, for both adult and children services.

Impact on Service User

- The attendance at MARAC by the Safeguarding team now ensures that all parties within the MARAC cases are taken into account, both adults and children.

8 Safeguarding Inspections

The Trust is registered with the CQC, without conditions. (A condition of registration can be imposed upon a provider where there is evidence that they are not compliant, to limit or restrict what they can do.) As at 31 March 2018, the Trust had 38 locations registered with the CQC.

The Trust's existing standards assurance process required services and subject matter experts, including SG services, to self-assess compliance against the five domains of the CQC's fundamental standards regulations that came into force in April 2015.

9 Safeguarding Education

Training in safeguarding children and adults is a mandatory requirement of all staff employed by the Trust, including the Board. The compliance levels for the Trust's mandatory and essential-to-role SG training were set at 85%. Within this performance, where shortfalls against compliance were identified for local teams or services, local improvement plans, risk assessment and supporting mitigations were put in place.

10 Safeguarding Supervision

Throughout 2017/2018 the provision of SG supervision has ensured that KCHFT fulfils its commitment and statutory responsibilities as a safeguarding organisation.

The SG supervision compliance level is set at 85% for the delivery of statutory supervision for identified staff within CYP Services. The year to date median figure (across Kent) is 87% against a compliance level of 85%.

Key Achievements in 2017/18

- The implementation of an updated Supervision Policy incorporating current recommendations and guidance.
- The inclusion of adult cluster leads having access to group supervision three times a year
- Achieving SG supervision compliance that has contributed to effective and robust safeguarding

Impact on service users

- Health Visitor's will have supervision increased from 3 times per year to 4 per year. This will increase the level of analysis when supporting children and families, to ensure effective and safe service delivery.
- Ad hoc supervision is offered to any KCHFT employee if the need is identified by the Safeguarding Team. This will ensure that adults and children that have access to KCHFT can be effectively safeguarded.
- Adult Cluster Lead Supervision will support the delivery of safe and effective practice to enhance safeguarding and support to our clients.

11 Safer Recruitment

There has been little change in legislation or national policy with regards to safer recruitment in the past year. The Trust's safer recruitment arrangements have, therefore, been maintained in line with existing policies. DBS checking compliance is 100%.

12 Safeguarding Audits

Safeguarding has developed in partnership with the Children and Young Peoples services a peer review audit that focuses on recommendations from Serious Case Reviews within Kent. The services are in the process of completing these audits.

The Trust participated in two multi-agency Self Assessments, as required by the KMSAB and KSCB.

Impact on child, young person, adult

- The audit findings will provide assurance and identify both areas of good practice and areas that require development; this will equally support the development and improvement of meeting the needs of service users, strengthen partnership working and ensure appropriate interventions are afforded in a timely manner.
- Self-Assessments ensure the Trust does not work in isolation, but rather in a joined-up manner with partners in the Kent health and social care economy.

13 Monitoring and Assurance Arrangements

KCHFT SG arrangements were monitored in various ways and at different levels:

- A monthly SG Planning Meeting provided the oversight of monitoring and assurance progress and supports, including strengthening and escalating associated assurance frameworks
- A bi-monthly Safeguarding Assurance Group considered the Trust's progress and performance against a Safeguarding Assurance Dashboard, where the Trust's safeguarding activities, functions and outputs were scrutinised
- Monthly Assurance Reports were presented to the Patient Safety and Clinical Risk group which is a sub group of the Quality Committee, which provided progress on safeguarding activities and performance, both internally and externally
- A SG Annual Report provided assurance to the Trust Board, Board of Governors and external organisations, e.g., CCGs and CQC, of the Trust's compliance against its statutory responsibilities
- Quarterly SG service development days, where all of the Trust's SG staff come together, to discuss key developments for the service and to discuss safeguarding cases to support SG practitioners' professional revalidation process
- The external monitoring and assurance arrangements were executed through the provision of a SG Performance Dashboard to commissioners, on a monthly basis
- Safeguarding staff were invited to contribute to Root Cause Analysis (RCAs) as required internally
- Attendance at the LSCB, LSAB and CRU Board meetings and a wide range of multi-agency meetings to represent the Trust

External assurance reporting to LSAB and LSCB which included:

- Completion of the KMSAB Self-Assessment Framework (SAF) and review of the same, that assessed the quality of safeguarding that the organisation provides to adults under their care. Completion of a section 11 of the Children Act 2004 SAF, which was led by the KSCB, required

partner agencies to review themselves against an agreed self-assessment tool and peer review of the same.

- Review of KCHFT involvement and reports for Serious Case Reviews, Case Reviews, Domestic Homicide Reviews and Serious Adult Reviews with the development and completion of supporting actions required as needed
- Gap analysis and development /completion of action plans, in response to key local and national cases.

14 Risk Management

The risks to delivering the Trust's SG agenda have been reviewed on a regular basis and high risk issues reported to the Board, via the organisation's risk assurance framework

The risks identified and addressed during 2017/18 included

- Vacancies, sickness and planned absences within SG services that may impact upon the Trust maintaining compliance against key performance indicators and responsibilities

Key actions were put in place to support these risks, this risk was shared with the CCGs and an action plan was developed, monitored and closed by the CCGs.

15 Equality and Diversity

The Trust is committed to safeguarding and protecting its most vulnerable service users, within which there may be specific sub-groups who are more vulnerable than others.

Julia Beavers
Acting Assistant Director for Safeguarding
7 June 2018

Kent Community Health NHS Foundation Trust

SAFEGUARDING DECLARATION

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

- Kent Community Health NHS Foundation Trust meets its statutory requirements in relation to Disclosure and Barring Service (DBS) checks for all new employees. Compliance is monitored centrally and there is an escalation process, including referrals to the DBS.
- Kent Community Health NHS Foundation Trust has a *Safeguarding Operational Strategy* and supporting policies and systems in place, that meet the requirements of *Working Together to Safeguard Children* (2015), Care Act 2014, *Care and Support Statutory Guidance* (2014), Mental Capacity Act 2005 and Local Safeguarding Board, multi-agency safeguarding procedures.
- Safeguarding training, which includes the requirements of the Mental Capacity Act/DoLS, the Children Act 2004, the Care Act 2014 and *Prevent*, is mandatory within the organisation induction programme for all new employees and refreshed at 3 yearly "essential-to-role" updates for eligible staff.
- Kent Community Health NHS Foundation Trust is committed to ensuring that the application of the Mental Capacity Act 2005 is embedded in service delivery. This includes the Deprivation of Liberty Safeguards amendment in 2007 and the Supreme Court ruling of 2014. KCHFT is proactive in assessing all potential DoLS cases and making the relevant applications and, where upheld, notifying the CQC of such authorisations.
- The Board level Executive Lead with the responsibility for safeguarding in Kent Community Health NHS Foundation Trust is the Chief Nurse, who is a standing member of the Kent Safeguarding Children and Adults Boards.
- Kent Community Health NHS Foundation Trust has lead safeguarding professionals - Named Doctors and Nurses for Safeguarding Children and Safeguarding Specialist Advisers, to fulfil the statutory requirements of *Working Together to Safeguard Children* (2015).
- Kent Community Health NHS Foundation Trust has lead safeguarding professionals – Named Nurses for Safeguarding Adults and Safeguarding Specialist Advisers, to fulfil the statutory requirements of the Mental Capacity Act 2005, the Care Act 2014 and the *Care and Support Statutory Guidance* 2014.
- Kent Community Health NHS Foundation Trust has a Safeguarding Assurance Group, which is chaired by the Chief Nurse.
- There are effective processes for following up children who miss outpatient appointments and for "flagging" children for whom there are safeguarding concerns.

- The Board reviews Safeguarding, via the Quality Committee, on a monthly exception reporting basis by operational services, which is supported by a quarterly organisation-wide Safeguarding Assurance Report and annually, when the Trust Board will receive a Safeguarding Annual Report. In addition, a rolling programme of internal assurance visits take place across the organisation and local compliance reports are produced to feedback on key findings and recommendations.
- Kent Community Health NHS Foundation Trust has a safeguarding audit programme in place, which provides the Board (and the Trust's Audit Committee) with assurance that safeguarding systems and processes are working effectively. In addition to single agency audits the Trust takes part in multi-agency audits with partner agencies.
- Kent Community Health NHS Foundation Trust is actively involved in partnership working with Kent County Council and other local agencies, in relation to the development and provision of multi-agency arrangements to safeguard and protect adults and children.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	3.5
Subject:	Annual Medicines Optimisation Report (2017/18)
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)

The use of medicines presents the opportunity to significantly improve patient outcomes. However, it also poses a potentially significant financial, safety and reputational risk to Kent Community Health NHS Foundation Trust (KCHFT). Therefore, as indicated in the NHS and Public Health Outcomes Frameworks, NICE Medicines Optimisation Strategy there is a need to optimise medicines use in order to achieve the best possible health outcomes for patients.

