

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 6 February 2020

in

The Committee Room
Tonbridge and Malling Council Offices
Gibson Building, Gibson Drive, Kings Hill
West Malling
Kent
ME19 4LZ

**Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 6 February 2020
in The Committee Room, Tonbridge and Malling Council Offices, Gibson Building,
Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ**

This meeting will be held in Public

AGENDA

1. STANDARD ITEMS

- | | | |
|-----|---|-----------------|
| 1.1 | Introduction by Chair | 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 28 November 2019 | Trust Chair |
| 1.5 | To receive the Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 28 November 2019 | Trust Chair |
| 1.6 | To receive the Trust Chair's Report | Trust Chair |
| 1.7 | To receive the Chief Executive's Report | Chief Executive |

2. BOARD ASSURANCE/APPROVAL

- | | | | |
|-----|--|-----------------------------|--------------|
| 2.1 | To receive the Patient Story | Chief Nurse | Presentation |
| 2.2 | To receive the Board Assurance Framework | Corporate Services Director | |

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|-----|--|------------------|
| 2.3 | To receive the Board of Directors Committee Membership and Designations Report | Trust Chair |
| 2.4 | To approve the East Kent Frailty Strategy | Medical Director |
| 2.5 | To receive the Draft Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24 | Chief Executive |

Board Committee Reports

- | | | |
|-----|---|--|
| 2.6 | To receive the Audit and Risk Committee Chair's Assurance Report | Chair of Audit and Risk Committee |
| 2.7 | To receive the Charitable Funds Committee Chair's Assurance Report | Chair of Charitable Funds Committee |
| 2.8 | To receive the Quality Committee Chair's Assurance Report | Chair of Quality Committee |
| 2.9 | To receive the Strategic Workforce Committee Chair's Assurance Report | Chair of Strategic Workforce Committee |

3. REPORTS TO THE BOARD

- | | | |
|-----|---|--|
| 3.1 | To receive the Integrated Performance Report | Director of Finance
Executive Directors |
| 3.2 | To receive the Learning From Deaths Report | Medical Director |
| 3.3 | To receive the approved Minutes of the Charitable Funds Committee meeting of 29 November 2019 <ul style="list-style-type: none"> • Charitable Funds Annual Report and Accounts 2018/19 | Chair of Charitable Funds Committee |

4. ANY OTHER BUSINESS

- | | |
|--|-------------|
| To consider any other items of business previously notified to the Trust Chair | Trust Chair |
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5. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

6. DATE AND VENUE OF NEXT FORMAL BOARD MEETING

Thursday 21 May 2020

**Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120
Upper Pemberton, Eureka Park, Kennington, Ashford Kent TN25 4AZ**

**UNCONFIRMED Minutes
of the Kent Community Health NHS Foundation Trust Board Meeting
held at 10am on Thursday 28 November 2019
in
Sevenoaks Town Council Offices, Bradbourne Vale Road, Sevenoaks
TN13 3QG**

Present:	John Goulston, Trust Chair (Chair) Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Peter Conway, Non-Executive Director Prof Francis Drobnewski, Non-Executive Director Gordon Flack, Director of Finance Louise Norris, Director of Workforce, Organisational Development and Communications Dr Sarah Phillips, Medical Director Gerard Sammon, Director of Strategy Dr Mercia Spare, Chief Nurse (Interim) Nigel Turner, Non-Executive Director
In Attendance:	Natalie Davies, Corporate Services Director Gina Baines, Committee Secretary (minute-taker)

28/11/01 Introduction by Chair

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

28/11/02 Apologies for Absence

Apologies were received from Bridget Skelton, Non-Executive Director; Lesley Strong, Chief Operating Officer/Deputy Chief Executive and Jen Tippin, Non-Executive Director.

The meeting was quorate.

28/11/03 Declarations of Interest

There were no conflicts of interest declared other than those formerly recorded.

28/11/04 Minutes of the Meeting of 25 July 2019

The minutes were read for accuracy.

The Board **AGREED** the Minutes.

28/11/05 Matters Arising from the Meeting of 25 July 2019

25/07/2019 Safeguarding Annual Report 2018/19 including the Safeguarding Declaration – Dr Spare confirmed that with regards to trends, themes, risks and learning, exceptions were reported through the Quality Committee papers.

The Board **RECEIVED** the Matters Arising.

28/11/06 Trust Chair's Report

Mr Goulston presented the report to the Board for information.

On behalf of the Board, Mr Goulston thanked Ms Sonja Bigg, the retiring Lead Governor for the considerable contribution she had made to the Council of Governors during her tenure. David Price, Public Governor Maidstone had been appointed as the new Lead Governor from 1 November 2019.

Mr Goulston commented on two service visits that he had attended in November 2019. He had observed the Maidstone Central multi-disciplinary team (MDT) meeting which had been held at a local GP surgery. Eight GPs had attended as well as representatives from a range of health and social care agencies. He had been impressed with the integrated team working approach and how the health and social care co-ordinators supported the clinicians to deliver joined up care for patients.

He had also visited the Healthy Communities Programme in Folkestone. Services involved included health visitors, school nurses and One You Team members who were working hard to encourage groups such as the Roma community to access the Trust's services.

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

28/11/07 Chief Executive's Report

Mr Bentley presented the report to the Board for information.

On behalf of the Board, Mr Bentley thanked Ms Strong for her many years' service to the NHS and the Trust. Her leadership as Chief Operating Officer/Deputy Chief Executive had been considerable and she would be greatly missed. Ms Pauline Butterworth, the new Chief Operating Officer would be taking up her post in mid-December 2019.

Mr Bentley had opened the well-attended Frailty Conference in east Kent the previous week. Dr Shelagh O'Riordan, Consultant Community Geriatrician and Clinical Director for Frailty was leading the work in partnership with the East Kent Hospitals University NHS Foundation Trust (EKHUFT).

In response to a question from Ms Barber regarding frailty services and how partners might support the work of the Trust's Rapid Transfer Of Care (RTOC) Service in east Kent in the future, Mr Bentley explained that different partners were supporting in different ways. The east Kent clinical commissioning groups (CCGs) along with EKHUFT were setting up frailty units in some areas which would continue to be developed. Dr Phillips suggested that more capacity was needed for the out of hospital frailty model. However, in the meantime, partnering with the in-patient service in EKHUFT allowed for more joined up working. Further investment was yet to be confirmed. Dr Shelagh O'Riordan's leadership was fundamental to maintaining the momentum for delivering frailty services as set out in the east Kent Frailty Strategy; and the Long Term Plan strengthened what the strategy set out to achieve. There was further work still to be done to integrate the medical aspects of the frailty model further, but the strong clinical leadership and improving relationships between all partners was very positive. Mr Flack commented that the east Kent CCGs were planning to spend £7.5million over the next four years on this model.

In response to a question from Mr Turner regarding the Trust's participation rate for this year's NHS Staff Survey and how it compared with other NHS organisations, Ms Norris explained that it was variable. The size and type of organisation had a significant impact on the level of response that was achieved.

In response to a question from Prof Drobiewski as to whether the survey was confidential, Ms Norris confirmed that all responses were confidential. Individual staff could not be identified by the Trust or the survey organisation.

In response to a question from Mr Goulston as to when the results would be published, Ms Norris confirmed that these would be received in February 2020. A report would be submitted to the Strategic Workforce Committee and Board in March 2020.

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

28/11/08 Patient Story

Dr Spare presented the video to the Board.

The story related to the experience of Mr Nunn who had been cared for by the Edenbridge Neighbourhood Care Team as part of the Transforming Integrated Care in the Community (TICC/Buurtzorg) programme.

In response to a question from Prof Drobiewski as to whether the clinicians felt that they were able to address the needs of the patient more easily than before, Dr Spare confirmed that they did. They were able to offer more holistic care, identifying more broadly what the patient and his carer needed and accessing this through a network which they could refer out to.

In response to a question from Mr Conway as to whether social care was integrated into the team, Dr Spare explained that this had been the intention. However, challenges around integrating the regulatory environments of health and social care had led the team to adopt a different approach. There had been a transfer of knowledge and skills from social care to the clinicians and social care was now becoming more responsive to the team's needs. Mr Flack added that the social care team was trying to adopt the same principles as the clinicians in the way that it worked. At a higher level, work was underway to see how TICC could be regulated effectively across health and social care.

The Board **RECEIVED** the Patient Story.

28/11/09 Board Assurance Framework

Ms Davies presented the report to the Board for assurance.

Mr Flack added that the Finance, Business and Investment (FBI) Committee had discussed Risk 99 (Electronic Patient Record) at its meeting the previous day and agreed that it should be reviewed. In particular, the implementation of the Kent and Medway Care Record element which the Committee had suggested might be a separate risk. The Executive team would consider this.

With regards to Risk 105 (Referral to Treatment Waiting Times), Dr Spare confirmed that the Quality Committee had reviewed it at its meeting earlier in the month and its comments would be reflected in the next iteration.

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

28/11/10 Quality Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.

In response to a question from Ms Davies regarding the staff flu vaccination programme, Ms Barber confirmed that the Quality Committee had received assurance on its progress. Although a number of staff were yet to take up the offer of vaccination, overall the Trust was ahead of where it had been the previous year. More detail was included in the Infection Prevention and Control Report.

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

28/11/11 Audit and Risk Committee Chair's Assurance Report

Mr Conway presented the report to the Board for assurance.

Mr Conway added that the Committee had been informed by Ms Davies of a fire incident at the Hawkhurst Community Hospital that had taken place on 15 October 2019. The Committee had received positive assurance via email on how the incident had been handled. The staff, which included a

number of agency staff, had responded well. No patients nor members of staff had been hurt by the fire.

28/11/12 Strategic Workforce Committee Chair's Assurance Report

Mr Turner presented the report to the Board for assurance.

The Strategic Workforce Committee had met the previous day and a verbal update was given.

There had been wide ranging discussions which had included positive assurance from the workforce report. This had given the Committee an opportunity to focus on future developments such as the 2020/21 campaign to recruit more than 500 staff and learning from best practice in the Trust. The Trust's Academy programme was working well and the Committee was informed that this had helped the Trust to retain its apprenticeship levy. With regards to the health and well-being of staff, the group was keeping the momentum going. The Committee had also received a report from Ms Strong, Chief Operating Officer regarding winter planning, staff flu vaccinations, service development and self-directed teams.

In response to a question from Mr Goulston regarding how the Trust was addressing disability and equality in the workplace, Mr Bentley commented that following the discussion of this topic at the Senior Leaders Conference, it had been debated further at that week's Management Committee meeting. There had been a healthy acknowledgement amongst the senior management team that more needed to be done and there had been a commitment to making the workplace a better place for inclusivity and diversity. Ms Norris would be developing a strategy which would be presented to the Management Committee in the New Year. Ms Norris added that with regards to diversity she was participating in an action research piece which looked at the Trust's recruitment processes and the unintentional barriers that were built in to this.

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

28/11/13 Charitable Funds Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.

Ms Barber confirmed that Ms Tippin had forwarded to Mr Goulston and Mr Bentley the legal opinion of the Trust's use of the name icare for its Charitable Fund and the summary of the Committee's discussion.

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

28/11/14 Integrated Performance Report

Mr Flack presented the report to the Board for assurance.

Further to Mr Flack's comment that with the improvement in the Referral To Treatment (RTT) waiting time Key Performance Indicator, the Trust would soon be in a position to apply to move back from level two to level one on the NHS Single Oversight Framework, it was agreed that as soon as the Trust was compliant, Mr Flack would make the application to NHS Improvement (NHSI) on the Trust's behalf.

Action – Mr Flack

With regards to the long waiting times in the Dental Service, the service had put a business case to NHS England (NHSE) to address this. As it would be some time before a decision was made, the Trust had agreed to fund additional capacity to reduce waiting times and this decision had been supported by the FBI Committee.

In response to a question from Mr Bentley regarding the investment in the RToC service in east Kent, Mr Flack confirmed that there had been an increase in investment. This amounted to £2.3 million and was double what had been originally commissioned. Mr Bentley commented that the service was financially stable and was helping to ease the winter pressures felt by the system.

With regards to the three recent external inspections that had involved services provided by the Trust, Dr Spare confirmed that she had received the draft reports from the Care Quality Commission and Public Health England which had been reviewed for factual accuracy. Once the final reports were published they would be circulated to the Board for information.

In response to a question from Prof Drobniowski regarding whether the investment in the RToC Service would help ease the winter pressures in the east Kent acute hospitals this winter, Mr Bentley was hopeful. Much depended on whether the current level of activity continued. The current level of demand was reflected nationally and extended to GP appointments and the ability of the social care system to respond.

In response to a question from Mr Goulston regarding the response by the acute trusts in west Kent to the current winter pressures, Mr Bentley indicated that they were also finding the environment challenging and this was consistent with the rest of the country.

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

28/11/15 Remuneration and Terms of Service Committee' Terms of Reference

Ms Norris presented the report to the Board for approval.

There was an error in the Terms of Reference. Section 4.1 should read 'The Council of Governors is required to approve the appointment of the Chief Executive'.

The Board **APPROVED** the Remuneration and Terms of Service

Committee Terms of Reference, subject to the amendment.

28/11/16 Emergency Planning and Business Continuity Annual Assurance Statement

Ms Davies presented the report to the Board for approval and added that since the completion of the report, the trust had received confirmation that it remained 'fully compliant' with the Emergency Preparedness Resilience and Response standards.

The Board commended the work of the Resilience Team. In response to a comment from Mr Bentley regarding the timeliness of the report and whether there was an alternative way to approve it earlier, it was agreed that the Board's decision-making map would be reviewed to consider the on-going timely approval of reports by the Board.

Action – Ms Davies

The Board **APPROVED** the Emergency Planning and Business Continuity Annual Assurance Statement.

28/11/17 Public Health Partnership Renewal Agreement

Mr Flack presented the report to the Board for endorsement.

Mr Bentley commented on the excellent work of the frontline staff and the local leadership who had been integral to the renewal of the partnership agreement with Kent County Council (KCC). Mr Chris Hopson, Chief Executive NHS Providers who had recently met with the Executive Team had expressed interest in this positive story around the NHS and local authorities working successfully together to deliver public health services.

The Board **ENDORSED** the Public Health Partnership Renewal Agreement.

28/11/18 Seasonal Infection Prevention and Control Report

Dr Spare presented the report to the Board for assurance.

In response to a question from Mr Flack as to whether offering a flu vaccination to staff at Corporate Induction was being taken up, Dr Spare indicated that over half of those attending had taken up the offer. Amongst those who had turned down the vaccination, there was a significant number of younger people who had indicated that they did not wish to have the vaccine put into their bodies. These comments had been passed back to the Communications Team who would be reviewing how the Trust explained the importance of immunisation to this group.

In response to a question from Prof Drobniowski regarding what was preventing staff from taking up the flu vaccination, Dr Spare indicated that there were a number of reasons. For some it was a moral judgement but for others there was a concern that the vaccination would give them the flu.

The Trust was sending out a clear message that this was not the case.

In response to a question from Mr Goulston as to whether the Trust could learn from other trusts who had had a higher take-up of the flu vaccination, Dr Spare confirmed that the Trust had buddied up with the flu team at Sussex Community NHS Foundation Trust (SCFT) where a shared action plan had been developed. Broadly there were no gaps in approach between the two organisations, except that SCFT had almost triple the number of peer vaccinators and staff were more generally supportive of the benefits of immunisation.

In response to a question from Prof Drobiewski regarding legionella control across the Trust's estate, Ms Davies confirmed that NHS Property Services (NHSPS) was the Trust's major landlord. There was an agreement that any major drop in temperature in its water systems should be reported to the Trust immediately and action taken. With regards to other landlords, the Trust continuously monitored water temperature at all the relevant sites. Any drop in temperature was escalated promptly. There was also an annual check of water tanks.

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

28/11/19 Learning From Deaths Annual 2018/19 Report

Dr Phillips presented the report to the Board for assurance.

The Board **RECEIVED** the Learning From Deaths Annual 2018/19 Report.

28/11/20 Freedom To Speak Up (FTSU) Report

Ms Davies presented the report to the Board for assurance.

Ms Norris commented that there had been an encouraging drop in the number of cases formally reported relating to bullying and harassment.

In response to a question from Ms Barber regarding whether an evaluation had been made of the effectiveness of the role of the Freedom To Speak Up Guardian, Ms Davies commented that informal feedback had indicated that staff were relieved to be able to talk through their worries with someone. It was agreed that consideration would be given to how more feedback could be captured more formally and reviewed.

Action – Ms Davies

In response to a question from Mr Bentley as to the Trust's FTSU Index percentage over the last four years, it was agreed that this would be investigated.

Action – Ms Davies

The Board **RECEIVED** the Freedom To Speak Up Report.

28/11/21 Minutes of the Charitable Funds Committee meeting of 30 January 2019

The Board considered the minutes of the meeting.

The Board **RECEIVED** the Minutes of the Charitable Funds Committee meeting of 30 January 2019.

28/11/22 Any Other Business

There was no other business to report.

28/11/23 Questions From Members of the Public Relating to the Agenda

In response to a question from Ms Ruth Davies, Public Governor Tonbridge and Malling regarding the 16 per cent of 118 pieces of National Institute for Clinical Excellence (NICE) guidance that were applicable to the Trust and had exceeded the internal three month target to complete the baseline assessment, Dr Phillips explained that having improved the process for filtering out non-applicable guidance, this percentage was coming down month on month. The CCGs were monitoring the Trust's performance.

In response to a further question from Ms Ruth Davies regarding the repatriation of community hospitals from NHSPS to the Trust, Ms Davies confirmed that Hawkhurst Community Hospital which Ms Ruth Davies had visited recently was owned by the Trust. Four properties were being considered for repatriation and this had been discussed at the FBI Committee meeting earlier in the week. A formal application for repatriation would be submitted to the Board at its meeting in March 2020, the Council of Governors would be kept informed of the progress.

In response to a question from Ms Sola Afuepa, Non-Executive Director Designate regarding what role TICC practitioners had in supporting their patients' mental health, Dr Spare explained a holistic approach to care was the underlying principle of the approach. Mental health support was delivered in line with Trust policies but where there were instances of acute mental health needs then the team would refer the patient to a specialist mental health practitioner.

