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 28 March 2019

in

Rooms 6 and 7
Kent Community Health NHS Foundation Trust offices
Trinity House
110 – 120 Upper Pemberton, Ashford
Kent
TN25 4AZ

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board to be held at 10am on Thursday 28 March 2019 in the Rooms 6 and 7,Kent Community Health NHS Foundation Trust offices, Trinity House,110-120 Upper Pemberton, Ashford Kent TN25 4AZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Chair	Trust Chair	
1.2	To receive any Apologies for Absence	Trust Chair	
1.3	To receive any Declarations of Interest	Trust Chair	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 31 January 2019	Trust Chair	Page 4 of 187
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 31 January 2019	Trust Chair	Page 14 of 187
1.6	To receive the Trust Chair's Report	Trust Chair	Page 17 of 187
1.7	To receive the Chief Executive's Report	Chief Executive	Page 20 of 187
2.	**BOARD ASSURANCE/APPROVAL**		
2.1	To receive the Patient Story – Quality Improvement Project To Reduce Podiatric Surgery On The Day Cancellations	Chief Nurse (Interim)	

2.2	To receive the Board Assurance Framework	Corporate Services Director	Page 25 of 187
	Board Committee Reports		
2.3	To receive the Quality Committee Chair's Assurance Report	Chair of Quality Committee	Page 31 of 187
2.4	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	Page 41 of 187
2.5	To receive the Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee	Page 47 of 187
2.6	To receive the Charitable Funds Committee Chair's Assurance Report	Chair of Charitable Funds Committee	Page 51 of 187
2.7	To receive the Integrated Performance Report		Page 54 of 187
	• Assurance on Strategic Goals	Director of Finance	
	• Quality	Chief Nurse (Interim)	
	• Workforce	Director of Workforce, Organisational Development and Communications	
	• Finance	Director of Finance	
	• Operational	Chief Operating Officer/ Deputy Chief Executive	
2.8	To approve a Constitutional Amendment	Director of Finance	Page 99 of 187

3. STRATEGY AND PLANNING

3.1	To approve the 2019/20 Operating Plan	Chief Executive	
	• Strategic Priorities	Director of Strategy	Page 102 of 187
	• Quality Priorities	Chief Nurse (Interim)	Page 105 of 187
	• Financial Plan incorporating	Director of Finance	Page 109 of 187
	○ Revenue and Capital Budgets		
	○ Capital Plan		

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4.	**REPORTS TO THE BOARD**		
4.1	To receive the 2018 NHS Staff Survey Report	Director of Workforce, Organisational Development and Communications	Page 117 of 187
4.2	To receive the Seasonal Infection Prevention and Control Report • Annual Infection Prevention and Control Report and Declaration	Chief Nurse (Interim)	Page 128 of 187
4.3	To receive the Patient Experience and Complaints Report	Chief Nurse (Interim)	Page 142 of 187
4.4	To receive the Risk Management Strategy	Corporate Services Director	Page 153 of 187
4.5	To receive the Use of the Trust Seal Report	Corporate Services Director	Page 176 of 187
4.6	To receive the Minutes of the Charitable Funds Committee meeting of 29 November 2019	Chair of Charitable Funds Committee	Page 179 of 187
5.	**ANY OTHER BUSINESS**		
	To consider any other items of business previously notified to the Trust Chair	Trust Chair	
6.	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA**		
7.	**DATE AND VENUE OF NEXT MEETING**		

Thursday 23 May 2019
Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent TN25 4AZ

Kent Community Health NHS Foundation Trust

Unconfirmed Minutes
of the Kent Community Health NHS Foundation Trust Board meeting
held at 10am on Thursday 31 January 2019
in Oak Room, Oakwood House, Oakwood Park, Maidstone
ME16 8AE

Meeting held in Public

Present:	John Goulston, Trust Chair (Chair) Pippa Barber, Non-Executive Director Peter Conway, Non-Executive Director Martin Cook, Non-Executive Director Designate Professor Francis Drobniewski, Non-Executive Director Designate Richard Field, Non-Executive Director Gordon Flack, Director of Finance Steve Howe, Non-Executive Director Louise Norris, Director of Workforce, Organisational Development and Communications Dr Sarah Phillips, Medical Director Dr Mercia Spare, Interim Chief Nurse Bridget Skelton, Non-Executive Director Gerard Sammon, Director of Strategy Lesley Strong, Deputy Chief Executive/Chief Operating Officer
In Attendance:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Corporate Services Director
Observer:	Louise Thatcher, Care Quality Commission

31/01/1 **Introduction by Chair**

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

Mr Goulston 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.

31/01/2 **Apologies for Absence**

Apologies were received from Jen Tippin, Non-Executive Director and Nigel Turner, Non-Executive Director and Mr Bentley, Chief Executive. The meeting was quorate.

31/01/3 **Declarations of Interest**

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

31/01/4 **Minutes of the Meeting of 29 November 2018**

It was confirmed that Emma Bond from the Care Quality Commission (CQC) had attended to observe the Formal Board meeting on 29 November 2018. The minutes would be amended accordingly.

The Board **AGREED** the minutes, subject to the amendment.

31/01/5 **Matters Arising from the Meeting of 29 November 2018**

It was agreed that the action relating to the Patient Story would remain open.

The other actions were confirmed and closed.

The Board **RECEIVED** the Matters Arising.

31/01/6 **Chair's Report**

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

Dr Mercia Spare was welcomed as Chief Nurse (Interim). A summary of Mr Goulston's visits to Trust services over the last two months was provided. He, along with other members of the Executive Team, had met with Mr Paul Carter, Leader of Kent County Council before Christmas. The NHS Providers Chairs and Chief Executives Network had also held an event which he and Mr Bentley had attended. The Trust's committees continued to meet regularly. He had had the opportunity to attend their meetings and was impressed by the level of assurance they provided.

Mr Goulston confirmed that he had been invited to join the panel to appoint an Independent Chair of the Kent and Medway Sustainability and Transformation Partnership (STP).

A number of new Governors had been elected recently and Mr Goulston would be welcoming them at the next Council of Governors meeting on 7 February 2019.

In conclusion, it was confirmed that Mr Field and Mr Howe would be standing down from the Trust Board. From 1 February 2019 they would become associate non-executive directors for the following three months. This would allow the transition of the new non-executive directors into their roles as members and chairs of various committees to be completed. Mr Goulston, on behalf of the Board, thanked Mr Field and Mr Howe for their hard work and efforts over the last few years in supporting the Trust.

It was agreed that a list of all the visits that had been undertaken by the Chair and non-executive directors in the two months preceding the Formal Board meeting would be included in the Board papers in future.
Action – Ms Davies

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

31/01/7 **Patient Story**

Dr Spare presented the video to the Board. This related to a complaint that had been received regarding the Trust's management of a patient who had been under the care of Faversham Cottage Hospital.

In response to a question from Mr Howe as to whether the pressure on community hospitals from the acute hospitals to move patients through the system quickly was impacting on the community hospitals step up service, Ms Strong indicated that there was pressure in the system but that this was being managed.

In response to a question from Ms Barber as to whether there could have been a better outcome for Kenneth, if the clinicians had been clearer as to their expectations, Dr Spare indicated that, while a different outcome was unlikely in this case, the Trust was working hard to embed personalised care plans for all patients.

In response to a question from Mr Flack regarding how the learning from this story might be shared with the rest of the organisation, it was confirmed that it would be placed on the staff intranet, Flo in the first instance. It was agreed that it should be shown in a number of other fora such as the Nursing Academy, Corporate Induction, the Seniors Leaders Conference, and the Operations Quality Improvement Network meeting.

The Board **RECEIVED** the Patient Story.

31/01/08 **Board Assurance Framework (BAF)**

Natalie Davies presented the report to the Board for assurance.

Ms Skelton confirmed that the Strategic Workforce Committee had discussed the workforce Risk 102, which updated Risks 73 and 37. The Committee had agreed that the articulation of the new risk was sound, although a minor wording change was suggested. With regards to its current score, this would be reviewed when the Committee met again in March 2019 following receipt of further data. The implementation of the actions and their outcomes would be monitored closely.

In response to a question from Mr Cook regarding how a significant local risks were escalated onto the BAF, Ms Davies explained the process and gave a recent example when this had happened.

In response to a question from Ms Barber regarding whether the Board

could expect to receive further assurance around the changes in the system architecture (Risk 103) when the STP Programme Board met the following month, Mr Goulston indicated that the risk was likely to be refined. It was a dynamic risk that would continue to be monitored by the Executive Team.

In response to a question from Prof Drobniewski regarding the risk rating of Risk 101 (Brexit preparedness), Ms Davies indicated that it was difficult to be certain of the correct score in such a dynamic environment. In such a situation, she advised the Board that it should satisfy itself that the proposed actions were the correct ones. The risk would be monitored closely and reviewed again at the Audit and Risk Committee when it met in February 2019.

The Board **RECEIVED** the Board Assurance Framework.

31/01/9 **Quality Committee Chair's Assurance Report**

Mr Howe presented the report to the Board for assurance.

In addition, Mr Howe confirmed that there would be an Extraordinary Quality Committee meeting on 18 February 2019 to review the methodology of the Quality Impact Assessments of the 2019/20 Cost Improvement Programme (CIP) schemes and the conclusions that had been reached.

With regards to "Referral To Treatment" waiting times, Dr Spare confirmed that she had met with Ms Strong to look at the processes that were in place for patients who were on the waiting lists. They had agreed that a Standard Operating Procedure be developed to address this.

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

31/01/10 **Strategic Workforce Committee Chair's Assurance Report**

Ms Skelton presented the report to the Board for assurance.

The Strategic Workforce Committee had met the previous day.

There had been a wide ranging discussion which had included sickness absence performance and, in particular, how the Trust was supporting managers to support those staff who have been diagnosed with stress; improving the quality of appraisals; the Nursing Academy; the General Data Protection Regulations (GDPR); a discussion of the recommendations made by the Royal College of Paediatrics and Child Health in its report to the Trust; the initial findings of the Staff Survey; workforce risks; and the implementation of devolved authority. With regards to the Nursing Academy it had been agreed that this would be a standing item at future Committee meetings. With regards to staff files compliance with GDPR, the Trust's internal auditors had found that the Trust had a good system in place but was not yet demonstrating consistent and embedded compliance. The

Committee had asked the HR Team to come back with a plan which would show how compliance would be achieved. This would be presented at the Committee's meeting in March 2019 and then at the Audit and Risk Committee meeting in May 2019. With regards to the Staff Survey, the raw data indicated that more staff felt that their work was being recognised and valued by the Trust than previously. This suggested that various initiatives were beginning to bear fruit. With regards to embedding devolved authority, the Committee supported the actions that had been proposed to embed it in services. It would be implemented incrementally in order to respond to learning.

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

31/01/11 **Audit and Risk Committee Chair's Assurance Report**

Mr Conway presented the report to the Board for assurance.

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

31/01/12 **Charitable Funds Committee Chair's Assurance Report**

Mr Field presented the report to the Board for assurance.

The Committee had met the previous day.

There had been a wide ranging discussion which included finalising the Charitable Funds Annual Report and Accounts for 2017/18. The Committee had requested that internal legal advice was sought regarding the use of the name by the Trust's Charitable Funds. The Executive Team would review its conclusions. A presentation had been given regarding the Bow Road Fund which was responsible for funds available to support community health care for the residents of Wateringbury and Nettlested. A number of schemes had been put forward and the Committee had agreed to support the purchase of equipment. With regards to the pilot schemes that had been proposed, the Committee had agreed that the funding source should be considered more widely including assessment of the potential and feasibility of recurrent funding.

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

31/01/13 **Integrated Performance Report (IPR)**

Assurance on Strategic Goals

Mr Flack presented the report to the Board for assurance.

In response to a question from Mr Conway regarding the efficacy of the spider diagrams in part one of the report, Mr Flack suggested that they could be omitted in future reports. Mr Sammon indicated that the report

suggested that the Trust was well-aligned to the strategic direction of the NHS, performing well in some key areas.

Quality

Dr Spare presented the report to the Board for assurance.

Workforce Report

Ms Norris presented the report to the Board for assurance.

The report had been scrutinised by the Strategic Workforce Committee the previous day. With regards to turnover, the trend had been downward over the last few months. With regards to the Stability Key Performance Indicator (KPI), the Strategic Workforce Committee had agreed the previous day to debate a target for this at its March 2019 meeting. With regards to the sickness absence KPI, the Trust continued to be over the target and the Strategic Workforce Committee had discussed what actions were required to trigger a change. With regards to staff turnover, performance was improving and was now very close to the target. With regards to the use of temporary staff, the numbers were increasing in order for the Trust to manage demand over the winter months.

Finance Report

Mr Flack presented the report to the Board for assurance.

The Finance, Business and Investment (FBI) Committee had received the full Finance Report the previous day.

The dispute between the Trust and NHS Property Services over a number of historic invoices had now been resolved. With regards to the year end outturn forecast, the headline figure continued to improve. However, the net surplus was comparatively small, inflated only by the receipt of incentive and reward bonuses at year end. As a consequence, the Trust had approached its partners within the STP to invite discussions on how the Trust could support system-wide projects financially such as the Kent Care Record.

Operational Report

Ms Strong presented the report to the Board for assurance.

In response to a question from Mr Cook regarding the slippage in performance in October 2018 of the End of Life Care KPI, Ms Strong explained that the reasons were unclear at this early stage. It had been suggested that there was an issue with reporting on the Community Information System but she would be investigating this further.
Action – Ms Strong

In response to a request from Ms Barber that a report on End of Life KPI

performance should be received by the Quality Committee, Dr Spare confirmed that she planned to update the Committee in March 2019. Dr Phillips added that this had been discussed at the Clinical Effectiveness Group meetings she chaired. The group had agreed that performance could improve by applying a Quality Improvement methodology; however, it was unlikely that this work would be concluded by March 2019.
Action – Dr Spare

In response to a question from Ms Barber regarding the under-performance of the "Percentage of Rapid Response Consultations Started Within Two Hours Of Referral Acceptance" KPI, Ms Strong reflected that the target had become out of date and was less relevant; and that clarification was required as to whether the activity coding was correct. She suggested that the metric required a review to ensure that it was fit for purpose.
Action – Ms Strong

In response to a request from Ms Barber that a chart for this KPI was included in the IPR, it was agreed that this would be included in the future.
Action – Ms Strong

In response to a question from Mr Field regarding how the Board could differentiate between acceptable variation in performance and a deteriorating trend, Gordon Flack confirmed that all the metrics would be reviewed at year end. A revised suite of all the KPIs would be presented to the Board for approval.

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

31/01/14 **Trust Preparedness for Brexit Report**

Ms Davies presented the report to the Board for assurance.

In response to a question from Ms Skelton regarding how the Trust was equipping its staff to manage patient anxiety around the consequences of a no deal Brexit, it was agreed that that would be included in the Trust's planning.
Action – Ms Davies

In response to a question from Mr Cook regarding the continued supply of food and fresh food to the Trust's community hospitals, Ms Davies confirmed that this had been planned for and would be included in any messaging.

In response to a question from Prof Drobniewski as to whether the potential limitation on travel around the county might lead to patients being seen by different clinicians to usual, Ms Davies responded that services would endeavour to continue running as normal for as long as possible. In the unlikely event of a major incident, a different set of rules would apply which were being planned for. The Board agreed that services were familiar with working to business continuity, but that the risk lay in the situation continuing for a long period of time.

Mr Goulston confirmed that the Board would continue to monitor its preparedness and that the Audit and Risk Committee would receive a report at its meeting in February 2019.

The Board **RECEIVED** the Trust Preparedness for Brexit Report.

31/01/15 **Winter Pressures Update Report**

Ms Strong presented the report to the Board for assurance.

In response to a question from Ms Barber regarding introducing some additional metrics to measure the performance of the Rapid Response Service, it was agreed that these could relate to the number of patients waiting in the acute hospital for community services and the number of patients waiting to transfer to other services. These would be included.
Action – Ms Strong

Mr Goulston commented that on his visits to the community hospitals, staff had highlighted that the main issues they faced when attempting to arrange the discharge of patients were around the lack of capacity for places for those with dementia. There was a need to create the right capacity for future years. Ms Strong agreed and added that this was being discussed with Maidstone and Tunbridge Wells NHS Trust. Ms Barber emphasised the need for this to be discussed at the STP level. Ms Norris highlighted that discussions were underway in West Kent to advance more integrated working.

The Board **RECEIVED** the Winter Pressures Update Report.

31/01/16 **Chief Executive's Report**

Ms Strong presented the report to the Board for information.

Mr Goulston confirmed that there had been an additional Board Part Two meeting on 18 January 2019. The agenda item had been to review the Executive Team's self-assessment of services against the CQC standards. This document was required to be submitted by Mr Bentley, Accountable Officer to the CQC as part of the inspection process.

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

31/01/17 **NHS Long Term Plan and Impact for Kent Community Health NHS Foundation Trust Report**

Gerard Sammon presented the report to the Board for information and assurance.

Mr Goulston highlighted the need to remain focused on what the plan meant for patients, their families and staff. Ms Norris commented that the Strategic Workforce Committee had considered the workforce implications of the plan. The Trust had already carried out some work such as the

launch of the Nursing Academy and the introduction of the Associate Clinical Practitioners.

In response to a question from Mr Cook as to how the non-executive directors could support the Trust both formally and informally, Mr Salmon suggested that they played an important role at the strategic level. Their views and the soundings they received from those within the organisation and patients could be brought to bear in Board level discussions.

In response to a question from Prof Drobniewski regarding the competitive barriers which existed historically within the internal NHS market, Mr Salmon recognised this reality but indicated that there had been a change in tone and approach. All stakeholders were being actively encouraged to collaborate.

Mr Goulston confirmed that the Trust's strategic priorities would be discussed at the Joint Board and Management Committee meeting in February 2019. A final draft would be received by the Board in March 2019 for approval, followed by a further update at its meeting in July 2019.

With regards to the Trust 2019/20 control total, Mr Field confirmed that this had been discussed by the Finance, Business and Investment Committee meeting the previous day. The risks to the Trust had been highlighted. These included the Public Health pay award which was yet to be agreed to be funded and pension contributions which, again, had still to be funded. Although the Trust had yet to fully achieve its CIP, the Committee was confident that it would be achieved to plan. In light of the assurance that had been given, the Committee recommended the control total to the Board which was accepted.

The Board **RECEIVED** the NHS Long Term Plan and Impact for Kent Community Health NHS Foundation Trust Report.

The Board **APPROVED** the 2019/20 control total.

31/01/16 **Learning from Deaths Reports**

Dr Philips presented the report to the Board for assurance.

The report had been received by the Quality Committee. It included, at the request of the Board, a summary of the most common themes which had been identified in areas for improvement. Ms Barber confirmed that, as the Mortality and Learning From Deaths Non-Executive Director Lead, she had observed the Learning Disabilities Mortality Review meeting. In order for the Trust to improve further, she suggested that it would be helpful to link with general community services as well as acute services.

The Board **RECEIVED** the Learning from Deaths Reports.

31/01/19 **Freedom To Speak Up Report**

Ms Davies presented the report to the Board for assurance.

In response to a question from Ms Skelton regarding refining the actions in the action plan against the recommendations by the National Guardian's Office, Ms Davies confirmed that Ms Skelton had fed back her comments about the report outside of that day's meeting and they had been welcomed.

The Board **RECEIVED** the Freedom To Speak Up Guardian's Report

31/01/20 **Community Hospitals Safer Staffing Review**

Dr Spare presented the report to the Board for approval.

In response to a question from Mr Howe as to whether this review would factor in the capacity to teach students on the ward in the future, following the introduction of the Nursing Academy and Associate Clinical Practitioners (ACPs) into the community hospitals, Ms Norris explained that when on the wards, the apprentices and ACP's would be working. With regards to rostering, wards already accommodated the impact of clinical placements within shifts. In response to a further question from Mr Howe as to whether a metric could be introduced to provide some kind of measurement, it was confirmed that this would be considered.
Action – Dr Spare

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

31/01/21 **Minutes of Charitable Funds Committee Meeting of 25 July 2018**

Mr Field presented the report to the Board for assurance.

The Board **RECEIVED** the Minutes of Charitable Funds Committee Meeting of 25 July 2018.

31/01/22 **Any Other Business**

There was no further business to discuss.

31/01/23 **Questions from members of the public relating to the agenda**

The meeting ended at 12.40pm.

31/01/24 **Date and Venue of the Next Meeting**

Thursday 28 February 2019, Rooms 6 and 7, Trinity House, Upper Pemberton, Kennington, Ashford, TN25 4AZ

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 31 JANUARY 2019 (PART ONE)

29/11/8	Patient Story	To investigate further the better of use of technology in the Home Enteral Nutrition (HEN) Service to reduce the chance of error as well as the commissioning decision relating to the patient pathway.	Dr Spare	An investigation is underway and further information is awaited.
31/01/6	Chair's Report	To include with the Board papers in the future, a list of the visits that had been undertaken by the Chair and non-executive directors.	Ms Davies	Action complete.
31/01/13	Integrated Performance Report (IPR) – Operational Report	To investigate why there had been a slippage in performance in October 2018 for the End of Life Care Key Performance Indicator (KPI).	Ms Strong	The data for this indicator has been reviewed and the correct exclusions applied to remove the cohort of patients who would not have a personalised care plan e.g. referred close to death.

31/01/13	Integrated Performance Report – Operational Report	To bring a report on End of Life KPI performance to the Quality Committee.	Dr Spare	This is being reviewed as part of a wider piece of work on plans of care which will be presented at the Clinical Effectiveness Group meeting in March 2019 and to the Quality Committee in April 2019.
31/01/13	Integrated Performance Report – Operational Report	• To review the Percentage of Rapid Response Consultations Started Within Two Hours of Referral Acceptance metric. • To include a chart for this metric in the IPR in the future.	Ms Strong	Additional narrative will be included in the next Integrated Performance Report with an SPC chart as a future development.
31/01/14	Trust Preparedness for Brexit Report	To include in the Trust's planning how the Trust would equip its staff to manage patient anxiety around the consequences of a no deal Brexit.	Ms Davies	Action complete. Agenda item.
31/01/15	Winter Pressures Update Report	To include additional metrics to measure the performance of the Rapid Response Service – the number of patients waiting in the acute for community services and the number of patients waiting to transfer to other services.	Ms Strong	A detailed dashboard is under development.

31/01/20	Community Hospitals Safer Staffing Review	To consider introducing a metric to reflect that Nursing Academy apprentices (NAs) and Associate Clinical Practitioners (ACP) would by studying as well as learning on the ward.	Dr Spare	There are identified periods of study in the training programme for both NAs and ACP. Delivery of this is monitored by the clinical student partners. Consideration of how this could be reflected as part of the impact on wider workforce will be undertaken as part of the next Safer Staffing Review in July 2019.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	1.6
Agenda Item Title:	Trust Chair's Report
Presenting Officer:	John Goulston, Trust Chair

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

Report Summary
The report sets out the service visits that were undertaken by the Trust Chair and non-executive directors between 1 February and 27 March 2019.

Proposals and /or Recommendations
To note the report.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

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Kent Community Health
NHS Foundation Trust

SERVICE VISITS AND EVENTS ATTENDED BY THE CHAIR AND NON-EXECUTIVE DIRECTORS

The report sets out the Kent Community Health NHS Foundation Trust (KCHFT) service visits and other events that were attended by the Trust Chair and non-executive directors between 1 February and 27 March 2019.

Name	Service visits	Stakeholder/ Partnership meetings / events	Other meetings / events
John Goulston	**5 February** – Whitstable and Tankerton Hospital **11 February** –Queen Victoria Memorial Hospital **18 February** – Adult Speech and Language Therapy and Clinical Nutrition and Dietetics (including visit to care home for swallowing assessment) Tonbridge and Edenbridge Community Hospitals **27 February -** Estuary View Medical Centre, Whitstable	**5 February** – Kent and Medway STP Clinical Lead **13 February -** Kent and Medway Integrated Care System Simulation Event **18 February -** Hosted Kent and Medway Providers Chairs and CEOs **22 February -** GP Clinical Lead for East Kent **12 March -** Leader of Kent County Council **13 March -** Interview panel member for Kent and Medway STP Chair	**7 February** – KCHFT Council of Governors **12 March** – KCHFT Council of Governors **18 March** – Lead and Deputy Lead KCHFT Governors
Pippa Barber		**9 March** - Dementia Friends Event, Westgate Hall, Canterbury. Public event in partnership with KCHFT and East Kent Hospitals University NHS Foundation Trust (EKHUFT)	**6 February** - Meeting with KCHFT Chief Nurse (Interim) **6 February** - Meeting with Niche. **18 February -** Extra Ordinary Quality Committee **19 February –** Quality Committee

Name	Service visits	Stakeholder/ Partnership meetings / events	Other meetings / events
Pippa Barber continued			**20 February -** Audit And Risk Committee **28 February -** Joint Management and Board Meeting **12 March** KCHFT Senior Leaders Conference **19 March** Quality Committee
Martin Cook			**5 February; 6 and 15 March** - Well-led for the future: development for NHS Board Members. Supplier demonstration day for new Community Information System (CIS). Moderation session for new CIS system.
Richard Field			**12 March** – KCHFT Senior Leaders Conference

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
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

To note the report.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

High level position described and no decision required.

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

CHIEF EXECUTIVE'S REPORT
March 2019

As previously I wanted to highlight to the Board the following significant developments since my last formal report during the Board meeting in January 2019.

Historically January, February and March is the time of year when the NHS comes under most demand for the services we provide, and this increased demand combined with the implementation of the NHS plan, published January 2019, the preparations for the new financial year starting in April 2019 and contingency planning in the event of the United Kingdom leaving the European Union without an agreement have been the focus of my attentions since the last time I reported to the Board.

Following my regular format people, patients and partnerships I share with the board the following

Staff

1. Leaders Conference

On 12th March 2019 we held our leaders' conference. Nearly 160 colleagues gathered together to talk through our proposed strategic and quality priorities for 2019/20. The conversations in the room were energising and very focused on the quality of care we provide for the people we serve, the feedback on our draft priorities and how the services will operate in the NHS following the publication of the NHS plan. The product of the conversations is reflected in the recommendations made to the Board later in the agenda.

In addition to the discussions which influenced the Board conversations the value of our leaders coming together at one time is the relationships which are enhanced and the sharing of experiences which the conference allows, this was very apparent during the meeting.

2. Service Visits

In late January I showed Charlie Elphicke, MP for the constituency including Deal Hospital, around Deal Hospital, as the local MP Mr Elphicke has always been a

strong advocate for the hospital and a keen supporter of local care, he praised the work of our team members and thanked them for their hard work.

The Chair and I visited Queen Victoria Memorial Hospital in Herne Bay to spend the morning with the leadership team from our nutrition and dietetics and adult and speech language therapy services.

John and I listened to the leadership team as it talked about working in highly innovative ways; about the patient-centred approach and the data they were collecting to support outcomes.

Since the last board report I have also been fortunate to attend our LGBTQ+ network meeting, the role which all of our staff networks in supporting our staff is invaluable, we need to be an employer in which every member of the team can be themselves and the networks help.

I have also spent time with the South-East Driveability service, who support clients to return to driving or to continue to drive post a period of illness, the service I saw was very compassionate with some excellent illustrations of the benefits of strong team input to how the service can operate, which I am sure has led to the growth of the service in the last 15 years.

3. Care Quality Commission Inspection

We do not know when the inspection of our core services will take place because the inspection is unannounced but we do know that the well-led element will centre around 8/9 May 2019. I am proud of the services which we provide, we don't get it right every time but we do seek to learn when we don't and I welcome being inspected as it will be a further opportunity for the Trust to showcase the great care we provide.

4. Staff Survey

We had a really pleasing set of results from the staff survey; we have taken some positive steps in the right direction, particularly improving our staff engagement.

It is encouraging that we improved in five themes, staff engagement, equality, diversity and inclusion, support from immediate managers, our safety culture and making sure there is a safe environment for staff to work in.

We have more to do, but the feedback shows a strong step in the right direction. A detailed presentation of the outcome is part of the board agenda which provides a more detailed chance for the Board to review the findings.
When seen with our other approaches to our team and when aligned with the strong national focus on workforce the scale of the challenge remains but there are very encouraging signs.

Partnerships

1. Bringing Buurtzorg to Kent

Around 70 people attended an engagement event at Repton Community Centre in Charing on 13 March to find out more about how our Buurtzorg-style team in Edenbridge is operating, and about our plans for a new team in Charing, east Kent.

There were presentations from Public World, and most importantly from our two nurses in The Edenbridge Team – Sue Griffin and Wendy Bennett, who so eloquently described the benefits of self-managing teams for patients and colleagues.

2. Let's discuss dementia – our members event

More than 100 people came together in Canterbury on 9th March to discuss dementia. The event held in partnership with East Kent Hospitals University NHS Foundation (EKHUFT) trust, included stalls and presentations from experts from both trusts, charities and voluntary organisations.

There was a busy dementia café, staffed by the students from The Oasis Academy, Isle of Sheppey, Chris Norris, a member of the Kent and Medway Partnership Trust dementia envoy gave an inspiring speech about his experience of living with dementia and everyone who attended left as a Dementia Friend. Members of the public fed back to say the event had helped to dispel their fears around dementia and given them an opportunity to learn more about the support available.

We also trialled some new devices for people with hearing loss and received positive feedback and helpful advice from the participants who used them.

3. Collaborative working with South East Coast Ambulance Foundation Trust

The key role in ensuring patient flow which our colleagues in the ambulance service is acknowledged, to recognise this the Trust, along with other providers in the South East, have signed a collaborative working agreement with the Ambulance service which codifies the way we will work for the people we serve.

Patients

1. Planning for exiting the European Union

Detailed planning has taken place for EU Exit in Kent and Medway. As part of that, NHS organisations, Kent County Council and Medway Council are working together to ensure that health and care services continue to run smoothly for local people.

In Kent, as across the rest of the country, we plan and rehearse for all eventualities that could disrupt services. This has been the approach adopted and should the plans need to be enacted we will manage against the plans.

2. Quality improvement programme

Uptake of QSIR Practitioner has been very encouraging. 66 individuals, including colleagues from the STP & CCGs have completed the full 5 days over 2 cohorts, with another full cohort of 50 due to start in May 2019. The challenge for these Practitioners is now to deliver a full QI project over the next 12 months.

We have partnered with East London Foundation Trust to deliver 4 initial QI one day packages, 56 people attended over the first two sessions and all rated the sessions as either 'good' or 'very good', and we are delighted that this included a patient representative. 2 more courses are planned for Dental services in London and our colleagues in the East Sussex area before delivery passes to our internal team. QI Fundamentals is open to interested patients and carers. Our patient engagement team is working on promoting this further in our established networks.

Now that the QI training programme is well underway the focus on ensuring tangible outcomes and improvements for patients, service users, carers and colleagues will take on an even more central position. A QI conference is planned for 15th July to showcase QI work in progress and offer all an opportunity to find out more about the QI programme.

As I indicated at the start of my report this is a very busy and demanding time for our teams, I would like to thank them for all that they do to make sure that the people we serve receive the best care possible.

Paul Bentley
Chief Executive
March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	2.2
Agenda Item Title:	Board Assurance Framework
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary

The function of the Board Assurance Framework (BAF) is to inform and elicit discussion about the significant risks which threaten the achievement of the Trust's strategic objectives.

To provide assurance that these risks are being effectively managed, the BAF details the controls in place to mitigate each risk, any gap in control, assurance of the controls' effectiveness, the actions planned and being executed together with the date by when the actions are due to be completed.

The full BAF as at 13 February 2019 is shown in Appendix 1.

Proposals and /or Recommendations

The Board is asked to note this report.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

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Kent Community Health
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

1. Introduction

1.1 The Board Assurance Framework (BAF) is comprised of strategic risks identified against the strategic goals defined within the Integrated Business Plan (IBP) in addition to risks identified against the achievement of business and operational objectives with a high gross (inherent) risk rating.

1.2 The BAF is therefore comprised of high risks. Refer to section 7 below for a definition of high risk.

1.3 Risks may be identified by Services or Directorates and escalated upwards to the Executive Team, or may be identified at the Board or any of its sub Committees.

1.4 The Executive Team review newly identified high risks to ensure that those with significant potential to impact on the achievement of strategic goals are recorded on the BAF and reported to the Board. This allows the Board to monitor mitigating actions. As actions are implemented, controls improve and this can enable the exposure to risk to reduce.

1.5 The full BAF as at 13 February 2019 is shown in Appendix 1. This version was last presented to the Exec Team on the 5 March 2019.

2. New risks

2.1 Since the BAF was last presented to the Board there have been no new risks added.

3. Risks that have been closed since the last report

3.1 Since the BAF was last presented to the Board no risks have been closed.

4. Risks that have been de-escalated since the last report

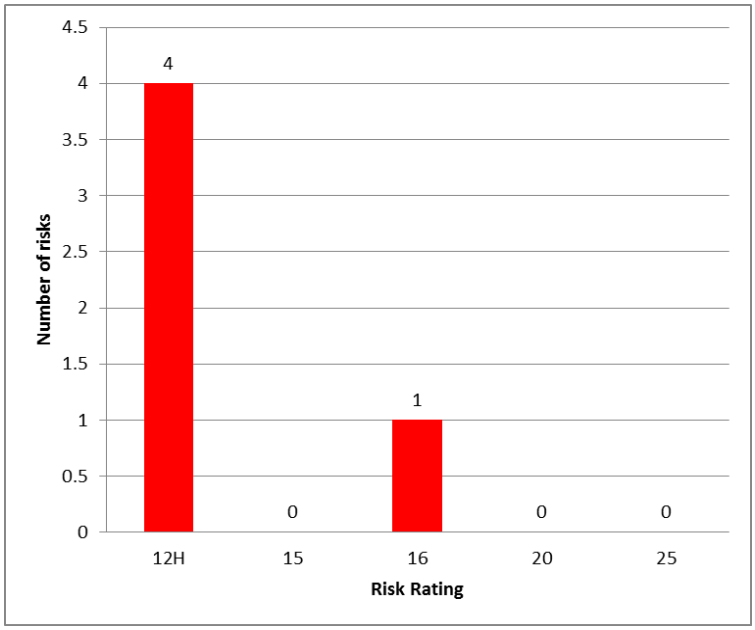
4.1 Since the BAF was last presented to the Board no risks have been de-escalated.

5. Risks previously de-escalated to Directorate risk registers that have closed

5.1 There are no risks that have been de-escalated to Directorate risk registers that have now closed.

5.2 The total number of risks documented on the BAF is five. Figure 1 (below) provides a visual representation of the organisational risk profile based on the current risk rating within section 1 of the BAF.

5.3 Figure 1: Organisational High Risk Profile



6. High risk definition

6.1 A high risk is defined as any risk with an overall risk rating of 15 or above, as well as those risks rated as 12 with a consequence score of 4. The risk matrix below provides a visual representation of this.

6.2 Figure 2: Trust risk matrix

		← *Consequence / Severity* →				
		Insignificant	Minor	Moderate	Major	Catastrophic
↓Likelihood ↓		**1**	**2**	**3**	**4**	**5**
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

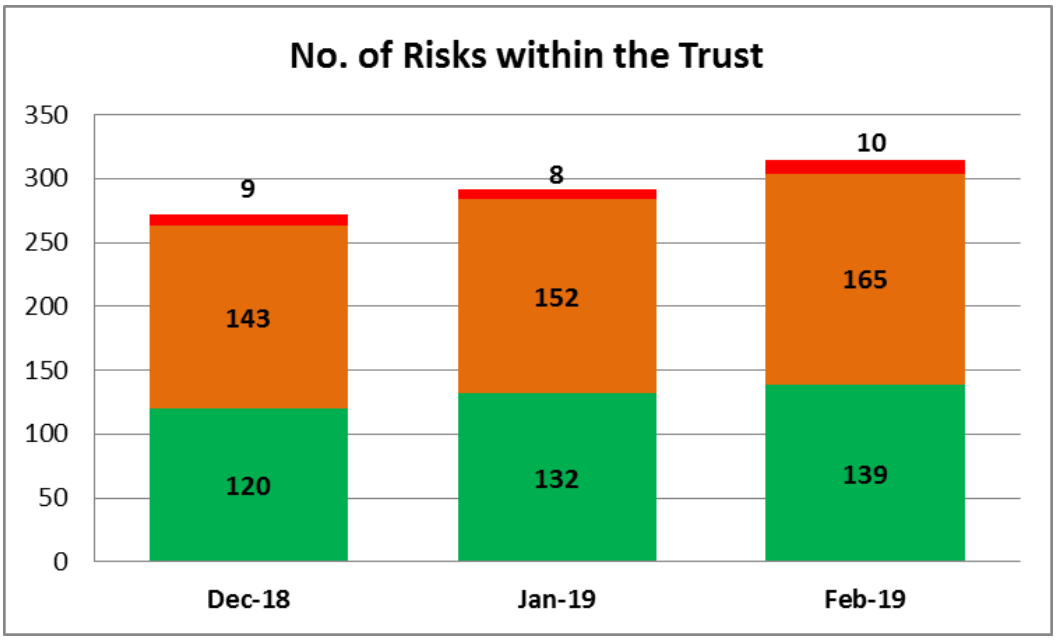
The scores obtained from the risk matrix are assigned grades as follows:

1 – 6	Low risk
8 – 12	Medium Risk
12 – 25	High Risk

7. Risk Overview

7.1 The total number of open risks within the Trust stands at 314 this is comprised of 139 low risks, 165 medium risks and 10 high risks. Figure 3 (below) provides a visual representation. Low risks are initially reviewed by Heads of Service with further reviews by the responsible officer at least bi monthly. Medium risks would initially be reviewed by Heads of Service and then onward to the Community Service Director/Assistant Director for approval, these would normally be reviewed on a monthly basis. All risks are extracted by the Risk Team on a weekly basis and the officer responsible for those risks that have passed their review date or target completion date are contacted by the team to prompt a review.

7.2 Figure 3: Organisational Risk Overview.



8. Recommendation

8.1 The Board is asked to consider the Board Assurance Framework in Appendix 1 and determine whether sufficient mitigating actions are in place to address these.

Barry Norton
Head of Risk
18 March 2019

Appendix 1
Board Assurance Framework Section 1
Risks with a high net risk rating which have not been tolerated.

Kent Community Health NHS Foundation Trust

Definitions:
Initial Rating = The risk rating at the time of identification

Current Rating = Risk remaining with current controls in place. This is reviewed monthly and should decrease as actions take effect.

