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 29 November 2018

in

Rooms 6 and 7
Trust Offices
Trinity House
110 – 120 Upper Pemberton
Kennington
Ashford
TN25 4AZ

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board to be held at 10am on Thursday 29 November 2018 in the Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Eureka Park, Kennington, Ashford, Kent TN25 4AZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Chair	Chair	
1.2	To receive any Apologies for Absence	Chair	
1.3	To receive any Declarations of Interest	Chair	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 27 September 2018	Chair	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 27 September 2018	Chair	
1.6	To receive the Chair's Report	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	

Board Committee Reports

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 Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee
2.5	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/ Deputy Chief Executive
2.6	To approve the Winter Plan	Chief Operating Officer/Deputy Chief Executive
2.7	To approve the Standing Financial Instructions	Director of Finance
2.8	To approve Board Membership and Non-Executive Director Responsibilities	Chairperson

3. REPORTS TO THE BOARD

3.1	To receive the Seasonal Infection Prevention and Control Report	Chief Nurse
3.2	To receive the Learning From Deaths Report	Medical Director
3.3	To receive the Patient Experience and Complaints Report	Chief Nurse
3.4	To receive the Freedom To Speak Up Report	Corporate Services Director

4. ANY OTHER BUSINESS

	To consider any other items of business previously notified to the Chair	Chair

Kent Community Health
NHS Foundation Trust

5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

6. DATE AND VENUE OF NEXT MEETING

Thursday 31 January 2019
Oakwood House, Oakwood Park, Maidstone, Kent ME16 8AE

Kent Community Health NHS Foundation Trust

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board
held at 10am on Thursday 27 September 2018
in the Motivation Room, The Village Hotel, Castle View, Forstal Road, Sandling, Maidstone ME4 3AQ

Meeting held in Public

Present:	Richard Field, Interim Chair (Chair) Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Ali Carruth, Chief Nurse 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 Jen Tippin, Non-Executive Director
In Attendance:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Corporate Services Director

27/09/1 **Introduction by Interim Chair**

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

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

27/09/2 **Apologies for Absence**

Apologies were received from Peter Conway, Non-Executive Director.

The meeting was quorate.

27/09/3 **Declarations of Interest**

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

27/09/4 **Minutes of the Meeting of 26 July 2018**

The Board **AGREED** the minutes.

27/09/5 **Matters Arising from the Meeting of 26 July 2018**

Ms Carruth confirmed that Norfolk Community Health and Care NHS Trust was in the benchmarking club which meant that the Trust could benchmark its Friends and Family Test scores with this organisation. The data was now included in the comparison table in the Integrated Performance Report (IPR).
Ms Strong had confirmed to Ms Barber the plans for the new triage arrangements in the minor injuries units (MIUs).
Ms Strong confirmed that she had included more detail in the IPR Operational Report which provided a breakdown by service.
Ms Strong confirmed that she had spoken to Mr John Fletcher, Public Governor Ashford and explained the plans that were being considered for the expansion of the One You shop in Ashford.

The Board **RECEIVED** the Matters Arising.

27/09/6 **Interim Chair's Report**

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

A visit to Elizabeth Ward at Victoria Hospital, Deal in August had given Mr Field the opportunity to meet the staff there and to be shown the new dementia friendly refurbishment that have been undertaken in the unit. He had been impressed by the work that had been completed to date and looked forward to it being completed in the near future. Staff welcomed the new features. Mr Field had been pleased to hear that similar work was being undertaken at Queen Victoria Memorial Hospital in Herne Bay and this work was due to commence immediately as part of the full ward refurbishment.

The Board **RECEIVED** the Interim Chair's Report.

27/09/7 **Chief Executive's Report**

Mr Bentley presented the report to the Board for assurance.

In response to a comment from Mr Field regarding the widely reported decrease in nursing applications to universities, Ms Norris explained that the Trust seconded staff to undertake their district nursing training. The Trust was keen to increase the number of commissioned places in universities to ensure that all district nurses had the opportunity to undertake the course. The feedback from universities was that they had not seen a significant drop in the number of students taking a nursing course, but they had seen a drop in the number of applications, especially from mature students. With regards to the Nursing Academy, the quality of the applications had been outstanding. There had been a number of high

quality applicants who had been unsuccessful but the Trust was in discussions with them about alternative roles in the organisation.

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

27/09/08 **Patient Story - East Kent Community Hospitals Quality Improvement Presentation**

Ms Carruth presented the video to the Board.

Ms Skelton praised the work undertaken and commented on the role of good leadership that was reflected in it. She suggested that the video also highlighted some of the key messages that had come out of The Big Listen with regards to the importance of valuing staff.

In response to a question from Mr Field as to whether this was an example of Quality Improvement (QI), Ms Carruth confirmed that QI methodology have been used. The learning from the exercise could be applied to other services and would be recognised as part of the QI process.

In response to a question from Ms Davies regarding whether the domestic staff had been included in the QI programme on Heron Ward, it was agreed that this would be investigated. It was suggested that they could contribute to future similar QI improvements on the wards.
Action - Ms Carruth

The Board **RECEIVED** the Patient Story.

27/09/9 **Quality Committee Chair's Assurance Report**

Mr Howe presented the report to the Board for assurance.

There had been no meeting in August 2018 but the Committee had met in September 2018 and had scrutinised reports one of which the Board would be receiving at that day's meeting. The Committee recommended it to the Board.

Ms Barber added that she had visited the Health Visiting Service and observed at first hand the issues that have been raised with the Committee. These issues were being addressed through a QI approach and additional management resources were also being made available. With regards to the new breastfeeding service, she had had the opportunity to talk to new mothers who were using the service. They had been positive about the support that they were receiving.

In response to a question from Mr Field regarding the lessons that could be learnt from taking over a service previously run by another provider, also commissioned by Kent County Council (KCC) Ms Strong indicated that the service had understood that there was a high level of expectation from the users of the service and staff had responded well to the challenge.

In response to a comment from Mr Bentley regarding the content of the report, it was agreed that more quantitative information would be helpful in the future where there were issues that required the Board's attention, albeit this should supplement the narrative not replace it.

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

27/09/10 **Strategic Workforce Committee Chair's Assurance Report**

Ms Skelton presented the report to the Board for assurance.

The Committee had met in July 2018 and the previous week in September 2018.

In response to a question from Mr Field regarding the senior management response to The Big Listen, Ms Skelton commented that the Committee had accepted the key themes that had been identified and the way in which they were being addressed. It had been suggested that staff did not always recognise that direct link between initiatives undertaken by the Trust in response to issues that had been raised by colleagues. This was being addressed. The response to the Big Listen was central to the retention and development work that was underway and would continue to remain at the top of the Committee's agenda.

With regards to the Committee meeting that had taken place the previous week, a range of items have been discussed including turnover, recruitment from the Philippines, the imminent staff flu campaign, mandatory training and the well led framework. Briefings had also been received on the culture change programme, the mental health 'Time To Change' programme, talent management, nurse and medical revalidation processes and the Nursing Academy.

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

27/09/11 **Charitable Funds Committee Chair's Assurance Report**

Ms Tippin presented the report to the Board for assurance.

The Committee had met in July 2018 and had received updates on the current half year balance of restricted and unrestricted funds. A report had also been received from the Communications and Marketing Team on its plan for 2018/19.

In response to a question from Mr Field regarding the pace at which the restricted funds were being utilised, Ms Tippin confirmed that there was now a clear view on how these funds could be used. The funds that related to the Queen Victoria Memorial Hospital, Herne Bay (QVMH) and Bow Road were the largest and were the Committee's priority. Mr Flack added that refurbishment was underway at QVMH. Plans were in place to spend charitable funds alongside the trust's own investment in the unit.

Following a comment from Mr Bentley regarding the various references made in all the Committee Chairs' assurance reports around the challenges made at the meetings, it was agreed that future reports would be more consistent in their wording and reflect that challenge was made by and accepted from all participants at the meetings.
Action – Committee Chairs

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

27/09/12 **Integrated Performance Report**

Mr Flack presented the report to the Board for assurance.

In response to a question from Mr Field regarding the pictorial representation of assurance relating to the Trust's strategic goals at the beginning of the report, it was agreed that a paragraph which summarised the key issues and areas of success would be added in the future.
Action – Mr Flack

Quality Report

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

In response to a question from Mr Flack regarding the gathering of the high number of surveys which the Trust undertook each month , Ms Carruth indicated that she would not like to see a decline in the number of patients surveyed. The gathering of the data was not a bureaucratic burden for staff as it was collected digitally and inputted by the patient.

Mr Howe suggested that the Quality Committee carry out a deep dive of the quality metric relating to the percentage of end of life patients with an updated personalised care plan at its next meeting in October 2018.
Action – Ms Carruth

In response to a question from Mr Field regarding the performance of the Trust in reducing falls, Ms Carruth explained that the Trust continued to participate fully in falls reduction program initiatives. Good outcomes from these were now being seen for patients. A similar commitment had been taken towards reducing the incidence of pressure ulcers with comparable outcomes. The Trust now wished to reduce the incidence of grade 2 pressure ulcers further and would be participating in a reduction programme to address this. Team members were praised for the outstanding effort they had made despite recognised staffing pressures and it was agreed that a message from the Board this would be sent to them.
Action - Ms Carruth/Ms Strong

Workforce Report

Ms Norris presented the report to the Board for assurance.

It was agreed that an additional indicator would be added to the turnover Key Performance Indicator (KPI) in future reports which reflected the stability of staffing i.e. the number of staff who remained in the Trust for one year or more.
Action – Mr Flack

In response to a question from Mr Field regarding whether any benchmarking was available for this new KPI, Ms Norris indicated that there was not. Further work would be carried out and the results would be presented to the Strategic Workforce Committee. However, current data included staff on fixed term contracts and the full data set would need to be refined to gain a truer picture.

In response to a question from Ms Barber regarding ensuring that staff had completed the majority of their statutory and mandatory training before the demands of the winter pressures took precedence, Ms Norris confirmed that those staff in the long term conditions and short-term services were encouraged to manage their training in this way. Training delivery capacity had been configured to support this approach.

In response to a question from Mr Bentley regarding the accuracy of the data and the trend line in Figure One, it was agreed that this would be checked.
Action – Ms Norris

In response to a question from Mr Field regarding the recruitment of nurses from the Philippines, Ms Norris explained that their start dates could not yet be confirmed. The process of registration was lengthy. However, she could confirm that the nurses that had been appointed had the required level of English to communicate in the community environment.

Finance Report

Mr Flack presented the report to the Board for assurance.

Operational Report

Ms Strong presented the report to the Board for assurance.

In response to a question from Ms Barber regarding the continued poor performance around Delayed Transfers of Care (DToC) at the Queen Victoria Memorial Hospital, Herne Bay, Ms Strong explained that in east Kent higher performance targets had been set by the local commissioners compared to other localities. With regards to the unit at QVMH, there were a variety of issues that have been identified. The service was working closely with Kent County Council (KCC) social services as a high number of DToCs were due to the social care element of the transfer pathway. Performance in east Kent did fluctuate and the nature of patients that were admitted to the unit at QVMH did have an impact on the overall DToC KPI.

In response to a question from Mr Field regarding the ambitious target for

the new End of Life KPI, Ms Carruth confirmed that this was correct. The report that would be presented at the following month's Quality Committee would address how this would be achieved and would also provide commentary on the change of practice that was required by staff to record the information accurately. It was agreed that the Board would receive an update through the Committee Chairs Assurance report.
Action - Mr Howe

In response to a question from Mr Field regarding the lower activity performance in the Dental Services, Ms Strong explained that the Kent contract had been agreed a number of years ago and did not accurately reflect the type of activity that was now undertaken. This impacted on the reported KPI. However, the London contract did reflect the newer type of activity. It was agreed that these two strands would be separated to provide a more accurate picture of performance in the future.
Action – Ms Strong

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

27/09/13 **Minutes of the Charitable Funds Committee meeting of 27 April 2018**

The Board considered the Minutes of the meeting.

The Board **APPROVED** the minutes of the meeting of 27 April 2018.

27/09/14 **Quarterly Patient Experience and Complaints Report**

Ms Carruth presented the report to the Board for assurance.

The Quality Committee had scrutinised the report at its September 2018 meeting and the Chair had recommended it to the Board.

Ms Tippin suggested that in future the report should include the percentage of respondents who were extremely likely to recommend the services that they used, in addition to the volume of surveys as currently reported.

Mr Bentley highlighted that the Trust had achieved the lowest level of complaints received since it had begun collecting the data. This was an incredible achievement and a tremendous testament to the professionalism of staff. It was agreed that this would be highlighted to staff.
Action - Ms Carruth/Ms Strong

In response to a question from Dr Phillips regarding whether a change in approach had been identified to achieve this performance, Ms Carruth suggested that the training of frontline staff to manage complaints as soon as they were raised was likely to have contributed. Ms Strong agreed that staff had improved in recognising problems early and resolving them quickly to patient's satisfaction.

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

27/09/15 **Equality and Diversity Annual Report**

Ms Norris presented the report to the Board for assurance.

Ms Barber suggested that in future reports additional information on the impact on staff should be recorded. Ms Tippin requested that a commentary on gender pay gap should also be included.
Action - Ms Norris

In response to a question from Mr Field regarding whether the Chair of the Disability Staff Network had been appointed, Ms Norris confirmed that it was still vacant. However, the work of the group carried on.

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

27/09/16 **Emergency Preparedness, Resilience And Response Annual Assurance Report**

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

The Board **RECEIVED** and **APPROVED** the Emergency Preparedness, Resilience and Response Annual Assurance Report.

27/09/17 **Any Other Business**

There was no further business to discuss.

27/09/18 **Questions from members of the public relating to the agenda**

Mr Pete Sutton, Public Governor Gravesham referred to the Equality and Diversity Annual Report. He highlighted that a significant number of senior staff did not state their ethnicity where data was collected from them. Ms Norris agreed but confirmed that staff could now update this data themselves. Staff would be reminded of this opportunity.
Action – Ms Norris

Ms Skelton added that the Strategic Workforce Committee would receive a report at its November 2018 meeting on staffing in the Dental Service as this service had a large number of Black and Minority Ethnic (BME) staff. It would feedback its findings to the BME Staff Network
Action - Ms Skelton/Ms Norris

The meeting closed at 11.50am.

27/09/19 **Date and Venue of the Next Meeting**

Thursday 29 November 2018, Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Eureka Business Park, Kennington, Ashford Kent TN 25 4AZ

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 27 SEPTEMBER 2018 (PART ONE)

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Patient Story – East Kent Community Hospitals Quality Improvement Presentation	To investigate whether the domestic staff on Heron Ward had been or would be included in the unit's Quality Improvement programme	Ms Carruth	This has been raised with the operational staff involved in the Quality Improvement work.
Charitable Funds Committee Chair's Assurance Report	To adopt a common Committee Chair's Assurance Report template which confirmed that challenge was made by and accepted from all participants at Committee meetings.	Committee Chairs	A template has been circulated to the Committee Chairs and adopted for future reports.
Integrated Performance Report	To include a paragraph at the beginning of future reports that summarised the key issues and areas of success for the Trust.	Mr Flack	Summary added to the next version of the Integrated Performance Report.
Integrated Performance Report	To bring a deep dive of the quality metric relating to end of life patients with an updated personalised care plan to the October 2018 Quality Committee meeting.	Ms Carruth	This is an agenda item at the October 2018 Quality Committee meeting.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Integrated Performance Report	To organise a message to staff regarding the Board's recognition of their outstanding performance despite staffing pressures.	Ms Carruth Ms Strong	A message has been sent. Action complete.
Integrated Performance Report	To add a stability Key Performance Indicator in the Workforce section of the report.	Mr Flack	Added to the next version of the Integrated Performance Report.
Integrated Performance Report	To check the accuracy of the data and the trend line in Figure One of the Workforce section of the report.	Ms Norris	The data was accurate and reported correctly.
Integrated Performance Report	For the Chair of the Quality Committee to provide an update at the November Board meeting regarding the quality metric relating to end of life patients with an updated personalised care plan.	Mr Howe	This will be included in the Chair's Assurance Report.
Integrated Performance Report	To separate the London and Kent strands of the Dental Services activity to provide a more accurate picture of performance.	Ms Strong	Actioned. This will be included in future reports.
Quarterly Patient Experience and Complaints Report	To highlight to staff their contribution towards the Trust receiving its lowest level of complaints since it had begun collecting data.	Ms Carruth Ms Strong	A message has been sent. Action complete.
Equality and Diversity Annual Report	To include a commentary on the gender pay gap in future reports.	Ms Norris	This will be incorporated into the next year's report.
Questions From Members Of The Public Relating To The Agenda	To remind senior staff of the opportunity to update their information including ethnicity on the Trust's workforce system.	Ms Norris	Senior staff have been reminded.

Agenda Item	Action agreed last meeting	By Whom	Current Status/Update
Questions From Members Of The Public Relating To The Agenda	For the Strategic Workforce Committee to receive a report into Black, Minority and Ethnic (BME) staffing in the Dental Service and to feedback its findings to the BME Staff Network.	Ms Skelton Ms Norris	A report will be presented to the Committee in November 2018.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Number:	1.7
Agenda Item Title:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive

Action - this paper is for:	Decision	☐	Information	☒	Assurance	☐

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

Proposals and /or Recommendations
Not applicable.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ Not applicable.

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

Kent Community Health
NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
November 2018

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

Staff

1. Annual General Meeting

At the end of September, we held our annual members' meeting, followed by our annual general meeting. The first element of the event concentrated on dementia, where more than 70 attendees volunteering to became a Dementia Friend. There was a marketplace where KCHFT staff, volunteers and partners showcased the services they provide for people living with dementia. The meeting also received presentations from the Interim Chair and officers of the Trust reflecting on 17/18, which had been a successful year for the Trust.

2. Time to Change

We signed the Time to Change pledge in October, confirming our commitment to mental health and wellbeing in the workplace for all our staff. The pledge commits the Trust to improve the quality of conversations about mental health to remove the stigma and make it easy to talk about as physical health. The most recent analysis suggests that one in four of the Kent and Medway population will have an issue with mental health wellbeing during their lives, and as such we need to support all our workforce to be able to explain their issues and help to reduce the stigma sometimes associated with mental health.

3. Senior Leaders Conference and Team Leaders Conference

Around 220 KCHFT leaders attended two events in October and November Topics under discussion were our devolving authority framework, the very important role of our staff networks and our approach to quality improvement projects, more of which is detailed below.

4. Quality Improvement Work

In October, we launched our quality improvement microsite – www.kentcht.nhs.uk/qi to support the work being undertaken across the trust to support one of our priorities for 2018/19 and beyond. Quality improvement and how it can work was discussed at the senior leaders and team leaders conferences as reflected above, it has also been a subject of agenda items for the Board and the Management committee, the prograame is now starting to gain momentum as we see to make QI business as usual within the Trust.

Partnerships

1. CIS Replacement Demonstration Day

As we move to replace our present patient information system, CIS we had a strong response, with around 200 members of staff at our IT supplier demonstration day in early November. This day was an opportunity to look at replacement of the current electronic patient record and related technology. Staff spent the day looking how the systems would support the patient pathway. The information gathered will be used in specifying our requirements in the formal procurement phase of the project, subject to Board approval. The replacement of the system is a key enabler of changing how we look after our patients and service user, with the ambition that the new system works for all our team members and has the capacity for interoperability with systems used by other providers.

Patients

1. Flu Vaccination Campaign

We commenced our Flu vaccination campaign in October and at the time of writing, 23% of our patient facing staff have received the vaccination. This compares favourably to the same time last year when 17.4% had received the vaccination.

42 vaccination sessions have taken place with a further 49 scheduled up until mid-February 2019.

We have lots of information on Flo, and our campaign this year is in partnership with Unicef. When we deliver any vaccination, we also commit to funding a vaccination of tetanus in the developing to young babies and expectant mothers.

I seek the support of the Board to encourage all team members to have the flu vaccination as a way of safeguarding their patients and service users in advance of the next outbreak which we must anticipate will take place sometime in the winter.

2. Winter Planning

Since the last time the board met we have commenced the plans we have made to manage services during the harsh winter months, this have plans have concentrated on four priorities:

- Staff wellbeing
- Improving patient flow through our services
- Team member recruitment
- Ensuring lessons are learnt from last year

Winter historically sees the health service under significant pressure and our planning and then more important delivery is key to making sure we react in the best way possible.

Finally since the last time we met as a Board Richard Field has handed over as Chair to John Goulston who commenced in November, I would like to welcome John and formally thank Richard for his leadership and support during his time as Interim Chair.

Paul Bentley
Chief Executive
November 2018

Kent Community Health
NHS Foundation Trust

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

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):
The paper summarises the Quality Committee meetings held on 16 October and 20 November 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 OCTOBER AND NOVEMBER 2018

This report covers the Quality Committee meetings held on 16 October and 20 November 2018.

Agenda item	Assurance and Key points to note	Further actions and follow up
Assurance reports were received from the Chairs of the Patient Safety and Clinical Risk Group, the Patient Experience Group, and the Clinical Effectiveness Group.	Clinical staff turnover, sickness levels and vacancies continue to be an area of concern, but principal quality and patient experience metrics remain within targets set.	
Personalised Care Plans – Compliance	The Board expressed concern that End of Life Personalised Care Plan compliance stood at 30% in September 18. Contributory factors were: • Recent move to electronic care plan record embedded within CIS. • The care plan could not be completed on tablets and relied on completion away from the patient using a desk top computer.	Mitigation: • Software has been developed to allow completion of care plans on tablets and is currently being brought into service; although this does not currently enable integrated care plans to be compiled (physio/nurse/SLT) hard copies of plans will be left in the patient's home and

Agenda item	Assurance and Key points to note	Further actions and follow up
Personalised Care Plans – Compliance continued	• A number of patients entered onto the caseload die within 72 hours.	individual service care plans can be viewed on CIS. • The Quality Committee will closely monitor compliance rates and are assured there will be improvement over the next two months. •
Mental Capacity and Deprivation of Liberty Safeguards (DoLS)	The Committee received an update to the forthcoming changes to the Mental Capacity Act (MCA) and the work undertaken to ensure the Trust remained compliant. Issues identified were: • The capacity of Kent County Council (KCC) to process the number of DoLS applications from within Kent leading to delays; • Potential that in future community hospitals will be responsible for authorising their own DoLS; • Over the period April to July, the Trust made 15 DoLS applications.	• Risk noted on Register. • Trust wide focus on training compliance. The Trust is currently meeting the 85% target in all areas except MCA level 3, where x3 members of staff are expected to complete training by the end of November 2018.
Autism Spectrum Disorder (ASD) Diagnostic Pathway Action Plan – North and West Kent	To undertake a diagnosis of ASD specialist assessment is required by a minimum of two professionals (usually a paediatrician/psychiatrist and speech and language therapist). Current waiting times in Dartford, Gravesham and Swanley (DGS) locality and West Kent where the	Mitigation • Risk score 12 • Increased SLT staffing via locum/bank cover to increase clinic appointments. • Flexible approach to managing

Agenda item	Assurance and Key points to note	Further actions and follow up
Autism Spectrum Disorder (ASD) Diagnostic Pathway Action Plan – North and West Kent continued	Trust delivers the pathway for children 0-11 can be +/- 24 months. Numbers of children on waiting list at M9 270. • Increasing level of demand for service. • Staff vacancy, particularly paediatricians.	appointments e.g. joint assessments. • Standardised screening questionnaires prior to initial 18week Referral To Treatment (RTT), so children not allocated to autism pathway unnecessarily. • Fortnightly teleconference review. • Prioritisation of need. • Trajectory to clear backlog – March 20.
Chronic Pain Service Consultant-Led Referral to Treatment Times (RTT)	The Committee was briefed on increasing demand pressures on the Chronic Pain Service which was leading to waits of over 18 weeks to see a consultant. Those not given priority through triage are waiting on average 25.1 weeks. Commissioners are unable to provide further investment. The Committee was also briefed on the circumstances surrounding a '52-week breach' for a patient who was in the custody of the prison service.	Mitigation • Remodelling of service. • Action Plan • Triage • Patient education • RTT compliant by January 2019 • Quality Committee is to conduct a deep dive into all operational RTT pressures January 2019.
CQC	The Chief Nurse was requested to provide assurance about preparedness for a Care Quality Commission (CQC) inspection: • Board Briefing on CQC methodology conducted.	

Agenda item	Assurance and Key points to note	Further actions and follow up
CQC continued	• Governors' briefing conducted. • We Care visits and reinspection's complete. • Trial PIR conducted. • External assistance sought to assist in Well Led preparation early in New Year.	
Ashford Long Term Services – embedding learning for pressure ulcer incidents	The Board will recall the Committee expressed concern about staff pressures and a number of Serious Incidents (SI) that had occurred in the Ashford Long Term Services earlier in the year. The local Clinical Resource Manager briefed the Committee on improvements to recruitment, caseload planning and the escalation process.	The team is due to be visited by Non-Executive Directors (NEDs) in the next month.
Policy Ratification	The Committee approved the following Trust policies: • Delivering Single Sex Accommodation Policy. • Clinical Protocol For Performing Visual Acuity Using The Longmar Crowded Test. • The Protocol For The Use Of Radical Extracorporeal Shock Wave Therapy In The Management Of Patients With Plantar Fasciitis. • The Protocol For Requesting X-Rays And Ultrasound Images For The Management Of Podiatry Patients. • Guidance For Weighing And Measuring Children	

Agenda item	Assurance and Key points to note	Further actions and follow up
Policy Ratification continued	Aged 14-19 Years. • Clinical Protocol For Pure Tone Audiometry Test. • Occupational Health Policy • Safe Staffing And Escalation Protocol For Inpatient Wards. • Safe Staffing Assessment And Escalation For Community Nursing Teams	

SC Howe CBE
Chair, Quality Committee
21 November 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Item:	2.3
Subject:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Chair of Strategic Workforce Committee

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context)
The paper summarises the Strategic Workforce Committee meeting held on 20 September 2018. A verbal update on the meeting held on 28 November 2018 will also be provided.

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 covers the Strategic Workforce Committee meeting held on 20 September 2018.

Area	Assurance and Key points to note	Further actions and follow up
Workforce Report	Accuracy of data issues found, now resolved. Importance of ensuring overlap/joined up working between clinical and workforce was discussed and agreed as important. Turnover is going up, on-going focus on retention. Drilled down but hot spots keep moving. Further successful recruitment from the Philippines; 9 now in the process. Flu campaign this year incentivised by 'Jab for a Jab' in third world countries. Assurance was sought that there would not be an impact on mandatory training compliance whilst bringing forward training during winter pressures.	The Chief Operating Officer (COO) will add another paragraph to the operational workforce paper that highlights the quality clinical issues being addressed at the same time as workforce.

Area	Assurance and Key points to note	Further actions and follow up
Well Led Review	Deloitte review confirmed that Kent Community Health NHS Foundation Trust (KCHFT) was in the top 25% quartile for governance/leadership, but an action plan has been agreed to sustain this. Highlights of plan: - using more up to date data at operational meetings - development programme for the Board - talent management progressed.	Need to focus on key recommendations not all 17 with equal weight. 'Accountability framework' needs governance agreed to determine timeline and scope. New Chair to look at role of the Non-Executive Director (NED) on the Sustainability and Transformation Partnership (STP).
Cultural Change programme	Cultural change proposal was supported with some further attention required on the alignment of need with output in the business case. Value tested including reduction of bureaucracy, proactive attitude, engaged leadership and empowerment leading to enhanced productivity and retention. Capacity to undertake during winter pressures is manageable as it is designed to help build resistance, empower and develop a 'we can' attitude.	

Area	Assurance and Key points to note	Further actions and follow up
Mental Health Update	Time to change initiative successfully launched on Flo with 32 champions volunteering. Assurance gained on induction, boundaries, support in hot spots and signposting to professionals.	
Talent Management	Useful learning gained from introduction of a new Talent Management Process, highlighting gaps in consistency of appraisals, development and criteria.	Focus to date on the process. Further work required on using the data to ensure we nurture the talent pool (value, develop, retain, succession planning)
Nurse Revalidation	Assurance received that the Trust has a robust process and is able to deal with any outlying cases quickly (2 in 2018).	
Medical Revalidation	Assurance received that the Trust has robust polices and systems in place for appraisal, work planning and revalidation of doctors. Huge progress has been made in this area with new policies developed and aligned, with a framework now designed to, in addition, highlight low level concerns so they can be picked up and addressed quickly.	

Area	Assurance and Key points to note	Further actions and follow up
Operational Workforce Report	This report now sets out key areas and key issues in day-to-day workforce operations to give the Committee assurance that these workforce challenges are being recognised and addressed.	COO to ensure triangulation with Quality Committee.
Transforming Integrated Care in the Community (TICC) Programme	Update on the TICC programme highlighted the need for clarity on governance of work as it has clinical and workforce challenges. Operational decisions to be made by the Programme Board after clinical assurance from the Quality Committee and people implications discussed at the Strategic Workforce Committee.	As part of Board development ensure all Board members are up to date with ambition and issues associated with TICC programme of work.
Workforce Race Equality Standards	White and Black Minority Ethnic (BME) now as likely as each other to receive disciplinary action. There are still issues with high reporting of BME less likely to be appointed from shortlisting and more likely to feel bullied. Communication has improved and unconscious bias training is in place. Specific training for BME and higher visibility champions.	Deep dive to take place in Dental due to higher intensity of BME.
Strategic Transformation and Workforce – West Kent	Update on work with clinical commissioning groups (CCGs) and other partners looking at different working models in West Kent using 'SWIPE' model. Data collection phase has commenced only.	

Area	Assurance and Key points to note	Further actions and follow up
Nurse Academy	Good progress with high level of applicants. 60 shortlisted for Nurse Associate and 71 for Registered Nurse, assessment days 15 and17 October. Quality of candidates meant that 53 further conversations are being had to try and attract people into existing roles as health care assistants.	Item to come to Committee each time highlighting progress, next steps and issues.
Forward Plan	The Committee forward plan is now in the common committee format.	Further work is underway to ensure a full match with the Committee's Terms of Reference.

Bridget Skelton
Chair, Strategic Workforce Committee
20 September 2018

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Item:	2.4
Subject:	Audit and Risk Committee Chair's Assurance Report
Presenting Officer:	Peter Conway, Chair of the Audit and Risk Committee

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):
The paper summarises the Audit and Risk Committee meeting held on 26 September 2018.

Proposals and /or Recommendations:
The Board is asked to receive the Audit and Risk 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.

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

Kent Community Health NHS Foundation Trust

AUDIT AND RISK COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Audit and Risk Committee meeting held on 26 September 2018.

Area	Assurance	Next Steps
Risk Management	The Board can continue to rely on risk management processes and the Board Assurance Framework (BAF).	(1) Gaps in controls and action plans (ie. the right hand side of the BAF) need improvement (*ongoing*) (2) Report on risks and preparedness for hard Brexit requested (*by November 2018*).
Internal Audit	Positive assurance on General Data Protection Regulation (GDPR) readiness and remediation plans giving rise to a low risk of sanctions.	Main areas needing remedy are HR related and these are under report to the Strategic Workforce Committee (SWC) (*by November 2018*).
Clinical Audit	Targets for both clinical audit activity and recruitment to research projects being met.	
Legal Services	Negligence claims, coroner activity, health and safety and other legal activity all being well managed.	Future Legal reporting to ARAC to be refined to avoid duplication with the Quality Committee scrutinised activity (*by November 2018*).
Risks in Partnership Working	Potential risks under payroll contract being well managed (see the report from the Finance, Business and Investment Committee).	Identified risks to be considered by the Management Committee (*by October 2018*).
Standards of Business Conduct	Positive assurance.	
Sustainability Strategy and Action Plans	Good work and progress since the outline plans received earlier in the year.	ARAC to scrutinise the Sustainability Report in the Annual Report and Accounts next year (*by May 2019.*
Fire Safety	Positive assurance received on activity, governance, remediation and future activity.	
Single Tender Waivers, Losses and Special Payments	Processes being well managed.	

Area	Assurance	Next Steps
Evaluation of the Meeting	Some discussion on potential duplication with other Board sub-committees. It was felt there is more between Board and sub-committees rather than across sub-committees.	The Committee Chair will review the Terms of Reference, forward plan and items coming to ARAC to de-duplicate and re-focus information sought (*by November 2018*).

Peter Conway
Chair, Audit and Risk Committee (ARAC)
September 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Number:	2.5
Agenda Item Title:	Integrated Performance Report Part One
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	☐	Information	☐	Assurance	☒

Report Summary

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.