In response to a further question from Ms Sola Afuepa regarding how the Trust was responding to the emergence of blurred professional clinical roles in delivering services, Ms Norris confirmed that the Trust welcomed these new roles and was providing opportunities. The challenge was that they did not always offer accreditation and professional registration which potentially made them less attractive as a career role

The meeting ended at 12 noon.

28/11/24 Date and Venue of the Next Meeting

Thursday 6 February 2020
The Committee Room, Tonbridge and Malling Council Offices, Gibson
Building, Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ

MATTERS ARISING FROM BOARD MEETING OF 28 NOVEMBER 2019 (PART ONE)

Minute number	Agenda Item	Action	Action Owner	Status
28/11/14	Integrated Performance Report	To apply to NHS Improvement for the Trust to move from level two to level one on the NHS Single Oversight Framework as soon as the Trust is compliant with the Referral To Treatment (RTT) waiting time Key Performance Indicator.	Mr Flack	The action will be taken and completed once RTT compliance is met. The Board will be informed when that takes place.
28/11/16	Emergency Planning and Business Continuity Annual Assurance Statement	To review the Board's decision-making map to consider the on-going timely approval of reports by the Board.	Ms Davies	Action complete. This has been fed into the forward plan.
28/11/20	Freedom To Speak Up (FTSU) Report	To consider how more feedback could be captured more formally and reviewed.	Ms Davies	A review process is in place. There are a limited number of cases available to provide trends, but overwhelmingly it is positive.

Minute number	Agenda Item	Action	Action Owner	Status
28/11/20	Freedom To Speak Up Report	To investigate what the Trust's FTSU Index percentage had been over the last four years.	Ms Davies	The FTSU Index scores were calculated as 2018:81%, 2017:81%, 2016:82%, 2015:79%. The results are based on the median of the four questions in the staff survey pertaining to freedom to speak up.

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	1.6
Agenda Item Title:	Trust Chair's Report
Presenting Officer:	John Goulston, Trust Chair

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary

The report sets out the service visits and partnership meetings that were attended by the Trust Chair and non-executive directors between 1 November 2019 and 15 January 2020.

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.

Thomas Fentem, PA and Project Officer	Tel: 01622 211900
	Email: thomas.fentem@nhs.net

**SERVICE VISITS AND PARTNERSHIP MEETINGS ATTENDED BY THE CHAIR
AND NON EXECUTIVE DIRECTORS OF KENT COMMUNITY HEALTH
NHS FOUNDATION TRUST**

Period covered – 1 November 2019 to 15 January 2020

Name	Service visits	Stakeholder/ Partnership meetings / events	Other meetings / events
John Goulston	<p>5 November - Multi-disciplinary Team meeting Maidstone Central Primary Care Network</p> <p>18 November - Healthy Communities programme, Folkestone</p> <p>16 December – East Kent Respiratory Team</p>	<p>12 November – Visit by Chris Hopson</p> <p>15 November - West Kent Integrated Care Partnership Development Board</p> <p>22 November - Kent & Medway Non-Executive Oversight Group</p> <p>26 November - Meeting with Chair of Kent & Medway NHS and Social Care Partnership NHS Trust</p> <p>5 December - NHS Providers Chairs and CEO network</p> <p>6 December - Stakeholder event for the recruitment of Kent & Medway Accountable Officer</p> <p>13 December - West Kent Integrated Care Partnership Development Board</p> <p>17 December - NHS Leadership event for Chairs and CEOs</p> <p>18 December - Medway and Swale Integrated Care Partnership, Chair's meeting</p> <p>6 January - Kent & Medway Non-Executive Oversight Group</p> <p>10 January - West Kent Integrated Care Partnership Development Board</p>	<p>7 November - Meeting with lead and deputy lead Governors</p> <p>14 November - Non-executive director recruitment stakeholder event and interviews</p> <p>20 November - Non-executive director recruitment stakeholder event and interviews</p> <p>22 November - Extraordinary Council of Governors meeting</p> <p>28 November - Board of Directors</p> <p>29 November – Charitable Funds Committee</p> <p>10 December – Board Development Day</p> <p>11 December – Audit & Risk Committee</p>
Sola Afuape (from 01/12/19)	16 December – East Kent Respiratory Team, Whitstable and Tankerton Hospital Ward		<p>28 November - Board of Directors</p> <p>10 December – Board Development</p>

Name	Service visits	Stakeholder/ Partnership meetings / events	Other meetings / events
Sola Afuape (Cont.)	and Facilities team. 20 December - Integrated Musculoskeletal Team (Churchill Centre)		Day 20 December - Executive 1:1 NED Induction 8 January – Executive 1:1 NED Induction and Network Leads
Pippa Barber	3 December – Schools Service, East Sussex 9 December – West and North Kent Nurses	13 December - NHS Providers NED Network	14 November - Non-executive director recruitment stakeholder event and interviews 19 November – Quality Committee 26 November – FBI 28 November - Board of Directors 29 November – Charitable Funds Committee 10 December – Board Development Day 11 December – Audit & Risk Committee 18 December - Chief Nurse Interview Panel 3 January – Meeting with Chief Nurse 10 January – Mortality Surveillance Group 15 January – Council of Governors
Peter Conway		5 November – South East Audit Chairs Forum	19 November – Quality Committee 26 November – FBI 28 November - Board of Directors 9 December – Paediatrician Interview 10 December – Board Development Day 11 December – Audit & Risk Committee

Name	Service visits	Stakeholder/ Partnership meetings / events	Other meetings / events
Peter Conway (Cont.)			15 January – Council of Governors
Professor Francis Drobiewski			14 November - Non-executive director recruitment stakeholder event and interviews 27 November – Strategic Workforce Committee 28 November - Board of Directors 10 December – Board Development Day 15 January – Council of Governors
Bridget Skelton	3 December – Schools Service, East Sussex		5 November – Shortlisting NED's 20 November - Non-executive director recruitment stakeholder event and interviews 26 November – FBI 27 November – Strategic Workforce Committee 10 December – Board Development Day 11 December – Audit & Risk Committee
Jen Tippin			29 November – Charitable Funds Committee
Nigel Turner			14 November - Non-executive director recruitment stakeholder event and interviews 27 November – Strategic Workforce Committee 28 November - Board

Name	Service visits	Stakeholder/ Partnership meetings / events	Other meetings / events
Nigel Turner (Cont)			of Directors 10 December – Board Development Day

Key -

Acronym	Full name
AGM	Annual General Meeting
ARC	Audit and Risk Committee
CEO	Chief Executive Officer
FBI	Finance, Business and Investment Committee
ICP	Integrated Care Partnership
KCC	Kent County Council
KCHFT	Kent Community Health NHS Foundation Trust
NED	Non-Executive Director
STP	Sustainability and Transformation Partnership



Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	1.7
Agenda Item Title:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report Summary
This report highlights key business and service developments in Kent Community Health NHS Foundation Trust in recent weeks.

Proposals and /or Recommendations
Not applicable.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
No <input checked="" type="checkbox"/> Not applicable.

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

CHIEF EXECUTIVE'S REPORT February 2020

As previously I wanted to highlight to the Board the following significant developments since my last formal report during the Board meeting in November 2019, the report follows my regular practice to categorise the report into patients, our people, staff teams and partnerships.

Patients

1. Winter

The implementation of our winter plan has been a key part of our operational delivery over the last 2 months. Both East and West Kent have experienced increased attendances at their Emergency Departments compared to the same period last year. Performance against the 4 hour standard has been challenging with West Kent slipping just below 90% and East Kent falling below 80% as demand has increased and patient flow has consequently slowed. Our teams have worked as part of the system to improve patient flow and ensure patient experience and outcomes are a priority. We have a number of key areas of focus to support this.

East Kent

15 Escalation beds were opened on the 2nd of January in Westview.

30 – 40 additional interim beds have been purchased and overseen to allow a discharge to assess model for complex patients.

The Rapid Transfer Team has been supporting discharge from both the gateways and wards in EKHUFT. The team aim to discharge 40 complex patients a day across the East Kent System.

Home with Support delivering up to 300 visits per day to support people at home following discharge from EKHUFT

West Kent

There has been a continued focus on Hospital at Home which has delivered a reduction of demand of 4664 bed days from the acute sites in the last year. The fractured neck of femur pathway in Tonbridge Cottage Hospital which has reduced acute length of stay for patients on this pathway, from 15.8 days to 6.9 days.

A telehealth pilot in 2 nursing homes to support staff to feel confident to maintain people in their homes has demonstrated significant outcomes and will now be 'rolled out' to an increased number of nursing homes with our nursing teams supporting this initiative.

The teams are working as an integrated part of the systems with escalation status being reviewed daily to ensure all necessary actions are taken to support safe patient flow across services.

2. ISO9001 quality standard

Discovery Orthotics based in Discovery Park, Sandwich has been awarded the ISO9001 accreditation.

ISO9001 is an international standard for quality management systems. To become certified, an organisation must follow the standards requirements, showcasing and embedding high quality, customer service and professionalism into its everyday work.

One of the benefits of this level of accreditation is that Discovery Orthotics is able to become a formal part of the NHS Supply Chain, which grows potential reach.

3. Wristbands to help patients with breathing problems

The trust is trialling wristbands to be worn by patients at risk of type two respiratory failure. The project involves patients being given a coloured wristband, which tells health professionals how much oxygen they need, should they become unwell.

The wristbands correspond with those being used in other hospitals, enabling ambulance and accident and emergency staff to initiate the appropriate level of oxygen for the patient.

Our People

1. Staff survey

In 2019, KCHFT was one of 10 community trusts benchmarked by Quality Health. The response rate for the trust was 58.8% (2753 people), which is in advance of

the average for community trusts, which stood at 49.9%. An analysis of the results will be released and an update provided to the board in due course

2. Self-directed teams

Conversations have begun with our teams about self-direction and what that could mean; there has already been an HR away day and a presentation to the Specialist and Elective services directorate to debate how best to proceed..

3. Appointments and returns

Pauline Butterworth took up her role as Chief Operating Officer in December 2019 following Lesley Strong's retirement. Lesley has returned to the Trust on a part time basis as Programme Director for the devolved authority project, and to provide some additional executive level capacity

I am delighted that Ali Carruth has returned from her maternity leave in a new role as the Director of Quality, Improvement and Patient Engagement. Dr Mercia Spare, after a full national recruitment process, was appointed as the substantive Chief Nurse.

Gordon Flack has taken the role as Deputy Chief Executive.

Partnerships

Since the last time the board met the outcome of the general election has become known and the Chair and I, along with our counterparts from other providers were part of a meeting to outline the next stages with the NHS long term plan. It is clear that the two 'headline' priorities are recovering the performance of the NHS which is struggling with the level of demand and to deliver on the NHS people plan, which will be published imminently. These represent a continuation of the priorities which we are working upon.

As part of the planning cycle for the next year 20/21 it was anticipated that a return for NHSEI would be required in February but at the time of writing the submission has been delayed because the planning guidance is not available, as such I will update the board on progress when we meet.

Given the demands on all parts of the NHS I invite the board to join me in formally thanking all team members in the Trust who are delivering compassionate care at the time of highest demand. All the leading indicators suggest we are continuing to do so at the high quality standards we set ourselves.

**Paul Bentley
Chief Executive
February 2020**

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	2.2
Agenda Item Title:	Board Assurance Framework
Presenting Officer:	Natalie Davies, Corporate Services Director

Action - this paper is for:	Decision <input type="checkbox"/>	Information <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>
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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 30 January 2020 is included.

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 <input checked="" type="checkbox"/> High level position described and no decisions required.

Barry Norton, Head of Transformation & Sustainability	Tel: 01233667744 Email: barry.norton@nhs.net
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**BOARD ASSURANCE FRAMEWORK
FEBRUARY 2020****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 3 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 30 Jan 20 is shown in Appendix 1.

2. Amendments to the BAF

- 2.1 Since the BAF was last presented to the Board there have been no new risks identified against the strategic objectives.
- 2.2 Since the BAF was last presented to the Board there has been one risk removed.

BAF ID 101 - "Uncertainty around EU exit may affect our ability to deliver core objectives"

3. High risk definition

- 3.1 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 an impact score of 4. The risk matrix below provides a visual representation of this.
- 3.2 Figure 1: Trust risk matrix.

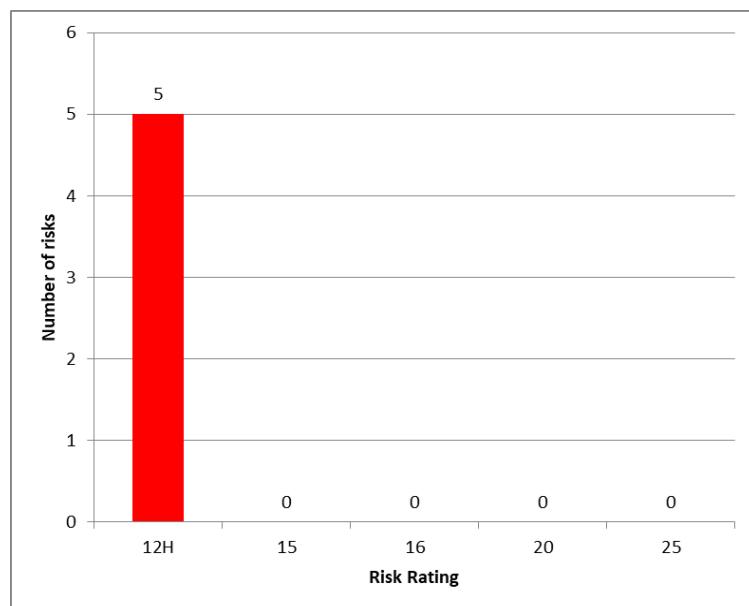
		← Impact / Severity →				
		Insignificant	Minor	Moderate	Major	Catastrophic
↓ Likelihood ↓		1	2	3	4	5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

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



4. Organisational Risk Profile

4.1 Figure 1: Organisational High Risk Profile



5. Risk Overview

5.1 The total number of open risks within the Trust stands at 215 this is comprised of 124 low risks, 85 medium risks and 6 high risks. Figure 3 (below) provides a visual representation. There are currently 25 out of date risks and 10 risks past their target completion date. 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.

6. Recommendation

- 6.1 The Board should review the Board Assurance Framework within Appendix 1 to ensure sufficient mitigating action is in place to address the risks.

Barry Norton
Head of Transformation & Sustainability
30 January 2020

Appendix 1 Board Assurance Framework Section 1

Risks with a high net risk rating which have not been tolerated.

Definition: = 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

Risk ID	Risk Description (Simple Explanation of the Risk)	Initial Rating	Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	Current Rating			Planned Actions and Milestones			
							C	L	R	G	L	R	
103	Integrating a clinical system including double running with the existing electronic system. The significant tasks relate to complex records in a new system during a phased service implementation and maintaining contemporary access to information and patient records and appropriate archive. The other significant task is the design of the input validation process which minimises clinical input error whilst running the old system as is. This also takes place when the implementation of the Kent Care Record is about to start from April 20 and may negatively impact on the EPR project competing for staff resources e.g. Board Committee Lead on Assurance: Finance, Business & Investment Committee	4 / 3	121	<ul style="list-style-type: none"> • Governance structure & project plan in place • Engagement with the project team delivering the Kent Care Record • Project Leadership to plan job descriptions • Expertise from NELFT • Phase implementation plan and resourcing appropriately • Communications plan developed with stakeholders Inc. • Operational risk and mitigations log 	<ul style="list-style-type: none"> • Regular Board reports linked to other projects • Project Group report to Management Committee, Exec Team and Board 	<ul style="list-style-type: none"> • Initiatives to implement new system for Comprehensive programme plan for replacement system to be developed in response to emerging financialscales • Implement phase one across children's services • Operational risk and mitigation log to be updated at every project board meeting • Resource assessment ongoing as part of the project governance structure. 	4	3	121	Work with Advance to develop data implementation strategy	Sarah Phillips/Unesh Gadhvi	Feb 2020	A
104	Changes to the system architecture and continued financial instability may provide uncertainty in the future delivery of integrated services	4 / 3	121	<ul style="list-style-type: none"> • Sustainability and Transformation Plan (STP) Programme • Board TORs and Membership • TORs for Local Care Boards; Frailty Group; Chief Executives Forum • STP Governance Structures • West Kent Improvement Board terms of reference • East Kent Transformation Board terms of reference • NHS IT system meeting terms of reference • Chief Executive as a SIRC or East CIP • Chair of the Board as a SIRC or West CIP • Strategic performance structure • West Kent integrated care partnership development board's terms of reference • East Kent integrated care partnership development board's terms of reference 	<ul style="list-style-type: none"> • 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 • Director of Strategy report to the Management Committee 	<ul style="list-style-type: none"> • Joint Board and Management Committee meeting to agree forward plan. • Continue to influence at STP level • Programme to manage the transition of PCNs into the new system architecture 	4	3	121	Individual Actions	Pauline Butterworth	Mar 2020	A
105	Challenges in meeting the referral to treatment waiting time target could impact on patient experience and the trust segmentation rating	4 / 3	121	<ul style="list-style-type: none"> • Access policy includes harm risk assessment for pts waiting over 16 weeks 	<ul style="list-style-type: none"> • Increase in demand raised with CCG's • No no decisions 	<ul style="list-style-type: none"> • Consultant led 18 week pathways; • Develop demand & capacity tools 	4	3	121	Individual Actions	Pauline Butterworth	Mar 2020	A
106	Board Committee Lead on Assurance: Quality Committee	Mar 2019	May 2019	Pauline Butterworth	<ul style="list-style-type: none"> • Regular reports IPR • SPIC-charts • Joint committee review of areas of concern approach to service improvement 	<ul style="list-style-type: none"> • Review emergency plans successful during testing • Flu vaccination programme • An established National Emergency Pressure Points Panel has been established to identify levels of system risk and recommend responses • Local targets have been set which include maximum of 14 patients in any one time in KCfFT community hospitals • Whole system winter plans have been agreed by the Local A&E KCfFT • Winter Pressure Plans • Actions have been identified in order to reduce the gap in controls relating to this risk. 	4	3	121	Individual Actions	Pauline Butterworth	Mar 2020	A
107	Board Committee Lead on Assurance: Quality Committee	Mar 2019	May 2019	Pauline Butterworth	<ul style="list-style-type: none"> • Staff in the organisation's services may suffer significant challenges as result of the impact of winter pressures. 	<ul style="list-style-type: none"> • Review emergency plans successful during testing • Flu vaccination programme • An established National Emergency Pressure Points Panel has been established to identify levels of system risk and recommend responses • Local targets have been set which include maximum of 14 patients in any one time in KCfFT community hospitals • Whole system winter plans have been agreed by the Local A&E KCfFT • Winter Pressure Plans • Actions have been identified in order to reduce the gap in controls relating to this risk. 	4	3	121	Individual Actions	Pauline Butterworth	Mar 2020	A
108	Board Committee Lead on Assurance: Quality Committee	Mar 2019	May 2019	Pauline Butterworth	<ul style="list-style-type: none"> • That the organisation's services may suffer significant challenges as result of the impact of winter pressures. 	<ul style="list-style-type: none"> • Review emergency plans successful during testing • Flu vaccination programme • An established National Emergency Pressure Points Panel has been established to identify levels of system risk and recommend responses • Local targets have been set which include maximum of 14 patients in any one time in KCfFT community hospitals • Whole system winter plans have been agreed by the Local A&E KCfFT • Winter Pressure Plans • Actions have been identified in order to reduce the gap in controls relating to this risk. 	4	3	121	Individual Actions	Pauline Butterworth	Mar 2020	A