Target Date = Month end by which all actions should be completed

Action status key:

Actions completed	G
On track but not yet delivered	A
Original target date is unachievable	R

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating C	Initial rating L	Initial rating Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	Current rating C	Current rating L	Current rating Rating	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target Date (end)
Integrate Services																			
99	Jan 2019	Gordon Flack	Implementing a clinical system including double running with the existing system and at the same time as the Kent Care Record is being implemented may negatively impact on production of timely information and service delivery.	4	3	12H	Governance structure & project plan in place Engagement with the project team delivering the Kent Care Record Project Leadership team job descriptions Phase implementation plan and resourcing appropriately Communication plans developed with stakeholders inc. commissioners.	Regular Board reports linked to other projects Project Group report to Exec Team and Board	Timescales to implement new system Comprehensive programme plan for replacement system to be developed in response to emerging timescales	4	3	12H	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Gordon Flack	Medium	**Nov 2019**
													Programme Manager being appointed to CIS change project	Gordon Flack	Sep 2018	G			
													Set up governance structure	Gordon Flack	Nov 2018	G			
													Structured programme of clinical engagement included in the programme.	Sarah Phillips	Nov 2019	G			
													Definition of programme structure and programme team	Gordon Flack	Sep 2018	G			
													Project leadership appointed.	Gordon Flack	Dec 2018	G			
103	Jan 2019	Paul Bentley	Changes in the system architecture may provide uncertainty in the future delivery of integrated services	4	3	12H	Sustainability and Transformation Plan (STP) Programme Board TORs and membership TORs for: Local Care Boards; Frailty Group; Chief Executives Forum STP Governance Structures Director of Strategy job description West Kent Improvement Board terms of reference East Kent Transformation Board terms of reference NHS I/E system meeting terms of reference	Local Care Investment received for both east and west Kent - Hospital at Home and Rapid Transfer of Care scheme. Community Care Funding increase in financial settlement Chief Exec report to the board Regular Strategic development update to the board Non executive membership of the STP board.		4	3	12H	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	High	**Mar 2019**
													Local Care Group implementation	Paul Bentley	Jul 2018	G			
													KCHFT involvement in CCG workforce group	Louise Norris		G			
													Review mitigation plans	Gordon Flack	Oct 2018	G			
													Recovery plan for east Kent	Gordon Flack	Oct 2018	G			
													Proactively seek opportunities to stabilise the system and support investment in local care	Gordon Flack	Mar 2019	G			
													Hospital at Home launch	Lesley Strong	Nov 2018	G			
													Agree 5 year contract wit CCGs	Gordon Flack	Mar 2019	A			
Prevent Illness																			
100	Nov 2018	Lesley Strong	Risk that the organisation's services may suffer significant challenges as result of the impact of winter pressures.	4	4	16	Emergency Planning exercises Flu vaccination Programme An established National Emergency Pressures Panel has been established to identify levels of system risk and recommend responses Reporting performance for Minor Injury Units Whole system winter plans have been agreed by the Local A&E Delivery Boards. These include escalation plans with key actions to be taken if certain triggers are reached. Extra bed capacity by reducing delayed transfers of care	Emergency Plans successful during testing Staff flu vaccination programme – this is underway for KCHFT staff. Local targets have been set which include maximum of 14 patients at any one time in KCHFT community hospitals Winter Pressure Plans. Actions have been identified in order to reduce the gap in controls relating to this risk.		4	3	12H	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Lesley Strong	Medium	**April 2019**
													Monitor Winter Pressure Plans through Governance structures - KPI's for East & West Kent have been agreed	Lesley Strong	Mar 2019	A			
													Flu Vaccination Programme Delivery	Mercia Spare	Feb 2019	A			
													Oversee the newly implemented 'Rapid Transfer service in the East in addition to the creation of local care schemes.	Lesley Strong	Mar 2019	A			
													Oversee the newly implemented Hospital at Home' scheme in the West ' in addition to the creation of local care schemes.	Lesley Strong	Mar 2019	A			
Develop Sustainable Services (Strategic Objective Enablers)																			
101	Dec 2018	Natalie Davies	Uncertainty around Brexit may affect our ability to deliver core objectives	4	3	12H	Local Health Resilience Partnership (LHRP) terms of reference Executive lead appointed Head of Resilience JD Action plan developed Brexit risk register established	Regular discussion and review at Exec/Management Committee and Board. NHS England (NHS E) reporting requirements met. LHRP meetings attendance. Further develop plan in response to new information. Monthly Trust Brexit meetings held. Working in collaboration with Clinical		4	3	12H	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Natalie Davies	Medium	**February 2019**
													Coordination with the STP ongoing	Paul Bentley	Feb 2019	A			
													Staff training on strategy and command groups which will be completed by the end of February	Natalie Davies	Feb 2019	A			
													Internal Brexit workshop and table top exercise to be held	Natalie Davies	Dec 2018	G			
													Fortnightly reviews - to keep plans under review	Natalie Davies	Feb 2019	G			

				Initial rating						Current rating							
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	C	L	Rating	Planned Actions and Milestones	Action owner	Confidence Assessment	Target Date (end)
Deliver High Quality Care at Home and in the Community																
102	Jan 2019	Louise Norris	Inability to recruit and retain staff could have a detrimental impact on maintaining quality of care and morale	4	3	12H	Strategic Workforce Committee ToRs, Service quality visits Director of Workforce JD; Workforce Strategy Agreed Operational workforce reports Complaints system established against agreed policy Friends and Family Test Talent Management Strategy Time to Change Champions system established	Service visit reported to quality committee, Workforce report to board, IPR KPIs reported and reviewed by Board, Safer Staffing reports, workforce plans, Time to hire benchmarks positively, bank fill rates improving, agency usage report. Workforce report to SWC	vacancies 9.69%, turnover 18.14%	4	3	12H		Louise Norris	Medium	**Dec 2020**

Individual Actions	Owner	Target Completion (end)	Status
Open Clinical Academy with 50 students	Louise Norris	Feb 2019	A
Scoping extension to clinical academy	Louise Norris	Sep 2019	A
International recruits arrive	Louise Norris	Jun 2019	A
Implement Big Listen action plan	Paul Bentley	Apr 2020	A
Implement QI strategy action plan	Sarah Phillips	Mar 2020	A
Implement well being action plan	Louise Norris	May 2019	A
Implement WRES action plan	Louise Norris	Mar 2019	A

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	2.3
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Pippa Barber, Chair of Quality Committee

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

Report Summary
The paper summarises the Quality Committee meetings held on 18 and 19 February and 19 March 2019.

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 (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

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Kent Community Health
NHS Foundation Trust

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Extra Ordinary Quality Committee meeting held on 18 February 2019.

Agenda item	Assurance and Key points to note	Further actions and follow up
Quality Impact Assessments (QIAs) of Cost Improvement Programme (CIP) schemes	The CIPs were presented by the Medical Director, Chief Nurse (Interim) and Chief Operating Officer with assurance being sort by the non-executive directors (NEDs) from the following committees, Quality, Workforce, Audit and Risk and Finance, Business and Investment. QIAs from the following services were discussed, with an emphasis on high risk scored areas Including Staff Experience. Specialist And Elective Services, Children's And Specialist Services, Public Health, Dental and Workforce Organisational Development and Communications, Finance. A number of schemes had been requested by the Chief Nurse (Interim) and Medical Director to return with further information before being signed off. The Chief Nurse (Interim) confirmed each scheme would have key performance indicators (KPIs) to monitor quality impact	Further QIAs to be completed and to be considered at the March Quality Committee meeting. East and West Kent Operations, Estates, Corporate, IT, Medical, Nursing and Quality.

Agenda item	Assurance and Key points to note	Further actions and follow up
	through the year which would be considered at directorate performance meetings. The Quality Committee agreed the NED Deep Dives would be carried out during 2019/20 on a small number of schemes. It was agreed that further deep dives could be suggested following the review at the March Quality Committee meeting.	

This report is founded on the Quality Committee meetings held on 19 February 2019.

Agenda item	Assurance and Key points to note	Further actions and follow up
February Quality Report	Assurance was sought on outstanding estates work at various community hospitals. Mercia Spare confirmed that this was on the risk register. There had been delays in delivery. However, the units at Tonbridge Cottage Hospital and Whitstable and Tankerton Hospital were on target to complete their refurbishment and the improvement of their bathrooms. Continued good progress was provided and noted on the management of pressure ulcers, avoidable falls and avoidable medication incidents. Quality Improvement (QI) projects are in place on medication incidents.	It was agreed that the target completion dates for the estate work would be confirmed.

Agenda item	Assurance and Key points to note	Further actions and follow up
February Serious Incidents (SI)	Assurance was sought on a number of areas. It was confirmed that the number of outstanding actions was continually reducing. Assurance was provided that all the root cause analyses from the investigations were reviewed. Actions were being completed and services were learning from incidents. It was important that the actions were clear about what was required. Whether to raise awareness amongst staff or design out errors at a fundamental level.	It was agreed that the quarterly themes and trends report would include a commentary.
Legal Services Report	The Committee received a report for the period October to December 2018. Assurance was sought on current risks and actions taken. Clarity was sought on the links between SIs and incidents set out in the report. It was confirmed that the Legal Services Team worked closely with the Serious Incidents Team.	It was agreed that the Committee would receive assurance in future reports that the Trust was learning from the themes identified in the legal claims, with the actions it had taken,
Quality Priorities 2018/19	The Committee received a Quarter 3 progress report. Good progress is being achieved in the majority of areas with excellent progress being made on the number of Quarter 1 projects being undertaken. The target is 20 by year end and by Quarter 3, 60 projects are active with QI training on target. Two priority areas remain a risk: Staff turnover (being monitored by the Strategic Workforce Committee) and 'all relevant patients will have a personalised plan of care'. Currently performance is 46% against a target of 65%.	A QI project is being put in place to review care plan delivery across the Trust. This remains on the short list for quality priorities in 2019/20. The Quality Committee will receive a further update in April.

Agenda item	Assurance and Key points to note	Further actions and follow up
Clinical Effectiveness Group Terms Of Reference	These have been amended and were approved by the Committee.	
Policies for Ratification	The committee approved the Policy for Prescription Security, and approved the Podiatric Surgery new Patient Assessment Standard Operating Procedure.	
Operations Directorate Quality Improvement Network Newsletter	The Committee received this and noted the significant work being undertaken. Assurance was given on achievement of wider learning across the teams. The newsletter was considered very helpful by the Committee.	It was agreed that on NED visits to services assurance should be sought on the team's awareness of the newsletter and content and visibility. NEDs would also attend some Network meetings
Service presentation: Community Paediatrics	Following a review of the service by the Royal College of Paediatricians, updates were provided by the service on the outcome of the visit, the subsequent report, and actions being taken by the team. The report identified a number of areas. An action plan is in place and these are being progressed. Assurance was sought on staff morale and how this is being tracked with the changes that have been put in place with the team. The risks of managing the waiting list for Autism Spectrum Disorder (ASD) patients were being actioned. The service reported they had introduced a sustainable model to manage the waiting times.	The actions in place will require on-going focus and work. It was agreed that further assurance was needed by the Quality Committee on progress and a further assurance update would be provided to the Committee in June 2019.

This report is founded on the Quality Committee meeting held on 19 March 2019.

Agenda item	Assurance and Key points to note	Further actions and follow up
Patient Safety and Clinical Risk Group Chair's Assurance Report	Assurance was received on a number of actions in place to enhance fire safety management at Queen Victoria Memorial Hospital (QVMH). Actions are now complete.	Quality Committee will seek further assurance of de-escalation of the risk level in next month's report.
	An escalating risk was reported with non-achievement of KPIs for antenatal contacts. Assurance was received on the clinical risk assessment being undertaken. A number of actions are being taken both internally with teams and on information sharing with acute Trust so workload can be planned and risks identified and actioned.	Achievement of KPIs will continue to be monitored through the Integrated Performance Report. A follow up report will be provided to the Committee on the clinical risk assessment process in place.
Monthly Quality Report	Good progress continues on achievement of reduction of Category 2 pressure ulcers .The Trust is on target to overachieve the agreed trajectory of a 10% reduction of avoidable harm. Currently achieving a 17% reduction .For Category 3 and 4 the Trust is also achieving well and on target to achieve a 10% reduction .Currently achieving a 50% reduction. .Recruitment to portfolio research studies is on track for achievement of target. CAUTI and UTI reduction targets will not be achieved this year. Actions are being taken within the Trust as well as working collaboratively across partners to effect further improvement.	

Agenda item	Assurance and Key points to note	Further actions and follow up
	The Chief Nurse (Interim) agreed to review and increase the visibility of community quality metrics in the report going forward.	
Serious Incidents Report	The monthly report showed an increase in numbers reported during February with assurance on immediate actions taken whilst the ongoing investigation takes place. Themes have been identified and assurance provided on learning and actions from previous SIs.	
We Care Review 2018 Annual Report	The annual report provided an overview of the 'we care' reviews and ratings undertaken throughout 2018 and the subsequent results and recommendations .Trust wide themes were identified and assurance was received on the governance groups that are overseeing the improvement work for the specific areas. Assurance was received that where appropriate these are on risk registers.	The 'we care' visit programme is being further developed this year with more in-depth visits. The programme will also be reviewed following feedback from the Care Quality Commission (CQC) visit.
Infection Prevention and Control Report	The Committee received and scrutinised the report covering the period between October 2018 and February 2019.Updates were provided on the system for MRSA screen compliance in community hospitals which is being reviewed and the need for continuous focus on CAUTIs and UTIs in line with the national agenda. Achievement level of staff flu vaccinations was discussed with further assurance sought including benchmarking	The Chief Nurse (Interim) agreed to bring to the May Committee meeting the Flu Vaccination Plan for this year in order for the programme to start in a timely way and aid increased uptake rates.

Agenda item	Assurance and Key points to note	Further actions and follow up
	with other organisations. The Quality Committee is content to recommend to the Board that the Trust is able to declare its compliance with The Hygiene Code.	
Integrated Performance Report; Operational Deep Dive Audiology Service Action Plan	A presentation was received and assurance given by the service managers on actions being taken to mitigate referral to treatment waiting times (RTT) non-achievement at four weeks and six weeks .A number of QI projects are in place and there is some impact to date.	Potential workforce solutions may be considered as part of Academy work; to be discussed at the Strategic Workforce Committee. Progress will be monitored through the IPR and further assurance sought if improvement is not seen in three months.
Quality Priorities 2019/20	The Quality Priorities for 2019/20 were considered by the Committee. Assurance was received that they have undergone extensive consultation through the last three months both internally to governance groups, staff, Governors and patients; and externally with commissioners. The Committee endorsed the Quality Priorities for 2019/20 and recommend approval by the Board.	Quality areas to be developed into the QI programme with SMART outcomes. A draft Quality Report including the priorities will be presented to the May Quality Committee meeting with progress reported quarterly to the Committee during 2019/20.

Agenda item	Assurance and Key points to note	Further actions and follow up
Medicines Policy	The purpose of this policy is to inform clinical staff involved with any of the processes associated with management of medicines. The policy was ratified.	
Clinical Audit Strategy and 2019/20 Annual Plan	Following a recommendation from the Audit and Risk Committee, the Terms of Reference of the Quality Committee have been amended to ensure it now has oversight of the clinical audit plan. The plan was presented and assurance provided of extensive consultation and input to its development. Clinical audit is one of the strands of QI and the plan this year has been considered and reviewed with this as a driver. There are 111 audits planned in the year (a reduction of 18% from 18/19). The plan was scrutinised by the Committee with assurance provided on links to QI work, capacity and prioritisation. The 2019/20 Clinical Audit Plan was approved.	
Quality Impact Assessments (QIA) of Cost Improvement Programme (CIP) schemes	The second group of CIPs were presented by the Chief Nurse (Interim), Medical Director, and Chief Operating NEDs for the following areas: West Kent Operations, Corporate, IT, Medical, Nursing and Quality. It was noted that one scheme, following triangulation with other known quality metrics, had not been agreed by the Chief Nurse (Interim) and Medical Director and was subsequently withdrawn from the list of CIPs.	QIAs are not yet approved by the Medical Director and Chief Nurse (Interim) for the East Kent area and Estates. These will need to be considered at April's Committee meeting. Financial budgets will be considered by the Finance, Business and Investment (FBI) Committee in March.

Agenda item	Assurance and Key points to note	Further actions and follow up
	The Committee was able to note that the CIPs that have been approved by the Chief Nurse (Interim) and Medical Director to date and sought assurance that the quality risks are being managed. The programme of deep dives by NEDs during the year has been agreed.	

Pippa Barber
Chair, Quality Committee
20 March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	2.4
Agenda Item Title:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Chair of Strategic Workforce Committee

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

Report Summary
The paper summarises the Strategic Workforce Committee meeting held on 30 January 2019. A verbal update on the meeting held on 20 March 2019 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. The paper will have no impact on people with any of the nine protected characteristics

Bridget Skelton, Non-Executive Director	Tel: 01622 211906
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Kent Community Health
NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on 30 January 2019.

Agenda item	Assurance and Key points to note	Further actions and follow up
Workforce Report	SPC charts were received for each of the workforce metrics, with an explanation or narrative to demonstrate the context of the data. Specifically we discussed the importance of examining the stability metric to ensure we retain people in their first year with us, the sickness target which is still a concern and the stress target which is having a downward trend following initiatives like Time to change, quality into action and work to eliminate bullying. The completion of appraisals 17/18 was excellent at 99.3%, we need to continue the on going work to improve the quality of the appraisal.	Committee to have a SPC tutorial at the next meeting. Stability and sickness targets to be reviewed as part of better understanding the value of the data now being presented.
Nursing Academy Update	The Academy with 46 starters begins 31 January, with a two day academy programme, before completing our two day induction, before connecting with their bases. Managers are being supported and a student forum being set up. The programme now has accreditation from Health Education England and received some funding.	To explore what a phase two could look like its feasibility with type of apprentice, scale and cost.

Agenda item	Assurance and Key points to note	Further actions and follow up
Disability Equality Standard	The WDES needs to be reported in August 2019. Plan is in place to ensure this is achievable, working to find ways to get reporting numbers higher, including helping people better understand the definition of disability and why we need the data.	
GDPR update	SWC requested our auditors conduct a review to test assurance on Staff Personal Files held locally by line managers. Audit of five managers and 50 files – concluded not compliant with some files carrying old information and others missing information. The immediate next step is to put a plan together to work towards compliance.	Plan to be designed to work towards GDPR compliance for staff personal files.
Deep Dive Sickness Absence	Examined the sickness % and days lost to understand better the causes and actions needed to improve. Anxiety, stress and depression along with MSK remain the two most common causes. The policy has been reviewed and significant Management actions taken including proactive support from ER, training, team stress initiatives, as well as a number of health and wellbeing activities.	The stress targets are being reviewed as part of the work to ensure workforce measures are meaningful and helpful.
BAME Dental Deep dive	Whilst the increase in the provision of Dental services in London has made a difference to the BAME representation within the Directorate, changes in the workforce across the Trust, notably the other five operations directorates have also had an impact on the	

Agenda item	Assurance and Key points to note	Further actions and follow up
	Trust ethnic diversity figures.	
Operational Workforce Report	Discussed the external review of the Community Paediatric Service in West Kent which had been facing both internal and external challenges. Assurance was obtained that improvement has already begun with the introduction of the Clinical Director role, as well as an improved performance of the Looked After Children (LAC) service, supported by an enhanced relationship between the local authority and the Trust. Many recommendations were made, with engagement of the teams involved are being implemented. SWC endorsed the executive team proposal to introduce a Trust Associate Specialist Grade to help secure this level of capability in both the community paediatric and the community geriatrician services, as part enhancing the skill mix within the teams. Workforce winter plans. There are many new schemes being introduced but difficulty remains recruiting to specialist and senior posts. It is too early to determine the success of the bank incentive scheme introduced in January to aid the Workforce winter plans. The bank fill % of total temp duties requested this year is 7.15% higher than in 2018.	SWC sought assurance that the Quality Committee also review and scrutinize the findings and the actions taken.

Agenda item	Assurance and Key points to note	Further actions and follow up
Staff Survey Raw Data Results	Full report out 8 February. Raw data is looking positive especially when looking at the biggest increased in response – The recognition I get for good work 7%, and The extent to which my organisation values my work 6%. This is encouraging after the level of effort we put into engaging and valuing our staff following last year's survey.	Analysis of full report will come to next SWC with a recommendation on areas that need special attention 2019/20.
Risk 73 and 37 Board Assurance Framework	SWC acknowledged that significant progress had been made against most of the actions associated with risk 73, and that it should be removed from the BAF. As recruitment and retention still remain a significant risk to the business it was recommended that risk 37 be reworded. There was rich debate as to wording of this risk and even more debate as to whether SWC had received enough robust data to recommend the risk be downgraded from 16 to 12. Triangulation could be shown where despite poor recruitment and retention no quality had been compromised but equally we did discuss examples where staff shortages had contributed to lower levels of staff morale and stress.	A recommendation as to the exact wording of this risk and the risk rating with robust data and benchmark analysis will come to the next SWC and then back to the Board.
Internal Transfer Scheme Review	The internal transfer process has been reviewed and a number of issues have emerged, resulting in the need to develop further guidance and learning.	
Clinical Practice of Doctors and Dentists	The policy for Clinical Practice of Doctors and Dentists was ratified.	

Agenda item	Assurance and Key points to note	Further actions and follow up
Policy		
NHS Ten Year Plan – Workforce Implementation Plan	A specific team has been set up to look at the workforce elements of the Ten Year Plan – Future of Medical staff, clinical workforce, better work place and leadership.	
Devolved Authority	Early work implementing devolved authority has started reducing the number of policies and procedures we have, a steer group providing clarity on turning actions into the right behaviours, drafting a scheme of delegation for Finance and recruitment, as well as beginning to look at test roll out areas in a Community hospital, health visiting, TICC and a specialist service. Useful lessons already being learnt about how to relinquish control and understanding what it means to an individual. Coaching and Action learning groups are well placed to support embedding devolved authority.	
Workforce Race Equality Standard WRES Report	WRES report was published in November.	SWC to receive a copy of actions from that and a summary of progress from the previous year.

Bridget Skelton
Chair, Strategic Workforce Committee
30 January 2019

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	2.5
Agenda Item Title:	Audit and Risk Committee Chair's Assurance Report
Presenting Officer:	Peter Conway, Chair of Audit and Risk Committee

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

Report Summary
The paper summarises the Audit and Risk Committee meeting held on 20 February 2019.

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 (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

Peter Conway, Non-Executive Director	Tel: 01622 211906
	Email:

Kent Community Health
NHS Foundation Trust

AUDIT AND RISK COMMITTEE (ARAC) CHAIR'S ASSURANCE REPORT

This report is founded on the Audit and Risk Committee meeting held on 20 February 2019.

Area	Assurance	Issues and/or Next Steps
Risk Management	1) The revised Board Assurance Framework (BAF) has been produced following a thorough review of processes, inputs and comparison with six other organisations. The Board can be assured that risk management and reporting continues to be effective across the Trust. This assurance was further tested and endorsed by a deep dive of the risk management processes and outputs in the Operations Directorate. 2) The Trust's Risk Management Strategy and Policy was reviewed	1) Some of the risks as currently articulated need further refinement (eg. risk 102 where the Strategic Workforce Committee (SWC) has suggested a number of enhancements including principles that should apply across all risks 2) The Board should note that 'actions' reflect activity at a point in time and will be updated as the planned mitigations evolve and the risks change 3) The ARAC will reconsider elements of the Risk Management Strategy and Policy in September to address what constitutes high risks (12+ score or 16+) and further revisions, particularly alignment Terms of References for Quality Committee and Strategic Workforce Committee, before signing off. In the meantime, the current Strategy/Policy document is OK.
Internal Audit and Counter Fraud	Positive assurance on performance monitoring, action plan progress and the implementation of prior recommendations.	1) Internal Audit has provided substantial assurance on GDPR readiness but not compliance. The Strategic Workforce Committee will follow through the specifics of the personnel files breaches. The ARAC requested advice on (1) what should be reported to the IC in

		respect of breaches and (2) what should be covered in the Annual Governance Statement (both with appropriate proportionality). The ARAC will then provide guidance to the Board 2) 2019/20 plans for both Internal Audit and Local Counter Fraud were agreed, subject to some minor tweaks.
External Audit	2019 Year End Plan reviewed and agreed.	
Clinical Audit	Progress report and draft 2019/20 plan received.	1) Current ARAC clinical audit responsibilities will transfer to the Quality Committee. The ARAC Chair will attend the March Quality Committee meeting when the 2019/20 plan will be agreed 2) Dawn Nortman, Head of Clinical Audit and Research to review unacceptable timescales of clinical audit reporting (from dashboard through to full report with action plan review) with Dr Sarah Phillips, Medical Director and Lesley Strong, Chief Operating Officer.
Freedom to Speak Up	Positive assurance received on process effectiveness.	Auditors were happy with assurance provided.
Standards of Business Conduct	Report received on risk management of pharmaceutical industry activities with the Trust. Positive assurance.	
NHS Improvement Licence Self Certification	Positive assurance received.	
Brexit	Updated papers and risk register received together with a verbal presentation by Jan Allen, Head of Emergency Preparedness, Resilience and Response.	1) A further report will go to the Management Committee in March. The Board can take assurance that the full panoply of risks are being considered and mitigated in conjunction with partners, Some risks are more difficult/intractable than others, particularly given the uncertainties 2) The Trust/Board will need to continue to be proportionate and balanced in its approach.

		3) Communications to patients will be critical and to be able to respond to simple questions such as ‘’will my nurse still visit me’
Single Tender Waivers, Losses and Special Payments	Processes being well managed and positive assurance received.	ARAC to consider potential governance weaknesses following the £35k write off of Coloplast involvement (Wound Care Services funding)
Interoperability features of new Community Information System (CIS)	Positive assurance received. Interoperability considerations well embedded in the project.	Given the complexity of the systems landscape, choices will have to made between some systems that are ‘’must dos’’ and others which are of less significance and interoperability not achieved at the outset
Cyber Security	ARAC to provide ongoing assurance to the Board.	The ARAC will receive assurance proposals and agree a way forward in September and then review progress annually in February in advance of the Annual Governance Statement.
Accounting Policies and Year-End arrangements	Timetable, policies and processes agreed.	ARAC to scrutinise the Environmental Sustainability Report within the Annual Report and ensure the comments and facts are evidenced
ARAC Terms of Reference	Reviewed.	Changes will be made and recommended to the Board in due course for 1) clinical audit 2) cyber security 3) physical security (lone working, fire safety, building security, health and safety)

Peter Conway
Chair, Audit and Risk Committee
25 February 2019

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	2.6
Agenda Item Title:	Charitable Funds Committee Chair's Assurance Report
Presenting Officer:	Jen Tippin, Chair of Charitable Funds Committee

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

Report Summary
The paper summarises the Charitable Funds Committee meeting held on 30 January 2019.

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

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

Jen Tippin, Non-Executive Director	Tel: 01622 211906
	Email:

Kent Community Health
NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Charitable Funds Committee meeting held on 30 January 2019.

Agenda item	Assurance and Key points to note	Further actions and follow up
Minutes and actions	The committee approved the minutes from the previous meeting.	
Annual report	The committee approved the report.	
Bow Road fund presentation	The committee approved the proposal for memory boxes to be provided to further organisations. The committee agreed to fund the pilot regarding living well sessions in the community if this is not funded by the executive team. The committee agreed to fund the proposed GP practice changes including a pill counter and asthma machine. The committee declined to apply the fund to complete the work to move services into the developing loft space at the practice.	• Further discussion required with other committees and executives to determine the funding of the pilot of the community living well sessions.
Marketing	The committee agreed not to pursue the proposal that fundraising during working hours be for iCare only.	• Donation envelopes including gift aid to be implemented. • Registration for 'Pennies from Heaven' to be looked into. • Legal opinion and risk review required

		around the trademark of the name 'iCare'. • Marketing paper to be brought to a future committee incorporating new fund ideas.
Assurance report	The committee noted the report.	
Committee effectiveness	The committee approved the paper.	• Paper to be circulated.
Terms of reference	The committee approved the terms of reference, subject to one potential amendment.	• Wording to be checked against FBI committee terms of reference and amended as appropriate.

Jen Tippin
Chair, Charitable Funds Committee
30/01/2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	2.7
Agenda Item Title:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance

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

Report Summary

The Integrated Performance Report is presented with the use of Statistical Process Control (SPC) charts. The use of these charts has been presented and agreed through the Executive Team, as well as the revised summary scorecard. It should be noted that the full Finance, Workforce and Quality reports are 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, with the SPC charts being used to show a rolling 25 month view of performance for each indicator. 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>

Within NHS Improvement's Single Oversight Framework, KCHFT have been moved from segment 1 to segment 2. This level is categorised as "targeted support offer" (segment 1 is "maximum autonomy"). The move from segment 1 to segment 2 is as a result of deterioration in performance in RTT and 6 week diagnostics and while RTT is now meeting target, 6 week diagnostics is failing to meet the 1% standard (99% of the waiting list under 6 weeks). See the operations section for details of actions to improve performance to meet the 1% standard and move KCHFT back to segment 1

Quality

- No new grade 2 pressure ulcers categorised this month (fifteen for the year and on target to meet annual target)
- Grade 3/4 pressure ulcers (9) below target for the year to date. 3 new ulcers categorised for January

- Community Hospital fill rates positive at 102% (day) and 98% (night)
- Normal variation trend for medication incidents, however increasing low harm incidents.

Workforce

- Turnover remains above the 16.47% target (17.2%), although reducing towards target level (marginally below lower control limit this month)
- Sickness absence remains above the Trust target for the month and consistently above the mean. Paper to Committee to increase target to 4.5%
- Vacancy rates have increased to 8.5% (although below the mean for the last 2 months with a high level or recruitment activity ongoing.
- An increase in temporary staff shift requests, although fill rates are showing normal variation.

Finance

- CIP savings currently 5.9% behind target, although forecast year end position is for full achievement
- Capital Expenditure year to date is £2,812k, representing 85% of the YTD plan
- YTD surplus ahead of plan (2.3%)

Operations

- NHS Health Checks (83%) and Stop smoking Quits (71.8%) remain behind plan but are improving through a period of normal variation.
- Health Visiting mandatory check performance against the New Birth and 6-8 week visit are both on target and showing normal variation.
- Referral to treatment incomplete wait times for consultant-led services continues to improve above the 92% target, following a period of adverse variation. No patients are now waiting above 36 weeks.
- 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 are marginally below the 99% target, although showing normal variation. To make further strides to achieving the standard regularly, the Audiology service are implementing a tracking process to forecast and prevent breaches by taking earlier action. Additionally, the service are

recruiting additional staff to cover maternity leave.

- The newly introduced End of Life indicator, measuring the level of electronic care planning for End of Life patients continues to fall below the 60% target, although is showing signs of improvement.
- Delayed Transfers of Care (DTOCs) consistent and below target year to date, showing a slight decrease in the last 2 months following an increase in October/November
- 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, although still being achieved most months. 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. The paper will have no impact on people with any of the nine protected characteristics

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Kent Community Health
NHS Foundation Trust

Integrated Performance Report 2018/19

March 2019 report

Part One

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Contents

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Glossary of Terms

SPC – Statistical Process Control

LTC – Long Term Conditions Nursing Service

ICT – Intermediate Care Service

Quality Scorecard – Weighted monthly risk rated quality scorecards

C.Diff – Clostridium Difficile

MRSA – Methicillin Resistant Staphylococcus Aureus

MIU – Minor Injury Unit

RTT – Referral to Treatment

GUM – Genitourinary Medicine

CQUIN – Commissioning for Quality and Innovation

MTW – Maidstone and Tonbridge Wells NHS Trust

WTE – Whole Time Equivalent

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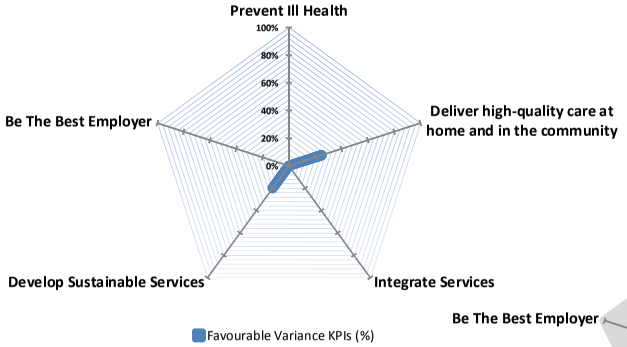
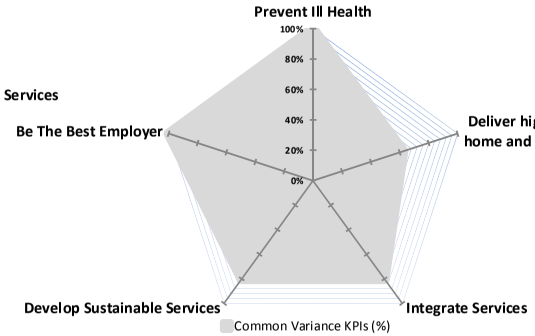
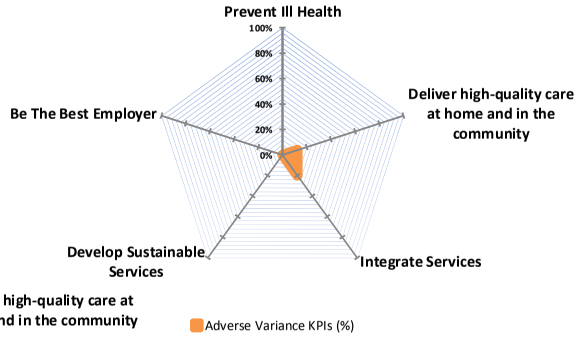
1.0 Assurance on Strategic Goals





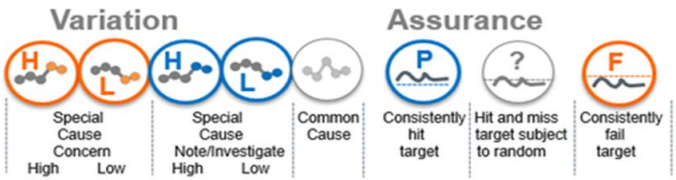


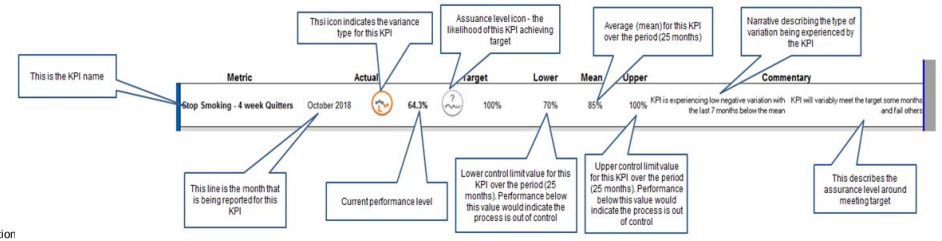
Within NHS Improvement's Single Oversight Framework, KCHFT have been moved from segment 1 to segment 2. This level is categorised as "targeted support offer" (segment 1 is "maximum autonomy"). The move from segment 1 to segment 2 is as a result of deterioration in performance in RTT and 6 week diagnostics and while RTT is now meeting target, 6 week diagnostics is failing to meet the 1% standard (99% of the waiting list under 6 weeks). See the operations section for details of actions to improve performance to meet the 1% standard and move KCHFT back to segment 1.

Overall, of the 37 indicators that we are able to plot on a statistical process control (SPC) chart, 13.5**% are experiencing favourable in-month variation (5, KPIs 2.5, 2.8, 2.11, 2.21 and 4.3), 8.1% are showing in-month adverse variance (3, KPIs 2.14, 2.20 and 3.5)** and the remaining 78.4**% (29) are showing normal variation.**

29.7% of the KPIs are consistently achieving target **(KPIs 1.4, 2.12, 2.13, 2.15, 2.18, 2.19, 2.22, 3.2, 4.3, 4.5 and**
18.9% (KPIs 1.1, 1.2, 2.8, 3.5, 3.6, 4.1 and 5.3) are consistently **failing,**
with the remaining **51.4% variably achieving target** with no trend of consistent achievement/failure.

Of the 9 indicators where an SPC chart is not appropriate, **88.9% (8) have achieved the in-month target,** with **11.1% (1, KPI 2.7) failing the target.**





Special Cause Concern - this indicates that special cause variation is occurring in a KPI, with the variation being in an adverse direction Low (**L**) special cause concern indicates that variation is downwards in a KPI where performance is ideally above a target line e.g. New Birth Visits. High special cause concern (**H**) is where the variance is upwards for a below target line KPI e.g. DNA Rate

Special Cause Note - this indicates that special cause variation is occurring in a KPI, with the variation being in a favourable direction. High (**H**)special cause note indicates that variation is upwards in a KPI where performance is ideally above a target line e.g. New Birth Visits. Low (**L**) special cause note is where the variance is downwards for a below target KPI e.g. DNA Rate.