To enable this, KCHFT has in place a five year Medicines Optimisation Strategy. The strategy offers an effective oversight of the use of medicines, enabling resources to be used safely, effectively & efficiently and improving the health and wellbeing of patients under the care of KCHFT.

The KCHFT Medicines Optimisation Strategy objectives are:

Objective 1: Strategic, Risk and Governance.
KCHFT will make medicines optimisation an integral part of the trust's medicines strategy, systems, working practices and culture at all levels.

Objective 2: Safe Use of Medicines.
KCHFT will have systems, processes and practices designed and in place to prevent or reduce the risk to patients from medicines.

Objective 3: Effective Choice of Medicines and Patient Outcomes.
KCHFT will have systems and processes in place to deliver good clinical outcomes through effective medicines optimisation supported by robust local decision making.

Objective 4: The Patient Experience.
KCHFT will involve patients (and carers) in the decisions made about their medicines and support them to take medicines as intended.

Objective 5: Environment for Medicines Optimisation.
KCHFT will continually work towards improving health environments that support optimal use of medicines and secure the best outcomes for patients.

Objective 6: Workforce for Medicines Optimisation.
KCHFT will have in place workforce planning, development and education and training to support the optimal use of medicines to ensure that services are delivered by competent and well trained staff.

2017/18 has been the fourth year of the Medicines Optimisation Strategy implementation. Significant progress has been made to achieve for each of the strategy objectives during this year. Of note is:

- Nationally the drugs expenditure has increased by over 7% on the previous year; KCHFT had a slight increases in the medicines spend in 2017/18 of 2% over the previous year 2016/17, however the overall medicine spend has reduced by 25% since 2014/15.

- The year-end figures 2017/18 show a decrease in overall medication incident reporting of 3% and a substantial decrease in reported low harms of 66%.

Medicines Optimisation involves continual improvement and the Pharmacy team support all KCHFT staff and patients to achieve this in the coming year.

Proposals and /or Recommendations
For the Board to receive the report.

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

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Kent Community Health
NHS Foundation Trust

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST
MEDICINES OPTIMISATION
ANNUAL REPORT 2017/18

Contents

Executive Summary

The use of medicines presents the opportunity to significantly improve patient outcomes. However, it also poses a potentially significant financial, safety and reputational risk to Kent Community Health NHS Foundation Trust (KCHFT). Therefore, as indicated in the NHS and Public Health Outcomes Frameworks, NICE Medicines Optimisation Strategy there is a need to optimise medicines use in order to achieve the best possible health outcomes for patients.

To enable this, KCHFT has in place a five year Medicines Optimisation Strategy. The strategy offers an effective oversight of the use of medicines, enabling resources to be used safely, effectively & efficiently and improving the health and wellbeing of patients under the care of KCHFT.

The KCHFT Medicines Optimisation Strategy objectives are:

Objective 1: Strategic, Risk and Governance.
KCHFT will make medicines optimisation an integral part of the trust's medicines strategy, systems, working practices and culture at all levels.

Objective 2: Safe Use of Medicines.
KCHFT will have systems, processes and practices designed and in place to prevent or reduce the risk to patients from medicines.

Objective 3: Effective Choice of Medicines and Patient Outcomes.
KCHFT will have systems and processes in place to deliver good clinical outcomes through effective medicines optimisation supported by robust local decision making.

Objective 4: The Patient Experience.
KCHFT will involve patients (and carers) in the decisions made about their medicines and support them to take medicines as intended.

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Medicines Optimisation involves continual improvement and the Pharmacy team support all KCHFT staff and patients to achieve this in the coming year.

Introduction

KCHFT provides a range of community health and care services to Kent's 1.8 million residents working from over 300 buildings including 9 community hospitals (166 beds), Minor Injury Units and Out-patient departments. The Trust employs approximately 5,400 staff with circa 2.0 million patient contacts each year. This makes the Trust one of the biggest providers of NHS community healthcare in the country.

Medicines are the most common health intervention in the NHS. Nationally the drugs expenditure has increased by over 7% on the previous year; KCHFT had a slight increases in the medicines spend in 2017/18 of 2% over the previous year 2016/17. The overall medicine spend has reduced by 25% since 2014/15. Managing medicines expenditure is a significant and important challenge however it is one part of medicines optimisation.

KCHFT works to optimise the use of medicines. Medicines optimisation is a patient focussed approach to obtain the best from investment and use of medicines. It requires a holistic approach, an enhanced level of patient centred professionalism and partnership between clinical professionals and patients.

The delivery of pharmacy services and the optimisation of medicines are intrinsically interwoven with the productivity of the clinical workforce and good patient outcomes and cannot be separated from a value perspective.

Medicines optimisation is about ensuring that the right patients get the right choice of medicines at the right time. By focussing on the patient and their experiences, the goal is to help patients to:

- Improve their outcome
- Take their medicines correctly
- Avoid taking medicines unnecessarily
- Reduce wastage of medicines
- Improve medicines safety

Ultimately medicines optimisation can help encourage patients to take ownership of their treatment.

KCHFT has in place a Medicines Optimisation Strategy which is driven and facilitated by the Trust's Pharmacy Team.

It is led by an experienced Chief Pharmacist, who also fulfils the role of Controlled Drugs Accountable Officer and Medicines Safety Officer for the Trust. The Chief Pharmacist is supported by five senior pharmacists: the operational leads for Adult Services, Children and Young Peoples Services (including Dental), Sexual Health Services, Medicines Quality and Governance and Medicines Information and Education. These Pharmacists lead teams of pharmacists, pharmacy technicians and support workers. The pharmacy team also involves patient representatives in their work. The patient representatives are considered by the team as special advisors.

The Pharmacy team work collaboratively with other health and social care provides to meet the objectives of the Medicines Optimisation Strategy.

Strategic Objectives

The KCHFT Medicines Optimisation Strategy aims to embed the four principles of medicines optimisation as outlined by the Royal Pharmaceutical Society and the principles of the NHS and Public Health Outcomes Framework, NICE Medicines Optimisation Strategy and standards into all aspects of medicines management.

The four medicines optimisation principles are;

- Aim to understand the patient's experience
- Evidence based choice of medicines
- Ensure medicines use is as safe as possible
- Make medicines optimisation part of routine practice

KCHFT has achieved the following against each of these objectives in the year 2017/18.

Objective 1: Strategic, Risk and Governance.
KCHFT will make medicines optimisation an integral part of the trust's medicines strategy, systems, working practices and culture at all levels.
Objective 1 has been achieved by having in place:

- A **five year Medicines Optimisation Strategy** with associated key performance indicators. This is reviewed regularly to measure progress and adapt as national guidance and circumstances direct. A formal annually updated occurs.

- **The Medicines Management Governance Group** provides governance and assurance to the Board that medicines optimisation is occurring to promote safe and effective use of medicines. This group also maintains the medicines optimisation risk register for the trust which is reviewed every two months by the Medicines Management Governance Group. Assurance is gained that actions are being undertaken to minimise risk identified. The MMGG met six times during 2017/18.

- **Medicines and Controlled Drug policies** which are updated to reflect changes in legislation, national guidance, findings of audits, inspections and following lessons learnt from analysis of incidents involving medicines. All of these policies are available to staff via the KCHFT intranet. Implementation of the policies is supported by the pharmacy team.

Controlled drug audits have been conducted by the pharmacy quality and governance team during 2017/18. The findings show that the audits were taking a long term to conduct and did not achieve sustained improvement. A new approach has been piloted of using a self-assessment tool combined with ad hoc visits. The pilot self-assessment tool has been well received by ward managers who will be able to use it for training. Pharmacy staff have participated in the We Care assurance visits with an emphasis on auditing the medicines processes using a prompt tool. These visits enable an holistic approach to medicines management to be taken. This work will be progressed in 2018/19 to establish whether this process provides enough assurance of medicines safety.