ID	Opened Date	Board Level Risk Owner	Risk Level	Risk Description (Simple Explanation of the Risk)	Initial Rating C L	Rating C L	Controls Description		Positive Assurances	Days in control or Negative Assurance C L	Planned Actions and Milestones										
							Current Rating														
102	Jan 2019	Louise Norris	Medium	Deliver High Quality Care at Home and in the Community	4 [2H]	4 [2H]	<p>Service visit reported to quality committee</p> <ul style="list-style-type: none"> • Vacancies 7.51%, turnover 15.85% • Workforce report to board • Workforce plan and reviewed by Board • Staffing reports • Workforce plans • Operational workforce established against agreed policy • Complaints system established • Friends and Family Test • Talent Management Strategy • Time to Change Champions system established • Agency usage report. • Workforce report to SWC • Quality Report to the Quality Committee 														
103	Jan 2019	Louise Norris	Medium	Develop Sustainable Services (Strategic Objective Enablers)	4 [2H]	4 [2H]	<p>Board Committee Lead on Assurance:</p> <ul style="list-style-type: none"> • Strategic Workforce Committee T&G's. • Service quality visits. • Director of Quality and Safety, Strategic Lead. • Workforce Strategy developed • Operational workforce established • Complaints system established against agreed policy • Friends and Family Test • Talent Management Strategy • Time to Change Champions system established • Agency usage report. • Workforce report to SWC • Quality Report to the Quality Committee 														
104	Jan 2023	Louise Norris	Medium	Deliver High Quality Care at Home and in the Community	4 [2H]	4 [2H]	<p>Board Committee Lead on Assurance:</p> <ul style="list-style-type: none"> • Strategic Workforce Committee T&G's. • Service quality visits. • Director of Quality and Safety, Strategic Lead. • Workforce Strategy developed • Operational workforce established • Complaints system established against agreed policy • Friends and Family Test • Talent Management Strategy • Time to Change Champions system established • Agency usage report. • Workforce report to SWC • Quality Report to the Quality Committee 														

Committee / Meeting Title:	Board Meeting - Part 1 (Public)			
Date of Meeting:	06 February 2020			
Agenda Number:	2.3			
Agenda Item Title:	Board of Directors Committee Membership and Designations Report			
Presenting Officer:	John Goulston, Trust Chair			

Action - this paper is for:	Decision	<input checked="" type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report Summary

This paper provides an update following recent changes to the Board of Directors and presents the proposal for Board membership and Non-Executive Director and Executive Director responsibilities with the required approval where appropriate.

The paper also presents proposals for Board recommendation to the Council of Governors as necessary.

Proposals and /or Recommendations

Not applicable.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No . Not applicable.

John Goulston, Trust Chair	Tel: 01622 211901
	Email: j.goulston@nhs.net

BOARD OF DIRECTORS - COMMITTEE MEMBERSHIP AND DESIGNATIONS

1. Introduction

The Constitution of Kent Community Health NHS Foundation Trust (the Trust) sets out the composition and makeup of the Board of Directors (the Board) both in terms of Executive and Non-Executive Directors roles. In addition, there are several other roles which are either required by Trust regulators or recommended as part of a system of good governance.

As the Board members are fully aware, there have been several changes to the Membership of the Board over the past year. In concert with this, further changes have been signalled and proposed for consideration.

This paper provides an update following recent changes to the Board of Directors. This report presents the proposal for Board membership and Non-Executive Director and Executive Director responsibilities with the required approval where appropriate. The paper also presents proposals for Board recommendation to the Council of Governors as necessary.

2. Board Membership

The Constitution sets out that the Board is made up of a maximum of seven Non-Executive Directors and a Chair in addition to this number. Equally, the maximum number of Executive Directors is seven.

Non-Executive Directors (NED)

- 2.1 Martin Cook stood down as a Non –Executive Director on 30 September 2019 and Jen Tippin is standing down as a Non-Executive Director on 29 February 2020 when her three year term of office expires. The Council of Governors has approved the appointment of Sola Afuape (from 1 December 2019) and Paul Butler (from 1 March 2020) as Non-Executive Directors. From 1 March 2020, the Non-Executive membership of the Board is as follows;

Chair: John Goulston

1. Pippa Barber
2. Peter Conway
3. Francis Drobniowski
4. Bridget Skelton
5. Nigel Turner
6. Sola Afuape
7. Paul Butler

Executive Directors

Following the retirement of Lesley Strong, Deputy Chief Executive and Chief Operating Officer on 30 November 2019, Pauline Butterworth has been appointed Chief Operating Officer (commenced on 16 December 2019) with Gordon Flack becoming Deputy Chief Executive in addition to his role as Executive Director of Finance. Mercia Spare has been appointed as Chief Nurse. Mercia has been our interim chief nurse for the past 12 months while Ali Carruth was on maternity leave. Ali has returned in a different role in January 2020 focusing on quality, so she can spend more time with her young family, whilst ensuring the Trust does not lose her skills. From 1 January 2020, the Executive Directors are as follows:

1. Paul Bentley, Chief Executive
2. Gordon Flack, Executive Director of Finance and Deputy Chief Executive
3. Sarah Phillips, Medical Director
4. Pauline Butterworth, Chief Operating Officer
5. Mercia Spare, Chief Nurse
6. Louise Norris, Director of Workforce, Organisation Development & Communications
7. Gerard Sammon, Director of Strategy

Natalie Davies, Corporate Services Director is a non-voting member of the Board.

3. Membership of Board Committees and Lead Roles

- 3.1 From 1 March 2020, the membership of Board Committees is set out in table 1 below. 'C' is used to signify the chairperson of the Committee; 'M' is used to signify a member of the Committee.

Table 1 - Membership of Board Committees

Board member	Audit & Risk Committee (2 NED's required for quoracy)	Charitable Funds Committee (1 NED required for quoracy)	Finance Business & Investment Committee (2 NED's required for quoracy)	Quality Committee (2 NED's required for quoracy)	Strategic Workforce Committee (2 NED's required for quoracy)	Remuneration and Terms of Service Committee
Pippa Barber	M	M		C		M
Peter Conway	C		M			M
Bridget Skelton	M		M		C	M
Nigel Turner				M	M	M
Francis Drobniowski		C		M	M	M
Sola Afuape		M	M	M		M
Paul Butler			C			M
Gordon Flack	Attends but not a member of ARC		M			
Sarah Phillips				M		
Pauline Butterworth			M	M	M	
Mercia Spare		M		M	M	
Louise Norris					M	
Gerard Sammon			M			

As part of good governance, all non-executive directors, the Chair and the Chief Executive are encouraged to attend at least one meeting per annum of the Board Committees that they are not formal members of.

3.2 In addition to the above responsibilities and excluding the Vice Chair and the Senior Independent Director (see section 4); there are the following assigned NED responsibilities:

- Mortality and Learning from Deaths – Pippa Barber
- Freedom to Speak Up – Sola Afuape
- End of life Champion – Francis Drobniowski

4. Chairs and Deputies of Board Committees

As detailed in Table 1, each of the Board committees has a chair. In the interests of good governance, each committee should also have a deputy chair. Table 2 proposes deputy

chair for each Board committee. This will be reviewed on an annual basis in order to ensure that we take account of succession planning.

Table 2 - Chairs and Deputy Chairs of Board Committees

Committee	Chair	Deputy Chair
Audit and Risk	Peter Conway	Pippa Barber
Finance Business and Investment	Paul Butler	Bridget Skelton
Charitable Funds	Francis Drobnewski	Sola Afuape
Quality	Pippa Barber	Francis Drobnewski
Strategic Workforce	Bridget Skelton	Nigel Turner
Remuneration and Terms of Service	John Goulston	Bridget Skelton

The Remuneration Committee will continue to be chaired by the Chair of the Trust with the Senior Independent Director as the Vice Chair of the Committee.

5. Vice Chair and Senior Independent Director

Paragraph 13.1 of the Trust's Constitution states that "The Council of Governors at a formal meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chair for such period not exceeding their term of office as a Non-Executive Director, as the Council of Governors may specify on appointment."

Vice Chair means the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties in accordance with paragraph 13.2 of the Constitution if the Chair is absent for any reason.

The Council of Governors at its meeting on 7 February 2019 approved the appointment of Peter Conway as Vice Chair of the Trust. Peter is also the Chair of the Audit and Risk Committee.

The Senior Independent Director is appointed by the Council of Governors. On 7 February 2019, the Council approved the appointment of Bridget Skelton as Senior Independent Director.

6. Non-Executive Director Terms of Office

The terms of office for the Non-Executive Directors are detailed in table 3 below.

Table 3 - terms of office for the Non-Executive Directors

First name	Surname	Start date	(Re)Appointment to the Board	Period of appointment	End date for appointment
Peter	Conway	01/03/2015	01/04/2018 (R)	3 years	31/03/2021
Bridget	Skelton	01/03/2015	07/04/2019 (R)	3 years	06/04/2022
Pippa	Barber	01/12/2016	01/12/2019 (R)	3 years	30/11/2022
Nigel	Turner	01/10/2018		3 years	30/09/2021
Francis	Drobniewski	01/10/2018	01/02/2019	3 years	31/01/2022
Sola	Afuape	01/12/2019		3 years	30/11/2022
Paul	Butler	01/03/2020		3 years	28/02/2023
John	Goulston	01/11/2018		3 years	31/10/2021

NB R – reappointed to the Board of Directors by the Council of Governors for a second term of 3 years. Non-Executive Directors and the Chair can stand for two 3 year terms of office.

Appointments of Non-Executive Directors are the responsibility of the Council of Governors. The Council of Governors has formed the Nomination Committee to consider the appointment and re-appointment of Non-Executive Directors and make recommendations to the Council.

7. Associate Non-Executive Director

In order to support succession planning and add to the diversity of thinking on Board of Directors, many NHS Foundation Trusts and NHS Trusts recruit one or more Associate Non-Executive Directors with a view to these individuals being excellent candidates to succeed Non-Executive Directors when their term of office expires or if a Non-Executive Director stands down.

An Associate NED would provide additional support to the Board and constructively challenge the Trust's ambitious vision for integrated care focused on improved public health outcomes, both in terms of strategy and successful execution of service change. The Associate Non-executive director role is used successfully in the NHS to support Board succession strategy and achieving a balance of Board level skills. Associate Non-executive directors cannot participate in any formal vote at Board.

The duties of an Associate Non-Executive Director would comprise:

- Contribute to the development of strategy, set organisational aims and ensure that financial and human resources are sufficient to enable business objectives to be achieved
- Demonstrate commitment to continuously improving outcomes, tackling health inequalities and securing the best use of public money

- Embrace effective governance, accountability and stewardship of public money and demonstrate an understanding of the principles of good scrutiny
- Contribute to ensure that the Trust Board remains “in tune” with the needs of our services and in the development of a culture where the interests of our patients and the community remain at the heart of discussions and decisions
- Represent and uphold the values of the Trust and be an appropriate role model, promoting equality and diversity for all our patients, staff and other stakeholders
- Uphold the values set out in the NHS Constitution demonstrating them in personal conduct and in the development of the culture of the Trust

It is anticipated that an Associate Non-Executive Director would require an equivalent of 2 days a month, however the time commitment may vary and a flexible approach should be taken. It is proposed that the role would attract a remuneration of £7,000 per annum and that the role should be for a 2 year term of office with the Chair having the ability to request to the Council of Governors an extension of 1 year.

8. Recommendations

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

- 8.1 From 1 March 2020, the Non-Executive and Executive Director membership of committees and additional duties as set out in Table 1 and paragraph 3.2.
- 8.2 From 1 March 2020, the Chairs and Deputy Chairs of the Committees as set out in table 2 and paragraph 4.
- 8.3 In order support succession planning, the Board of Directors is asked to approve the recommendation to the Council of Governors to recruit at least one Associate Non-Executive Director as set out in paragraph 7.

John Goulston, Chair

24 January 2020



Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	2.4
Agenda Item Title:	East Kent Frailty Strategy
Presenting Officer:	Dr Sarah Phillips, Medical Director

Action - this paper is for:	Decision <input checked="" type="checkbox"/>	Information <input type="checkbox"/>	Assurance <input type="checkbox"/>	<input type="checkbox"/>
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Report Summary

The East Kent Frailty Strategy for approval.

Proposals and /or Recommendations

To approve the strategy.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No

High level position described and no decisions required.

Dr Sarah Phillips, Medical Director	Tel: 01622 211922
	Email: sarahphillips4@nhs.net

East Kent Frailty Strategy Summary

A whole system commitment to change

The Local Care vision in East Kent is to develop a new model of care that enables people to live as independently as possible by delivering high quality, person centred care that integrates hospital, social care, community and voluntary services around the networks of GP practices.

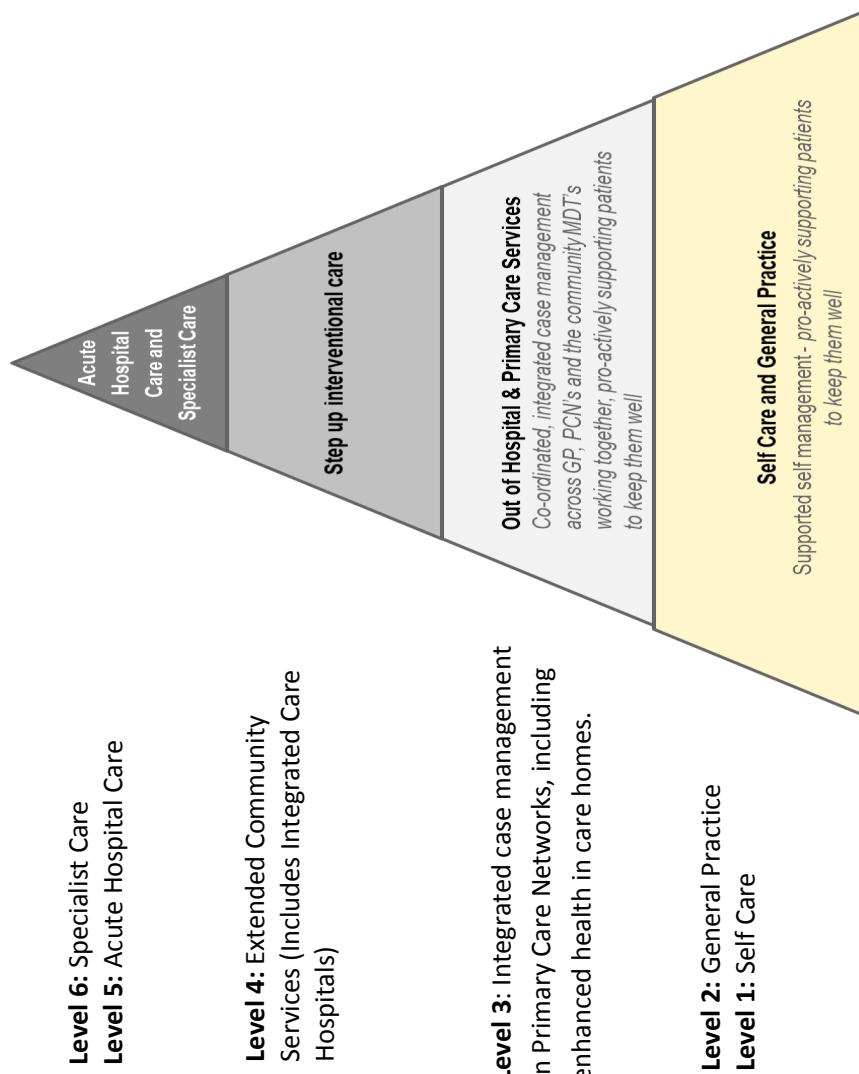
Definition of frailty and system approach:

1. We have defined a frail person as a person with multiple, complex needs, at risk of developing adverse outcomes such as dramatic changes in their physical and mental well-being, after even an apparently minor event which may compromise their health.
2. People who are frail or at risk of becoming frail, require multiple agencies to work together to plan and deliver a co-ordinated package of care and support to enable them to achieve positive person centred outcomes.
3. As a system, this means assessing and planning care needs will be vital to achieving better outcomes for people with complex needs and reducing the need for crisis or emergency care
4. A foundation of good practice will mean coordinating frail people's support needs across all of the agencies and people involved in their care, including informal care and support as well as that provided by voluntary and community sector groups. Identification of the patient cohort and complex care assessment is key to the delivery of the model.
5. The foundation of the frailty model is the Integrated Case Management (ICM) where the provision of integrated out of hospital care, in the patient's home or place of residence, will be the norm. There will be a strong focus on improved self-care and self-management, facilitated by highly effective, proactive care and support planning, bespoke case management and care navigation
6. Keeping people with frailty at home is key to the model of care. However, when a patient is appropriately admitted the integrated model will enable timely discharge with the right level of care

EK and frailty - an integrated whole-system commitment to change

The development of a whole-system frailty model based on the principles of Integrated Case Management (ICM) with true collaboration between the Acute Trust, Community Trust, primary care and other community and voluntary sector partners focused on establishing a continuum of care using innovative ways of working within community multi-disciplinary teams. New ways of working across the system workforce will be in place including joint roles and staff working across the pathway.