Non-SPC KPI on target
Non-SPC KPI performance under review
Non-SPC KPI off target

	Metric	Actual		Target	Lower	Mean	Upper	Commentary
1. Prevent Ill Health	**KPI 1.1 Stop Smoking - 4 week Quitters**	January 2019	**71.8%**	100%	41%	63%	84%	KPI is currently unlikely to meet target without a process change with the upper control limit below the target level
	KPI 1.2 Health Checks Carried Out	January 2019	**83.0%**	100%	56%	72%	87%	KPI is currently unlikely to meet target without a process change with the upper control limit at then target level
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	January 2019	**90.1%**	90%	88%	92%	96%	KPI will mostly achieve target but the control limits indicate that failing the target is a possibilty within the current process
	KPI 1.4 Health Visiting - 6-8 week check undertaken by 8 weeks	January 2019	**86.4%**	80%	85%	90%	94%	KPI is consistently achieving the target with the lower limit above the target. This suggests failing to meet the target is unlikely to occur.
	KPI 1.5 School Health - Reception Children Screened for Height and Weight	February 2019	**94.0%**	90% (year end)			KPI is cumulative through the school year	KPI has achieved the target for the 18/19 school Year
	KPI 1.6 School Health - Year 6 Children Screened for Height and Weight	February 2019	**93.0%**	90% (year end)			KPI is cumulative through the school year	KPI has achieved the target for the 18/19 school Year
	KPI 1.7 LTC/ICT - Admissions Avoidance (using agreed criteria)	January 2019	**6534**	5257	4419	5778	7138	KPI will variably meet the target some months and fail others
	KPI 1.8 % LTC/ICT patients that had at least one visit which Avoided a Hospital Admission	January 2019	**17.7%**	15.0%	12.5%	16.5%	20.5%	KPI will variably meet the target some months and fail others

	Metric	Actual		Target	18/19 YTD Actual	18/19 YTD Target	Commentary
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**	January 2019	**0**	1	5	8	There have been 5 Amber/Red ratings for the financial year to date with April (2) being the highest month
	KPI 2.2 Never Events	February 2019	**0**	0	0	0	No never events experienced this year. Last event in December 2016
	KPI 2.3 Infection Control: C.Diff	February 2019	**0**	0	1	0	One case occurred in January 2019, the first case since Febraury 2018
	KPI 2.4 Infection Control: MRSA cases where KCHFT provided care	February 2019	**0**	0	4	0	4 cases this year (One in each of April, August, September and October)

	Metric	Actual		Target	Lower	Mean	Upper	Commentary	
	KPI 2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days	February 2019	**0.00**	0.19	-0.20	0.16	0.51	KPI is experiencing low positive variation, with the last 8 months experiencing no moderatre and severe falls	KPI will variably meet the target some months and fail others

	Metric	Actual		Target		Lower	Mean	Upper	Commentary	
2. Deliver high-quality care at home and in the community	**KPI 2.6 Avoidable Pressure Ulcers - Grade 3 & 4**	February 2019	**0**		1	-2.9	1.1	5.1		KPI will variably meet the target some months and fail others. There have been 9 incidents this year compared to 15 by the same stage of 2017/18
	KPI 2.7 Percentage of End of Life patients with an updated Personalised Care Plan (PCP)	January 2019	**39.1%**		60.0%				Currently too few data points to plot an SPC chart	KPI is consistently failing the target, with signs of improvement. This KPI is a new target and data collection. See Operational Report for more detail
	KPI 2.8 Contractual Activity: YTD as % of YTD Target	January 2019	**98.0%**		100.0%	95.5%	97.7%	99.8%	KPI is experiencing high positive variation, with the last 8 months performing above the mean	KPI will consistently fail the target, with the upper limit below the target. This suggests achievement is likely to be down to chance without a process or target change
	KPI 2.9 Trustwide Did Not Attend Rate: DNAs as a % of total activity	January 2019	**3.6%**		4.0%	3.1%	3.6%	4.1%		KPI will variably meet the target some months and fail others.However, the target is near the upper limit suggesting failure to meet target is unlikely.
	KPI 2.10 LTC/ICT Response Times Met (%) (required time varies by patient)	January 2019	**96.5%**		95.0%	94.9%	96.7%	98.4%		KPI will variably meet the target some months and fail others, although failure is unlikely with the target marginally above the lower limit
	KPI 2.11 Percentage of Rapid Response Consultations started within 2hrs of referral acceptance	January 2019	**94.5%**		95.0%	87.8%	94.3%	100.8%	KPI is experiencing high positive variation, with the last 8 months performing above the mean	KPI will variably meet the target some months and fail others
	KPI 2.12 Total Time in MIUs: Less than 4 hours	January 2019	**99.8%**		95.0%	99.5%	99.8%	100.1%		KPI is consistently achieving the target with the target significantly below the lower limit
	KPI 2.13 Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways	January 2019	**96.5%**		92.0%	92.5%	95.3%	98.0%	KPI is now showing normal variation following a period of negative variation below the mean	KPI is consistently achieving the target with the lower limit above the target, suggesting failure to meet target is an unlikely event.
	KPI 2.14 AHP (Non-Consultant Led) Referral to Treatment Times (RTT)	January 2019	**93.3%**		92.0%	91.3%	94.2%	97.0%	KPI is experiencing low adverse variation with the last 9 months below the mean, although showing signs of improvement	KPI will variably meet the target some months and fail others
	KPI 2.15 Access to GUM: within 48 hours	January 2019	**100.0%**		100.0%	100.0%	100.0%	100.0%		Consistently meeting target. Failure to meet target would be considered a chance event without a process change. Has met target for the last 5 years
	KPI 2.16 Length of Community Hospital Inpatient Stay (Median Average)	January 2019	**19.3**		21.0	15.0	20.1	25.2		KPI will variably meet the target some months and fail others
	KPI 2.17 Research: Participants recruited to national portfolio studies (Year to Date)	February 2019	**282**		160				KPI is cumulative	KPI is consistently achieving the target of 60 per quarter
	KPI 2.18 Percentage of patient goals achieved upon discharge for planned and therapy services	January 2019	**89.1%**		80.0%	85.0%	89.9%	94.8%		KPI is consistently achieving the target as the lower limit is signifcantly above the target. This would mean failure to meet target would likely be due to chance
	KPI 2.19 Friends and Family - Percentage of Patients who would Recommend KCHFT	February 2019	**97.2%**		95.0%	95.8%	97.1%	98.5%		KPI is consistently achieving the target as the lower limit is above the target. This suggests failing to meet target is an unlikely event.
	KPI 2.20 Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp) - Response Rate	February 2019	**16.0%**		20.0%	12.3%	17.6%	22.8%	KPI is experiencing low adverse variation with the last 13 months below the mean	KPI will variably meet the target some months and fail others
	KPI 2.21 Clinical Audit: % of audit recommendations implemented by deadline	February 2019	**96.0%**		90.0%	45.8%	76.2%	106.5%	KPI is experiencing high positive variation, with the current month performing above the mean	KPI will variably meet the target some months and fail others
	KPI 2.22 NICE Technical Appraisals reviewed by required time scales following review	February 2019	**100.0%**		100.0%	100.0%	100.0%	100.0%		Consistently meeting target. Failure to meet target would be considered a chance event without a process change. Has met target for the last 5 years

	Metric	Actual		Target	Lower	Mean	Upper	Commentary	
3. Integrate Services	KPI 3.1 Delayed Transfers of Care from a Community Hospital bed as a % of Occupied Bed Days	January 2019	10.7%	9.5%	4.8%	10.2%	15.6%		KPI will variably meet the target some months and fail others
	KPI 3.2 Percentage of LTC/ICT Referrals coming from within KCHFT	January 2019	18.8%	10.0%	15.1%	18.9%	22.7%		KPI is consistently achieving the target with the target considerably below the lower limit
	KPI 3.3 CQUINs (% of CQUIN money achieved to 18/19 Q3)	December 2018	97.7%	100%				SPC not appropriate for this metric	KPI will variably meet the target some months and fail others, with 3 of the last 8 quarters achieving 100%
	KPI 3.4 Home First cost saving - reduction of excess bed days - Monthly Average £s (West Kent)	January 2019	-£52,360	£40,000	-£78,177	£21,711	£121,600	Negative saving this month as the excess bed days was higher for the Home First patient cohort	KPI will variably meet the target some months and fail others
	KPI 3.5 Average wait time (minutes) for MTW Accident and Emergency Services	January 2019	396	240	243	318	392	KPI is experiencing high adversevariation with the current month's wait performing above the upper control limit	KPI is consistently failing the target as the lower limit is above the target. This suggests performance is unlikely to decrease to meet target without a process change
	KPI 3.6 Average wait time (minutes) for EKHUFT Accident and Emergency Services	January 2019	383	240	276	346	415		KPI is consistently failing the target as the lower limit is above the target. This suggests performance is unlikely to decrease to meet target without a process change

	Metric	Actual		Target	Lower	Mean	Upper	Commentary	
4. Develop sustainable services	KPI 4.1 Percentage of LTC/ICT Face to Face Contacts carried out in a clinic (target to increase)	January 2019	3.4%	5.0%	2.8%	3.7%	4.6%		KPI is consistently failing the target with the target above the upper limit. This suggest achieving target without a process change will be down to chance and needs review
	KPI 4.2 Bed Occupancy: Occupied Bed Days as a % of available bed days	January 2019	91.1%	87.0%	83.6%	89.5%	95.4%		KPI will variably meet the target some months and fail others
	KPI 4.3 Income & Expenditure - Surplus (%)	February 2019	2.3%	1.0%	1.2%	1.5%	1.9%	Commentary	KPI is consistently achieving the target as the lower limit is above the target. This suggests performance is unlikely to decrease to below target
	KPI 4.4 Cost Improvement Plans (CIP) Achieved against Plan (%)	February 2019	94.1%	100.0%	68.3%	84.8%	101.2%		KPI will variably meet the target some months and fail others, expecially early in each financial year
	KPI 4.5 External Agency spend against Trajectory (£000s)	February 2019	£427,360	£628,000	£205,353	£385,748	£566,144		KPI is consistently achieving the target as the upper limit is below the target. This suggests performance is unlikely to increase to above target

	Metric	Actual		Target	18/19 YTD Actual	18/19 YTD Target	Commentary
	KPI 4.6 Annual Value of Tenders Won by KCHFT (of those that reach award stage - £000s)	February 2019	£0	No Target	£3,323	No Target	One Tender awarded to KCHFT this year - NHSE – Specialised HIV & Complex Disability Equipment (2 Year Contract)
	KPI 4.7 Annual Value of Tenders Lost by KCHFT (of those that reach award stage - £000s)	February 2019	£0	No Target	£1,495	No Target	Two Tenders have been unsuccessful this year - Discharge to Assess Lot 1 and Northern Ireland Orthoses

	Metric	Actual			Target		Lower	Mean	Upper	Commentary
5. Be The Best Employer	**KPI 5.1 Sickness Rate**	February 2019		**4.33%**		3.90%	3.87%	4.50%	5.14%	KPI will sometimes achieve the target, although will fail more often due to the lower limit being marginally below the target
	KPI 5.2 Sickness Rate (Stress and Anxiety)	February 2019		**1.16%**		1.15%	0.98%	1.28%	1.57%	KPI will variably meet the target some months and fail others
	KPI 5.3 Unplanned Turnover	February 2019		**15.3%**	F	14.1%	14.6%	15.6%	16.6%	KPI is consistently failing the target with the target below the lower limit. This suggest achieving target without a process change will be down to chance and needs review
	KPI 5.4 Mandatory Training: Combined Compliance Rate	February 2019		**95.4%**	P	85.0%	90.4%	95.9%	101.3%	KPI is consistently achieving the target as the lower limit is above the target
	KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce)	February 2019		**8.5%**		9.7%	6.6%	8.9%	11.1%	KPI will variably meet the target some months and fail others

2.0 Quality Report

2.1 Assurance on Safer Staffing

The shift fill rates for community hospital wards are set out below. Day shifts fill rates for registered nurses have increased in February. The day fill rates rise to 102% increasing 5% from January, while the night shift fill rate remains at 98%. This was because Faversham were overfilled at 125% and Hawkhurst 107%, mainly due to overlapping of long day shifts at the beginning and end of the day.

Only Edenbridge had a day RN fill rate below 95% at 89.3%. Faversham, Deal and Sevenoaks all had night RN fill rates under 95%, though at 94.6% they are only just below with just 3 night shifts below planned staffing each.

Where RN shifts were unable to be filled by bank or agency the wards increased the use of HCA staff to expand general capacity which has resulted in an overfill rate for HCAs. 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. Primrose ward has no planned RN shifts because it is a therapy ward, though they employed temporary staffing to provide nursing cover and had 45 RN day shifts and 26 RN night shifts on e-roster.

Staffing is reviewed daily and shortages are escalated as per the Inpatient Wards Safe Staffing Assessment and Escalation Protocol.

	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	125.0%	148.2%	94.6%	146.4%	840	1050	1260	1867.5	616	583	616	902
Deal	100.0%	123.8%	94.6%	96.4%	840	840	1260	1560	616	583	616	594
QVMH	101.8%	117.9%	100.0%	100.0%	840	855	1260	1485	616	616	616	616
Whit &Tank	99.1%	145.0%	98.2%	144.6%	840	832.5	1050	1522.5	616	605	616	891
Sevenoaks	97.3%	113.1%	94.6%	98.8%	840	817.5	1260	1425	616	583	924	913
Tonbridge - Goldsmid	97.3%	85.0%	101.8%	90.3%	840	817.5	1050	892.5	616	627	341	308
Tonbridge - Primrose (HCA% includes some RN activity)	N/A	112.5%	N/A	120.2%	0	0	1260	1417.5	0	0	924	1111
Hawkhurst	107.1%	104.2%	100.0%	96.4%	840	900	1260	1312.5	616	616	616	594
Edenbridge	89.3%	116.1%	96.4%	96.4%	840	750	840	975	616	594	616	594
Total	102%	119%	98%	111%	6720	6863	10500	12458	4928	4807	5885	6523
	Over 90% Fill Rate			65% to 90% Fill rate				Less than 65%			Over 110%	

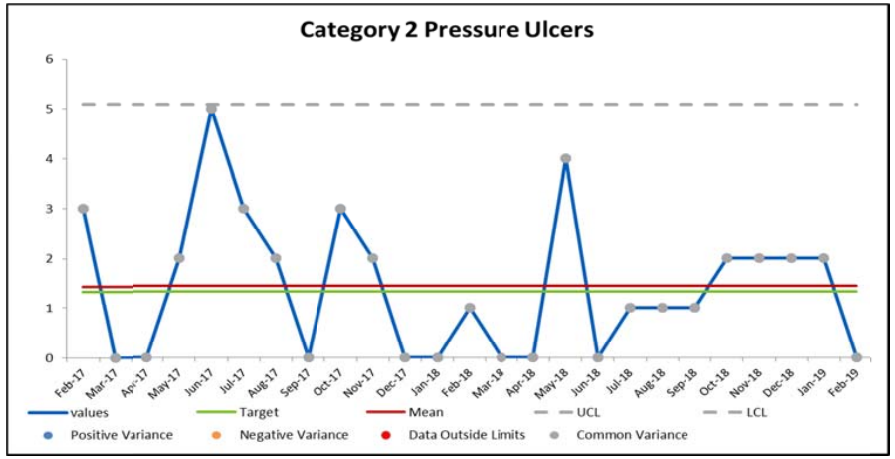
The Integrated care unit at West View is staffed by KCHFT, but contracted to Kent County Council so is not included within KCHFT's National Return to NHS England and not registered with the CQC under KCHFT. For this reason it is analysed separately to keep continuity between the data published on the external website and the data within the NHS England dataset. Currently they only have one unit of 15 beds open and the registered nurse fill rate is Green for day and night shifts.

	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	101.8%	61.7%	107.1%	78.6%	840	855	1860	1147.5	616	660	924	726

2.2 Assurance on Pressure Ulcers

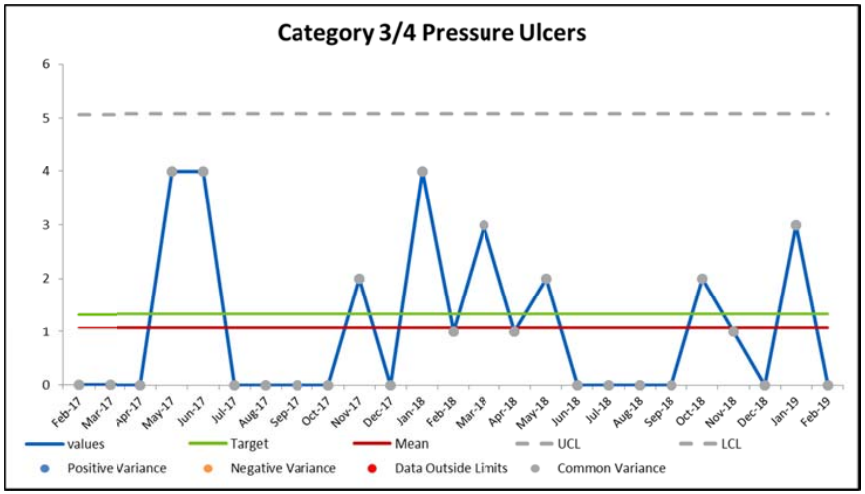
2.2.1 Category 2 Pressure Ulcers

No category 2 avoidable pressure ulcers were reported in February with the cumulative total for this financial year to the end of February being 15. The trust is on target of achieving the agreed trajectory of a 10% reduction in avoidable harms on the previous year of 18, reaching a 17% reduction in avoidable harm for the financial year to date.



2.2.2 Category 3, 4 or Ungradable Pressure Ulcers

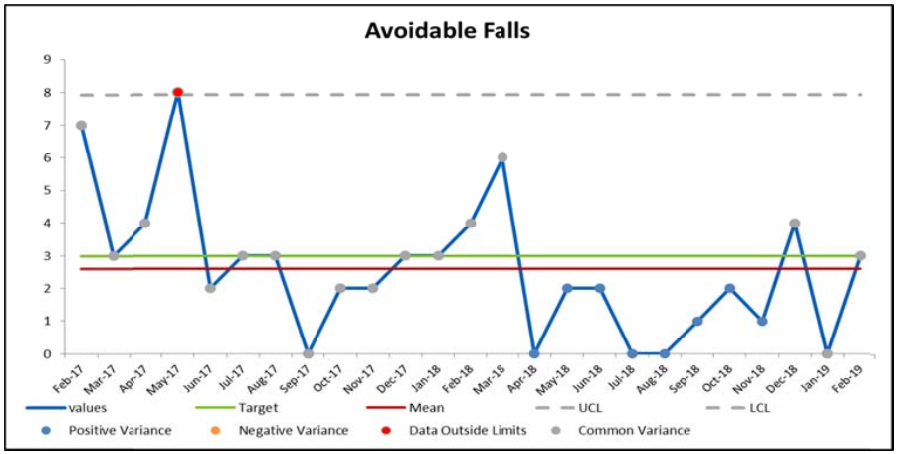
The number of avoidable serious harms acquired in our care to the end of February is 9. The trust is on target to achieve the agreed trajectory of 10% reduction in avoidable harms, reaching a 50% reduction for the financial year to date.



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.

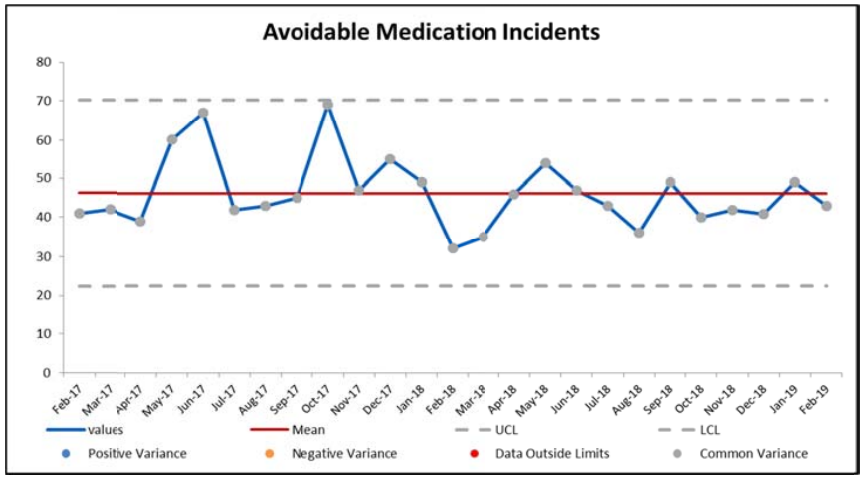
2.3 Assurance on Falls

There were 57 falls reported across KCHFT in February 2019, three of these were found to be avoidable all resulting in no harm to the patient, occurring at Hawkhurst, Whitstable & Tankerton and Deal Community Hospitals. The number of avoidable falls has reduced since Q1 (May 2017) and remain consistently low with a slight rise in December.



2.4 Assurance on Medication incidents

A total of 43 avoidable medication incidents, acquired in our care, have been reported and investigated to date during February 2019. Avoidable medication incidents continue to reduce.

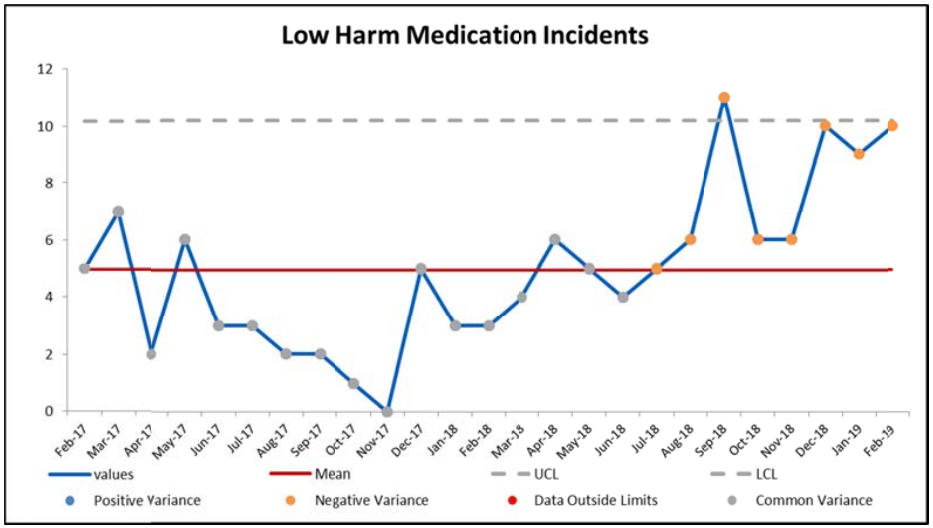


The highest reported category of avoidable incidents was omitted medication making up 51% of the total number during February 2019. The second highest reported category of avoidable incidents was wrong quantity making up 12% of the total number during February 2019.

Of the 43 avoidable incidents that occurred during February 2019:

- 33 (77%) resulted in no harm to the patient with the majority of these being omitted medication.
- 10 (23%) resulted in low harm to the patient with the majority of these being omitted medication.

These related to 2 separate patient's requiring insulin not being added to a visit list; a pain relieving medication patch was not changed during a weekly visit and a prison patient had run out of medication due to the patient's account being closed in error. All incidents were investigated and the lessons learnt have been shared.



The number of low harm incidents during the last 3 months is noted to be marginally under the upper control limit. On reviewing the incidents, these mainly related to missed insulin due to visits not being added to visit lists and incorrect amounts of insulin administered identified as the cause. There were no incidents that resulted in severe harm or death of a patient.

2.5 Assurance on Patient Experience

2.5.1 Meridian Patient Experience survey results

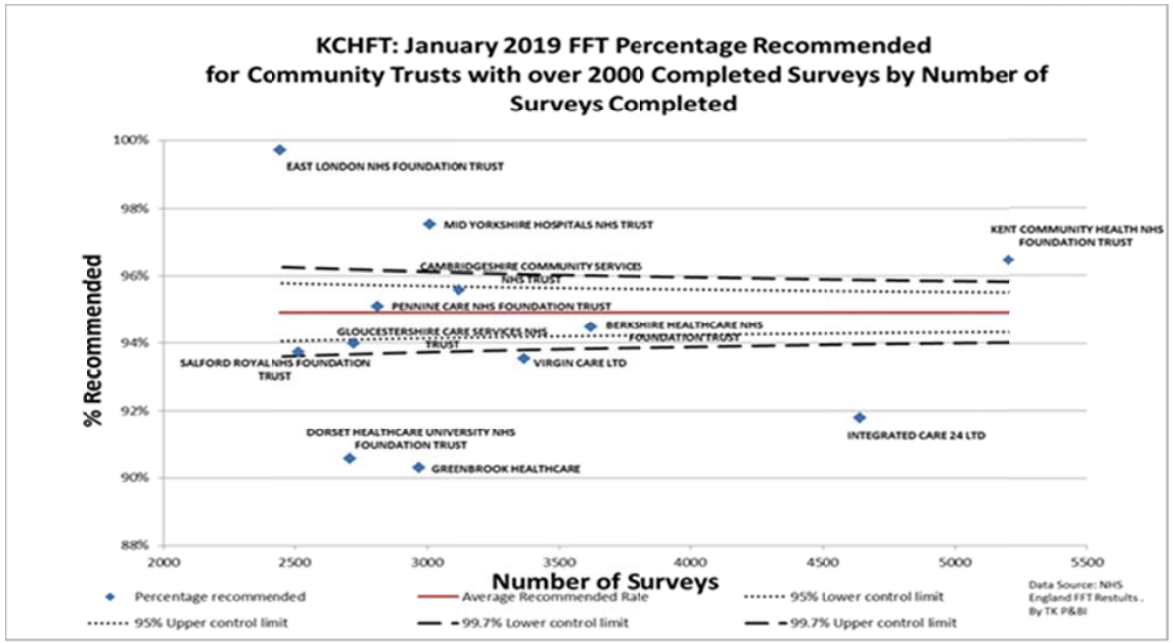
5,385 surveys were completed by KCHFT patients, relatives and carers with a strong combined satisfaction score of 97.3% in February. Survey volumes have slightly decreased in February (5,385) when compared with January (5,623). This is in line with the general trend seen over recent years following the increase in completed surveys in January, possibly as a result of a backlog of data inputting for paper surveys from the Christmas period. The difference between January and February of 238 completed surveys is spread widely across the services and not as a result of any service in particular.

2.5.2 The NHS Friends and Family Test (FFT)

The NHS Friends and Family Test score for February of 97.2% recommend is slightly higher than January's score (96.5%). In February, 0.4% of our patients chose not to recommend the service they received, compared with 0.6% in January. 37 people chose the 'don't know' response in February compared to 59 in January. 16 of the 'don't know' responses were from children and there were 5 for the dental service. The remaining 16 were for a variety of services.

Currently most of the trusts we compare ourselves against complete far fewer surveys and it seems that those with fewer surveys often have higher recommended rates. The funnel chart below looks at all community trusts (or private community health providers) with over

2000 surveys for the month of January 2019. Out of these KCHFT has the third best FFT score. The spread between the best scores and the worst means that only 5 fall within the control lines with 3 performing better and 4 worse than you might expect per number of surveys conducted.



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. The target for February was achieved.

KPI Actions Target %	April >35%	May >35%	June >55%	July >55%	Aug >75%	Sept >80%	Oct >80%	Nov >85%	Dec >85%	Jan >90%	Feb >95%
Due audit implemented - KPI 4.6 Target April >35%	43%	59%	58%	69%	78%	78%	86%	90%	86%	89%	96%
Actions overdue by than 3 months - KPI 36 Target <=10%	0%	1%	6%	5%	10%	11%	5%	4%	1%	1%	0%
Actions overdue by than 6 months - KPI 37 Target <=5%	2%	4%	2%	2%	0%	0%	0%	0%	0%	3%	1%

2.6.2 Clinical Audit Reporting

This relates to receiving the full report within a specified timeframe after receipt of dashboard reporting. Stepped target introduced for reporting and target for end of year increased from 50% to 80% following ongoing improvement in performance. At the beginning of April 2018 only 55% of final reports were received within the timeframe stipulated by their assurance level (see below for timeframes). By end of February 2019 this had risen to 80% representing achievement of target.

KPI Target 80%	April 50%	May 50%	June 60%	July 60%	Aug. 70%	Sept. 70%	Oct. 80%	Nov. 80%	Dec. 80%	Jan. 80%	Feb. 80%
Receipt of full report within specified timeframe	55%	62%	67%	68%	74%	79%	82%	87%	77%	77%	80%

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	Quarter 3	Quarter 4	Achieved
Recruitment to portfolio studies	74	155	252	282	Yes

2.6.4 National Institute for Clinical Excellence (NICE)

Priority for the last year has been to reduce the backlog of assessed NICE Guidance pre 2018 and there are 0 guidelines and quality standards that have not been assessed. This has been achieved through a NICE QI project and the formation of a NICE Task and Finish Group which reports quarterly to CEG.

In terms of recent NICE guidance/standards 14 were issued in February 2019. 3 of these were deemed applicable to at least one service throughout the Trust. The aim internally is to have the initial review completed by 1 June 2019 giving the nominated lead 3 months to complete the baseline assessment for each piece of guidance – this is not a statutory timeframe. 19 (out of 184 issued) pieces of NICE Guidance from January 2018- November 2018 have been under review for more than 3 months. This is being monitored by CEG and the NICE Task and Finish Group.

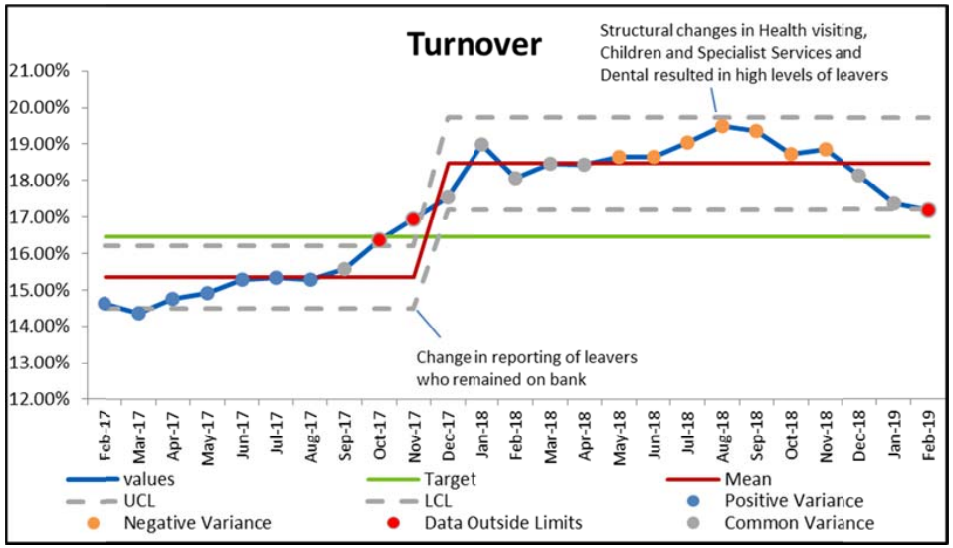
Statutory timeframe of 90 days is only in place for Technology Appraisals (TA). Reviews for TAs are completed by Medicines Management within timeframe.

3.0 Workforce Report:

3.1 Assurance on Retention

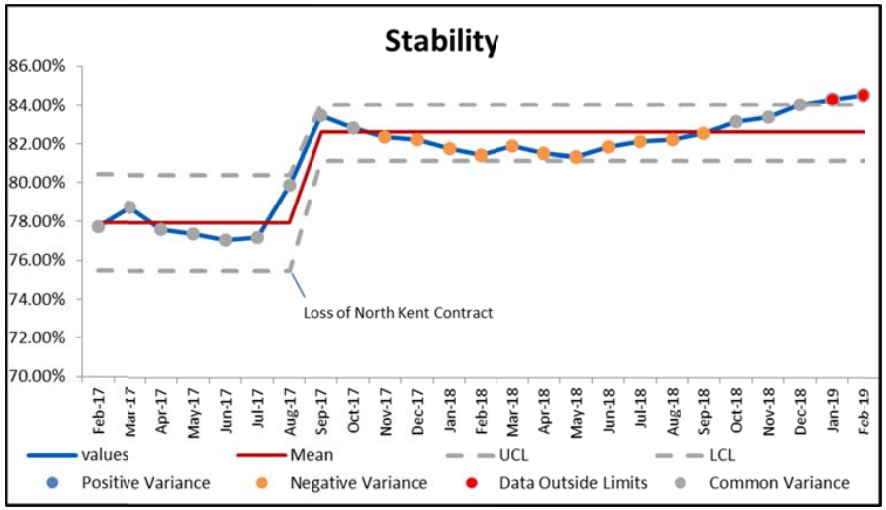
3.1.1 Turnover

Turnover is experiencing common cause variation but is failing to meet the target. However, the downward trend in turnover continues as the outputs of the BIG Listen are implemented. Our staff survey results and in particular our scores for staff engagement are a further indication that the work to target turnover is beginning to have an impact.



3.1.2 Stability

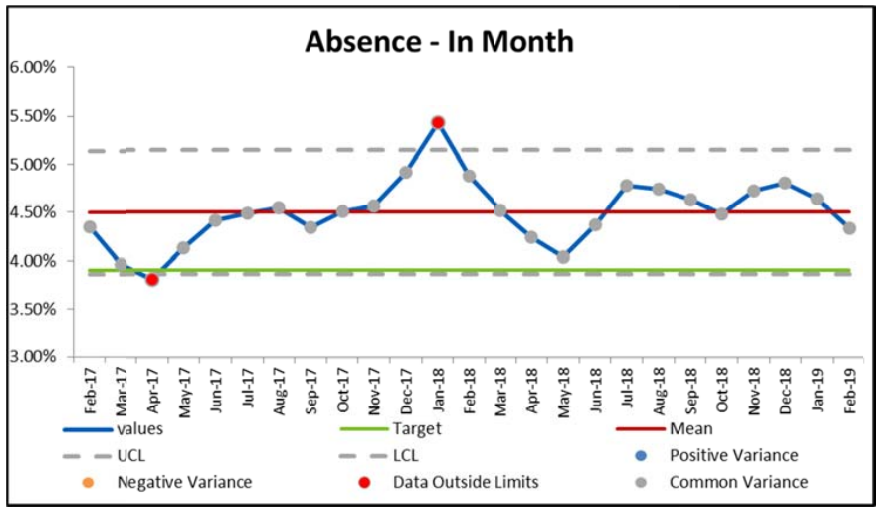
Stability continues to perform above the mean and upper control limit, indicating a strong period of performance. It is recommended that a target be set at 85%.



3.2 Assurance on Sickness

3.2.1 Sickness Absence

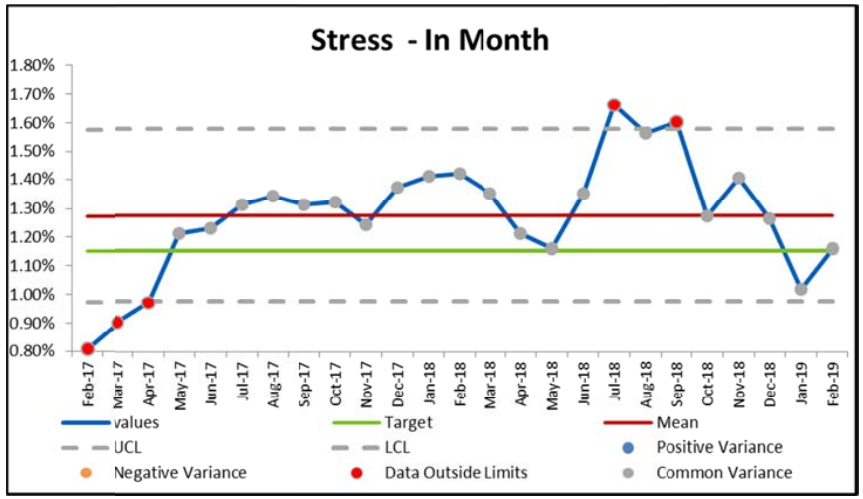
The sickness absence performance is currently operating within the control limits but as the Trust target is set at the lower control limit the likelihood of the target being met is subject to random variation. This means that either the target should be reconsidered or the system needs to be redesigned. In a separate paper to the Committee it is recommended that the target is revised to 4.5% from 3.9%.



3.2.2 Stress Absence

Recent figures show a short term improvement in performance over the winter of 2018 as impetus from the Trust's initiatives around stress take effect. However, this improvement has not yet been long-standing enough to demonstrate a long term change in this area momentum in this area needs to be maintained across the Trust.

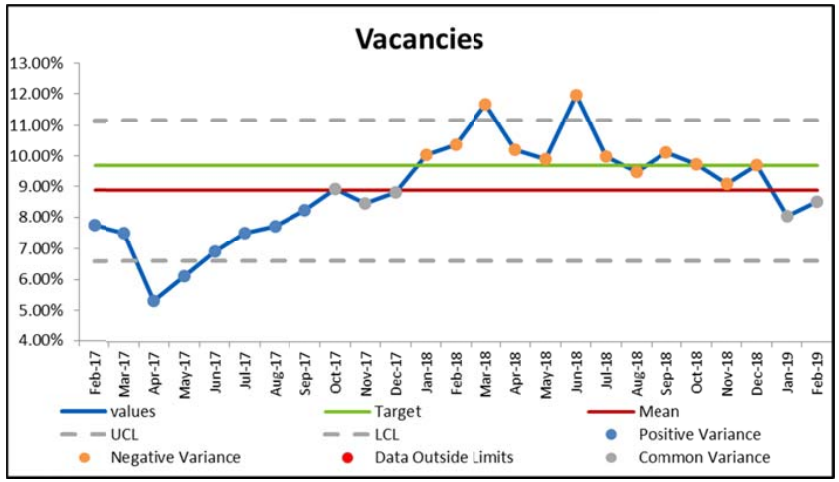
Initiatives in place include the Time to Change project, which continues at pace with local action plans being developed within services in January. Our anti-bullying campaign also continues across the Trust.



3.3 Assurance on Filling Vacancies

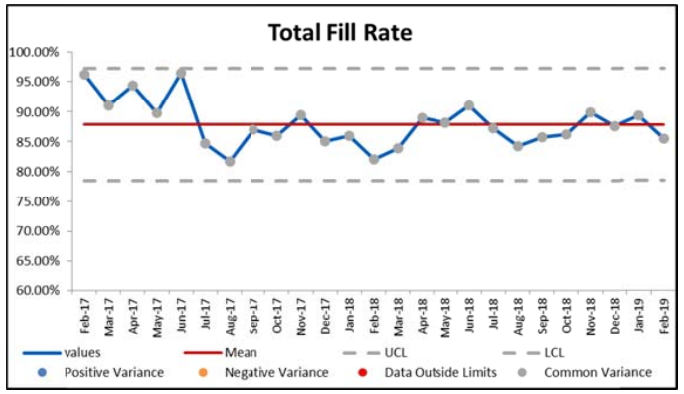
3.3.1 Establishment and Vacancies

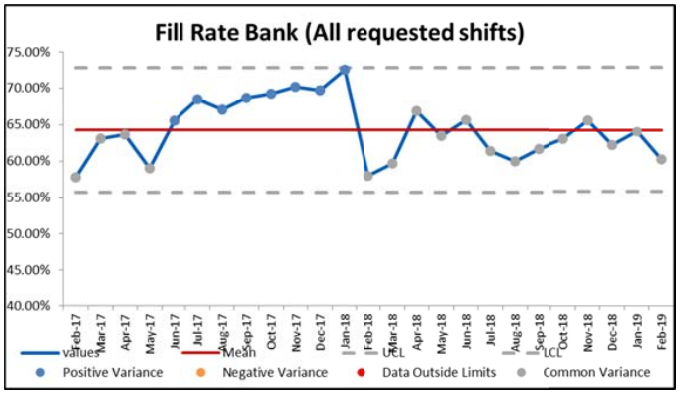
Vacancies have been below the mean for the last 2 months as well as below the target. January saw a significant drop in the vacancy rate, whilst in February it has increased slightly. However recruitment activity remains high with targeted campaigns in East Kent. January saw over 43% of all recruitment activity taking place in East Kent adults and Public Health.



3.3.2 Temporary Staff Usage

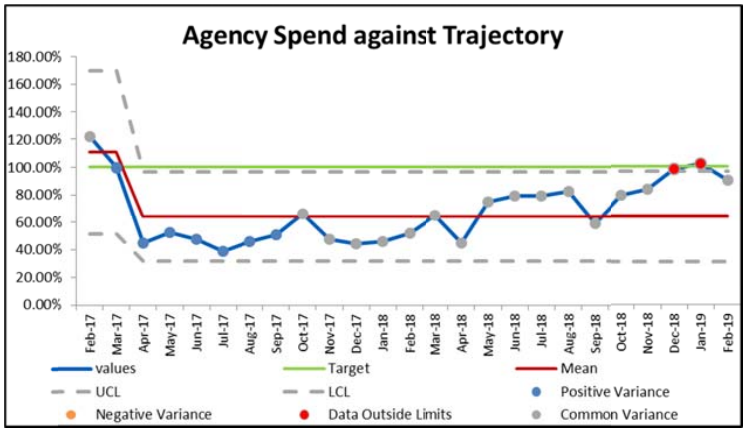
There is no target set for the Bank fill rate although locally the team are set a 70% bank fill rate of the total filled shifts. The bank fill rate for all filled shifts is meeting this target for the first time this month. The figure above reports the bank fill rate for all requested shifts which is a lower figure.





3.3.3 Agency Spend

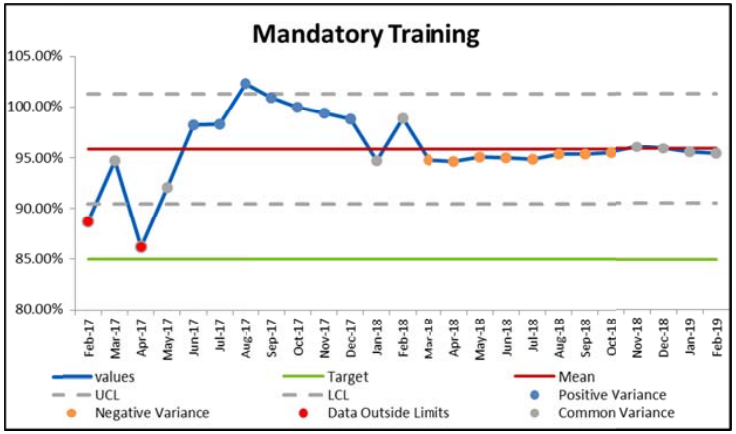
With the pressures in the system December and January saw increases in the use of agency staff which has seen a drop in February. It is worth noting that this winter has not seen the peaks reached last winter.



3.4 Assurance on Training Compliance

3.4.1 Mandatory Training Compliance

Mandatory Training figures are currently in a state of natural variation around the mean, and are consistently above the target. We have just started end of year appraisals and the Management Committee has agreed a closing date for this to happen by the end of April to allow time for the audits to take place prior to the Talent Boards in July/August.



4.0 Finance Report:

4.1 Assurance on Financial Sustainability

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	4,664	2,800	1,864
Year End Forecast £k	5,000	3,128	1,872

The Trust achieved a surplus of £4,664k to the end of February.

Pay has underspent by £9,486k, and non-pay and depreciation/interest have overspent by £825k and £73k respectively.
Income has under-recovered by £6,725k.

The forecast is to deliver a surplus of £5 million which is £1,872k ahead of the plan for the year.

Use of Resource Rating — Rag rating: Green

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

The Trust has scored the maximum '1' rating against the Use of Resource rating metrics for M11 2018-19.