- The **medicines quality of care improvement system continues to develop.** It provides a robust oversight of clinical risks associated with medicines but also striving to improve quality of medicines care in both satisfactory areas as well as those of already high performance. The work is led by the trusts **Medicines Safety Officer.** The year-end figures 2017/18 show a decrease in overall medication incident reporting of 3% and a substantial decrease in reported low harms of 66%. It would be healthy to see an increase in the number of near miss SafeMeds reported.

‘A ‘high’ reporting rate should not be interpreted as an ‘unsafe’ organisation, and may actually represent a culture of greater openness.’ (*NHS medicines Safety organisational patient safety reports (NRLS official statistics) April 2015 to September 2015 (published April 2016)*

Two examples of safety initiatives include the prescription first campaign using an acronym PREPARE to remind nursing staff to read the prescription before administering medicines. PREPARE stands for

P= Prescription first
R= Read the notes
E= Explain to the patient
P= Prepare the medicine
A= Administer safely
R= Record accurately
E= Every patient every time

The second initiative is the design of a KCHFT patient contract leaflet using the NHS constitution as a basis for empowering the patient to take responsibility for their own recovery and wellbeing. This idea was to address incidents involving missed visits by community nursing staff. One way to avoid harm is to empower patients with capacity to communicate missed visits to the nursing base as soon as possible.

- A **Medicines Optimisation Business Plan** is in place which is updated annually. It provides details of financial planning, management and reporting systems; both for internal reporting and external reporting to commissioners.

- A **Chief Pharmacist** that leads a team of pharmacists, technicians and support workers and reports to the Medical Director is in place.

Objective 2: Safe Use of Medicines.
KCHFT will have systems, processes and practices designed and in place to prevent or reduce the risk to patients from medicines.

Objective 2 was achieved. Described below are examples of how this objective has been achieved and improved during 2017/18:

- All **medicines policies are supported by standard operating procedures** that provide practical step by step details of how to apply the contents of policies, these in turn are supported by educational packages, professional pharmaceutical and clinical provided by the clinical team and Medicines Information service. Audits of adherence with medicines policies are undertaken throughout the year on a rolling basis. Good to high standards are maintained in services

- The Safemed subgroup and Medicine Management Governance Group have been working the **WHO Third Global Patient Safety Challenge** to reduce harm from medication errors by 50%. Although KCHFT has not had any reported avoidable moderate or severe harm medication incidents in 2017/18 the groups will still work towards lowering all harm from medication incidents.

- The **clinical pharmacy services in community hospitals** are well developed. Clinical and professional **pharmacy services to domiciliary** patients have developed at pace during the year.

Examples of Pharmacy Domiciliary Care

The initial focus of the pharmacy technician led community service was on the self-administration scheme in domiciliary setting made significant savings have been made. In East Kent a total 103 patients no longer requiring a Community Nurse to visit (either self-medicating or carer administering) with **a saving of 33,723 patient visits by Community Nursing staff.** Calculating at £40 per visit, this equates to **a saving of £1,363,520.**

An extension of the support for insulin-dependent diabetics was to task the technicians to undertake a **training and competence programme for carers working within Care Homes (Residential) East Kent**. From November 2017 to the date on this report, a total of **87 carers** from **23 Care Homes (Residential) in East Kent** have had training from the Pharmacy Technicians.

In West Kent, the technicians also take referrals from the **Home Treatment Service** following up on specific aspects of patient care.

Pharmacy staff supported community nursing staff with the **flu campaign** in East Kent.
In October 2017 the vast majority of housebound patients had received their flu vaccinations.
In West Kent, the technicians are **following up patients after discharge**. A visit in a patient's own home following discharge from hospital has the advantages of greater understanding of how a patient takes their medication; making sure that all intended changes have been actioned; taking away stock piles of medication; streamlining ordering and putting in place long term plans for medicines management. These actions reduce potential for re-admission to hospital.

- KCHFT pharmacy staff have led collaborative working with primary care and CCG colleagues to improve the provision and safe administration of palliative care medication, more effective and efficient process for authorisation to administer medicines by community nurses.

- Development and delivery of professional and clinical support and educational packages to special schools.

Feedback from Forelands Fields School, Head Teacher 24th September 2017
It is my pleasure to write to you to give formal detail on the benefits that your service has provided for Foreland Fields School.
Policy and practice: Nirusha and her team have provided a full and thorough analysis of our policies working closely with us to ensure they meet national and county guidance, but also that they fit the needs of our school. Included in this was an audit of our current practice, which was excellent as it provided us with external validation of our practice. The report that followed this up was detailed and effective in providing next steps for development. I have been amazed at the time and commitment that has been put into the support that we have received. I cannot think of any other training organisation that has provided our school with this level of support. Not only are the team experts in their field, but they understand the need to work closely with school to understand their setting.
Training: Staff feedback from the training sessions is overwhelmingly positive. The expertise from the team is so obvious that it makes staff want to listen and also encourages the acceptance of change of practice when this is required. Training is truly bespoke, from the creation of resources to the delivery of the training.
Advice line: This is very helpful as it provides quick, yet detailed answers from experts. I highly recommend this service.
We will continue to work with Nirusha and her team and consider this expenditure from our CPD budget to not only be highly effective, but also cost effective.

- Participation in the Canterbury Vanguard model of care, by a pharmacist and technician has been positive. The pharmacist and technician have been funded for 2018/19 to continue the work.

A patient, with undiagnosed memory issues, was convinced that she was managing her medicines well, yet her irregular fast heart rate showed otherwise (130+bpm). The consultant geriatrician, who is part of the CHOC team, was particularly concerned, informing the group that if she didn't start to take her medicines soon, she would end up in hospital or worse.

With repeated weekly visits, we were able to prove to the patient that she had not been taking her medicines correctly through a combination of counting the tablets and taking her pulse. These visits allowed us to build a relationship and work out when the best time in the day for her to take her medicines, recognising her autonomy and allowing her to be part of the decision making process.

By the end of our time with her she was concordant with her medicines and her heart rate had reverted to a normal regular rate (60bpm).

In addition to this medical intervention, the newly formed relationship allowed us to also show her, with the aid of her daughter, that she needed some extra help at home to carry out her daily tasks, taking the strain off her husband and daughter – she had been fiercely resistant previously to outside help.

The pharmacy team were able to feed this back to the weekly meeting and because of the presence of a local council case manager, facilitate the social care needs assessment required allowing a prompt evaluation of the situation to get the help required, in addition she was referred to the community mental health nurse for an in-depth cognitive assessment. Her daughter described her mum as receiving a 5-star service.

Objective 3: Effective Choice of Medicines and Patient Outcomes.
KCHFT will have systems and processes in place to deliver good clinical outcomes through effective medicines optimisation supported by robust local decision making.
Below are details of how objective 3 has been achieved:

- The **Medicines Information** has seen record numbers of enquires this year.

An example of recent feedback on how the service provides support to frontline staff and patients is below:

"I am a SLT working in the Learning Disabilities Service (Adults) and have used the Medicines Information Service on a number of occasions to help achieve best outcomes for our clients. On one occasion the service supported us by looking at medicines commonly used by our service users, highlighting possible side effects relating to swallowing difficulties, for example, dry mouth, alertness, respiratory, dehydration and reflux and we now use this form as part of our initial assessment of dysphagia so that we are aware of how these medications impact on the swallow. It has been useful to have quality feedback relating to whether medicines for clients with dysphagia can be crushed or taken with thickened water/apple sauce/juice or whether they can be provided in solution form. I have then been able to provide this information to GP's to help inform their clinical decision making when clients are not managing to take medication safely due to swallowing difficulties. In my experience the service is always efficient, friendly and extremely thorough with the advice given."

- **Bespoke educational packages** have enabled target training to healthcare teams across the organisation

Example: Syringe driver training

Following a serious incident, a task and finish group was set up to resolve a number of issues identified. This included revising policies, training and delivering additional ad hoc training sessions in order to support staff. Recent peer reviewed feedback from the revised training sessions is quoted below:

"The session is thorough, excellent and very informative……."