The foundation of the frailty model is Integrated Case Management (ICM) – which proactively supports and manages the frail and elderly within the community



Geriatric led services to support the emergency needs of our acutely unwell patients with frailty. This is likely to include; Frailty assessment units, medical and surgical liaison service for provision of Comprehensive Geriatric Assessment (CGA) wherever the patient is in hospital.

Rapid assessment and access to interventional care to support patients with frailty for all urgent needs, with the aim to provide urgent care at home. This is likely to include; acute response teams (e.g. ART) providing hospital at home services, community hospital step up, point of care testing, CGA as part of integrated frailty assessment services, dementia support and end of life targeted support

Integrated Case Management (ICM) embedded in primary care networks for people living with moderate or severe frailty and including end of life care. This will include; proactive anticipatory care planning at home or in care homes, within the context of a multiagency MDT and will access services such as social prescribing, falls prevention, medicines optimisation, health coaching and specialist services.

Self-care and supported self-management people living with mild and moderate frailty and their carers to manage their physical and mental health and wellbeing, build community resilience and make informed choices when their health changes.

The goal of the model is that patients will be facilitated to move between the levels as their needs escalate and de-escalate, based on effective clinical streaming. This will ensure they are only within secondary care when their medical and/or surgical needs require acute intervention. Services will operate as an integrated system with staff being able to work across the levels of care sharing knowledge and expertise.

Committee / Meeting Title:	Board Meeting - Part 1 (Public)			
Date of Meeting:	06 February 2020			
Agenda Number:	2.5			
Agenda Item Title:	Draft Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24			
Presenting Officer:	Paul Bentley, Chief Executive			

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report Summary	
Due to the time scales involved and further to the Board meeting of 30 October 2019, the Board gave authority to the Chief Executive to sign off the Kent and Medway Five Year Strategy Delivery Plan. This paper presents the current document which has been submitted to NHS England/NHS Improvement for consideration.	
A message from the Kent and Medway Sustainability and Transformation Partnership:	
<p>'In January 2018, the NHS published its Long Term Plan for the next 10 years. All systems across England were required to develop a local five year plan in response to the NHS Long Term Plan over the summer and autumn of 2019. Attached for information is our draft Kent and Medway five year plan, subject to final discussion with NHS England/NHS Improvement. Our plan sets out the continued transformation of our system, building on all of the work to date under the Kent and Medway Sustainability and Transformation Partnership (STP). It sets out our commitment to become a high performing Integrated Care System (ICS), delivering high quality services, improving the overall health and wellbeing of our population, investing in prevention and embedding prevention through the ICS, and working to address health inequalities. Our plan was developed with widespread engagement of staff from across our system, discussed at our system forums and informed by four public engagement events.'</p>	
The plan is a technical document and once it has been finalised with NHS England/NHS Improvement, we will publish a shorter more digestible public facing summary. Following the endorsement of plan at the STP/ICS Partnership Board on 4 November 2019, clinical commissioning group (CCG) governing bodies and provider Boards are asked to support and endorse the plan. Detailed implementation will be addressed through annual operational planning.'	

Proposals and /or Recommendations
To note the report.

Relevant Legislation and Source Documents
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Has an Equality Analysis (EA) been completed?
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No <input checked="" type="checkbox"/>
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High level position described and no decisions required.
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**Transforming
health and social care**
in Kent and Medway

DRAFT

**Kent & Medway
Strategy Delivery Plan
19/20 to 23/24**

Bringing the NHS
**Long Term Plan
to life**
in Kent and Medway

**Submission to NHS England
and NHS Improvement**

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.



Foreword (1/2)

I am delighted to present this five year **Strategy Delivery Plan** for the health and care system in Kent and Medway. This plan describes our priorities and actions over the next five years to continuously improve the health and wellbeing of our population, and to address the challenges of our health and care system. We have engaged widely in developing this plan, focusing on what matters most to local people. However, this plan reflects the current status of our system and over the next six to nine months, there will be significant changes in the way that services are organised, not least the merger of our existing eight Clinical Commissioning Groups to form a single CCG for Kent and Medway. Such changes will prompt us to reflect on this Plan and to launch a refreshed vision and strategy as we move closer to becoming an Integrated Care System.

In the summer of 2018, the government announced increased funding for the NHS in England resulting in the publication of a **Long Term Plan for the NHS** in January 2019; setting out guidelines for how the increased investment should be spent in local systems. The Plan signals a need for more integrated services, an increased focus on prevention and more targeted action on the biggest killers and disablers of our population. We welcome this set of national priorities as it accords with our own in Kent and Medway.

We are a system comprised of partners from across the NHS, local authorities, the voluntary sector and patient groups with a shared goal of achieving '**Quality of Life, Quality of Care**'. By providing high quality personalised care we will support people to live their best lives - helping people to look after their physical health, mental health and wellbeing; preventing avoidable illness; and supporting people with complex needs to best manage their health and look after their independence.

In Kent and Medway, we have a number of **structural challenges** with the way our services are organised and delivered, impacting both clinical and financial sustainability. We are working together as a system to implement long term solutions to these challenges, in a phased approach. In 19/20, we launched our system wide Workforce Transformation Strategy which aims to **make Kent and & Medway a great place to live, work and learn**. This has seen the creation of the Kent and Medway Medical School, an exciting collaboration of partners that will attract and train future doctors from 2020. We are also developing the Kent and Medway Academy for Health and Social Care to focus on system wide solutions to strategic challenges such as creating fulfilling lifelong careers in health and care.

Our first clinical priority area is the development of a network of hyper acute stroke units to ensure that providers can consistently deliver high quality services. This will result in more people surviving a stroke and improved quality of life and independence for people who have had a stroke. At a place level, our East Kent transformation programme is assessing two potential options that propose using our hospitals differently in the future to improve standards, with a single centre for specialist services and separating planned and emergency care, to benefit both types of services. This will be subject to formal consultation before a final decision is made.

Foreword (2/2)

Over the next five years we will look at options in relation to vascular and other more specialist services as well as looking at the options to improve care through networking of services across Medway, North Kent and West Kent.

Since the creation of the K&M Sustainability and Transformation Partnership in 2016 we have made **great strides in integration** including the implementation of system wide programmes for transforming primary care, creating multi-disciplinary teams to support people with complex needs, and prevention across the life course. In September 2019, our CCGs unanimously agreed to merge to become a single CCG across K&M in a move which will enable a focus on improving population health, commissioning at scale, and removing unwarranted variation.

This plan includes explicit commitment of all partners to invest in **population health and prevention**, ensuring that prevention is part of every single health and care pathway. Across the system we are tackling the **underlying drivers of health inequalities**. By taking positive action on underlying issues, such as smoking, obesity and alcohol consumption, we will reduce deaths and disability caused by cardiovascular disease, stroke, diabetes, respiratory disease and some cancers such as lung and colon. We know that the burden of issues such as smoking and obesity does not affect our population equally and that in areas of deprivation these issues contribute to inequalities. Additionally, we know that feeling lonely has a major impact on both our physical and mental health. Together, we need to do more to tackle **deprivation and social isolation**.

In this plan, you will see our priorities and actions to improve outcomes for all major conditions. This is underpinned by an overriding principle that our care pathways focus on the person and their needs and goals, not just a condition. This plan includes also explicit commitments to:

- Continue to improve our **cancer services** and ensure that more cancers are diagnosed earlier at stages 1 and 2 and that more people survive cancer
- Focus on our population's **mental health**, expand mental health services and better look after the physical health of people with severe mental illness
- Ensure that children, young people and adults with **SEND, Learning Disabilities and autism** and their families and carers receive the care and support they need and deserve

This plan is a call to arms for a fundamental change in the way that care is delivered in Kent and Medway and that enables all of us to lead our best lives.

Glenn Douglas

Contents (1/3)

	Section title	Page number
1.	Introduction	Page 7
	Our vision for Kent and Medway	
	Our approach to developing this plan	
	Implementing this Strategy Delivery Plan	
2.	Summary our Strategy Delivery Plan	Page 12
	Needs of our population	
	Our system challenges	
	Our strategic objectives and priorities	
	Our strengths and areas of opportunity	
3.	Strategic objective 1) Improving care quality and experience	Page 24
	Our approach to quality	
	A new model of integrated care closer to home – Primary and community based care, Urgent & Emergency Care, Planned Care	
	Acute services sustainability	
	Delivering the Long Term Plan in clinical and service areas – Cancer, Mental Health, Maternity and Neonatal, Children and young people, Learning disabilities and autism, Stroke, Diabetes, CVD, Respiratory, End of life care	
4.	Strategic objective 2) An increased focus on population health and prevention	Page 61
	Our approach to population health management	
	Our approach to prevention	

Contents (2/3)

	Section title	Page number
5.	Strategic objective 3) Driving financial balance, efficiency and productivity	Page 69
	Investing in delivery of the LTP	
	Delivering financial balance	
	Reducing growth in demand through prevention and integration	
	Making best use of capital	
6.	Strategic objective 4) Transformation of our workforce and infrastructure	Page 75
	Workforce: Making Kent and Medway a great place to live, work and learn	
	Digital: Delivering a digital transformation and providing more digitally enabled care	
	Our estates strategy: transforming our estate for the future	
7.	Strategic objective 5) A new integrated care system delivery model	Page 90
	An Integrated Care System for Kent and Medway	
	Innovation	
	Role of the voluntary sector and volunteering	
8.	Monitoring implementation of our Strategy Delivery Plan	Page 100
	Governance	
	Supporting delivery, assurance and risk management	
	Future engagement on our plans	
	Next steps	

Section one

Introduction

Introduction continued

Our vision for Kent and Medway

Three years ago, we created the Kent and Medway Sustainability and Transformation Partnership, bringing together over 19 partners from health, local authorities, voluntary sector and patient groups across Kent and Medway to work together to transform and improve services. Our vision for 'Quality of Life, Quality of Care' is the driver behind all of our transformation and improvement initiatives. We are pleased that the ethos of the NHS Long Term Plan is firmly reflected in our own vision. Our vision is informed by the Joint Health and Wellbeing Strategies of our two authorities Kent County Council and Medway Council*.

In Kent and Medway, we want to create a population where people are supported to live well and stay well, recognising that our health is impacted by everything around us – our living environment, our working environment, our families and communities – and that good health is a combination of good physical health, good mental health and our overall wellbeing. We want to create vibrant, strong communities where people support one another across the generations.

Over the summer of 2019, our Sustainability and Transformation Partnership has been working across the Kent and Medway system with staff, clinicians and our population to develop this five year Strategy Delivery Plan. Our Plan sets out the strategic objectives and priorities for Kent and Medway and how we will implement the NHS Long Term Plan locally. The Long Term Plan itself was developed with extensive engagement of the people who know best what needs to change – with staff and patients from across the county.

Delivering this plan over the next five years and beyond requires significant investment, some of which will come from dedicated Long Term Plan funding and some of which will need to be met from our baseline funding. This requires us to make decisions about what to do when. This task will continue beyond the publication of this plan and will be tackled as part of each year's operational and financial planning. We also have a significant need for capital investment and will continue to work closely with national bodies on how this requirement will be met.

Our vision for Kent and Medway:

Quality of life, quality of care

Our goals are to:



Our vision is for everyone in Kent and Medway to have a great quality of life by giving them high-quality care.

- Encourage people to live well and independently, preventing ill health

- Give people access to high-quality care and support in the right place, at the right time

- Deliver high-quality, joined-up health and social care to help people reach their life goals

- Empower people to manage their own health and care with confidence

We will achieve this by:



- Transforming care: We will join up care so patients receive a better outcome and experience

- Working smarter: Together, we will unlock more time and money to deliver better care for patients

- Enabling change: We will have the right workforce, buildings, digital technology and finance to support change to happen.

- Commissioning consistently: We will lead the development of a strategic commissioner to pay for, design and deliver entire services across a population, where it makes sense to do so

* https://www.kent.gov.uk/_data/assets/pdf_file/0014/12407/Joint-health-and-wellbeing-strategy.pdf

https://www.medway.gov.uk/_2369/health_and_wellbeing_strategy_2012.pdf

Introduction continued

Our approach to developing this plan

The Kent and Medway Strategy Delivery Plan 19/20-23/24 has been developed in collaboration with a wide network of local experts from across health and social care. Every stage of its creation has been clinically led, with contributions from a range of GPs and clinical specialists. Our system wide STP Clinical and Professional Board have provided input to the plan at their meetings in August, September and October. Additionally, we have utilised a range of system forums and boards to discuss and develop the proposals in this plan (see right).

Whilst this is a Kent and Medway level plan setting out system level ambitions, work has been performed with colleagues in our localities to ensure the plans are locally owned. We have brought together clinicians, commissioners, service managers and finance professionals to discuss the proposals as they have developed and to ensure that they are underpinned by realistic finance and workforce assumptions.

The plan builds on the progress and achievements of the Kent & Medway Sustainability and Transformation Partnership over the past three years, recognising that we have already made significant progress in areas such as the plans for reconfiguration of stroke services to improve outcomes for people who have had a stroke, the East Kent transformation programme to develop a system for East Kent that will consistently deliver high quality care into the future, collective commitment across all partners to implement more joined up care closer to home in ‘Local Care’, fewer people smoking than ever before, and improved performance against cancer waiting standards. Our plan builds on this strong foundation, using the NHS Long Term Plan as a helpful framework against which to review our progress to date and to identify additional areas of focus.

System forums involved in the development of this plan

Health and Wellbeing Boards	STP Non-Executive Directors Oversight Group
STP/ICS Partnership Board	STP Clinical and Professional Board
STP Finance Group	STP Patient and Public Advisory Group
CCG Governing Bodies	Provider Boards
Local Care Board	Primary Care Board
Digital Workstream Group	Dementia Improvement Board
Cancer Strategy Delivery Group	Joint Committee of CCGs for Cancer
Joint Committee of CCGs for Stroke	Mental Health Improvement Board
Local A&E Delivery Boards	Prevention Workstream Group
Local Maternity System Board	Diabetes Oversight Group Board
Workforce Board	HR Directors Group

Most importantly of all, we have held four engagement events across Kent and Medway to discuss our NHS Long Term Plan response and test our thinking with the public, as well as undertaking targeted engagement activity on specific priority areas, including surveys and focus groups with seldom-heard groups. As well as these events, we have conducted staff briefings, and discussed the plan as it progresses with wider stakeholders, for example district and borough councils, MPs, and Health and Wellbeing Boards for Kent and Medway.

Introduction continued

Implementing this strategy delivery plan

Delivering through our new Integrated Care System framework

We will become an Integrated Care System by 2021 which will enable us to go further and faster in areas such as making decisions collectively and driving integration. In September 2019, our Clinical Commissioning Groups unanimously agreed to merge to become a single CCG across Kent and Medway in a move which will enable a focus on improving population health, commissioning at scale, and removing unwarranted variation. The merger was approved by NHS England and NHS Improvement on 21st October 2019.

Our Integrated Care Partnerships, comprising Primary Care Networks, will be empowered to design and deliver their local services in a way that achieves improved outcomes for local people. Our Primary Care Networks are bringing together GP practices and developing expanded primary care teams to build a resilient primary care for the future and provide more community based care.

This new way of organising ourselves, to drive integration and a focus on population health, is a very different landscape. We recognise that the governance arrangements of the Sustainability and Transformation Partnership need to change as we move to become an Integrated Care System with a more formal set of structures than have existed under the STP. We will initiate a governance review working with system partners on the principles to guide the development of options and recommendations for ICS governance, including the arrangements for clinical and patient representation, accountabilities for quality governance, patient safety and outcomes. We will need to look at the accountabilities that should reside with Integrated Care Partnerships (ICPs) and the accountability relationship between the single CCG and the ICPs.

Keeping our strategy live

In Kent and Medway, we believe it is important that this strategy remains a live, dynamic process. This Strategy Delivery Plan has been prepared according to a national timetable for all systems across England to prepare five year plans in response to the national NHS Long Term Plan by Autumn 2019. We recognise that the contents of this plan reflect a point in time and that the coming year will see significant change for Kent and Medway as we make further strides in becoming an Integrated Care System, including the planned merger of our CCGs by April 2020, accelerated development of our four Integrated Care Partnerships and the bedding down of our 42 Primary Care Networks (PCNs). We have developed a Primary Care Strategy led by Primary Care professionals and we recently held our first conference of the Clinical Directors of the 42 PCNs. Over the next 6 to 12 months our ICPS and PCNs will develop considerably in their leadership and working arrangements including partnership working.

As such, we are proposing to develop a refreshed vision for our Integrated Care System in spring/summer 2020. This will be part of a wider Organisational Development programme which we will start to implement now to support us in the changes we need to make to become an Integrated Care System by 2021. We will also need to produce a commissioning strategy for the new Kent and Medway single CCG. Additionally, our ICPs will be developing, for the first time, their operational plans in early 2020. Consequently, we intend to launch a new ICS vision in spring/summer 2020 that will build on all of the work to date but will look further ahead to the next five to ten years. Our strategic objectives and priorities will be further refined as we develop a Kent and Medway Population Health Outcomes Framework. In light of all this, we aim to develop a Strategy Delivery Plan refresh in late 2020. This refresh will take account of any additional targeted funding awarded to Kent and Medway to support the implementation of the Long Term Plan.

We will monitor whether the priorities and actions set out in this plan are having the intended impact on our patients and our population. We will identify the interventions which have greatest impact and we will ensure that they are implemented across our geography.