CIP — Rag rating: Amber

	Actual	Plan	Variance
Year to Date £k	3,536	3,757	-221
Year End Forecast £k	4,080	4,080	0

The Trust achieved CIPs of £3,536k to the end of February against a plan of £3,757k, which is £221k behind target.
94.1% of the total annual CIP target has been removed from budgets at month eleven.

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

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	33,936	29,341	4,595
Year End Forecast £k		29,635	

Cash and Cash Equivalents as at M11 close stands at £33,936k, equivalent to 59 days operating expenditure.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	2,812	3,306	494
Year End Forecast £k	3,761	3,485	-276

Capital Expenditure year to date is £2,812k, representing 85% of the YTD plan.
The Trust's forecast capital expenditure for 2018-19 is £3.8m, representing a £276k variance to plan. The forecast overspend of £276k relates to investment in WiFi and Pharmacy infrastructure for which additional central funding (PDC) has been received.

Agency Trajectories — Rag rating: Green

	M11			YTD		
	Actual £	Trajectory £	Variance £	Actual £	Trajectory £	Variance £
External Agency Expenditure (inc. Locums) £k	427	627	200	4,595	6,906	2,311
Locum Expenditure £k	142	106	-36	1,071	1,169	98

External agency expenditure (inc. locums) was £427k against £627k trajectory in February.
(YTD £4,595k against £6,906k trajectory).
Locum expenditure in February was £142k against £106k trajectory.
(YTD £1,071k against £1,169k trajectory).

4.2 Key Messages

Surplus: The Trust achieved a surplus of £4,664k (2.3%) to the end of February. Cumulatively pay has underspent by £9,486k, and non-pay and depreciation/interest have overspent by £825k and £73k respectively. Income has under-recovered by £6,725k

Continuity of Services Risk Rating: EBITDA Margin achieved is 3.8%. The Trust scored 1 against the Use of Resources Rating, the best possible score.

CIP: The Trust achieved CIPs of £3,536k to the end of February against a plan of £3,757k, which is £221k behind target.

Cash and Cash Equivalents: The cash and cash equivalents balance was £33,936k, equivalent to 59 days expenditure. The Trust recorded the following YTD public sector payment statistics 99% for volume and 98% for value.

Capital: Spend to February was £2,812k, representing 85% of the YTD plan. The full year plan is £3.5m and the Trust expects to spend this plus £0.276m on wifi and pharmacy infrastructure for which additional central funding has been received.

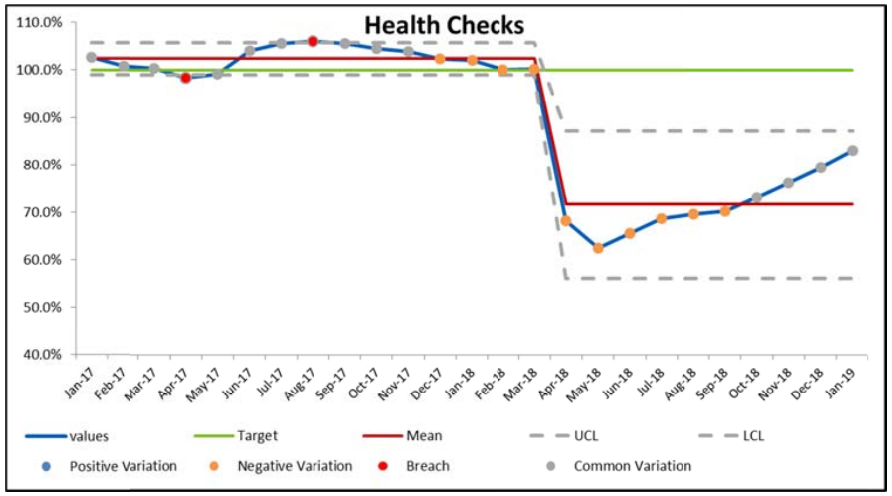
Agency: Temporary staff costs for February were £1,154k, representing **8.5%** of the pay bill. Of the temporary staffing usage in February, £285k related to external agency and £142k to locums, **3.2%** of the pay bill. There were gross vacancies of **372** WTE, an increase of 26 compared to January, and **8.5%** of the budgeted establishment.

5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits

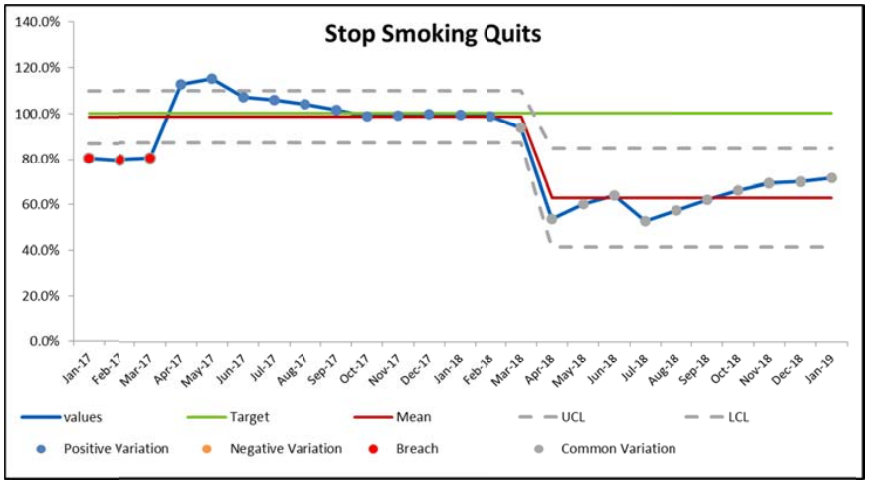
Health Checks



Health Checks is now experiencing a period of normal variation for the last 4 months, following a recalculation of the control limits due to the significant change when the NHS Health Checks IT infrastructure changed on the 1st April 2018 which is a new IT system procured by KCC. However, the trend looks to be a positive shift above the mean. KCC was aware of this issues 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 is on the Health Improvement risk register also. The change to monthly queries has improved the quality of data imported and resolved most of the invitation errors that were reported. The target trajectory has been amended in line with 'amber' figures, although KCHFT are continuing to explore other opportunities for Health Check delivery in an effort to maintain and improve performance as much as possible.

Stop Smoking Quits

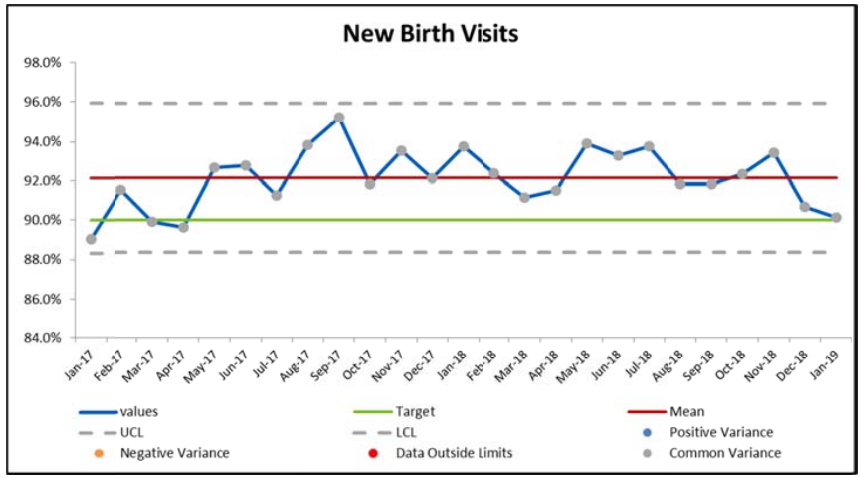


Stop Smoking quits also had a significant event after the ONE YOU Services had implemented a new IT system combining three client pathways into one as per the new contractual agreement with KCC, mainly impacting the ability of our 3rd parties to upload their intervention outcomes onto the new data system. Q3 shows an uplift from Q1 and Q2 as 3rd parties have received focused and sustained support to update outcomes pulling us in line with 2017 performance (Nov 18 - 43.58% of target, Nov 17 - 45.68% of target) which is encouraging. Smoking prevalence continues to move in a downwards trend, and with the successful outcomes of the Home Visits for pregnant mums, KCC and KCHFT will be meeting to discuss new approaches to engaging the county's toughest and hardest to reach smokers.

5.1.2 Health Visiting

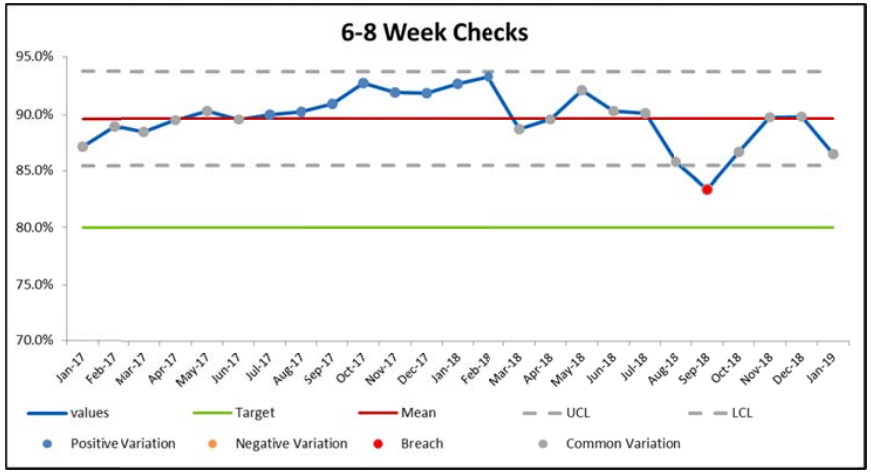
New Birth Visits

Performance has seen a slight dip for the last two months, although the month 9 and 10 level is likely to improve following a data cleanse (which has been delayed due to data availability issues from CIS). Otherwise this KPI is experiencing normal variation. The target of 90% has been consistently achieved and is closely monitored through the monthly district level reports.



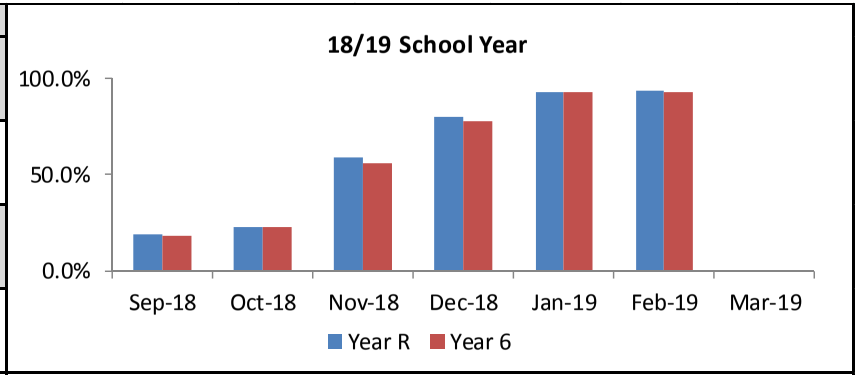
6-8 Week Checks

There was a dip in months 5-7, with month 6 performing outside of the control limits. However, performance has since improved and has stabilised, with the target being consistently achieved. Month 10 has dipped slightly but is expected to improve following a data cleanse. Monthly processes continue to be in place for localities to drill down into any adverse trends.



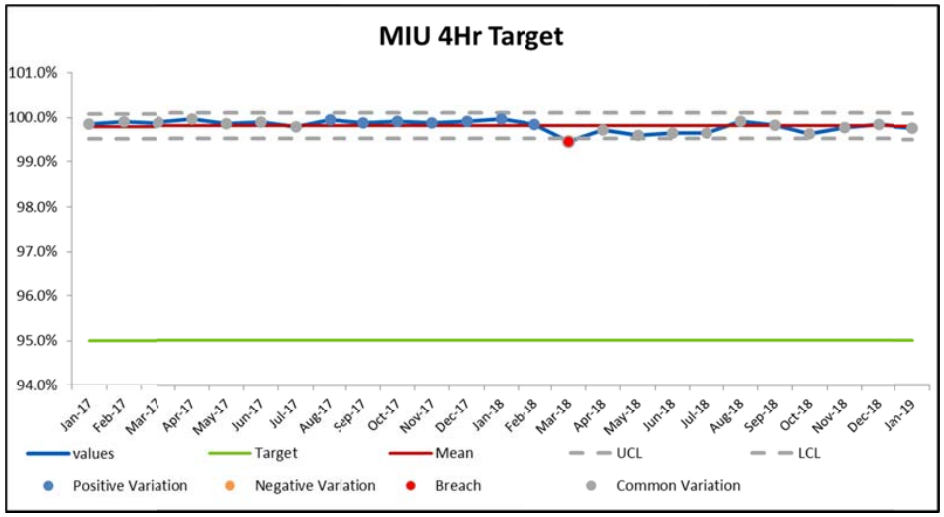
5.1.3 National Child Measurement Programme (NCMP)

	Year R	Year 6
Current Month	**94.0%**	**93.0%**
18/19 School Year to Feb-19	**94.0%**	**93.0%**
17/18 School Year	**97.3%**	**95.7%**
Annual Target	**90%**	**90%**



The measurement programme for Year R and 6 pupils has met the trajectory for the 18/19 school year, with both programmes achieving the 90% target for the school year

5.1.4 Minor Injury Units (MIU) 4 Hour Wait Target

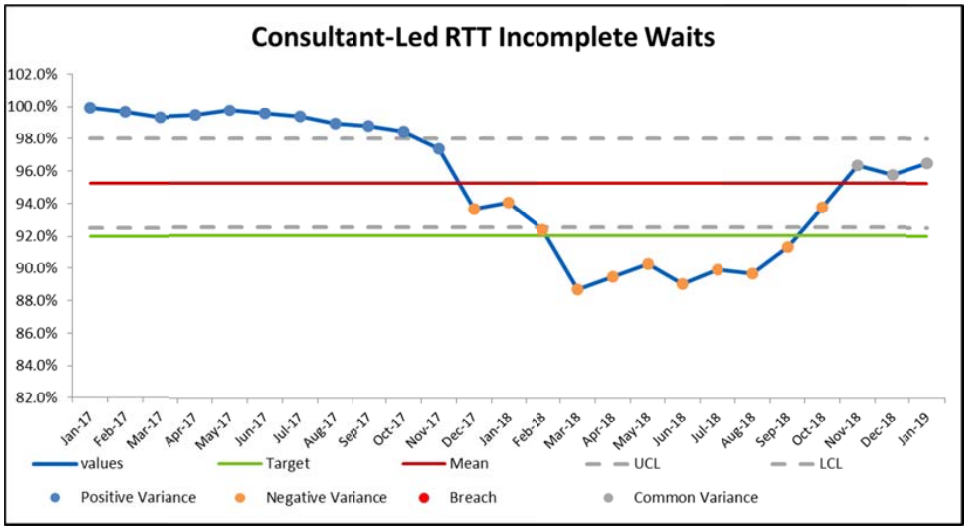


KCHFT's achievement of the 4 hour wait target for Minor Injuries Units has consistently been high, with very little variation from the mean. Although there was a small decrease in March 2018 which resulted in marginally breaching the lower control limit, this was still significantly above target for the month. Indeed, the control range suggests that failing target is highly unlikely to happen.

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

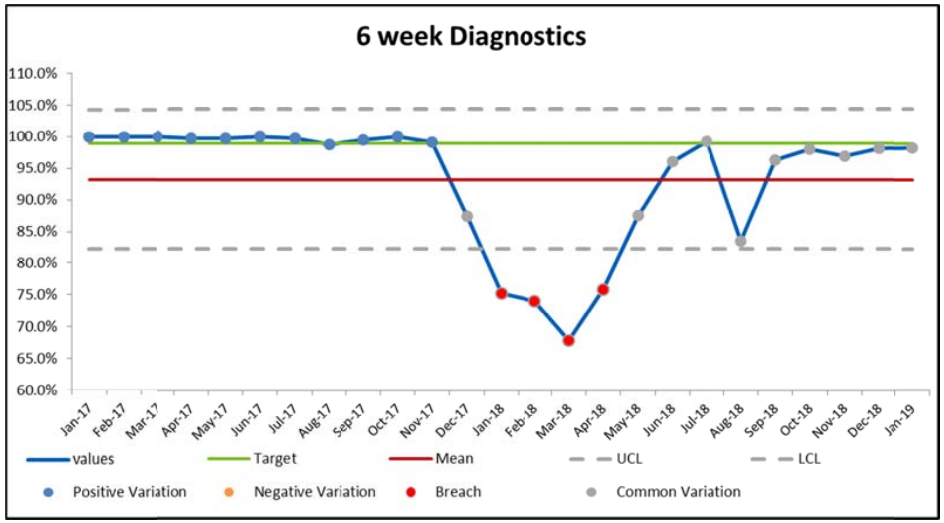


The proportion of patients on a consultant-led Referral to Treatment (RTT) pathway at month end who are waiting less than 18 weeks worsened between August 2017 and March 2018 and then stabilised. However, the position has greatly improved in the last 3 months, with the result being that the target has been achieved and performance has improved above the mean.

	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	709	78	33	0	0	96.0%
Orthopaedics	2896	406	146	0	0	95.8%
Children's Audiology	352	0	0	0	0	100.0%
Community Paediatrics	591	122	7	0	0	99.0%
KCHFT Total	4548	606	186	0	0	96.5%

The above table shows the current breakdown of the waiting list for all services on a consultant-led pathway. 96.5% of waits are now below 18 weeks, with no waits above 36 weeks. The average wait for patients waiting over 18 weeks is 21.3 weeks.

5.1.7 6 Week Diagnostics (Audiology)



While 6 week diagnostics waits for paediatric audiology experienced a period of adverse variation from January 2018 to April 2018, performance has improved in recent months and is experience normal variation. However, recent performance is generally marginally below the challenging 99% target within 6 weeks (1% over 6 weeks as per NHSI Single Oversight Framework standard).

The 1% standard is challenging for the trust to achieve given the small volumes of patients the standard relates to and therefore the impact of singular patients to the achievement. Average waiting numbers at month end are 430, therefore it only requires 5 patients to be breaching the standard on average for the standard to not be met (often caused by patient DNAs).

The Audiology service is a small team of 12.68 WTE which currently has 11.8% of clinical staff on maternity leave and 21% on term time only contracts. This will be impacting the March and April capacity, however the service are working with the team to identify more short term measures to increase capacity

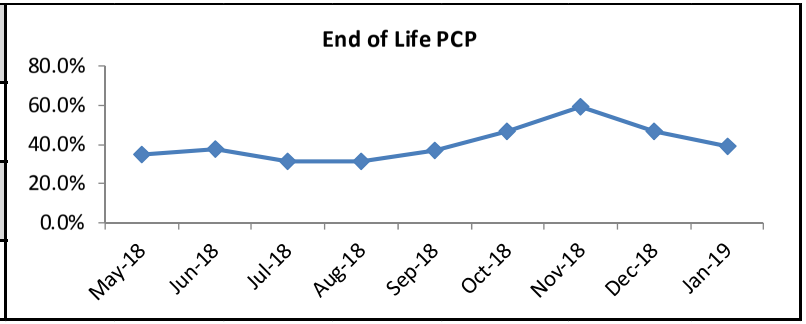
To make further strides to achieving the standard regularly, the Audiology service are implementing a tracking process to forecast and prevent breaches by taking earlier action. Additionally, the service are recruiting additional staff to cover maternity leave.

As a consequence of continual breaches of the 1% standard, KCHFT have been moved into segment 2 of the NHSI Single Oversight Framework (receiving targeted support)

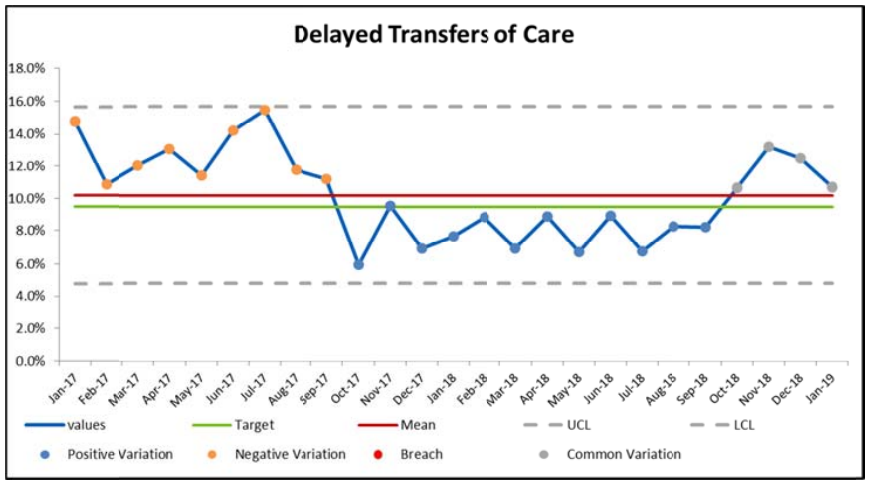
5.1.8 End of Life Care

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 38.2%, the personalised care planning window on CIS is being monitored at a locality level and performance is generally improving. The target for this year has been set at 60%

Current Month	**39.1%**
18/19 YTD	**38.2%**
17/18	**N/A**
Annual Target	**60.0%**

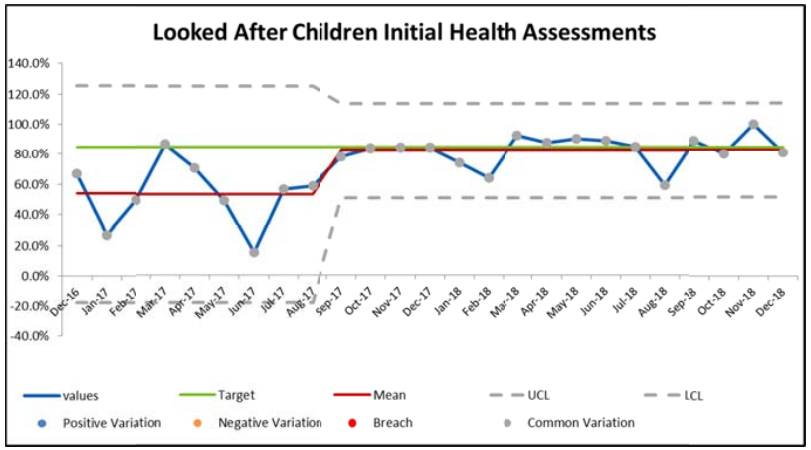


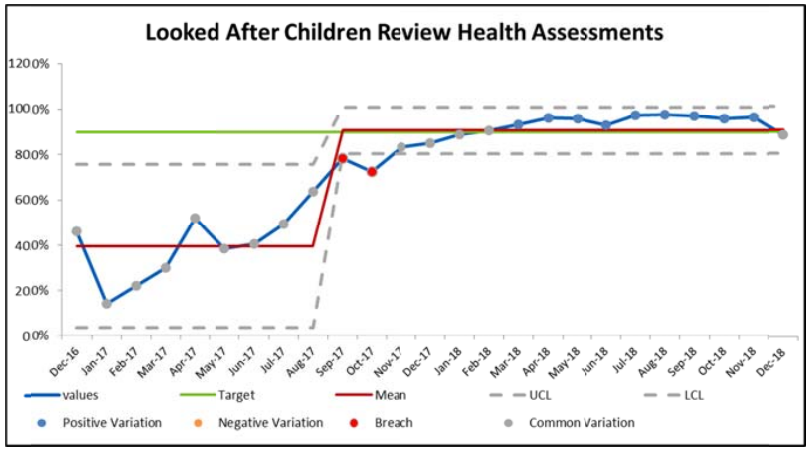
5.1.9 Delayed Transfers of Care (DTOCs)



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. There was a sustained period of improved performance from October 2017 to September 2018, although this period has ended with the last 4 months above the mean. This has been caused by an increased level of delayed transfers in East Kent, although the position improved in month 10.

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





Initial Health Assessment (IHA) performance is showing normal variation and is achieving target most months. However, performance is still variable and liable to failing target some months (as in month 10). This is due to late requests being received from KCC and which KCHFT is struggling to influence. We have an additional KPI to ensure that we complete the IHA within 23 days of receipt of the referral which achieves target most months.

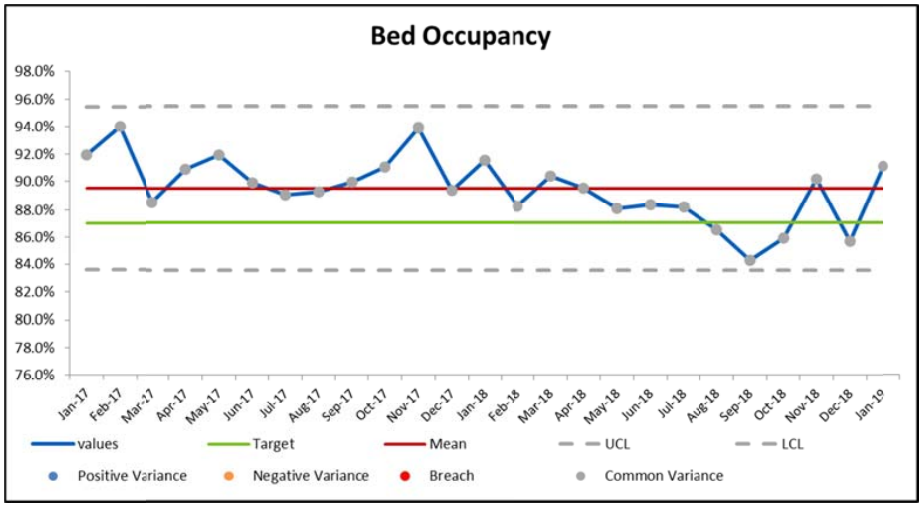
Compliance with the Review Health Assessment target was experience a period of positive variation above the mean and although has dipped this month this is not deemed a significant change asyet

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

Bed Occupancy is showing a varying trend with no periods of special cause variation or changes in performance that would be a particular concern. Although months 5-7 and 9 were below target and lower than the mean level of occupancy. This has highlighted that the dip in performance should not be of concern at this stage, especially with the improvement in the M10 position.



5.1.13 CQUIN

The Q3 CQUIN achievement (% of potential income) is at 100% (95.6% in Q2), with the YTD position at 97.7%. However, 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

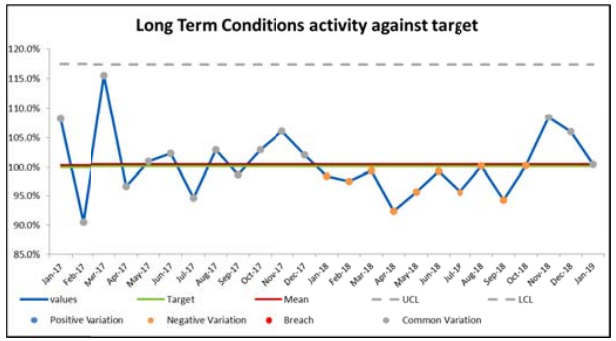
During January 2019 KCHFT carried out 187,873 clinical contacts, of which 10,220 were MIU attendances. For the year to January 2019 KCHFT are 2% below target for services that have contractual activity targets in place, a slight decline on the M9 position. The largest variances are within Intermediate Care Services (-10%) and Specialist and Elective Services (-6.4%).

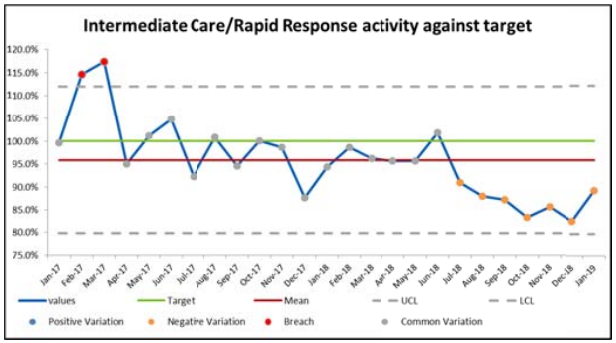
Service Type	M10 Actual	YTD Actual	YTD Target	YTD Variance	Movement	Internal BRAG	Contract BRG
Long Term Conditions	56,891	544,806	549,533	-0.9%	Positive		
Intermediate Care	19,975	195,080	216,744	-10.0%	Positive		
MIU Attendances	10,220	111,752	93,507	19.5%	Positive		
Community Hospital Admissions	220	1,935	1,517	27.6%	Positive		
Community Hospital Occupied Bed Days (WK)	2,236	20,747	21,627	-4.1%	Positive		
Community Hospital Occupied Bed Days (EK)	2,415	23,063			Positive		
Specialist and Elective Services	28,132	266,070	284,233	-6.4%	Positive		
Learning Disabilities - Face to Face	3,885	71,938			Positive		
*Children's Universal Services	37,437	720,821			Positive		
Children's Specialist Services	16,985	152,812	151,735	0.7%	Positive		
Dental Service - All currencies	9,477	99,621	102,254	-2.6%	Positive		
All Services (contractual)	**144,136**	**1,392,823**	**1,421,150**	**-2.0%**	Positive		
All Services (including those without targets)	**187,873**	**1,793,989**	**N/A**	**N/A**	Positive		

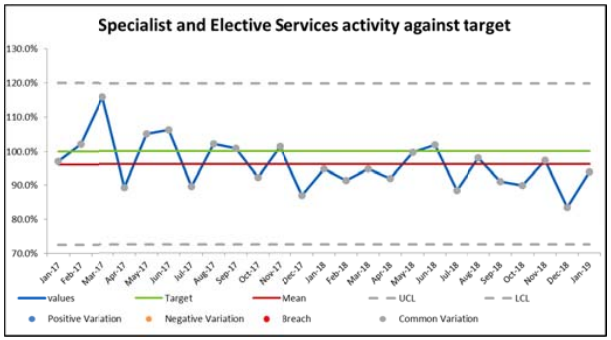
	Internal	Contract
	>+5%	>+10%
	>-5%	>-10%
	+/- 2.5-5%	n/a
	<+/- 2.5%	<+/- 10%
		No Target

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

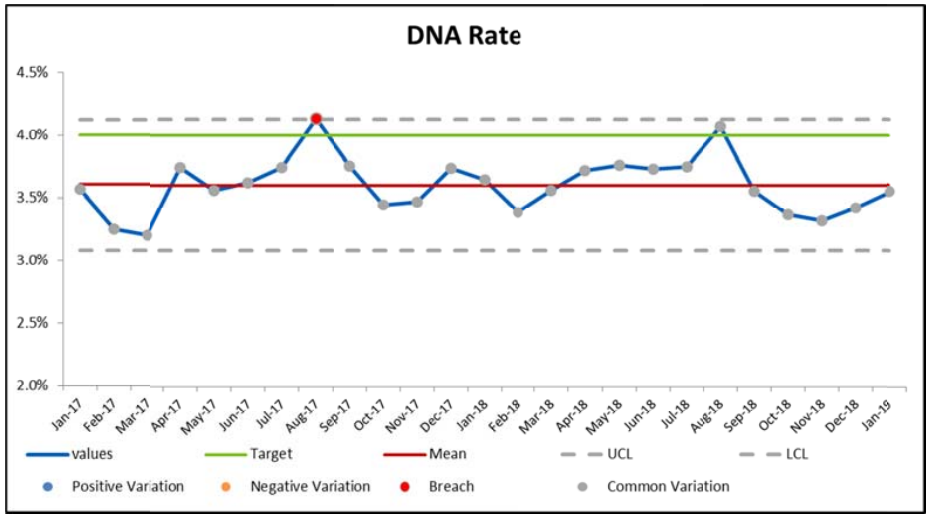
The following charts show the monthly activity against target for Long Term Conditions, Intermediate Care Services and Specialist and Elective Services, with both Specialist and Elective Services and ICT services showing an improvement in M10. Long Term Conditions and SES Services are both experiencing periods of normal variation; with the biggest concern is ICT/Rapid Response which has experienced lower than average levels in the last 7 months. One of the main reasons for this is due to the large variances experienced in Ashford and South Kent Coast. While there have been staffing shortages, there has been a reduction in activity in recent months due to the extended hours introduced in Long Term Conditions that has resulted in a portion of activity now been captured within that service rather than Rapids (hence the increase in LTC activity against plan). This is planned to be addressed through the activity plans for next year in East Kent





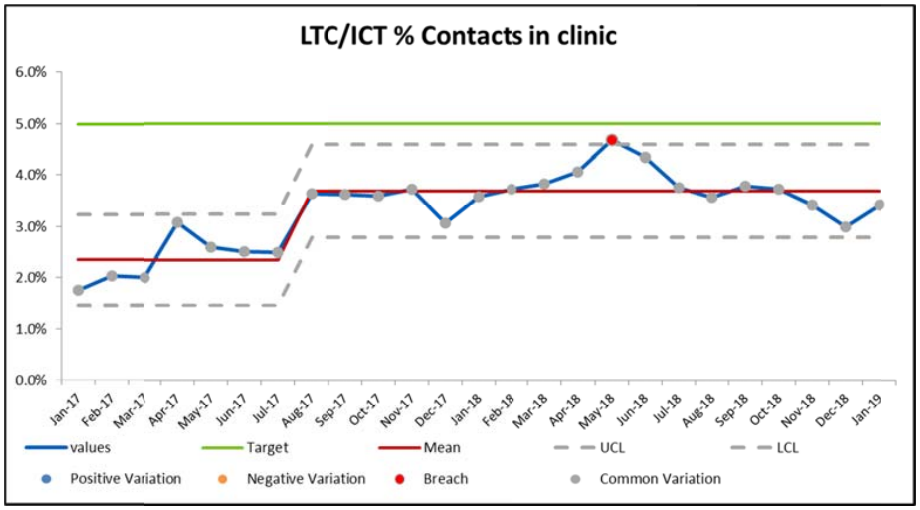


5.2.2 DNA rates



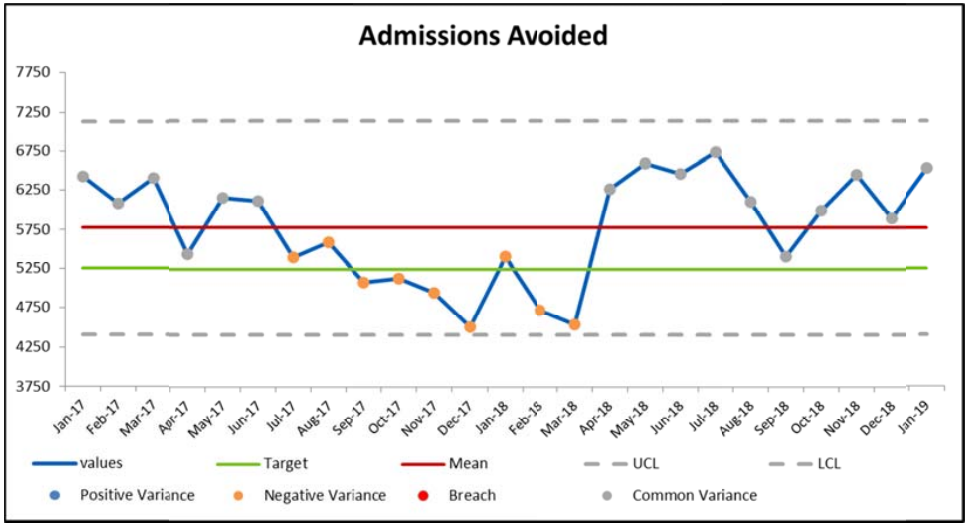
DNA rates continue to fall below the target of 5%, although are significantly higher within some services, particularly children's therapies. The general variation is normal, variably performing above and below the mean with no discernible pattern. However, with the target close to the upper control limit then this would indicate that it is unlikely that levels would increase above target.

5.2.3 Clinic based activity



The target for Long Term and ICT services is to increase clinic based activity to at least 5% of all activity carried out. While this has increased through initiatives such as the wound clinics, with the process limits recalculated form August 2017, we are currently unlikely to achieve this target without some form of process change or re-evaluating the target. The above chart shows that the current upper control limit is around 4.6% which would suggest reaching 5% is unachievable in the current environment, so will be looked at as part of the KPI review taking place for 2019/20 reporting

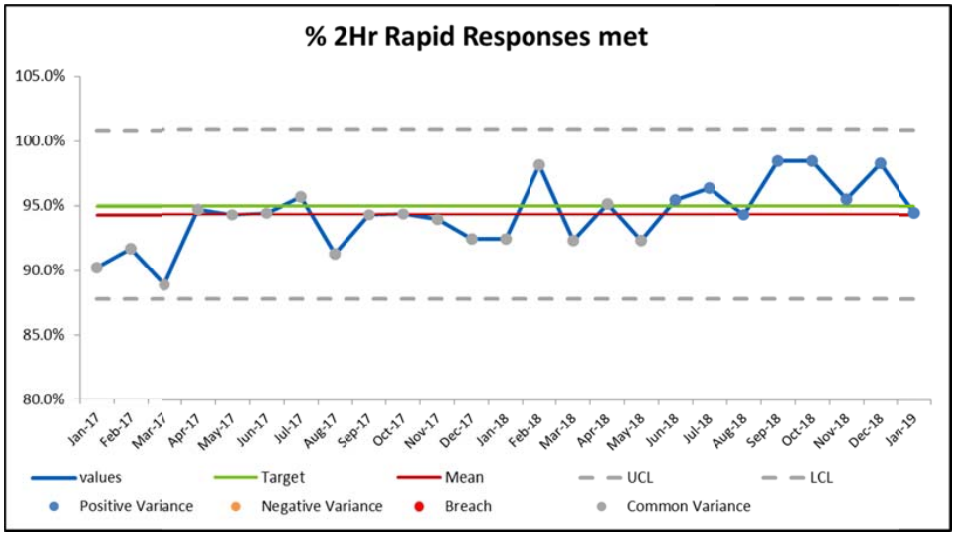
5.2.4 Admissions Avoided



There have been a higher level of admissions avoided in the last 10 months, although the above chart indicates that performance is still variable month to month. Year to date performance against target is favourable, although with performance being variable, achieving the target monthly is not always guaranteed.

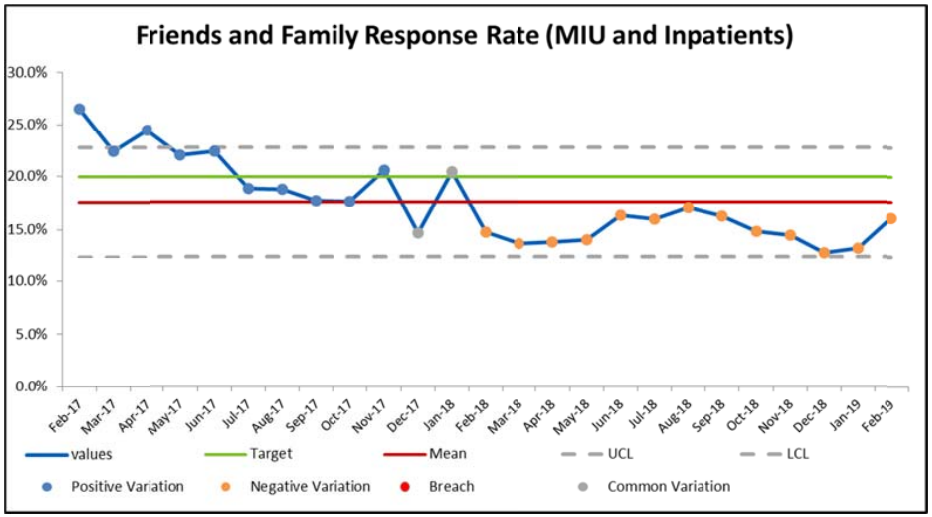
5.2.5 Rapid Response referrals seen within 2 hours

While the mean level of performance is currently sitting marginally below the target level of 95%, the last 8 months have shown a positive trend with a period of special cause variation above the mean. If this continues the mean should increase, although given the volatility and the high 95% target, it's unlikely the control limits will fully move above the target level in the near future to give full assurance of continual achievement.