- The process for the **introduction of medicines** includes a review and assessment of the clinical evidence base, suitability for use by clinical staff/patients, risk assessment associated procedures and the financial implications. These are continually reviewed in light of feedback from staff, patients and carers, drug safety notices, changes in licenced indications and incidents. This process links closely with the CCG medicines groups

- Specific audits to evaluate **Omitted Dose** Audit and **Antibiotic** use in community hospitals were under taken. The results of the omitted dose audit showed that levels of omitted doses continue to be extremely low at 0.91 per cent. The antibiotic audit provided assurance of compliance with best practice. Both of these audits will in future be conducted on a frequent basis rather than annually

- **PGD audit:** This has been replaced by contemporaneous monitoring of prescribing using MIU and Sexual health electronic systems. Data indicates good standards of practice

- KCHFT has in place a five year **antimicrobial strategy** which supports the National Public Health England Strategy. The implementation of the strategy is monitored by the Antimicrobial Stewardship Committee (AMSC). This AMSC links with K&M CCG and provider trusts AMSCs under taking joint initiatives. The group encourages trust-wide participation in the national Annual Antibiotic Awareness Week. The Antimicrobial e learning package has been updated and is available to all staff. KCHFT participates in the East and West Kent CCG antimicrobial stewardship groups.

- KCHFT Pharmacy take a leading role in the Kent and Medway Sustainability Transformation Programme which has worked on improving medicines optimisation with catheters, Melatonin and drugs for attention deficit disorders as well as best price for medicines e.g. biosimilar drugs.

Objective 4: The Patient Experience.
KCHFT will involve patients (and carers) in the decisions made about their medicines and support them to take medicines as intended.

- The KCHFT Medicines Policy supports the use of **Patient Own Drugs** (PODs) and promotes **self-medication.** The use of PODs and self-medication both in community hospitals and in domiciliary settings has the advantage of ensuring patients are familiar with the medication they use and reduces waste to the whole health economy.

Patient A was identified as being potentially able to self-administer insulin. When first visited she was adamant that she did not want to administer her insulin, she just wanted her funny turns to stop. The Pharmacy technicians concentrated on enabling her to monitor her blood sugar levels and avert hypos. When she was confident to do this it was suggested that she learn to administer her insulin. The patient now administers her own insulin and monitors her blood sugar levels. She no longer has funny turns.

Invested £185,000 additional pharmacy staff to support patients to self-administer medicines, and worked locally with community nurses, GPs and patients to improve the quality of communication with patients about medicines. Through this programme, and by improving the relationships and understanding of medicines optimisation across and with other organisations, the trust estimates annual savings of £1 million from fewer nurse visits and medicines waste reductions.

- **Patient representatives** are active members of the Medicines Management Governance Group and its sub-groups. The Chief Pharmacist considers the patient representatives as special advisors and greatly values their input.

Objective 5: Environment for Medicines Optimisation.
KCHFT will continually work towards improving health environments that support optimal use of medicines and secure the best outcomes for patients.

Objective 5 has been achieved by;

- All areas in which medicines are **stored and administered** are regularly audited.
- KCHFT has worked over previous years to reduce the **waste of medicines**. During 2017/18 the extremely low level of waste in the community hospitals has been maintained.
- KCHFT Controlled Drugs Accountable officer is an active member of the NHS England Kent, Surrey, Sussex CDLIN.
- During the year the pharmacy team has supported a change in culture of the trust to increase **research.**

KCHFT Pharmacists have been taking part in research lead by Medway school of pharmacy to assess the value in pharmacists diagnosing AF and treating. As seen on BBC South East.

Sexual Health Services have taken part in two clinical trials of medicines in this year.

Objective 6: Workforce for Medicines Optimisation.
KCHFT will have in place workforce planning, development and training to support the optimal use of medicines, in order to ensure that services are delivered by competent and well trained staff.

Examples of how this objective has been achieved are as follows:

- The Pharmacy team has in place a **workforce plan** that is continually reviewed in light of commissioning changes and improvements in practice. Preparing for the future by working to support preregistration pharmacist and technicians in collaboration with acute and CCG colleagues.
- KCHFT **Medicines Information** pharmacist leading on STP work stream to form a Kent and Medway MI collaborative.

- The **Medicines Education** team have an established role in the provision of medicines related education and training for KCHFT staff. The training covers a broad range of topics from an introduction to medicines management to more specialists training for nurses in topics such as the use of syringe drivers.

Example: Development of prescribers and progression to advanced practice The Medicines Education Team play a key role in the support and development of new prescribers and other advanced practice roles. The team take an active role in supporting the NMP application process by advising prospective prescribers and scrutinising applications. The team also provide pastoral and educational support to staff undertaking prescribing courses. Furthermore the team support qualified prescribers and other advanced practitioners through activities such as conferences and support forums, signposting, and delivery of training.

- The new model of clinical supervision for pharmacy staff was implemented with positive feedback.

Conclusion

The report above shows that the safe and effective use of medicines has been maintained to a high standard; that improvements have been made and that there is a growing culture not only to improve effective medicines use in the adequately performing services but also to continue to improve the high performing services. Patients and community members of all ages are involved in shaping and working with the pharmacy service to optimise medicines use. KCHFT pharmacy are also active members of national groups that are shaping the new models of care in the NHS i.e. membership of the Lord Carter Review Reference Group, development of the hospital model metric for community services and bench marking for community and mental health.

It is important that the Trust values the contribution of the pharmacy team and recognises the need to match pharmacy resources to demand in order to maximise medicines optimisation opportunities.

The changing NHS environment poses many challenges for the optimisation of medicines, but it also provides many opportunities. KCHFT's Chief Pharmacist and Pharmacy team intend to seize these opportunities to continually improve medicines use and thus patient outcomes.

The Year Ahead (2018/19)

The past year has seen the NHS drugs bill grow by over 7% last year. This was considerably faster than growth in the overall NHS budget. In some cases newer medicines displace other health costs or older categories of treatment. However within this fast growing pharmaceutical expenditure there are also opportunities for efficiency.

Reviewing the use of medicines and impact of this on the cost and efficiency of the entire pathway, not unit cost of a medicines in isolation is vital. This can be achieved by:

- Driving more efficient pathways and the optimisation of the nursing and support staff workforce, through more effective use of medicines.
- Improving the patient experience by best choice of medicines across the patient pathway
- Increasing resource for patient centred review of medicines
- Identifying and focusing on a "top 10" list of medicines by value
- Making best use of evidence to drive improved patient outcomes

In the forthcoming year (2018/19), the Pharmacy Team aim to lead and support the trust to achieve all the objectives set out in the KCHFT Medicines Optimisation Strategy and the pharmacy/medicines goals of the Kent and Medway STP.

Below is a selection of activities that will be occurring to achieve this in the coming year:

- Implement new ways of working for the pharmacy team across Kent that put focus on safer discharge from community hospitals and preventing admission to hospital or care homes.

- Strengthen a medicines quality improvement culture involving all staff and patients. Integrate medicines optimisation component into the 'We Care Visits' pharmacy, introduce controlled drug and medicines self-assessment and using all incidents as an opportunity to make improvements.

- Lead on the implementation of a Kent and Medway Collaborative Medicines Information Service.

- Facilitate the development of two STP work streams to develop a collaborative focusing on wound care and education of pharmacy staff.

- Develop the use of electronic system to support medicines optimisation e.g. the use of Refine D /Define and ePACT 2.

- Identify the gaps in pharmacy workforce that are required to improve medicines optimisation and seek funding to address.

- Work collaboratively with provider trusts and commissioning organisations, KCC, Kent and Medway Innovation, Kent County Council and Voluntary groups to facilitate medicines optimisation.

- Play an active part in national and regional initiatives Lord Carter reference group (self-med tech work Lead medicines & pharmacy STP work, NHS bench marking.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	26 July 2018
Agenda Item:	3.6
Subject:	Annual Patient Experience and Complaints Report
Presenting Officer:	Ali Carruth, Chief Nurse

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):

The aim of this report is to provide assurance that the Trust gathered patient feedback, responded to complaints and acted on this feedback to improve services during 2017/18. It contains details of patient and service user feedback for the period of 1 April 2017 to 31 March 2018 and is taken from the Meridian surveys. Complaints are recorded following the Trust's complaints process.

Proposals and /or Recommendations:

The Board is asked to receive the report.

Relevant Legislation and Source Documents:

No. High level position described and no decisions required.

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Kent Community Health NHS Foundation Trust

PATIENT EXPERIENCE AND COMPLAINTS ANNUAL REPORT

1. Introduction

The aim of this report is to provide assurance that the Trust gathered patient feedback, responded to complaints and acted on this feedback to improve services during 2017/18. It contains details of patient and service user feedback for the period of 1 April 2017 to 31 March 2018 and is taken from the Meridian surveys. Complaints are recorded following the Trust's complaints process.

2. Patient Experience

2.1 Meridian data

2.1.1 The Trust's overall patient experience score for the year is **96.8%** based on **63,326** completed surveys.

2.1.2 There was a decrease in survey returns compared with 2016/17 (5,884 less surveys), however the satisfaction score remained consistent at (96.8%).