Section two

Summary of our Strategy Delivery Plan

Needs of our population

In summer 2019, Kent County Council and Medway Council jointly produced a [Kent and Medway Health Needs Assessment](#), the results of which have directly informed the setting of priorities in this plan. We have unacceptable differences across Kent and Medway in the underlying drivers of poor health (such as smoking and obesity) which results in health inequalities. There is a clear link between health inequalities and deprivation and that as a system we need to do more to tackle deprivation.

Causes of preventable ill-health

Smoking - 15% of people in Kent and 14.7% of people in Medway smoke, which is higher than the national average.

Obesity – Obesity is rising and directly contributes to many serious illnesses such as diabetes. In Medway, obesity levels are higher than the national average for both adults and reception year children. While in Kent, levels are similar to the national average, we have high levels of obesity in Thanet and Dover.

Alcohol and substance misuse – There are an estimated 17,053 dependent drinkers across Kent and Medway, approximately 37,800 adults who drink more than 14 units a week, contrary to department of health guidelines, and approximately 7000 opiate and/or crack cocaine users. Rates of death and harm linked to alcohol and substance misuse are generally higher in areas of deprivation

- Rates of *respiratory disease* are generally lower than national average but we have pockets where under 75s mortality due to respiratory disease is significantly higher – in Dover, Thanet, Swale and Medway
- The number of people over the age of 65 with a diagnosis of *dementia* in Kent and Medway is estimated to be 23,375, with 14,298 (61.17%) having a confirmed diagnosis. Some dementia is preventable, with good management of cardiovascular health.

To improve the health of our population against these major conditions, our plan includes both preventative actions and targeted interventions delivered in Primary Care aimed at people at high risk.

In 2017, 4,893 people died from *cancer* in Kent and Medway, accounting for 29% of all deaths and 40% of deaths for under 65s. Over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. While mortality rates in Kent are in line with national average, they have been increasing in recent years. There is more to be done on prevention, screening, and earlier diagnosis. Continued action on smoking, diet and physical activity will reducing the risks of developing specific types of cancer including lung and colon cancer.

Multi-morbidity and frailty

Approximately 20% of the Kent and Medway population have more than one long term condition, known as ‘multi-morbidity’, rising to 40% in over 50s and 70% in over 85s. There is a strong link between multi-morbidity and deprivation, with around 21% of people living in the most deprived areas having multiple conditions compared to 16% in the most affluent areas.

- People with multiple conditions are more likely to become frail – and frailty doesn’t just affect the elderly. Identifying frailty risk early enables earlier intervention and maximises quality of life and independence.

In Kent & Medway, we are taking a population health approach to managing the overlap between frailty and multi-morbidity by identifying people at risk and supporting them with integrated multi-disciplinary teams.

- **Stroke** prevalence is around the national average although rates are higher in some areas. Stroke is the largest cause of severe disability

Needs of our population

Mental health

We all have mental health and we will all experience challenges with our mental health at some point in our lives. Since 2014, rates of severe depression have increased in Kent and Medway and suicide rates are higher than both the national average and regional neighbours, particularly in men. The co-existence of mental health problems like depression or anxiety with other problems such as obesity, smoking, alcohol misuse and poor self-care is also increasing. People with severe mental health illness are more likely to have a physical health condition and die on average 15 years earlier than people with no mental illness.

There is an urgent need to take a population health approach to looking after the mental health and emotional wellbeing of our population. We need targeted action on expanding services and ensuring that people can access the right support. We need to focus on improving the physical health of people with mental illness and recognise that good health is a combination of physical health, mental health and wellbeing.

Dementia

Currently, only just over 61% of individuals over the age of 65 in Kent and Medway suspected to have dementia have a diagnosis. We need to ensure that people receive a timely diagnosis and receive the appropriate support to ensure they remain as independent as possible, for as long as possible.

Healthy start in life

Obesity in pregnancy, low birth weight and rates of breastfeeding are amongst some of the most relevant issues in Kent and Medway where we could have a positive impact on giving babies a healthier start in life. One in five pregnant women in Kent and one in four pregnant women in Medway were obese in 2017, a 1% and 2% increase from 2015. 3% of pregnant women in K&M were morbidly obese.

Low birth weight is associated with a number of different factors, one of which is smoking. While the rate of smoking in pregnancy has been falling, there is more to do to reduce from the current rate of 14.2% to the Local Maternity System (LMS) target of 6% by 2022.

- Rates of breastfeeding in the first 48 hours of life differ significantly across Kent and Medway, with Maidstone and Tunbridge Wells NHS Trust reporting highest rates and Dartford and Gravesham NHS Trust reporting the lowest.

Children and young people

There are a wide range of needs for children in Kent and Medway:

- Around 13% of children and young people aged 5 to 19 years are estimated to have a mental health condition and there is particular concern for looked after children
- 1 in 5 primary school children are obese or overweight
- The rate of teenage pregnancies is above regional average
- Children in early years do not have adequate vaccination coverage
- The number of children with life-limiting conditions has increased in recent years, while the rate of deaths is declining owing to advances in diagnosis and care. The need for palliative and end of life care is growing year on year
- Rate of children with SEN type autism is higher than national average
- Rate of children and adults with SEND, LD or autism receiving physical health checks varies significantly across Kent and Medway and this unwarranted variation must be reduced
- In early 2019, Ofsted and the Care Quality Commission (CQC) conducted a joint inspection of services for children and young people in Kent with special educational needs and/or disabilities (SEND) which identified a number of weaknesses. Kent County Council and the NHS are committed to working together to address these weaknesses

Summary of our population needs

What people have told us

In developing our plan we have drawn on extensive previous engagement with local people, as well as carrying out specific and targeted engagement activity to inform the development of the strategic priorities set out in this document. You can read all about these events in our [Strategy Delivery Plan Engagement Document](#). In summary terms, here are main things that local people want to see in their services:

For prevention

- Helping people improve their health and make healthier lifestyle choices
- Recognising and tackling the wider determinants of health
- Making the most of community resources to improve health and wellbeing

For mental health

- Improving quality and how care is organised, including communication between different services and with patients
- Making it easier to access care, including improving awareness among all NHS staff and having more mental health staff in front-line services
- NHS, schools, employers and councils and communities working together to raise awareness of mental health problems and to improve mental health and wellbeing

For Dementia

- Better information about post diagnostic services, activities and carer support
- Better access to technology that could give reminders and provide additional security and peace of mind
- Access to a wider range of activities and services which are aimed specifically at men

For cancer

- Improving how cancer services are currently organised
- Getting a quick referral and diagnosis
- Communication within the NHS and with patients and their families, and raising awareness to support earlier diagnosis and help prevent cancer

For primary and community based care

- Getting enough of the right staff, with the right skills in primary and community care
- Making it easier to access the right care quickly and close to home
- Making sure primary and local care is well planned, consistent and joined up

For children and young people

- Improving current services and communication within the NHS and with social care
- Working with parents, families and schools to raise awareness of and prevent mental health problems and to better support children with mental health needs
- Taking a more proactive approach to targeting families who don't take up vaccinations, working with them to understand and overcome concerns

For digital transformation

- Encouraging and helping people to use digital technology, including NHS staff, where appropriate, without losing face to face contact
- Making better use of digital technology to improve health and quality of care
- Making better use of digital technology to connect different health and care services

Our system challenges

Geographical and demographic challenges

Kent and Medway is a large geographical area (1,368 square miles) including many towns, villages and rural areas, surrounded on three aspects by water and in close proximity to London. The county has a very long coastline particularly in the south and east of the county; and more urban and light industrial towns in the north and west. It is a major transitory route for the continent through the port of Dover and the Channel Tunnel in Folkestone. Transport across the county can be challenging both by road and public transport. We have pockets of high levels of deprivation, particularly in our coastal areas and in parts of Medway, driving significant differences in health outcomes as referenced earlier in our description of population needs. Close proximity to London has an impact on our ability to recruit and retain staff. Adopting a range of approaches to tackle this and to make K&M a great place to live, work and to learn is a pivotal strand of our Workforce Transformation Strategy (see right for more detail on workforce challenges).

The population of Kent and Medway in 2018 was estimated to be approximately 1.85 million people, an increase of 0.8% from the previous year. Most of this growth was from the Kent area, where growth was higher than both the national average and that of the South East. The population is expected to increase to 2.1 million by 2031 with local authority housing forecasts indicating that some 178,600 housing units are planned by 2031. In north Kent, there will be significant concentrated population growth from the Ebbsfleet Healthy New Town, with 15,000 new homes including a high number of young families. Whilst the significant population growth in Kent increases demand for services, it also provides an opportunity to recruit and train more people in health and care skills.

As with the rest of England, we also have an ageing population. The number of older people is growing quickly. Growth in the number of over 65s is over four times greater than those under 65; an ageing population means increasing demand for health and social care, for example, there are currently around 14,000 people living with dementia in K&M.

Workforce challenges

It is recognised by national regulators that Kent and Medway has some of the most difficult workforce challenges across the South East and that we have made significant progress since the inception of the Kent and Medway STP to tackle these issues. We have developed a system wide Workforce Transformation Strategy and underpinning the Strategy is a set of plans for short, medium and long term solutions, recognising that growing future workforce supply to the numbers required is a long term endeavour.

We have shortages in general practice that are amongst the worst in the country. This is exacerbated by the age profile of our staff with 25% of GPs and 55% of general practice nurses approaching retirement. Transforming out of hospital care including implementing new models of community based care is a significant strand of our long term strategy and this will require us to address challenges in community staffing including in community nursing and Allied Health Professionals. We have shortages of key mental health professional workforce including psychiatrists and nurses. There are specific concerns in relation to the cancer workforce required by 2022 including specific gaps in gastroenterology, histopathology, and clinical and diagnostic radiology. There are shortages of skilled social care workforce providing direct care and support in our local communities, with over half of all vacancies in Kent and Medway being within social care. These shortages can directly impact the quality of care that is provided to patients as well as increasing the workload and strain for our staff.

We are tackling our workforce challenges through implementation of a system wide strategy, working at a system level on areas best addressed collectively (for example, by promoting life long careers and attracting young people into health and care professions) as well as working at an organisational level on targeted local recruitment, retention and best place to work schemes aligned to system wide principles. We will adopt system ways of working to ensure that all components of the system work together collaboratively to grow our workforce for the future.

Our system challenges

Acute services sustainability

Across Kent and Medway we have a number of structural challenges with how our services are organised and delivered which can impact the quality of our services. Resolving these structural challenges is also the key to long term clinical and financial sustainability of our services, alongside actions to build the workforce for the future and to deliver streamlined and efficient services.

These challenges need to be addressed in a phased approach and our first clinical priority has been to implement a new model for **stroke services** in response to our providers continuously struggling to meet quality standards. Following a review of services in 2014, a proposal was developed to establish a network of hyper acute stroke units and acute stroke units operating 24 hours a day, 7 days a week. This change will mean that more people survive a stroke and, for those who have had a stroke, improved quality of life and independence. Over the next five years, we will look at the case for change for other specialist services, starting with vascular services. Our goal will be to identify where services are not consistently delivering high quality care, to assess the case for change and to develop a set of options for change which will be rigorously analysed and subjected to engagement with our population.

At a place level, the delivery of services in **East Kent** is not sustainable. In 2016, clinicians and leaders in East Kent published a case for change setting out the reasons why change is needed – long waits to see a GP, long waits in A&E, challenges with attracting and retaining enough staff to deliver services and the need to deliver services differently moving more care closer to home. Our East Kent transformation programme was established to steer the work to develop new models of care in East Kent and a series of options for the future configuration of urgent, emergency and acute medical care. Through an appraisal process, this has resulted in the shortlisting of two potential options that propose using our hospitals differently in the future to improve standards, with a single centre for specialist services and separating planned and emergency care, to benefit both types of services. This will be subject to formal consultation before a final decision is made.

The capital requirements in East Kent are a pressing cause for concern, with significant backlog maintenance to ensure that conditions for patients and staff are safe and appropriate. Regardless of which option is the confirmed option, the issues of the current hospital estate will need to be addressed.

The implementation of **Local Care** has been continuing at pace in East Kent and this will be a key part of the solution for East Kent; under either option. Local Care teams are providing joined up, personalised care close to home which focuses on keeping people well, avoiding unnecessary hospital admissions, and maintaining wellness and independence.

Whilst we do not believe major service reconfiguration is required in the same way as is being pursued in East Kent, in our other areas – West Kent, Medway & Swale, Dartford, Gravesham and Swansley – we need to conduct a needs assessment of the services that require more networking between acute providers or consolidation in order to ensure services are sustainable and able to deliver the best outcomes. In Medway and Swale specifically, we will utilise the newly formed Integrated Care Partnership to look at the clinical and financial viability of services into the longer term.

You can read more about our approach to challenges of acute services sustainability in Section 3

Our system challenges

Diagnostic services

Improving diagnostics in healthcare is a global objective of effective healthcare systems. We need to continuously improve how quickly and accurately we diagnose conditions and illnesses. In Kent and Medway, we have particular challenges affecting our diagnostics capacity and processes associated with both workforce challenges and availability of diagnostic equipment.

In particular, shortages of radiologists impact our diagnostic services. However, our broader workforce challenges impact the availability of our consultants and other clinical professionals to support diagnostics.

There are examples across K&M of patients requiring diagnostic support via an emergency admission but not being able to access an MRI, CT or ultrasound in the evenings/weekends as well as long waits for particular types of investigations such as neurological investigations.

In East Kent, our transformation programme is tackling challenges of access to diagnostics. This will also need to be considered as part of the work that needs to be undertaken in other parts of the county as we look at the need to network services between hospitals or to consolidate provision of services. Additionally, within our cancer programme we are implementing a range of improvements to support early diagnosis.

However, the work on diagnostics now needs to span beyond East Kent and cancer to a wider diagnostics review that will encompass both a speciality view and a geographical view.

Options will need to include consideration of networked models as well as the potential major diagnostic centre in the Kent and Medway geography. Digital will need to play a significant role in the transformation of diagnostic services, with increasing levels of automation to speed up processes and free up staff time as well increased use of artificial intelligence to support earlier and more accurate diagnosis.

Quality challenges

All of the challenges described - workforce, acute system sustainability and diagnostics – are all inextricably linked and all compound to affect the quality of our services at times. Quality services are services that are safe, effective, and provide as positive a patient experience as possible.

Two of the acute trusts have been in special measures for quality in recent years and as a system we struggle to meet the constitutional targets of A&E four hour waiting times, cancer waiting times, and 18 week referral to treatment standard. Some of our acute trusts still report higher than expected cases of MRSA and C difficile. Many of our patients receive excellent care, but there are also examples of where care has fallen short of the required standard. It is this variation in quality of care that our five year plan will tackle.

Despite support and continued improvement projects, the quality of care across the Kent and Medway geography remains challenged. The only solution is to work together as a system to enhance the care for our population in relation to both prevention and intervention and prioritise the development of new models of care to keep people well for longer.

We also know that we need a greater focus on recognised Quality Improvement methodologies and a cultural change in the way we approach improvement. Quality Improvement must be at the heart of system and organisational culture, with a focus on identifying the root causes of issues, improving processes, measuring and sustaining that improvement.

Our system challenges

Financial position and investment

Delivering this plan requires significant investment, some of which will come from dedicated Long Term Plan funding and some of which will need to be met from our baseline funding. This requires us to make decisions about what to do when. This task will continue beyond the publication of this plan and will be tackled as part of each year's operational and financial planning.

Kent and Medway is a financially challenged system, and as previously described in this chapter, some of the key reasons for this include growing demand for services combined with how some of our services are currently configured. By ensuring that our services are both clinically and financially sustainable we will drive a route to long term financial balance. Additionally, we also know that there are significant opportunities for productivity and efficiency across Kent and Medway, for example, in pathology, back office functions and our use of temporary staffing. In terms of care delivery, by reducing unwarranted variation and streamlining care pathways to remove unnecessary delays we will both improve patient outcomes and experience while also releasing valuable staff time to reinvest in the improvements set out in this plan.

You can read about more about our approach to driving efficiency and productivity in section 5.

We have a significant need for capital investment. Whilst we are doing all that we can to utilise existing estate and to move care closer to home, there remain instances where we will require new buildings and where we need to maintain our current buildings. The investment required for the East Kent transformation and to implement our Local Care model of care closer to home is a significant element of our capital requirement. We will continue to work with national bodies as to how this requirement will be met to support delivery of this plan.

You can read about our estates strategy in section 6.

Our five strategic objectives

To meet the needs of our population and to address our system challenges we will focus on five strategic objectives:

What our K&M Health Needs Assessment says

- **Cancer** is the number one cause of premature death
- **Cardio Vascular Disease** is the biggest cause of disability
- **Stroke** is the single largest cause of complex disability
- 90% of adults with **diabetes** have preventable type 2 diabetes
- Higher levels of **respiratory disease** in areas of deprivation
- **Frailty and multi-morbidity** are rising
- **Health inequalities** between most and least deprived areas

What people have told us they want to see

Prevention – healthier lifestyle choices

MH – quality and ease of access to services

Cancer – increased efforts to raise awareness to prevent and diagnose cancer earlier as well as quicker referral and diagnosis

Children and Young People – better support for children and young people with MH problems as well as improving vaccination rates

Primary and community care – easier access to the right staff and bringing care closer to home

Digital transformation – Better use of digital services to connect health and care services and improve health and quality of care.