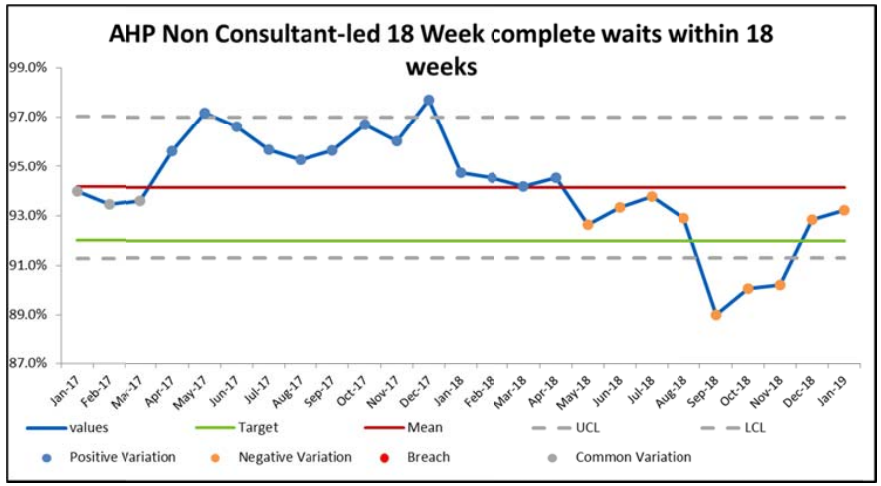
5.2.6 Friends and Family Test (Patients surveyed for MIUs & Community Hospitals) - Response Rate

While the level of performance has shown a long period of adverse variation with the last 13 months performing below the mean, there are signs of improvement with M11 experiencing an increased number of surveys. The decline has been evident across most MIU sites, most notably Sheppey, Sittingbourne and Sevenoaks. The head of service is looking into the reasons for this and will address to ensure surveys levels are increased.



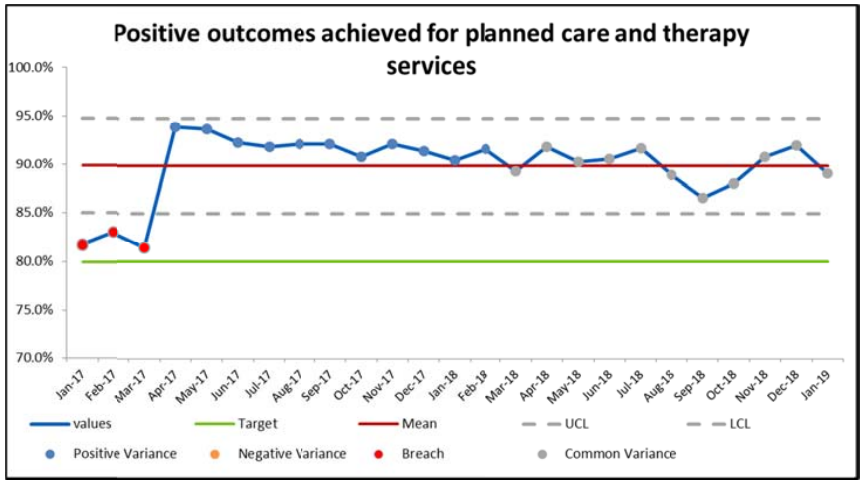
5.3 Assurance on Local Wait Times

Waiting times for all non consultant-led AHP services are still within a period of special cause variation with the last 9 months' performance being below the mean, although M10 has improved further on M9 above the target level of 92%. The previous dip was partially down to the clearing of the backlog in some services, with a view to reduced long waits on the waiting list, particularly within West Kent Block AQP Physiotherapy and as a result performance is now improving



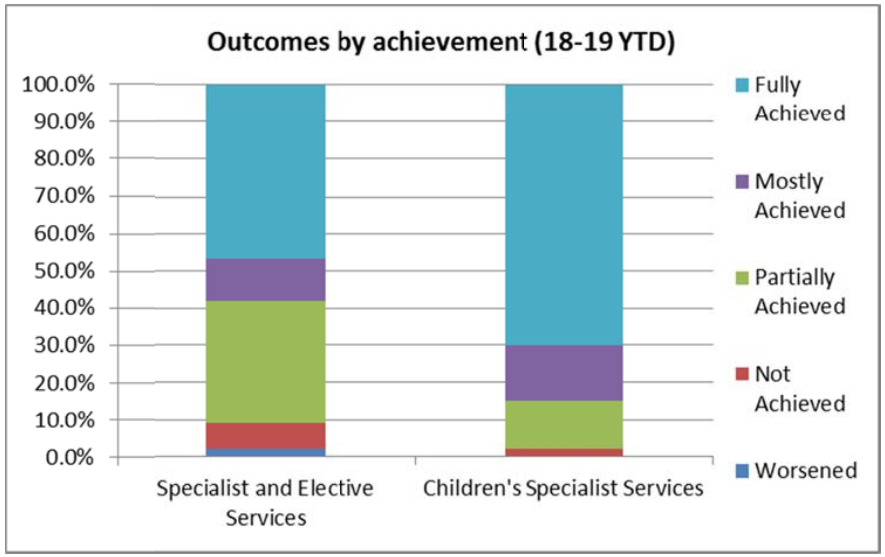
5.4 Outcomes

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, with the below showing no special cause variation in recent months. The below chart also shows that achievement of target is always likely to occur unless a process change occurs, as the control limits indicate the range of performance varying month to month should not fall low enough to breach target.



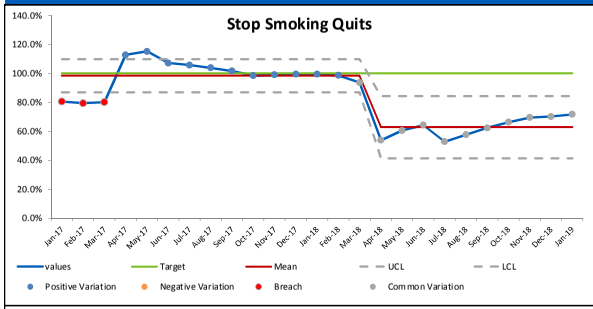
The following table and chart shows the proportion of the grading of each outcome for the year to date, split by service type for further detail on outcomes. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised.

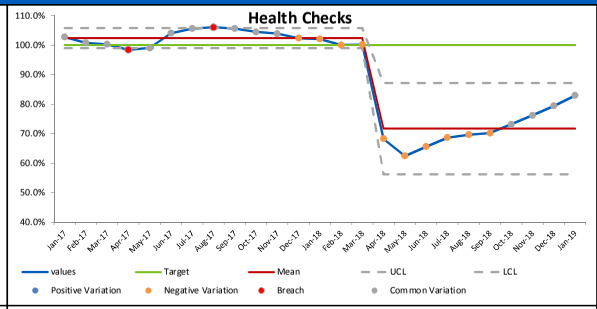
	Specialist and Elective Services	Children's Specialist Services
Worsened	2.1%	0.0%
Not Achieved	7.3%	2.3%
Partially Achieved	32.7%	13.1%
Mostly Achieved	11.0%	14.4%
Fully Achieved	46.9%	70.2%

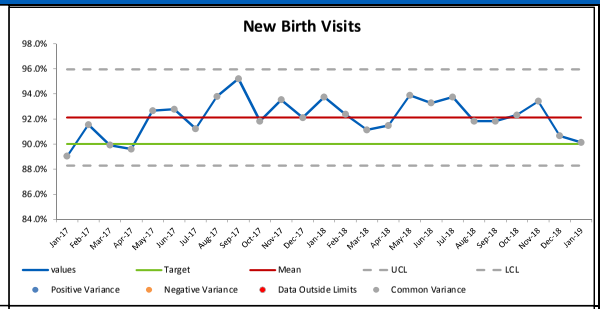


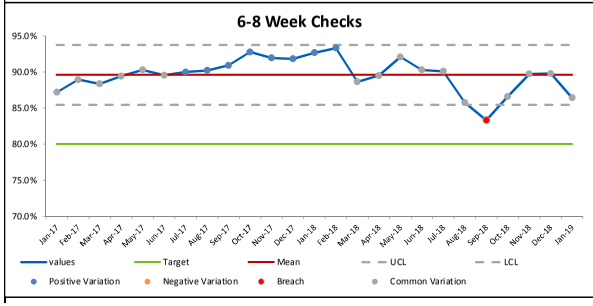
Appendix - Scorecard SPC Charts

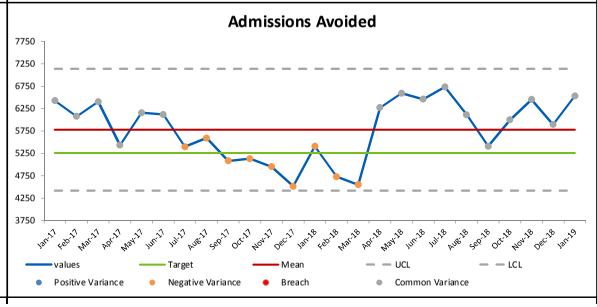
1. Prevent Ill Health

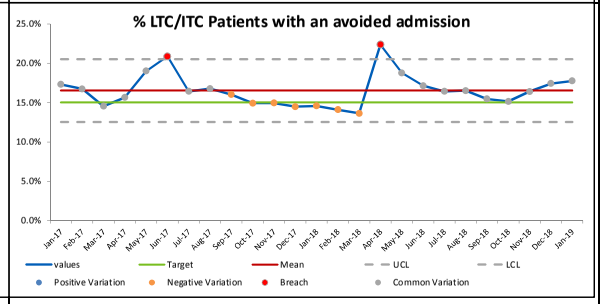






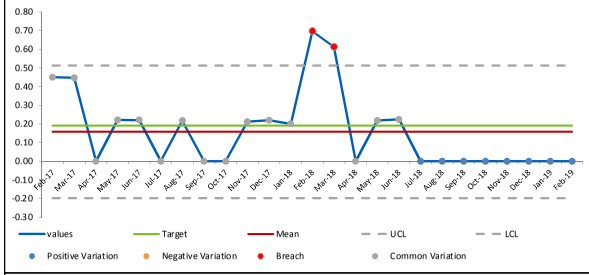




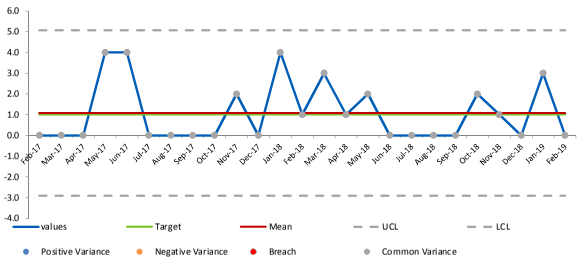


2. Deliver high-quality care at home and in the community

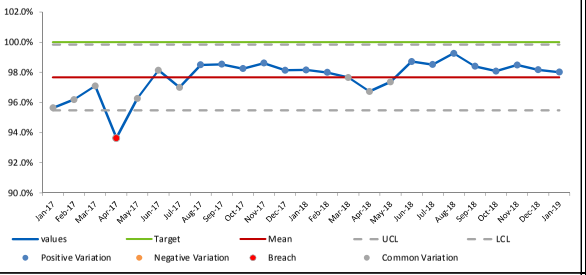
Moderate and Severe falls per 1,000 bed days



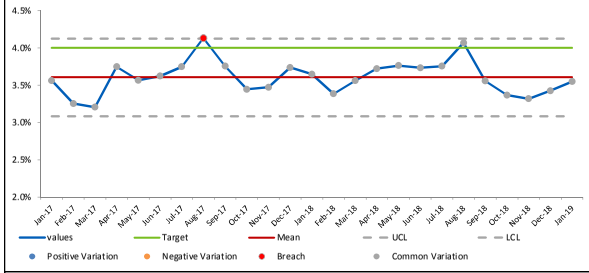
Category 3/4 Pressure Ulcers



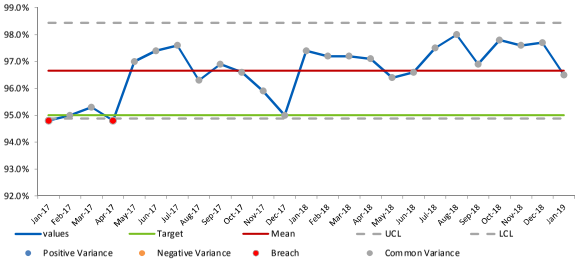
Contractual activity against target



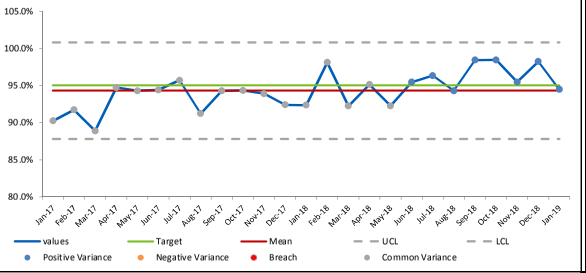
DNA Rate



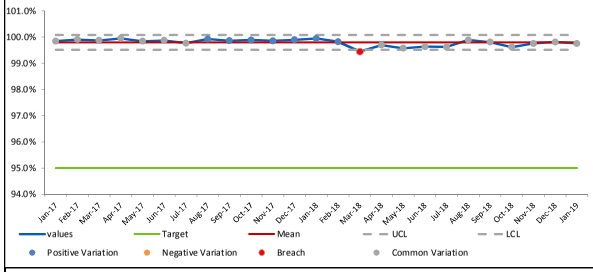
LTC/ICT Response Times Being Met



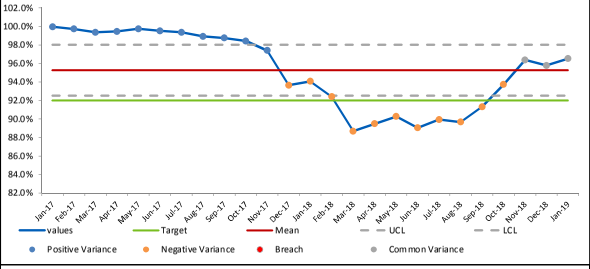
% 2Hr Rapid Responses met



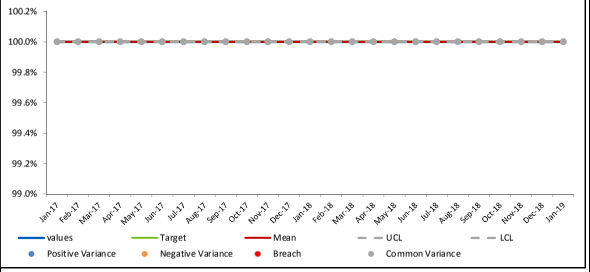
MIU 4Hr Target



Consultant-Led RTT Incomplete Waits

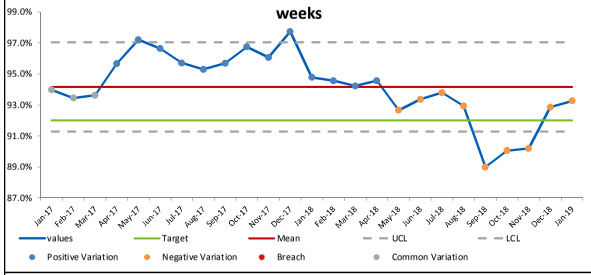


GUM Access within 48Hrs

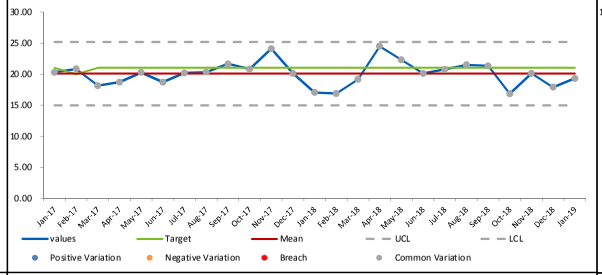


2. Deliver high-quality care at home and in the community

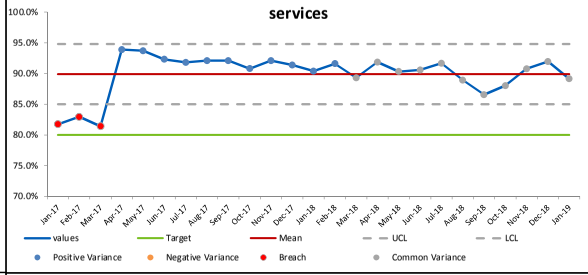
AHP Non Consultant-led 18 Week complete waits within 18 weeks



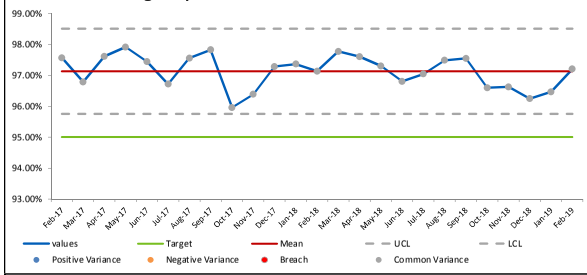
Median length of stay (days)



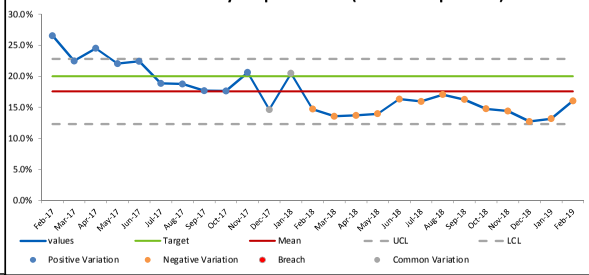
Positive outcomes achieved for planned care and therapy services



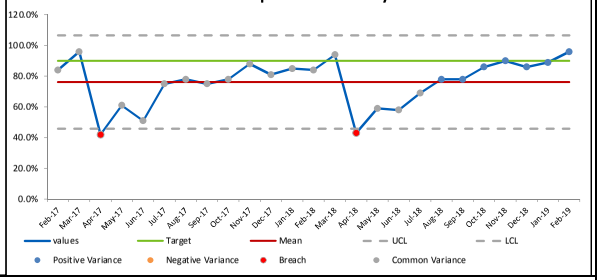
Percentage of patients who would recommend our services



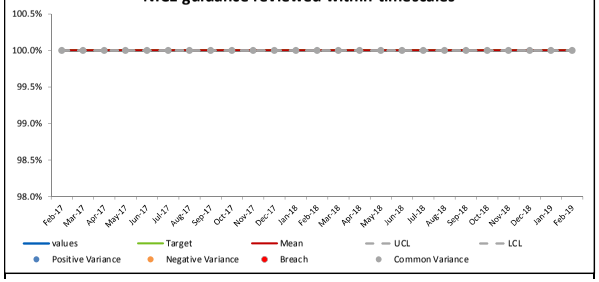
Friends and Family Response Rate (MIU and Inpatients)



Clinical Audit Implementations by deadline

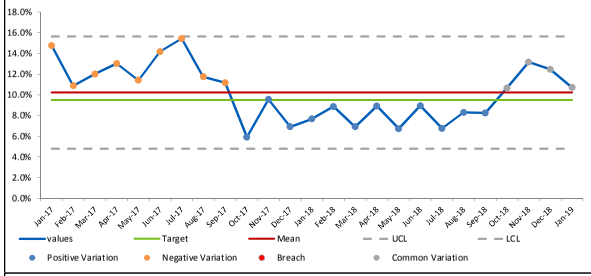


NICE guidance reviewed within timescales

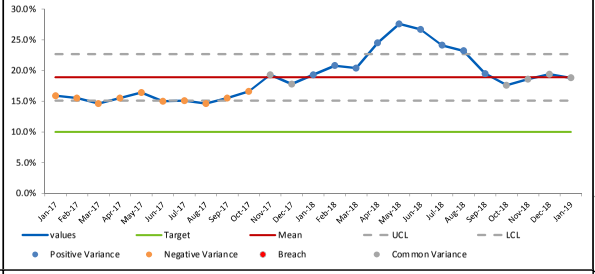


3. Integrate Services

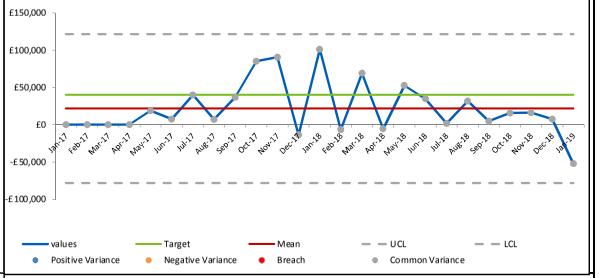
Delayed Transfers of Care



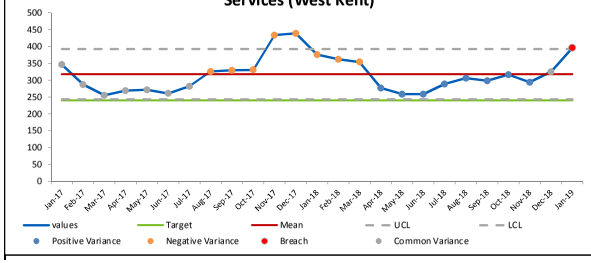
Percentage of ICT/LTC Referrals from within KCHFT



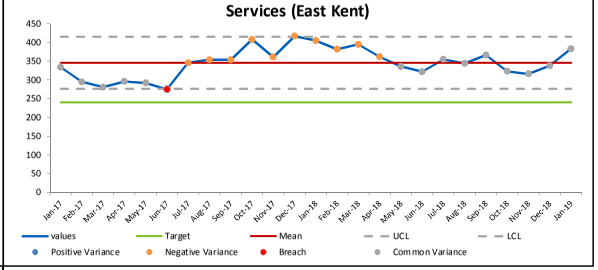
Home First saving - West Kent



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

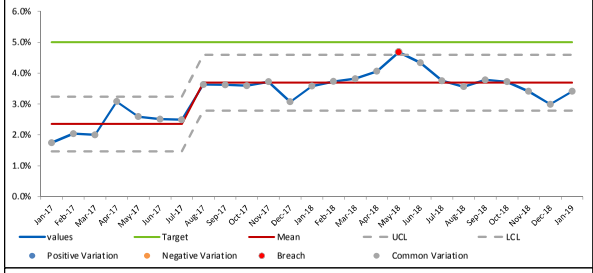


Average wait time (minutes) for Accident and Emergency Services (East Kent)

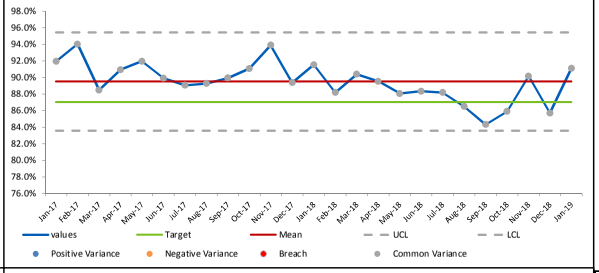


4. Develop sustainable services

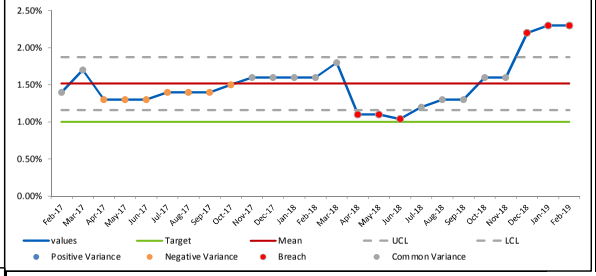
LTC/ICT % Contacts in clinic



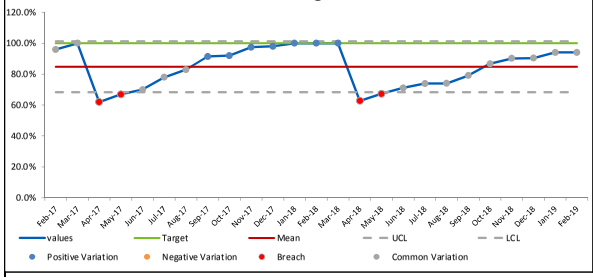
Bed Occupancy



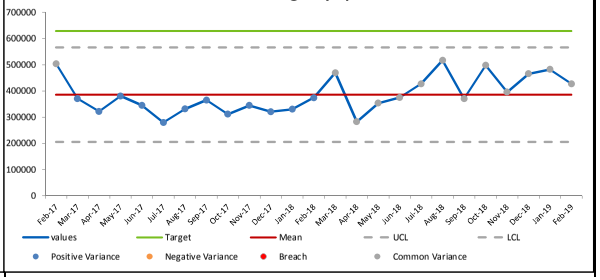
Income and Expenditure Surplus vs plan



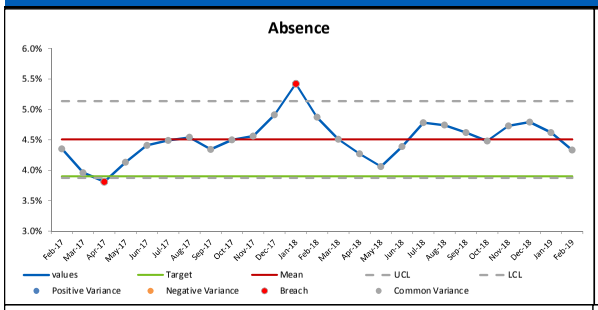
CIP Achieved Against Plan

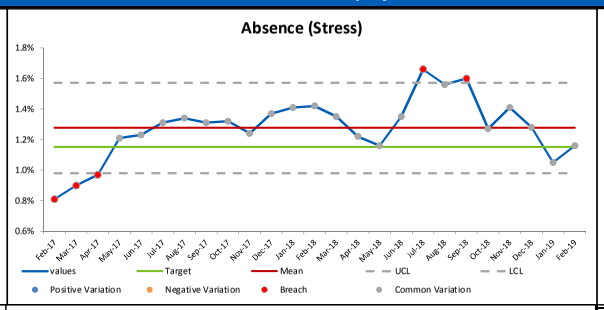


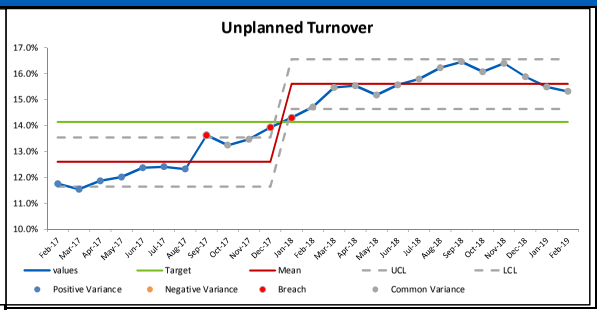
External Agency Spend

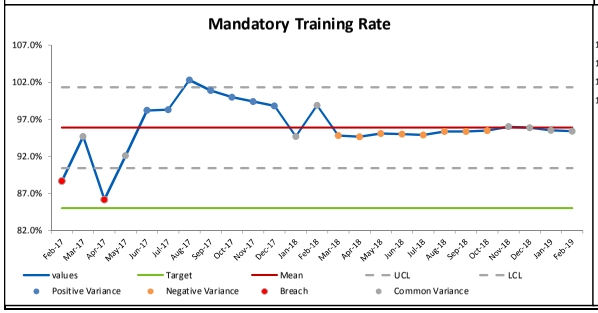


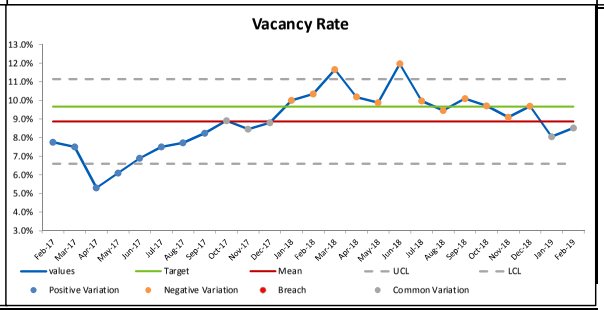
5. Be The Best Employer











Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Item:	2.8
Subject:	Constitutional Amendment to the Standing Financial Instructions (SFIs)
Presenting Officer:	Gordon Flack, Director of Finance

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

Report Summary (including purpose and context)
The report sets out the detail of a proposed minor change to the Standing Financial Instructions.

Proposals and /or Recommendations
To approve the proposed change to SFIs.

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

CONSTITUTIONAL CHANGE

1. **Introduction**

Following the last update informed in November 2018, a further minor change has been proposed to the Standing Financial Instructions (SFIs):

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

Instead, the Terms of Reference for the Audit and Risk Committee have been expanded to cover security controls (including cyber security) as part of the Audit and Risk Committee's responsibility to provide oversight of governance, risk management and internal control processes.

2. **Recommendation**

The Board is asked to approve the proposed change to the Standing Financial Instructions.

Gordon Flack
Director of Finance
March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	3.1
Agenda Item Title:	2019/20 Operating Plan
Presenting Officer:	Paul Bentley, Chief Executive

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

Report Summary

This paper combines the planning documents which have been generated for the 2019/20 financial year.

The paper includes:

- Strategic Priorities
- Quality Priorities
- Operating Plan incorporating both Capital and Revenue Budgets
- Capital Plan

The Board has previously considered the Mission, Vision and Strategic Goals of the organisation and agreed that no changes were required. The documents which follow this covering paper reflect this agreement with the objective of demonstrating how the agreed strategy is translated into priorities and plans for the coming year.

These documents have been widely consulted on within the organisation and with external stakeholders where appropriate. A great deal of feedback has been received, particularly from staff who have contributed meaningfully to the development of the documents and in particular the Strategic Priorities and the Quality Priorities.

Proposals and /or Recommendations

The Board is asked to **approve** the:

- Strategic Priorities
- Quality Priorities
- Operating Plan incorporating both Capital and Revenue Budgets
- Capital Plan

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒ High level position described.

Paul Bentley, Chief Executive	Tel: 01622 211900
	Email: p.bentley@nhs.net

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	3.1
Agenda Item Title:	2019/20 Strategic Priorities
Presenting Officer:	Gerard Sammon, Director of Strategy

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

Report Summary
The annual refresh of the Trust's priorities has been undertaken and this paper summarises the process used to develop them and proposes what they should be for 2019/20.

Proposals and /or Recommendations
The Board is asked to approve the strategic priorities for 2019/20.

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

Gerard Sammon, Director of Strategy	Tel: 01622 211938
	Email: Gerard.sammon@nhs.net

Kent Community Health
NHS Foundation Trust

STRATEGIC PRIORITIES 2019/20

1. Introduction and Background

1.1 The annual refresh of the Trust's priorities has been undertaken and this paper summarises the process used to develop them and proposes what they should be for 2019/20.

2. Development of the priorities

2.1 The Trust's strategy and a set of draft priorities was first presented and discussed in a Trust Board development session in December and taken to the Management Committee in January. Assessments undertaken demonstrated that the Trust's strategy and goals remained consistent with current healthcare policy and direction and attuned to the external environment and therefore weren't considered necessary to revisit, but there was a need to develop the draft priorities further.

2.2 A joint Trust Board and Management Committee meeting in February provided feedback that the priorities were the right ones, but asked for them to be refined and defined more sharply so that they meant something for all our staff. The draft priorities were also shared for views with the Council of Governors and Staff Partnership Forum who affirmed their direction.

2.3 A second version of the priorities taking this feedback were then presented at the Trust's Leadership event for their thoughts and subsequently directly with all the staff in the organisation. There were 249 responses from staff with over 85% agreeing the quality, integrated care and workforce priority were appropriate and 75% stating the digital priority was appropriate.

2.4 Qualitative feedback from these recent exercises has subsequently been used to produce the final set of priorities that are for approval today. For example, the relationship with quality improvements leading to better outcomes, the importance of developing, valuing and retaining our staff and making sure that staff had the right training and technology to improve care.

2.5 The proposed Trust priorities are set out below:

- **Improve quality:** Innovate, improve and learn – so everyone gets the best health and wellbeing outcomes.

- **Support our people:** Engage, develop and value our people so they deliver high-quality care throughout long, rewarding careers.

- **Join-up care:** Progress partnerships between health and social care, so people feel supported by one multi-skilled team.

- **Develop our digital:** Invest in technology and training to give more time to care, better access to services and the power of information to all.

3. Next steps

3.1 The benefit of consistency in the Trust's strategy and priorities is there are already significant programmes of work mapped to them. For example the 'Improve quality' priority is aligned to the Quality, Service Improvement and Redesign (QSIR) programme and the 'Develop our digital' has the Community Information System (CIS) replacement programme rolling out next year. The service objectives are also mapped to the Trust priorities and will be reviewed during the March and April performance reviews to ensure they enable robust tracking of objectives, and therefore the strategic priorities.

4. Recommendation

4.1. The Board is asked to approve the strategic priorities for 2019/20.

Gerard Sammon
Director of Strategy
March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	3.1
Agenda Item Title:	2019/20 Quality Priorities
Presenting Officer:	Dr Mercia Spare, Chief Nurse (Interim)

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

Report Summary
Every Quality Report must contain the Trust's priorities for improvement to be achieved in the following year. This paper presents Kent Community Health NHS Foundation Trust's (KCHFT) 2019/20 Quality Priorities.

Proposals and /or Recommendations
The Board is asked to approve the KCHFT Quality Priorities for 2019/20.

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

Dr Mercia Spare, Chief Nurse (Interim)	Tel: 01622 211900
	Email: m.spare@nhs.net

Kent Community Health
NHS Foundation Trust

QUALITY PRIORITIES 2019/20

1. Executive Summary

1.1 Every Trust Quality Report must contain the Board agreed priorities for improvement, to be achieved in the following year. These priorities are taken from the three dimensions of quality as set out by Lord Darzi in the 2008 publication "High Quality for all". Kent Community Health NHS Foundation Trust's (KCHFT) have added a fourth dimension to ensure this is extended to our people. The four dimensions of quality are:

- Improving patient safety;
- Improving clinical effectiveness;
- Improving patient experience;
- Improving staff experience.

1.2 This paper identifies the propose quality priorities and describes the consultation and engagement process for the development and identification of KCHFT's Quality Priorities for 2019/20.

2. Quality priorities consultation process

2.1 The 2018/2019 Quality Priorities for KCHFT have been selected and identified through a robust consultation and engagement process (see Table 2.1). As part of the Quality Report guidance NHS Foundation Trusts must;

" describe areas for improvement in the quality of relevant health services that the NHS foundation trust intends to provide or sub-contract in 2019/20. The description must include:

- *at least three priorities for improvement (agreed by the NHS foundation trust's board) indicating the relationship, if any, between the identification of these priorities and the reviews of data relating to quality of care;*
- *how progress to achieve these priorities will be monitored and measured;*
- *how progress to achieve these priorities will be reported;*
- *Include a rationale for the selection of the priorities and whether/how the views of patients, the wider public and staff were taken into account."*

Table 2.1 Development and consultation process

Timeline	
December 2018	Long list of potential Quality Priorities were constructed based on current risks, national priorities (CQUINs etc.), operational business plans and the NHS long term plan. In addition, these were mapped to the Trust's strategy and goals to ensure consistency. This was presented to the Board for review. Amendments were made based on feedback.
January – February 2019	The amended long list of potential priorities were sent for consultation through the development of a consultation paper and electronic survey. This was shared with patients through the patient engagement team and presented at the joint Board and Management Committee, Council of Governors and members, Patient Experience group, Clinical Effectiveness group, operational team meeting, staff partnership forum and the operational quality improvement network. In addition, they were presented to our main commissioners; East Kent CCG, West Kent CCG, Swale CCG and KKC quality lead and they were sent out to all staff via Flo and Flo mail.
March 2018	Collectively, 86% of those people consulted supported the areas identified as potential priorities. Results from the consultation identified the top priorities for each dimension. These were presented via a facilitated session at the Leader's conference (13 March 2019) where the 2019/20 Quality Priorities were agreed.

3. KCHFT Quality Priorities 2019/20

3.1 To align with our quality strategy objectives and to increase engagement the approach used to measure and monitor the Quality Priorities will be based on quality improvement principles and methodologies. Through the consultation process the following four Quality Priority areas were agreed by KCHFT Leaders as the Trust's Quality Priorities for 2019/20.

- **Improving patient safety**
  To implement an early warning system and escalation process that prevents harm and promotes agreed outcomes and wellbeing.

- **Improving clinical effectiveness**
  To use research and Qi methodologies to provide an evidenced based approach to improve our care and services.

- **Improving patient experience**
  Development and delivery of services and pathways in collaboration with people and carers at all stages of their journey.

- **Improving the experience of people**
  Enable and empower our people to maintain personal and team wellbeing.

3.2 Each of these priorities will be developed into a Quality Improvement (QI) programme, by first identifying the specific, measurable, achievable, realistic and timed (SMART) outcomes.

3.3 The 2019/20 Quality Priorities will be published within the Annual Quality Report 2019/20. This will include the priorities, their rationale for inclusion and how they will be measured and reported. The draft report will be presented to the Quality Committee in May 2019. Progress will be monitored quarterly through the Quality Committee and outcomes reported within the 2019/20 Quality Report.

4. Recommendations

4.1 The Board is asked to approve the KCHFT Quality Priorities for 2019/20.

Dr Mercia Spare
Chief Nurse (Interim)
19 March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Item:	3.1
Subject:	Revenue and Capital Budgets 2019/20
Presenting Officer:	Gordon Flack, Director of Finance

Action - this paper is for:	Decision	x	Assurance	☐

Report Summary (including purpose and context)
This paper presents the income and expenditure budgets and capital plan for 2019/20 for approval. The income and expenditure budgets show that the Trust is planning to make a surplus of £2,350k in 2019/20, in line with the control total, supported by £2,200k of provider support funding, and is planning to spend £9,654k of capital.
Proposals and /or Recommendations
The Board is asked to agree the budgets.

Relevant Legislation and Source Documents
Monitor NHS Foundation Trusts Annual Reporting Manual NHS Manual for Accounts 2017-18
Has an Equality Analysis (EA) been completed?
No. High level position described.

Gordon Flack, Director of Finance	Tel: 01622 211934
	Email: gordon.flack@nhs.net

Kent Community Health
NHS Foundation Trust

2019/20 BUDGETS FOR APPROVAL

1. Summary

This paper presents the Board with the 2019/20 budgets for approval. It describes the assumptions made in arriving at these budgets.

2. Introduction

The 2019/20 budget has been built up from the rollover 2018/19 budget, and using the following assumptions:

- The budget delivers a surplus of £2,350k, 1.0%, including £2,200k of provider support funding (PSF).
- The capital plan is affordable without external borrowing.
- The Trust is not reliant on non-recurrent CIP or other savings in order to meet its targets.
- Budgets are sufficient to deliver safe and effective services.

A budget setting framework, which included the principles for budget setting, was agreed by the Finance, Business and Investment Committee in November 2018 and has been implemented in calculating 2019/20 budgets.

Budgets are based on the month nine full year budget adding in any full year effects from 2018/19 (related to service developments, decommissioning and non-recurrent items), removing 2019/20 CIP, adding inflation and incremental progression costs, and removing unutilised reserves. Where relevant, budgets have been aligned to rotas (particularly for wards and cleaning staff). All enhancements have been budgeted in line with actual work patterns.

3. Summary Income and Expenditure Budgets for 2018/19 and 2019/20

Table 3.1 shows the summary income and expenditure budgets for 2018/19 and 2019/20.

	Closing Budget 2018/19	Start Budget 2019/20
Income	-225,897	-235,577
Pay	164,643	171,959
Non Pay	55,012	57,793
EBITDA	3,114	3,475
Grand Total	**-3,128**	**-2,350**

Table 3.1: Summary Income and Expenditure Budgets

4. Income and Expenditure and WTE Budgets for 2018/19 and 2019/20 – By Directorate

Table 4.1 below shows the income and expenditure budgets by directorate for 2018/19 and 2019/20 noting some income is devolved to directorate level.