2.1.3 This decrease was largely due to a reduction in feedback collected by the Minor Injuries Units (MIUs). In 2017/18 these services collected 22,972 surveys with a satisfaction score of 96.8%, whereas in 2016/17 they collected 27,500 (a reduction of 4,616 surveys). This took place despite an increase in attendances from 16/17 to 17/18. To help increase feedback the MIUs are trialling a new data collection method whereby receptionists ask a patient for their email address on booking in so that, with permission, they can email a survey to them.

2.1.4 Despite this, 20.2% of patients visiting our MIUs and 39% of patients discharged from our community hospitals gave us their feedback, exceeding the Trust's target of surveying 10% of caseload.

2.2 Friends & Family Test

2.2.1 The Trust's NHS Friends and Family Test (FFT) score demonstrates an extremely positive recommend rate of 97.2%, which is consistent with 2016/17 (97.3%).

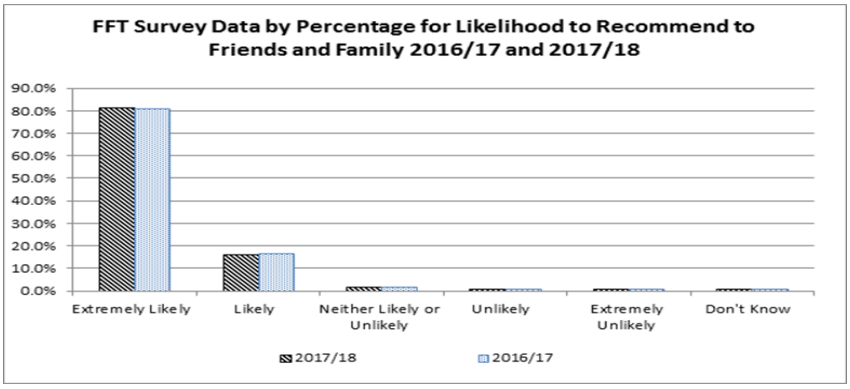
2.2.2 59,052 people answered the FFT question, with a minority of 0.6% patients being unlikely or extremely unlikely to recommend the service they used. The table below compares 2017/18 with 2016/17.

	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
2017/18	**97.19%**	0.62%	59,052	47,957	9,433	844	166	201	451
2016/17	**97.34%**	0.55%	66,775	53,992	11,004	891	192	173	523

2.2.3 There has been a drop in FFT surveys conducted in 2017/18 compared to 2016/17. The drop in surveys is the only significant difference with the responses closely matching between 2016/17

and 2017/18. There is a slight increase in the patients that are extremely likely to recommend, balanced by a slight drop in those likely to recommend (both less than 1% change). The combined unlikely or extremely unlikely to recommend responses make up less than 1% of total responses.

2.2.5 All surveys which receive an unlikely or extremely unlikely response to the FFT question are included in reporting and teams take action and make improvements in response to negative feedback whenever possible.



2.3 Competencies

2.3.1 Patient experience is measured across seven key areas. The table below demonstrates overall scores with extremely positive responses.

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 2017/18	34,114	97.95%	93.48%	99.39%	97.64%	98.39%	98.97%	99.27%
Trust Total 2016/17	37,698	98.08%	93.89%	99.31%	97.22%	98.47%	99.04%	99.45%

2.3.2 Community nursing and intermediate care teams ask two questions in their surveys relating to co-ordinated care. Scores for these questions are less positive than in other areas 93.48% for 34,114 surveys 2017/18. The two questions asked are as follows:

- When assessing ALL your health and social care needs, did the different professionals supporting and caring for you in the community work well together?
- You will have a care plan describing how your needs will be met. Did the different professionals supporting and caring for you in the community work well together in setting up and agreeing this plan with you?

2.3.3 Despite the reduction in the number of surveys completed, the competency scores remain consistently high, as in 2016/17, with Co-ordinated Care remaining the lowest scoring competency during both years.

2.3.4 Negative comments were received for the following teams under this competency: Community Nursing; Heart Failure; Intermediate Care; Lymphoedema; Rapid Response; West Kent Urgent Care Home Treatment.

2.3.5 The main themes arising from comments made were in relation to poor communication between patients/GPs/hospitals/pharmacists; delays in equipment, care plans – either no care plan seen

or no involvement in the care plan. Quality improvements have been introduced by services as a result of survey feedback in these areas.

2.4 Palliative Care Surveys

2.4.1 One of the Trust's Quality Goals for 2017/2018 was to increase survey feedback from patients/families/carers receiving palliative care to 40 surveys per quarter. The survey was initially introduced in October 2016 and only 5 surveys were completed by 31 March 2017, with a satisfaction score of 88.9%. In 2017/18, 47 surveys were completed with a satisfaction score of 95.4% showing a demonstrable improvement, however still short of the expectation outlined in the Quality Goal. Whilst there was an increase in feedback from this particular group of service users and the higher survey returns gave a more realistic satisfaction score, it is recognised that the Trust would like to continue increasing feedback received.

2.4.2 The Patient Experience Team continues to promote the use of the survey on the End of Life Workspace, through the staff intranet and with the End of Life Champions but recognises the specific challenges for staff asking for survey feedback. With the aim of gaining more feedback a series of 'Listening Events' in summer 2018 are being planned for patients, carers and families currently receiving palliative and end of life care. Other feedback relating to end of life care comes through online methods and in the form of compliments and complaints. All feedback is reported quarterly to the End of Life Steering Group for discussion and to identify areas for improvement.

2.5 Online Forums

2.5.1 Throughout the year 123 reviews were made using on-line forums such as NHS Choices and Care Opinion. The Trust's public website contains links to NHS Choices, Care Opinion and Healthwatch on the 'Have your Say' page to encourage feedback via that route. All comments are responded to and feedback is used to improve services. Of those reviews 63% (78) were positive and 45 (37%) were negative. 76 of the positive reviews were left for MIUs and related to kind, friendly efficient staff and service with 13 negative reviews relating to the ability to have their condition treated and the waiting times. Other negative reviews left relate to staff attitude and were mostly for dental services. The Trust recognises the impact of non-clinical staff on patient experience and following a successful training programme delivered for dental staff which reduced negative feedback from patients, the Learning and Development Team is planning similar training which will be delivered trust wide where required.

2.6 Healthwatch

2.6.1 The Trust has built a strong relationship with Healthwatch. Meetings are held on a quarterly basis to discuss ways of collaborative working and Healthwatch representatives are active members of the Patient Experience Group. The Patient Experience Team receives feedback from patients via Healthwatch; however feedback is in very small amounts in comparison with other providers. The feedback is detailed by location, service, topic, issue and outcome. The outcomes can be any of the following: assisted with information, signposted, referred, complaint made, issue logged and issue escalated. The link to Healthwatch has been placed on the Trust's public website to encourage more feedback through this route.

2.7 Patient Experience Group

2.7.1 The Trust's Patient Experience Group is chaired by the Deputy Chief Nurse and has regular attendance from patient representatives and voluntary groups. Staff representation includes operational and quality leads. The Group reviews monthly patient experience data and receives updates from services in relation to areas of concern and areas of improvement. Local Patient Experience Groups are led by some services, such as Sexual Health, the Kent Continence Service and the community hospitals which involve patients working together with teams.

3. The Patient Advice Liaison Service (PALS) Team

3.1 The role of PALS is to be the first point of contact for patients and their families/carers should they have a problem or need information. The service points people in the right direction by signposting them to services and providing contact details. They liaise with staff and managers to help patients and relatives find a speedy resolution of problems they are experiencing or concerns they may have.

3.2 The PALS Team received a total of 6,871 enquiries in 2017/18 with the following breakdown:

Directorate	Total
Adults	3968
Adults – Health Improvement	94
Children & Young People	2034
Dental Services	132
Sexual Health	52
HR	252
Other Directorates	339
Total	6,871

3.3 The PALS team was formerly known as the Customer Care Team. Following feedback from patients, carers and families the name was changed to PALS as this term is more widely understood by people wishing to seek help from their service.

4. Compliments

4.1 Services are encouraged to log compliments. It is estimated that there is substantially more feedback that is not shared centrally and the table below showing a total of 1,466 is a snapshot of the compliments received across KCHFT.
A new method of logging compliments is being introduced in May 2018 to enable staff to record their service's compliments using the Meridian system.