Our system challenges

- Long coastline and proximity to London
- Workforce challenges particularly in primary care, social care, mental health and cancer
- Acute services sustainability challenges
- Quality challenges

- 1) Improving care quality experience** - This strategic objective covers a wide range of delivery priorities including developing our ICS accountability framework for quality and *Delivering integrated care closer to home* (expanded primary care and community care services). We are *transforming urgent and emergency care* to ensure that A&E is only used for serious urgent care needs and emergencies. We also know that resolving a number of *structural challenges* that impact the clinical and financial sustainability of our services is critical. Lastly, this objective includes a number of *specific priorities to improve care and outcomes* for a number of clinical and service areas.
- 2) An increased focus on population health and prevention** - This strategic objective includes developing our approach to population health management to improve overall population outcomes. Prevention will be embedded throughout the ICS and at the start of every care pathway. Our approach to prevention follows the life course as well as targeted actions on priority areas of smoking, obesity, alcohol, MH, health protection, cancer and other major conditions
- 3) Driving financial balance, efficiency and productivity** – This strategic objective covers our actions to address our financial challenges including meeting the government's four tests for best use of taxpayers' investment in the NHS
- 4) Transformation of our workforce and infrastructure** – This strategic objective starts with our Workforce Transformation Strategy and the actions being taken to address our workforce challenges. Digital transformation is a critical enabler to improving care quality and transformation and to providing the infrastructure to support population health management. Our estates strategy is aligned to our clinical strategies to deliver a fit for purpose estate for the future, with a significant capital requirement.
- 5) A new Integrated Care System delivery model** – This strategic objective is about a new way of organising ourselves, in line with national policy, that will better enable integration of services, put an end to unwarranted variation and drive a focus on population health.

Our strategic planning framework

Our strategic planning framework has been informed by our STP programmes, the Kent and Medway Health Needs Assessment, listening to what local people want, and the national priorities as set out in the NHS Long Term Plan.

Strategic objectives	Delivery Priorities	Principles cutting across our strategic objectives
1. Improving care quality and patient experience (Section 3 of this plan)	<ul style="list-style-type: none"> • Implementing an ICS quality framework and quality priorities • Delivering more care outside of hospital including resilient primary care and community care • Addressing clinical and financial sustainability of acute services • Transforming urgent and emergency care • Transforming outpatients and ensuring timely planned care • Improving services and care outcomes for cancer, MH, maternity and neonatal, children and young people, LD and autism, stroke, CVD, diabetes, respiratory disease, end of life care 	<ul style="list-style-type: none"> • Adopting a 'health in all policies' approach across all partners in the development of new policies to consider the impact on population health • Promoting self management, self care and citizen activation
2. Increased focus on population health and prevention (Section 4 of this plan)	<ul style="list-style-type: none"> • Implementing population health management (PHM) including a K&M outcomes framework informed by this Strategy Delivery Plan • Developing capacity and capabilities for PHM • Embedding prevention throughout the system and in every pathway • Supporting more people to stop smoking and preventing children and young people from ever starting to smoke • Taking a place based approach to tackle obesity • Identifying people at risk of alcohol and substance misuse in the community and supporting them with targeted interventions • Tackling health inequalities at a place based level 	<ul style="list-style-type: none"> • A relentless focus on driving out unwarranted clinical variation • A step change in digitally enabled care including online guidance to support self-care • Creating the infrastructure to enable integrated datasets • Continue to explore opportunities to deliver productivity savings of c£53-90m by 23/24 through areas such as: <ul style="list-style-type: none"> ○ Continued implementation of best practice processes (<i>GRIFFT, Right Care, Model hospital</i>) ○ Delivering a single pathology service for Kent & Medway ○ Developing a collaborative 'bank' for medical and nursing staff across K&M
3. Driving financial balance, efficiency and productivity (Section 5 of this plan)	<ul style="list-style-type: none"> • Deliver against financial trajectories for the 5 year period • Achieve success in bidding for targeted funding from national bodies to support the delivery of our plan • Deliver c12m productivity savings in 19/20 • Continue to explore opportunities to deliver productivity savings of c£53-90m by 23/24 through areas such as: <ul style="list-style-type: none"> ○ Continued implementation of best practice processes (<i>GRIFFT, Right Care, Model hospital</i>) ○ Delivering a single pathology service for Kent & Medway ○ Developing a collaborative 'bank' for medical and nursing staff across K&M 	<ul style="list-style-type: none"> • Promoting self management, self care and citizen activation
4. Transformation of our workforce and infrastructure (Section 6 of this plan)	<ul style="list-style-type: none"> • Implementing the K&M Transformation Strategy • A step change in digitally enabled care including online guidance to support self-care • Creating the infrastructure to enable integrated datasets • Implementation of the K&M Shared Care Record • Completing and implementing the K&M analytics strategy • Delivery of our K&M estates strategy including success in national bidding rounds for funding 	<ul style="list-style-type: none"> • A new integrated care system delivery model (Section 7 of this plan)
5. A new integrated care system delivery model (Section 7 of this plan)	<ul style="list-style-type: none"> • A system commissioner to commission at scale and drive a focus on population health • Development of Integrated Care Partnerships to deliver high quality integrated care and tackle local health inequalities • Development of Primary Care Networks to create a resilient primary care and expanded community care delivering personalised anticipatory care • Development of innovation, research, and quality improvement • Expanded joint working between the NHS, local authorities, voluntary sector, and wider partners 	<ul style="list-style-type: none"> • A relentless focus on driving out unwarranted clinical variation • A step change in digitally enabled care including online guidance to support self-care • Creating the infrastructure to enable integrated datasets • Implementation of the K&M Shared Care Record • Completing and implementing the K&M analytics strategy • Delivery of our K&M estates strategy including success in national bidding rounds for funding

By doing all of this we will achieve for the population:

- Increase in healthy life expectancy
- Improved wellbeing and resilience
- Reduced health inequalities

Our priorities for the population of Kent and Medway by 2023/24

By delivering the priorities across our five strategic objectives, we will deliver improved outcomes and benefits for the population. The below is a set of priorities for the population that have been identified through the development of this plan. This will be supplemented with a K&M Population Health Outcomes Framework to be developed in early 2020. *Please note that the below is not exhaustive and does not cover all of the benefits and outcomes described in this plan – you will find these within individual chapters.*

A good start in life for babies, children and young people	Good health and wellbeing for working age adults	Good health and wellbeing for people who are frail and/or have multiple conditions	Across our population
<ul style="list-style-type: none"> Less than 6% of women will smoke during pregnancy Increased breastfeeding rates by providing more support for more women who choose to breastfeed and through promotion of benefits Some 2000 women will receive perinatal MH support Increase vaccination uptake Around 16,000 children and young people accessing mental health services Reduced gap in rates of obesity for reception year children between the most and least deprived areas Reduced waiting times for children and their families for autism spectrum disorder assessments Children with complex needs will be supported by a community based multi-disciplinary team 	<ul style="list-style-type: none"> Even more people will have received psychological therapies for common MH problems (c60,000) A reduction in the age incidence of stroke More people will survive stroke and those who do will have better quality of life and independence Around 6,500 people will have been supported by the Diabetes Prevention Programme A lower rate of diabetic complications A lower rate of premature mortality and disability from CVD Less than 12% of population will smoke A reduced gap in obesity levels between the most and least areas More people will be supported by Alcohol Care Teams 	<ul style="list-style-type: none"> More people with complex needs (including people with MH conditions and people with complex LD or autism) will have been supported by a multi-disciplinary team, supporting them to stay well Some 30,000 people will have benefited from a social prescribing referral At least 30,000 people will have benefited from a care and support plan Incidence of falls in older people and frail people will reduce Reducing levels of premature mortality for people with mental health conditions and for people with LD or autism More people with LD or autism will receive community based care More people will receive a timely diagnosis for dementia and be guided to the right care and support Nearly 80% of people with LD and autism will have had a physical health check 	<ul style="list-style-type: none"> c61% of cancers will be diagnosed earlier at stages 1 and 2 leading to more people surviving cancer 70% to 100% of our general hospitals with a major ED will have liaison psychiatry services in place to support people with a mental health need Following a successful Mental Health Wellbeing campaign, more people will know their ‘five a day’ for the mind More people will report that they feel comfortable discussing mental health and that they have been able to access the right services through a ‘no wrong door’ approach Suicide will reduce by 10% More people will have received urgent care and advice outside of A&E settings Almost all of our population will have been able to access online consultations Careers will report they feel better supported by a range of different resources

Our strengths and opportunity areas

We have set strategic objectives and priorities to address our challenges and the needs of our population. It is important to recognise that in delivering on our strategic objectives and priorities, we will build and capitalise on our key strengths and achievements including:

- Our GP leaders unanimously voting to merge our existing CCGs to create a single CCG across K&M to commission at scale, put an end to unwarranted variation and drive population health management
- Our ambitious and driven Primary Care Network clinical directors
- Our commitment to meeting the national investment standard in Mental Health and the progress in achieving parity of esteem between physical and mental health
- Our improved cancer performance for treating patients within 62 days of referral, taking us to the second best performing cancer alliance in the country for this standard.
- Our commitment to embedding prevention throughout the ICS and in every pathway
- Our work on the Kent Integrated Dataset which has enabled us to develop a detailed understanding of our population
- Our track record of coming together to agree future direction, for example, our collective commitment to the Local Care model and our Primary Care strategy owned and led by Primary Care professionals
- Our track record of partnership working with the STP comprising over 19 partnership organisations – see slide 98 for list of members

As we continue to implement our strategic objectives and priorities, we will actively target themes where we know that there are opportunities to be further exploited including:

- Further development of our long term digital strategy including the role that digital will play in transforming how people look after their health and wellbeing and in transforming how care is delivered and experienced. We recognise that we have many pockets of innovation and excellence across Kent and Medway. We now need to develop a long term strategy which drives consistent application of high impact digital tools and solutions
- A greater focus on identifying and spreading innovation, irrespective of which part of the system is the instigator. This will be reliant on the ability to evaluate impact effectively and to adopt a change management model which enables innovation to be swiftly implemented and spread
- Further integration of our primary and community care strategies via joined up implementation plans, with a focus on the overall population health outcomes to be achieved
- Further integration of mental health services into our care models for prevention, PCN working and community based care, urgent and emergency care and planned care – this will ensure that mental services are not seen and experienced as standalone services but are integrated with services for physical health
- A focus on developing capacity and capability for quality improvement within our Integrated Care Partnerships, including Primary Care Networks, such that we continuously improve our care delivery
- Opportunities to ‘build for health and wellbeing’ from the outset in the context of Ebbesfoot Healthy New Town. This exciting development provides opportunities to innovate and to learn from this experience for the wider benefit of Kent and Medway.

These areas will be revisited as part of our strategy refresh in 2020

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality

A single national definition of what we mean by ‘quality’ was first introduced following Lord Darzi’s review of the NHS in 2008/09 - care that is safe, clinically effective, and that provides as positive an experience for patients as possible. All three dimensions must be present to deliver a high quality service. This is the definition adopted in Kent & Medway.

Our proposed strategic quality priorities for the next five years

- We will implement new ICS governance arrangements for quality assurance which will include safeguarding, infection prevention and control (IPC) and patient safety
- We will invest in developing our capacity and capabilities for quality improvement across the system, utilising recognised Qi methodologies to continually drive improvement
- We will further develop our quality framework to increase the focus on early warning signs
- We will work both within and across ICPs to support quality improvement by learning from complaints and incidents and to identify and spread good practice
- We will invest in developing our workforce, introducing new roles as well as ensuring a culture that allows the leaders of the future to be identified, developed and supported to achieve
- A significant step in system working for quality is the establishment of a new Nursing and Clinical forum to bring together the senior nursing leaders from providers, commissioners and education across Kent and Medway. The forum is currently defining its purpose but aims to provide nursing and clinical advice and guidance to the Clinical and Professional Board. The forum will provide strategic direction to areas such as workforce and quality strategy as well as supporting the transitional arrangements and developments as the system establishes an Integrated Care System and Integrated Care Partnerships. This strategy recognises that Primary Care Networks (PCNs) are at differing levels of maturity and therefore the quality support offered needs to flex and be tailored to their individual needs. An Allied Health Professional Cabinet has also been set up to look at the priorities across AHP disciplines.

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality continued

K&M Quality Priorities for 19/20 and 20/21

The below priorities have been developed and signed off the Nursing and Clinical Forum:

- To ensure clinical quality, leadership and accountability are clearly understood across all commissioned services
- To ensure mechanisms are in place and working well to provide assurance on the quality of all commissioned services, ensuring local needs and variations are addressed
- To promote an open and transparent culture between commissioners and provider organisations across each ICP and the ICS to identify and implement areas of best practice and learning
- To support the care sector improving the quality of care delivered
- To ensure that people have a positive and safe experience of care and that the individual is at the centre of care
- To ensure that a competent workforce is in place to deliver the transformations both in and out of hospital
- To reduce variation in all aspects of quality including outcomes related to premature deaths in both physical and mental health settings
- To ensure robust Quality Assurance and Improvement Framework developed to support emerging Primary Care networks and new models of care

As a result of adopting the Darzi definition of quality, our priorities are necessarily broad and span areas outside of the scope of traditional CCG quality functions. Delivering on these quality principles will require actions from functions and organisations across the system; in particular there is a significant role for digital transformation and workforce transformation to drive quality. Our ICPs will need to be at the forefront of driving continuous improvement in services and using evidence and data effectively.

Safety

In order to achieve our priorities we will need to ensure that we foster a standardised process across the system in safeguarding, care planning, investigating and quality assurance to reduce risk to patients and enable comparison of themes, trends and promote shared learning. Providers across K&M have described the following areas for action to directly improve clinical outcomes:

- Reducing falls, ensuring the 3 high impact interventions are carried out
 - Reducing the number of pressure ulcers that are acquired whilst under our care
 - Ensuring nutritional assessments are embedded reducing concerns and incidents relating to nutrition and hydration optimising health for recovery
- In addition there are work streams across providers aimed at
- Ensuring that healthcare associated infections are reduced, including the prescribing and management of antibiotics and promoting good antimicrobial stewardship
 - Prioritising the reduction to the length of stay and support the prevention of re admissions
 - Improved quality of care for the deteriorating patient, promoting early recognition, response and appropriate escalation in all areas of care; including the sepsis pathway. All stakeholders in the systems are working to create a safety culture that embraces 'lessons learned' and recognises human factors that influence clinical practice and decision making. In order to achieve this there will need to be good governance and peer review of serious incidents to seek assurance that learning has embedded, by reviewing progress of completion and effectiveness of actions. Primary care will be support to adopt safety tools such as ECLIPSE live and PINCER.
 - We will ensure Quality Impact/Combined Impact assessments are completed and reviewed when implementing change including monitoring of potential risks.

Strategic Objective 1) – Improving care quality and patient experience

Our approach to quality continued

Safety continued

- Develop digital ways of working to improve the interoperability between the systems to ensure seamless data sharing which will support more time to care and reduce risk (see digital chapter)
 - Support leadership and quality development in the care sector
 - Deliver the Kent and Medway workforce Plan as an integral part of safety
- Actions to ensure compliance with National Patient Safety Strategy*
- The strategy aims to commit to a continuous improvement of person/patient safety by building on the foundations of a patient safety culture and patient safety system. This includes the delivery of three strategic aims: Insight, Involvement and Improvement.
- We will:
- Provide leadership to local systems and within 5 years we will have created a coalition of resources to support the ICPs to have developed, implemented plans and evaluated outcomes aligned with the NHS Long Term Plan. This will include leadership support to the care sector
 - Set the ambition for delivering the strategy locally to ensure alignment with regional priorities and have delivered these within the 5 years
 - Ensure the establishment of acute trust-based medical examiner scrutiny of all deaths in acute hospitals by April 2020, and all deaths by April 2021
 - all deaths in acute settings are scrutinised by medical examiners by
 - Support work with the emerging PCNs to develop their role in safety improvement, with a fully matured system within 5 years

- Ensure that delivery of the strategy achieves the right balance between assurance and improvement within ICP and Care settings.
- Encourage uptake of the new patient safety curriculum and training with this being fully embedded within 5 years
- Encourage the implementation of early warning systems and within 5 years have an established system that recognises these and is able to respond to prevent poor quality
- Incorporate insights from pilot site systems into plans to implement the awaited Patient Safety Incident Response Framework (PSIRF) by summer 2021
- Improve patient involvement in patient safety by ensuring that patient representatives are members of safety-related committees throughout the system by April 2021

At a strategic level the system commissioner will:

- Support STP/ICs across Kent and Medway to implement features of the NHS Patient Safety Strategy with it being fully embedded by 21/22
- Share learning within and across the systems including non-NHS providers and the Care Sector; escalating concerns from PSIRF
- The system commissioner will work with regulators to:
 - Encourage contribution to the patient safety specialist network
 - Deliver the Patient Safety Improvement programme through the improvement programmes for maternity and neonatal safety, medicines safety and mental health safety improvement programme
- Support the replacement of the National Reporting and Learning System (NRLS) and Strategic Executive Information System (StEIS) with the new Patient Safety Management System (PSIMS) by March 2021

Strategic Objective 1) – Improving care quality and patient experience

Our approach to Quality continued

Effectiveness

To ensure that care is effective we will need to continue to work to improve the flow of patients through whichever pathway of care best meets their needs, with effective and seamless transfer and care across and between providers, delivering timely and safe treatment through both emergency and planned pathways. There will need to be continued work to reduce mortality rates; improve the care and treatment patients receive following a stroke and to see this reflected in the published national data (HSMR, SHMI, SSNAP). There will be work to develop and expand shared care protocols and improved drug monitoring, including medicines management in the care sector.

To improve outcomes for women and babies the achievement of the Better Births agenda will be prioritised and the outcomes monitored. So that the system is better enabled to identify and evidence improvements in outcomes of care, quality improvement methodologies and digital solutions will be adopted.

Experience

We will ensure that there are excellent public and patient engagement plans to improve the way we engage and receive feedback from patients ensuring vulnerable groups and those with complex needs are given the opportunity to respond. The intelligence gathered from all groups will be utilised in the co-design and co-production of patient pathways across the system through the use of the ESTHER philosophy as set out in the Workforce plan.