Directorate	Closing Budget 2018/19	Start Budget 2019/20
Operations	144,331	156,285
Childrens Specialist Services	24,268	24,483
Dental	10,756	11,233
East Kent	35,565	41,622
Operations Management	1,308	1,378
Public Health	32,358	30,594
Specialist & Elective Services	19,069	20,894
West Kent	21,007	26,082
Corporate Services	4,226	4,118
Nursing & Quality	3,502	3,501
Medical Director	2,315	2,506
IT	6,521	6,042
Estates	17,329	16,018
Finance Directorate	3,457	3,618
HR, OD & Communications	4,136	4,768
Depreciation	3,114	3,475
Reserves	431	3,155
Central Income	-192,490	-205,835
Grand Total	**-3,128**	**-2,350**

Table 4.1 Income and Expenditure Budgets by Directorate

Table 4.2 below shows the WTE budgets by directorate for 2018/19 and 2019/20.

Directorate	Closing WTE 2018/19	Start WTE 2019/20
Operations	3,670	3,792
Childrens Specialist Services	648	640
Dental	211	220
East Kent	880	946
Operations Management	35	37
Public Health	760	766
Specialist & Elective Services	544	543
West Kent	592	640
Corporate Services	55	60
Nursing & Quality	58	57
Medical Director	50	56
IT	133	125
Estates	219	219
Finance Directorate	91	90
HR, OD & Communications	107	134
Depreciation	0	0
Reserves	-106	-103
Central Income	0	0
Grand Total	**4,277**	**4,429**

Table 4.2 WTE Budgets by Directorate

The budgets for 2019/20 include the following changes from the 2018/19 budgets:

- The full year effect of Kent Immunisations tender and the loss of the East Sussex service.
- Removal of part year budgets for DGS Sexual Health Services (£589k, but value still to be agreed with MTW).
- Transfer of discharge to assess income targets from East Kent to Central Income as the service is now part of the block contracts with CCGs (£1,021k).
- Transfer block income target for Medway Podiatry from Specialist and Elective Services to Central Income (£903k).
- Transfer funding for the children's counselling service from School Nursing to Psychological Services (within Dental directorate) following the move to an in-house provision from a sub-contract with CXK (£525k).
- Increase funding for depreciation from Reserves (£361k).
- Fund cultural change programme in HR from Reserves (£301k).
- Additional funding for Quality Improvement to Finance from Reserves (£197k).

The following funding for new service developments has been included:

- East Kent CCGs:
  - Out of hospital beds (£3,500k).
  - West View moved to block funding (transfer income target from East Kent Adult Services to Central Income, £1,106k).
  - Medicines Management (£278k).
  - Additional non-recurrent funding (£191k).

    - Reduction in funding for key delivery seven (-£1,600k).

- West Kent CCG:
    - Falls Service (£656k).
    - Rapid Response (£357k).
    - Home Treatment Service (£734k).
    - Frailty Nurses (£385k).
    - Therapists for Long-Term Conditions (£329k).
    - Primrose moved to block (transfer income target from West Kent Adult Services to Central Income, £1m.
    - Home Treatment Team income moved to block (transfer income target from West Kent Adult Services to Central Income, £1,292k).

- North Kent CCGs:
    - Additional funding for Minor Injury Units (£151k).

- MTW:
    - Removal of part year budgets for DGS Sexual Health Services (£589k, but value still to be agreed).
    - Additional funding for minor injury units (£300k, held within Reserves).

The CIP target for 2019/20 is £5.3m - equivalent to 2.2% of the Trust budgets. A 2019/20 CIP targets and methodology paper was submitted to the September 2018 Management Committee. The Committee approved a differentially higher corporate (IT, Workforce, Organisational Development and Communications) and Estates CIP target and specific additions based upon the Model Hospital benchmarking tool. This allowed for clinical services to work to a lower 2% CIP target and corporate services to work to a minimum 3% CIP target of their budgets.

Demographic funding of £1.89m is included reflecting the funding agreements with CCGs and NHS England for 2019/20.

The second year of the Agenda for Change pay deal has been reflected in budgets. The medical and dental pay award for 2019/20 has not yet been confirmed, so reserves of £280k have been set aside to cover the increased costs.

A tariff inflator of 3.8% and efficiency of 1.1% has been added to CCG and NHS trust income as per the national guidance. NHSE contracts (excluding Dental services) also include a centralised procurement saving of 0.05%. Dental contracts with NHSE have been uplifted by 0.65% as agreed with commissioners. No inflationary uplift has been applied to the income from local authorities, a funding gap of c. £1.2m.

Table 4.3 below shows the budgets and budgeted WTEs for 2018/19 compared to 2019/20 together with an explanation for significant movements in the budgets between years:

	2018/19 BUDGET WTE	2018/19 BUDGET £000	2019/20 BUDGET WTE	2019/20 BUDGET £000	Variance Between Years	Explanation of Main Changes
AfC pay award central funding	0	2,841	0	0	-2,841	Pay award funded through CCG contracts
Charitable and Other Contributions to Expenditure	0	67	0	67	0	
Clinical Commissioning Groups	0	134,300	0	148,772	14,472	
Department of Health	0	0	0	0	0	
Education and Training	0	1,509	0	1,658	149	
Injury Cost Recovery Scheme	0	368	0	381	13	
Local Authorities	0	45,964	0	44,575	-1,389	Westview now funded by Ashford CCG not KCC (-£1,000k)
NHS England	0	22,339	0	22,586	247	
NHS Foundation Trusts	0	3,179	0	3,231	52	
NHS Trusts	0	6,185	0	5,796	-389	Cessation of DGS Sexual Health Service (part-year, -£589k), MIU increase £337k
Non NHS: Other	0	2,902	0	1,779	-1,123	West Kent Home Treatment Service now funded by CCG not IC24 (-£1,126k)
Non NHS: Private Patients	0	140	0	177	37	
Non-Patient Care Services to Other Bodies	0	899	0	877	-23	
Other	0	2,729	0	3,478	749	
Provider Support Funding (PSF)	0	2,474	0	2,200	-274	
INCOME Total	**0**	**225,897**	**0**	**235,577**	**9,680**	
Allied Health Professionals	604	26,344	617	28,703	2,360	Service Developments (£802k), Reinstatement of North Kent MSK (assumed service would cease part year in prior year budget setting (£650k)
Apprenticeship Levy	0	653	0	710	56	
Consultants	20	3,306	23	3,471	164	
Medical Career/Staff Grades	66	6,379	69	7,044	665	Service Developments (£375k)
Medical Trainee Grades	3	322	2	287	-36	
NHS Infrastructure Support	1,312	41,082	1,324	42,867	1,784	Service Developments (£595k), increase in STP posts (£316k offset by income)
Non-Executive Directors	2	168	2	218	51	
Other Scientific, Therapeutic and Technical Staff	91	4,258	103	5,059	801	Service Developments (£158k), School Counselling Service from outsourced contract to in-house provision (£246k)
Registered Nursing, Midwifery and Health Visiting Staff	1,227	55,931	1,247	56,692	761	Service Developments (£664k)
Support to Allied Health Professionals	108	2,771	105	2,760	-10	
Support to Nursing Staff	714	19,843	805	21,898	2,055	Service Developments (£1,960k) including Rapid Transfer of Care (£1,166k)
Support to Other Clinical Staff	137	3,873	144	4,129	257	
Redundancy Costs	0	5	0	0	-5	
East Kent Savings	0	-207	0	-207	0	
CIP Achieved (next year) Pay	-2	27	0	24	-3	
CIP Target Pay	-6	-109	-11	-1,696	-1,587	
North Kent Savings	0	-4	0	0	4	
PAY Total	**4,277**	**164,643**	**4,429**	**171,959**	**7,316**	
Audit Fees Payable to the External Auditor	0	64	0	64	0	
Clinical Negligence	0	453	0	453	0	
Consultancy	0	185	0	352	167	
Drugs Costs	0	6,248	0	6,103	-145	
Education and Training - Non-Staff	0	848	0	1,153	305	
Establishment	0	6,385	0	10,075	3,690	Increase in budget reserves and cost pressure reserves
Increase/(Decrease) in Impairment of Receivables	0	0	0	0	0	
Operating Lease Expenditure	0	7,290	0	7,010	-280	
Operating Lease Expenditure (net)	0	0	0	0	0	
Other	0	1,347	0	1,056	-290	
Premises - Business Rates Payable to Local Authorities	0	585	0	563	-22	
Premises - Other	0	7,422	0	7,286	-136	
Research and Development - Non-Staff	0	0	0	0	0	
Supplies and Services – Clinical (excluding drugs costs)	0	17,800	0	18,890	1,089	Health & Social Care beds (£2,387k) less Hilton Nursing contract ceased and moved to employed staff (£1,206k reduction)
Supplies and Services - General	0	1,233	0	1,093	-140	
Transport	0	5,518	0	5,675	157	
CIP Contingency	0	0	0	64	64	
CIP Target Non Pay	0	-280	0	-1,967	-1,687	
Sexual Health Savings	0	-85	0	-76	9	
NONPAY Total	**0**	**55,012**	**0**	**57,793**	**2,781**	
Amortisation	0	102	0	185	83	
Depreciation	0	2,821	0	3,088	267	
Finance Income	0	72	0	180	108	
PDC Dividend Charge	0	263	0	382	119	
BUDGET TOTAL	**4,277**	**3,128**	**4,429**	**2,350**	**-778**	
SURPLUS %		-1.4%		-1.0%		

Table 4.3 – Budgeted Income and Costs and Budgeted WTEs by Subjective Category for 2018/19 and 2019/20

5. Cost Pressures

Cost pressures totalling £5.97m were identified and prioritised at budget setting. The budgets set include a cost pressures funding of £3.0m within the Trust Reserves position.

6. Contingency

£1.18m (0.5% of income) of reserves are being held as a contingency against unknown risks and pressures. There is a further £750k contingency reserve for potential loss of income.

7. Capital Plan

Table 7.1 below shows the capital plan for 2019/20 which totals £9.654 million. The capital plan will be funded from cash generated from the in-year depreciation charge and previous years' surpluses.

Capital Projects	2019-20 Capital Plan £000s	
Estates Developments (incl. Capitalisable Responsive Maintenance and Energy Efficiency)	1,460	
IT Rolling Replacement and Network/Server Upgrades (investment in Infrastructure)	661	
IT Developments (incl. CIS replacement and Kent & Medway Care Record)	6,407	*
IT Security	547	
Dental	329	
Other Minor Schemes (incl. Specialist Medical Equipment)	250	
Total Capital Plan 2019-20	**9,654**	

Table 7.1 - Capital Plan for 2019/20

* includes current planning estimates for capital expenditure on the CIS Replacement and Kent & Medway Care Record systems.

8. Cashflow

The cash position for 2019/20 is expected to remain good, with a planned decrease in the overall cash balance from £29.6m in March 2019 to £27.4m in March 2020. This will be subject to change, as a result of any additional PSF funding which the Trust may receive related to 2018/19.

STATEMENT OF CASH FLOWS	Plan 31/03/2020 Year Ending £000s
Cash flows from operating activities	
Operating surplus/(deficit)	**2,552**
Non-cash income and expense:	
Depreciation and amortisation	3,273
(Increase)/decrease in receivables	2,401
Increase/(decrease) in trade and other payables	-452
Increase/(decrease) in other liabilities	-171
Increase/(decrease) in provisions	-250
Net cash generated from / (used in) operations	**7,353**
Cash flows from investing activities	
Interest received	180
Purchase of property, plant and equipment and investment property	-9,434
Net cash generated from/(used in) investing activities	**-9,254**
Cash flows from financing activities	
PDC dividend (paid)/refunded	-382
Net cash generated from/(used in) financing activities	**-382**
Increase/(decrease) in cash and cash equivalents	**-2,283**
Cash and cash equivalents at start of period	**29,635**
Cash and cash equivalents at end of period	**27,352**

Table 8.1: Cashflow Statement for 2019/20

9. Working Capital

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

10. Recommendation

The Trust Board is recommended to approve these budgets.

Gordon Flack
Director of Finance
19 March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	4.1
Agenda Item Title:	2018 NHS Staff Survey Report
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

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

Report Summary

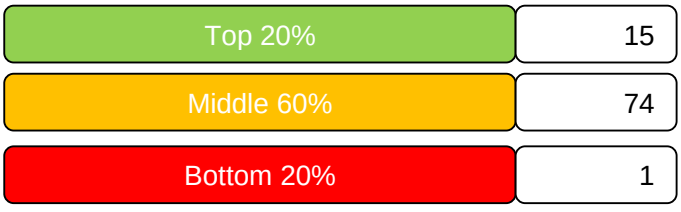
Kent Community Health NHS Foundation Trusts' performance significantly improved in five key themes (Equality, diversity and inclusion; Immediate manager; Safe Environment – Violence; Safety culture; Staff Engagement). This demonstrates that the devolvement culture programme is continuing to having an impact and the staff engagement work has been positively received.

In total, 2,682 colleagues participated in the survey, which is a response rate of 59.7%. This was a 2.3% decrease from 2017. However, is higher than comparators whereby the average response rate was 53% and higher than the national response rate which was 45.7%.

When comparing the key questions KCHFT scored significantly better than last year in 35% of questions, significantly worse in 4% of questions and there was no significant difference in the remaining 61% of questions compared to last years' findings.

The Trust scored significantly better than comparators in 4 Key Theme areas and in 48% of question responses. Out of 90 questions there were only 2 where the trust was below average, compared nationally with other similar providers; which was around staff feeling pressured to come to work, and training, learning or development opportunities not being identified.

The chart below summarises the questions where KCHFT scored amongst the top 20%,
middle 60% and bottom 20% of comparator organisations:



KCHFT also scored significantly higher in 7 Themes when compared to the national results.

Those areas identified for improvement from the 2017 staff survey results had all significantly improved in this year's results.

Proposals and /or Recommendations

The Board is asked to:

- Note the results of the 2018 annual staff survey
- Agree the development of action plans at a local level to address areas that are below the national average or other Community Trust comparator organisations
- Agree the management committee debate and resulting corporate actions to improve the following areas:
    - Staff feeling pressured to come to work
    - Ensuring staff training, learning and development is identified and actioned
    - Staff experiencing musculoskeletal problems (MSK) as a result of work activities
    - Reducing the numbers of errors, near misses, or incidents that would have hurt staff, patients/service users.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

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Kent Community Health
NHS Foundation Trust

STAFF SURVEY REPORT 2018

1.0 Introduction

1.1 This report presents a summary of the findings of the 2018 National NHS Staff Survey conducted by Kent Community Health NHS Foundation Trust (KCHFT).

2.0 Results of the National Staff Survey 2018

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

2.2 KCHFT decided to undertake a full census of staff for the 2018 survey which meant that 4, 518 staff were issued with a self-completion questionnaire. Like 2017 the full census data was used to enable benchmarking with similar organisations to take place. The results from the KCHFT questionnaires were used to benchmark KCHFT with 15 other community trusts across England. These results are publicly available and used by the Care Quality Commission when assessing organisations relating to compliance with essential standards of quality and safety. The survey also demonstrates our delivery against the NHS Constitution.

2.3 The results have been presented in a different format this year. The questionnaire has 90 questions in 31 key finding areas. All questions are now scored out of 10 and a new theme of morale was introduced this year. The results are summarised under 10 key theme headings:

- Equality, diversity and inclusion
- Health and wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment – Bullying and harassment
- Safe environment – Violence
- Safety culture
- Staff engagement

2.4 The detailed report of the 2018 sample survey results for KCHFT can be downloaded from: www.nhsstaffsurveys.com

3.0 Key Findings of the 2017 survey results based on the KCHT census

3.1 Response Rate

3.1.1 KCHFT decided to undertake a full census of staff for the 2018 survey. Questionnaires were issued to 4,518 staff. After excluding respondents later known to be ineligible, a usable sample of 4,495 remained, of which 2,682 were returned. KCHFT therefore had a response rate of 59.7%.

3.1.2 The 2018 response rate for the Trust has decreased from 2017 (62%). However, the average response rate for Community Trusts was 53% and the average response rate nationally was 45.7% so KCHFT has performed well.

3.2 Summary of Key Findings

3.2.1 The table below shows summary of the changes in Key Findings compared to the 2017 results:

Theme	2017 score	2018 score	Statistically significant change?
Equality, diversity and inclusion	9.4	9.5	⬆
Health and wellbeing	6.2	6.2	Not significant
Immediate managers	7.2	7.4	⬆
Morale	-	6.2	Not applicable
Quality of appraisals	5.6	5.8	Not significant
Quality of care	7.3	7.3	Not significant
Safe environment – Bullying and Harassment	8.5	8.6	Not significant
Safe environment – Violence	9.7	9.8	⬆
Safety Culture	6.9	7.0	⬆
Staff engagement	6.9	7.0	⬆

Table 1

3.2.2 KCHFT had 5 Key Themes that were significantly higher than last year and 4 remained the same.

3.3 KCHFT Comparison to 2017 Results

3.3.1 When comparing the key questions KCHFT scored significantly better than last year in 35% of questions, significantly worse in 4% of questions and there was no significant difference in the remaining 61% of questions compared to last years' findings.

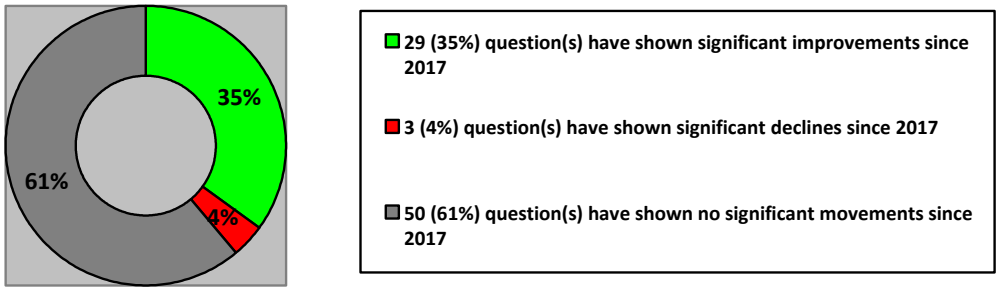


Chart 1

3.3.2 The questions that have shown significant declines since last year were:

- In the last 12months have you experienced musculoskeletal problems (MSK) as a result of work activities?
- In the last month have you seen any errors, near misses, or incidents that would have hurt staff?
- In the last month have you seen any errors, near misses, or incidents that could have hurt patients/service users?

3.3.3 Actions need to be agreed to address the increasing number of musculoskeletal problems that staff are experiencing as well as the number of errors, near misses, or incidents that could have led to harm.

3.4 Benchmarking – KCHFT compared to other Community Trusts

3.4.1 Themes

There are 16 Community Trusts in the benchmarking group. When comparing the key themes KCHFT scored significantly better than the sector in 4 themes (Equality, diversity and inclusion; Immediate manager; Quality of appraisals; Safe Environment – Bullying and Harassment). There was no significant difference between KCHFT and the other Community Trusts in relation to the other 6 key themes.

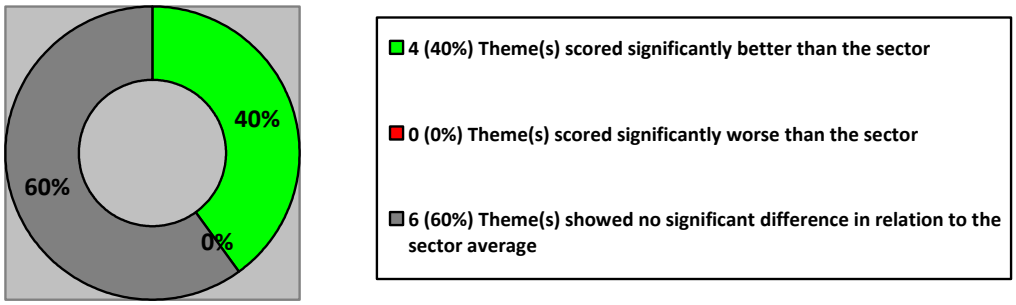


Chart 2

3.4.2 Questions

When comparing the key questions of the survey with our comparators, KCHFT scored significantly better than the sector in 48% of questions, significantly worse than the sector in 2% of questions, and there was no significant difference in the remaining 50% of questions.

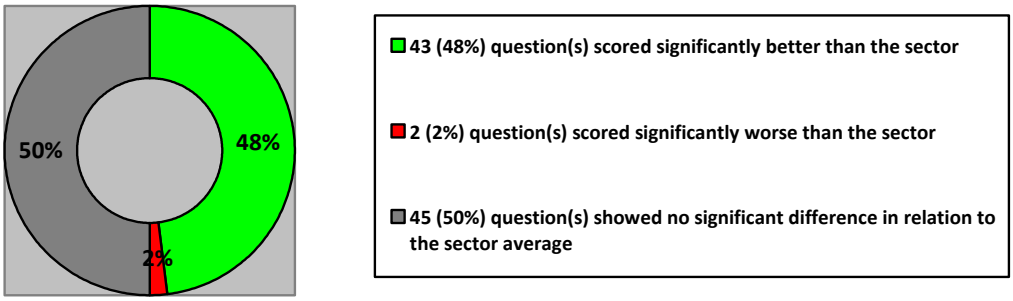


Chart 3

3.4.3 The two questions that KCHFT scored significantly worse than the sector in were:

- Have you put yourself under pressure to come to work?
- Were any training, learning or development needs identified?

Actions need to be identified to address these in the Staff Survey action plans.

3.4.4 The table below shows the variations by key theme between KCHFT and the other Community Trust comparators:

Theme	Org.	Sector	Diff.
Equality, diversity and inclusion	9.47	9.25	+0.22 (Sig.)
Health and wellbeing	6.17	6.00	+0.16 (Not Sig.)
Immediate managers	7.37	7.10	+0.27 (Sig.)
Morale	6.20	6.12	+0.08 (Not Sig.)
Quality of appraisals	5.77	5.50	+0.27 (Sig.)
Quality of care	7.46	7.41	+0.05 (Not Sig.)
Safe environment – Bullying and Harassment	8.59	8.34	+0.25 (Sig.)
Safe environment – Violence	9.76	9.73	+0.03 (Not Sig.)
Safety Culture	7.03	6.90	+0.14 (Not Sig.)
Staff engagement	7.05	7.08	-0.02 (Not Sig.)

Table 2

3.5 Benchmarking – KCHFT compared to National results

3.5.1 The table below shows the variations by key theme between KCHFT and the National staff survey results:

Green = better than last year Red = worse than last year
White = same as last year / no previous year comparison

Theme	Org.	National	Diff.
Equality, diversity and inclusion	9.47	9.01	+0.46 (Sig.)
Health and wellbeing	6.17	5.90	+0.27 (Sig.)
Immediate managers	7.37	6.83	+0.54 (Sig.)
Morale	6.20	6.10	+0.10 (Not Sig.)
Quality of appraisals	5.77	5.46	+0.31 (Sig.)
Quality of care	7.46	7.40	+0.06 (Not Sig.)
Safe environment – Bullying and Harassment	8.59	7.98	+0.61 (Sig.)
Safe environment – Violence	9.76	9.44	+0.32 (Sig.)
Safety Culture	7.03	6.69	+0.34 (Sig.)
Staff engagement	7.05	7.00	+0.05 (Not Sig.)

Table 3

3.5.2 KCHFT scored significantly higher in 7 Themes when compared to the national results.

3.6 Top and Bottom Ranking Scores for Key Findings

3.6.1 Out of the 16 comparator Community Trusts, 10 undertake their staff survey through Quality Health. The chart below summarises the questions where KCHFT scored amongst the top 20%, middle 60% and bottom 20% of these 10 Quality Health contracted organisations.

Chart 4

3.6.2 The 15 questions where KCHFT scored in the top 20% were:

- The team I work in has a set of shared objectives.
- I receive the respect I deserve from my colleagues at work.
- [How satisfied are you with] The recognition I get for good work.
- [How satisfied are you with] The amount of responsibility I am given.
- My immediate manager gives me clear feedback on my work.
- The last time you experienced physical violence at work, did you or a colleague report it?
- Experienced harassment, bullying or abuse at work from other colleagues in the last 12 months.
- The last time you saw an error, near miss or incident that would have hurt staff or patients/service users, did you or a colleague report it?
- We are given feedback about changes made in response to reported errors, near misses and incidents.
- In the last 12 months, have you had an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review?
- Did it (the appraisal, annual review, development review or KSF review) help you to improve how you do your job?
- Did it (the appraisal, annual review, development review or KSF review) help you agree clear objectives for your work?
- Did your manager support you to receive training, learning or development?
- Have you had any training, learning or development in the last 12 months?
- Has your employer made adequate adjustment(s) to enable you to carry out your work?

3.6.3 The 1 question where KCHFT scored in the bottom 20% was:

- Were any training, learning or development needs identified?

3.6.4 So although the Trust scored well in appraisal completeness and participation in training, learning or development, staff feedback is that the Trust has not assisted them in identifying their training, learning or development needs. This therefore needs to be an area of focus for 2019.

4.0 Comparing 2018 staff survey results against those areas targeted in the 2017 KCHFT Action Plan

4.1 Last year the Board agreed that all directorates should focus on Key Findings bottom ranking scores and where there had been a decline from the 2016 scores. A detailed action plan was developed and progress has been monitored throughout the year.

4.2 The key areas of focus for last year's action plan were:

- Staff engagement
- Staff satisfaction
- Staff motivation
- Staff recommendation of the Trust as a place to work or receive treatment

4.3 The 2018 survey results show that staff engagement has increased since last year. Other related scores that have improved are immediate managers, quality of appraisals, safe environment measures and safety culture. All of these improve staff engagement, satisfaction and motivation.

4.4 The results for the specific questions in the staff survey relating to staff recommending the Trust as a place to work and as a place to receive treatment, both of these questions saw an improvement on last year's results of approximately 2%.

4.5 Therefore the 2017 staff survey action plans have had a direct positive impact on the 2018 results.

5.0 Action Planning

5.1 Each locality and directorate has been asked to analyse their specific findings and develop an action plan to address key areas of concern where they are below the national average. Our communications plan includes presentation of key findings to key groups (Strategic Workforce Committee, Management Committee, Staff Partnership Forum). Findings are being discussed within each locality/directorate with action plans developed, agreed and monitored.

5.2 At a corporate level the focus of work will be on what actions need to be taken to have a positive impact on:

- Staff feeling pressured to come to work
- Ensuring staff training, learning and development is identified and actioned
- Staff experiencing musculoskeletal problems (MSK) as a result of work activities
- Reducing the numbers of errors, near misses, or incidents that would have hurt staff, patients/service users.

It is recommended that a debate occurs at the Management Committee on what actions need to be taken to address these areas.

6.0 Conclusion

6.1 Overall, the survey findings for 2018 are very positive in most areas with some significantly better scores than last year and compared to our national comparators.

6.2 There are a minimal number of areas to focus on but it is essential that KCHFT continues to strive to improve all scores.

6.3 These 2018 staff survey results will demonstrate to staff that what they have to say really does matter and that as a Trust we do listen and we do act on feedback.

7.0 Recommendation

7.1 The Board is asked to:

- Note the results of the 2018 annual staff survey

- Agree the development of action plans at a local level to address areas that are below the national average or other Community Trust comparator organisations

- Agree the management committee debate and resulting corporate actions to improve the following areas:

    - Staff feeling pressured to come to work
    - Ensuring staff training, learning and development is identified and actioned
    - Staff experiencing musculoskeletal problems (MSK) as a result of work activities
    - Reducing the numbers of errors, near misses, or incidents that would have hurt staff, patients/service users.

Louise Norris
Director of Workforce, Organisational Development and Communications
March 2019

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	4.2
Agenda Item Title:	Infection Prevention and Control Seasonal Report
Presenting Officer:	Mercia Spare, Chief Nurse (Interim) and DIPC

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

Report Summary

This paper provides a summary of infection prevention and control activity between 1 October 2018 and 28 February 2019, and includes the Trust Infection Prevention and Control Declaration 2019 required by the Hygiene Code.

- There was 1 *Clostridium difficile* Infection reported in January, with no level 3 lapse in care identified. This is the only case this financial year. New national objectives for *Clostridium difficile* have been published, and will completely change the way we set objectives, and report cases from 1 April 2019.

- There was one MRSA bacteraemia reported in October, the PIR identified no learning for KCHFT.

- MRSA screening compliance for podiatric surgery was 100% in this time frame.

- MRSA screening compliance for the community hospitals has varied through this time frame, 100% compliance was achieved in December and January, but other months 95%, 94% and 84%, however this pertains to 1 missed screen in 2 months, but 4 missed in February 2019. All patients subsequently tested negative. The MRSA policy is currently under review.

- Gram Negative Bacteraemia Blood Stream Infection (GNBSI) surveillance continues, both in KCHFT and across Kent and Medway. There has been no significant reduction in cases across the county, but KCHFT continue to identify learning from all cases to focus the IPC team workplan.

- The Trust are participating in the Kent and Medway strategic and local operational meetings – as one of 3 pilot sites in the UK looking at leadership requirements for cross system working for Infection prevention and control and antimicrobial stewardship. The Trusts Assistant Director of Infection prevention and control Chairs the operational group, and Gail Locock is seconded as DIPC to the Kent and Medway strategic system. A letter has been received from Ruth May (CNO England) and Professor Stephen Powis (Medical Director NHS England) supporting this, and setting out clear requirements for Boards of provider organisations to ensure they are aware

of their Trust's action plans for HCAI reduction and Antimicrobial stewardship

- The Antimicrobial Stewardship committee continues to meet. Both IPC and Pharmacy are involved in the Kent & Medway IPC/HCAI Leadership Pilot, and internal plans are to amalgamate the Trust Infection prevention and Control subcommittee with the antimicrobial stewardship committee, to reflect the system wide collaborative approach.

- For this reporting period there were 6 CAUTI's and 40 UTI's reported, and whilst in all cases, correct prescribing and treatment was found, this breaches our reduction target for cases. However it is not currently possible to ascertain rates until the end of the financial year (per 100,000 occupied bed days). In December – despite being above target for cases, we had actually reduced our rate.

- Cleaning reports for January indicate compliance with national standards in all sites except Sevenoaks. This has been an ongoing situation due to staffing, with domestic staff prioritising the ward. Recruitment has occurred at this site, with 2 new staff commencing early March and another 3 staff awaiting a start date.

- Trust Compliance with hand hygiene training was reported as 93% and mandatory training 97% in January. Compliance amongst clinical staff was 90.9% for hand hygiene, and 96.5% for mandatory training.

- There have been 6 outbreaks of infection in this time, 4 respiratory outbreaks (not influenza) and 2 norovirus. In all cases the wards remained opened to admissions, with bays closed and in isolation measures..

- The Trust staff flu campaign has concluded, and at the close of the Trust sessions, 57% of patient facing staff had received their vaccination – the same as 2017/18

- There were 2 incidents of failure to decontaminate instruments though IHSS (our central sterilisation service) and a marked decrease in quality of service from the contracted service. The Assistant Director of Infection Prevention and Control and the KCHFT Trust independent authorised engineer undertook an inspection and audit, and whilst compliance to decontamination requirements was found, concerns have been raised regarding other systems and processes relating to quality. It was also ascertained that IHSS had been sold to another company recently, who were also selling the healthcare aspects, potentially putting decontamination and quality processes at risk.

- The Authorised engineer for decontamination has also undertaken an assessment in dental service where reprocessing takes place. Verbally he reported full compliance – but a written report is still awaited.

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

- highlight gaps in assurance, and evidence risk reduction actions. There have been multiple incidents of either loss of thermal control or loss of water in healthcentres, but all have been resolved, with staff implementing infection prevention and control measures effectively, and where required, thermal disinfection took place, with subsequent monitoring.

- The IPC Team continues to lead on the Trust 'SEPSIS' awareness programme, there is a plan for IPC link practitioners to be 'SEPSIS' champions and ensure SEPSIS posters and algorithms are available through every service. The new NEWS 2 assessment form will also prompt staff to 'consider sepsis'

- The Trust declares compliance with The Hygiene Code

Proposals and /or Recommendations
To note the report.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

Lisa White, Assistant Director Infection Prevention and Control	Tel: 07795427421
	Email: lisa.white1@nhs.net

SEASONAL INFECTION PREVENTION AND CONTROL (IPC) 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 was one *Clostridium difficile* infection identified in January, the case was investigated and found that the case was unavoidable and due to appropriate antimicrobial prescribing in the Acute when the patient was in ICU. However, the IPC team and ward were not informed of the result, until the paper copy of the result was received one week later, so learning was identified in relation to clinical staff checking specimen results regularly.

New objectives have been released for clostridium difficile infections for 2019/20, changing the allocation of cases to four new 'attributions':

- **hospital onset healthcare associated:** cases that are detected in the hospital three or more days after admission
- **community onset healthcare associated:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks
- **community onset indeterminate association:** cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous 12 weeks but not the most recent four weeks
- **community onset community associated:** cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the Trust reporting the case in the previous 12 weeks.

The plan for KCHFT objectives will be brought to the next Quality Committee, but ideally our Trust will investigate all cases with both the acute trust and clinical commissioning group (CCG) and ensure any lessons identified are shared (as we now do with MRSA and gram negative bacteraemias).

2. MRSA Bacteraemia

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 CCG or acute trust manage these investigations, with a co-ordinated response to any learning identified through organisational Infection Prevention and Control committees and CCG Quality meetings.

There was one MRSA bacteraemia reported in October in a patient who received care from the Maidstone central Community team, for leg wounds. A full investigation was undertaken with the acute trust, CCG and KCHFT and there was no identified learning for KCHFT in relation to this case.

3. MRSA screening

The expected standard is 100% compliance with screening in line with policy.

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Target	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %
Actual Community Hospital	81%	92%	67%	76%	100 %	95%	95%	94%	100 %	100 %	85%	
Acutal – Podiatric surgery	100 %	98%	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	100 %	

In Podiatric Surgery MRSA screening compliance has been achieved, however in the community hospitals there have been six screens that were not completed in the expected timeframe. Each of these cases related to a delay in the ward staff checking acute trust results to ascertain if screening was required. In all cases the results were MRSA negative.

Separately the IPC Team is reviewing screening requirements for our patients admitted to community hospitals, with a plan to change screening criteria to only those admitted from their own home (or care home) as the acute trusts are screening all their patients, and we would have access to their results.

4. **Gram Negative bacteraemia Blood Stream Infections (GNBSI)**

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.

Gram Negative Bacteraemia Blood Stream Infections (GNBSI) surveillance continues, both in KCHFT and across Kent and Medway. There has been no significant reduction in cases across the county, but KCHFT continues to identify learning from cases to focus the IPC Team work plan.

The Trust is participating in the Kent and Medway strategic and local operational meetings; as one of three pilot sites in the UK looking at leadership requirements for cross-system working for Infection prevention and control and antimicrobial stewardship. KCHFT Assistant Director of IPC is the chair of the operational group, and Gail Locock is seconded as DIPC to the Kent and Medway strategic system. A letter has been received from Ruth May (CNO England) and Professor Stephen

Powis (Medical Director NHS England) supporting this, and setting out clear requirements for boards of provider organisations to ensure they are aware of their Trust's plans for HCAI reduction and Antimicrobial stewardship (see appendix 1).

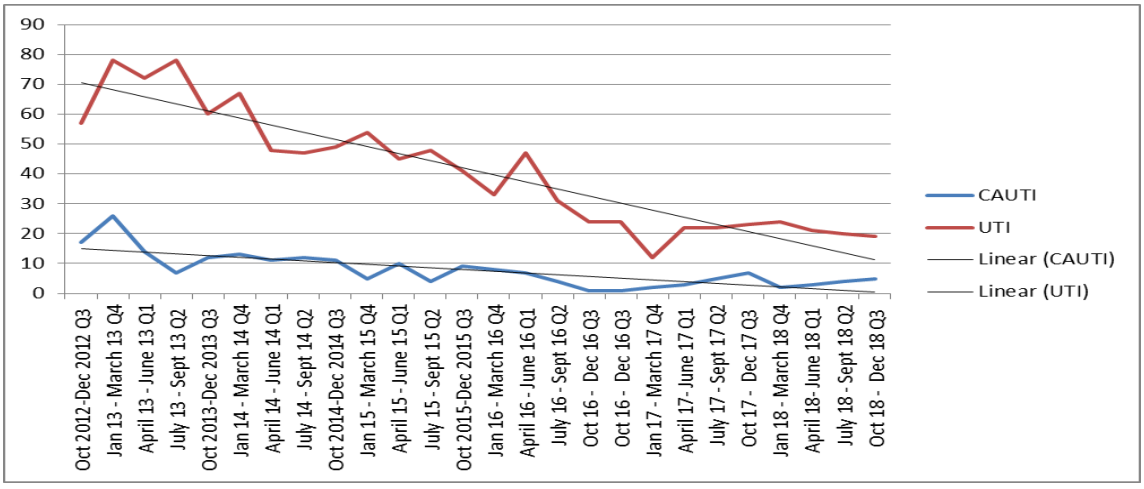
In KCHFT compliance is regularly reviewed against the Hygiene Code and NICE guidelines for antimicrobial stewardship. The plan for KCHFT is to amalgamate the Infection Prevention and Control sub-committee and the Infection Prevention and Control Committee, in order to directly mirror the Kent and Medway wide approach and effectively implement both local and system wide changes. Our focus remains on CAUTI and UTI reduction as this has been identified as our highest risk in KCHFT and the correct specimen collection and antimicrobial prescribing for this. The Trust CAUTI/UTI action plan continues to be updated, and the latest national documents for Catheter care will be implemented across the county.

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.

For this reporting period there were six CAUTI's and 40 UTI's reported, and whilst in all cases correct prescribing and treatment was found, this breaches our reduction target for cases. However it is not currently possible to ascertain rates until the end of the financial year per 100,000 occupied bed days. In December, despite being above target for cases, we had actually reduced our rate compared to the same timeframe in 2017/18.

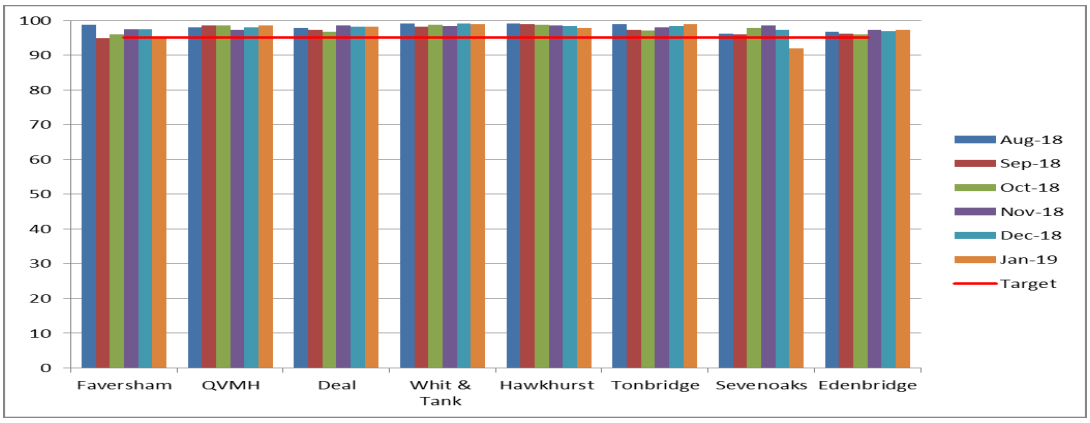
KCHFT commenced collection of UTI and CAUTI data in October 2012, therefore we can now see the progress we have made in the last 5 years below. There has been a 75% reduction in CAUTI numbers and 70% reduction in UTI numbers, however, in 2016 there was a change in the number of hospital beds, so rate reduction per 100,000 OBDs is over 40%, and the Trust continues to focus on continuing this downward trend.



6. Cleaning and Environment

The Infection Prevention and Control sub-committee monitors the progress of all areas, see cleaning summary for six months up to January 2019 below.