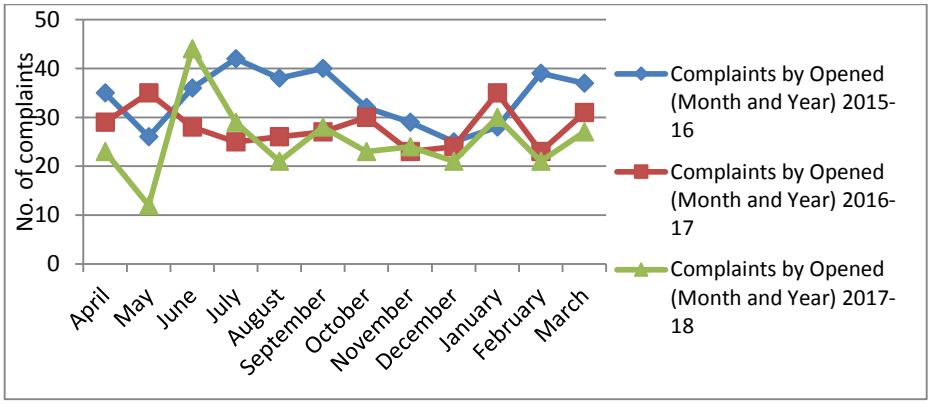
Directorate	Total
Adults	660
Adults – Health Improvement	358
Children & Young People	250
Dental Services	10
Sexual Health	182
Other Directorates	6
Total	**1,466**

5. Complaints

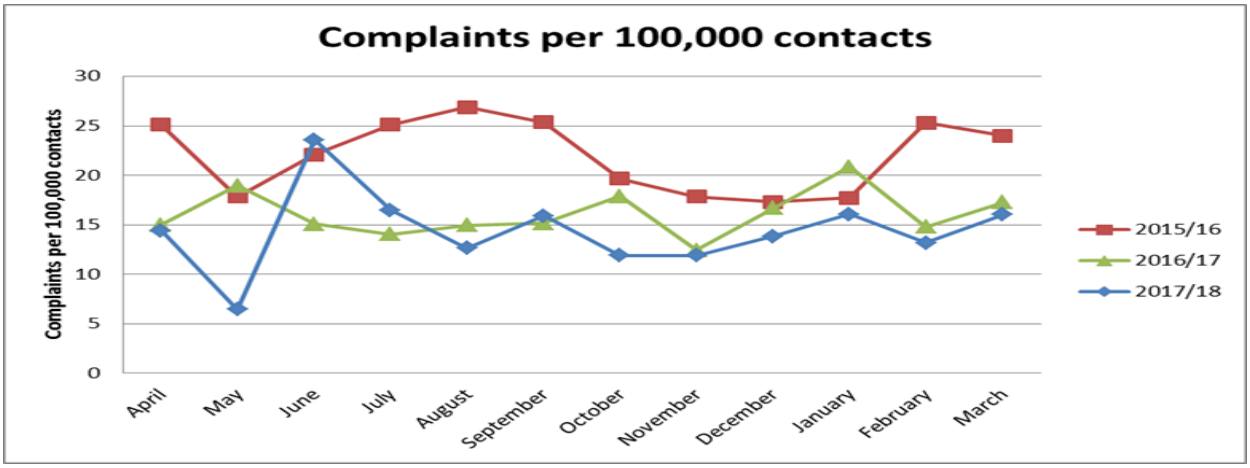
5.1 During 2017/18, **29,713** people answered the survey question ***'If you recently raised a concern or complaint directly with this service, do you feel it was responded to and*** **acted** ***upon?'***
The Trust wide satisfaction score was **92.8%** with **27,573** respondents answering positively. In comparison to 2016/17, **32,889** surveys were completed with a satisfaction score of **93.5%** with **30,751** of respondents answering positively.

5.2 To improve how staff handle complaints which are raised directly with them, the Patient Experience Team has introduced on-line training on how to handle complaints which is available for all staff. Improvements have also been made to the staff intranet, giving detailed information on what to do when a complaint is raised. Induction training also includes a session on how to resolve and handle complaints effectively.

5.3 In the year 2017/18, 303 complaints were received in comparison with 336 in 2016/2017 showing a downward trajectory. The graph below demonstrates the numbers of complaints received in the last three years. With the exception of the spike in complaints received in June 2017, which followed a lower number in May, numbers of complaints received are lower or consistent with numbers in 2016/17 and 2015/16.



5.4 The graph below reflects the number of complaints per 10,000 contacts for 2017/18 in comparison with 2016/17 and 2015/16 which demonstrates a lower rate of complaints per 10,000 than the previous years.

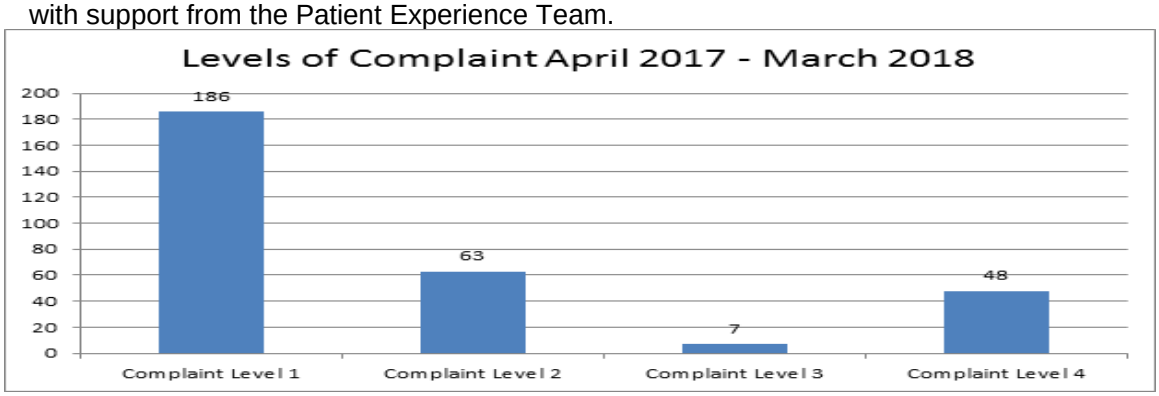


5.1 Benchmarking against other providers

5.1.1 KCHFT is benchmarked against other community trusts via the Benchmarking Network and is below the average number of formal complaints per 1,000 WTE staff members.

5.2 Levels of Complaints

5.2.1 Complaints are logged under levels determined by the nature and complexity of the complaint following the Trust's Customer Care Policy. Level 1 complaints are resolved locally by services with support from the Patient Experience Team.



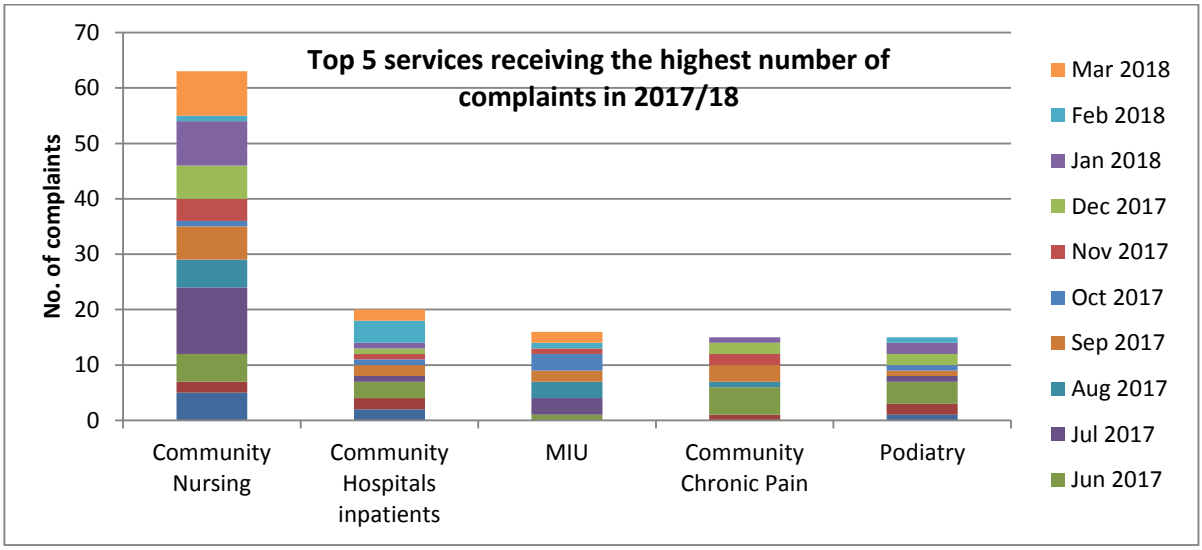
5.2.2 A description of each level is included in the table below.