<u>Key Highlights from report</u>

Quality

- Five new grade 2 pressure ulcers categorised this month (three for October and two for previous months)
- Grade 3/4 pressure ulcers well below target for the year to date.
- Community Hospital fill rates positive at 92% (day) and 99% (night)
- Reducing overall trend for medication incidents; however increased low harm incidents.
-

Workforce

- Turnover remains above the 16.47% target at 18.72%, although this has reduced from 19.35% last month
- Sickness absence remains above the Trust target at 4.44% for the financial year to date, with the largest directorate, Operations (83.28% of workforce), at 4.68%
- Vacancy rates remain high at 9.71%, with a high level or recruitment activity ongoing.
- An increase in temporary staff shift requests, although fill rates are increasing.

Finance

- CIP savings currently 13.2% behind target, although forecast year end position is for full achievement
- Capital Expenditure year to date is £1,301k, representing 46% of the YTD plan
- YTD surplus ahead of plan (1.6%)

Operations

- NHS Health Checks (70.1%) and Stop smoking Quits (55.9%) remain behind plan.
- Health Visiting mandatory check performance against the New Birth and 6-8 week visit, while both remain on target, are on the downturn. Both have experienced drops for the last 2 months running.
- Referral to treatment incomplete wait times for consultant-led services remains below the 95% target, although increased in September to 91.3%. One patient in the Chronic Pain service had been waiting longer than 52 weeks at the end of September.
- Some waiting times for other AHP services on an non consultant-led pathway are high, with particular reference to MSK Physio in west Kent (Block)
- Audiology 6 week diagnostics now achieving target (96% in month 6)
- The newly introduced End of Life indicator, measuring the level of electronic care planning for End of Life patients, is slowly improving but continues to fall below the 60% target.
- Delayed Transfers of Care (DTOCs) consistent and below target.
- For Specialist and Children's service, reported outcomes are being either partially or fully achieved in 90% of cases.
- Late requests from KCC are impacting the performance against the Looked After Children 28 day initial assessment national

target. Internal timescales are meeting the standard but are reliant on receiving the requests within 5 working days • Activity for Intermediate Care services in east Kent, as well as some Specialist and Elective Services (in particular Podiatry, Epilepsy, Diabetes and Continence) continue to fall significantly below the annual plan.

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

Relevant Legislation and Source Documents
Not Applicable
Has an Equality Analysis (EA) been completed?
No ☒ High level position described and no decisions required.

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

Kent Community Health
NHS Foundation Trust

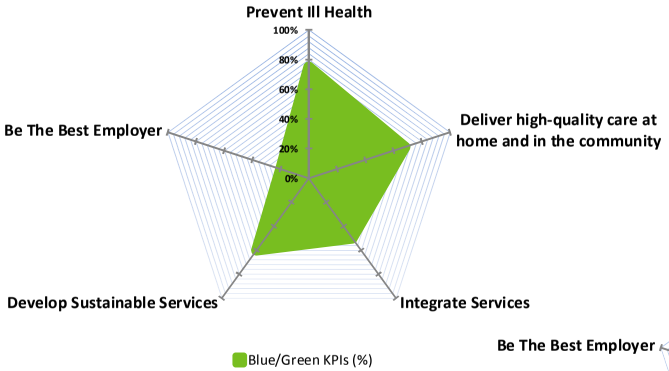
Integrated Performance Report 2018/19

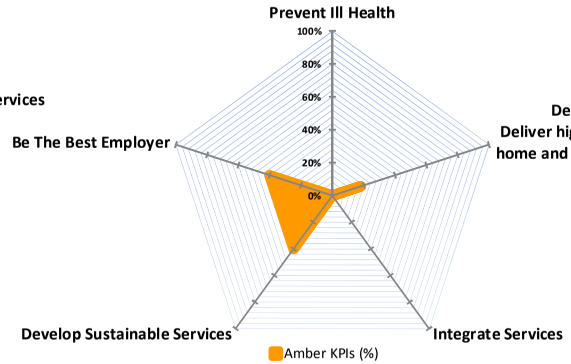
November 2018 report

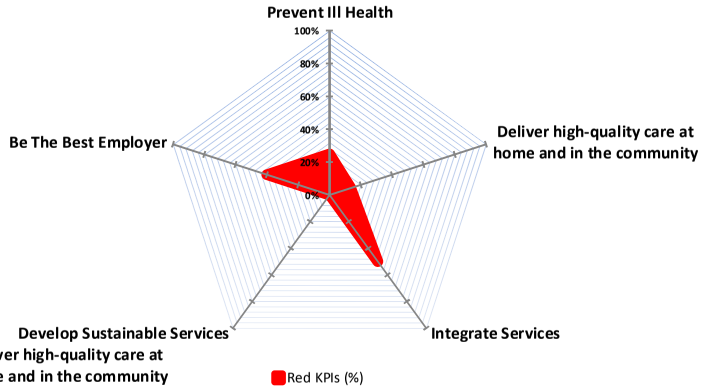
Part One

we care

1.0 Assurance on Strategic Goals







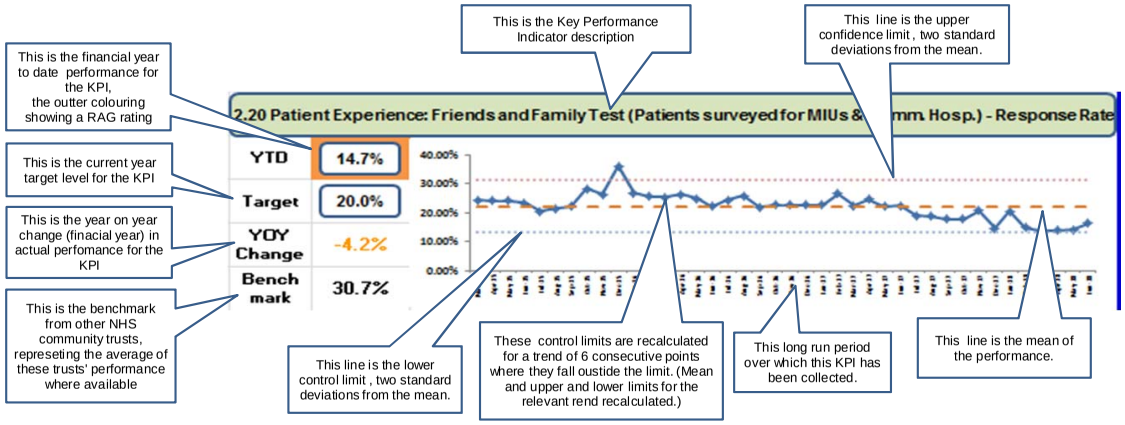
Prevent Ill Health' is the best performing strategic goal with 75% of KPIs performing at either blue (achieving aspiration) or green (achieving target).

50% (3 of 6) of the "Integrate Services" indicators are red currently. However, it should be noted all 3 of these are new indictors related to whole systems working so are under review

Overall, of the 46 indicators, 61% are blue/green, 17.5% are amber and 21.5% are red.

Of the red indicators, 6 are improving, and 4 have worsened since last month's report.

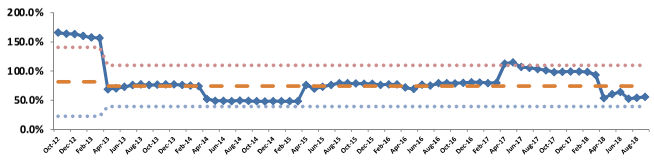
Run Charts explained



1. Prevent Ill Health

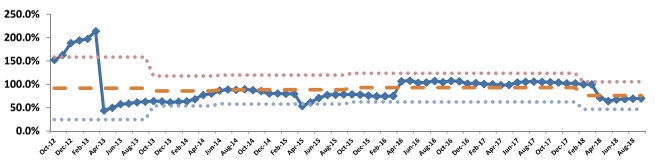
KPI 1.1 Prevention: Stop Smoking - Nos. of 4 week Quitters (Kentwide): YTD performance against trajectory (%)

YTD	55.9%
Target	100.0%
YOY Change	-37.9%
Bench mark	N/A



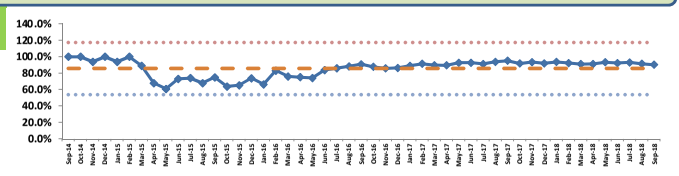
KPI 1.2 Prevention: Health Checks Carried Out (Kentwide): YTD performance against trajectory (%)

YTD	70.1%
Target	100.0%
YOY Change	-30.1%
Bench mark	N/A



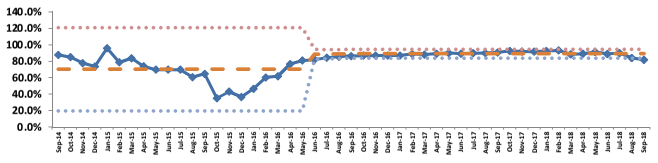
KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days

YTD	92.0%
Target	90.0%
YOY Change	-0.5%
Bench mark	N/A



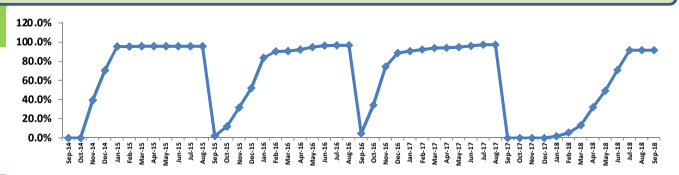
KPI 1.4 Health Visiting - 6-8 week assessment undertaken by 8 weeks

YTD	87.7%
Target	85.0%
YOY Change	-3.2%
Bench mark	N/A



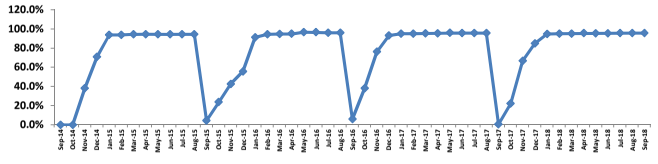
KPI 1.5 School Health - Reception Children Screened for Height and Weight

YTD	91.7%
Target	90.0%
YOY Change	78.5%
Bench mark	N/A



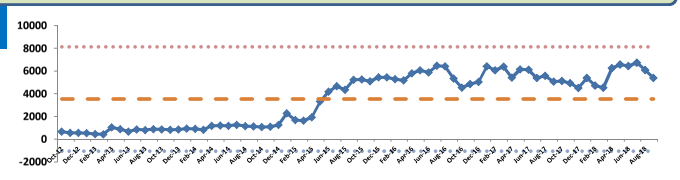
KPI 1.6 School Health - Year 6 Children Screened for Height and Weight

YTD	95.6%
Target	90.0%
YOY Change	0.4%
Bench mark	N/A



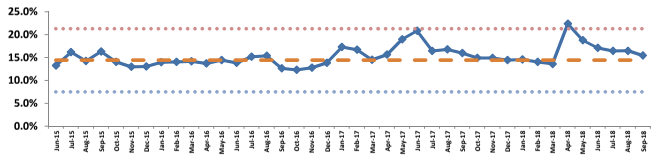
KPI 1.7 LTC/ICT - Admissions Avoidance (using agreed criteria)

YTD	37575
Target (YTD)	31539
YOY Change	N/A
Bench mark	N/A



KPI 1.8 Percentage of LTC/ICT patients that had at least one visit which Avoided a Hospital Admission

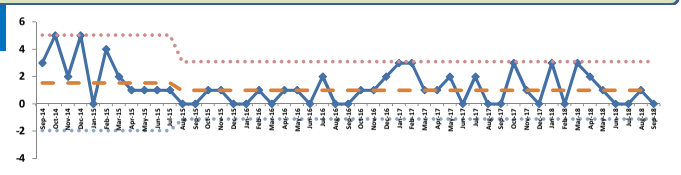
YTD	17.8%
Target	15.0%
YOY Change	1.8%
Bench mark	N/A



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

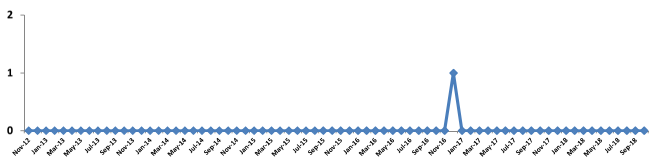
KPI 2.1 Number of Teams with an Amber or Red Quality Scorecard Rating (Year to Date)

YTD	4
Target	12
YOY Change	-11
Bench mark	N/A



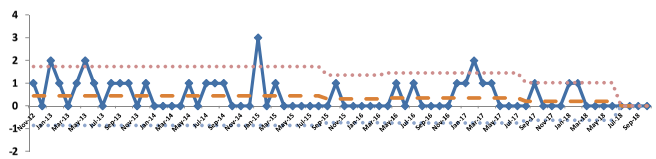
KPI 2.2 Never Events: Number

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



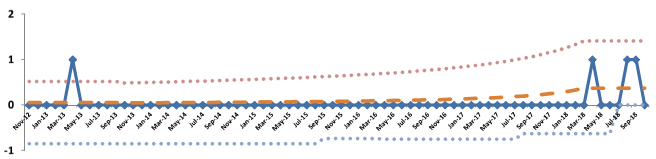
KPI 2.3 Infection Control: C.Diff (Target <6 cases in year) (Target YTD)

YTD	0
Target	6
YOY Change	-4
Benchmark	N/A



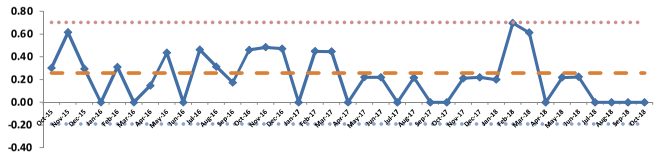
KPI 2.4 Infection Control: MRSA cases where KCHFT provided care (Target 0 cases)

YTD	3
Target	0
YOY Change	3
Benchmark	N/A



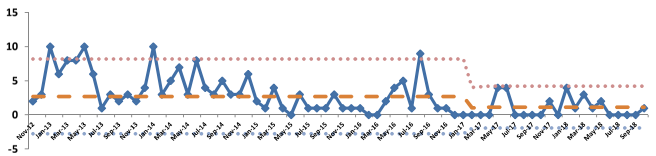
2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days

YTD	0.06
Target	0.19
YOY Change	-0.15
Benchmark	N/A



2.6 Avoidable Pressure Ulcers - Grade 3 & 4 (Target YTD)

YTD	4
Target	16
YOY Change	-14
Benchmark	N/A

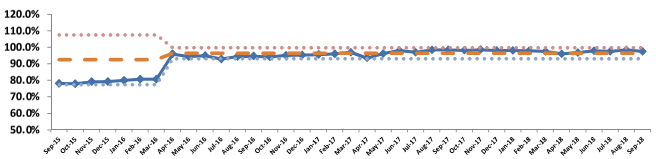


2.7 End of Life Care: Percentage of End of Life patient with an updated Personalised Care Plan (PCP)

YTD	33.0%
Target	60.0%
YOY Change	N/A
Benchmark	N/A

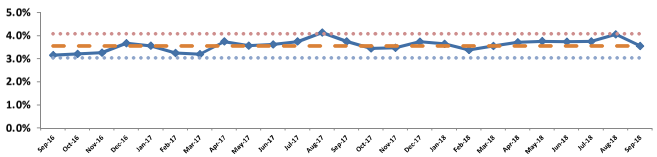
2.8 Contractual Activity: YTD as % of YTD Target

YTD	97.5%
Target	100.0%
YOY Change	-0.1%
Benchmark	N/A



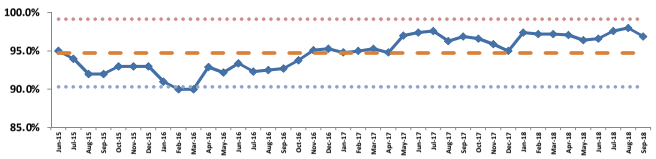
2.9 Trustwide Did Not Attend Rate: DNAs as a % of total activity.

YTD	3.8%
Target	4.0%
YOY Change	0.1%
Benchmark	4.0%



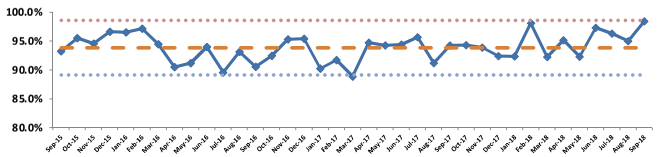
2.10 LTC/ICT Response Times Met (%)

YTD	97.1%
Target	95.0%
YOY Change	0.5%
Benchmark	N/A



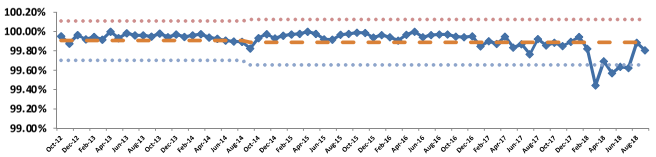
2.11 Rapid Response - Percentage of Consultations started within 2hrs of referral acceptance (Trustwide)

YTD	95.8%
Target	95.0%
YOY Change	1.8%
Benchmark	93.7%



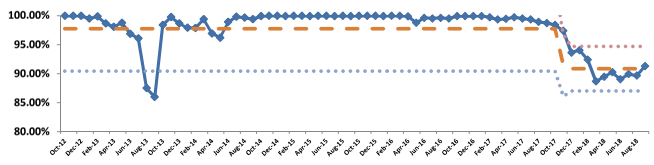
2.12 Total Time in MIUs: Less than 4 hours

YTD	99.70%
Target	95.0%
YOY Change	-0.1%
Benchmark	99.4%



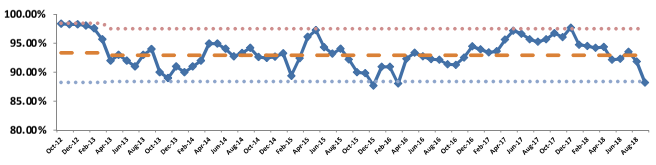
2.13 Consultant Led 18 Week RTT (Monthly Target 95%) - Incomplete Pathways

YTD	90.0%
Target	95.0%
YOY Change	-6.7%
Bench mark	98.0%



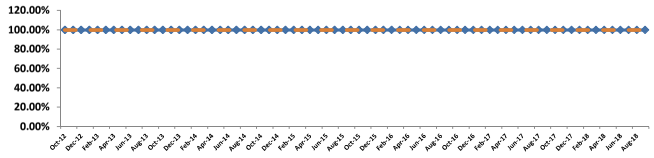
2.14 Allied Health Professionals Referral to Treatment Times (RTT)

YTD	92.1%
Target	95.0%
YOY Change	-3.8%
Bench mark	97.6%



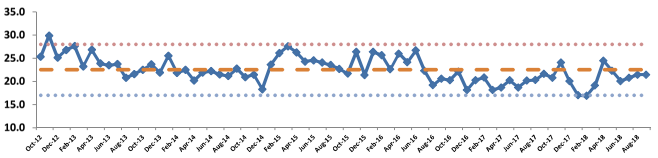
2.15 Access to GUM: within 48 hours (Monthly Target 100%)

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



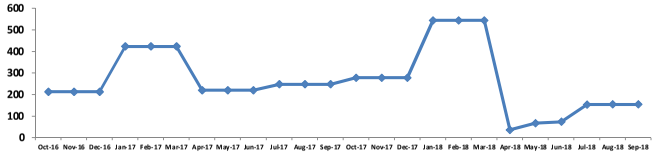
2.16 Length of Stay (Median Average)

YTD	21.8
Target	21.0
YOY Change	1.9
Bench mark	25.6



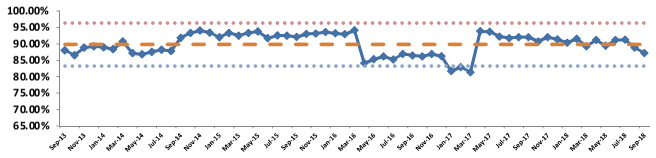
2.17 Research: Participants recruited to national portfolio studies (Year to Date)

YTD	155
Target	240
YOY Change	N/A
Bench mark	N/A



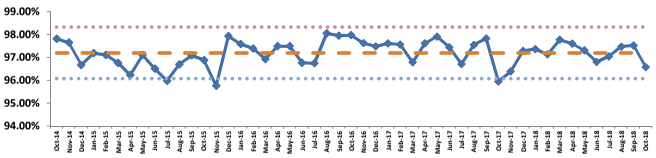
2.18 Outcomes: Percentage of outcomes achieved upon discharge for planned care and therapy services.

YTD	89.9%
Target	80.0%
YOY Change	-1.9%
Bench mark	N/A



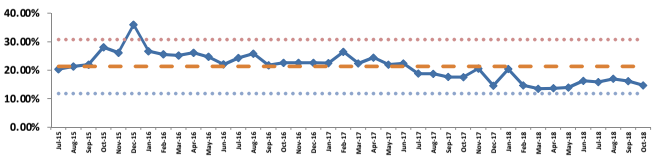
2.19 Patient Experience: Friends and Family - Percentage of Patients who would Recommend KCHFT.

YTD	97.2%
Target	95.0%
YOY Change	-0.1%
Bench mark	95.8%



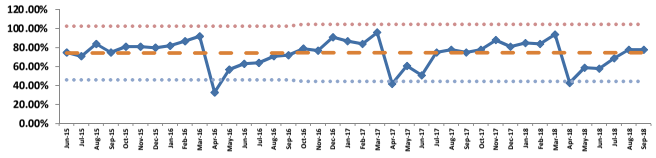
2.20 Patient Experience: Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp.) - Response Rate

YTD	15.4%
Target	20.0%
YOY Change	-3.4%
Bench mark	30.7%



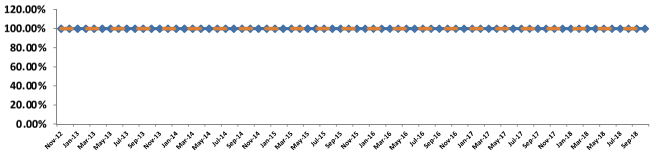
2.21 Clinical Audit: percentage of audit recommendation implemented by deadline.

YTD	78.0%
Target	95.0%
YOY Change	-16.0%
Bench mark	N/A



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

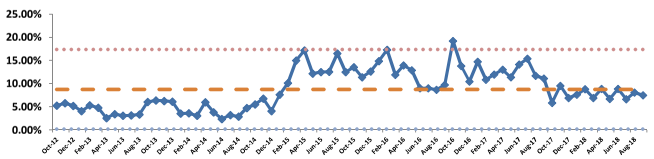
YTD	100.0%
Target	100.0%
YOY Change	0.0%
Bench mark	N/A



3. Integrate Services

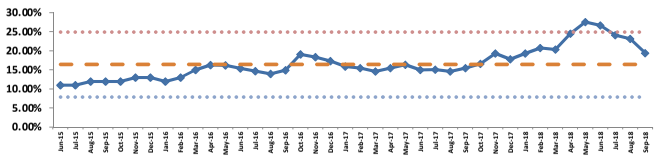
3.1 Delayed Transfers of Care as a % of Occupied Bed Days

YTD	7.8%
Target	9.5%
YOY Change	-2.4%
Bench mark	12.5%



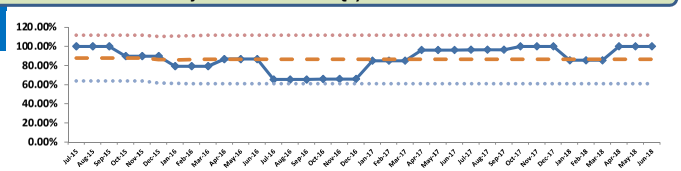
3.2 Percentage of LTC/ICT Referrals coming from within KCHFT

YTD	24.3%
Target	10.0%
YOY Change	7.1%
Bench mark	N/A



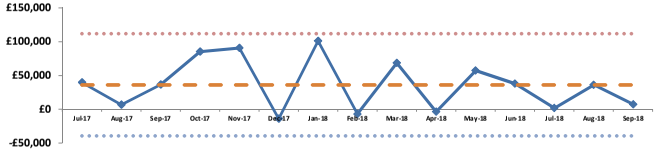
3.3 CQUINs: combined measure of CQUIN performance (% of CQUIN money achieved to 18/19 Q1)

YTD	100.0%
Target	85.0%
YOY Change	N/A
Bench mark	N/A



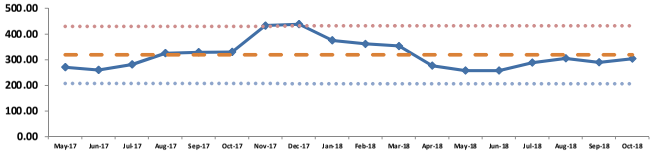
3.4 Home First cost saving associated with reduction of excess bed days - Monthly Average £s (West Kent)

YTD Average	£22,979
Target	£40,000
YOY Change	-£16,617
Bench mark	N/A



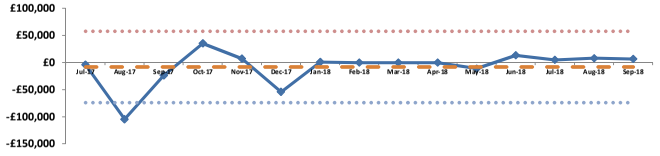
3.5 Average wait time (mnutes) for Accident and Emergency Services (West Kent)

YTD Average	283
Target	240
YOY Change	-53
Bench mark	N/A



3.6 Home First cost saving associated with reduction of excess bed days - Monthly Average £s (East Kent)

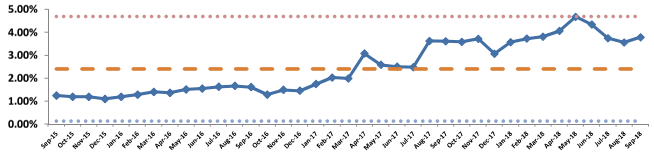
YTD Average	£4,522
Target	£10,000
YOY Change	£12,643
Bench mark	N/A



4. Develop sustainable services

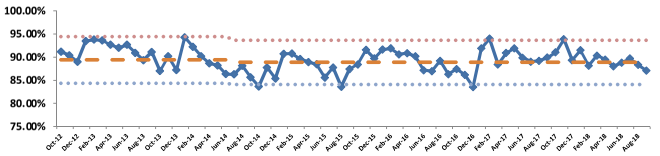
4.1 Percentage of LTC/ICT Face to Face Contacts that were carried out in a clinic

YTD	4.0%
Target	5.0%
YOY Change	0.7%
Bench mark	N/A



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

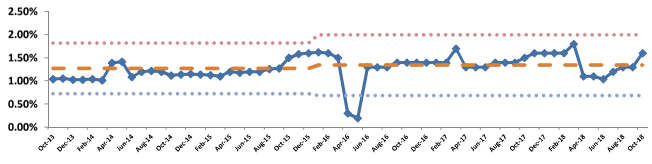
YTD	88.6%
Target	87.0%
YOY Change	-1.9%
Bench mark	90%



4. Develop sustainable services

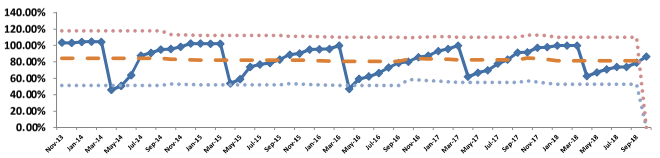
4.3 Income & Expenditure - Surplus (%)

YTD	1.6%
Target	1.0%
YOY Change	-0.2%
Bench mark	1%



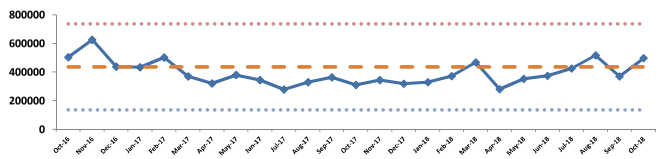
4.4 CIP Achieved against Plan (%)

YTD	86.8%
Target	100.0%
YOY Change	-13.2%
Bench mark	75%



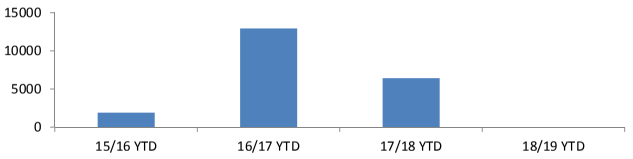
4.5 External Agency spend against Trajectory (£000s)

YTD	2825
Target	4396
YOY Change	N/A
Bench mark	N/A



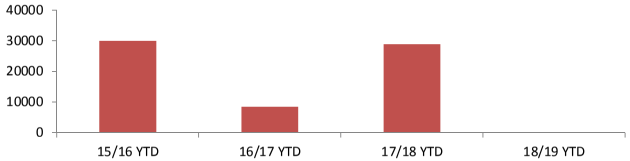
4.6 Annual Value of Tenders Won (of those that reach award stage - £000s)

YTD	0
Target	N/A
YOY Change	-6
Bench mark	N/A



4.7 Annual Value of Tenders Lost (of those that reach award stage - £000s)

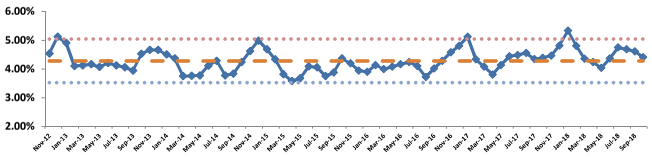
YTD	0
Target	N/A
YOY Change	-29
Bench mark	N/A



Be The Best Employer

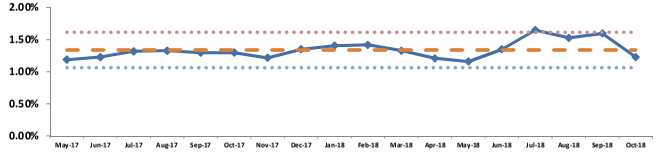
5.1 Sickness Rate

YTD	4.44%
Target	3.90%
YOY Change	-0.01%
Bench mark	4.40%



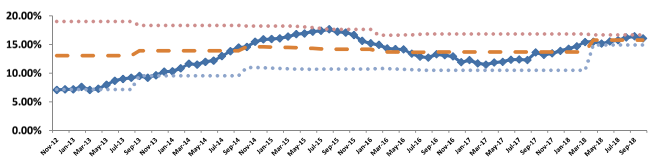
5.2 Sickness Rate (Stress and Anxiety)

YTD	1.39%
Target	1.15%
YOY Change	0.11%
Bench mark	N/A



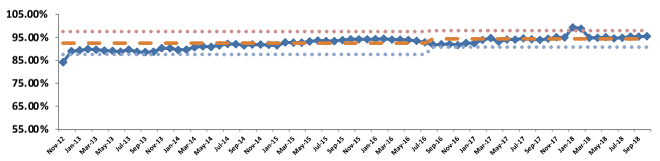
5.3 Unplanned Turnover Rate

YTD	16.07%
Target	14.13%
YOY Change	0.61%
Stretch Target	12.13%



5.4 Mandatory Training: Combined Compliance Rate

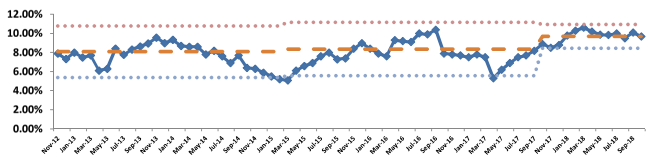
YTD	95.5%
Target	85.0%
YOY Change	0.69%
Bench mark	86.80%



Be The Best Employer

5.5 Gross Vacancy Factor (percentage of the budgeted WTE unfilled by permanent workforce)

YTD	9.70%
Target	9.66%
YOY Change	-0.90%
Stretch Target	7.66%



2.0 Quality Report

2.1 Assurance on Safer Staffing

The shift fill rates for community hospital wards are set out below. The day fill rate for registered nurses (RN) in October was 92%, a slight increase from 90% in September. The night shift fill rate for RN's was 99%, an increase from 98%. The Chief Nurse will provide commentary on any areas less than 95%.

Six hospitals had day shifts with an RN fill rate of below 95%. Edenbridge Hospital increased from the 77% in September but still had the lowest fill rate at 84.7%, Deal 88.7%, Tonbridge Goldsmid 90.3%, Hawkhurst 91.9%, QVMH 93.5.3% and Sevenoaks 94.4%. Edenbridge had challenges covering their RN vacancies, and Deal has not been able to cover the vacant shifts due to staff on long term sickness. All the hospitals had a night fill rate over 95%.

Primrose ward does not have substantive RN staff because it is a therapy ward only, but due to higher patient dependency and acuity they employed RN cover for 45 day shifts and 29 night shifts.