To directly improve the experience for the person /patients we will:

- Improve the transition of care for children and young people to adult services

- Ensure timely decision making for the provision of End of Life Care
- Make personalised care a priority, including consent and capacity assessments to ensure collaborative decision making and the use of ESTHER cafes to include the person's experience in MDTs, risk assessment, and focus on the patients' needs
- To support the experience for patients we will ensure that staff feel valued through good staff engagement and appraisals and learning from new models of care. We will support the development of staff to strengthen the NHS, social care and care sector pool of talent, develop new and enhanced roles to improve pathways of care and raise staff morale and encourage retention and progression. It is our aim to improve the staff survey results to reflect that staff want to work for the NHS, social care and the care sector and for organisations to be recognised as outstanding employers

Strategic Objective 1) – Improving care quality and patient experience

Quality Governance

As we transition towards a system commissioner as part of the ICS with four ICPs across Kent and Medway, the current governance arrangements will need to develop. Specific attention is being given how the care sector and non-NHS providers are involved and represented, they are part of the emerging quality structures of all four ICPs. Recruitment to a single Chief Nurse across the system commissioner will commence following the appointment of the Accountable Officer in late 2019. This post will be crucial to the design and development of the new governance arrangements.

The Nursing and Clinical and Professional forum will be instrumental in identifying the appropriate soft and hard intelligence required to develop datasets, dashboards, thresholds and statistical analysis tools that are used across the system. It is envisaged that the current routes for quality escalation of concerns to the K&M Quality Surveillance Group will be replaced with a quality oversight group which will include all key stakeholders will review emerging safety concerns.

Safeguarding teams across K&M are working collaboratively across the ICS footprint to ensure there is sufficient expert capacity to effectively safeguard both children and adults. The collaborative approach to safeguarding is delivered through each member of the team leading on portfolios that align to national safeguarding directives, legislative requirements and local need.

Operational safeguarding will be delivered from within the ICPs (including the PCNs and Social Care) achieving the frontline objectives of the Kent and Medway Boards & Partnerships, providing performance, audit & experiential data as evidence of achievement & sustainability.

Designated nurses/professionals within the system commissioner will provide a strategic overview of the safeguarding governance of the ICPs and provide a valuable expert resource to the system and partners to ensure that learning is shared and that national programmes are appropriately delivered at the local level. External scrutiny will be achieved through the national safeguarding team and the local safeguarding boards and partnerships.

Quality assurance

We will take an approach to quality assurance that focuses on an objective overview of how well the whole system operates in order to prioritise activity and identify gaps, weaknesses and strengths against known risks. This approach, embedded in a culture of mutual respect, will allow partners to hold each other to account on the evidence available, and support the ongoing development of a culture of constructive challenge and improvement. Benchmarking tools and audits will be used to help identify areas for improvement.

By adopting the “Three Line of Defence” methodology used in a range of national and local assurance models, our approach focuses on developing assurance across partnerships that supports the management of risk and provides an understanding of both the operational delivery of services and the effectiveness of the system in meeting the needs of our population.

This methodology will provide a balance between the frontline, the organisational and the system oversight, using early warning indicators and a dashboard to help us to identify and track good or poor system performance and focus on new issues or risks. Success and the impact will be measured against defined outcome measures which will be developed during 2020/21.

Strategic Objective 1) – Improving care quality and patient experience

Quality Assurance continued

The **first** tier of assurance will take place at the local ICP operational level, coming from those delivering the frontline services, assuring that performance is monitored, risks identified and addressed, and objectives are achieved.

- Development of dashboards that incorporate an early warning mechanism

- System/peer assurance process, shared quality committee process
- Agreed escalation process and threshold
- Consistency of approach (policy, process, procedure) within the system
- ICP and safeguarding quality forums
- Care Sector Registered Managers Network to develop quality improvement mechanisms supported by the Design and Learning Centre (DLC) Learning
- Hub feeding back into the Local Workforce Action Board.

The **second** tier of assurance will be at a strategic level via the Clinical Commissioning Group and giving an overview of the activity and quality of care being delivered to the population, including that care is delivered in line with set expectations and standards.

- Agreed system quality metrics and KPIs
- Adapted QSG approach to strategic system assurance
- Consistency of approach (policy, process, procedure) across ICPs
- Agreed escalation process and threshold

The **third** tier of assurance will be of an independent nature and will provide assurance of the whole system, highlighting gaps, weaknesses and strengths. This assurance approach will be in development during 2019/20 and fully embedded in 2020/21

Quality Improvement

There is commitment across our system to embed quality improvement in how we manage change, and organisations have trained staff in a variety of complementary methodologies including Quality, Service Improvement and Redesign (QSiR), Lean / Six Sigma, Dartmouth Clinical Microsystems, and General Practice Improvement Leaders (GPIL).

- As we develop our integrated care system we will build on this capacity and capability across all settings of health and social care, ensuring that more people are trained and empowered to take forward these evidence-based approaches to continuous improvement.

Embedding QI is a critical part of the development of our ICPs, where we aim to build teams that can support this work across their locality with a range of skills including data and analysis, change management and quality improvement. The care model framework set out in our clinical and professional vision takes exactly this approach, starting with understanding the needs of a particular cohort, designing and testing interventions to meet these needs, and evaluating the impact. These approaches will help us address our unwarranted variation alongside programmes such as GIRFT and RightCare.

The impact of any planned service change or improvement will be assessed by the application of a Combined Impact Assessment. This tool, which will be agreed for use across Kent and Medway, will combine an assessment on quality alongside our obligations under the Equality Act (2010) to undertake impact assessments against the protected characteristics.

Section three

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

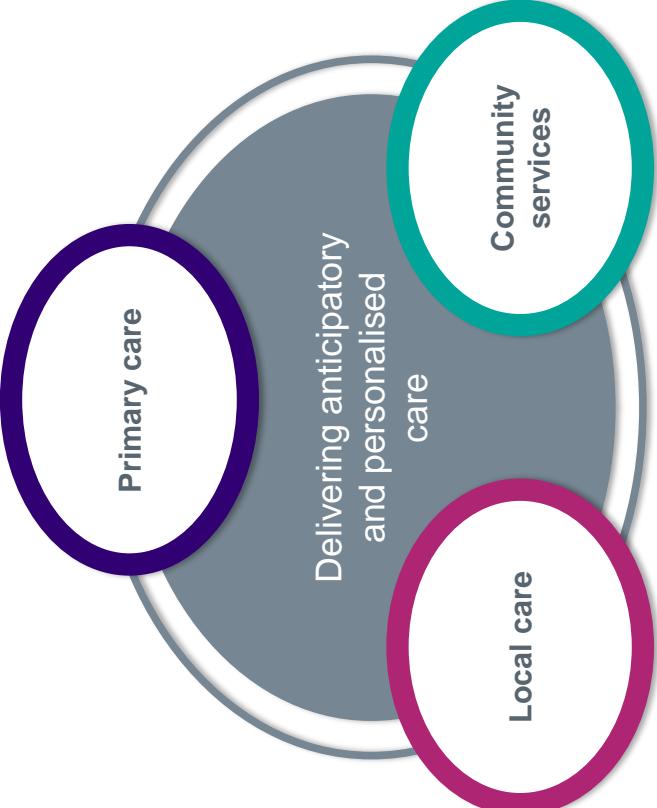
Primary and community based care

Our approach to transforming out of hospital and expanding primary and community based care is made up of three strands: building a resilient Primary Care, implementing our Local Care model of multi-disciplinary team working and investing in our Community services. None of these areas are exclusive of the others and over time we see the boundaries between these areas blurring even further. We are organising ourselves around the person and their needs, rather than around organisations and services. By bringing together all of these strands in how we deliver care, we will deliver care that is more anticipatory and personalised. We are implementing specific initiatives to support personalised care, in line with national policy, but personalised care in Kent and Medway is a consistent ethos that underpins our strategies and plans for primary care, wider community services and Local Care – and indeed more broadly across all of the clinical and service areas outlined in this plan. It means focusing on the whole person and their needs and goals, focusing on ‘total health’ - physical health, mental health and wellbeing, supporting people to look after their health and wellbeing, and empowering people in decisions about their health and care. By doing this, we will fundamentally change patient experience and long term outcomes. The creation of a single CCG across Kent and Medway will create further opportunities to strengthen the delivery of personalised care through new commissioning strategies.

Primary Care – We are investing in primary care through delivery of our primary care strategy, including strengthening core general practice, and the development of 42 Primary Care Networks across K&M, implementing new roles and digitally innovations to meet our workforce challenges. Over time, PCNs will take on increasing responsibilities for improving the overall health of local populations

Community services – We are investing in community services to ensure that more people receive the right care they need at home with multi-disciplinary teams providing crisis response and reablement. We are rolling out the renowned Buurtzorg model of self-managed teams, proven to focus on the needs of the patient

Local Care - We are completing the roll out of MDTs for adults and older people with complex needs across Kent and Medway, utilising the successful MDT principles we have developed locally. MDTs span competences from across health, social care and voluntary sector. Over the next five years, we will roll out MDT working for children with complex needs, people with co-occurring conditions, and for people with learning disabilities and autism. Mental health support and services span all strands, however, we recognise that we have more to do to integrate our mental health pathways and ensure ‘no wrong door’ for access MH support or services.



Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home

Primary and community based care

One of the five major practical changes set out in the NHS Long Term Plan is to “boost out-of-hospital care, and finally dissolve the historic divide between primary and community health services.” The 2016 Kent & Medway Case for Change set out the challenges facing out-of-hospital care, including:

- 30% of patients in acute hospital beds would be better looked after in an alternative setting
 - 12% of admissions through A&E are avoidable through more consistent decision making at the front door, or through better health and social care provision in the community
 - 25% of community hospital patients would be better cared for at home or in other community setting
 - There is wide variation in whether people would recommend their GP practice to a friend – between 68% and 84% (national average 78%)
- The 2018 Case for Change refresh supported this stating, ‘that a priority area for focus is avoiding hospital admissions for people with long term conditions and supporting their carers’.
- Additionally, we know that primary care is the bedrock of out of hospital care and that we have significant workforce challenges in primary care in K&M. Our shortages in GPs are amongst the worst in the country and we have a significant volume of GPs approaching retirement.
- This has led to the dedicated establishment of programmes across Kent and Medway for Primary Care and Local Care.

Our primary care strategy

We have undertaken significant engagement and co-design to develop a single primary care strategy for Kent and Medway, led in partnership with the Kent Local Medical Committee. This strategy is owned by primary care, including our new PCN Clinical Directors, with a commitment from all partners to ensure that we deliver it.

Our vision for primary care is to have healthy people, happy communities, and valued colleagues. We have set out what we hope primary care will look like in five years time, and a realistic set of phased improvement priorities over the next five years to achieve this. We have undertaken detailed work to understand the affordability of these and where we need to make further investment as a system to deliver them.

Our priority themes are based on what we heard from primary care:

- Care redesign for patients and communities
- Workforce and workload
- Digital
- Estates
- Finance and contracts
- Communications and engagement
- Primary care networks
- Measurable implementation plans

You can read more in our Primary Care Strategy

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Development of primary care networks

Our development of primary care networks (PCNs) begins with stabilising core general practice, the bedrock of PCNs, and this is a focus in our primary care strategy. It then builds on what local areas have already been doing to support primary care at scale – we are not starting from scratch. Building successful PCNs means creating expanded primary and community care teams. As part of our primary care strategy, we have co-designed a consistent support offer for our PCNs. This is being coordinated centrally but delivered locally, maximising the resource that we already have in the system.

In September 2019 we brought all of our PCN Clinical Directors together to discuss this support offer, their development, and allocation of the PCN Development Funding that we have been given as a system. These Clinical Directors have also contributed directly to the phasing of priorities for primary and local care. Our PCN development offer builds on the national maturity matrix and will enable everyone working in a PCN to be able to do four things:

- Take care of you e.g. personal leadership development
- Take care of your colleagues e.g. developing effective teams
- Take care of your community e.g. care transformation projects, population health management
- Get the basics right e.g. IT, governance, financial flows

Our commitment to additional investment in primary and local care means that PCNs will be able to access significant support to put them in the best position to deliver all of the national requirements across the next five years, as well as work in partnership across their ICP on our wider ambitions for local care and improved population health.

As they evolve, ICPs are working with their PCNs to develop plans for what can be done in partnership, which includes the involvement of community providers. This year, we have allocated funding to PCNs for three things:

- **Clinical Director leadership development:** we are excited by the number of new leaders who have chosen to step up as Clinical Directors, and will ensure they get significant individual support to develop in these roles. In addition to funding, Clinical Directors have access to support from our Training Hubs who are running dedicated programmes, as well as coaching and mentoring
- **Primary care network development:** every PCN has received some funding for development and delivery of a local plan that helps build network maturity, backed by dedicated support from local CCG teams. We have not been prescriptive on what we expect from these plans, allowing networks the freedom and headspace to work on local priorities in partnership
- **Service improvement projects:** in 19/20 we are focusing on improving data quality and coding to enable PCNs to have an accurate baseline for improvement. In addition to this, we are providing access to support from central teams trained in quality improvement methodology. Through this we will build the capacity and capability to run service improvement projects targeted at improving on system priorities where we know we have significant unwarranted variation; or targeted at areas that will put PCNs in a stronger position to deliver the new service specifications

Our PCN leaders are visionary and ambitious, however we must recognise that there is a gap between what they are currently able to deliver with the resources and time that they have had available, and the much wider five year vision. More funding is part of the solution, but is not the only thing we need to do to bridge this gap. In partnership with the Kent Local Medical Committee (LMC), we will continue to provide backfill to release clinical time for all of our Clinical Directors to come together and work with us on designing the future.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Our Local Care model

Our Local Care model has been the cornerstone of our STP since its creation. Our Multi Disciplinary Team (MDT) model of personalised care ensures that the needs and preferences of the individual are honoured for optimal functional health and quality of life. We have been rolling out MDTs across Kent & Medway for adults and older people with complex needs and frailty, aligned to the 42 Primary Care Networks. Our agreed 'MDT Framework for Primary Care Networks ensures consistency and quality of the delivery of personalised care across all 42 PCNs.

Some considerable engagement with a range of stakeholders has led to the development of eight key interventions which will deliver holistic personalised care, and align to the national Universal Personalised Care agenda:

- Care and support planning with community navigation and case management
- Self-care and management
- Healthy living environment
- MDTs, integrated coordinated as close to home as possible
- Single point of access
- Rapid response
- Discharge planning and reablement

Access to expert opinion and timely access to diagnostics

By doing this, we are intending to have a positive impact on the following:

- Unnecessary A&E attendances and patient admissions
- Reducing length of stay
- Positive outcomes for patient activation, independence and wellbeing

We have made significant progress on this ambition and have MDTs in place within each PCN to deliver integrated health and care services close to where people live. This is something we must continue to drive; integrated working at scale and pace to make personalised care the norm. Over the next five years we will deliver an integrated health and social care model of personalised care to all frail elderly patients and adults with complex needs that focuses on delivering high quality, outcome-focused, person centred, coordinated care that is easy to access and that enables people to stay well and live independently for as long as possible in their home setting.

We will transform local services to deliver proactive care and support, focused on promoting health and wellness rather than care and support that is solely reactive to ill health. Core to the model of care is the philosophy of health and care services working together to promote and support independence, utilising statutory, voluntary and, where appropriate, independent sector services to deliver the right care, in the right place, at the right time.

Over the next five years the MDT approach will expand to provide services for children with complex needs and people with learning disabilities and autism. These MDTs will include a broader range of staff than those already in place, be aligned to the PCNs and comprise of staff working across health, local authority, voluntary and care sectors.

Extensive engagement has been undertaken across the system to develop an agreed 'MDT Framework for Primary Care Networks', including links to our 'top tips' for MDT working.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Our Local Care model

The Multi-Disciplinary Team (MDT)

The concept is to prevent duplication from multiple services, prevent the patient having to repeat themselves, to co-ordinate the patient's care, to put the patient at the very centre of their care, to identify any unmet need gaps and work as a team to address the patient in a cohesive way.

The patient is at the **centre of the plan of care** and is involved in the decision making process and the planning of their **anticipatory care management plan**.

Social prescribing

About 30% of the referrals from the MDT meetings are for social prescribing, as a way to improve outcomes for people; keeping people well, independent and resilient by connecting them to community based support, services, resources and assets. Across K&M we have agreed a set of principles for rolling out social prescribing and community- based support to meet the needs of local populations. We are developing a business case for a single IT platform to facilitate better coordination of social prescribing.

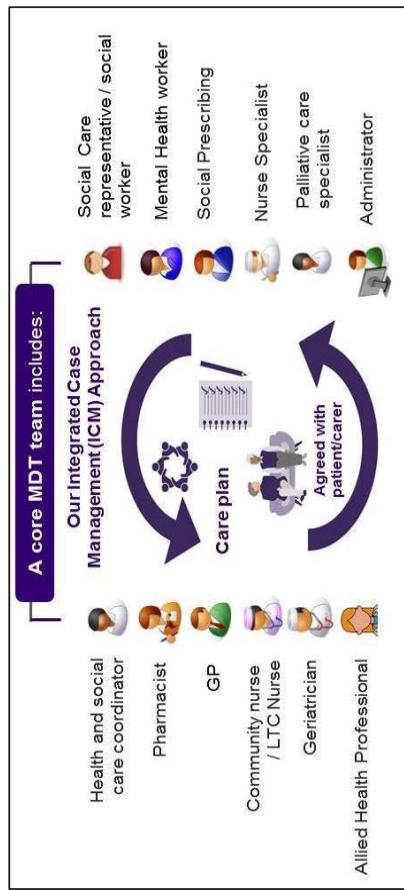
By 23/24 some 30,000 people will have benefited from a social prescribing referral.

Care planning

Our model of integrated case management (ICM) supports shared decision making and care planning. The focus is to drive personalisation, help people to maintain independence, provide care closer to home and build community resilience. Our ICM approach aims to build relationships between health and social care professionals to improve health and wellbeing outcomes for patients at high risk of future emergency admission to hospital.

ICM is initially aimed at the top 3% of the population with the highest risk stratification scoring or severe frailty. The service aims to reduce unnecessary hospital admissions, reduce avoidable A&E attendance, and facilitates early discharge from in-patient beds.

By 23/24, at least 30,000 people will have benefited from a care and support plan



Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

While our Local Care model is the heart of out of hospital services, there is a significant transformation agenda taking place within community services more broadly.