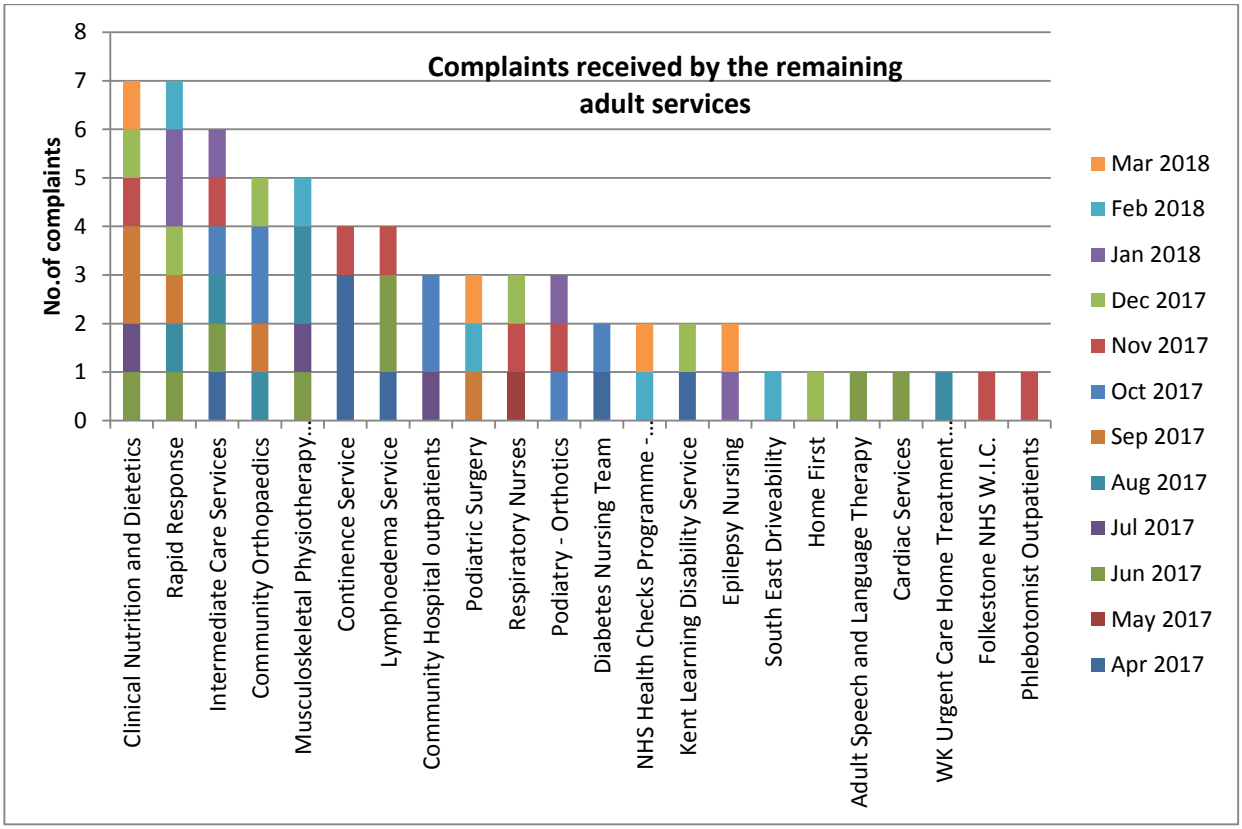
Category	Description
Level 1	Something for which it should be possible to get a quick solution and which does not warrant full complaints procedure
Level 2	Something which will require contact with one or more services which may take a short time, might involve some correspondence but unlikely to warrant an in-depth investigation
Level 3	A serious complaint that requires full investigation. Includes serious clinical complaints, complaints linked to Serious Incidents (SIs)
Level 4	A complaint involving more than one provider. For example KCHT plus GP or an acute trust. KCHFT maybe leading the complaint on or contributing to the response by the lead Provider

5.3 Complaints in Adult Services

5.3.1 Numbers of complaints for adult services for 2017/18 are set out in the chart below.:

- Community Nursing services continue to receive the highest number (63) as would be expected as they have the highest number of patient contacts (610,672) making a complaints per contacts percentage of 0.010%.
- Community hospital inpatients received 20 complaints from 52,503 contacts (0.038%)
- MIUs received 16 complaints from 97,612 contacts (0.016%)
- Community chronic pain received 15 complaints from 15,713 (0.095%)
- Podiatry received 15 complaints from 85,700 contacts (0.017%).

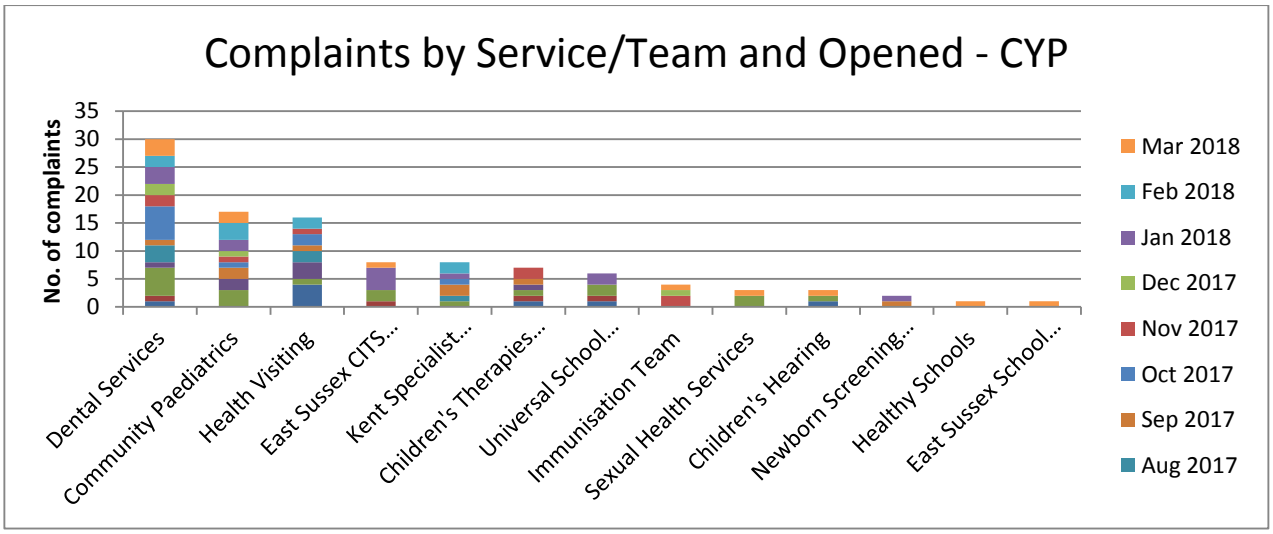




5.4 Complaints in CYP and Dental Services

5.4.1 Numbers of complaints for children's and dental services for 2017/18 are set out in the chart below.:

- Dental received the highest number of complaints (30) from 135,194 contacts (0.022%)
- Community paediatrics received 17 complaints from 8,926 contacts (0.190%)
- Health visiting received 16 complaints from 258,723 contacts (0.006%)
- East Sussex Children's Integrated Therapy Service received 8 complaints from 21,698 contacts (0.036%)
- Kent Specialist Community Children's nursing and Short Break Services received 8 complaints from 19,382 contacts (0.041%)
- Children's Therapies Service received 7 complaints from 78,633 contacts (0.008%)
- School Nursing received 6 complaints from 61,879 contacts (0.009%).



5.5 Themes and details by subject

The most common reason for a complaint being made was clinical treatment, followed by communications, access to treatment or drugs, appointments including delays and cancellations and staff.

5.5.1 Clinical treatment

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

5.5.2 Communications

Complaints are received which relate to communication across all services between hospitals, GPs, patients, staff and carers.

5.5.3 Access to treatment or drugs

Complaints of this nature include patients being unhappy with the new continence provider, wait for equipment for child, delays and difficulties in getting podiatry and dental appointments, delays in receiving speech and language therapy.

5.5.4 Appointments including delays and cancellations

This category includes appointments including delays and cancellations and waiting times. For example waiting times to be seen by chronic pain service and cancellations made by the dental service.