There have been additional HCAs on a number of shifts in most hospitals, the majority of these have been to cover when the RN shifts could not be filled, and additionally Whitstable and Tankerton, QVMH and Faversham required additional staff to provide safe care for patients with cognitive impairment. The ward matrons have been asked to ensure that where additional staff are requested for patients with cognitive impairment this is added to the red flag submission as the numbers reported are not reflected in the red flag report. One ward (QVMH), now has a therapeutic worker in post, Deal has a therapeutic worker on maternity leave and the remaining east Kent wards are in the process of recruitment. Therapeutic workers are not in place in west Kent.

	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RN's	HCA's	RN's	HCA's	RN's		HCA's		RN's		HCA's	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
Faversham	97.6%	134.4%	98.4%	108.1%	930	907.5	1395	1875	682	671	682	737
Deal	88.7%	132.8%	95.2%	106.5%	930	825	1395	1852.5	682	649	682	726
QVMH	93.5%	124.2%	98.4%	117.7%	930	870	1395	1732.5	682	671	682	803
Whit &Tank	98.4%	151.6%	100.0%	119.4%	930	915	1162.5	1762.5	682	682	682	814
Sevenoaks	94.4%	115.1%	98.4%	100.0%	930	877.5	1395	1605	682	671	1023	1023
Tonbridge - Goldsmid	90.3%	101.3%	98.4%	109.7%	930	840	1162.5	1177.5	682	671	341	374
Tonbridge - Primrose (HCA% includes some RN activity)	N/A	83.3%	N/A	67.7%	0	0	1395	1162.5	0	0	1023	693
Hawkhurst	91.9%	128.5%	100.0%	100.0%	930	855	1395	1792.5	682	682	682	682
Edenbridge	84.7%	127.4%	100.0%	100.0%	930	787.5	930	1185	682	682	682	682
Total	**92%**	**122%**	**99%**	**101%**	**7440**	**6878**	**11625**	**14145**	**5456**	**5379**	**6479**	**6534**
	Over 90% Fill Rate			65% to 90% Fill rate				Less than 65%			Over 110%	

The fill rate Westview KCC integrated units is set out below. The unit at Westview has 15 beds. Staffing is reviewed daily and shortages are subject to the same escalation processes as other KCHFT wards.

	Day Fill Rate %		Night Fill Rate %		Day				Night			
	RN's	HCA's	RN's	HCA's	RN's		HCA's		RN's		HCA's	
					P hours	A hours	P hours	A hours	P hours	A hours	P hours	A hours
West View	100.0%	81.3%	101.6%	80.6%	930	930	1860	1140	682	693	1023	825

All wards are currently undertaking the audit for the 6 monthly safer staffing reviews.

2.2 Assurance on Pressure Ulcers

The following tables compare our current position for avoidable pressure ulcers acquired within our care, with incidents in 2017/18. Figures may change following completion of investigations.

2.2.1 Category 2 Pressure Ulcers

There have been 2 pressure ulcers acquired in our care that, following investigation, have now been categorised as avoidable.

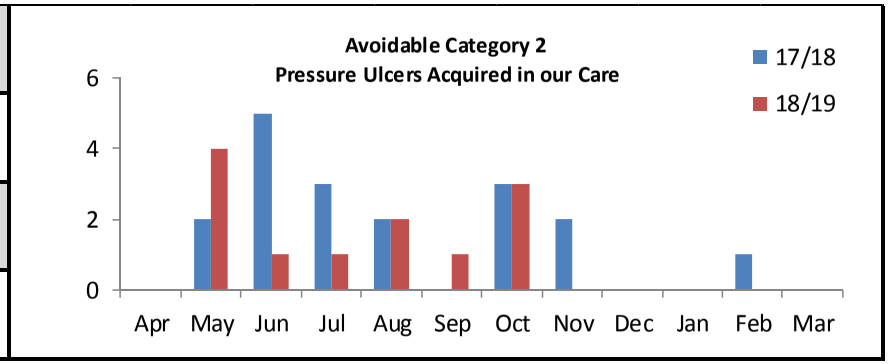
August - One additional avoidable pressure ulcer occurred in Long Term Services, Ashford.

September - One avoidable pressure ulcer occurred in the inpatient ward at Whitstable and Tankerton.

In October there have been 3 avoidable pressure ulcers:

- Edenbridge inpatient ward at the community hospital
- Ashford long term service community nursing
- Shepway long term services community nursing

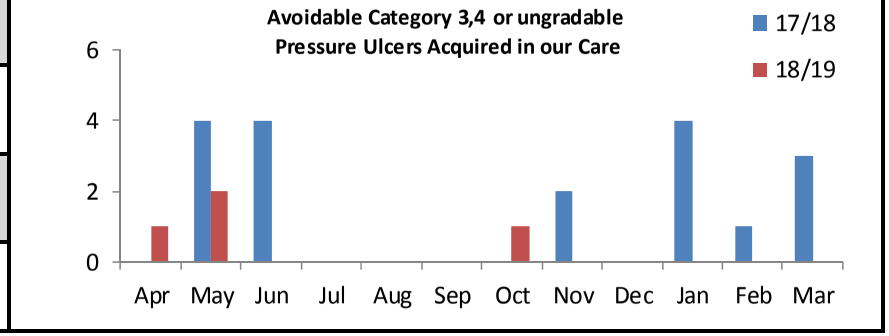
Current Month	**3**
18/19 YTD	**12**
17/18	**18**
Annual Target	**17**



2.2.2 Category 3, 4 or Ungradable Pressure Ulcers

There was one avoidable grade 3 pressure harm, acquired in our care, in October and this was in long term services, Canterbury.

Current Month	**1**
18/19 YTD	**4**
17/18	**18**
Annual Target	**17**

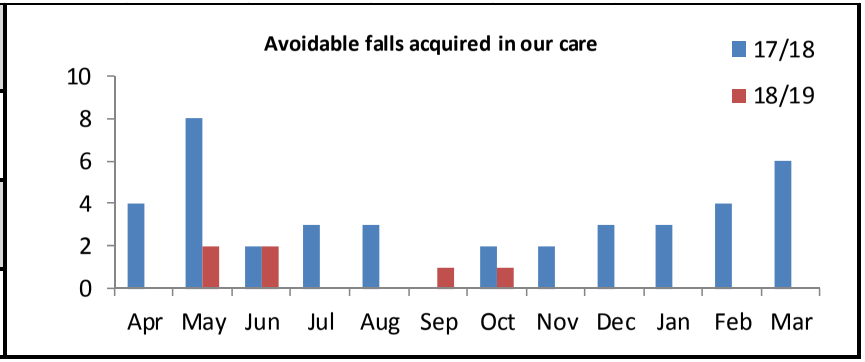


The Tissue Viability Team leads a pressure harm reduction group, and the team are working closely with teams where pressure harms occur to identify key themes lessons to allow learning to be shared.

2.3 Assurance on Falls

There were 47 falls reported across KCHFT in October 2018, one of which was acquired in our care and found to be avoidable. A patient being nursed in an observable bay was found on the floor between the chair and the bed. The patient was on a high low observable bed, the mattress was at the side of the bed, 15 minute safety checks were in place as the patient was at high risk of falls and a sensor alarms were in place. However, the sensor alarm was not transferred from the bed sensor to the chair sensor by the bank nurse on duty, so therefore did not alert staff when the patient was mobilising. This resulted in low harm to the patient. Staff have been reminded on the importance of transferring required sensor equipment to ensure patient safety.

Current Month	**0**
18/19 YTD	**6**
17/18	**40**
Annual Target	**37**



2.4 Assurance on Medication incidents

A total of 18 avoidable medication incidents, acquired in our care, have been reported and investigated to date during October 2018.

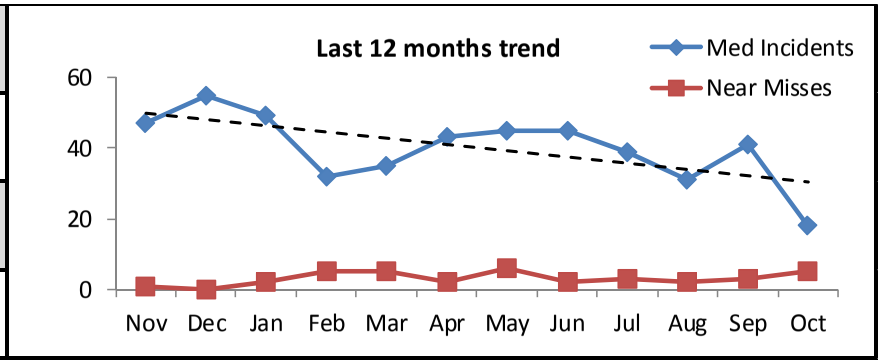
The highest reported category of avoidable incidents were omitted medication and wrong quantity, making up 22% each of the total number during October 2018. The second highest reported category of avoidable incidents is wrong frequency, and wrong method of preparation /supply incidents making up 17% each of the total number during October 2018.

Of the 18 avoidable incidents that occurred during October 2018:

15 (83%) resulted in no harm to the patient with the majority of these being omitted medication.

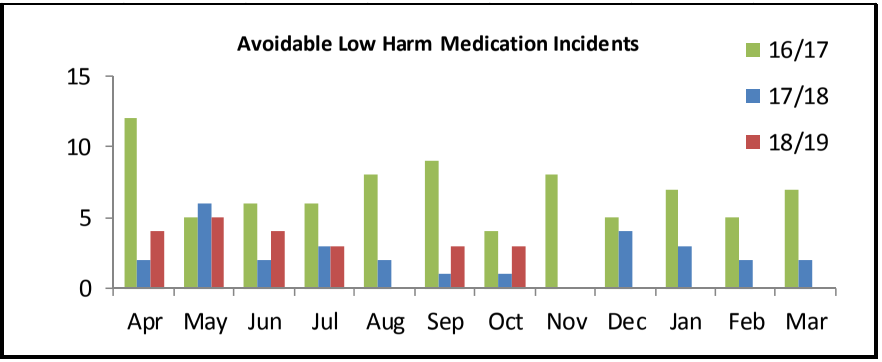
3 (17%) resulted in low harm to the patient with these incidents being wrong frequency, wrong quantity and wrong drug / medicine. These related to a contraception injection being administered after one week instead of two weeks, the administration of a wrong drug and a double dose of a drug being administered. The patients were monitored in all cases.

Current Month	**18**
18/19 YTD	**262**
17/18	**583**
Target	**523**



All incidents were investigated and the lessons learnt have been shared. There were no incidents that resulted in moderate harm, severe harm or death of a patient.

Current Month	**3**
18/19 YTD	**22**
17/18	**28**
Annual Target	**24**



2.5 Assurance on Patient Experience

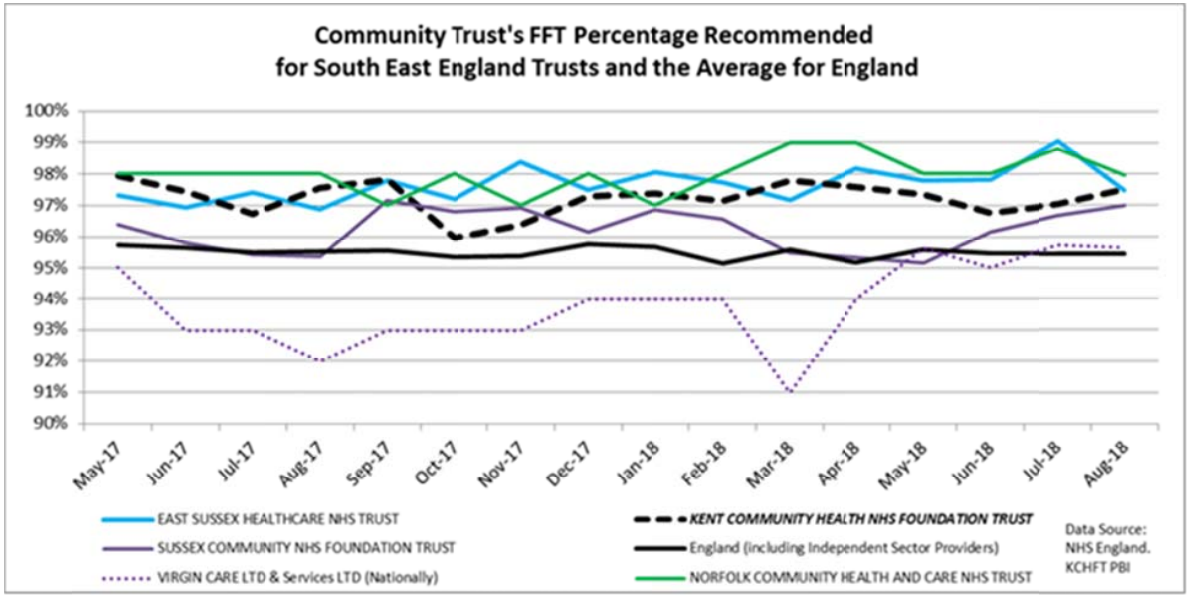
2.5.1 Meridian Patient Experience survey results

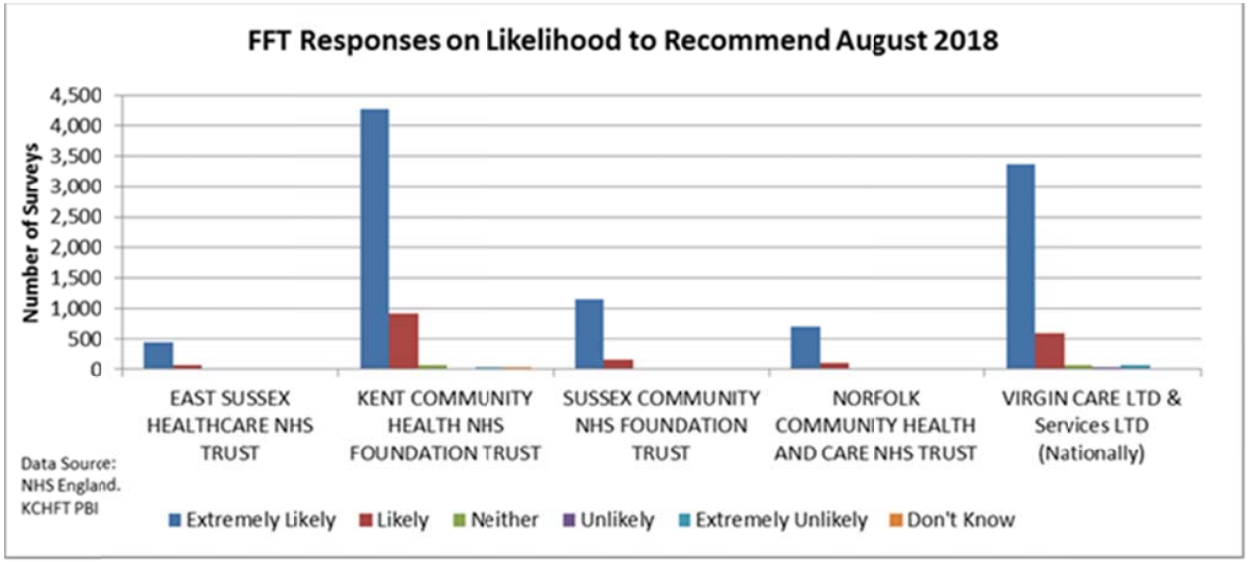
5,460 surveys were completed by KCHFT patients, relatives and carers with a strong combined satisfaction score of 97.02% in October. Survey volumes have increased in October compared with September. This is due to more survey completions by sexual health and dental services.

2.5.2 The NHS Friends and Family Test (FFT)

The NHS Friends and Family Test score for October shows that satisfaction levels have slightly decreased (96.6%) when compared with September's score of 97.5%. In October 2018, 0.55% of our patients chose not to recommend the service they received, compared with 0.68% in September. 47 people chose the 'don't know' response in October compared to 27 in September. 15 of the 'don't know' responses were children and there were 9 for the dental service.

To assist with benchmarking, Norfolk Community Health and Care NHS Trust, who have been given a CQC rating of outstanding, are included in reporting. Norfolk average around 98% for their NHS FFT score, however they collect less than a ¼ of the surveys conducted by KCHFT as a ratio of their service provision.


Community Trust's FFT Percentage Recommended
for South East England Trusts and the Average for England
100%
99%
98%
97%
96%
95%
94%
93%
92%
91%
90%
May-17
Jun-17
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18
Jul-18
Aug-18
EAST SUSSEX HEALTHCARE NHS TRUST
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST
SUSSEX COMMUNITY NHS FOUNDATION TRUST
England (including Independent Sector Providers)
VIRGIN CARE LTD & Services LTD (Nationally)
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST
Data Source:
NHS England.
KCHFT PBI


FFT Responses on Likelihood to Recommend August 2018
Number of Surveys
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
EAST SUSSEX HEALTHCARE NHS TRUST
KENT COMMUNITY HEALTH NHS FOUNDATION TRUST
SUSSEX COMMUNITY NHS FOUNDATION TRUST
NORFOLK COMMUNITY HEALTH AND CARE NHS TRUST
VIRGIN CARE LTD & Services LTD (Nationally)
Data Source:
NHS England.
KCHFT PBI
Extremely Likely
Likely
Neither
Unlikely
Extremely Unlikely
Don't Know

2.6 Assurance on Clinical Audit and Research

2.6.1 Audit

The annual KPI target is for 95% of clinical audit recommendations to be implemented. This is achieved via a stepped target during the year. September target not achieved in Adults East, Adults SES, CYP Specialist Services and Dental. This will be monitored and progressed during the month.

KPI Actions Target %	April >35%	May >35%	June >55%	July >55%	Aug >75%	Sept >80%
Due audit recommendations implemented - KPI 4.6 Target April >35%	43%	59%	58%	69%	78%	78%
Actions overdue by more than 3 months - KPI 36 Target <=10%	0%	1%	6%	5%	10%	11%
Actions overdue by more than 6 months - KPI 37 Target <=5%	2%	4%	2%	2%	0%	0%

2.6.2 Clinical Audit Reporting

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

KPI Target 50%	April	May	June	July	Aug.	Sept.
Receipt of full report within specified timeframe	55%	62%	67%	68%	74%	79%

2.6.3 Research

KCHFT works to deliver an annual recruitment pledge to the Kent Surrey and Sussex Clinical Research Network to deliver high quality national studies (known as portfolio studies) to local patients. This is a Key Performance Indicator for research.

Key Performance Indicators – Reporting Target 2017/18 = 240	Quarter 1	Quarter 2	Achieved
Recruitment to portfolio studies	74	155	Yes

2.6.4 National Institute for Clinical Excellence (NICE)

The number of NICE guidance/ standards that were issued in September 2018 was fourteen.

The number of guidance/standards issued in May 2018 that were due for assessment in September 2018 was seven. Four of the guidance/ standards issued were deemed applicable to at least one service throughout the Trust.

3.0 Workforce Report:

3.1 Assurance on Retention

3.1.1 Turnover

October's Turnover rate was 18.72% (874 leavers over 4668.75 average headcount in the rolling 12 month period November 2017 – October 2018), a decrease of 0.63% on September 2018 figure of 19.35%. Trust Headcount has increased from 4606 to 4623 since September, an increase of 17 staff.

Fig.1 Turnover Rates by Month

Current Month	**18.72%**
18/19 YTD	**18.72%**
17/18	**18.81%**
Target	**16.47%**

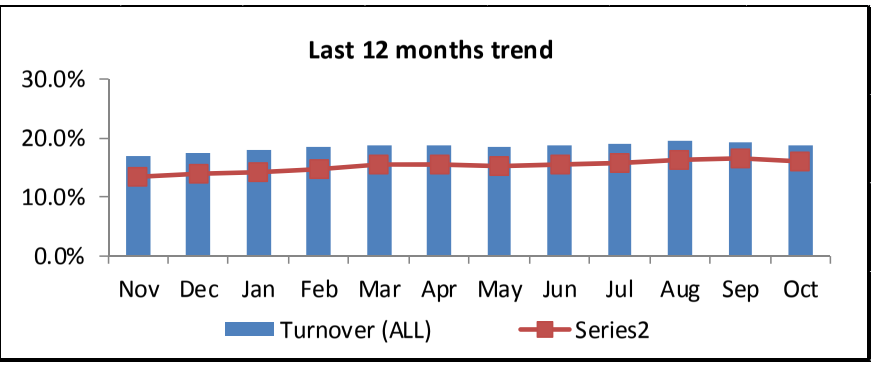


Fig.2 Directorate Turnover and Proportion

Directorate	Turnover %	Proportion %
Operations Directorate	19.11%	83.28%
IT	13.48%	2.88%
Nursing & Quality Directorate	16.55%	1.41%
Medical Director	12.57%	1.21%
HR, OD & Communications	25.08%	2.05%

Finance Directorate	19.63%	1.84%
Corporate Services Directorate	21.85%	1.19%
Estates	14.66%	6.14%

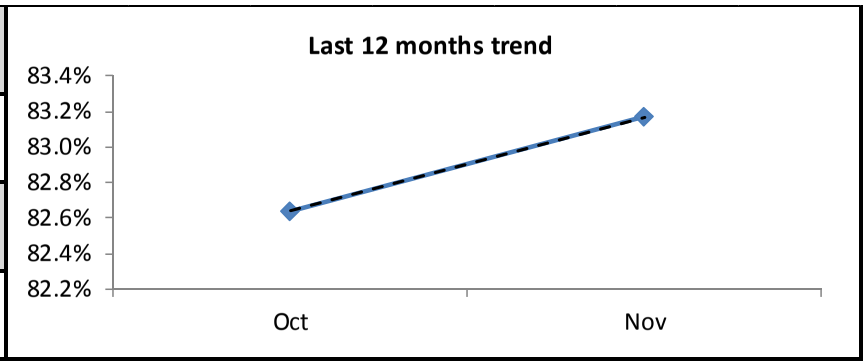
The table above illustrates turnover by Directorate throughout the Trust over the last 12 months. Although some areas show a high turnover they are proportionally very small parts of the organisation where a small number of changes will have a big impact on the turnover percentage figures detailed.

3.1.2 Stability

As requested we have included a new metric to highlight the stability of the workforce. This new metric measures the number of staff remaining in employment over the 12 month rolling period ending in the month being reported on (e.g. November 2017 – October 2018).

In October 2018, this figure stands at 83.17% at the Trust level, or 4,795 employees were in post at the start of the period, with 3,988 still remaining in post at the end. This is a slight increase on the figures for September 2018 - 82.64%, or 4,810 employees in post at the start of the period, with 3,975 remaining at the end.

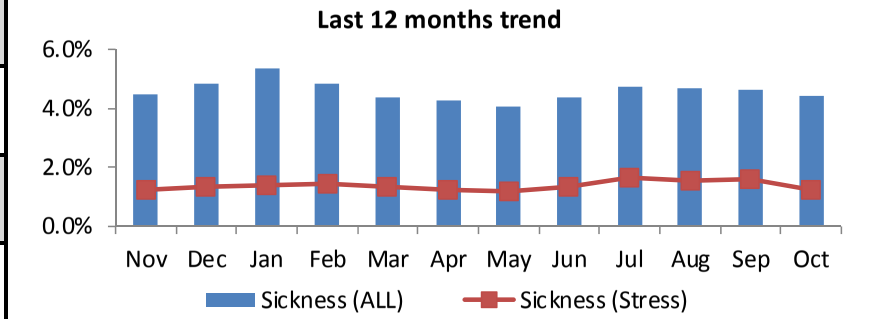
Current Month	**83.2%**
18/19 YTD	**83.2%**
17/18	**N/A**
Annual Target	**TBC**



3.2 Assurance on Sickness

3.2.1 Sickness Absence

Current Month	**4.41%**
18/19 YTD	**4.44%**
17/18	**4.45%**
Annual Target	**3.90%**



Sickness remains above the Trust target at 4.44% financial year to date (target 3.90%) or 182.5k days of lost time, which saw an increase from the September position (4.42%). October's in-month sickness rate (4.41%) saw a decrease in the sickness rate from September (4.62%). Nationally Community Service providers average a sickness rate of 4.68%.

Fig.3 Sickness Absence by Directorate (financial year to date)

Directorate	Sickness %	Time Lost (Hours)	Indicative Days Lost*	Proportion of Trust Staff (%)
Operations Directorate	4.68%	1,200,754.5	160,100.6	83.28%
IT	2.97%	28,609.9	3,814.7	2.88%
Nursing & Quality Directorate	2.29%	10,032.4	1,337.7	1.41%
Medical Director	1.19%	4,494.4	599.3	1.21%
HR, OD & Communications	4.55%	34,433.3	4,591.1	2.05%
Finance Directorate	2.04%	12,840.4	1,712.1	1.84%
Corporate Services Directorate	1.61%	6,231.8	830.9	1.19%
Estates	4.56%	71,550.4	9,540.1	6.14%
	4.44%	1,368,946.9	182,526.3	

*based on a 7.5hr day

All Directorates recorded sickness levels below the Trust target, except Operations at 4.7%, HR, OD & Comms at 4.55% and Estates at 4.6%. Across the Trust over 1.3m hours (or over 182,000 7.5hr days) were lost due to sickness.

Fig.3 Sickness Reasons

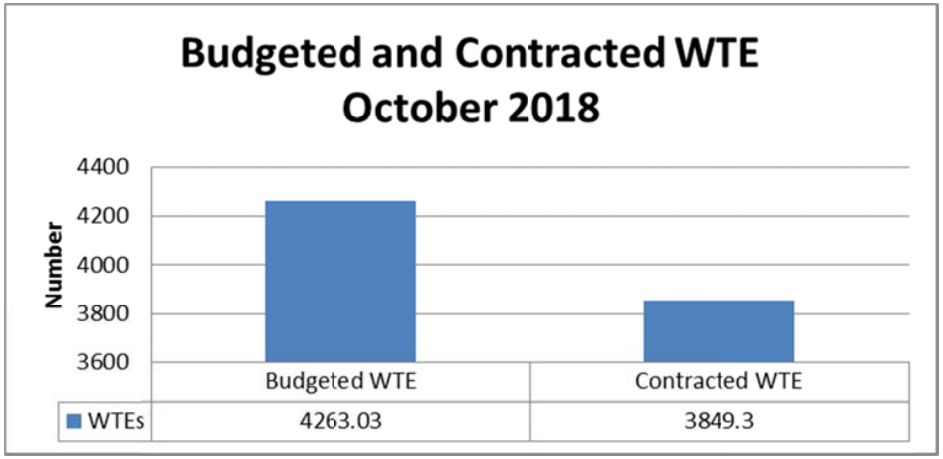
Absence Reason (Top 5 reasons only)	Proportion of Total Absence %	Time Lost (Hours)
S10 Anxiety/stress/depression/other psychiatric illnesses	31.46%	146,614.3
S12 Other musculoskeletal problems	13.86%	64,571.38
S13 Cold, Cough, Flu - Influenza	10.84%	50,505.08
S25 Gastrointestinal problems	7.63%	35,564.87
S11 Back Problems	5.59%	26,037.09

3.3 Assurance on Filling Vacancies

3.3.1 Establishment and Vacancies

Vacancy rates went up in September 2018 to 10.1% as the effect of winter initiatives were felt However, vacancies have since dropped again in October 2018 to 9.71% as high levels of recruitment activity has taken effect.

Fig.4 Budgeted / Contracted FTE



Budgeted WTE has decreased by 1.75 WTE from Sept 2018 to Oct 2018, Contracted WTE has increased by 14.90 WTE in the same period. The main change in Budgeted WTE was the removal of dental core trainee posts as the staff in post are now employed by Barts and recharged to the Trust and there were some other minor changes relating to smaller skill mix/CIP.

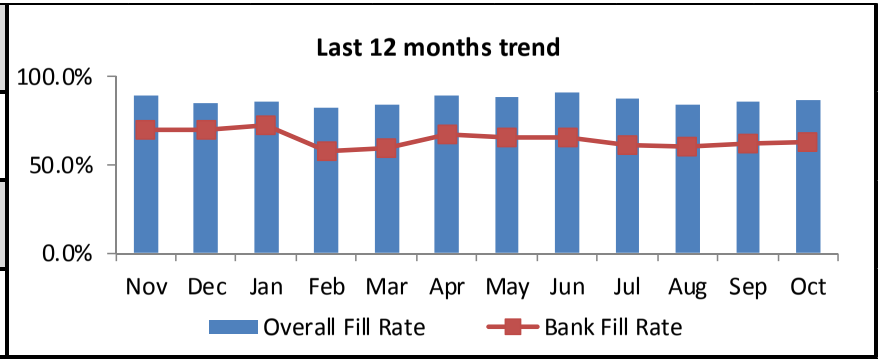
Activity continues to support local recruitment plans. Recruitment to the Nursing academy continues with offers having been made to fill all the student nurse posts, with 25 expected to start in February. A further day has been allocated for the end of November to attempt to fill all 25 Student Nursing Associate roles. Any candidates suitable but not appointed are being redirected to posts in services.

3.3.2 Temporary Staff Usage

There were 6,108 temporary staff shifts requested in October 2018, an increase of 7.52% (427 shifts) on last month's demand (5,681 shifts).

Fig.5 Agency/Bank Fill Rate

Current Month	**86.20%**
18/19 YTD	**87.33%**
17/18	**86.52%**
Target	**90.00%**



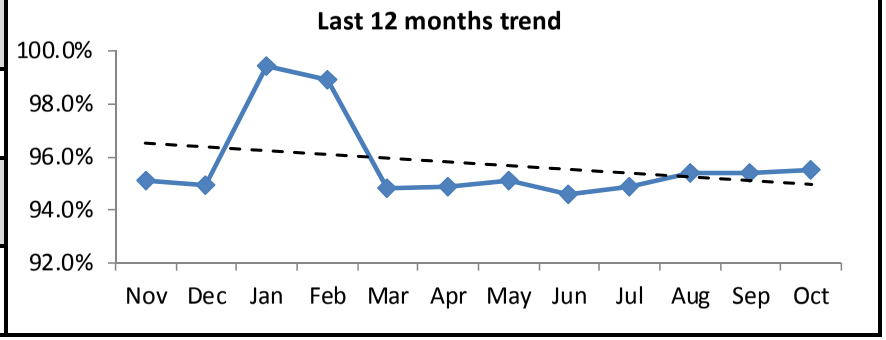
86.20% of shifts were filled in October an increase of 0.53% between September 2018 and October 2018. 843 out of 6108 requests for temporary staff went unfilled. Bank fill rate was 63.00% of shifts (5265 shifts) again an increase on the figures from September 2018 (61.7%).

The use of non-compliant price cap agencies decreased in October 2018 to 3.2% (or 198 shifts) from the September figure of 3.8%.

3.4 Assurance on Training Compliance

Fig. 5 Mandatory Training Compliance

Current Month	**95.5%**
18/19 YTD	**95.5%**
17/18	**94.8%**
Annual Target	**85.0%**



Mandatory training compliance increased from 95.35% in September to 95.49% in October 2018, whilst completed appraisals have remained static for September and October at 99.3%

Last month we reported Fire Safety for community hospitals and MCA Level 3 as being below 85% target both have moved above this target.

There are no mandatory subjects this month with less than 75% compliance.

4.0 Finance Report:

4.1 Assurance on Financial Sustainability

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	2,024	1,520	504
Year End Forecast £k	3,128	3,128	0

The Trust achieved a surplus of £2,024k to the end of October.

Pay and depreciation/interest have underspent by £6,503k and £96k respectively and non-pay has overspent by £3,986k.
Income has under-recovered by £2,108k.

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 M7 2018-19.

CIP — Rag rating: Amber

	Actual	Plan	Variance
Year to Date £k	2,114	2,436	-322
Year End Forecast £k	4,080	4,080	0

The Trust achieved CIPs of £2,114k to the end of October against a plan of £2,436k, which is £322k behind target.
87% of the total annual CIP target has been removed from budgets at month seven.

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	34,378	28,802	5,576
Year End Forecast £k		29,865	

Cash and Cash Equivalents as at M7 close stands at £34,378k, equivalent to 59 days operating expenditure.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	1,301	2,816	1,515
Year End Forecast £k	3,751	3,485	-266

Capital Expenditure year to date is £1,301k, representing 46% of the YTD plan.
The Trust's forecast capital expenditure for 2018-19 is £3.8m, representing a £266k variance to plan. The forecast overspend of £266k relates to investment in WiFi infrastructure for which additional central funding (PDC) has been agreed.

Agency Trajectories — Rag rating: Green

	M7			YTD		
	Actual £	Trajectory £	Variance £	Actual £	Trajectory £	Variance £
External Agency Expenditure (inc. Locums) £k	498	628	130	2,825	4,396	1,571
Locum Expenditure £k	159	106	-52	640	744	104

External Agency Expenditure (Inc. Locums) was £498k against £628k trajectory in October. (YTD £2,825k against £4,396k trajectory).
Locum Expenditure in October was £159k against £106k trajectory. (YTD £640k against £744k trajectory).