Overall site scores – 6 monthly (Aug 18 – Jan 19)



Cleaning reports indicate compliance with national standards in all wards except Sevenoaks. This has been reportedly due to staffing issues, with domestic staff prioritising the ward cleaning over other lower risk areas of the hospital site. Recruitment has occurred at this site, with two new staff commencing first week in March and another three staff awaiting a start date.

7. Training

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

Trust Compliance with hand hygiene training was reported as 93%, and mandatory training 97% in January. Compliance amongst clinical staff was 90.9% for hand hygiene, and 96.5% for mandatory training.

Training compliance January 2019

Locality	Infection prevention & Control L1	Infection prevention & Control L2	Infection prevention & Control L3	Hand Hygiene L1	Hand Hygiene L2
846 L4.1 4217 East Kent	100.0%	94.7%	95.8%	100.0%	100.0%	89.8%
846 L4.1 4217 East Kent	100.0%	100.0%	95.7%	100.0%	86.5%	88.8%
846 L4.1 4217 East Kent	100.0%	100.0%	100.0%	100.0%	90.9%	76.2%
846 L4.1 4217 East Kent	100.0%	100.0%	93.5%	100.0%	80.0%	85.8%
846 L4.1 Children's Specialist Services	100.0%	100.0%	96.3%	99.0%	100.0%	94.0%
846 L4.1 Children's Specialist Services	100.0%	N/A	97.0%	100.0%	N/A	87.2%
846 L4.1 Dental	N/A	100.0%	N/A	N/A	100.0%	N/A
846 L4.1 Dental	100.0%	100.0%	98.1%	100.0%	100.0%	92.3%
846 L4.1 Operations Management	100.0%	100.0%	N/A	100.0%	100.0%	N/A
846 L4.1 Operations Management	100.0%	N/A	90.9%	100.0%	N/A	90.9%
846 L4.1 Public Health	100.0%	100.0%	96.2%	100.0%	92.3%	87.7%
846 L4.1 Public Health	100.0%	100.0%	97.0%	100.0%	100.0%	98.5%
846 L4.1 Public Health	100.0%	100.0%	N/A	100.0%	100.0%	N/A
846 L4.1 Public Health	100.0%	100.0%	93.1%	95.7%	92.5%	93.1%
846 L4.1 Public Health	100.0%	100.0%	97.3%	100.0%	93.5%	95.5%
846 L4.1 Public Health	100.0%	N/A	97.0%	100.0%	N/A	93.9%
846 L4.1 Specialist and Elective Services	100.0%	99.3%	98.3%	98.0%	98.6%	94.3%
846 L4.1 West Kent	100.0%	100.0%	96.3%	100.0%	91.4%	88.6%
846 L4.1 West Kent	N/A	89.7%	95.2%	N/A	89.7%	97.6%
846 L4.1 IT	100.0%	N/A	N/A	97.1%	N/A	N/A
846 L4.1 4302 Clinical Governance	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 4307 Patient Experience	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 4308 Tissue Viability	100.0%	N/A	N/A	87.5%	N/A	N/A
846 L4.1 Chief Nurse	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Chief Nurse	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Chief Nurse	100.0%	N/A	100.0%	100.0%	N/A	100.0%
846 L4.1 Chief Nurse	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Medical Director	100.0%	N/A	100.0%	100.0%	N/A	100.0%
846 L4.1 Medical Director	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 HR, OD and Communications	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 HR, OD and Communications	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 HR, OD and Communications	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Business Development and Service Impr	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Finance	100.0%	N/A	N/A	95.7%	N/A	N/A
846 L4.1 Finance and IT Management	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Performance & Business Intelligence	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Corporate Services	100.0%	N/A	N/A	97.5%	N/A	N/A
846 L4.1 Corporate Services	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Corporate Services	100.0%	N/A	N/A	100.0%	N/A	N/A
846 L4.1 Estates	100.0%	100.0%	N/A	100.0%	100.0%	N/A
846 L4.1 Estates	100.0%	100.0%	N/A	100.0%	86.7%	N/A
846 L4.1 Estates	100.0%	93.9%	N/A	100.0%	94.3%	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

There have been six outbreaks of infection in this time, four respiratory outbreaks (not influenza) on Goldsmid ward, Hawkhurst, Whitstable and Tankerton and Faversham and two norovirus outbreaks in Deal (one in November and one January) In all cases the wards remained opened to admissions, with bays closed and in isolation measures. The influenza vaccine this year was very close to the circulating flu, therefore we have not seen the peaks in cases we did in the years where the virus drifted from the vaccine.

8.1 Staff flu vaccination programme

The internal flu vaccination sessions concluded in February 2019, with 57% of patients facing staff receiving the vaccine. This is the same as last year. A ‘lessons

learnt' meeting is being held, to obtain feedback from staff, and direct the plan for 2020/21.

9. Decontamination

There were two incidents of failure to decontaminate instruments effectively though IHSS (our central sterilisation service) Each case has been investigated by both KCHFT and IHSS, and lessons learned for both organisations, lessons relate to dental staff cleaning cement off instruments prior to sending to IHSS, and IHSS staff identifying cement. The other lesson was in relation to the 'tagging ' of clean and dirty boxes of instruments, and it was identified some services in KCHFT used the 'blue tag' to identify dirty instruments – when IHSS use the blue tag to identify 'clean instruments'.

Since October 2018 KCHFT have also noted a considerable decrease in the quality of service received by IHSS, in relation to missed deadlines for deliveries, incorrect deliveries (i.e. to the wrong site) and missing and broken instruments. This impacted on services, and was identified in a contract meeting in December 2018. The medical devices manager requested an action plan from IHSS, and a dental lead was meeting monthly with IHSS to address some of the issues directly, however no improvement had been seen.

Following this, the Assistant Director of IPC and the KCHFT Trust independent authorised engineer undertook an inspection and audit of IHSS premises at Aylesford and Aylesham on 6 February 2019, and whilst compliance to decontamination requirements was found, concerns were raised regarding other systems and processes relating to quality. It was also ascertained that IHSS had been sold to another company recently, who were also selling the healthcare aspects again, potentially putting decontamination and quality processes at risk. KCHFT have formally written to IHSS requesting actions to address the concerns, and services are currently reviewing alternative possible sources of decontamination, if IHSS should be unable to continue to provide us with a service (this has been added to risk registers in dentistry and podiatry).

The Authorised engineer for decontamination has also undertaken an assessment in dental service where reprocessing takes place. Verbally he reported full compliance – but a full report is still awaited.

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. Hydrotherapy user groups have recommenced, and local and standard protocols are being reviewed.

10.SEPSIS

The IPC Team continues to lead on the Trust 'SEPSIS' awareness programme. There is a plan for IPC link practitioners to be 'SEPSIS' champions and ensure

SEPSIS posters and algorithms are available through every service. The new NEWS 2 assessment form will also prompt staff to ‘consider sepsis’

11. 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 we are focussing on managing local outbreaks of infection, and ensuring our staff continue to comply with IPC Trust policies and protocols.

Lisa White
Assistant Director of Infection Prevention and Control
March 2019

Kent Community Health NHS Foundation Trust

INFECTION PREVENTION AND CONTROL DECLARATION 2019

The Board of Kent Community Health NHS Foundation Trust is assured that the following are in place, in line with the Hygiene Code.

- Kent Community Health NHS Foundation Trust meets statutory requirements in relation to the Hygiene Code.

- Kent Community Health NHS Foundation Trust has an Infection Prevention and Control policy in place to ensure best practice and to reduce HCAI's

- All staff within Kent Community Health NHS Foundation Trust are provided with infection prevention and control training on induction, and regularly through employment, which includes practical training and assessment in hand hygiene. The training is mandatory for all staff, and Compliance is monitored centrally and reported to the Board.

- The Board level Executive Lead with the responsibility for infection prevention and control in Kent Community Health NHS Foundation Trust is the Chief Nurse/Director of Infection Prevention and Control (DIPC) ensuring that Infection Prevention and Control is prioritised on the quality agenda.

- Kent Community Health NHS Foundation Trust has an Infection Prevention and Control Team with responsibility for delivering the Infection Prevention and Control Work plan

- Kent Community Health NHS Foundation Trust has a bi-monthly Infection Prevention and Control Sub Committee which is chaired by the Chief Nurse/DIPC.

- There is an annual audit programme, to monitor compliance with the Infection Prevention and Control policies and guidelines.

- The Board reviews Infection Prevention and Control data across the organisation on a monthly basis, via the Performance Report. The Quality Committee receive a full report from the Assistant Director of Infection Prevention and Control quarterly which is then presented to the Board by the

DIPC. The Trust Board receive an annual report on Infection Prevention and Control.

By email:

Glenn Douglas
Chief Executive of Kent & Medway STP

08/11/2018

Dear Glenn,

Kent and Medway System Infection Management Leadership

Thank you for inviting us to the Kent and Medway System Leadership meeting on 19th October 2018 to discuss infection prevention, antimicrobial stewardship and healthcare associated infection (HCAIs) leadership across the whole health economy. We were impressed by the approach taken and the appointment of a system Director of Infection Prevention and Control (DIPC); this provides an excellent opportunity to shape new ways of working.

Kent and Medway is one of three health economy pilot sites across England that we are supporting to understand what leadership needs to be in place for infection management, ranging from preventing infections to antimicrobial stewardship (AMS). Learning and experience of how cross-system leadership in the field of infection prevention and antimicrobial resistance can be developed and supported to engage and assist reductions in infections across healthcare boundaries will enable us to determine the impact on healthcare associated infections, including Gram negative bloodstream infections. This will support the ambition to halve the number of these infections by March 2021.

At the meeting on 19th October, we discussed some of the opportunities the teams felt may improve system leadership within antimicrobial stewardship and prescribing. There is, for example, potential to develop a new role across Kent and Medway for a consultant antimicrobial pharmacist that could support the DIPC in providing expertise within this field. We have also offered the system support with prescribing data analysis which will be aimed at antimicrobial pharmacists, precribers of antimicrobials and infection prevention teams across the system.

We would like to suggest the following actions to support the ongoing cross-system improvement work:

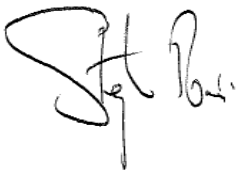
- Support the reduction of HCAIs and improve AMS by reviewing and acting on regular reports from the Kent and Medway Director of Infection Prevention and Control (DIPC)

- All organisations to have completed a self-assessment against The Health & Social Care Act 2008: Code of Practice on the prevention and control of infection and related guidance and National Institute for Health and Care Excellence (NICE) Antimicrobial Stewardship: systems and processes for effective antimicrobial medicine use Baseline Assessment Tool and boards to have oversight of the content. A gap analysis together with an action plan stating requirements needed to meet compliance to be produced.
- Assurance to be provided to the Kent and Medway DIPC that each organisation or trust is reducing HCAIs, reducing antibiotic prescribing and improving antimicrobial stewardship
- To strengthen senior professional engagement, all boards to ensure that their DIPCs and/or Director of Public Healths are attending the Kent and Medway Infection Control and Antimicrobial Stewardship Committee.
- We would encourage all providers to submit the voluntary risk factor data for Gram negative bloodstream infections and antimicrobial prescribing/review to as this will give a wider view of areas for interventions to drive improvements.
- We would like to use Kent and Medway as a reference site for this new way of developing system wide improvement plans to address this very important agenda.

We would like to take this opportunity to thank you for your continued support with this system leadership pilot and we hope that you are able to see the benefits of closer working to reduce Gram negative bloodstream infections and to improve antimicrobial stewardship.

If you have any questions in relation to the matters set out in this letter, please contact Gaynor Evans, Clinical Lead for GNBSIs at NHS Improvement, by email at gaynor.evans2@nhs.net.

Yours sincerely,



Professor Stephen Powis

National Medical Director

NHS England

Ruth May

Executive Director of Nursing, Deputy CNO, National Director of Infection, Prevention and Control

NHS Improvement

[cc Gail Locock, Director of Infection Prevention, Kent and Medway]

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	4.3
Agenda Item Title:	Patient Experience and Complaints Report
Presenting Officer:	Dr Mercia Spare, Chief Nurse (Interim)

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

Report Summary
This report provides a summary of information regarding complaints, Patient Advisory Liaison Service (PALS) and patient experience feedback across all clinical services for Quarter 3, 1 October to 31 December 2018.

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

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

Sue Mitchell, Assistant Director for Patient Safety and Experience	Tel: 01233 228851
	Email: s.mitchell13@nhs.net

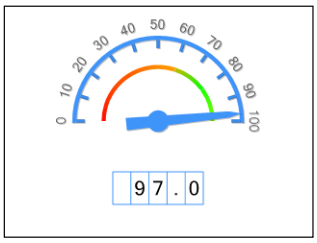
Kent Community Health
NHS Foundation Trust

PATIENT EXPERIENCE AND COMPLAINTS REPORT

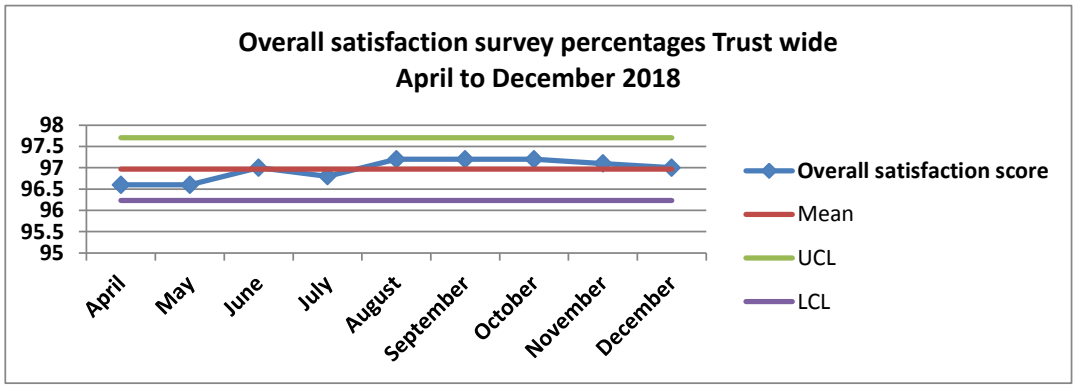
This report provides a summary of information regarding complaints, Patient Advisory Liaison Service (PALS) and patient experience feedback across all clinical services for Quarter 3, 1 October to 31 December 2018.

1.0 Combined Satisfaction Score (local surveys)

15,662 surveys were completed by KCHFT patients, relatives and carers with a strong combined satisfaction score of **97%** in Quarter 3.

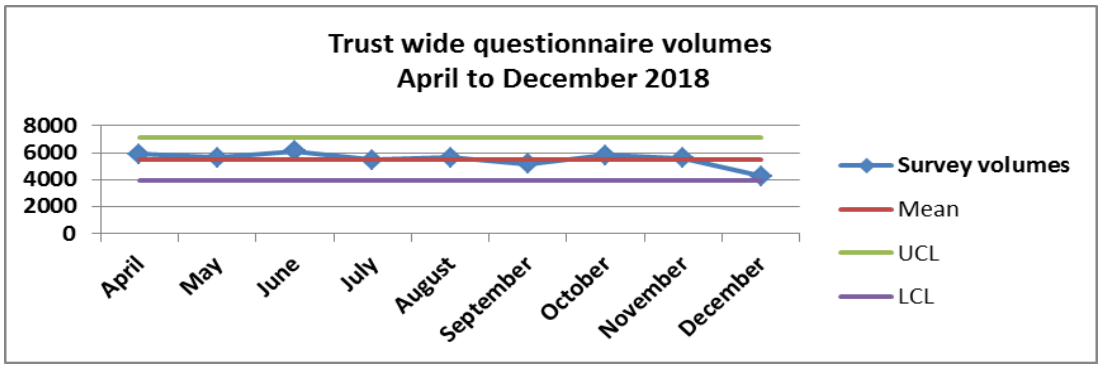


Overall satisfaction survey percentages Trust wide from April to December 2018 were consistently good, with a fluctuation from month to month of less than 1%.



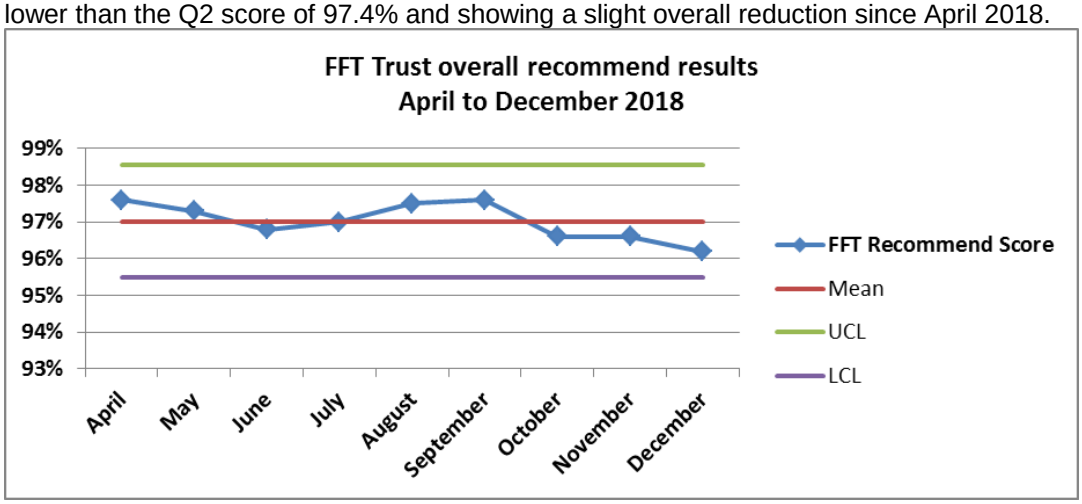
2.0 Meridian Surveys

Survey volumes have decreased slightly in Q3 when compared with Q2. This is in line with the general trend seen over recent years due to the run up to and over the Christmas period and is not related to any specific services. Survey volumes are anticipated to follow the usual trend and increase in January 2019.

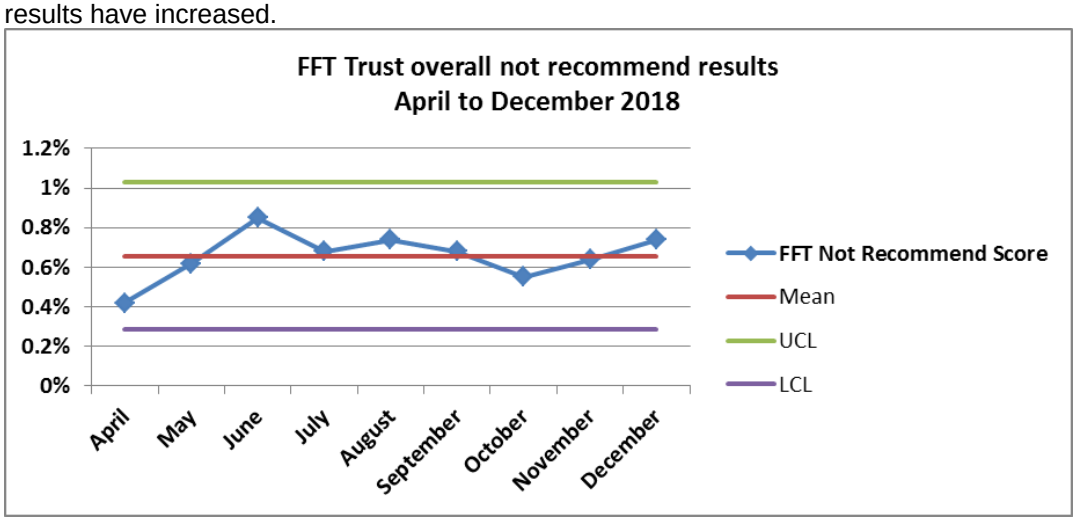


3.0 NHS Friends and Family Test (FFT) - How likely are you to recommend this service to friends and family if they needed similar care or treatment?

14,818 FFT surveys were completed during Q3. The FFT recommend score for Q3 was 96.5%, slightly lower than the Q2 score of 97.4% and showing a slight overall reduction since April 2018.



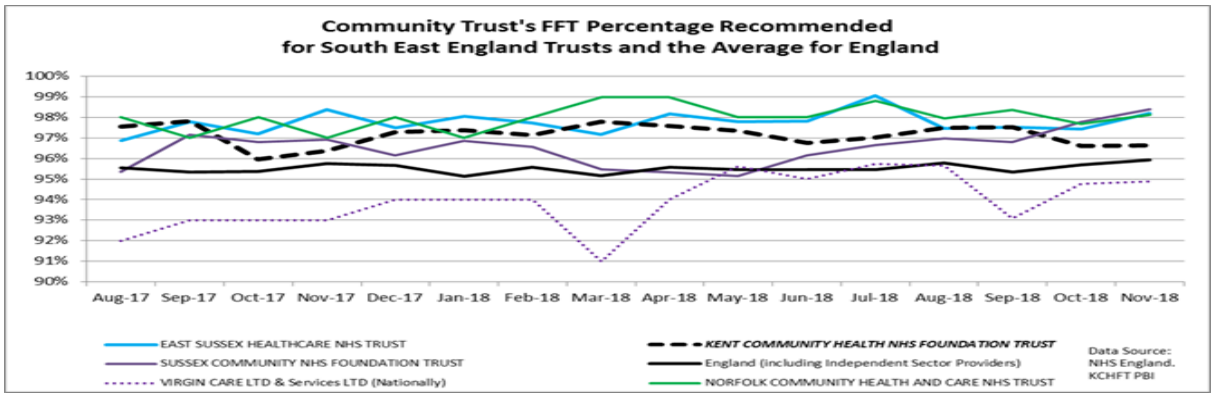
0.6% (94) of our patients chose not to recommend the service they received by answering unlikely or extremely unlikely response, compared with 0.7% in Q2. However, since April 2018 Not Recommend results have increased.

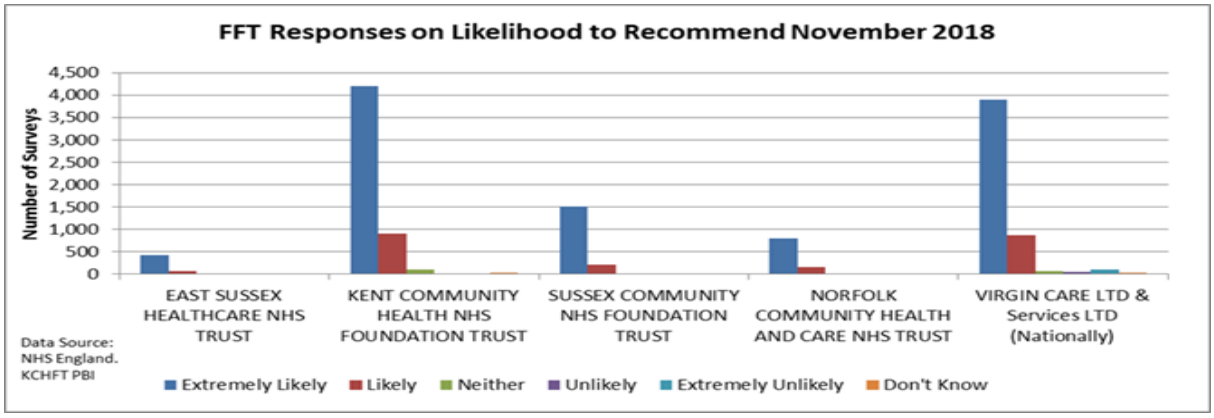


The percentage for each FFT question response in relation to the number of surveys is shown below:

Quarter	Total responses	Extremely Likely	Likely	Neither Likely or Unlikely	Unlikely	Extremely Unlikely	Don't Know
Q3 2018/19	14818	79.1%	17.4%	2.0%	0.3%	0.4%	0.8%
Q2 2018/19	15058	78.8%	18.6%	1.3%	0.3%	0.4%	0.6%
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%

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 averages 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 - Minor Injury Units (MIUs)

FFT recommend scores for all MIUs were high in Q3, ranging from Sevenoaks (96%) to Sittingbourne (100%). Only 8 unlikely / extremely unlikely responses were received out of a total of 3,892 completed surveys, equating to 0.2%. Gravesham had the greatest number of surveys completed (1,473), followed by Folkestone (957) and Deal (518).

3.2 FFT - Community Hospitals

Community hospitals also scored very highly with the FFT question in Q3, with the exception of QVMH (88.2%). 34 surveys were completed for QVMH during the period and only 1 patient gave a negative FFT response (unlikely). One patient chose 'neither likely nor unlikely' and 15 chose the 'likely' response. The low score is as a result of the weighting calculation used for the FFT responses. Survey volumes for most hospitals saw either a decrease in numbers throughout Q3 or a fluctuation from month to month, with the exception of Hawkhurst and Sevenoaks hospitals. The number of completed surveys for Sevenoaks increased over Q3 and Hawkhurst returns remained level over the whole period.

3.3 FFT Extremely likely and unlikely responses

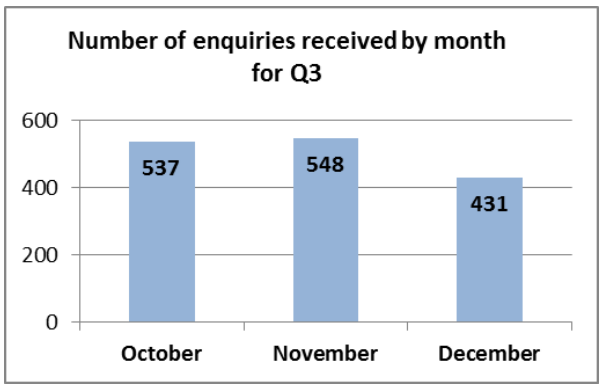
Directorate	Unlikely	Extremely unlikely	Total
Public Health and Children's Specialist and Learning Disability Services inc Dental (5) & Sexual Health (3)	**5**	**10**	**15**
Adult	**8**	**7**	**15**
Health Improvements	**0**	**0**	**0**
	13	**17**	**30**

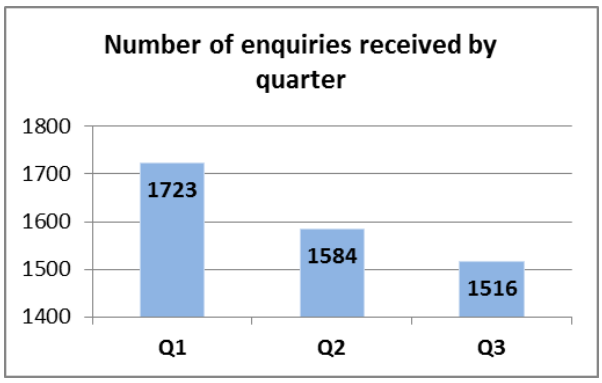
Of the 30 unlikely/extremely unlikely response, 5 surveys completed by children 10 responses appear to have been answered incorrectly as the remainder of the feedback was positive. In the remaining 15 responses, the majority of feedback was linked to waiting times to be seen in walk-in clinics and for scheduled appointments. 2 responses were about the treatment received not meeting expectations. Single comments were made about staff attitude; misplaced records at an MIU appointment and one patient felt that staff ignored their request. 2 people gave multiple reasons for not recommending the service they used.

The following surveys were responded to in detail by services concerned:

395211	52.50%	13 Dec 2018	**Children's Speech and Language Therapy - Gravesham**	Extremely unlikely
Feedback: Huge waiting time of 1 year! Awful. Group workshop not appropriate to specific cases, all just general advice. Actually see our child! Not actually seen by the service! Shocking!!				
The service is aware that there are long waiting times for children to access therapy, but there shouldn't be a year wait for a workshop. The current pathway is that a parent workshop is the first contact for many of the pre-school referrals that come in. One of the locality teams has been trialling group assessments so a child is seen for a quick screening assessment before the parent is asked to attend a workshop. This makes sure the child is put on the right pathway. In January 2019 the service plans to consider duplicating this approach in other localities.				
397247	8.33%	27 Dec 2018	**Community Nursing – Sevenoaks**	Extremely unlikely
Feedback: The nurse today blatantly ignored a very important request I've previously made regarding access to my home. Only one or two DNs take into account my severe Autism. I feel discriminated against for having a disability by the very people who are meant to be helping me.				
At the next team meeting staff are to be reminded of the importance of accessing a patient's property through the agreed access point. Action added to improvement plan.				
394781	85.71%	12 Dec 2018	**Community Chronic Pain - Ashford**	Extremely unlikely
Feedback: The building is completely inappropriate for our visit, the appointment was for pain clinic - the room we were seen in was next to a gym which had a negative emotional effect on my husband's health. The building is miles away from the car park; the reception is round the back of the building making it uncomfortable to get there by mobility scooter. We have previously been seen at St Stephens Walk, which has parking nearer and is much more accessible for disabled people and doesn't have super fit people staring at a young disabled man making him feel inferior and useless. Please change the pain clinic venue from the Stour Health Centre. (Contact details left for service to make contact).				
The clinician apologised to this patient at the time of the appointment. The patient has been reassured that future appointments will not be booked at the same location. Following completion of this survey, the service undertook to contact the patient to offer a further apology. This feedback will be discussed with the admin coordinator and project lead as this is a new venue that the service has recently starting using. The service are looking for alternative locations, however, in order to provide a service to patients in the Ashford area, there are currently no alternative locations.				

4.0 Patient Advisory Liaison Service (PALS) enquiries for Q3 2018





Most calls received during Q3 were telephone number enquiries (1,132) and 384 other enquiries which mainly related to appointments (96) and signposting (67). 44 of the signposting calls were from KCHFT staff and 23 from external people indicating that this service is valuable to both staff and patients.

Other main themes related to access/treatment (38), complaints (27) and communication (11). The number of calls taken regarding staff attitude was very low during Q3 (6). The highest number of calls related to Podiatry (55), Health Visiting (33), Chronic Pain (27), Community Orthopaedics (20), Community Nursing (15), Community Paediatrics (14) and MSK Physiotherapy (14).

Calls for Podiatry were high in October (35) due to patients having difficulty with booking appointments / getting through on the appointment line. The issue was resolved by the service having new a telephone

booking system installed and new staff appointments to manage the phone lines. Calls reduced over the remainder of Q3 (12 November / 8 December).

In relation to reduced provision by the commissioners for breastfeeding support peers and groups earlier in 2019, calls were still being received by PALS in relation to signposting (18). As a result of the changes in provision, breast feeding champions were appointed within the service, new breastfeeding information has been added into the Red Book and details added to all answerphone messages directing women to the national helpline and website for out of hours' advice. Calls continued to reduce over Q3 (9 in November / 6 in December).

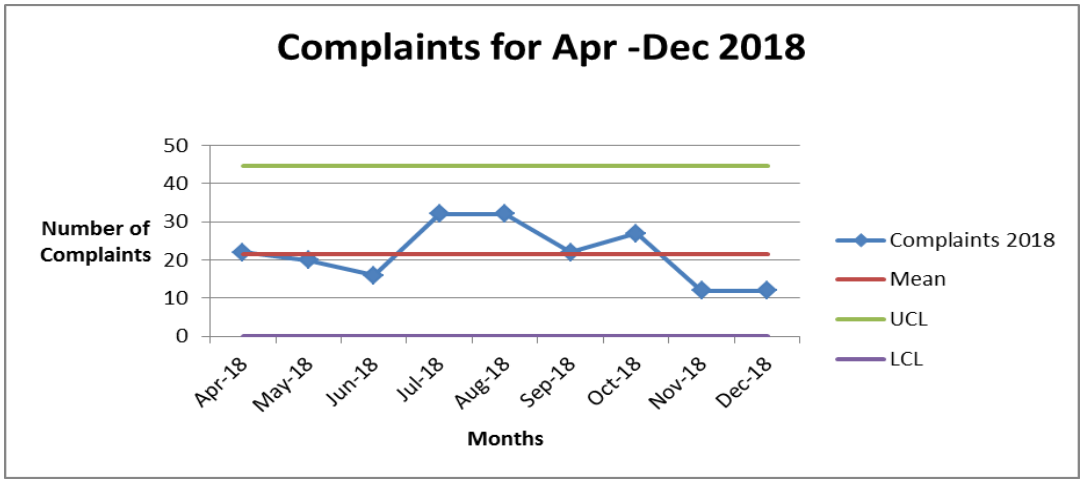
5.0 Patient reviews received via NHS Choices / Patient Experience generic email for Q3, 2018
25 reviews were received for services listed below. 13 were positive, 7 negative and 5 mixed.

Service	Number of reviews:		
	Positive	Negative	Mixed
Community Nursing			2
Dental Service, New Street Clinic			1
Minor Injury Unit, Deal	3		
Minor Injury Unit, Gravesham	1		1
Minor Injury Unit, Sevenoaks	4	2	
Minor Injury Unit, Sittingbourne	2	1	1
Phlebotomy, Herne Bay		1	
Podiatry	1	2	
Physiotherapy (MSK) - Sheppey Community Hospital	1	1	
Pulmonary Rehabilitation Service	1		

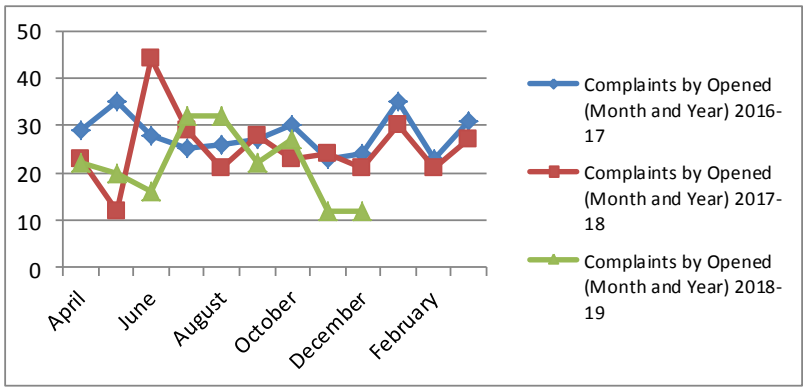
The majority were for the MIUs, with Deal and Sevenoaks receiving the most. The main positive themes related to care and compassion, short waiting times and treatment. Themes from negative feedback related mainly to waiting times at MIUs, lack of information and accessing other services.

6.0 Complaints received in Q3
In Quarter 3 a total of 51 complaints were logged. Of these 11 were multi-agency complaints, 6 being led by KCHFT, 3 by EKHUFT and two by NHS England. 3 of the 51 cases were related to end of life care.

The following graph shows numbers of complaints received since April 2018.



The following graph shows complaints received by month for the last 3 years.



6.1 Themes and trends of complaints for Q3

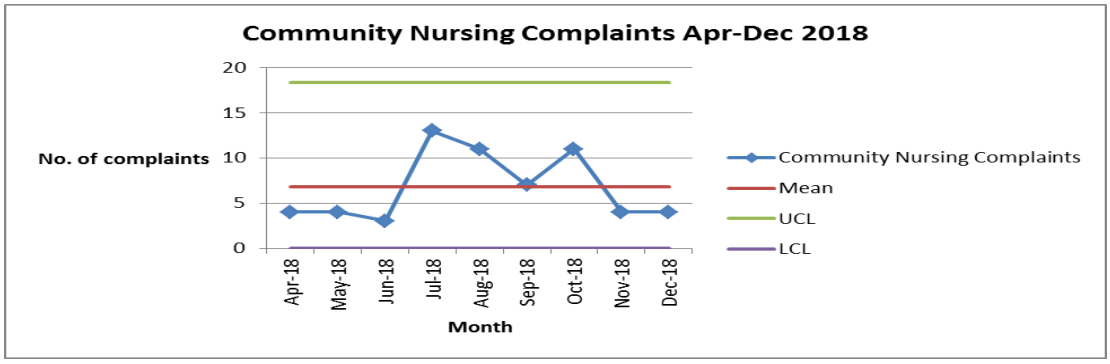
Theme	No. of complaints	Subject of complaints
Access to treatment and drugs	7	• Continence issues • Access to children's therapies and equipment – escalated and reported as a Serious Incident • Referrals (chronic pain and dental) • Lack of speech and language therapy and occupational therapy
Clinical treatment	16	• Querying care provided • Catheter change issues and lubricant used • Complainant felt not listened to about paediatric concerns • Querying speech and language therapy input • Querying implant removal process • Querying advice given at Minor Injury Unit (MIU) visit • Missed fracture at MIU (escalated and reported as a Serious Incident) • Deteriorating pressure sores • End of life care
Referrals, appointments, admissions, discharges and transfers	11	• Delays in visit for blood tests, blocked catheters, podiatry and flu jabs (one was escalated and reported as a Serious Incident) • Lack of / delay in getting dental appointments • Patient believed to be unfit for discharge from community hospital • Missed and reduced numbers of visits • Lack of appointments for therapy
Values and behaviours	3	• staff attitude being considered as rudeness when dealing with patients • a parent's perceived discrimination of their child as part of the National Child Measurement Programme (NCMP).
Communication	14	communication with • staff, other organisations, information given to patients and their families (one was escalated and reported as a Serious Incident)

6.2 Community nursing complaints

Community nursing services received 18 (35.3%) of the 51 complaints between October and December 2018, of all complaints received.

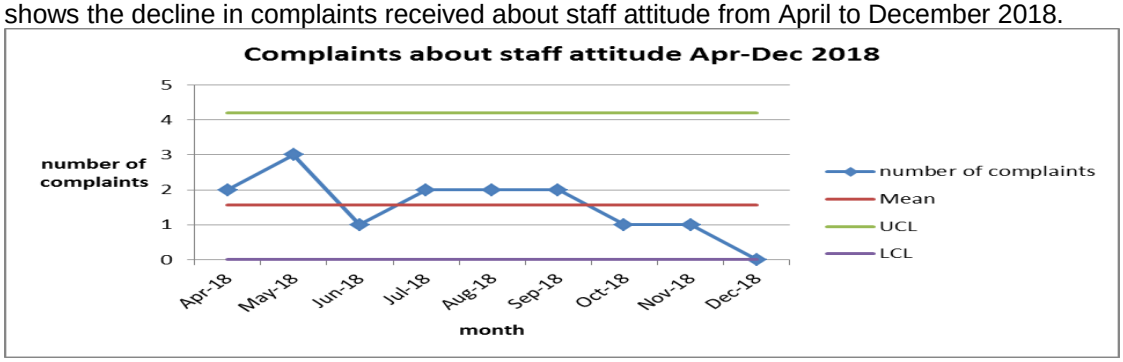
Team	No. of complaints	Subject of complaint
Ashford	2	• 2 x end of life care • continence assessment query • care provided by Hilton nursing
South Kent Coast	2 x Shepway 2 x Dover/Deal	• Delay in visit after fall • End of life care • Delay in contacting patient after referral • Delay in contact after being notified patient had died
Thanet	9	• 3 x failure to visit by nurses • Delay in visit for flu jab

		• Catheter care query • Visit by nurse when patient was in bathroom, patient not located before nurse left without providing care • Delays in getting blood test • Not listening to patient's views about treatment • Nursing care for pressure ulcers
Maidstone and Malling	1	• queries over catheter care and whether policy was being followed



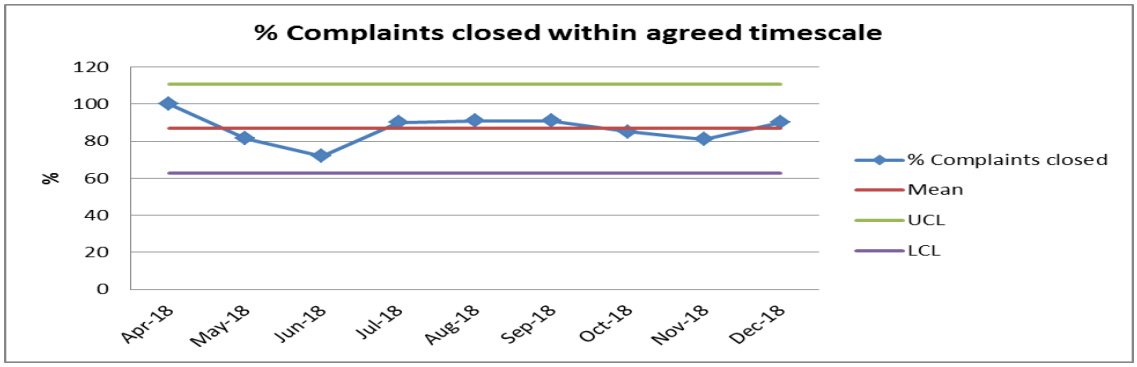
6.3 Complaints regarding staff attitude

2 complaints were received about staff attitude between October and December 2018. The graph below shows the decline in complaints received about staff attitude from April to December 2018.