5.5.5 Staff

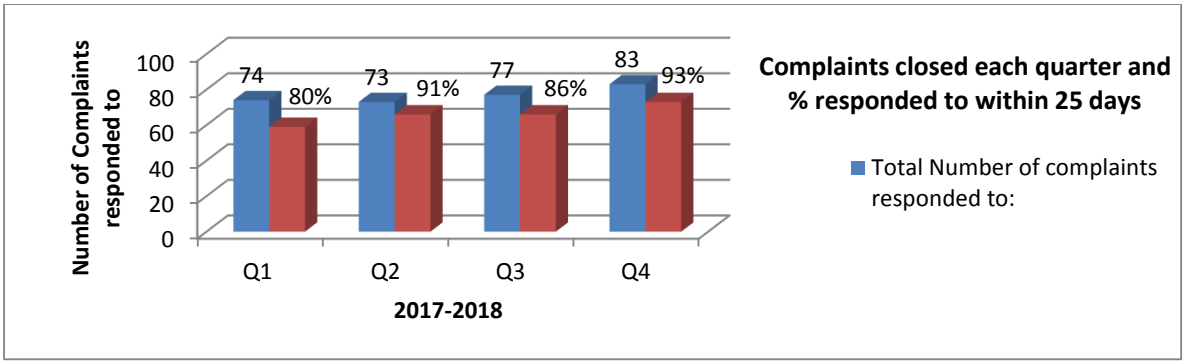
This category includes complaints about staff attitude, professional behaviour, failure of staff to introduce themselves and breaches of confidentiality.

5.6 Ombudsman Cases

There have been no complaint cases referred to the Ombudsman during 2017/18. During Quarter 1 KCHFT received 1 Ombudsman ruling. East Kent Hospitals University NHS Foundation Trust was leading on this complaint and it involved KCHFT as the patient was unhappy with rehabilitation care and treatment received in Heron Ward, QVMH following a stay in the Queen Elizabeth the Queen Mother Hospital, Margate. The case was not upheld by the Ombudsman.

5.7 Complaints Responses

5.7.1 The timescale for responding to each complaint is dependent on the nature of the issues raised and the level of investigation required. For the majority of complaints the Trust aims to respond within 25 working days. For more complex complaints, for example those involving a number of different specialties, organisations or a serious incident that requires a root cause analysis, a longer timescale for the response is agreed with the complainant allowing time for a thorough and fair investigation to be undertaken – this may take up to 60 working days to complete.



5.7.3 The Trust recognises the importance of responding to complainants within agreed timescales and this continues to be monitored. Improvements have been introduced which include a template

detailing dates sent to those involved in the investigation and approval process and escalation to line managers when drafts are delayed from the investigating managers.

5.8 Re-opened complaints

5.8.1 The team monitor the number of re-opened complaints.

- Comments or enquiries are those which are not logged as a formal complaint but are subsequently re-opened as a complaint. There were three of these re-opened in 2017/2018.
- There were twenty level 1 complaints re-opened. Level 1 complaints are those which are anticipated to be resolved quickly. The quality of the response to these complaints will be reviewed and monitored as these are the highest number of complaints which are re-opened.
- There were ten level 2, three level 3 and ten level 4 complaints.

5.9 Complaints Process Feedback

5.9.1 The Patient Experience Team surveys complainants to gain feedback on how they experienced the process of making a complaint. The return of surveys from complainants is relatively low with 18 received through the reporting period.

5.9.2 Four complainants advised that they would have liked more contact with their complaints officer. As a result of this feedback the Patient Experience Team has undertaken improvements to the complaints process and the acknowledgement letter has been updated to include:

- A question about the complainant's preferred method of communication.
- A summary of the scope of the investigation.
- Advice about being updated with agreed timescales.
- Reference to the Customer Care Policy.
- Opening hours of the Patient Experience Team office.

5.9.3 Four complainants were not satisfied with the outcome of their complaint investigation as outlined in the response they received. The Patient Experience Team attends a Kent and Medway Complaints Managers' Network with other local providers who have all highlighted similar challenges when surveying complainants on their experience of the complaints process.

5.9.4 In collaboration with the Patient Experience Group, the complaints survey was revised and relaunched in Q3. The 1 response received during Q4 was very positive and the complainant was 100% happy with the complaints process, the way the complaint was handled and the outcome and chose not to add any comments.

6. Learning from Patient Feedback

The Patient Experience Team continues to work with services to report on all feedback which has been received through the various methods used by patients, their families and carers. Improvement plans are developed and actions which have been agreed are monitored and reported to the Patient Experience Group. During 2017/18 staff have been involved in making many improvements to their services and a selection of these are detailed below:

6.1 Communication

Communication is one of the key themes which is evident in all forms of patient feedback received. A number of actions have been undertaken to improve communication as a result of this feedback and are reported in the monthly Patient Experience Performance Reports.

7. Improvements/Innovations during 2017/18

7.1 The Patient Experience Team modified their telephone system to be able to record calls received by the service. This has improved the quality of service provision and enables the team to listen back to callers' queries/complaints to ensure key concerns are fully addressed. When a complaint is made by telephone the scope of the complaint is confirmed in writing, if agreed by the patient.

7.4 The Patient Experience Team designed complaints e-learning training for all staff that describes exactly what to do if a member of staff is approached by someone wishing to make a complaint. This training went live in January 2018 and the results of the quiz at the end of the training are recorded by Learning and Development. To date 76 staff have completed this training. Staff are

expected to have undertaken this training before attending the half day face to face training designed for team leaders and managers.

7.5 Complaints Process/Handling: The Patient Experience Team undertook a self-assessment exercise against the required standards for the CQC Responsive Domain (R4) in order to be able to provide assurance that people's concerns and complaints are listened and responded to and are used to improve the quality of care. Minor gaps in assurance and areas for improvement were identified. The resulting Improvement Plan had the following four objectives:

- There is an active review of complaints and how they are managed and responded to.
- 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. There is openness and transparency in how complaints are dealt with. Complaints and concerns are always taken seriously, responded to in a timely way and listened to; improvements are made to the quality of care as a result of complaints and concerns.
- All staff know how to support people to raise a concern or make a complaint.

7.7 This plan contains SMART actions and has been measured and monitored through the monthly Patient Experience Team meetings and reported to the Senior Nursing & Quality Meeting. An audit of complaints process management is due to be undertaken in Q2 of 2018/2019.

8. Summary

- KCHFT continues to receive a high number of survey returns in comparison with other community providers with a consistently high satisfaction rate.
- Services continue to ensure they are able to obtain feedback from their service users using the method most appropriate to them.
- Services continue to use patient feedback to improve delivery of care.
- Numbers of complaints continue on a downward trend.
- Quality Improvement work on the way the Trust manages complaints is progressing well.

Sue Mitchell
Assistant Director Patient Safety and Experience
May 2018

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 26 July 2018
Rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 - 120 Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN25 4AZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Interim Chair	Interim Chair	
1.2	To receive any Apologies for Absence	Interim Chair	
1.3	To receive any Declarations of Interest	Interim Chair	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 24 May 2018	Interim Chair	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 24 May 2018	Interim Chair	
1.6	To receive the Interim Chair's Report	Interim Chair	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	Chair of Quality Committee	

2.3	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	
2.4	To receive the Charitable Funds Committee Chair's Assurance Report	Deputy Chair of Charitable Funds Committee	Verbal
2.5	To receive the Integrated Performance Report	Chief Operating Officer/ Deputy Chief Executive Deputy Director of Finance	
2.6	To approve the Six Monthly Community Hospitals Safer Staffing Review	Chief Nurse	
3.	**REPORTS TO THE BOARD**		
3.1	To receive the Quarterly Infection Prevention and Control Report	Chief Nurse	
3.2	To receive the Annual Infection Prevention and Control (DIPC) Report	Chief Nurse	
3.3	To receive the Quarterly Mortality and Learning from Deaths Report	Medical Director	
3.4	To receive the Annual Safeguarding Report including Safeguarding Declaration	Chief Nurse	
3.5	To receive the Annual Medicines Optimisation Report	Medical Director	
3.6	To receive the Annual Patient Experience and Complaints Report	Chief Nurse	
4.	**ANY OTHER BUSINESS**		
	To consider any other items of business previously notified to the Interim Chair	Interim Chair	
5.	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA**		

Kent Community Health
NHS Foundation Trust

6. DATE AND VENUE OF NEXT MEETING

Thursday 27 September 2018
Motivation Room, Village Hotel, Castle View, Forstal Road, Sandling, Maidstone ME14 3AQ