4.2 Key Messages

Surplus: The Trust achieved a surplus of £2,024k (1.6%) to the end of October. Cumulatively pay and depreciation/interest have underspent by £6,503k and £96k respectively, and non-pay has overspent by £3,986k. Income has under-recovered by £2,108k.

Continuity of Services Risk Rating: EBITDA Margin achieved is 2.9%. The Trust scored 1 against the Use of Resources Rating, the best possible score.

CIP: £2,114k of savings has been achieved to October against a risk rated plan of £2,436k which is 13.2% behind target. The full year savings target of £4,080k is forecast to be achieved in full.

Cash and Cash Equivalents: The cash and cash equivalents balance was £34,378k, equivalent to 59 days expenditure. The Trust recorded the following YTD public sector payment statistics 99% for volume and 98% for value.

Capital: Capital Expenditure year to date is £1,301k, representing 46% of the YTD plan. The Trust's forecast capital expenditure for 2018-19 is £3.8m, representing a £266k variance to plan. The forecast overspend of £266k relates to investment in WiFi infrastructure for which additional central funding (PDC) has been agreed.

Agency: Agency expenditure was below trajectory for October and for the YTD.

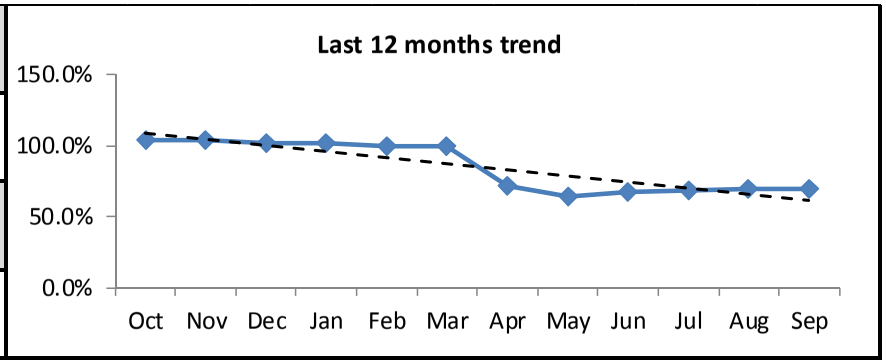
5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits

Health Checks

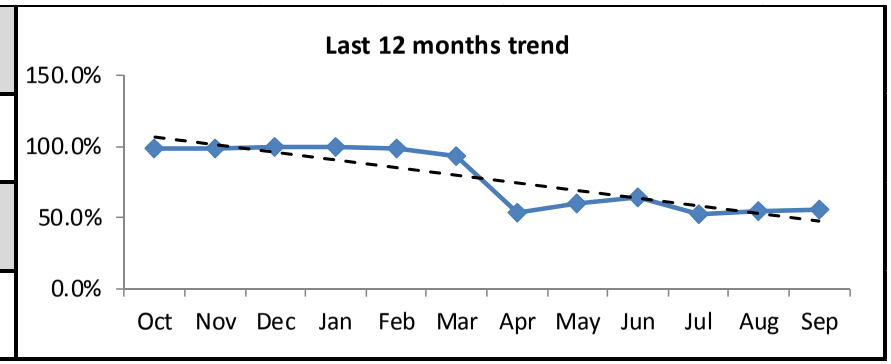
Current Month	70.1%
18/19 YTD	70.1%
17/18	100.2%
Annual Target	100.0%



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. KCC is aware of this issue and is performance managing the contract to try and resolve the issues outlined. In this respect, it has been agreed that the Apollo query runs will be initiated on a monthly basis from October 2018 (this was originally agreed as quarterly), which should help minimise any potential data errors and improve assurance for the GP practices. This on the Health Improvement risk register also. KCHFT trying to negotiate 18/19 target as this is the first year of a five year cohort to see if the target could be spread as this programme is very difficult to catch up once there is a poor start to the year.

Stop Smoking Quits

Current Month	55.9%
18/19 YTD	55.9%
17/18	93.8%
Annual Target	100.0%

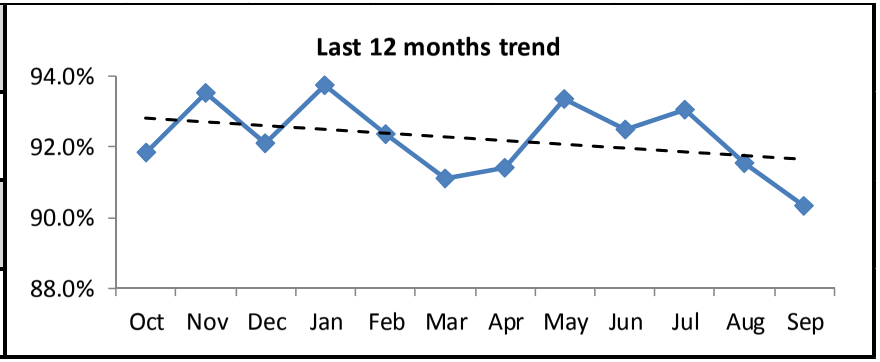


The ONE YOU Services has implemented a new IT system combining three client pathways into one as per the new contractual agreement with KCC. There have been some issues with the new IT system and the service now has a focus on supporting the third party providers. The numbers are lower and the service will work hard to get the IT system up to date. The last few months have seen recovery improvements following the action plans in place. The drop in the number of quits from April coincided with the implementation of the new integrated data management system. The team will be working with 3rd party providers to ensure that all outcomes are updated over the coming weeks in readiness for the Q2 Department of Health submission in December.

5.1.2 Health Visiting

New Birth Visits

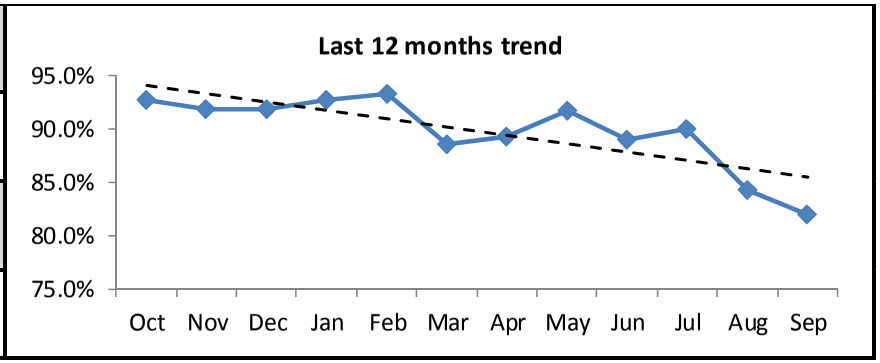
Current Month	**90.3%**
18/19 YTD	**92.0%**
17/18	**92.5%**
Target	**90.0%**



A slight downward trend is evident in the last couple of months, with Month 6 performance at 90.3%. The target of 90% has been consistently achieved and will be closely monitored through the monthly district level reports.

6-8 Week Checks

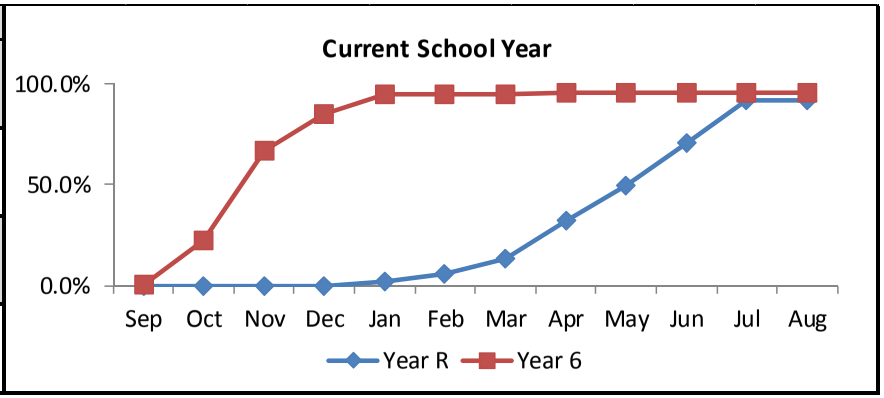
Current Month	**82.0%**
18/19 YTD	**87.7%**
17/18	**91.0%**
Target	**85.0%**



Month 6 performance has worsened to 82% having improved in month 4. There is an evident downward trend in the last 2 months, although the target of 85% for quarter 2 was achieved. 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 and it is hoped data cleansing will slightly improve the Month 6 position retrospectively (as it has done for Months 4 and 5.

5.1.3 National Child Measurement Programme (NCMP)

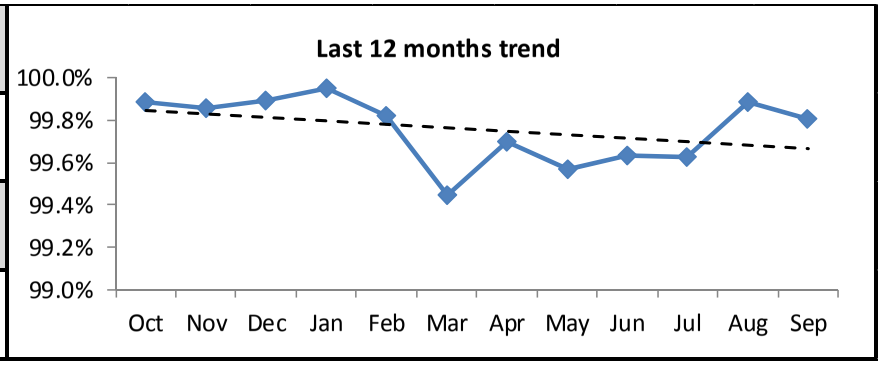
	Year R	Year 6
Current Month	**91.7%**	**95.6%**
17/18 School Year YTD	**91.7%**	**95.6%**
16/17 School Year	**97.3%**	**95.7%**
Annual Target	**90%**	**90%**



The measurement programme for Year 6 pupils has been completed for the 2017/18 school year, with a 95.6% completion rate, slightly down on last year. The reception year measurement programme reached 91.7%, achieving the trajectory and meeting the national target. The 2018/19 will begin shortly

5.1.4 Minor Injury Units (MIU) 4 Hour Wait Target

Current Month	**99.8%**
18/19 YTD	**99.7%**
17/18	**99.8%**
Target	**95.0%**



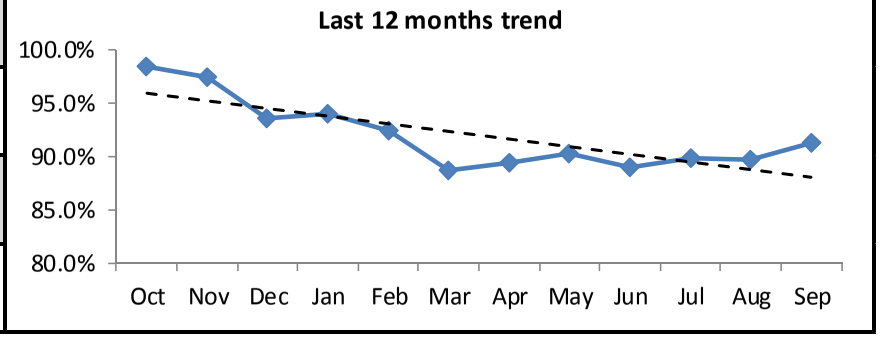
KCHFT's achievement of the 4 hour wait target for Minor Injuries Units has consistently been high, with 99.7% seen within 4 hours in 2018/19. There has been a slight increase in the number of breaches in the last few months, although the 4 hour target in Month 6 was still 99.8%

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	**91.3%**
18/19 YTD	**90.0%**
17/18	**96.7%**
Target	**92.0%**



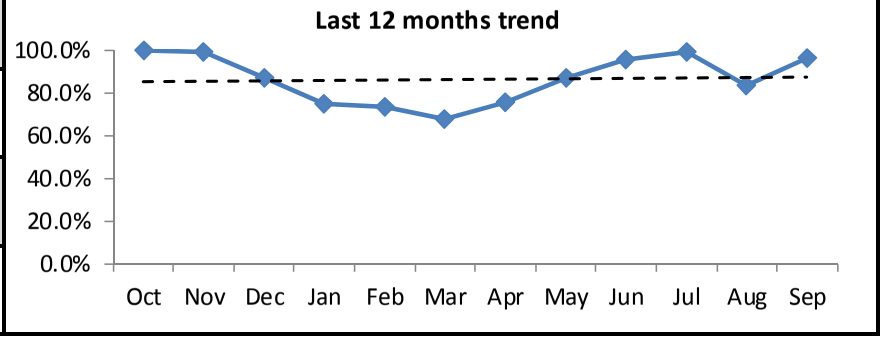
The proportion of patients on a consultant-led Referral to Treatment (RTT) pathway at month end who are waiting less than 18 weeks worsened between August 2017 and March 2018. The vast majority of our incomplete pathways over 18 weeks are within our Adult Chronic Pain and Orthopaedics services in east Kent. There has been increased demand pressure on this service which has caused a growing waiting list and discussions with commissioners to assist with the issue have so far proved difficult, with no further investment. KCHFT has been working on remodelling the services to improve the situation and this has started to take effect. Month 6 performance has improved slightly to 91.3% and it is expected that changes made to the service delivery will improve the position further over the next few months

	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	742	283	213	20	1	81.4%
Orthopaedics	2459	387	227	0	0	92.6%
Children's Audiology	384	0	0	0	0	100.0%
Community Paediatrics	484	182	7	0	0	99.0%
KCHFT Total	4069	852	447	20	1	91.3%

The above table shows the current breakdown of the waiting list for all services on a consultant-led pathway. While only 91.3% are below 18 weeks, the majority are between 18-36 weeks. The average wait for patients waiting over 18 weeks is 24.8 weeks.

5.1.7 6 Week Diagnostics (Audiology)

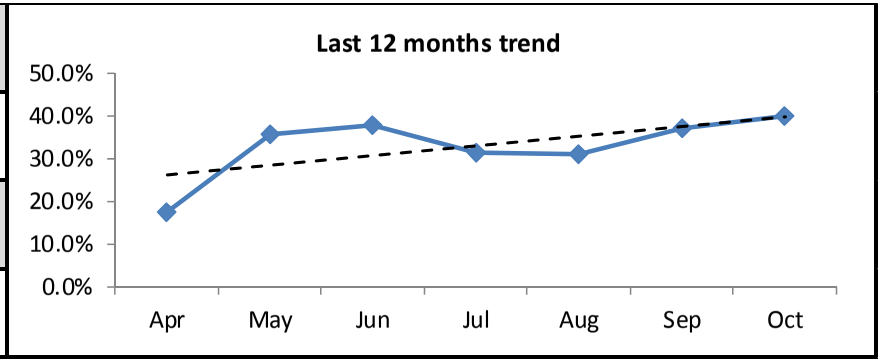
Current Month	**96.4%**
18/19 YTD	**89.8%**
17/18	**91.8%**
Annual Target	**95.0%**



There has been an improvement in performance in Month 6, with the service rectifying a backlog arising over the summer period. At the end of Month 6, 96.4% of children waiting for diagnostics had been waiting less than 6 weeks.

5.1.8 End of Life Care

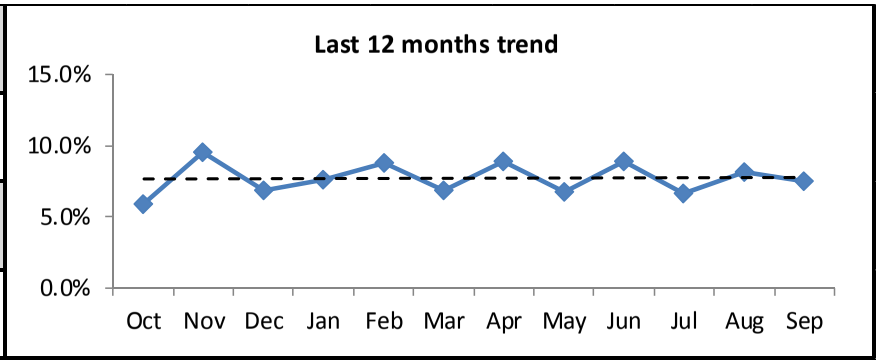
Current Month	**40.0%**
18/19 YTD	**33.0%**
17/18	**N/A**
Annual Target	**60.0%**



The end of life indicator is new for 18/19, reporting the percentage of End of Life patients who had an updated personalised care plan at their time of death; therefore no trend data is available prior to April 2018. While the performance for the year to date equates to only 33%, the personalised care planning window on CIS is still being embedded and the trajectory is an improving one. The target for this year has been set at 60%

5.1.9 Delayed Transfers of Care (DTOCs)

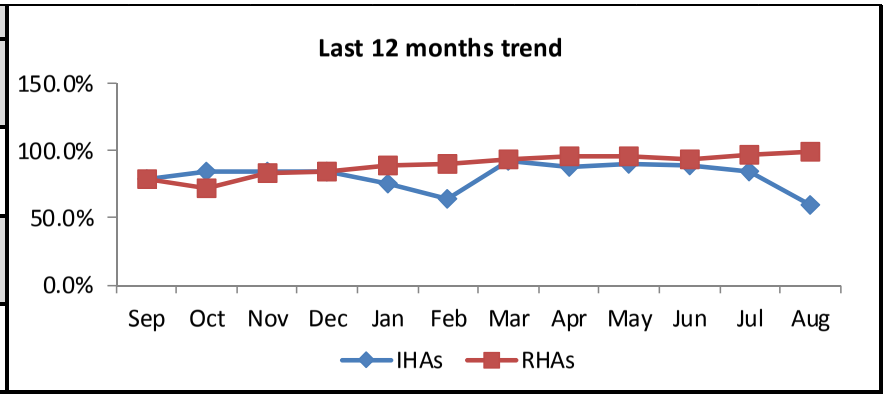
Current Month	**7.5%**
18/19 YTD	**7.8%**
17/18	**10.2%**
Annual Target	**9.5%**



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 stable trend generally, with the year to date position 7.8 after a small decrease in M6 to 7.5%.

5.1.10 Looked After Children Initial Health Assessments (IHAs) and Review Health Assessments (RHAs)

	IHA	RHA
Current Month	**60.0%**	**99.2%**
18/19 YTD	**81.4%**	**96.7%**
17/18	**68.8%**	**67.7%**
Annual Target	**95%**	**95%**



The dip in performance for IHA is due to 8 Late Requests due to issues that were outside of KCHFT control. We have an internal KPI to ensure that we complete the IHA within 23 days of receipt of the referral which was 100% for this reporting period.

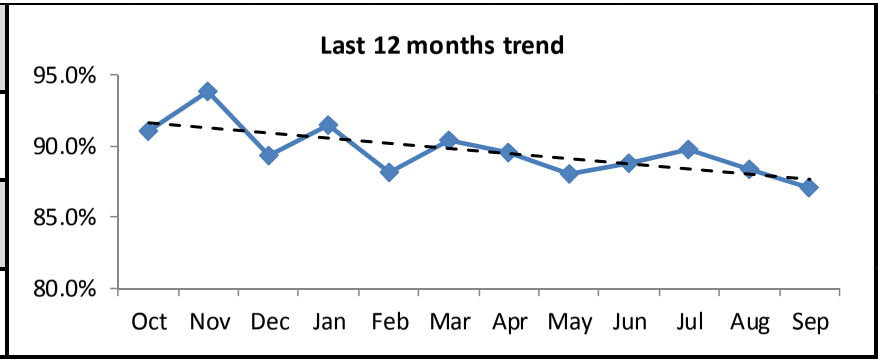
Compliance with RHA remains above 95%

5.1.11 NHS Number Completeness

NHS Number completeness across KCHFT's main systems are consistently c.100%, with the main exception being new births yet to have a NHS number assigned (although later updated) and Overseas MIU attendances.

5.1.12 Bed Occupancy

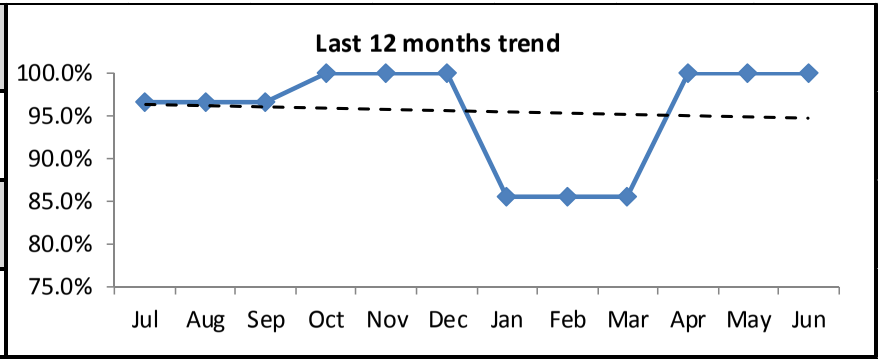
Current Month	**87.1%**
18/19 YTD	**88.6%**
17/18	**90.5%**
Target	**88-92%**



Bed Occupancy has shown a relatively static trend across the last 12 month, although month 6 is slightly below the 17/18 performance at 87.1%, just within the ideal threshold of 87-92%

5.1.13 CQUIN

Current Quarter	**100.0%**
18/19 YTD	**100.0%**
17/18	**89.7%**
Annual Target	**100.0%**



CQUINs are now in place for 18/19 and the estimated Q1 achievement is at 100%, although the weighting of the CQUINS means that a proportionally higher value is placed on Q4.

5.2 Assurance on activity and productivity

5.2.1 Activity

Service Type	M6 Actual	YTD Actual	YTD Target	YTD Variance	Movement	Internal BRAG	Contract BRG
Long Term Conditions	49,511	317,439	330,453	-3.9%	Negative		
Intermediate Care	18,277	120,766	129,809	-7.0%	Negative		
MIU Attendances	10,978	70,444	56,229	25.3%	Negative		
Community Hospital Admissions	180	1,108	910	21.8%	Negative		
Community Hospital Occupied Bed Days (WK)	1,994	12,645	12,936	-2.3%	Negative		
Community Hospital Occupied Bed Days (EK)	2,263	13,886			Negative		
Specialist and Elective Services	24,400	160,722	169,420	-5.1%	Negative		
Learning Disabilities - Face to Face	3,391	57,524			Negative		
*Children's Universal Services	25,466	567,361			Negative		
Children's Specialist Services	14,455	88,977	86,968	2.3%	Positive		
Dental Service - All currencies	9,459	53,239	58,731	-9.4%	Positive		
All Services (contractual)	**129,254**	**825,340**	**845,457**	**-2.4%**	Negative		
All Services (including those without targets)	**160,374**	**1,049,455**	**N/A**	**N/A**	Negative		

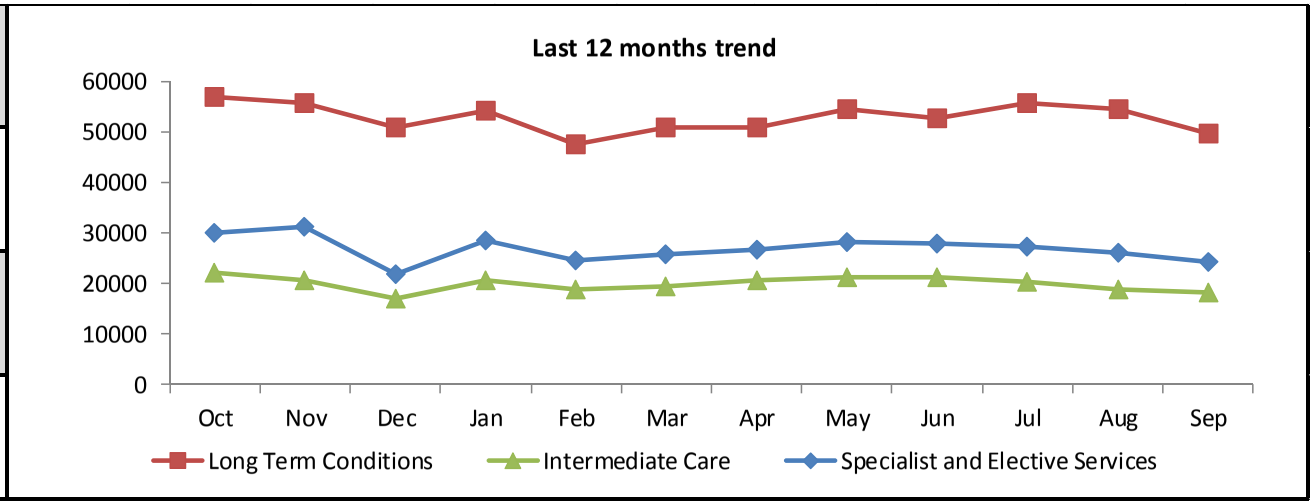
	Internal	Contract
	>+5%	>+10%
	>-5%	>-10%
	+/- 2.5-5%	n/a
	<+/- 2.5%	<+/- 10%
		No Target

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

During September 2018 KCHFT carried out 160,374 clinical contacts, of which 10,978 were MIU attendances. For the year to September 2018 KCHFT are 2.4% below target for services that have contractual activity targets in place, a slight decline on the M5 position. The largest variances are within Long Term Conditions (-3.9%), Intermediate Care Services (-7%), Specialist and Elective Services (-5.1%) and Dental Services (-9.4%).

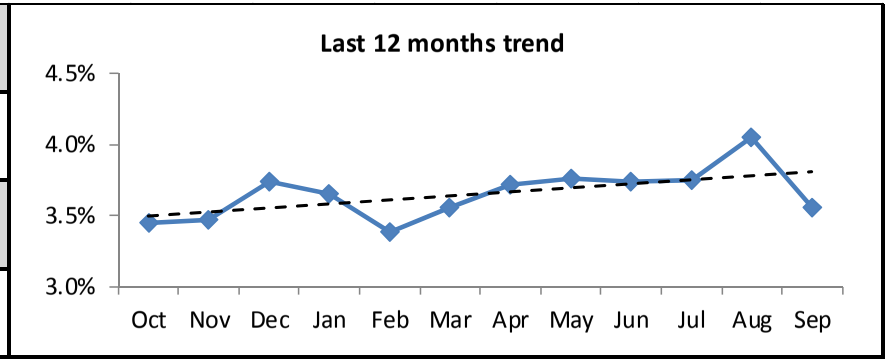
The following graph shows the monthly activity levels for Long Term Conditions, Intermediate Care Services and Specialist and Elective Services, which are currently lower than the first half of 2017, although the Meridian productivity work is hoped to improve activity levels through better efficiency and activity recording.

Current Month	97.6%
18/19 YTD	97.5%
17/18	97.6%
Target	100.0%



5.2.2 DNA rates

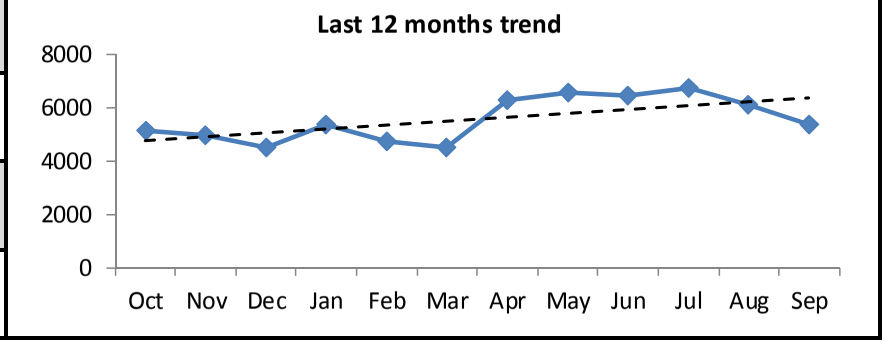
Current Month	3.6%
18/19 YTD	3.8%
17/18	3.7%
Annual Target	5.0%



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 increasing, although M6 dropped back after a higher level in M5.

5.2.3 Admissions Avoided

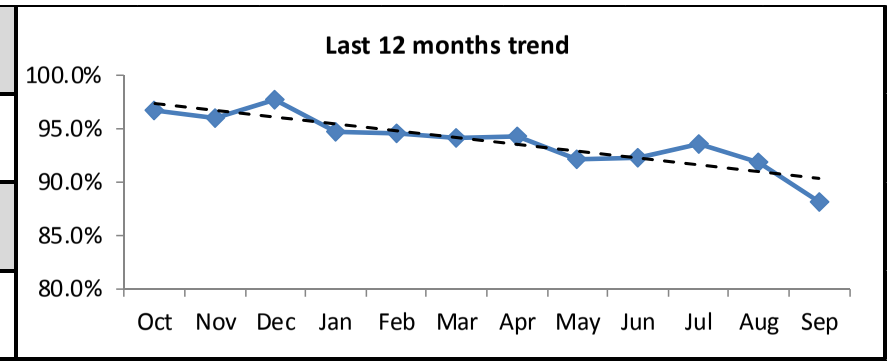
Current Month	**5408**
18/19 YTD	**37575**
17/18	**63078**
Annual Target	**63054**



During September 2018, 5,408 admissions were avoided by our Nursing and Intermediate Care services, showing a decrease compared to the increasing recent trend. Additionally, 15.5% of patients accessing those services had an admission avoided during August compared to an average of 15.9% during 2017/18

5.3 Assurance on Local Wait Times

Current Month	**88.2%**
18/19 YTD	**92.1%**
17/18	**95.9%**
Annual Target	**95.0%**



Waiting times for all AHP services continues to decline slightly, although this is impacted by the waits for our Chronic Pain and Orthopaedics services. September waits within 18 weeks worsened to 88.2%, compared to a 17/18 aggregate performance of 95.9%, with the lowest performing services being Chronic Pain, Orthopaedics, West Kent Block AQP Physiotherapy and Podiatric Surgery. The dip in recent months is partly down to the clearing of the backlog in some services, with a view to reduced long waits on the waiting list, particularly within Chronic Pain, as well as increased waits within West Kent Block AQP Physiotherapy

Service level assurance

Chronic Pain - The service action plan in place from August 2018 has led to an improving picture in the Month 6 incomplete wait performance. Patients on the waiting list (Incomplete pathways) who are waiting more than 18 weeks have reduced from 487 in Aug 18 to 208 on 6/11/18.

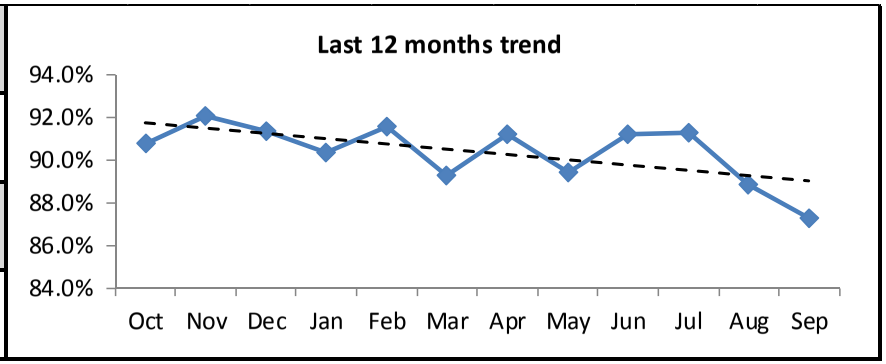
Orthopaedics – Total referrals into the service and the numbers triaged to be seen in the Community Orthopaedic service increased in quarter 1. New staff in post in April and May have gradually been phased into clinical work and their capacity will increase up to Dec 2018. A business case submitted to EK CCGs to increase the staffing resources in the community orthopaedic service was rejected in January 2018. The West Kent AIC MSK development programme has now progressed so that all MSK referrals pass through the orthopaedic triage point. This will increase demand both in the triage hub and within the orthopaedic and Physiotherapy clinics.

West Kent Physiotherapy (Block) – The total of patients waiting over 18 weeks on the Block contract has increased from 18% to 58% in the past 12 months. The service currently receives 250 referrals per month above current service capacity. As a result of this demand the waiting list has grown, with 624 patients currently waiting over 52 weeks and 58.4% of the waiting list having waited over 18 weeks. The CCG are aware of the pressures on the service and have prepared a paper on service change which KCHFT have not yet seen. KCHFT have been informed that changes will not be in place until the new financial year the risk being that during this time waiting times will continue to increase despite the best efforts of the team to increase capacity.

Podiatric surgery – There have been a number of waits this year between 18-36 weeks with the year to date compliance around 43%. However, work to clear the backlog has meant that the current waiting list has only 8.3% above 18 weeks, meaning the RTT compliance should greatly improve over the next few months. It is predicted that all patients will be seen within 18/52 by the end of December.