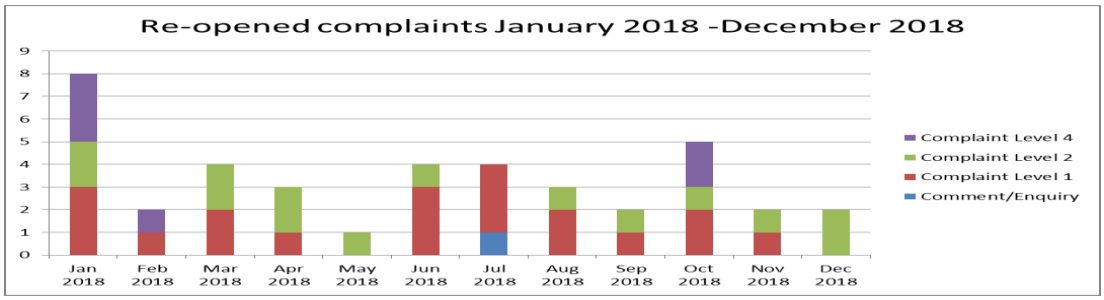
6.4 Closed Complaints

During Q3, 63 complaint cases were closed. 55 (87.5%) were closed within the agreed timescales. 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.



6.5 Re-opened complaints from January 2018 to December 2018

Numbers generally remain low, Level 1 complaints appear more likely to re-open, although it was two level 2 complaints in December. Staff are supported by the complaints officers to provide a robust response. 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. A Standard Operating Procedure (SOP) for complaints handling is also now available.



6.6 General question on surveys relating to complaints handling Q3 2018

During Q3, 10,449 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 97.5%, an increase when compared to Q2 when 9,731 people answered this question with a lower satisfaction score of 93.23%.

6.7 Feedback from complaints process survey

The complaints survey continues to be sent to complainants with their response. 33 surveys were sent during Q3. 5 completed surveys were received in total which equates to a response rate of almost 15%.

- 3 complainants felt overall their complaint had been handled well or very well. Results for the overall handling of the complaints question are shown below.
- One complainant felt their complaint had been handled poorly and one very poorly as follows:

Poorly: The complainant gave mainly positive answers, yet felt their complaint had been handled 'poorly' overall. They felt their parent had been treated badly due to their age. As a result of this feedback the complaint was re-opened. A response addressing the remaining issues raised was sent from the local clinical resource manager, Ashford locality.

Very poorly: The complainant had left their details asking for a response to their feedback. The Patient Experience Manager has been unable to make contact despite using the method requested by the complainant.

7.0 Lessons learned and improvements made

During Q3, a total of 27 actions were raised as a result of patient feedback received via the Meridian surveys or complaints. 21 actions were closed during the quarter and details of these have either been included in previous monthly reports or are shown in point 7.1 and 7.2 below.

7.1 Actions / improvements made during December 2018 from complaints

Service	Issue or problem identified and action taken
Rapid Response, Maidstone	Family member was unhappy with visit from nurses to confirm death of a relative as they did not inform the GP. **Action taken:** • Verification of Death policy has been updated accordingly • A copy of the policy is available as a mail merge document on CIS and Flo • Staff are now emailing patient details to GPs when verifying a death
Rapid Response, Ashford	Patient felt that the staff member did not provide appropriate treatment when dealing with a blocked catheter. **Action taken:** The importance of ensuring consent without patients/families feeling pressurised was discussed in a team meeting held on 30.10.18.

Service	Issue or problem identified and action taken
Diabetes Nursing	Patient was unhappy with the attitude of a staff member. **Action taken:** The staff member has received additional peer review sessions with the diabetes lead specialist nurse.
Rapid Response, Maidstone	Following the insertion of a syringe driver, the nurse gave the patient additional dosages of prescribed oral medication. The nurse should have sought advice from medicines management. **Action taken:** • Rapid Response and community nursing staff attended a training session on syringe driver medication management and symptom control facilitated by the lead pharmacist of medicines information and education and the nurse consultant for end of life care • KCHFT has extended access to 3 Boots pharmacy stores that are keeping a stock of end of life medication • All nurses have been made aware of the availability of the KCHFT on call pharmacist • Nurses have been advised that they must contact either the hospice or on call GP if they feel the prescribed medication is not providing adequate symptom control for a patient, regardless of the time of day or night • The service spoke with the complainant (patient's husband) to explain the action taken
Community Hospital (Inpatient), Faversham	Family unhappy with the care provided by hospital regarding the following: • antibiotics were stopped • the discharge process • physio for patient • lack of buff sheet on discharge • changes to medication not communicated • poor communication with family from staff member **Action taken:** Staff attended 2 workshops; 1 on complaints and the other on how staff can work effectively together to provide the best care for their patients.
Community Nursing, Ashford	A family member was concerned when a staff member revisited patient's home unexpectedly. **Action taken:** • A development plan for the member of staff was put in place • This included re-reading and understanding the KCHFT Sharps policy and No Access policy. A refresher in Information Governance (IG) knowledge was undertaken, in particular the documentation of key codes • Training was identified and completed for clinical record keeping and the law and dementia awareness • Member of staff reminded to document any untoward event on CIS • Member of staff agreed to telephone patients if their visit time changes • A full review took place at the member of staff's probation meeting
Community Nursing, Ashford	A family member was unhappy that the patient should have received community nursing visits twice daily, however the nurse only came once. **Action taken:** • A new allocation process has been implemented within the locality. Patients are RAG rated on CIS, red – visit within 24 hours, amber - visit within 48hrs green – visit within 3 days. If a patient's visit is deferred the RAG rating is changed to red • All admin posts are now filled to enable CIS to be monitored effectively
Community Nursing, Ashford	EKHUFT led on this complaint and requested comments on the nursing care provided by KCHFT regarding deterioration and continence issues to include in their response. **Action taken:** • A new internal referral has been implemented from the bladder and bowel team facilitated via CIS. • GPs informed of referral process

7.2 You said, we did (YSWD): feeding back changes that have been made to our patients

A total of 18 You said, We did examples from closed actions were uploaded onto the relevant service pages on the public website during Q3. The below YSWD examples were uploaded onto the KCHFT public website during December.

Service	You said	We did
East Sussex Children's Int. Therapy Service	Parents were unhappy that their child had to wait for suitable equipment.	All localities have adopted a new process for monitoring equipment requests to ensure deliveries are made efficiently.

Adult Diabetes Nursing Service	A patient was unhappy with the attitude of a member of staff.	The staff member has received additional peer review sessions with the diabetes lead specialist nurse.
Community nursing, Ashford	A relative was concerned when a staff member revisited the patient's home unannounced.	The staff member has been reminded of the importance of the No Access Policy and in future will always telephone patients in advance if their visit time changes.
Community nursing, Ashford	A family member was unhappy that the patient should have received community nursing visits twice daily, however nurse had only visited once.	A new allocation process has been implemented within the locality and admin staff appointed to monitor this.
Community nursing, Ashford	A continence assessment was delayed as the referral process had not been well organised.	An internal process has been implemented to ensure continence referrals are carried out efficiently. The GP surgery has been advised of the new process.
Faversham Cottage Hospital	A patient felt a staff member had come across as being uncaring and rude.	All staff have undertaken or are booked to attend customer care training.

8.0 Compliments recorded on Meridian

8.1 Compliments received from patients/carers/families
During Q3, 461 compliments were recorded on Meridian. This equates to 247 for adult services, 151 for Public Health and Children's Specialist and Learning Disability Services, 57 for health improvement services and 6 for Nursing and Quality (Community Medicines Team and Pharmacy Services). Compliments are made by patients and relatives thanking staff for their excellent care. Staff are often complimented on their kindness and friendliness and praised for being understanding and supportive.

8.2 Compliments received from other services and external providers
During Q3, **57** compliments were recorded on Meridian (**18** in October, **24** in November and **15** in December). **8** for adult services, **44** for Public Health and Children's Specialist and Learning Disability Services, **4** for health improvement services and **1** for Nursing and Quality. Compliments were mainly from other organisations thanking staff for reasons such as providing training, working with students, undertaking health checks and assisting social workers with finding placements for young children.

9.0 Key improvements
During Q3 the Patient Experience Team produced 3 specialist surveys to assist services in collecting feedback from hard to reach patients:

- **Community Learning Disability Service:** The trial of a short audio/pictoral survey was rolled out at the end of November and is going well with a total of 29 completed surveys during Q3. All surveys have scored extremely well. The overall scores were 100% for questions 'Did we help you today?' and 'Were you happy with what we did?' and 96.6% for 'Would you like us to come back?'.
- **Forget Me Not Patient Feedback form** (for patients with a confirmed diagnosis of dementia or those with a cognitive impairment): A total of 41 surveys were completed during the pilot that commenced in Hawkhurst and Faversham community hospitals in October. The survey is being rolled out for use across all community hospitals in January 2019.
- **Dental Services:** An easy read/pictoral survey was introduced during December. It is available in paper format, via the public website and was uploaded onto the service's Meridian iPads. This survey is targeted for completion by patients with learning disabilities and those for whom English is not their first language. The Immigration Removal Centres and London clinics hope to gain valuable feedback using this survey as they treat patients with a wide range of diverse cultures. A total of **80** surveys were completed by 5 of the dental clinics during the 2 week period in December with very good overall satisfaction scores.

10.0 Recommendations
The Board to note the report.

Sue Mitchell
Assistant Director Patient Safety and Experience
14 January 2018

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	4.4
Agenda Item Title:	Risk Management Strategy
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary
This Strategy aims to ensure that there is a consistent and effective approach to Risk Management across the organisation by embedding it into the Trust's processes and practices.

Proposals and /or Recommendations
To receive the strategy.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
Yes ☒

Shane Webber, Assistant Director of Compliance	Tel: 01233 667747
	Email: shanewebber@nhs.net

Kent Community Health
NHS Foundation Trust

Risk Management Policy and Strategy

Document Reference No.	CQS017
Status	Final
Version Number	Version 3.7
Replacing/Superseded policy or documents	Risk Management Policy Version 3.6
Number of Pages	22
Target audience/applicable to	All staff
Author	Head of Risk
Acknowledgements	Assistant Director of Compliance, Corporate Services Director
Contact Point for Queries	Head of Risk
Date Ratified	March 2018
Date of Implementation/distribution	May 2018
Circulation	Policy dissemination / Flo
Review date	March 2021
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EXECUTIVE SUMMARY

This policy and strategy aims to ensure that there is a consistent approach to risk management across the organisation by embedding it into the Trust's processes.

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

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

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

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

Governance Arrangements

Governance group responsible for developing document	Corporate Assurance and Risk Management Group - CARM
Circulation group	FLO, Policy Distribution
Authorised/Ratified by Governance Group/Board Committee	Audit and Risk Committee
Authorised/ratified on	March 2018
Review Date	March 2021
Review criteria	This document will be reviewed prior to review date if a legislative change or other event dictates.

Key References

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

Related Policies/Procedures

Title	Reference
Incident Policy	CQS016
Health and Safety Policy	HS012
Serious Incident Policy and Procedure (including Never Events)	CQS027
Lone worker Policy	HS015
Managing Violence and Aggression Policy	HS018
Standard Infection Control Precautions Policy	IPC010
Education and Workforce Development Policy	HR016
Privacy and Dignity Policy	QC001
Accessible Information Policy	IML006
Learning from Experience Policy	IML005

Document Tracking Sheet

Version	Status	Date	Issued to/approved by	Comments / summary of changes
3.0	Approved	28/02/2013	Trust Board	Published
3.1	Approved	20/02/2014	Audit and Risk Committee	Minor amendments
3.2	Approved	26/02/2015	Audit and Risk Committee	Minor amendments
3.3	Approved	25/02/2016	Board	Minor amendments to the strategy
3.4	Approved subject to amendment as noted in 3.5	15/02/2017	Audit and Risk Committee	Updated wording of strategic goals Updated golden thread to include new Trust values Removal of appendices and link to documents on Flo
3.5	Pending approval	30/03/2017	Board	Amendments to sections 4.2.5 – 4.2.7 to clarify wording of risks across multiple services
3.6	Approved subject to amendment	30/03/2017	Board	Amendment to the strategic goals in 1.9.2. Formatting tidied, staff names removed, related policies updated
3.7	Final	March 2018	Board	Minor amendments, see summary below

Summary of Changes

Change from a Strategy to a Policy and Strategy
Amendments including insertion of training, definition of tolerated risk, update to governance group responsibilities and risk categories.
Formatting and numbering tidied

CONTENTS

1.0 INTRODUCTION

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

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

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

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

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

1.5 What is a Risk?

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

1.6 What is Risk Management?

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

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

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

1.7 Why manage Risk?

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

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

1.8 Who this Policy and Strategy applies to

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

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

1.9 Aims and objectives of this Policy and Strategy

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

1.9.2 To achieve this vision, the Trust's has identified four key areas:

(1) Building high performing local integrated teams, with GPs and based around groups of General Practices

(2) Dedicating time, resources, expertise and leadership to fully implement the 'Home First' service model across Kent.

(3) Ensuring that patients and clinicians have access to high quality specialist community services.

(4) Making a step change impact in prevention and health promotion in Kent.

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

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

1.9.5 The policy and Strategy describes:

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

1.10 Organisational Context

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

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

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

- Incident Policy
- Serious Incident Policy and Procedure (including Never Events)
- Customer Care Policy
- Claims Management Policy
- Health and Safety Policy
- Business Continuity Plan
- Lone worker Policy
- Violence and Aggression Policy
- Security Management Policy
- Learning From Experience Policy

1.11 Equality, Diversity and Inclusion

1.11.1 Communication and the provision of information are essential tools of good quality care. To ensure full involvement and understanding of the patient and their family in the options and decision making process about their care and treatment, all

forms of communication (e.g. sign language, visual aids, interpreting and translation, or other means) should be considered and made available if required. These principles should be enshrined in all formal documents.

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

1.11.3 The privacy and dignity rights of patients must be observed whilst enforcing any care standards e.g. providing same sex carers for those who request it. (Refer to Privacy and Dignity Policy).

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

1.11.5 Staff must be aware of personal responsibilities under equality legislation, given that there is a corporate and individual responsibility to comply with equality legislation. This also applies to contractors when engaged by the Trust, for NHS business.

1.12 Equality Analysis

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

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

1.12.3 Protected Characteristics under the Equality Act 2010 are:

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

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

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

2.0 ROLES AND RESPONSIBILITIES

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

2.2 Chief Executive

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

2.2.2 The Chief Executive:

- Designates responsibility and authority to the Executive Team to ensure the necessary organisational structure and resources to implement policies and effectively manage risks.
- Is accountable to the Board for ensuring that it receives the appropriate level of information to enable it to be assured that systems to manage risks and maintain quality service provision are operating effectively.
- Through the responsibility delegated to the Directors, is aware of all key decisions made within the Trust. They ensure actions to reduce risk are considered when strategic, operational or financial decisions are made, including the means by which effectiveness of action to reduce risk and maintain quality and patient safety is monitored.
- Uses this information to provide assurance to the Board in the Annual Governance Statement that risk is managed and mitigated regardless of source as far as is reasonably practicable.
- Identifies to the Trust Board by means of the BAF where a risk may need to be accepted by the Trust Board and those risks which may affect the ability of the Trust to meet its strategic objectives.

2.3 Corporate Services Director

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

leading on clinical risk management and the Director of Finance leading on financial risk management.

2.4 Directors

2.4.1 Directors are responsible for:

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

2.5 Assistant Directors / Community Service Directors

2.5.1 Assistant Directors / Community Service Directors are responsible for:

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

2.6 Heads of Service

2.6.1 Heads of Service are responsible for:

- Ensuring that risk management processes, including Risk Registers, are in place and managed effectively within their service.
- Ensuring that the risk management process is embedded within their service, which will include ensuring that all teams and departments produce, or contribute to a Risk Register and submit it by an agreed deadline.
- Reviewing and approving all risks raised by their service, and recording the action plan.
- Where needed, meet with the risk team to review and update risks.
- Consulting the relevant subject matter expert when determining controls and producing an action plan to reduce the risk further.
- The management of all low and medium rated risks.

2.7 Team / Department Managers

2.7.1 Team / Department Managers are responsible for:

- Ensuring that risk management processes, including Risk Registers, are in place within their service.
- Ensuring that the risk management process is embedded within their team.
- Receive training to support the implementation of risk management

2.8 All employees

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

- Familiarise themselves with this policy and Strategy
- Reporting risks to their line manager.
- Reporting near misses and incidents as described in the Incident Policy
- Reporting risks appropriately where staff are concerned that a member of staff or patient may be involved in a terrorist activity or is being radicalised. Further information can be sought from the Safeguarding Service.
- Being aware of known risks within their working environment – team / department managers will be able to inform employees of these.
- Being familiar with emergency procedures for their area of work.
- Complying with policies and procedures and not to interfere with or misuse any equipment which is provided for health and safety purposes.
- Attending any relevant training as advised by their line manager.

2.9 Head of Risk

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

2.10 Organisation Risk Management Structure

2.10.1 Kent Community Health NHS Foundation Trust Board:

- Owns the organisation's Risk Management Policy and Strategy
- Defines the organisation's overall risk appetite.

- Receives sufficient assurance that the Risk Management Policy and Strategy is being adhered to.

- Monitors and acts on escalated risks.

- Demonstrates that it takes reasonable action to assure itself that the Trust's business is managed efficiently through the implementation of controls to manage risk.

- Appoints the Audit and Risk Committee to confirm the risk appetite for identified risks and to provide assurance that appropriate action is taken to control risk in line with the risk appetite.

- Appoints the Quality Committee to provide assurance and be assured that appropriate action is taken to control all aspects of clinical risk.

2.10.2 Audit and Risk Committee

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

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

2.11 Quality Committee

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

2.11.2 The Quality Committee's key responsibilities are to:

- Provide advice to the Board on the escalation of quality and safety risks onto the Corporate Risk register/Board Assurance framework.

- Review high level risks on the Trust clinical risk register which relate to patient safety and recommend appropriate actions

- Receive progress and assurance reports from the Nursing and Quality Directorate on the Monitor Quality Governance Framework action plan.

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

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

2.12 Finance, Business and Investment Committee

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

2.13 Executive Team Meeting

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

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

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

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

2.14 Corporate Assurance and Risk Management Group

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

2.15 Patient Safety and Clinical Risk Group

2.15.1 The Patient Safety and Clinical Risk Group review all high rated clinical risks and there movement. Additionally the group identifies themes and trends throughout clinical services. Areas of concern are escalated to the Executive Team as appropriate.

2.16 Operational Directorates' Quality Groups

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

2.17 Links between Assurance Committees

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

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

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

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

3.0 RISK MANAGEMENT FRAMEWORK

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

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

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

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

3.5 Risk Assessment and Management Process

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

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

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

3.6 Identifying Risk

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

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

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

- Potential non-achievement of objectives
- Claims
- Complaints
- Incidents, including Serious Incidents
- Near Misses
- Audits
- Care Quality Commission Quality Risk Profile
- Health and Safety Law
- Legislation
- Patient feedback

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

3.7 Analysing Risk

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

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

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

3.8 Assessing Risk

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

3.8.2 The risk rating is established by looking at the two elements of the risk: the severity level of the impact (between 1 and 5, with 1 being insignificant and 5

being catastrophic) and the likelihood of the consequence occurring (between 1 and 5, with 1 being rare and 5 being almost certain).

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

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

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

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

3.9 Categorising Risk

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

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

3.10 Risk Appetite

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

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

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

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

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

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

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

3.11 Treating Risk

3.11.1 Based on the risk assessment, the Head of Service (or delegated responsible person) will decide an appropriate risk response:

- Treat the risk (the most common response) – in which case an action plan to gain further control will be written.
- Tolerate the risk, in which case no further action will be taken to reduce the risk, although the risk should still be documented along with a detailed description of the controls, as the effectiveness of these will need to be monitored.
- Terminate the activity giving rise to the risk.
- Transfer the risk – place the hazard and associated risks under the control of a body outside the organisation who have the necessary system and competencies to effectively manage the risk. It may also be possible to transfer risk actions between directorates if the risks can be more easily addressed with the skill set in the alternative directorate. This will be determined and agreed at CARM.

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

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

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

3.12 Adding / Updating a Risk on a Risk Register

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

3.12.2 Risks must be reviewed regularly and at least on a bimonthly basis. Where review deadlines lapse, the Risk Management Team will follow this up through the bi monthly risk meetings with services/directorates.

4.0 RISK ESCALATION AND FEEDBACK

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

4.2 Department and Team

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

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

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

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

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

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

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

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

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

4.3 Executive Team

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

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

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

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

4.4 Management responsibility for different levels of risk within the organisation

4.4.1 Heads of Service are responsible for validating all risk assessments, and for ensuring that sufficient controls are in place. Risks which are rated as high will be reported to the Director responsible for the service raising the risk by exception. The Head of Service should ensure that an action plan to gain further control is documented, taking advice from the subject matter expert where applicable.

4.4.2 Risk Grade:

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

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

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

5.0 TRAINING AND AWARENESS

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

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

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

5.4 Risk Management awareness training sessions are delivered by the Risk Management Team by contacting directly.

5.5 Online 'How 2' Training is available through flo.

6.0 MONITORING COMPLIANCE AND EFFECTIVENESS OF THIS POLICY AND STRATEGY

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

What will be monitored	*How will it be monitored*	*Who will monitor*	*Frequency*
Manager's knowledge of this policy and Strategy with specific reference to the authority of all managers with regard to managing risk	CARM membership and quality of the risk registers	Corporate Services Directorate CARM Chair	Annually
Quality and effectiveness of Board Assurance Framework and risk management processes	Audit of framework	Internal Audit	Annually

7.0 EXCEPTIONS

7.1 There are no exceptions to this policy and strategy.

8.0 GLOSSARY & ABBREVIATIONS

8.1 Glossary:

Term	**Meaning**
Action Plan	Something that is going to be done to mitigate the risk (to reduce the likelihood or the consequence of it occurring). An action plan will be on-going over a specified period of time and will be owned by an individual
Board Assurance Framework (BAF)	The Board Assurance Framework (BAF) is a tool to assist the Board in assessing and mitigating the principal risks to the achievement of strategic objectives. . The tool also identifies gaps in control measures and gaps in assurances, as well as providing a means to monitor the work that is being done to mitigate the risk. The BAF is comprised of strategic risks identified against the strategic goals defined in the Five Year Strategy in addition to risks identified against the achievement of business and operational objectives. To provide assurance that these risks are being effectively managed, the BAF details the controls in place to mitigate each risk, any gap in control, assurance of the controls' effectiveness, the actions planned and being executed together with the date by when the actions are due to be completed. Each action on the BAF is given a Red, Amber, and Green (RAG) status. This enables actions that have either breached their initial target completion date or are considered unachievable to be identified more readily, and enables action owners to be held to account.
Control	Something that is already in place to reduce the consequence or likelihood of a risk effect occurring. If a control will be put in place in the future then this forms part of an "action plan" and is not considered a control.

Term	Meaning
Datix	Datix is the computerised Risk Management Tool used by KCHFT. It brings together information from risk, incidents, complaints and claims and facilitates reporting between these disciplines.
Gross Risk Rating	The risk identified at the point the risk is initially recorded. This rating will reflect controls in place at the time the risk was identified
Net Risk Rating	The level of risk currently remaining, given the controls currently in place. This risk rating should reduce as actions identified are implemented
Risk Rating	Once the impact and likelihood of a risk being realised has been evaluated, multiplying the consequence score by the likelihood score will give the risk rating: a value between 1 and 25
Risk Register	A Risk Register summarises information gained from the risk management process. It provides a description of the risk, the current controls in place, the current risk rating, a summary of the action plan, the date by when the actions are due to be completed by, the person responsible for completing the actions as well as the residual risk rating. It is used to communicate information about Risk around the organisation. Risk Registers are produced from Datix, the computerised Risk Management Tool used by KCHFT.
Risk Response	Describes whether the risk will be Treated, Tolerated, Terminated or Transferred. Commonly known as the “Four T’s”.
Tolerated risk	The Trust tolerates risks under the following circumstances: • The risk score is in line with the corporate risk appetite. • Further controls are prohibitive for reasons of cost, resources or operational constraints. • The Trust has developed all possible internal controls and is reliant upon third party activity to further reduce the risk. Where risks are tolerated above the corporate risk appetite, they remain under review. The Trust will implement further controls as soon as circumstances allow.

8.2 Abbreviations:

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

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	4.5
Agenda Item Title:	Use of Trust Seal Report
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary
To update the Board on the use of the Trust Seal and submit the Register of Sealings for the period April 2018 to March 2019.

Proposals and /or Recommendations
The Board accepts the record at Appendix 1 as a true representation of the Register of Sealings for the period April 2018 to March 2019.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ High level position described. The paper will have no impact on people with any of the nine protected characteristics

Gina Baines, Assistant Trust Secretary	Tel: 01622 211906
	Email: gina.baines@nhs.net

Kent Community Health
NHS Foundation Trust

USE OF TRUST SEAL REPORT

1. Introduction

The purpose of this report is to update the Board on the use of the Trust Seal and show the Trust's Register of Sealings from April 2018 to March 2019.

2. Background

Best practice for Governance and Assurance requires that a record is maintained detailing those occasions when the official Seal of the Trust is fixed to documents. It also requires that a report of all such sealings should be made to the Board at least annually, together with details of signatories. Appended to this report is the register of all occasions in which the Trust Seal has been applied to documents, together with the Officer/s Attesting the Sealing and to whom the document was disposed. In accordance with best practice this record is presented for information.

3. Recommendation

It is proposed that the Board accepts the record at Appendix 1 as a true Register of Sealings for the period April 2018 to March 2019 (inclusive).

Gina Baines
Assistant Trust Secretary
21 March 2019

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The Register of Trust Seals 2018/19

Date of sealing	No of copies sealed	Description of Document	Parties	Relating to	Names of persons attesting sealing	How document disposed of
19/06/2018	1	Renewal Lease By reference To An Existing Lease	Anthony Record and Carole Record KCHFT	Unit A Beechwood Business Park Gordon Road Whitfield Dover	Gordon Flack Director of Finance	Returned to Legal Services by hand
18/07/2018	1	Lease	Rablare Ltd and KCHFT	The Oast (Unit D) Hermitage Court Hermitage Lane Maidstone Kent ME16 9NT	Paul Bentley Chief Executive Gordon Flack Director of Finance	Returned to Legal Services by hand
27/11/2018	1	Underlease	Community Health Partnerships Ltd and KCHFT	Part of Lordswood Community Healthy Living Centre Sultan Road Lordwood ME5 8TJ	Paul Bentley Chief Executive Gordon Flack Director of Finance	Returned to Legal Services by hand
27/11/2018	1	Underlease	Community Health Partnerships Ltd and KCHFT	Part of Rainham Healthy Living Centre 103 - 107 High Street Rainham ME8 8AA	Paul Bentley Chief Executive Gordon Flack Director of Finance	Returned to Legal Services by hand
27/11/2018	1	Underlease	Community Health Partnerships Ltd and KCHFT	Part of Rochester Community Healthy Living Centre	Paul Bentley Chief Executive Gordon Flack Director of Finance	Returned to Legal Services by hand
27/11/2018	1	Underlease	Community Health Partnerships Ltd and KCHFT	Part of Balmoral Gardens Community Healthy Living Centre Balmoral Gardens Gillingham ME7 4PN	Paul Bentley Chief Executive Gordon Flack Director of Finance	Returned to Legal Services by hand

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	28 March 2019
Agenda Number:	4.6
Agenda Item Title:	Minutes of the Charitable Funds Committee Meeting of 29 November 2018
Presenting Officer:	Jen Tippin, Chair of Charitable Funds Committee

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

Report Summary
The paper presents the confirmed Minutes of the Charitable Funds Committee meeting of 29 November 2018.

Proposals and /or Recommendations
The Board is asked receive the confirmed minutes.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No ☒ High level position described and no decisions required. The paper will have no impact on people with any of the nine protected characteristics

Jen Tippin, Non-Executive Director	Tel: 01622 211906
	Email:

Kent Community Health NHS Foundation Trust

CONFIRMED Minutes of the Charitable Funds Committee held on Thursday 29 November 2018 in Room 6 and 7, Kent Community Heath NHS Foundation Trust Offices, Trinity House,110 – 120 Upper Pemberton, Eureka Business Park, Kennington, Ashford, Kent TN25 4AZ

Present: Jennifer Tippin, Non-Executive Director (Chair)
Pippa Barber, Non-Executive Director
Carol Coleman, Public Governor, Dover and Deal
Richard Field, Non-Executive Director
John Goulston, Trust Chair
Lesley Strong, Chief Operating Officer/Deputy Chief Executive

In Attendance: Gina Baines, Committee Secretary/Assistant Trust Secretary (note-taker)
Paul Ducker, Deputy Convenor, Staff Side (representing Neil Sherwood, Convenor Staff Side)
Jo Treharne, Head of Campaigns
Sammy Whitehouse, Business Manager Adult Clinical Services East Kent
Carl Williams, Head of Financial Accounting

033/18 Introduction by Chair

Jennifer Tippin welcomed everyone present to the meeting of the Charitable Funds Committee meeting.

034/18 Apologies for Absence

Apologies were received from Jo Bing, Assistant Financial Accountant; Gordon Flack, Director of Finance; Stephanie Rhodes, Head of Service, Long Term Services West Kent; Neil Sherwood, Convenor Staffside; and Jane Thackwray, Strategic Delivery Manager.

The meeting was quorate.

035/18 Declarations of Interest

There were no Declarations of Interest given apart from those formally noted on the record.

036/18 Minutes and Matters Arising from the Meeting of 25 July 2018

The following amendment was made:

030/18 Forward Plan – paragraph 3 – The sentence should read: 'This would then be included in the Committee's Annual Report to the Board in May 2019'.

The Minutes were **AGREED** by the Committee, subject to the amendment.

Matters Arising

The Matters Arising from the previous meeting were reviewed and updated as follows:

030/17 Annual Marketing Plan – Jo Treharne confirmed that a short article had appeared but this would be expanded upon in the next addition of the Trust's magazine. Action closed.
027/18 – Marketing The Charitable Funds Report – Collection tins were located in all the community hospital shops. Monies were returned by the shop manager to the Communications Team and banked. Action closed.
028/18 Restricted/Unrestricted Funds Financial Update Quarter One – A presentation on the Bow Road fund had been deferred to the January 2019 meeting. Action open.
029/18 Committee Effectiveness Review – Jo Treharne confirmed that this was in her report that the Committee was receiving that day. Action closed.
030/18 Forward Plan – Action open.

All other open actions were closed.

The Matters Arising Table was **AGREED.**

037/18 Relevant Feedback from Other Committees

Quality Committee

Lesley Strong confirmed that the Quality Committee had received and scrutinised the Trust's annual PLACE Inspection Report that assessed its community hospital environments. Heron Ward at Queen Victoria Memorial Hospital, Herne Bay had been included. It had highlighted work that required to be carried out and which linked to the report which would be presented later in the meeting regarding the Mermikides Heron Ward Restricted Fund spending plans.

038/18 Draft 2017/18 Accounts

Carl Williams presented the report to the Committee for assurance.

The independent examination of the accounts by Grant Thornton, the

Trust's external auditors had gone well. The accounts were yet to be approved and any comments that the Committee might make would be fed back to the auditors at this stage. Grant Thornton had requested further information regarding the restrictions relating to the Mermikides Heron Ward Restricted Fund. The Trust had provided all the documentation that it had and was attempting to obtain a copy of the will. The auditors were happy with what had been provided.

In response to a question from Jen Tippin regarding the timeline for the approval and submission of the accounts, Carl Williams confirmed that the final audited annual report and accounts would be submitted to the January 2019 Committee meeting for approval. The deadline for the submission of the approved accounts to the Charities Commission was 31 January 2019.

In response to a comment from Richard Field regarding whether the Annual Report provided an opportunity to provide more detail about the donors of legacies and promote this form of giving, it was agreed that it did. Unfortunately, there was very little detail available about the donor of the large legacy that had been received in 2017/18, despite extensive research undertaken by the solicitor handling it. It was suggested that in future there should be an editorial in the Trust's Community Health magazine when a substantial legacy was made. Permission from the donor would be sought wherever possible. For the 2017/18 annual report it was agreed that the Communications and Finance teams would review and decide the best way to present the details for the large legacy received due to the lack of information available about the donor.
Action – Carl Williams/Jo Treharne

The Committee **NOTED** the Draft 2017/18 Accounts Report.

039/18 Marketing the Charitable Funds Report

Jo Treharne presented the tabled report to the Committee for assurance.

Jo Treharne had liaised with Jo Bing to confirm that the process that was being put in place with regards to donating to i care via Facebook was acceptable.

In response to a question from John Goulston regarding whether the Trust should reconsider the name of its Charitable Funds charity 'i care' as it was the same as some other companies that provided domiciliary care in the UK and possibly further afield, it was agreed that this would be discussed by the Executive Team. The Committee acknowledged that the duplication of the name could cause some confusion as well as the possibility of a legal challenge over brand ownership.
Action – Lesley Strong

It was confirmed that there would be an additional member in the Communications Team from January 2019 who would be delegated to look

after the charity. The post would be funded out of the Communications budget. Lesley Strong cautioned that the Committee needed to understand the cost of running the charity to ensure that any costs did not outweigh their benefit to it.

Carl Williams commented that there was a decline in donations to the charity compared to previous years. It was unclear why that should be the case but it was suggested that donations were being given to the League of Friends at the community hospitals which was a different charity to i care.

The Committee **NOTED** the Marketing the Charitable Funds Report.

040/18 Fund Manager Presentation – Mermikides Heron Ward Restricted Fund

Sammy Whitehouse presented the report to the Committee for assurance.

In response to a question from Richard Field regarding the benefit of having a larger budget to use on the refurbishment, Sammy Whitehouse confirmed that different pieces of work would be assigned to different funding streams. Richard Field welcomed the fact that the charitable funds had acted as a pump primer for the bigger project and it was hoped that this approach would be used again in the future. Sammy Whitehouse confirmed that she would provide further updates to the Committee in the future.
Action – Sammy Whitehouse

The Committee **NOTED** the Fund Manager Presentation – Mermikides Heron Ward Restricted Fund.

041/18 Reserves Policy

Carl Williams presented the report to the Committee for approval.

The Committee **APPROVED** the Reserves Policy.

042/18 Forward Plan

Jen Tippin presented the report to the Committee for approval.

It was agreed that at the January 2019 Committee meeting there would be a presentation by the Bow Road Fund Manager and a report from Jo Bing regarding the wider charity landscape. The Annual Report and Accounts would also be submitted for approval.

Carol Coleman highlighted that she had attended a volunteers meeting recently. It had been confirmed that there were reminiscences tablets at Deal Community Hospital but a similar resource did not appear to be

available in the community hospitals in West Kent. She asked if any charitable funds could be made available to make some purchases for these hospitals and it was agreed that this would be investigated
Action – Lesley Strong

Carol Coleman also highlighted that there were commercial organisations in East Kent who might help support the development of a sensory garden. It was agreed that she would speak with her Governor colleagues who represented East Kent constituencies about lobbying any relevant companies.
Action – Carol Coleman

In response to a question from John Goulston as to whether the charity should lobby corporate firms to be their charity of the year, Jen Tippin confirmed that the Trust had been successful previously with the Maidstone Lions Club. Experience had shown that the likelihood of success could be improved if the charity could offer a project for the company to be aligned with. It was agreed that a report would be presented at the January 2019 meeting.
Action – Jo Treharne

The Forward Plan would be updated.
Action – Gina Baines

The Committee **APPROVED** the Forward Plan.

043/18 Any Other Business

There was no other business.

The meeting ended at 4.45pm.

044/18 Date and time of next meeting

Wednesday 30 January 2019, 12.30pm, The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone, ME16 9NT

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board to be held at 10am on Thursday 28 March 2019 in the Rooms 6 and 7,Kent Community Health NHS Foundation Trust offices, Trinity House,110-120 Upper Pemberton, Ashford Kent TN25 4AZ

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
1.1	Introduction by Chair	Trust Chair	
1.2	To receive any Apologies for Absence	Trust Chair	
1.3	To receive any Declarations of Interest	Trust Chair	
1.4	To agree the Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 31 January 2019	Trust Chair	Page 4 of 187
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 31 January 2019	Trust Chair	Page 14 of 187
1.6	To receive the Trust Chair's Report	Trust Chair	Page 17 of 187
1.7	To receive the Chief Executive's Report	Chief Executive	Page 20 of 187
2.	**BOARD ASSURANCE/APPROVAL**		
2.1	To receive the Patient Story – Quality Improvement Project To Reduce Podiatric Surgery On The Day Cancellations	Chief Nurse (Interim)	

2.2	To receive the Board Assurance Framework	Corporate Services Director	Page 25 of 187
	Board Committee Reports		
2.3	To receive the Quality Committee Chair's Assurance Report	Chair of Quality Committee	Page 31 of 187
2.4	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	Page 41 of 187
2.5	To receive the Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee	Page 47 of 187
2.6	To receive the Charitable Funds Committee Chair's Assurance Report	Chair of Charitable Funds Committee	Page 51 of 187
2.7	To receive the Integrated Performance Report		Page 54 of 187
	• Assurance on Strategic Goals	Director of Finance	
	• Quality	Chief Nurse (Interim)	
	• Workforce	Director of Workforce, Organisational Development and Communications	
	• Finance	Director of Finance	
	• Operational	Chief Operating Officer/ Deputy Chief Executive	
2.8	To approve a Constitutional Amendment	Director of Finance	Page 99 of 187

3. STRATEGY AND PLANNING

3.1	To approve the 2019/20 Operating Plan	Chief Executive	
	• Strategic Priorities	Director of Strategy	Page 102 of 187
	• Quality Priorities	Chief Nurse (Interim)	Page 105 of 187
	• Financial Plan incorporating	Director of Finance	Page 109 of 187
	○ Revenue and Capital Budgets		
	○ Capital Plan		

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4.	**REPORTS TO THE BOARD**		
4.1	To receive the 2018 NHS Staff Survey Report	Director of Workforce, Organisational Development and Communications	Page 117 of 187
4.2	To receive the Seasonal Infection Prevention and Control Report • Annual Infection Prevention and Control Report and Declaration	Chief Nurse (Interim)	Page 128 of 187
4.3	To receive the Patient Experience and Complaints Report	Chief Nurse (Interim)	Page 142 of 187
4.4	To receive the Risk Management Strategy	Corporate Services Director	Page 153 of 187
4.5	To receive the Use of the Trust Seal Report	Corporate Services Director	Page 176 of 187
4.6	To receive the Minutes of the Charitable Funds Committee meeting of 29 November 2019	Chair of Charitable Funds Committee	Page 179 of 187
5.	**ANY OTHER BUSINESS**		
	To consider any other items of business previously notified to the Trust Chair	Trust Chair	
6.	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA**		
7.	**DATE AND VENUE OF NEXT MEETING**		

Thursday 23 May 2019
Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent TN25 4AZ