5.4 Outcomes

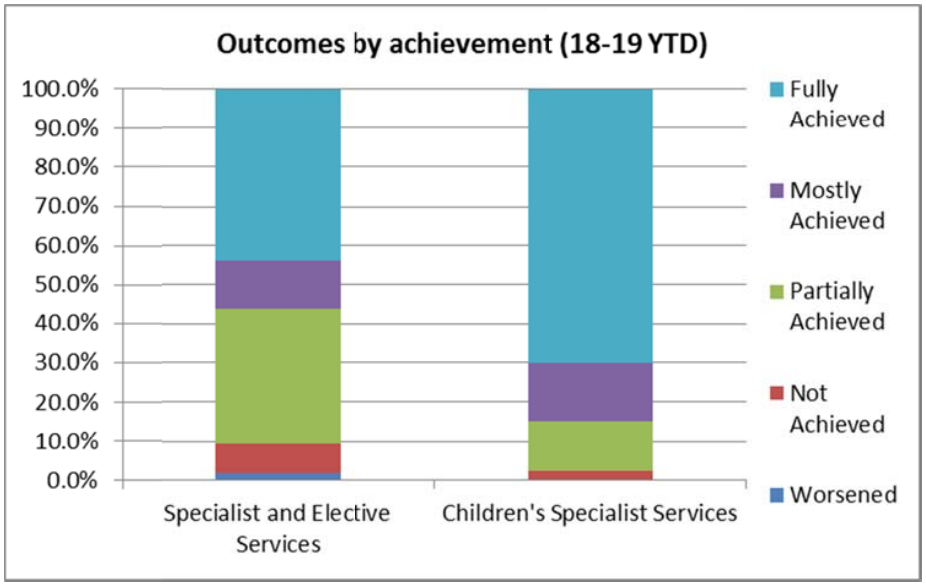
Current Month	**87.3%**
18/19 YTD	**89.9%**
17/18	**91.8%**
Annual Target	**80.0%**



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 with a drop experience in Months 5 and 6. It is planned to start included outcomes for further services later in 18/19 due to the introduction of Personalised Care Plans (PCPs) and goal achievement on CIS.

The following table and chart shows the proportion of the grading of each outcome for the year to date, split by service type for further detail on outcomes. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised.

	Specialist and Elective Services	Children's Specialist Services
Worsened	1.9%	0.0%
Not Achieved	7.9%	2.3%
Partially Achieved	34.2%	13.0%
Mostly Achieved	12.0%	14.7%
Fully Achieved	44.1%	70.0%



Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Item:	Winter Plan
Subject:	2.6
Presenting Officer:	Lesley Strong, Chief Operating Officer/Deputy Chief Executive

Action - this paper is for:	Decision	x	Assurance	

Report Summary (including purpose and context)

This winter period is expected to be as challenging as the previous winter. A Kent Community Health NHS Foundation Trust (KCHFT) Winter Steering Group was established to support the implementation of our initiatives that aim to reduce system wide pressures and improve staff health and well-being.

KCHFT has a key role to play in managing winter pressures particularly in supporting patient flow. This paper sets out the Trust plans developed as partners in the health and social care systems in East and West Kent to the ensure patient flow is maintained so that patients receive safe care in the right place during the winter period. The plan covers four main areas:

- Supporting system flow through improving patient discharge and preventing admission
- Workforce
- Increasing capacity of existing services
- Escalation plans

Proposals and /or Recommendations

The Board is asked to approve the plan.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No. High level position described.

Lesley Strong	Tel: 01622 211937
Chief Operating Officer, Deputy Chief Executive	Email: lesley.strong@nhs.net

Kent Community Health NHS Foundation Trust

WINTER PLANNING 2018/19

1. Introduction

During the last winter 2017/18 there was a great increase in demand for care across the country and this was compounded by the worst flu strain in seven years. The pressures were so severe that acute trusts were asked to suspend planned operations by the National Emergency Pressures Panel. There is a national expectation that this winter 2018/19 will prove as challenging as last year.

There has been a significant amount of planning at Trust and whole system level with our partners to prepare for this winter. The aim is to ensure that services are in place to face the expected increase in demand and to ensure the continued safe and responsive delivery of high quality of care.

Community services have a key role to play in managing winter pressures particularly in supporting patient flow. This paper sets out Kent Community Health NHS Foundation Trust's (KCHFT) plans developed as partners in the health and social care systems in East and West Kent. The aim is to ensure patient flow is maintained so that patients receive safe care in the right place during the winter period and the health and well-being of our staff is maintained. The plans align with the Trust and Sustainability and Transformation Partnership (STP) strategy for local care.

The plan focuses on the following key areas:

- Supporting system flow through improving patient discharge and preventing admission
- Workforce
- Increasing capacity of existing services
- Escalation plans

2. Background

2.1 Review of 2017/18

Although winter pressures are generally regarded as being greater in January and February these extended far longer into the year in 2018. There were major

challenges in both East and West Kent with significant periods of time at the higher levels of escalation, OPEL 3 and 4 (Operating Pressures Escalation Levels).

The Trust has participated in NHS England (NHSE) South East Region debrief in May 2018 to look at lessons learnt. These have been reviewed at a whole system level in East and West Kent and within the Trust and have been incorporated into the plans for this winter.

2.2 KCHFT Planning

This year the internal review and the development of the plan has been overseen by an Operational Winter Steering Group. This has brought together representative of clinical and corporate services. This will move to weekly calls to review the impact of actions during January and February.

The plans have been tested jointly with our health and social care partners.

3. Assessment

The plan aims to ensure responsiveness in periods of excessive pressure throughout the winter period by working in partnership with members of the local health and social care systems to avoid going into OPEL 4, the highest level of escalation. At this level patient care and safety could be compromised.

3.1 Supporting system flow through improving patient discharge and preventing admission

Last year's plans have been further developed during the year so they are more robust to face increasing demands e.g. Home First.

There are agreed transformation schemes to improve patient flow through the STP local care initiatives. Mobilisation of these schemes has been planned to cover the additional activity required for the winter period. These developments include:

- In West Kent adult services:
    - An increase in the rapid response and home treatment service by 20 w.t.e additional staff to give capacity for additional patients to be treated by the service.

    - Virtual Ward. As part of Maidstone and Tunbridge Wells NHS Trust's winter planning they have scoped the need for a virtual ward. The new model of care will enable patients to leave the acute hospital as soon as they are clinically stable and complete the remainder of their acute pathway at home remaining under the care of the Consultant. The service is being implemented with 3 agreed pathways. The aim is to have 30 patients on the service at any one time and to be fully in place by January.

The first patient will be discharged to the service this month with a gradual increase.

- Falls service – a new service will proactively work with patients identified as at risk of falls

- Community Cluster frailty nurses – to provide a new role to support the cluster Multi-Disciplinary Teams (MDTs) to proactively manage patients with long term conditions to prevent hospital admissions

- In East Kent adult services:
  - Rapid transfer service which focuses on supporting the discharge of complex patients either home or to short term rehabilitation within a community hospital or private care home. This is a key element of East Kent's plan with the aim of 30 complex patient discharges a day. The service started on 5 November 2018.

- Proactive work with high risk groups that are affected during the winter period:
  - Flu vaccinations for housebound patients are underway by community nurses in conjunction with GP service.

  - The flu campaign in schools will be delivered by December

  - Communication campaign on staying well during winter in the Trust's winter magazine

- Community Hospitals
  There has been ongoing work during the year to ensure patients are discharged as soon as their needs are met and reducing the number of patients whose discharge is delayed. Additionally there are plans for short term initiatives over winter:

  - Identification of escalation beds if required into current community hospitals.

  - Admission criteria for these community beds will be flexed where possible and where appropriate to maximise discharges from the Acute Trust at times of pressure.

  - Plans for a pop up ward e.g. at Sheppey Hospital if required

3.2 Workforce

- Staff Health and Wellbeing

  Maintaining the health of our staff and reducing sickness absence via the Staff flu campaign which is underway. There are staff vaccination clinics taking place across the Trust and staff are able to access the flu vaccination at a community pharmacy and recharge the cost. This year a vaccination in a third world country will be donated by the Trust for every staff vaccination completed.

- The operational Managers on call system for adult services has been revised to be more flexible and to increase the payment for those managers in recognition of the significant amount of work undertaken out of hours during periods of high pressure.

- There will be the need for additional staff and to ensure the workforce is as fully established as possible.

  - Recruitment and retention of staff is an ongoing priority for the Trust. The winter planning group have worked with resourcing to ensure vacancy rates are low as possible going into the winter period. Additional staff have been added to the resourcing office and each operational area has identified additional administrative staff to support recruitment at a local level. There is a high level of recruitment activity.

  - There will be a need for increased capacity in the temporary staff workforce.

    An incentive scheme for bank workers has been agreed to encourage them to work more shifts when the pressure is highest.

    The initiative will to be in operation for January and February, and for clinical staff only.

    - If workers work 7.5 hours more than their previous average, they receive a bonus of £50
    - If workers work 22.5 hours more than their previous average, they receive a bonus of £125
    - If workers work 30 hours more than their previous average, they receive a bonus of £250

3.3 Increasing capacity of existing services and reducing bureaucracy

During the year there has been significant work to maximise the efficiency of services. KCHFT has been working with Meridian Productivity to develop a predictive tool that supports daily mapping of staffing demands. The system has been developed as a way of predicting staffing risks ahead of time to enable teams to fill shifts. Reports from Meridian also offer assurance frameworks to understand trust capacity and demand. This is now in place across adult community services at a local team level and will be valuable to map the areas of increased demand and if any staffing changes need to be made to cope with this.

The Trust has been focusing on reducing bureaucracy to release time to care through a quality improvement approach.

Additional planned actions include:

- Reducing non-essential training throughout Jan and Feb 2019. Staff have been encouraged to access training before Christmas to maintain their compliance against statutory and mandatory training
- Pause all non-essential meetings throughout Jan and Feb 2019
- Mapping and staggering of annual leave

3.4 Escalation plans

The whole system plans have been agreed and are overseen by the Local A&E Delivery Boards. These include escalation plans with key actions to be taken by all partners if certain triggers are reached using the OPEL scales. A robust on call system at manager and director level is in place and able to respond when necessary.

Reporting is via SHREWD (Single Health Early Warning Database) and includes real time reporting of key indicators including:

- OPEL rating of individual organisations and whole systems
- A&E performance
- Bed occupancy of all providers
- Number of discharges from acute per day
- Stranded and super stranded patients

At an organisation level KCHFT will be monitoring:

- Workforce: sickness absence, vacancies
- Community hospital: Length of Stay (LOS), Delayed Transfer of Care (DToC), bed occupancy, infection control incidents
- Specific project outcomes e.g. Rapid Transfer Service, Virtual Ward

4. Conclusion

The Board is asked to review and approve the planned actions to respond to the expected winter pressures.

The plan is flexible in its approach to be able to respond to other pressures during this period of time e.g. Care Quality Commission (CQC) inspection and the impact of a no deal Brexit. The Board will receive an update report in January 2019 with any modifications that have been required.

Lesley Strong
Chief Operating Officer/Deputy Chief Executive
November 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Item:	2.7
Subject:	Standing Financial Instructions
Presenting Officer:	Gordon Flack, Director of Finance

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

Report Summary (including purpose and context)

Following the last update informed in March 2018, some further minor changes have been made to the Standing Financial Instructions (SFIs):

- removal of reference to standards of business conduct guidance HSG (93)5 which has been superseded by the NHS Improvements "Managing Conflicts of Interest in the NHS Guidance for staff and organisations" and;
- reference to NHSLA (NHS Litigation Authority) has been updated to reflect this organisation's name change to NHS Resolution.

Proposals and /or Recommendations

To approve the Standing Financial Instructions.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No. High level position described.

Gordon Flack, Director of Finance	Tel: 01622 211900
	Email: gordon.flack@nhs.net

Kent Community Health
NHS Foundation Trust

Standing Financial Instructions

1 Introduction

1.1 General

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

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

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

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

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

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

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

1.2 Responsibilities and delegation

The Board of Directors

1.2.1 The Board exercises financial supervision and control by:

1.2.1.1 formulating the financial strategy;

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

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

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

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

The Chief Executive and Director of Finance

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

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

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

The Director of Finance

1.2.6 The Director of Finance is responsible for:

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

1.2.6.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems

incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these SFIs;

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

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

1.2.6.4.1 the provision of financial advice to Directors and Officers;

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

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

1.2.7 **Directors and Officers**

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

1.2.7.1 the security of the property of the Trust;

1.2.7.2 avoiding loss;

1.2.7.3 exercising economy and efficiency in the use of resources;

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

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

Contractors and their employees

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

2 Audit

Audit and Risk Committee

2.1.1 In accordance with the SOs, the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference and following guidance from the NHS Audit and Risk Committee

Handbook, which will provide an independent and objective view of internal control by:

2.1.2 overseeing internal and external audit services;

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

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

2.1.5 monitoring compliance with SOs and SFIs;

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

2.1.7 reviewing aged debtors/creditors balances and explanations/action plans and scrutinise of any write offs;

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

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

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

2.4 **Director of Finance**

The Director of Finance is responsible for:

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

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

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

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

2.4.4.1 a clear opinion on the effectiveness of internal control in accordance with current Assurance Framework guidance issued by NHS Improvement including for example compliance with control criteria and standards;

2.4.4.2 major internal financial control weaknesses discovered;

2.4.4.3 progress on the implementation of internal audit recommendations;

2.4.4.4 progress against plan over the previous year;

2.4.4.5 strategic audit plan covering the coming 3 years; and

2.4.4.6 a detailed plan for the coming year.

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

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

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

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

2.5.4 explanations concerning any matter under investigation.

2.6 **Role of internal audit**

Internal audit will review, appraise and report upon:

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

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

2.6.3 the suitability of financial and other related management data;

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

2.6.4.1 fraud and other offences;

2.6.4.2 waste, extravagance, inefficient administration;

2.6.4.3 poor value for money or other causes.

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

2.7 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

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

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

2.10 **External audit**

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

Fraud and corruption

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

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

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

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

Security management

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

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

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

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

Finance, Business and Investment Committee (FBI)

2.19 The FBI committee has responsibility for the following ;

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

2.19.2 Monitor performance against Cost Improvement Plans;

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

2.19.4 Approve treasury management policy and scrutinise implementation.

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

Preparation and approval of plans and Budgets

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

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

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

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

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

3.2.2 accord with workload and manpower plans;

3.2.3 be produced following discussion with appropriate Budget Holders;

3.2.4 be prepared within the limits of available funds; and

3.2.5 identify potential risks.

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

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

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

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

3.7 **Budgetary delegation**

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

3.7.1.1 the amount of the Budget;

3.7.1.2 the purpose(s) of each Budget heading;

3.7.1.3 individual and group responsibilities;

3.7.1.4 authority to exercise virement;

3.7.1.5 achievement of planned levels of service; and

3.7.1.6 the provision of regular reports.

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

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

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

3.11 **Budgetary control and reporting**

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

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

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

3.11.1.2 movements in working capital;

3.11.1.3 movements in cash and capital;

3.11.1.4 capital project spend and projected outturn against plan;

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

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

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

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

3.11.4 monitoring of management action to correct variances; and

3.11.5 arrangements for the authorisation of Budget transfers.

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

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

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

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

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

3.12 **Capital expenditure**

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

3.13 **Monitoring returns**

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

4 Annual accounts and reports

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

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

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

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

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

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

5 Bank and GBS accounts

5.1 General

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

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

5.2 **Bank and GBS accounts**

The Director of Finance is responsible for:

5.2.1 bank accounts and GBS accounts;

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

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

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

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

Banking procedures

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

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

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

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

Tendering and review

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

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

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

Income systems

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

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

Fees and charges

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

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

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

Debt recovery

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

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

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

Security of cash, cheques and other negotiable instruments

6.9 The Director of Finance is responsible for:

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

6.9.2 ordering and securely controlling any such stationery;

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

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

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

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

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

7 Tendering and contracting procedure

7.1 Duty to comply with SOs and SFIs

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

7.2 EU Directives governing public procurement

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

7.3 Reverse eAuctions

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

7.4 Other Department of Health and Social Care guidance

The Trust shall comply as far as is practicable with the requirements of the Department of Health and Social Care “Estatecode” in respect of capital investment and estate and property transactions. In the case of management consultancy

contracts the Trust shall comply as far as is practicable with Department of Health and Social Care guidance "The Procurement and Management of Consultants within the NHS" and with NHSI guidance..

Formal competitive tendering

7.5 **General applicability**

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

7.5.1.1 the supply of goods, materials and manufactured articles;

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

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

7.6 **Health care services**

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

Exceptions and instances where formal tendering need not be applied

7.7 Formal tendering procedures need not be applied where:

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

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

7.7.3 regarding disposals as set out in SFI 7.24 below;

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

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

7.8.2 where the requirement is covered by an existing contract;

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

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

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

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

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

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

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

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

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

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

7.11 **Fair and open procurement process**

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

7.12 **List of approved firms**

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

7.13 **Building and engineering construction works**

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

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

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

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

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

7.15 **Contracting/tendering procedure**

Invitation to tender

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

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

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

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

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

7.15.3 Every tender for building or engineering works (except for maintenance work, when Estatecode guidance shall be followed)

shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors. These documents shall be modified and/or amplified to accord with Department of Health and Social Care guidance and, in minor respects, to cover special features of individual projects.

Receipt and safe custody of tenders

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

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

Opening tenders and register of tenders

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

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

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

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

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

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

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

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

7.15.13.1 the name of all firms individuals invited;

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

7.15.13.3 the date the tenders were opened;

7.15.13.4 the persons present at the opening;

7.15.13.5 the price shown on each tender;

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

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

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

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

7.16 Admissibility

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

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

7.17 Late tenders

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

7.17.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left

the custody of the Chief Executive or his Nominated Officer or if the process of evaluation and adjudication has not started.

7.17.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his Nominated Officer.

7.18 **Acceptance of formal tenders**

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

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

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

7.18.3.1 experience and qualifications of team members;

7.18.3.2 understanding of client's needs;

7.18.3.3 feasibility and credibility of proposed approach;

7.18.3.4 ability to complete the project on time.

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

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

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

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

7.18.6.2 that best value for money was achieved.

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

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

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

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

7.19.1 **General position on quotations**

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

7.19.2 **Competitive quotations**

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

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

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

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

7.19.3 **Non-competitive quotations**

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

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

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

7.19.3.3 miscellaneous services, supplies and disposals;

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

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

Competitive quotation need not be applied where:

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

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

7.19.5 **Quotations to be within financial limits**

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

7.19.6 **Authorisation of tenders and competitive quotations**

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

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

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

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

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

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

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

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

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

7.20 **Preferred procurement route**

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

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

7.21 **Private finance for capital procurement**

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

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

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

7.21.3 the proposal must be specifically agreed by the Board.

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

7.22 **Compliance requirements for all contracts**

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

7.22.1 the Trust's SOs and SFIs;

7.22.2 EU Directives and other statutory provisions;

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

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

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

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

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

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

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

7.24 **Health care services agreements**

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

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

7.25 **Disposals**

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

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

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

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

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

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

7.26 **In-house services**

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

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

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

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

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

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

7.26.4 The evaluation team shall make recommendations to the Board.

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

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

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

8 NHS service agreements for provision of services

8.1 **Service Contracts**

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

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

8.1.2.1 the standards of service quality expected;

8.1.2.2 the relevant national service framework (if any);

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

8.1.2.4 the NHS National Performance Assessment Framework; and

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

8.2 **Reports to Board of Directors on Service Contracts**

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

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

9.1 Remuneration and terms of service

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

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

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

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

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

9.1.2.1.3 arrangements for termination of employment and other contractual terms;

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

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

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

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

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

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

9.2 **Funded establishment**

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

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

9.3 **Staff appointments**

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

9.3.1.1 authorised to do so by the Chief Executive; and

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

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

9.4 **Processing payroll**

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

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

9.4.1.2 the final determination of pay and allowances;

9.4.1.3 making payment on agreed dates; and

9.4.1.4 agreeing method of payment.

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

9.4.2.1 verification and documentation of data;

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

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

9.4.2.4 security and confidentiality of payroll information;

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

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

9.4.2.7 methods of payment available to various categories of Officers;

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

9.4.2.9 procedures for the recall of cheques and bank credits;

9.4.2.10 pay advances and their recovery;

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

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

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

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

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

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

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

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

9.5 **Contracts of employment**

The Board shall delegate responsibility to an Executive Director for:

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

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

10 Non-pay expenditure

10.1 **Delegation of authority**

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

10.1.2 The Chief Executive will set out:

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

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

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

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

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

10.3 **System of payment and payment verification**

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

10.4 **The Director of Finance will:**

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

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

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

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

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

10.4.4.2 certification that:

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

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

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

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

10.4.4.2.5 the account is arithmetically correct;

10.4.4.2.6 the account is in order for payment;

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

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

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

10.5 **Prepayments**

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

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

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

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

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

10.6 **Purchase orders**

Purchase orders for goods and/or services must:

10.6.1 be consecutively numbered;

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

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

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

10.7 **Duties of Officers**

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

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

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

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

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

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

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

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

10.7.5.2 Managing Conflicts of Interest in the NHS Guidance for staff and organisations;

10.7.5.3 the Code of Conduct for NHS Managers 2002; and

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

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

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

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

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

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

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

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

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

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

11 External borrowing

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

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

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

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

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

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

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

12 Investments

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

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

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

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

13.1 Capital investment

The Chief Executive:

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

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

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

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

13.2.1 that a business case is produced setting out:

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

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

13.2.1.3 appropriate project management and control arrangements;

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

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

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

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

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

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

13.6.1 specific authority to commit expenditure;

13.6.2 authority to proceed to tender;

13.6.3 approval to accept a successful tender.

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

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

13.9 **Private finance**

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

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

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

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

13.10 **Asset registers**

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

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

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

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

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

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

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

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

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

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

.

13.11 **Security of assets**

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

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

13.11.2.1 recording managerial responsibility for each asset;

13.11.2.2 identification of additions and disposals;

13.11.2.3 identification of all repairs and maintenance expenses;

13.11.2.4 physical security of assets;

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

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

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

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

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

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

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

14 Stores and receipt of goods

14.1 General position

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

14.1.1 kept to a minimum;

14.1.2 subjected to proper control and recording; and

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

Control of stores, stocktaking, condemnations and disposal

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

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

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

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

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

14.7 A designated Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation,

disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

14.8 **Goods supplied by NHS Supply Chain**

For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance who shall satisfy himself that the goods have been received before accepting the recharge.

15 Disposals and condemnations, losses and special payments

Disposals and condemnations

15.1 **Procedures**

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

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

15.1.3 All unserviceable articles shall be:

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

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

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

Losses and special payments

15.2 **Procedures**

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

15.2.2 Any Director or Officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance

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

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

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

15.2.4.1 the Board of Directors; and

15.2.4.2 the external auditor.

15.2.5 Within delegated limits, the Management Committee shall approve the writing-off of losses.

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

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

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

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

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

16 Information technology

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

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

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

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

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

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

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

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

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

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

16.4.1 details of the outline design of the system; and

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

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

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

16.6 **Risk assessment**

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

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

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

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

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

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

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

17 Patients' property

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

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

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

17.2.2 hospital admission documentation and property records; and

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

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

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

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

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

Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

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

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

18 Funds held on trust

18.1 Corporate trustee

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

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

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

18.2 Accountability to Charity Commission and Secretary of State

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

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

18.3 Applicability of SFIs to funds held on trust

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

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

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

The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the guidance "Managing Conflicts of Interest in the NHS Guidance for staff and organisations" issued by NHS Improvement and is also deemed to be an integral part of the SOs and SFIs.

20 Retention of records

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

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

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

21 Risk management and insurance

Programme of Risk Management

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

21.2 The programme of risk management shall include:

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

21.2.2 engendering among all levels of staff a positive attitude towards the control of risk;

21.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

21.2.4 contingency plans to offset the impact of adverse events;

21.2.5 audit arrangements including; internal audit, clinical audit, health and safety review;

21.2.6 a clear indication of which risks shall be insured; and

21.2.7 arrangements to review the risk management programme.

21.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement of Internal Control within the annual report and accounts as required by current NHS Improvement guidance.

21.4 **Insurance: risk pooling schemes administered by NHS Resolution**

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.5 **Insurance arrangements with commercial insurers**

The Trust, as a Foundation Trust, can enter into insurance arrangements, for areas not covered by the risk pooling schemes, with commercial insurers. The Board will approve commercial insurance arrangements.

21.6 **Arrangements to be followed by the Board in agreeing insurance cover**

21.6.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

21.6.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.6.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the "**Deductible**"). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the Deductible in each case.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Number:	2.8
Agenda Item Title:	Board Membership and Non-Executive Director Responsibilities
Presenting Officer:	John Goulston, Chairperson

Action - this paper is for:	Decision	☒	Information	☐	Assurance	☐

Report Summary

The Constitution of Kent Community Health NHS Foundation Trust (the Trust) sets out the composition and makeup of the Board of Directors (the Board) both in terms of Executive and Non-Executive Directors (NED) roles. In addition, there are several other roles which are either required by Trust regulators or recommended as part of a system of good governance.

As the Board members are fully aware, there have been several changes to the Membership of the Board. In concert with this, further changes have been signalled and proposed for consideration.

The purpose of this paper is to present the proposal for Board membership and Non-Executive Director responsibilities for the approval where appropriate. The paper also presents proposals for Board recommendation to the Council of Governors as necessary.

Proposals and /or Recommendations

The Board is asked to approve the following:

7.1 Gerard Sammon, Director of Strategy is added, with immediate effect, as the seventh executive member of the Board.

7.2 Table 1 and paragraph 3.2

7.3 The Chairs and Deputy Chairs of the Committees are established as set out in table 2 and paragraph 4.

7.4 Richard Field resumes as the Vice Chair of the Board.

There will be a follow up paper for the Board of Directors meeting on 29 January 2019 that covers:

1. The timing for Martin Cook and Francis Drobniewski to become NEDs replacing Richard Field and Steve Howe who are both standing down from the Board.
2. The impact that the above will have on NED membership of Board committees.
3. Proposal for a new vice chairperson to replace Richard Field.
4. Proposal for Bridget Skelton to be re-appointed to the Board.

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

John Goulston, Chairperson	Tel: 01622 211900
	Email: natalie.davies1@nhs.net

Kent Community Health NHS Foundation Trust

BOARD OF DIRECTORS MEMBERSHIP AND DESIGNATIONS

1. Introduction

The Constitution of Kent Community Health NHS Foundation Trust (the Trust) sets out the composition and makeup of the Board of Directors (the Board) both in terms of Executive and Non-Executive Directors roles. In addition, there are several other roles which are either required by Trust regulators or recommended as part of a system of good governance.

As the Board members are fully aware, there have been several changes to the Membership of the Board. In concert with this, further changes have been signalled and proposed for consideration.

The purpose of this paper is to present the proposal for Board membership and Non-Executive Director responsibilities for the approval where appropriate. The paper also presents proposals for Board recommendation to the Council of Governors as necessary.

2. Board Membership

The Constitution sets out that the Board is made up of a maximum of seven Non-Executive Directors and a Chairperson in addition to this number. Equally, the maximum number of Executive Directors is seven.

2.1 The current membership (from 1 November 2018) of the Board is as follows:

Chairperson: John Goulston

Non-Executive Directors (NED):

1. Pippa Barber
2. Peter Conway
3. Richard Field
4. Steve Howe
5. Bridget Skelton
6. Jennifer Tippin
7. Nigel Turner

Non-Executive Director Designates (no voting rights)

1. Martin Cook
2. Francis Drobniewski

Executive Directors

1. Paul Bentley
2. Lesley Strong
3. Gordon Flack
4. Ali Carruth
5. Sarah Phillips
6. Louise Norris

2.2 **Proposal**

The following is proposed for Board approval:

- Gerard Sammon, Director of Strategy is added, with immediate effect, as the seventh executive member of the Board.
- From 23 November 2018, Ali Carruth is going on maternity leave. Mercia Spare will be Acting Chief Nurse from 23 November and will be a voting member of the Board.

3. Membership of Board Committees and Lead Roles

3.1 The Current membership of Board Committees by NEDs is set out below. 'C' is used to signify the chairperson of the Committee; 'M' is used to signify a member of the Committee.

Table 1 - NED membership of Board Committees

NED	**Audit & Risk Committee** *(2 NED's required for quoracy)*	**Charitable Funds Committee** *(1 NED required for quoracy)*	**Finance Business & Investment Committee** *(2 NED's required for quoracy)*	**Quality Committee** *(2 NED's required for quoracy)*	**Strategic Workforce Committee** *(2 NED's required for quoracy)*
Pippa Barber				M	
Peter Conway	C				
Richard Field	M	M	C		
Steve Howe				C	
Bridget Skelton	M		M		C
Jennifer Tippin		C	M		
Nigel Turner					M
Francis Drobniewski				*M*	
Martin Cook			*M*		

While any NED's attendance at Committee can contribute to quoracy, several Committees would benefit from constant membership to support quoracy.

In addition to the above responsibilities and excluding the Vice Chair and the Senior Independent Director (see section 4); there are the following assigned NED responsibilities:

- Mortality and Learning from Deaths – Pippa Barber
- Freedom to Speak Up – Jennifer Tippin

- End of life Champion (non-mandatory) – Steve Howe

3.2 Proposal

The Non-Executive membership of Board Committees as detailed in table 1 is recommended for Board approval:

The NED additional responsibilities set out above are proposed to continue.

4. Chairs and Deputies of Board Committees

As detailed in Table 1, each of the Board committees has a chairperson. In the interests of good governance, each committee should also have a deputy chairperson. Table 2 proposes deputy chairpersons for the Board committees:

Table 2 - Chairs and Deputy Chairs of Board Committees

Committee	Chairperson	Deputy Chairperson
Audit and Risk	Peter Conway	Richard Field
Finance Business and Investment	Richard Field	Bridget Skelton
Charitable Funds	Jen Tippin	Richard Field
Quality	Steve Howe	Pippa Barber
Workforce	Bridget Skelton	Nigel Turner

The Remuneration and Terms of Service committee will continue to be chaired by the Chairperson of the Trust.

5. Vice Chair and Senior Independent Director

The Constitution sets out that Vice Chairperson of the Board is appointed by the Board. The Senior Independent Director is appointed by the Council of Governors.

The Council has approved the appointment of Bridget Skelton as Senior Independent Director for her term of office.

With the appointment by the Council of Governors of John Goulston as Chair of the Trust from 1 November 2018, it is proposed that Richard Field resumes as Vice Chair of the Trust.

6. Non-Executive Director Terms of Office

The terms of office for the Non-Executive Directors are shown below.

First name	Surname	Start date	(Re)Appointment to the Board	Period of appointment	End date for appointment
Peter	Conway	01/03/2015	01/04/2018	3 years	31/03/2021
Steve	Howe	01/03/2015	01/04/2018	3 years	31/03/2021
Bridget	Skelton	01/03/2015	07/04/2016	3 years	06/04/2019
Pippa	Barber	01/12/2016	01/12/2016	3 years	30/11/2019

First name	Surname	Start date	(Re)Appointment to the Board	Period of appointment	End date for appointment
Jennifer	Tippin	01/03/2015	01/03/2017	3 years	29/02/2020
Richard	Field	01/03/2015	01/04/2017	3 years	31/03/2020
Francis	Drobniewski	01/10/2018		3 years	30/09/2021
Nigel	Turner	01/10/2018		3 years	30/09/2021
Martin	Cook	01/10/2018		3 years	30/09/2021
John	Goulston	01/11/2018		3 years	31/10/2021

Appointments of Non-Executive Directors are the responsibility of the Council of Governors. The Council of Governors has formed the Nomination Committee to consider the appointment and re-appointment of Non-Executive Directors and make recommendations to the Council.

Richard Field and Steve Howe have both given notice that they wish to resign from the Board in 2019. At the point that they resign, Martin Cook and Francis Drobniewski will become NEDs of the Board

7. Recommendations

The Board is asked to **approve** the following:

7.1 Gerard Sammon, Director of Strategy is added, with immediate effect, as the seventh executive member of the Board.

7.2 Table 1 and paragraph 3.2

7.3 The Chairs and Deputy Chairs of the Committees are established as set out in table 2 and paragraph 4.

7.4 Richard Field resumes as the Vice Chair of the Board.

There will be a follow up paper for the Board of Directors meeting on 29 January 2019 which will cover:

- The timing for Martin Cook and Francis Drobniewski to become NEDs replacing Richard Field and Steve Howe who are both standing down from the Board.
- The impact that the above will have on NED membership of Board committees.
- Proposal for a new vice chairperson to replace Richard Field.

John Goulston
Chairperson
19 November 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Number:	3.1
Agenda Item Title:	Quarterly Infection Prevention and Control Report
Presenting Officer:	Ali Carruth, Chief Nurse

Action - this paper is for:	Decision	☐	Information	☐	Assurance	☒

Report Summary

This paper provides a summary of infection prevention and control activity between 1 July and 30 September 2018.

- There were no *Clostridium difficile* Infections in July – September.
- There were two MRSA bacteraemia's reported in September (one delayed from August) where Kent Community Health NHS Foundation Trust (KCHFT) staff provided care. Post Infection Review (PIR) meetings were held for both cases. In one case it was identified potential improvements in communication between teams and other care providers, however there was no identified learning deemed to have directly caused the bacteraemia for KCHFT staff. In the second case there was no direct learning identified.
- MRSA screening compliance for podiatric surgery was 100% for July – September.
- MRSA screening compliance for the community hospitals was 76% in July; 100% in August and 95% for September. In July, this related to 5 missed screens (4 at Queen Victoria Memorial Hospital, Herne Bay (QVMH) and 1 at Whitstable and Tankerton Hospital) and 1 missed screen at QVMH in September. The Head of Quality and Matron have an action plan to address these issues. The Infection Prevention and Control (IPC) Team continues to support teams.
- Gram Negative Bacteraemia Blood Stream Infections (GNBSI)
  All community cases are investigated; some common themes include urinary catheters and wounds. The IPC Team is working with operational teams, to ascertain if there are lessons to be learnt.

	Ecoli Kent KCHFT	**Klebsiella** Kent KCHFT	**Pseudomonas** Kent KCHFT
June	129 12	28 4	9 1
July	141 11	32 1	7 3
August	129 10	39 1	20 2
September	125 13	31 3	18 2

- The NHS Improvement (NHSI) East Kent collaborative for reduction of Gram negative bacteraemias has commenced. The 'Hydration' pilot across East Kent Hospitals University NHS Foundation Trust (EKHUFT) and KCHFT (Whitstable and Tankerton community hospital) commenced 10 September and the project is planned to continue until the end of the first week of December 2018.

- For this reporting period there were 2 CAUTI's for both August and September. There were 5, 6 and 9 UTI's reported in July, August and September respectively against a target of less than 1 and 7 respectively. In all CAUTI / UTI's the samples were taken appropriately, and the correct antimicrobials prescribed – as per PHE guidance. Despite there being a rise in numbers for September, we remain on target to meet this year's trajectory for UTI reduction, and slightly over trajectory for CAUTI's, however numbers are so small, so it is not easy to ascertain if the target will be met.

- Cleaning reports for September indicate compliance with national standards in all wards except Sevenoaks and Faversham, where the standard has not been achieved. This has been raised with the Head of Facilities who is addressing the situation.

- Trust compliance with hand hygiene training was reported as 92%, and mandatory training 95% in September. Compliance amongst clinical staff was 90.3% for hand hygiene, and 93.6% for mandatory training.

- In July there were 2 outbreaks of diarrhoea and vomiting (one of these was confirmed norovirus). There were no outbreaks in August and 1 outbreak in September of diarrhoea and vomiting – unknown cause. Patients during the outbreak periods were isolated or cohorted enabling the wards to remain

Kent Community Health NHS Foundation Trust

open.

- The Water Safety Committee continues to meet to highlight gaps in assurance, and evidence risk reduction actions.
- There have been no decontamination issues in this time frame. The Authorised Engineer for Decontamination has been requested to audit the processes undertaken by Dental in the centres where they re-process locally in November.
- The Antimicrobial Stewardship Committee continues to meet. Both the IPC Team and Pharmacy Team are involved in the Kent and Medway IPC/HCAI Leadership Pilot. This will influence Antimicrobial work going forward.
- There have been no decontamination issues in this time frame

Proposals and /or Recommendations
Report for assurance. The Board 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.

Rowena Chilvers – Deputy Head Infection Prevention and Control	Tel: 07507594780
	Email: rowenachilvers@nhs.net

QUARTERLY INFECTION PREVENTION AND CONTROL REPORT

1. *Clostridium difficile* infection (CDI)

Objective: The Trust will be attributed no more than 4 cases of *Clostridium difficile* infections with no level 3 lapses in care in 2018/19.

There have been no *Clostridium difficile* infections for the reporting period July –30 September.

2. MRSA Bacteraemia

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 have been no reported cases for the month of July. There were 2 MRSA bacteraemias cases reported in September (one was for August that was reported in September) where KCHFT had provided patient care. Both cases had a Post Infection Review (PIR) meeting held.

- The first case (August), the patient was seen by Podiatry and community nurses in the West. The PIR identified potential improvements in communication between the podiatry and community nursing service and other care providers, but there was no learning identified deemed to have directly caused the bacteraemia for KCHFT staff. The podiatry and community nursing teams are now identifying actions to help improvements in communication with other health providers.
- In the second case (September), a patient was discharged from Faversham Cottage hospital 4 weeks prior to the bacteraemia, and no direct learning was identified in the PIR.

3. MRSA screening.

The expected standard is 100% compliance with screening in line with policy.
In Podiatric Surgery MRSA screening compliance was 100% for July - September

<u>Community hospitals</u>
In July, 76% compliance was achieved, pertaining to 5 missed screens – 4 in QVMH and 1 in Whitstable and Tankerton. The IPC Team is now working collaboratively with the operational Head of Quality and the Strategic Delivery Manager to help QVMH

improve practice. There was also 1 missed screen at Whitstable and Tankerton Hospital, and the IPC Team is supporting clinical staff to follow process.

August 100% compliance was achieved.

In September there was one missed screen QVMH resulting with 95% compliance. The IPC Team is continuing to support this unit with the Matron and Head of Quality to consistently improve implementation of the MRSA screening protocol.

Separately the IPC Team is reviewing screening requirements for our patients admitted to community hospitals. Currently national guidance states we do not have to screen our patients; however, we wish to take a more risk based approach.

4. Gram Negative bacteraemia Blood Stream Infections (GNBSI) – KCHFT plans for reduction

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.

In the chart below are the numbers of Kent wide Gram negative infections followed by the number of significant KCHFT staff input.

	Ecoli		Klebsiella		Pseudomonas	
	Kent	KCHFT	Kent	KCHFT	Kent	KCHFT
June	129	12	28	4	9	1
July	141	11	32	1	7	3
August	129	10	39	1	20	2
September	125	13	31	3	18	2

All community cases are investigated; common themes include urinary catheters and wounds. The IPC Team is working with operational teams, to ascertain if there are lessons to be learnt.

4.1 Kent and Medway System Wide Leadership Forum.

Gail Locock (Chief Nurse) has been seconded from North Kent CCG's to lead on the Kent and Medway strategic approach to reduction of HCAI's. Currently a meeting is due to be held with the Director of Nursing for NHSI and Medical Director for NHSE to lay out the future direction of the strategic and local groups. The KCHFT IPC Team will be chairing the working group sitting under the strategic group. The first meeting is planned for November 2018.

4.2 East Kent Collaborative for reduction Gram negative Blood Stream Infections (BSI)

The initial meetings of the collaborative have completed, with representation from KCHFT, East Kent CCG's and EKHUFT. East Kent has attended the collaborative meetings hosted by NHSI. Four projects have been identified to be piloted using the Plan Do Study Act (PDSA) process and then potentially implemented across the whole of the East Kent health and social care economy. The initial project has focussed on 'hydration'. There are 4 wards in EKHUFT alongside KCHFT Whitstable and Tankerton Community Hospital involved during this pilot.

The Hydration pilot commenced 10 September, and the project is planned to continue until the end of the first week of December.

5. Urinary Tract Infections (UTI) and Catheter Associated UTI's

The aim for 2018/19 is to have no more than 12 hospital acquired CAUTI's, and no more than 82 UTI's in our community hospitals.

UTI

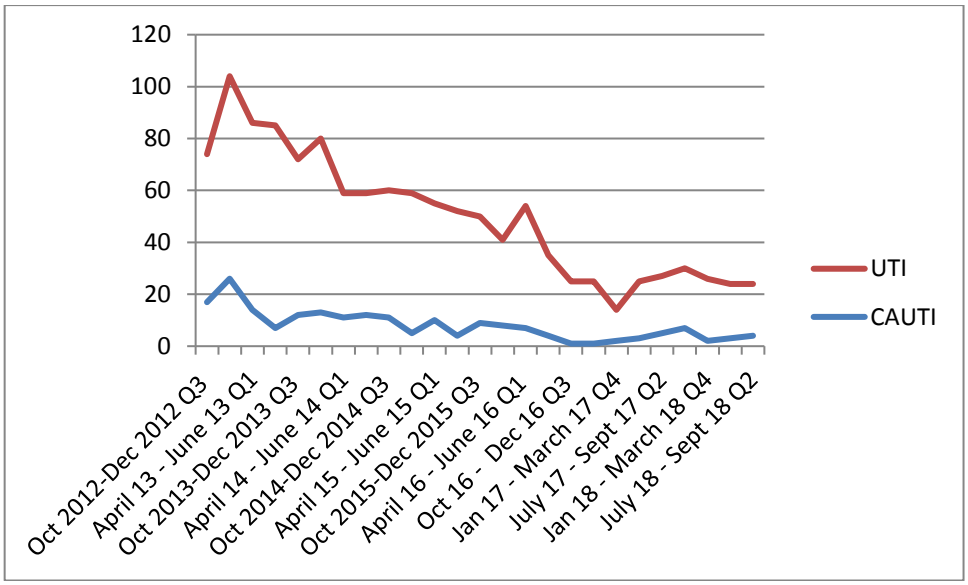
- In July, there were 5 UTI's reported; August reported 6 and September reported 9 cases.

CAUTI

- In July, there were no reported CAUTI's; August and September both reported 2 cases each.

In all CAUTI / UTI's the samples were taken appropriately, and the correct antimicrobials prescribed – as per PHE guidance. There appears to be an increase in reported CAUTI's recently, and over the preceding year, and the IPC Team and Trust are continually focussing on ways to reduce this.

KCHFT commenced collection of UTI and CAUTI data in October 2012. Therefore we can now see the progress we have made in the last five years below. There has been a 75% reduction in CAUTI numbers and 70% reduction in UTI numbers. However, in 2016 there was a change in the number of hospital beds, so rate reduction per 100,000 OBDs is over 40%



	Oct 12 - Sept 13	Oct 13 - Sept 14	Oct 14 - Sept 15	Oct 15 -Sept 16	Oct 16 - Sept 17	Oct 17 - Sept 18
UTI	285	222	167	152	80	88
CAUTI	64	48	31	28	11	16

5.2 Health care economy CAUTI/UTI work

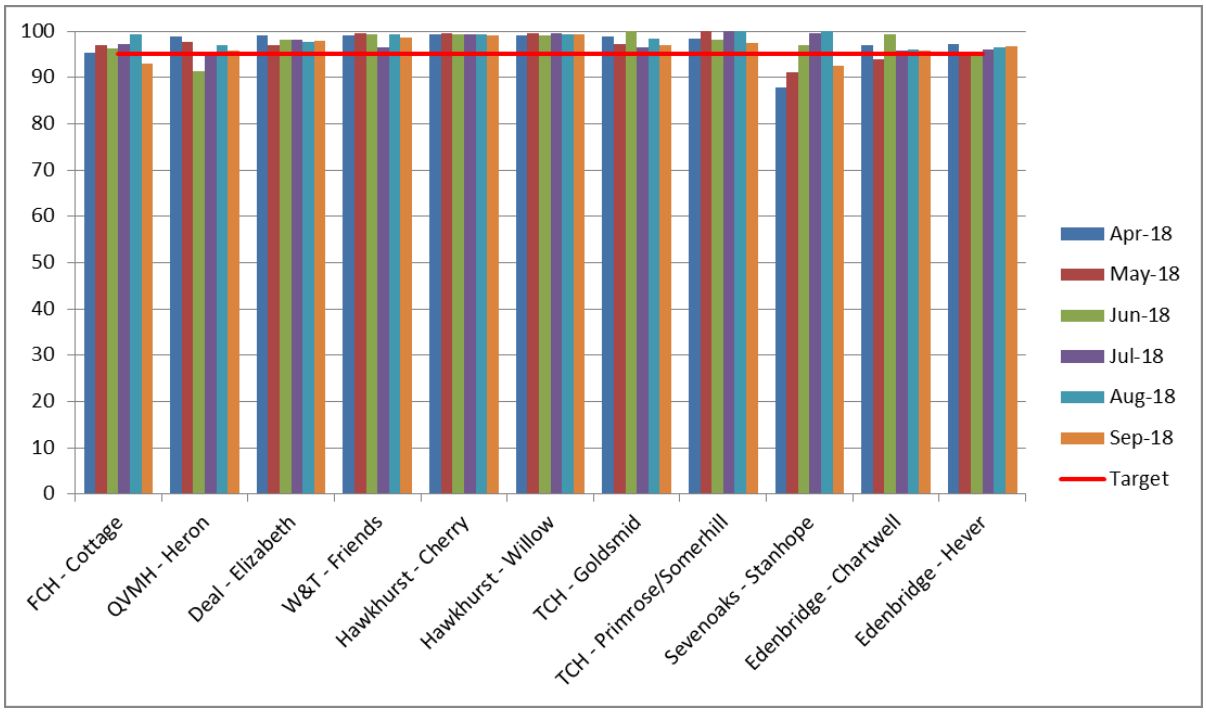
In East Kent UTI and CAUTI pathways have been agreed across all healthcare providers, and once the national PHE guidance is published, this will be launched and rolled out.

The Kent and Medway wide group have almost finalised guidelines for catheter insertion and ongoing care – these are also awaiting final national PHE guidance before ALL providers in Kent implement the agreed documents.

6. Cleaning and Environment

The IPC Assurance Group closely monitors the progress of all areas; see cleaning summary for six months up to September 2018 below.

Overall ward scores – 6 monthly (April – September 2018)



Standards in Sevenoaks and Faversham dropped below 95% compliance in September. Faversham was due to annual leave of supervision on site resulting in reduced volume of auditing affecting the overall score. At Sevenoaks this was due to significant reduction in staffing levels throughout the site. This has been raised with the Head of Facilities who is addressing the situation.

7. Training

The Education and Workforce Development (EWD) Team collect and collate all training figures on behalf of the IPC Team. The target is 85% compliance for all infection control training.

Trust Compliance with hand hygiene training was reported as 92%, and mandatory training as 95% in September. Compliance amongst clinical staff was 90.3% for hand hygiene, and 93.6% for mandatory training.

The IPC Team contact teams where non-compliance is identified to encourage compliance, and ensure the teams have access to link workers.

Kent Community Health NHS Foundation Trust

Training compliance September 2018 – below

Locality	Sub Locality	Infection prevention & Control L1	Infection prevention & Control L2	Infection prevention & Control L3	Hand Hygiene L1	Hand Hygiene L2	Hand Hygiene L3
846 L4.1 4217 East Kent	846 L4 4217 East Kent Urgent Care	100.0%	98.6%	93.1%	100.0%	93.0%	88.2%
846 L4.1 4217 East Kent	846 L4 Ashford & Canterbury LTC	100.0%	100.0%	92.0%	100.0%	90.5%	87.2%
846 L4.1 4217 East Kent	846 L4 East Kent Management	100.0%	100.0%	87.5%	100.0%	100.0%	75.0%
846 L4.1 4217 East Kent	846 L4 SKC & Thanet LTC	100.0%	93.3%	86.5%	100.0%	80.0%	81.2%
846 L4.1 Children's Specialist Serv	846 4103 L4 Children's Specialist Services	100.0%	92.9%	93.6%	100.0%	92.9%	95.4%
846 L4.1 Children's Specialist Serv	846 6200 L4 Children's Specialist Services	100.0%	N/A	90.9%	100.0%	N/A	88.4%
846 L4.1 Dental	846 4105 L4 Children & Adult Talking Therapy Se	N/A	100.0%	N/A	N/A	100.0%	N/A
846 L4.1 Dental	846 4216 L4 Dental Services	100.0%	100.0%	94.7%	100.0%	100.0%	94.7%
846 L4.1 Health Improvement Tean	846 4401 L4 Health Improvement Teams	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
846 L4.1 Health Improvement Tean	846 6600 L4 Health Improvements Teams	100.0%	100.0%	100.0%	80.0%	100.0%	95.5%
846 L4.1 Operations Management	846 4101 L4 Management of Children's Services	100.0%	100.0%	100.0%	100.0%	50.0%	N/A
846 L4.1 Operations Management	846 4209 L4 Management of Adult Services	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Public Health	846 4102 L4 Health Visiting (Public Health)	100.0%	100.0%	91.9%	100.0%	85.7%	92.5%
846 L4.1 Public Health	846 4102 L4 School public Health	100.0%	100.0%	97.3%	100.0%	100.0%	92.0%
846 L4.1 Public Health	846 4215 L4 Public Health	100.0%	100.0%	N/A	100.0%	100.0%	N/A
846 L4.1 Public Health	846 4402 L4 Sexual Health	100.0%	100.0%	98.3%	100.0%	89.3%	87.9%
846 L4.1 Public Health	846 L4 Immunisations	100.0%	N/A	100.0%	100.0%	N/A	90.0%
846 L4.1 Specialist and Elective Se	846 4206 L4 Specialist & Elective Services	100.0%	99.3%	96.1%	100.0%	96.4%	91.1%
846 L4.1 West Kent	846 4204 L4 West Kent Locality	100.0%	100.0%	94.6%	100.0%	87.0%	88.5%
846 L4.1 West Kent	846 7850 L4 North Kent	N/A	100.0%	95.1%	N/A	93.5%	90.2%
846 L4.1 IT	846 4220 L4 IT	100.0%	N/A	N/A	97.7%	N/A	N/A
846 L4.1 4302 Clinical Governance	846 4302 L4 Clinical Governance	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 4307 Patient Experience	846 L4 4307 Patient Experience	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 4308 Tissue Viability	846 L4 4308 Tissue Viability	100.0%	N/A	N/A	87.5%	N/A	N/A
846 L4.1 Chief Nurse	846 4301 L4 Deputy Chief Nurse	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Chief Nurse	846 4303 L4 Infection Prevention and Control	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Chief Nurse	846 4304 L4 Chief Nurse	100.0%	N/A	100.0%	100.0%	N/A	100.0%
846 L4.1 Chief Nurse	846 4305 L4 Safeguarding	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Medical Director	846 4306 L4 Medicines Management	100.0%	N/A	84.8%	100.0%	N/A	87.9%
846 L4.1 Medical Director	846 4350 L4 Medical Director	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 HR, OD and Communicat	846 4300 L4 Management of Human Resources	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 HR, OD and Communicat	846 4502 L4 Human Resources	100.0%	N/A	100.0%	100.0%	N/A	100.0%
846 L4.1 HR, OD and Communicat	846 4503 L4 Communication & Patient Engagem	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Business Development a	846 4601 L4 Business Development & Service	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Finance	846 4550 L4 Finance	100.0%	N/A	N/A	93.8%	N/A	N/A
846 L4.1 Finance and IT Managem	846 4560 L4 Finance and IT Management	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Performance & Business	846 4602 L4 Performance & Business Intelligence	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Corporate Services	846 4701 L4 Corporate Services	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Corporate Services	846 4702 L4 Executive Teams	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Corporate Services	846 4703 L4 Corporate Assurance & Legal	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Estates	846 4554 L4 Estates Management	100.0%	100.0%	N/A	100.0%	100.0%	N/A
846 L4.1 Estates	846 4555 L4 Site Overheads	100.0%	100.0%	N/A	100.0%	86.7%	N/A
846 L4.1 Estates	846 4556 L4 Facilities Service (Soft FM)	N/A	94.8%	N/A	N/A	84.7%	N/A

The IPC Team has contacted all heads of service and team leads to address non-compliant areas, and there is an improvement in compliance since the previous report.

8. Outbreaks

In July there were 2 outbreaks of diarrhoea and vomiting (one of these was confirmed norovirus). There were no outbreaks in August and 1 outbreak in September of diarrhoea and vomiting – unknown cause. Patients during the outbreak periods were isolated or cohorted enabling the wards to remain open. The IPC Team supported the teams throughout these incidents. All wards have received their updated outbreak folder packs containing current information/posters to refer to.

9. Water safety and incidents.

The Water Safety Committee continues to meet to discuss the assurances required, revise polices and protocols and identify gaps and actions where necessary.

10. Antimicrobial Stewardship.

The Antimicrobial Stewardship Committee continues to meet, and implement actions from the five year plan. Preparations are underway for Antibiotic Awareness Week 12-18 November 2018.

Discussions are underway to merge Infection Prevention Control (IPC) and Antimicrobial Stewardship (AMS) meetings in some format. Both the IPC Team and the Pharmacy Team are involved in the Kent and Medway IPC/HCAI Leadership Pilot. This will influence Antimicrobial work going forward.

11. Decontamination

There have been no decontamination issues in this time frame but the Authorised Engineer for Decontamination has been requested to audit the processes undertaken by Dental in the centres where they re-process locally in November, with the annual re-audit of IHSS due early 2019.

12. Conclusion

The IPC Team is predominantly focussing on Gram negative bacteraemia surveillance and lessons identified through these investigations, and implementing the actions required to reduce these cases. The regional and national collaborative work also continues. Locally the team are preparing for winter outbreaks and winter pressures, and all services have access to their support. In October, the Trust Influenza Vaccination Campaign commences.

Rowena Chilvers
Deputy Head of Infection Prevention and Control Team
November 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Item:	3.2
Subject:	Learning From Deaths Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision	☐	Assurance	X

Report Summary

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 the Quality Committee and the 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, any patients who die under our care with serious mental health needs, all children and all patients with learning disability.

Since May 2018, mortality reviews of community hospital inpatient deaths have been conducted through a centralised process where the review team is made up of a doctor, a ward matron or other senior member of ward staff, a pharmacist, a quality lead and centralised administrative support. Members rotate on a monthly basis to maintain a degree of independence and this replaces the previous process of hospital multidisciplinary team (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.

An internal process for reviewing deaths of patients with Learning Disabilities has been put in place alongside the Learning Disabilities Morality Review (LeDeR) programme process for additional assurance, for best practice and to meet the Trust's ethical obligations. This is outlined in more detail in the attached report and learning from this process is expected to be gathered in the coming months and will be reported to the Mortality Surveillance Group and Quality Committee.

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
For assurance.

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

Dr Sarah Phillips	Tel: 01622 211922
Medical Director	Email: sarahphillips4@nhs.net

Kent Community Health NHS Foundation Trust

LEARNING FROM DEATHS REPORT JULY TO SEPTEMBER 2018

1. Introduction

1.1 National guidance on learning from deaths requires 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.

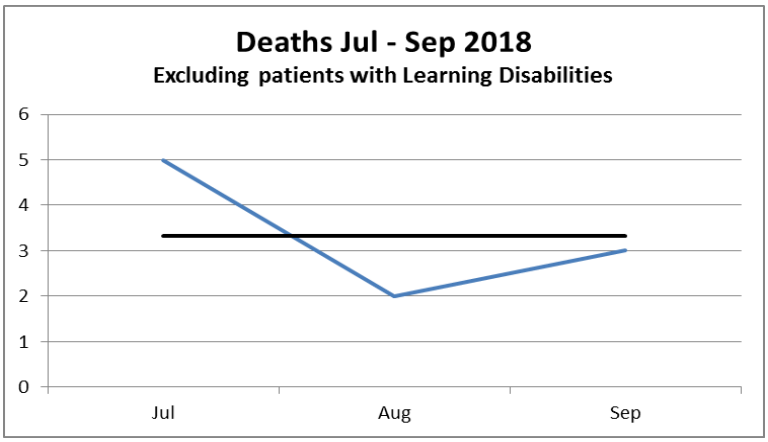
2. September Dashboard

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**
3		2	4*		6	0	0
This Quarter (QTD)		**Last Quarter**	**This Quarter (QTD)**		**Last Quarter**	**This Quarter (QTD)**	**Last Quarter**
10		12	15		11	0	0
This Year (YTD)		**Last Year**	**This Year (YTD)**		**Last Year**	**This Year (YTD)**	**Last Year**
49		22	46		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 tables below outline key areas of good practice along with areas for learning identified in reviews completed this quarter, along with the actions taken. These are also reviewed in the monthly Mortality Surveillance Group (MSG).

3.2 All areas of good practice and areas for learning are reported at the monthly matrons' meetings in the East and West and wider dissemination to all ward staff is encouraged.

Areas of Good Practice	
Whitstable and Tankerton	**Faversham**
- Good, respectful interaction with family including offering refreshments and time alone with patient. - Family was integral to end of life experience. Staff involved family and were considerate of their needs, such as allowing them to stay in the side room throughout. Very person-centred care evident. - Clear notes on CIS re monitoring and comfort. Other teams such as safeguarding and dietetics were involved to ensure patient received high level of care. Although patient couldn't verbalise, they wrote a positive comment on the "This is Me" sheet about being happy with the care provided.	- Appropriate recognition and transition to End of Life care. - Good documentation around family's concerns; staff kept trying to communicate with them despite challenges. - Catheter passport in place. - All Best Interest, MCA, DoLs and Safeguarding forms completed. Good end of life medication management and good documentation on CIS. Overall very good management of a complex patient.

Areas of Good Practice	
- Anticipatory care medicines were in place at the right time, with good communication with family well documented on CIS. The patient's wife was an inpatient at Faversham at the time and was given the option to visit/transfer over to see her husband, demonstrating compassion that staff were willing to arrange this.	
Queen Victoria Memorial Hospital - Care was considered holistically including pressure areas and catheter care. Good documentation on CIS and good communication with patient's son in final days.	**Hawkhurst** - Good practice in contacting hospice re pacemaker as well as making funeral directors aware. Extremely positive feedback received from family via Meridian survey re excellent care, stating how all staff went "above and beyond." Clear notes and filing.

Areas for Learning	Comments/Actions
Documentation	
- Recommend increased use of electronic nursing assessment on CIS. Care plans should be fully on the PCP template.	- Recommendation fed back to ward matron and disseminated more widely at monthly matrons' meeting.
- There was a slight discrepancy with the death and discharge timings on CIS (noted as discharged from ward at 16:30 and died at 18:59; paper notes confirm death occurred at 15:00)	- Discrepancy fed back to ward matron and disseminated more widely at monthly matrons' meeting.
- Not specifically documented that bereavement leaflet was given.	- This is common across all community hospitals; staff typically give out documentation after death as a matter of course and have supportive conversations with family members, but it is not always evidenced in the notes. Work is ongoing with Nicola Le Prevost, Consultant Nurse for End

Areas for Learning	Comments/Actions
	of Life Care, to create a checklist for after death so that the giving of bereavement information can be more consistently evidenced.
Medicines - Oxygen used for EOL patient; possibly inappropriate - Glycopyrronium used without sedation or pain relief which are usually co-prescribed. - No anti-emetic prescribed along with morphine. - EOL medication use should have been reviewed but was not, and normal medications were not stopped.	- Nicola Le Prevost, Consultant Nurse for End of Life Care is working with Pharmacy to develop training for community hospital staff on end of life medications to ensure that best practice is followed. The mortality review session membership also now includes a pharmacist so that issues with medications can be more easily picked up and areas identified where staff may benefit from education.

4. **Learning Disability (LD) Mortality Review Process Update**

4.1 Following the Mazars report and CQC mandate, the Trust is required to undertake reviews of every death of a person with a Learning Disability who was accessing or waiting for services. There are two separate processes involved; each death should be subject to an internal review, as well as being submitted to the LeDeR programme. The LeDeR programme was originally commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and aimed to support local areas to review the deaths of patients with Learning Disabilities, share common themes and trends, and take forward the lessons learned in order to make improvements to service provision.

4.2 It was expected that themes, trends and learning would be gathered through the Kent and Medway LeDeR Strategy Group which meets quarterly. Due to capacity issues nationally, only 10% of deaths have been reviewed and therefore KCHFT have not received feedback and shared learning. There have not been any reviews completed for any person's death in Kent or Medway since August 2017 and there are no additional resources or funding associated with the LeDeR programme. The Kent and Medway LeDeR Strategy meeting is not yet fully functional and does not provide the level of information that KCHFT require to identify lessons and problems in healthcare delivery.

4.3 The lack of feedback from the LeDeR programme has necessitated the development of a more robust internal review process so KCHFT can gather learning from deaths. The process that was in place before LeDeR; i.e. reviews using Datix, was useful but did not provide the level of detail which is required.

The new internal review process will reflect best practice, give assurance and help the Trust to meet its ethical obligations. The Confidential Inquiry into Premature Deaths of People with Learning Disabilities (CIPOLD) found that people with Learning Disabilities have significantly lower life expectancies than people without. The aspiration is to analyse circumstances and causation leading to deaths so that intervention can change practice to ensure people with Learning Disabilities lead more fulfilled lives.

4.4 The first Learning Disability Service (LDS) Mortality Review Group meeting has been held and the draft process confirmed and communicated to staff. Embedded below is a flowchart to outline internal governance processes and to demonstrate how this process links with the regional LeDeR process, along with a 12 month analysis report.


LD mortality review process v1.pdf


LDS Reporting of Deaths Analysis Repc

4.5 The LDS Mortality Review Group will review all deaths of people with Learning Disabilities dating back to April 2017; this amounts to 65 deaths. All of these were originally subjected to an initial line manager review on Datix. None were escalated as potential SIs and there is confidence that any safeguarding issues would already have been considered.

4.6 The LDS mortality review process has established criteria that would flag the need for an Enhanced Review (as opposed to a Simple Review); this includes unexpected deaths, if the person had been admitted to an acute hospital more than three times within the last nine months, if the patient died out of the county, or if there were safeguarding or mental capacity issues to consider. Enhanced Reviews are multi-disciplinary reviews and, where possible, families/carers will also be involved in reviews.

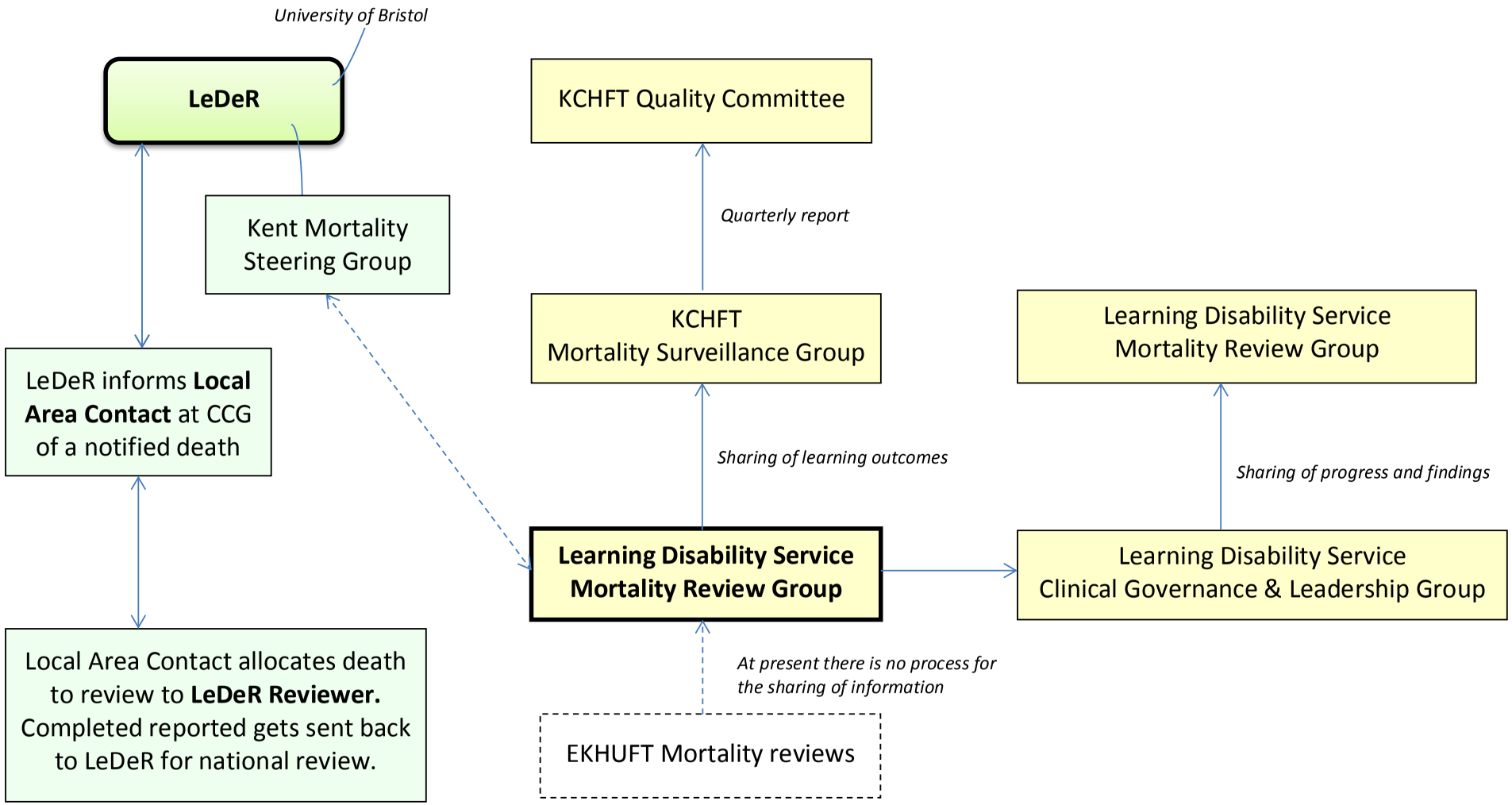
4.7 A Specialist Practitioner has been recruited on a fixed term basis for 12 months to lead on the internal review process and review historical deaths. Review meetings have been arranged to take place every three to four weeks until the backlog is cleared.

4.8 Learning from the mortality reviews will be brought to the LD Quality Management Meeting and the Mortality Surveillance Group, and reported to the Quality Committee quarterly.

Sarah Phillips
Medical Director
14 November 2018

Learning Disability Mortality Review Process and LeDeR

Kent Community Health NHS
NHS Foundation Trust



Version 1

Learning Disability Service Reporting of Deaths and Review Process

Kent Community Health NHS
NHS Foundation Trust

Initial notification/awareness of a death

↓

If the client is open to Adult Learning Disability Services

i.e. on caseload or open referral at time of death

↓

Report on **LeDeR** (or ask care home, etc if this has been reported on LeDeR)

↓

Report on **Datix**

If there has been no incident leading to the death, report this as 'Implementation of Care', 'No harm' and tick the box to indicate this involves a death.
If the death has been reported as a Serious Incident this will follow a RCA investigation as per policy.

← Specialist Practitioner will be notified and update Mortality register

↓

Line Manager will undertake **initial review** and determine whether this requires a Standard review or an Enhanced review.

↓

Standard Review:
Line Manager to complete investigation section on Datix

Complex Review:
Line Manager - In the Investigation section on Datix, complete as much information as possible and indicate that this will receive an Enhanced review.

A death may require an Enhanced review if the following factor(s) are indicated (not exhaustive list):

- *'unexpected' death*
- *accelerated expected death*
- *involvement in CCR or MyHN*
- *3 admissions to acute hospital < 9 wks.*
- *DNR*
- *Sepsis*
- *Safeguarding involvement*
- *Out of county*
- *BME*
- *Under 25yrs*

↓

LDS Mortality Review Group meeting
1. Review of deaths marked as requiring an Enhanced review - using mortality review document
2. Review backlog of deaths
3. Review progress of 'Pending' reviews

→ Update Datix and Mortality Register

↓

Learning to be shared at LDS Clinical Governance meeting, LDS Quality Management Team meeting, and KCHFT Mortality Surveillance Group

Specialist Practitioner to link internal review with LeDeR review

5 September 2018
Review Jan 2019

Version 1

Kent Community Health NHS Foundation Trust

LEARNING DISABILITY SERVICE - REPORTING OF DEATHS ANALYSIS REPORT

Overview

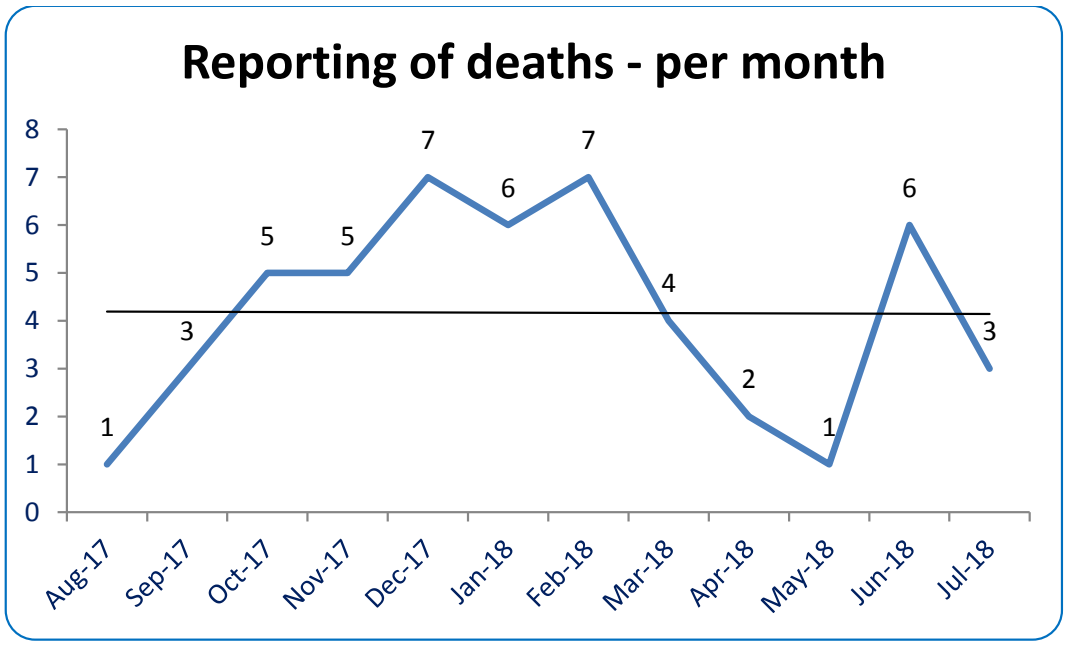
August 2017 – July 2018 = 54 incidents reported on Datix.

Four were not acquired in our care (i.e. not on our caseload) ∴ 50 individual Datix reports.

In 97% of cases, the incidents (deaths) were reported as unavoidable. In one case, however, this was reported as avoidable, although the avoidable factors were from external sources. It can be confirmed, therefore, that there have been no incidents or events that have directly or indirectly caused or accelerated a death from the learning disability service.

There were no Serious Incidents reported.

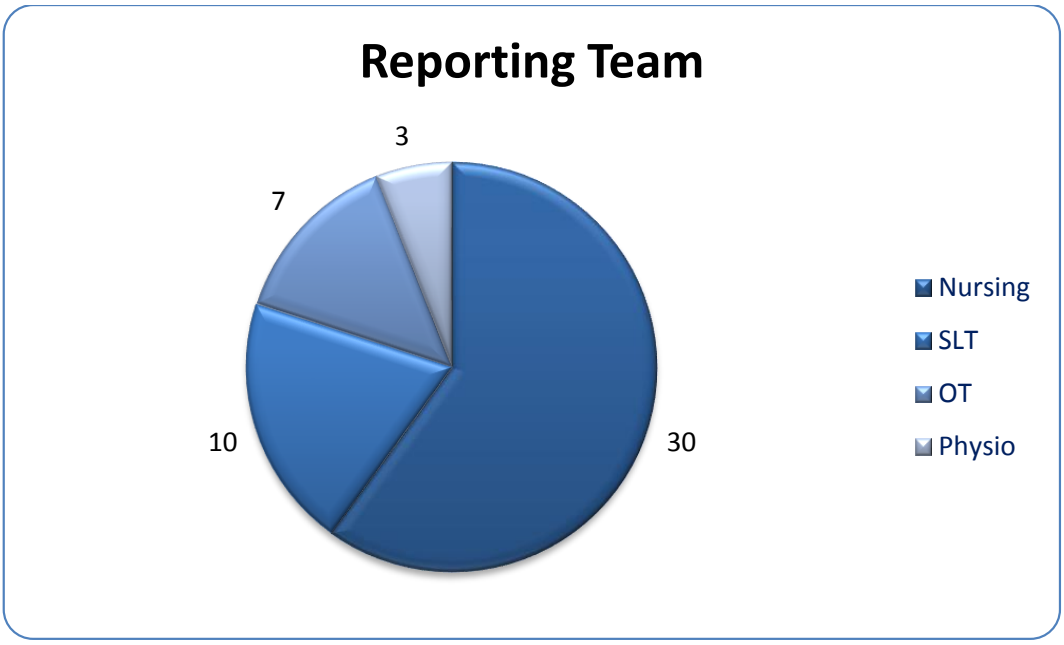
Month



There was a marked increase in the reporting of deaths in the winter months and into spring.

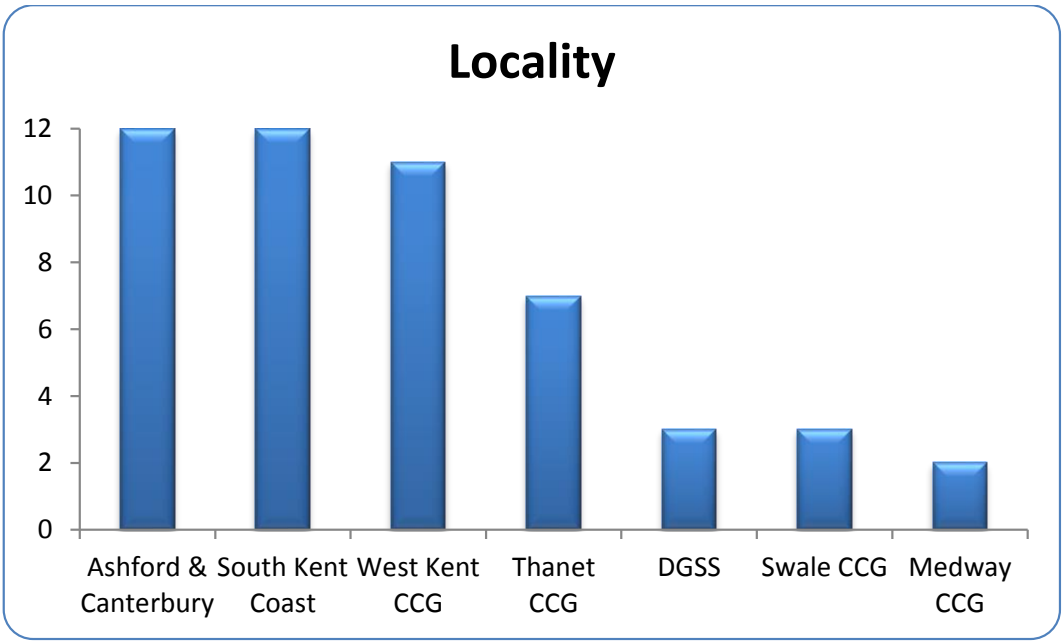
The linear trend-line indicates a steady pattern of reporting over the twelve month period.

Professional team

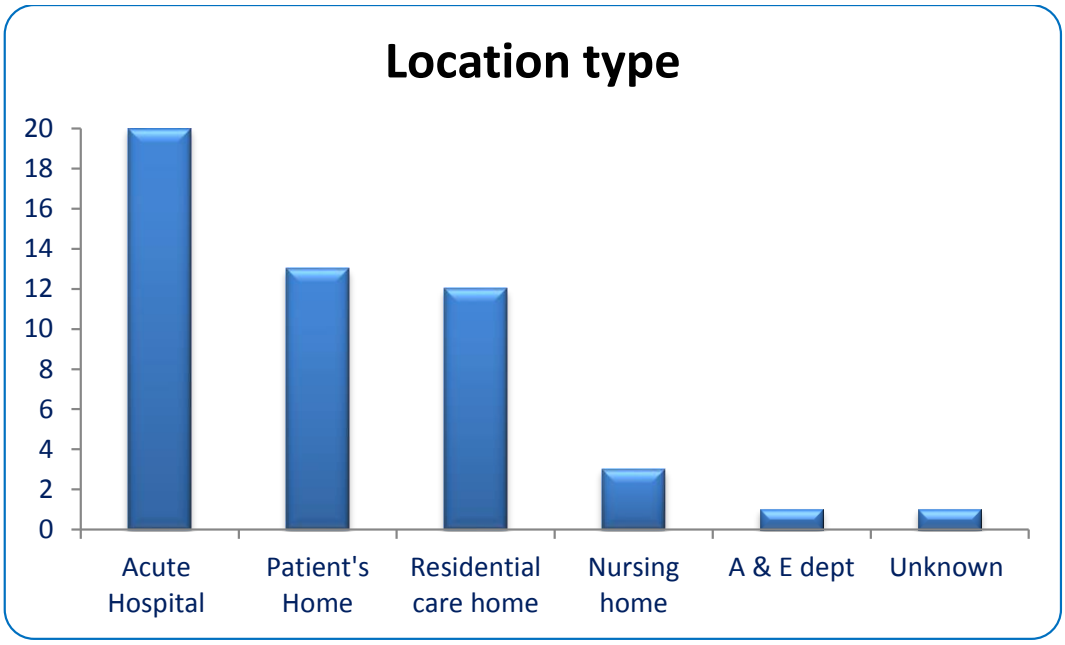


60% reports came from Nursing.

Reporting Locality



Location of event

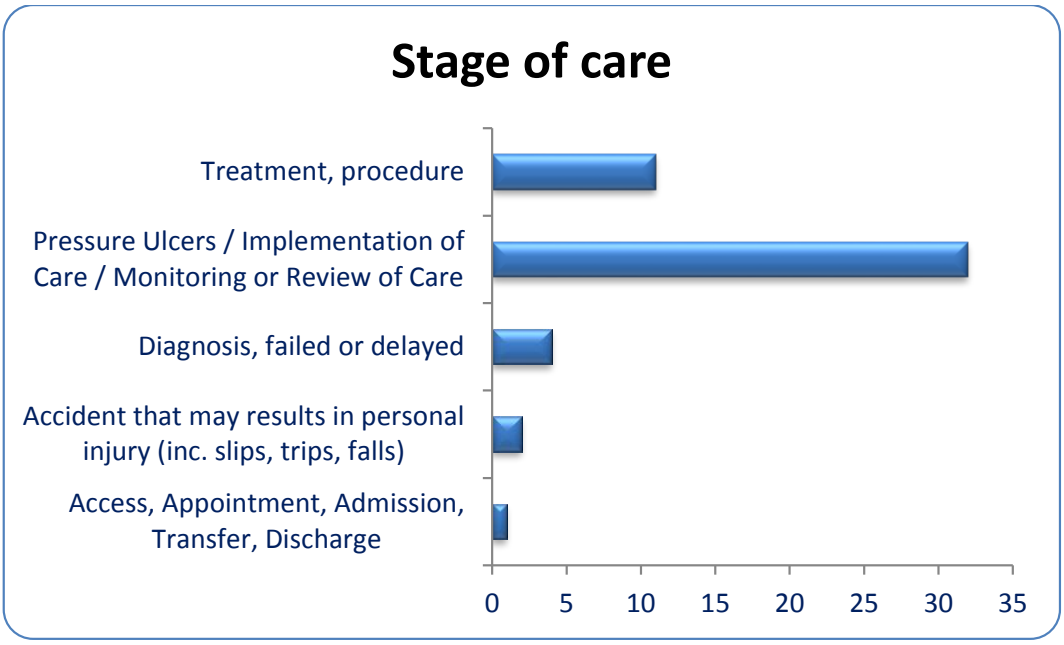


The majority of deaths were reported whilst at acute hospital (40%).

Location type can be further broken down to the following:

Patient's Home	13
William Harvey Hospital	8
QEQM Hospital	7
Unknown	5
Medway Maritime Hospital	3
Maidstone Hospital	2
Maylands Residential home	2
Newington Road Residential home	1
Shipbourne Road Residential home	1
Adisham House Residential home	1
Cameron Lodge Residential home	1
Emily Jackson Residential home	1
Pepenbury Residential Home	1
Sandgate Manor Residential Home	1
Shore Lodge Residential Home	1
St Stephens Nursing Home	1
Wombwell Hall Nursing Home	1

Stage of Care

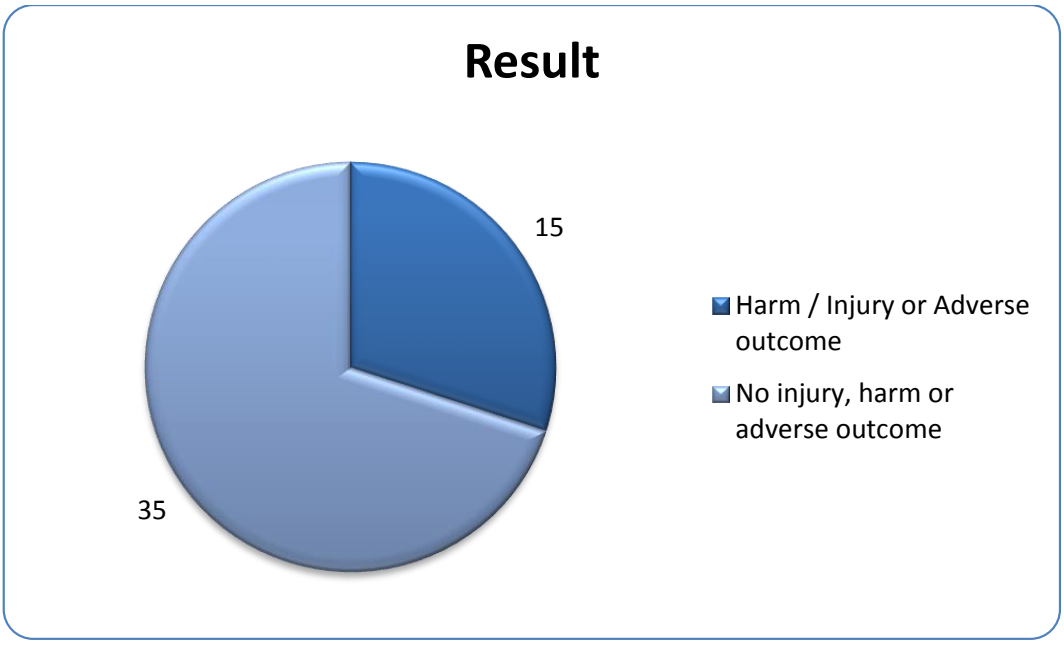


'Implementation of Care' was the highest report stage of care, although it is unclear of the difference between this selection and 'Treatment, procedure'.

On further examination:

Diagnosis, failed or delayed (4)	Suspected sepsis. Incident reported as not avoidable.
	Unclear why this was reported as a delayed diagnosis (83202)
	Unclear why this was reported as a delayed diagnosis (83357)
	Unclear why this was reported as a delayed diagnosis (84387)
Accidents that may result in personal injury	Unclear why this was reported as an accident (heart failure & pneumonia) (84397)
	Unclear why this was reported as an accident (physical deterioration) (83435)

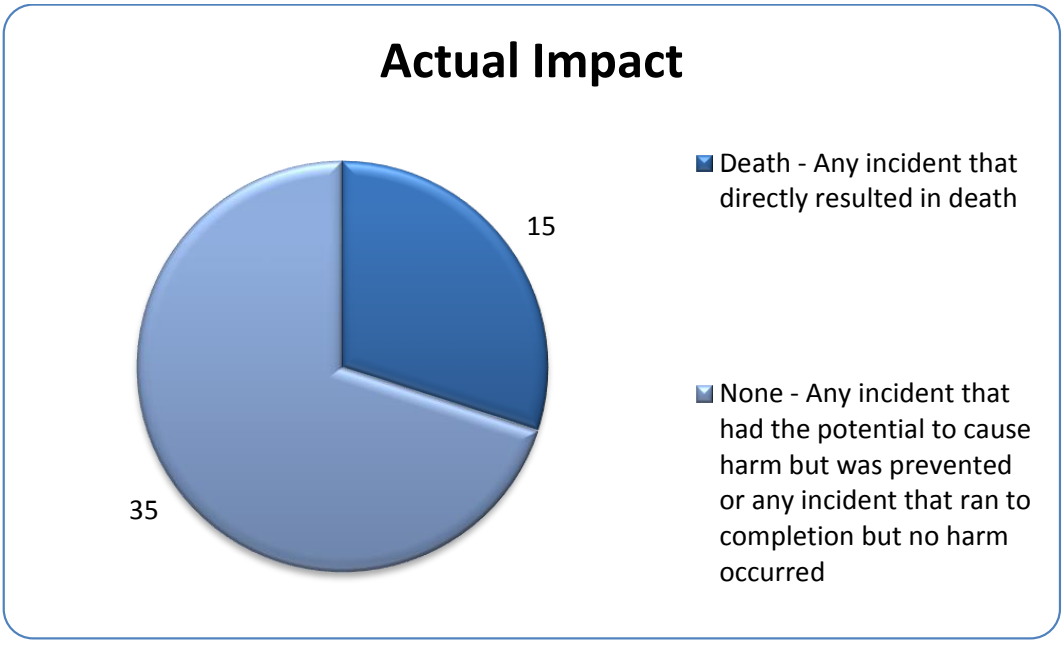
Result



30% of reports were indicated as resulting in harm; 70% resulted in no harm.

There is no known written procedure on how to report deaths (not incident-related), so this would explain the discrepancies in reporting (Trust policy).

A similar pattern can be seen in the 'Actual Impact' section, however, this implies that the LDS has had 15 deaths as a result of an incident occurring. To clarify, this is not the case.



It has been confirmed by the Risk team that a non-incident death should be reported as no harm, with the box ticked indicating that a death has occurred.

Recommendations

Further analysis of circumstances surrounding these deaths, demographics, etc will be examined in further via the LD service Mortality Review Group (to be piloted end August 18).

The Datix ‘description’ of these incidents should be reviewed to identify how many deaths would constitute a ‘simple’ or ‘complex’ death review.

Report to be shared at the Clinical Governance and Leadership Forum and with the Trust’s Mortality Surveillance Group.

Mark Anderson
Deputy Head of Service – Learning Disabilities
20 August 2018

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Item:	3.3
Subject:	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):
This report is to provide assurance that the Trust gathered patient feedback, responded to complaints and acted on this feedback to improve services. It contains details of patient and service user feedback for Quarter Two 2018.

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

Relevant Legislation and Source Documents:
No. High level position described and no decisions required.

Sue Mitchell	Tel 07393 240018
Assistant Director for Patient Safety and Experience	Email: s.mitchell13@nhs.net

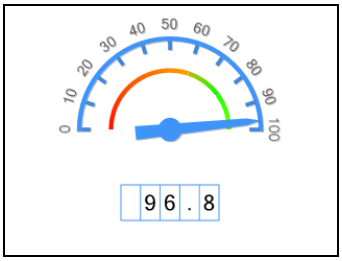
Kent Community Health
NHS Foundation Trust

Patient Experience and Complaints Quarterly Performance Report
Quarter 2 – 2018/19

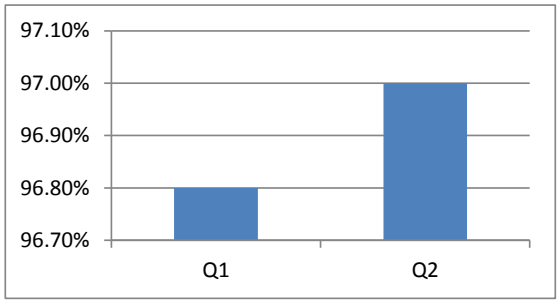
This report provides a summary of information regarding complaints, PALS and patient experience data across all clinical services for Quarter 2, 1 July 2018 to 30 September 2018.

1.0 Combined Satisfaction Score

15,928 surveys were completed by KCHFT patients, relatives and carers with a strong combined satisfaction score of **97%** in Q2, consistent with the score in Q1.

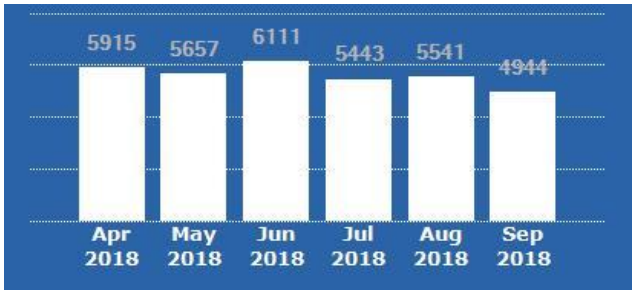


Overall satisfaction survey percentages trust wide for the last 6 months were consistently good and a small increase was seen in Q2.



2.0 Meridian Surveys

Questionnaire volumes (numbers of surveys completed) for last 6 months:



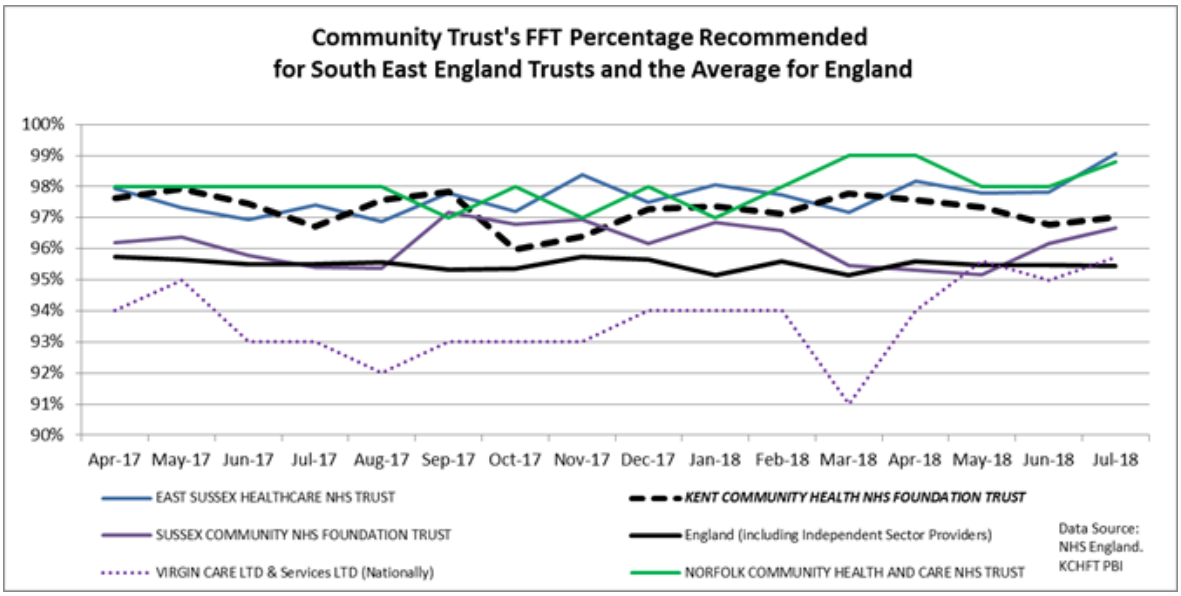
Survey volumes have decreased slightly in Q2 when compared with Q1, which is in line with the general trend seen over recent years during the summer months.

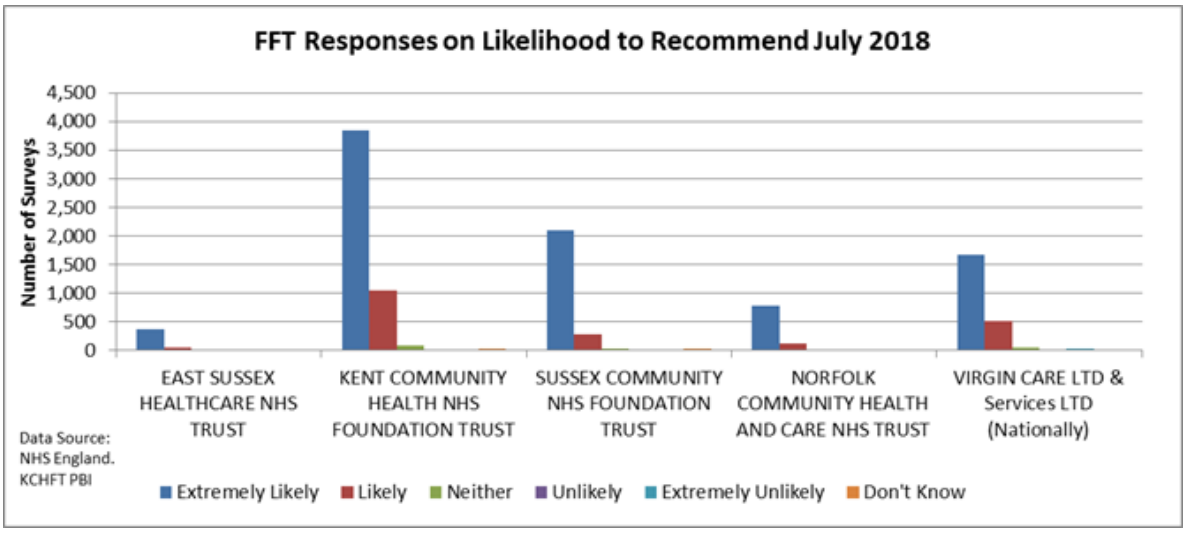
3.0 NHS Friends and Family Test (FFT) scores:

How likely are you to recommend this service to friends and family if they needed similar care or treatment?

The NHS Friends and Family Test recommend score for Q2 was **97.36%**, consistent with the Q1 score of **97.23%.** In Q2 2018, **0.70%** of our patients chose not to recommend the service they received, compared with **0.63%** in Q1. In Q2 just **106** unlikely or extremely unlikely responses were chosen from a total of **15,065** FFT questions answered.

To assist with benchmarking, Norfolk Community Health and Care NHS Trust, who have been given a CQC rating of outstanding, are now being included in reporting. Norfolk average around **98%** for their NHS FFT score, however they collect less than a ¼ of the surveys conducted by KCHFT as a ratio of their service provision.





3.1 FFT Trust overall quarterly results for 2018

Quarter	Recommend	Not Recommend	Total Responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q2 2018/19	97.36%	0.70%	15058	11864	2796	199	50	56	93
Q1 2018/19	97.23%	0.63%	15694	12201	3059	224	43	56	111
Q4 2017/18	97.35%	0.60%	12903	10210	2351	170	31	46	95

The percentage for each FFT question response in relation to the number of surveys is shown below:

Quarter	Total responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q2 2018/19	15058	78.8%	18.6%	1.3%	0.3%	0.4%	0.6%

Quarter	Total responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q1 2018/19	15694	77.7%	19.5%	1.4%	0.3%	0.4%	0.7%
Q4 2017/18	12903	79.1%	18.2%	1.3%	0.2%	0.4%	0.7%

FFT scores for patients who would recommend services remain high and are consistent when compared with the previous two quarters. FFT scores for Q2 broken down by CCG, minor injury units and community hospitals are shown in **Appendix 1**.

3.2 Minor Injury Units (MIUs)

FFT scores for all MIUs were high in Q2, ranging from Sevenoaks (**96.94%** recommend) to Edenbridge (**99.84%** recommend). Only **22** unlikely / extremely unlikely responses were received out of a total of **5,641** completed surveys, equating to **0.4%.** Gravesham had the greatest number of surveys completed (**1,882**), followed by Folkestone (**1,017**). All other MIUs had **640** or fewer completed surveys. Caseload data is currently not available from the Performance Team to enable a comparison against number of patients seen in the MIU's.

3.3 Community Hospitals

Community hospitals scored very highly with the FFT question in Q2, with the exception of Hawkhurst (**85.71%).** 28 surveys were completed for Hawkhurst during the period and the FFT score was reduced as 2 patients answered 'don't know' and 2 chose the 'netiher likely nor unlikely' response. The remaining 25 responses were positive.

Thre was a reduction of inpatient survey volumes from June to August 2018 due to the hospitals undertaking the National Intermediate Care Audit. An increase was seen in September for Deal, Faversham and Whitstable and Tankerton hospitals. No difference in the number of completed surveys was seen in September for Edenbridge, Hawkhurst and Tonbridge Cottage Hospital (Goldsmid ward). Sevenoaks and Tonbridge Cottage Hospital (Somerhill and Primrose ward) survey numbers declined in September and no surveys were completed for QMVH, Herne Bay. Discharge data is currently not available from the Performance Team to enable a comparison against number of patients seen in the MIU's.

Survey volumes received by community hospital for Q2 and over a 6 month period are shown in **Appendix 2**.

3.4 FFT Extremely likely and unlikely response survey details for September 2018

Directorate	Unlikely	Extremely unlikely	Total
Public Health and Children's Specialist and Learning Disability Services (inc Dental (4), Sexual Health (1) and CLDT (0)	3	9	**12**
Adult	15	4	**19**
Health Improvements	0	0	**0**
	18	**13**	**31**

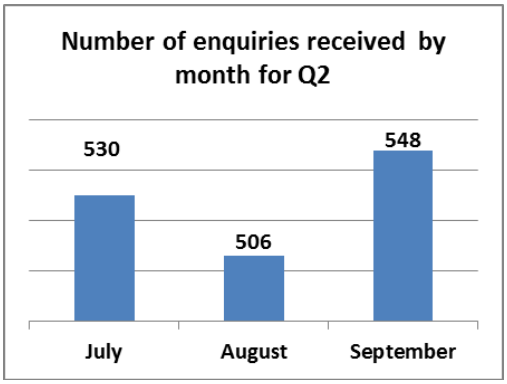
Four FFT responses were on surveys completed by children. 5 responses appear to have been answered incorrectly as the remainder of the feedback was positive. No qualitative data was given for 3 of the responses. In the remaining 19 responses, the majority of feedback was linked to **communication, waiting times to be seen in walk-in clinics and for scheduled appointments**. Others related to signposting, availability of other services and the environment. Single comments were made about treatment, medication, a delay in receiving results and staff shortages. 1 survey was completed about the package of care/treatment being provided by nursing. Full details of survey data by service where 'unlikely' and 'extremely unlikely' answer options have been chosen are detailed in **Appendix 1**.

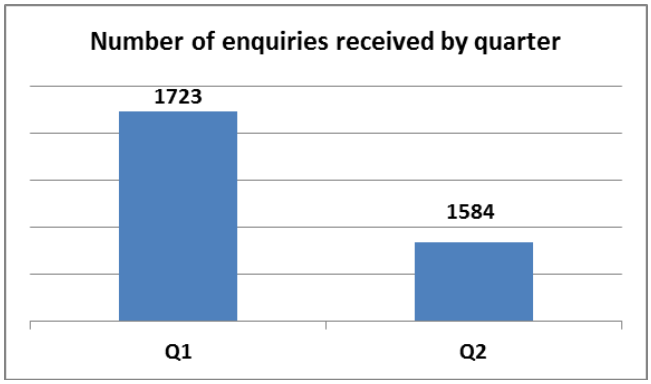
The following surveys were responded to in detail by services concerned:

Survey ID	Score	Date	Service	FFT response
379169	0.00%	19 Sep 2018	**Minor Injury Unit, Sevenoaks)**	Extremely unlikely
Comment: *We called this morning to confirm xray hours and it would have been helpful if we were told there was a staff shortage so we could have made an informed decision to come back. We will not be coming back and will tell others of our bad experience.*				
Note: Staff shortage was relevant to MIU staff, not x-ray.				
A sign was on display advising that 'due to unforeseen circumstances we only have 1 clinician and this will increase waiting times'. The staff shortage was due to sickness so the service was not aware until that morning which left only one practitioner until midday when another practitioner could start. Rosters are fully staffed but sickness always causes an issue because there is only a small number of staff on duty and one person going sick has a major impact.				
380828	0.00%	27 Sep 2018	**Minor Injury Unit, Sevenoaks)**	Unlikely
Comment: *Lack of communication and very long wait when only 6 people waiting for assistance.*				
On 27 September the staff had a team meeting and essential training in the morning. There was a bank nurse to cover this period and the communication board was completed showing an approximate 1.5 hour wait. All patients were seen treated and discharged within 4 hours.				
375795	0.00%	01 Sep 2018	**Community Nursing - Folkestone**	Extremely unlikely
Comment: Nurse came yesterday without supplies to change dressings. Previous nurse apparently was ordering them. Dressings not changed yesterday but Nurse said she would come today and ring to say when she was en route. No visit, no phone call, not even to say she wasn't coming. Dressing not changed since Tuesday, it is Saturday now. And no idea when the Nurse will now visit. Unacceptable 'service'. If an infection develops in the wound, this matter will have to be escalated. Other comments and service response: • *No Care Plan shared. No supplies provided to re-dress wounds. No effective communication. No visit when it was scheduled. Clearly nil communication between different Community Nurses.* **Service response:** The current process for the supply of wound dressings is via the GP, this can cause delays due to producing script and then supply via chemist including delivery. Process is changing within next 6 weeks as going to have supply of dressings at all bases ordered directly for patients to prevent this in future. All patients should have Local referral unit number so that they can contact regarding visits. This may have been in relation to the Hythe team who have been compromised with staffing levels. • *No copy (care plan) left with patient, only accessible on line.* **Service response:** All wound care plans are within wound matrix on system accessible for patient care, this is supplied to patient on subsequent visits as part of their PCP, due to CIS this cannot be completed on first visit. All visiting staff would be aware of the plan as available electronically. • *How do we raise a complaint? Can't find details on line. No leaflet left with patient even with contact details. 01303 717400 (Shepway) number not answered out of hours or even to have a recorded message of what to do in these circumstances.* **Service response**: Will ensure patients are given contact information on a first visit if it is required for the LRU. • *Turn up when you say you will. Ring when you say you will. Or ring if you can't come. Communicate. And then communicate some more.* **Service response:** This information will be shared with all staff. • *Completely vulnerable to the service the Community Nurses provide as am housebound. No others choices of how to access services beyond calling an ambulance which is not warranted.* **Service response:** If patient had contacted ambulance service they would have been redirected to community teams if appropriate. Could be avoided by ensuring that patients have adequate contact information.				
380649	55.56%	27 Sep 2018	**Community Orthopaedics - Thanet**	Extremely unlikely
Comment: *The whole process was shambolic from the disorganised room which included misplaced*				

consent forms to a store cupboards for syringes in total disarray, culminating in a "messed up" (practitioner's words) steroid injection. The syringe came apart and I could feel the fluid in my palm. I was told this may not work as only half of the medication was administered Other comments: *Process for booking appointment too long winded. I could only get through to an answer phone when I tried to make contact so had decided I would e mail today this survey has helped me voice my concerns.* Details were left for so the service could contact.
The service contacted patient and apologised profusely. Explained that needle malfunction was an equipment rather than clinical error. The service will make follow-up call to patient in six weeks to see whether injection has had desired effect. A second injection can be offered. Store cupboards to be tidied.

4.0 Patient Advisory Liaison Service (PALS) enquiries for Q2 2018





Most calls received during Q2 were phone number enquiries (1,257) and 297 general enquiries. Themes seen in Q2 were relating to treatment/access (20), home visits (20) and staff attitude (10). PALS continued to receive calls during Q2 from service users who had received appointment letters and believed they were ringing the service to discuss their appointment. The main services involved were Health Visiting (39), Podiatry (73) and MSK (49).

Concerns from patients unable to get through to the Podiatry service continue, however these have have greatly decreased in September.

5.0 Patient reviews received via NHS Choices / Patient Experience generic email for Q2 2018
50 reviews were received for services listed below. 41 were positive, 6 negative and 3 mixed.

The majority of reviews were for the MIUs, with Deal, Gravesham and Sheppey receiving more. The main positive themes related to care and compassion, staff attitude, waiting times, medication and treatment. Themes from negative feedback related to waiting times at MIUs and accessing services i.e. x-ray and phlebotomy. A full breakdown of reviews by service and themes is in **Appendix 3** with some examples of reviews received.

6.0 Complaints

General question on surveys relating to complaints handling Q2 2018
During Q2, **9,731** 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 is a positive **93.23%**, in comparison to Q1 when **11,281** people answered this question with a slightly lower satisfaction score of **92.44**%. A list of services scoring low for this question in Q2 is shown in **Appendix 4**.

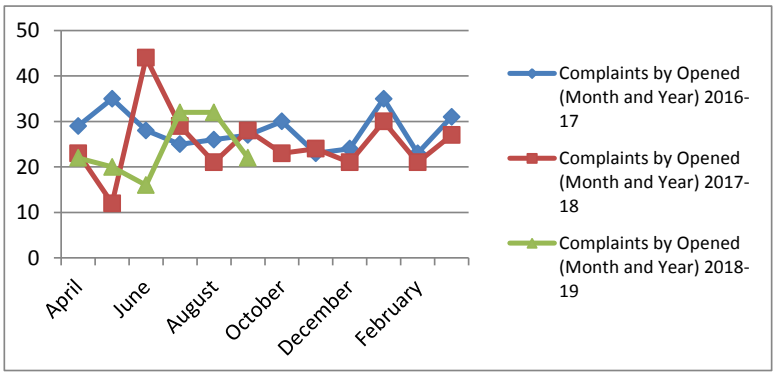
Feedback from complaints process survey

The complaints survey continues to be sent to complainants with a covering letter with their response. 43 surveys were sent during Q2. 5 completed surveys were received in total during the quarter (2 in July, 3 in August and 0 in September), this almost equates to a response rate of 21%.

Complaints received in Q2

In July and August 2018, 32 complaints were received each month and in September there were 22. There were 14 multi-agency complaints, 6 being led by KCHFT, 5 by EKHUFT and one being led by NHS England, the GP and KCC. 3 of these were end of life cases. More detail is available in **Appendix 4**.

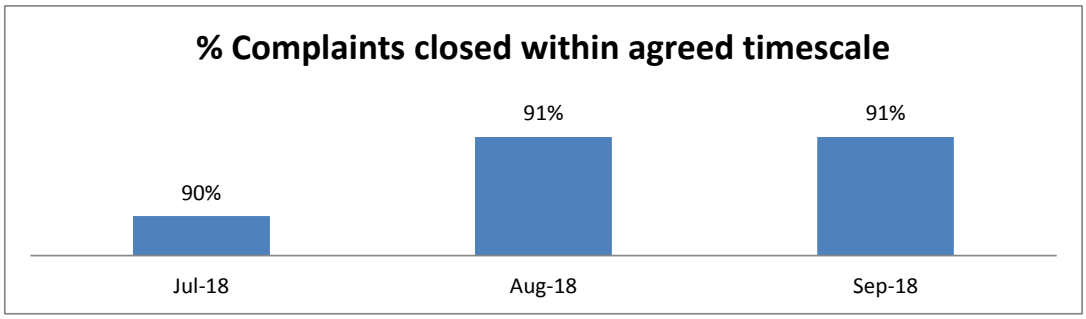
The following graph shows complaints received by month for the last 3 years.



Closed Complaints

During Q2, 78 complaint cases were closed. 90% were closed within the agreed timescales. The last 3 months have been very consistent.

The 8 complaints falling outside the time frame were due to delays in the service investigating/drafting the response and delays in the approval process. Complainants are kept updated on any delays using their preferred method of communication. Delays are closely monitored and an escalation process is in place. This process is detailed in the Complaint Handling Guidance ratified by the KCHFT Patient Experience Group on 26.9.18. The guidance has been distributed to senior managers and is also available on flo. It includes a Standard Operating Procedure (SOP) and the complaints approval process structure.



Community nursing complaints

Community nursing services received 31 complaints between July and September 2018.
5 were for the Ashford team as follows:

- two complaints about the number of visits being provided
- comments requested from EKHUFT as part of their response on care and contact from continence service
- Perception that incorrect treatment was being provided
- end of life care

7 were for the Canterbury team as follows:

- care provided to a patient at end of life
- hand hygiene issues which patient believed may have resulted in them getting an infection
- family unhappy with 3 unannounced visits by different services when patient has dementia. Not pre-arranged to make sure main carer/spouse was at home
- 2 x patients' wounds had deteriorated
- patient's discharge from caseload as not housebound
- unhappy with wound care provided, lack of nursing and staff assessing it was no longer necessary to visit daily

4 were for the Shepway teams as follows:

- difficulty in getting blood test taken and discussions with patient about being housebound
- issues after discharge from hospital, correct care and equipment being provided
- 2 complaints related to end of life care and communication with the family and a delay in receiving pain medication

8 were for Thanet teams as follows:

- delay in a continence referral from an external patient coming to Kent
- 5 complaints regarding nurses not attending for a fasting blood test / wound dressing care and general lack of communication
- roughperceived inappropriate treatment by staff member
- perceived lack of support on injecting insulin

3 were for the Dover/Deal teams as follows:

- visits stopped and patient then became unwell
- delay in visit for blocked catheter
- comments requested from GP on end of life care

3 were for the Maidstone and Malling teams as follows:

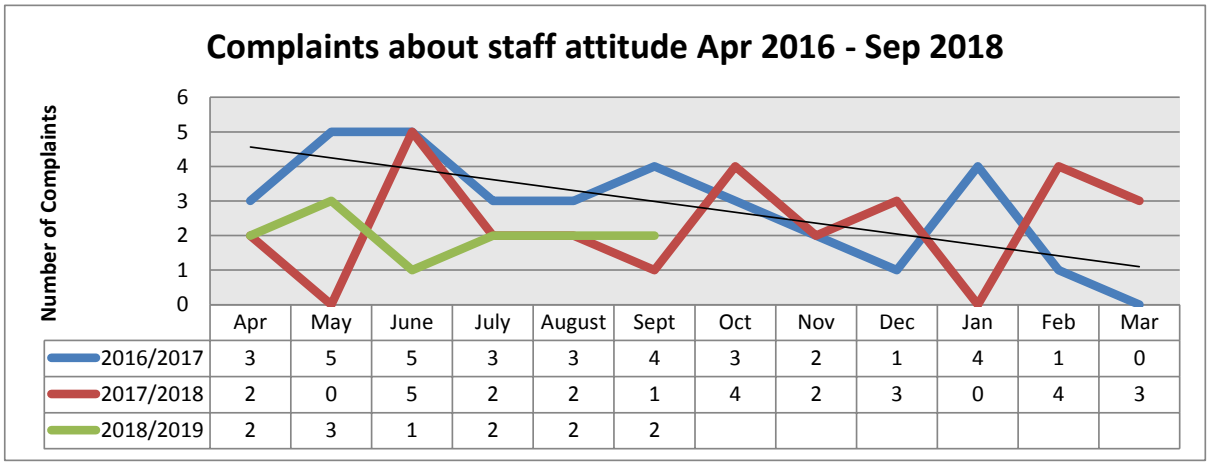
- communication regarding discharge from caseload as patient was not housebound, query regarding reduction in number of visits and care being complete

1 was for the Sevenoaks, Tonbridge and Tunbridge Wells teams as follows:

- stopping visits to inject as patient had been taught to self-administer.

6 comment/concerns were also received for community nursing services.

6 complaints were received regarding staff attitude between July and September 2018. The graph below demonstrates a downward trend in comparison to the last 2 years.

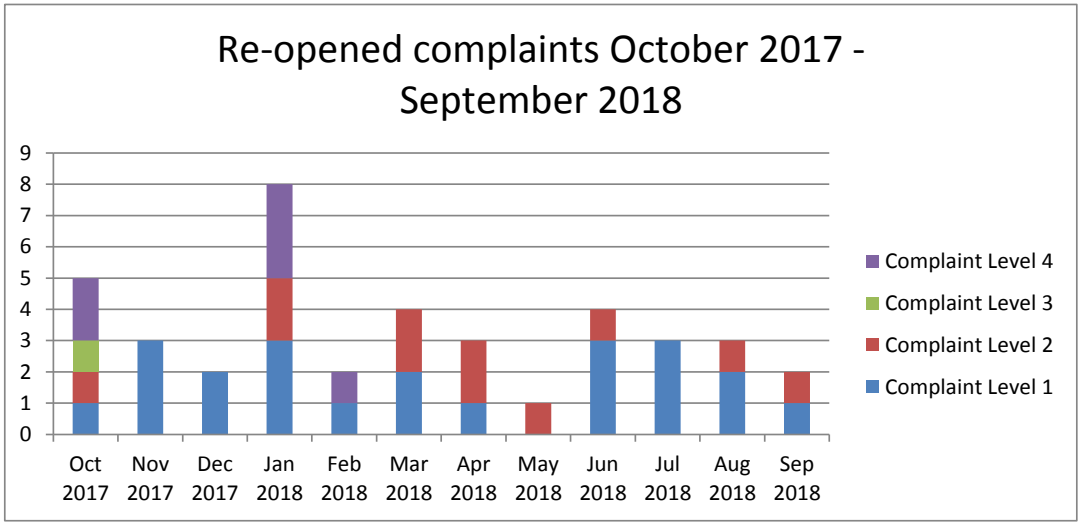


	Apr	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	Mar
2016/2017	3	5	5	3	3	4	3	2	1	4	1	0
2017/2018	2	0	5	2	2	1	4	2	3	0	4	3
2018/2019	2	3	1	2	2	2						

Re-opened complaints from October 2017 to September 2018

Numbers remain generally low, however this is monitored. Level 1 complaints appear more likely to re-open. Staff are supported by the 2 complaints officers. The Patient Experience Team flo page has a resource pack providing information on handling telephone calls with complainants, setting up meetings and creating draft responses. This along with our e-learning and face to face training package supports

staff throughout the complaints process. As previously mentioned a Standard Operating Procedure (SOP) for complaints handling is also now available for reference purposes.



7.0 Themes and trends of complaints for Q2

Complaints received in Q2 were logged under the following themes:

- Clinical treatment
- Referrals, appointments, admissions, discharges and transfers
- Values and behaviours
- Communication

Clinical treatment
40 complaints were logged in this category. 3 complaints were received were in relation to:

- Patients perceiving treatment by staff to be rough
- Misdiagnosis or lack of diagnosis at MIU
- Being unhappy with end of life care provided

Referrals, appointments, admissions, discharges and transfers
23 complaints were logged in this category. 2 complaints were received in relation to:

- Delays in getting appointments (audiology and dental)
- Patients being unhappy that visits had been stopped as deemed not to be housebound
- Patients unhappy that removed from dental list as do not meet criteria
- Missed and reduced visits for wound dressings
- 3 families experienced difficulties re-arranging community paediatric appointments

Values and behaviours
10 different complaints were logged in this category. Key themes related to staff attitude being seen as rudeness when dealing with patients.

Communication
There were 13 different complaints concerning communication with staff and information given.

A brief reason for each complaint received and further information is available in **Appendix 4**.

8.0 Lessons learned and improvements made

8.1 You said, we did (YSWD): feeding back changes that have been made to our patients

A total of 7 You said, We did examples were uploaded onto the relevant service pages on the public website during Q2. **Details of these are shown in Appendix 5.** The below YSWD examples for actions completed during September are due to be uploaded onto the KCHFT public website during October.

Service	You said	We did
Dental Service, Hillingdon	Paying for parking on site can only be done by phone.	Information has been added to appointment letters advising patients of the process so that they are aware before attending the clinic.
Dental Service	Patients had problems contacting the London clinics as details on how to do this were difficult to find.	Contact details have been updated on the service leaflet and also added to our public website.
Dental Service, Hainault Health Centre	Patients were not always receiving notification of cancelled or changes to their appointments.	Our system has been updated so that a text message is sent to patients when an appointment is cancelled or changes made.
Health Visiting Service	Some mums with babies asked for more advice on food intolerance and reflux.	Health visitors have been given training from a dietitian to be able to provide support.
Health Visiting Service	Mums requested more information on signposting to specialist services for breastfeeding advice.	Information has been added to the Red Book on where they can access more specialist advice.
Postural Stability service	When attending a group exercise class, patients with a hearing impairment said they found it difficult to hear the presenter.	The service tested various types of equipment with patients and found the Roger Pen to be the most effective. This equipment is now available for patients attending group sessions.

8.2 Improvements made by the Postural Stability service

In September 2017 the Postural Stability Service undertook to investigate the possibly of purchasing equipment to assist clients with a hearing impairment when attending group exercise classes. This was as a result of feedback from patients who advised that they had difficulty hearing the presenter. The service, with the support of an Engagement Team manager, tested the Roger Pen with assistance from Action on Hearing Loss, with patients during their exercise session. This was well received. The Roger Pen is an alternative to a portable hearing loop. It is a small portable device with a microphone that clips onto the instructor and a receiver is worn by the recipient. The hearing aid of the person is set to the hearing loop setting and those without a hearing loop can wear headphones.

Following a successful bid for funds, equipment has been purchased for use by services with an identified need. The Postural Stability Service now has 2 sets of equipment which have been used with patients in Folkestone and Thanet. The service will continue to trial the equipment and plans to request a third set for the Sheppey team. The following positive feedback has been received from patients:

- One patient said they found the equipment superb, it was excellently clear and helped block the sound of other participants so that they could hear the instructor perfectly.
- One patient said the implant helped improve the clarity a small amount so that she could hear the instructor a little better.
- One patient using the headset reported that it was perfect in helping him hear. With his hearing aids alone, he could hear the instructor if there was none, or very little ambient sound. As soon as other volumes went up, he found that he struggled to hear the instructor. However, when he put on the loop and headset, the majority of other sounds were muted and he was able to hear the instructor with absolute clarity. He finished by enquiring where he could buy one from and actually looked quite moved by it!

An article on the use of this equipment is to be published in the Winter edition of Community Health magazine.

9.0 Selection of patient and carer/family positive comments received via Meridian

Podiatry - Ashford	I found the time it took from initial referral to appointment and treatment very quick. All staff were lovely and professional in their duties and understanding of my nerves.
Wound Medicine Centre Sevenoaks Hospital - Sevenoaks	Friendly, efficient and extremely capable staff who have made such a positive difference to my Dads well being.
Health Visiting - Shepway	The Health Visitor was reassuring and gave me a lot of information regarding myself and my baby.
Home Enteral Nutrition Service - Whitstable	As a long term patient of the HEN Team, I find it very comforting to have continuity and back up when needed. The help and advice I have received thus far has enabled me to enjoy a more normal life. They always follow up on any queries.
CHATS (Child and Adult Therapy Service) - Essex	I have been listened to and questioned to help me express my issues. I have even been set tasks and advised to help cope with my stresses. (Aged 12-18)
Community Chronic Pain	The teacher has help me so much and made an enormous improvement to my pain levels and therefore my life. I will use these techniques for the rest of my life.
Kent Childrens Speech and Language Therapy - Parent Carer Survey	Today's session has been extremely helpful. Staff amazing. I feel my concerns about my 16 month old were listened to. Physio amazing with children. Offered all the support we could need
Dental (Adults and Children) - Shrewsbury Centre	The staff are very supportive and friendly. The care and treatment given was excellent. My daughter was scared at the beginning of the treatment, then she looking forward for the appointments with excitement
Health Visiting - Gravesham	I always feel respected and listened to. My views and family lifestyle are considered whenever advice is offered.
Lymphoedema Service - Herne Bay	Unbelievably effective treatment, transformative, really making a difference to my quality of life. Staff courteous, great sense of humour, knowledgeable.

10.0 Compliments recorded on Meridian

During Q2, **527** compliments were recorded on Meridian (194 in July, 210 in August and 123 in September). This equates to 296 for adult services, 180 for Public Health and Children's Specialist and Learning Disability Services, 49 for health improvement services and 1 for the PALS team. Compliments continue to be made by patients and relatives thanking staff for the excellent care and service provided. Staff are often complimented on their kindness and friendliness and praised for listening and being supportive. Another Meridian survey is being built to capture compliments that services receive from other healthcare professionals and service providers (i.e. KCC). This will be promoted to staff as soon as it is ready.

Examples of compliments received for inpatient ward staff and community nursing teams are detailed in **Appendix 3**.

11. Recommendations

11.1 The Trust Board is asked to note the report and recommend any further actions and assurances that are required and identify any issue for escalation to the Trust.

Sue Mitchell
AD Patient Safety & Experience
21 November 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	29 November 2018
Agenda Number:	3.4
Agenda Item Title:	Freedom To Speak Up Report
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision	☒	Information	☐	Assurance	☐

Report Summary

The report provides a summary of concerns raised by staff under the Freedom to Speak Up policy from 1 April 2018 to 1 November 2018. These are the concerns logged by the Freedom to Speak Up Guardian.

Proposals and /or Recommendations

To note the report and agree the following recommendations:

- To analyse KCHFT performance against the 13 recommendations from the Nottinghamshire report.
- To develop the FTSU ambassador role within KCHFT. Quarterly FTSU ambassador meetings to take place, setting expectations of the role and following a planned targeted way of ensuring that all teams are aware of the FTSU roles and how to access support.
- To relaunch the role.
- To develop case studies and continue to report on themes and trends from cases.

Relevant Legislation and Source Documents

Freedom To Speak Up Policy
A review of the handling of speaking up cases – The National Guardian's Office

Has an Equality Analysis (EA) been completed?

No ☒

High level position described.

Sarajane Poole, Head of Quality, Governance and Professional Standards/ Freedom To Speak Up Guardian	Tel: 07500 605 263
	Email: sarajane.poole@nhs.net

Kent Community Health NHS Foundation Trust

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. Introduction

1.1 There are now more than 570 Freedom to Speak Up Guardians and Ambassadors across NHS organisations in England. Some of these are full-time posts, some part-time and some are added to people's day job. In the period up to March 2018, they had dealt with over 3,000 concerns, 1,240 of which related to patient safety issues and over 60 per cent related to unacceptable behaviour, including alleged bullying and harassment[1].

1.2 Sir Robert Francis QC has urged NHS Boards and managers to welcome staff raising concerns (whistleblowing), in the same way as staff are encouraged to report incidents. Kent Community Health NHS Foundation Trust's (KCHFT) policy is in line with the national Freedom to Speak Up (Whisteblowing) policy. This says that staff should initially try to raise concerns with their manager or a more senior manager, but if this does not lead to satisfactory action (for example an investigation) or if the staff member feels more comfortable for whatever reason, they can contact the Freedom to Speak Up Guardian for advice and support. It is all in support of creating a more open culture that puts patient and staff safety at the heart of what we do.

1.3 No-one should experience discrimination or be victimised for speaking up, but we know fear of this can prevent staff from doing so. Those who raise concerns via the Freedom to Speak Up process can expect to receive support and advice from the Trust's Freedom to Speak Up Guardian, as will managers with whom the concerns are raised. The role of the Freedom to Speak Up Guardian is to be impartial and ensure that a fair and timely investigation into concerns takes place and that outcomes, actions and learning are shared.

1.4 This report covers the period 1 April 2018 to 1 November 2018.

2. Summary of cases

2.1 Appendix 1 contains a summary of the 25 cases dealt with from 1 April to 1 November 2018, this compares to 17 in the previous six months. Three were informal and 22 required the FTSU Guardian to either escalate or support staff to escalate. The main themes of concerns raised to date are, as with the previous six months:

- Attitude and behaviour of managers – alleged bullying culture

[1] Source: National Office of the Freedom to Speak Up Guardian

- Apparent failure of middle managers to resolve concerns that are raised locally.
- Patient safety

2.2 Within the data submitted 4 cases were raised by staff members going through either the Capability or Disciplinary process. All contacted the FTSU Guardian due their perceptions of lack of support from their managers or not understanding why they were going through these processes. Of the 4 cases 1 case believed that they were going through this process due to speaking up.

2.3 All cases that have been escalated to managers by the Guardian have been listened to and taken forward by the manager who then updates the FTSU Guardian with progress.

2.4 Following the original Guardian stepping down from the role, the post had been covered in the interim by Sarajane Poole Head of Quality, Governance and Professional Standards for Public Health, Children's Specialist and Learning Disabilities Services. In supporting the role, it was identified that a system of support should be put in place, including the enhancement of the Ambassadors role (discussed below), backfill of the post and personal resilience support available to the Guardian.

3. Fostering a culture of openness

3.1 The Freedom to Speak Up Guardian has a key role in fostering a culture of openness. The Trust currently has 16 ambassadors supporting the FTSU Guardian. The role of the ambassadors to date has been in support of promoting a Speaking Up culture in the organisation. The Ambassadors report that many of them do not yet feel ready to offer support to individuals on a one to one basis and this will be the subject of training for those who would like to develop in this way. The role of the Ambassator is currently described as:

- Encourage colleagues with concerns to speak up, by providing informal advice
- Sign-post to the FTSU Guardian for more formal advice/intervention
- Help to promote positive examples of changes that have occurred as a result of speaking up
- Be willing to speak up in a positive way and thereby be a role model for colleagues.

The Guardian is working with the Ambassadors to support them in this role through developing training and support for them.

3.2 Staff who have sought advice from the FTSU Guardian generally express relief that they have been listened to. By being thanked for speaking up and by being assured that they will be supported, these staff say they feel safer to speak up. A feedback survey has now been launched to ask all

people who raise concerns whether, given their experience they will speak up in future. Debriefs have also been offered to staff members when FTSU cases close. This has occurred on 2 occassions to ensure that in depth learning can be identified and lessons carried forward. The 2 staff members involved have reported that this has been very beneficial as it has followed up on the support that they received whilst speaking up. The debriefs can also be used as case studies for the organisation.

3.3 Staff members contact the Freedom To Speak Up Guardian directly either by phone or email. There is a facility accessed via FLO on the FTSU page.

3.5 The National office released a review of the handling of speaking up cases within Nottinghamshire Healthcare NHS Trust during November 2018. 13 recommendations have been made from this report. KCHFT is in the process of mapping itself against these recommendations to ensure that we are handling cases under the standards and protections of FTSU even when they have not been reported to the Guardian.

3.6 The We Care reviews have highlighted that some staff members are not aware of the FTSU Guardian or Ambassadors roles or how to access the service. This is being addressed by an initial targeted campaign to visit these teams.

3.7 The guidance that the CQC follow as part of the Well Led inspection from the National Office has been reviewed by the current FTSU Guardian to ensure that we continue to perform strongly against them.

1. **Appointment:** It is recommended that FTSU Guardians apply for the role as opposed to being appointed.
2. **Potential conflicts of interest**: All guardians and ambassadors are requested to reflect on potential conflicts that holding an additional role could bring. None of our 16 ambassadors hold roles in human resources. The number of ambassadors means that should a conflict of interest arise, another ambassador could support.
3. **Local networks**: Our network of ambassadors are from a range of staffing groups, clinical and non-clinical and a range of grades from Bands 2 to 8 to provide assurance that all staff have appropriate support and opportunity to speak up.
4. **Diversity**: Our Speaking Up Ambassadors are diverse in age, but not in ethnicity. Staff were asked to volunteer for the training, there was no formal applications as the trust wanted busy clinical staff to be able to volunteer without adding to their workload.
5. **Communication and training**: While we have a campaign and a range of campaign materials to support Freedom to Speak Up, the recent We Care Reviews suggest more could be done to raise the profile of the role. By using the Ambassador role to its fullest this can be changed. The teams that have been identified within the We Care reviews have received targeted awareness of the role. All induction

training is evaluated, in line with this recommendation, and FTSU is included in corporate induction.

6. **Partnership**: Our FTSU Guardian and some Ambassadors have been visiting team meetings on request to raise the profile of the role and develop good working relationships with all parts of the organisation, meeting regularly with Staffside. Further meetings are planned with other stakeholders as an on-going programme of raising the profile.
7. **Access to senior leadership**: Our FTSU guardian has a bi-monthly meeting with the chief executive to discuss themes of recent cases.
8. **Board reporting:** All FTSU cases are reported to the Board.
9. **Feedback:** A feedback survey is sent to everyone who raises a case with the FTSU guardian.
10. **Time**: The FTSU is given time to attend training and support staff members.

3. **Forward Plan**

- A report will be brought to the Workforce Committee in 1 month, analysing KCHFT performance against the 13 recommendations from the Nottinghamshire report and making recommendations.
- The FTSU ambassador role will be further developed within KCHFT. Quarterly FTSU ambassador meetings to take place, setting expectations of the role and following a planned targeted way of ensuring that all teams are aware of the FTSU roles and how to access support.
- On-going and targeted highlight of the FTSU Guardian and Ambassador role.
- Strengthen the support for the Guardian and Ambassadors including access to peer support, counselling and professional development.
- To develop case studies and continue to report on themes and trends from cases.

4. Recommendation

The Board is asked to note the report.

Sarajane Poole
Freedom to Speak Up Guardian
November 2018

Kent Community Health
NHS Foundation Trust

**Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 29 November 2018 in the
Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House,
110 – 120 Upper Pemberton, Eureka Park, Kennington, Ashford, Kent TN25 4AZ**

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Chair	Chair	
1.2	To receive any Apologies for Absence	Chair	
1.3	To receive any Declarations of Interest	Chair	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 27 September 2018	Chair	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 27 September 2018	Chair	
1.6	To receive the Chair's Report	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	

	Board Committee Reports	
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 Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee
2.5	To receive the Integrated Performance Report	Director of Finance Chief Operating Officer/ Deputy Chief Executive
2.6	To approve the Winter Plan	Chief Operating Officer/Deputy Chief Executive
2.7	To approve the Standing Financial Instructions	Director of Finance
2.8	To approve Board Membership and Non-Executive Director Responsibilities	Chairperson
3.	**REPORTS TO THE BOARD**	
3.1	To receive the Seasonal Infection Prevention and Control Report	Chief Nurse
3.2	To receive the Learning From Deaths Report	Medical Director
3.3	To receive the Patient Experience and Complaints Report	Chief Nurse
3.4	To receive the Freedom To Speak Up Report	Corporate Services Director
4.	**ANY OTHER BUSINESS**	
	To consider any other items of business previously notified to the Chair	Chair

Kent Community Health
NHS Foundation Trust

5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

6. DATE AND VENUE OF NEXT MEETING

Thursday 31 January 2019
Oakwood House, Oakwood Park, Maidstone, Kent ME16 8AE