Of note is our implementation of the Buurtzorg model of care. Founded in the Netherlands in 2006/07, Buurtzorg is a unique district nursing system and involves small teams of nursing staff and other community staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood. The model has garnered international acclaim for being entirely nurse-led with both the RCN and The King's Fund welcoming the remarkable success of the Buurtzorg model. A significant reason why Buurtzorg has managed to provide excellent patient-centred care been due to its approach of putting patient self-management at the heart of its operation.

The model focuses on personalisation; it starts from the patient perspective, and works outwards to create solutions that enable improved independence and quality of life. The model empowers individuals and encourages self-reliance. There's an emphasis on small teams of staff working with each individual and their families and carers to access all the resources available in their social networks and neighbourhood to support them to be more independent. The nursing teams have a flat management structure, working in 'non-hierarchical self-managed' teams. This means they make all the clinical and operational decisions themselves. Aspects of the Buurtzorg model are in stark contrast to historical provision in England where 'health' and 'social care' have typically been provided by two entirely separate teams. People requiring care at home are often seen by multiple staff members on a given day and may not see the same care worker or nurse again. The Buurtzorg model provides continuity of staffing.

The types of benefits to patients of this care model include increased levels of wellbeing and independence ; more confidence to self care with less reliance on health and social care services. Patients feel more empowered, supported and reassured through continuity of staff and wider engagement with their local communities.

The types of benefits to staff include higher levels of job satisfaction through deeper more meaningful relationships with both patients and colleagues as well as a sense of trust, autonomy and control.

Kent County Council, Kent Community Health NHS Trust and Medway Community Healthcare are now implementing the Buurtzorg model across Kent and Medway through the Transforming Integrated Community Care (TICC) project, a four year health and Europe research project that aims to create systemic change in health & social care, providing services better suited to our ageing population and addressing holistic needs.

TICC will enable us to implement new ideas and practice quickly; increase staff productivity, recruitment, retention creating a blueprint for successful transfer of social innovative service models in health and social care from one county to another benefitting all public/private services. We have an ambitious roll out plan across the County starting with our test and learn community nursing teams in Ashford, Charing, Edenbridge and Medway and a domiciliary-care led team of occupational therapists, enablement support and care workers based in the Ashford town area.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Primary and community based care continued

Key progress to date

Significant progress has been made across K&M in the delivery of our local care model to support all 42 PCNs; with each one having an aligned multidisciplinary team, working to deliver integrated case management, for adults with complex needs and frailty. To date, all are achieving their agreed trajectories of personalised anticipatory care plans, helping individuals to stay well and supported in the community.

To augment this 'Frailty Pathways' have been developed including bespoke frailty units to support 'hot frailty clinics' for step up step down crisis care, we are working with our NHSE/I lead to ensure links with the reconfiguration of 111 in terms of a seamless crisis response and single point of access.

Consistency in delivery and quality

For 2019/20 we have an agreed deliverables framework for local care. Across local and primary care we are presently working on an aligned outcomes framework.

Our 'Primary Care Strategy' has been well received, having been co-designed with primary care colleagues. It also includes an agreed support offer for PCN development.

To ensure consistency and quality we have worked with key stakeholders across the system to develop an 'MDT Standards Framework for PCNs', including 'top-tips' for MDTs, which we have now shared both locally and nationally (mentioned on page 28).

We have also agreed a K&M 'Quality Standard' for Primary Care; a set of consistent local enhanced services for key delivery priorities.

Social prescribing
There has been an additional investment of £15m, across health and local authority into social prescribing in 2019/20. There is a collective agreement, longer term, to align contracts and link with the new social prescribing posts within each PCN.
To support this we have agreed to move to a full business case for the provision of one social prescribing platform across K&M.

Supporting carers

This has also been a key focus and we have engaged a wide range of stakeholders to co-design an 'app' to support anyone in a caring role (paid or unpaid); building on the award winning 'Stop Look Care' booklet from Brighton and Hove CCG. Stage 1 of the development provides the fundamental elements in caring for someone and also how to access support for the individuals who care. Stage 2 will provide a comprehensive directory of services and access for on-line training resources, free of charge, to all care agencies.
We are pleased the app is in the final stages of the NHS Digital Pathfinder programme, hoping for national roll out.

Sharing learning

To date we have hosted two K&M wide conferences for local care in 2018 and 2019 (the 2019 conference was attended by 200 people across 45 different health and care organisations). We also held a K&M wide conference for PCN Clinical Directors in September 2019 to co-design our support offer to PCNs.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Transforming urgent and emergency care

Nationally, and across Kent and Medway (K&M), we have an urgent and emergency care (UEC) system under significant pressure, but also one in the midst of profound change. The Long Term Plan sets out actions to ensure patients get the care they need, fast, and to relieve pressure on Emergency Departments (ED). New service channels such as Urgent Treatment Centres (UTCs) are being designated across England.

For those that do need hospital care, emergency admissions are increasingly being treated through same day emergency care (SDEC) without need for an overnight stay. This model will be rolled out across all acute hospitals and nationally the ambition is to increase the proportion of acute admissions typically discharged on day of attendance from a fifth to a third. Building on hospitals' success in improving outcomes for major trauma, stroke and other critical illnesses conditions, new clinical standards will ensure patients with the most serious emergencies get the best possible care. In partnership with local councils' further action to cut delayed hospital discharges will help free up pressure on hospital beds.

In Kent and Medway, delivery against the four hour A&E standard is challenged. We have a specific set of priorities for transforming UEC (see right) that are complimented by our work to create a resilient primary care for the future and to implement our Local Care Model. The transformation of UEC in Kent and Medway is dependent on all of these transformations coming together in a whole system approach to materially change how and where patients receive care. This level of change will take time to realise its full impact and is affected by the scale of workforce challenges across K&M. However, we are making good progress and our plans are supported by national bodies.

Urgent and Emergency Care will be led by the four Local A&E Delivery Boards (LAEDBs) geographically based around the four Integrated Care Partnerships in Kent.

- Our strategic priorities for UEC are:
- **Urgent Treatment Centres (UTCs)** that are primary care led, open at least 12 hours per day every day, offering appointments that can be booked through 111 or GP referral, and are equipped to diagnose and deal with the most common ailments for which people attend ED
 - **High Intensity User (HIU) services** will support patients who frequently attend A&E to resolve the reasons for their attendances, linking in with existing networks of support service including those from the third sector

- **Same Day Emergency Care (SDEC) units** will support each ED by providing rapid assessment and care to allow the majority of patients to return home the same day
- **Reducing delayed transfers of care (DTOC) and length of stay (LOS)** – improved hospital flow will have a positive impact on ED. Ensuring appropriate LOS and avoiding DTOCs involves a multi-faceted, system wide approach, working with primary care, community care and local authorities
- **Quality improvement initiatives in ED** aimed at streamlining processes and ensuring good access to expert opinion and diagnostics. Additionally, quality improvement initiatives aimed at improving flow throughout a hospital can help to release clinician time to support ED.
- **Embed a single multidisciplinary Clinical Assessment Service** within the newly commissioned 111 service to provide specialist services from a range of different professionals, encompassing physical and mental health
- **Developing our emergency care pathways for Mental Health**, including alternatives to ED such as crisis cafes and sanctuaries

Taking these actions will stem the rising increase in demand in EDs and ensure that EDs deliver safe and effective services, however, as a system it will remain challenging to consistently meet the four hour waiting standard over the five year period.

Strategic Objective 1) – Improving care quality and patient experience

A new model of integrated care closer to home continued

Improving planned care

Delivery across Kent & Medway against the national referral to treatment time standard has been challenged through 2018-2019. Recruitment and retention of key clinical staff has been, and remains, a critical challenge.

Delivery of reduced waiting times and improved pathways of care are key priorities shared by all partners within Kent & Medway. Providers and commissioners are working together to achieve national Referral to Treatment (RTT) expectations and those outlined in the national Long Term Plan. Delivery in ICPs will be enabled by key shared work across workforce, digital development and estates. ICPs will agree jointly-owned demand and capacity plans, incorporating utilisation of Independent Sector (IS) capacity. Continuous improvement in Emergency and Non-Elective Care management across Kent will enable more effective, planned and reliable use of NHS and IS Elective Care capacity.

In this context, CCGs and Trusts in Kent & Medway have been increasingly looking to work more collaboratively using a mix of approaches. These have varied across ICPs, from using new contract models such as an Aligned Incentives Contract (AIC) or large-scale Prime Provider contracts, to developing joint plans between CCGs and providers for outpatient transformation. Local partners are continuing to use these contract models and plans to focus on redesign of whole clinical pathways, better use of technology and expansion of collaborative contract models that encourage joint working. All four ICP areas have plans, agreed by providers and the CCGs, focused on the key Elective Care aims across Kent & Medway.

- Improving performance against 18 week Referral to Treatment (RTT), including working towards the utilisation of capacity alerts and the delivery of the 26 week programme
- Reducing the inconsistencies
- Addressing workforce pressures
- Ensuring the application of the Kent and Medway Referral and Treatment criteria (RATC) is applied consistently across all providers

Aside from speciality specific approaches, there are three main areas where we are working as a system:

Workforce - In each ICP, providers will cease to compete with one another for key clinical staff but will act collaboratively. Furthermore, providers across the ICS will recruit on consistent rates for permanent, temporary and locum staff.

Transforming outpatients - ICPs are working with local providers to manage waiting lists through their Transforming Outpatients workstreams which have seen the introduction of a number of one stop shop approaches and an increase in non-face to face follow-up clinics to improve use of capacity. In support of this a number of telephone clinics, nurse led clinics and the introduction of virtual clinics utilising Skype and video technology have been introduced. ICPs will also look to maximise their approach to offering advice and guidance functionality.

Right Care and Getting It Right First Time (GIRFT) - All the ICP systems are working collaboratively to agree opportunities identified through these national programmes and through Outpatient Transformation projects to ensure that shared, jointly-owned delivery projects are established. The opportunities, areas of focus and projects are specific to ICPs. ICPs are reviewing speciality patient pathways across a spectrum of planned care areas including, Ear, Nose and Throat (ENT), Neurology, Urology, Gynaecology and Gastroenterology.

Despite taking these actions, our performance against referral to treatment times and diagnostic waiting times remains challenged over the five year period. We intend to re-cast our diagnostic waiting times projection as part of a dedicated diagnostics review across Kent and Medway, which will drive up performance. In terms of referral to treatment time, we will initiate further work at both a system and an ICP level to identify further local opportunities as well as system level opportunities to treat patients across ICP areas. This will require system level oversight and assurance to track delivery and impact of initiatives.

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

East Kent Transformation Programme

We are working with our patients, public and other stakeholders to look at how we develop local care and options for changing the way our hospitals in east Kent are organised (covering a broad range of services including emergency care, planned care, outpatients). The four East Kent CCGs have delegated authority for taking forward the transformation programme to a joint committee, which is supported by a robust programme infrastructure. We are taking forward this change programme because:

- We know that the acute hospitals in East Kent are set up makes it difficult to provide consistently good care. For example people spending too long waiting in A&E and waiting too long for treatment. The current configuration of services is also not financially sustainable. By making changes we can improve the quality of care and establish a more sustainable model of care.
- We also know many people, including complex elderly frail patients, are often treated in the acute hospital setting when their needs are better met in an alternative setting of care. Both data analysis and bed audits undertaken by clinical teams have identified that this could be as many as one in three acute hospital beds being used to support individuals whose needs could be met through an alternative care model.
- We expect GPs, community staff, mental health, social care and other professionals to be working together in local teams everywhere in East Kent to provide more joined-up care for people with complex health needs. This is facilitated by the development of Primary Care Networks and the East Kent Integrated Care Partnership. In terms of acute care, all three main hospitals in East Kent are equally important for future care and need to be used so they provide care by working together, not as separate entities.

In order to achieve this change, we identified a long list of possible options for the roles of the three hospitals and assessed these against hurdle criteria, which were developed with clinicians, patients and the public, and other stakeholders. This resulted in two options emerging for the reconfiguration of hospital services as a medium list:

- **Option 1:** A major emergency centre at the William Harvey Hospital in Ashford, an emergency centre at the Queen Elizabeth the Queen Mother Hospital in Margate, and an integrated care hospital at the Kent and Canterbury Hospital.
- **Option 2:** A major emergency centre at the Kent and Canterbury Hospital with the other two hospitals becoming integrated care hospitals

The detailed evaluation of the above two options is now in the process of being finalised. Both options were considered against five criteria:

- Clinical sustainability
- Accessibility
- Strategic fit

- Ease of implementation
- Financial sustainability.

The outcome of the evaluation will be presented to NHS England in a pre-consultation business case, seeking approval to move to public consultation in February. Ahead of submitting the business case, the proposal will be submitted in November to the South East Coast Clinical Senate for their consideration in order to inform NHS England's assurance process.

Strategic Objective 1) – Improving care quality and patient experience

Acute services sustainability

Acute services sustainability

Stroke services

Kent and Medway providers have continuously struggled to meet the quality standards of the national Stroke Sentinel National Audit Programme (SSNAP). Most scores are below average and although there have been some improvements since June 2014, this has been slow and is inconsistent. This indicated a clear need to improve the quality of stroke care in Kent and Medway. We have significant challenges in workforce and our stroke services are not configured in line with evidence based national best practice.

The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. The national guidance for stroke states that the quality of a stroke unit is the single biggest factor that can improve a person's outcome following a stroke, and developing these is the main objective of the stroke review. Successful stroke units, both hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a stroke-skilled multi-disciplinary team that is able to meet the collective needs of the patient. The proposal was, therefore, to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across the Kent and Medway area. This will deliver many benefits for patients, most notably more people will survive stroke and have improved quality of life and independence.

Following the development of options, options appraisal and public consultation, the Joint Committee for stroke agreed that three HASU/ASUs would be established at Darent Valley Hospital, Maidstone Hospital and William Harvey Hospital. We are committed to the proposals agreed by the joint committee following consultation and we are endeavouring to implement these proposals as soon as possible, pending the outcome of legal challenges.

Vascular

Approximately 13,000 patients in Kent and Medway receive vascular treatment each year, (about 2,600 specialised and 11,400 non-specialised) currently delivered by six hospitals, of which only two are specialised vascular centres providing the full range of complex vascular care.

The national standards state there should be 24-hour access to specialist care and a minimum catchment population of 800,000 to ensure doctors treat enough different types of vascular cases to remain expert. However, there is only a small pool of the specialist surgeons and interventional radiologists available and neither of our 2 vascular centres have sufficient skilled staff. Both centres serve a population of less than 800,000 as patients from Tunbridge Wells and Dartford, Gravesend and Swanley access services in London.

A long list of possible options has been considered for Vascular services in K&M. A clinical review of those options has been undertaken and the recommended option is for a single vascular arterial centre supported by other non arterial sites in K&M. The single arterial centre would be located at one of the two current vascular centres in east Kent and Medway.

Activity numbers are being finalised and will be presented to commissioners and the Joint Health Overview and Scrutiny Committee (JHOSC) A formal consultation is being planned for early 2020. This will also be linked to the wider reconfiguration work being undertaken in East Kent.

Section Three

Strategic Objective 1) – Improving care quality and patient experience

Delivering the NHS Long Term Plan in clinical and services areas

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Cancer

The NHS Long Term Plan sets two bold ambitions nationally for improving cancer outcomes – that by 2028:

- 55,000 more people each year will survive cancer for five years or more
- 75% of people will be diagnosed at an early stage (stage one or two)

In 2017, 4,893 people died from cancer in Kent and Medway. The mortality rate from all cancers has been falling over time locally and nationally. However, cancer remains the leading cause of premature death in Kent and Medway, accounting for 29% of all deaths and 40% of deaths in those aged under 65-years in 2017. There were 10,359 new cases of cancer registered in 2016/17, the majority of which were in people under 75 years of age. This is a 13.5% rise from 9,127 in 2011/12.

In Kent & Medway, our overall 1-year survival rate across all tumours is 71.7% which is below the national average, and our 5-year survival rate is 46.7% also below the national average (CADEAS, 2019). The key to improved survival rates is to diagnose cancer earlier and, in Kent and Medway, our current early stage diagnosis rate is 51.8% with the expectation nationally that we achieve 75% by 2028.

The Kent and Medway Cancer Alliance brings together clinicians and managers from health, social care and other services to transform the diagnosis, treatment and care for cancer patients. These partnerships enable care to be more effectively planned across local cancer pathways. In advance of the anticipated establishment of a single CCG from April 2020, our existing CCGs have set-up a joint committee of clinical commissioning groups (JCCCG) to make joint decisions. It is the publicly accountable governance forum driving forward our collective strategy for improving cancer care and outcomes.

Since the first meeting of the Joint Committee in March 2018, the following progress and improvements have been made:

- Significant improvement with 62 day cancer performance across K&M
 - the Cancer Alliance position has moved from 19 out of 19 alliances to 2nd out of 19 alliances for the latest reported month August 2019 (83.8%)
- Progress with implementation of streamlined diagnostic pathways in line with national recommendations for lung, colorectal and prostate Cancer which means patients are getting diagnosed faster
- Initiated a pilot in Dartford in July 2019 to support patients presenting with vague and indeterminant symptoms accessing diagnostic tests quicker
- In partnership with the South East London Cancer Alliance, we are working to improve cross-boundary issues and tertiary referrals to ensure safer and faster diagnosis for patients in the transfers of care
- As a result of the alignment of the STP with the Cancer Alliance, we have established a clear reporting and governance structure to ensure that timely decisions and clinical priorities are discussed appropriately
- Focused work with clinicians in our priority Tumour Site Specific Groups (TSSGs) to streamline patient pathways and improve services for our patients
- Agreed stratified pathway protocols for breast, prostate and colorectal cancer to support the personalised care agenda

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Cancer continued

Our strategic priorities for improving cancer care and outcomes are:

- **Prevention** – as over half of cancers can be prevented, prevention is a critical focus of our cancer strategy, with a focus on smoking prevention, diet, obesity, alcohol consumption, and HPV vaccination
- **Screening** – we will focus on increased uptake of screening programmes to support early diagnosis, in particular bowel due to the current variation across our CCG geographies and the strong evidence base that early diagnosis of bowel cancer has a significant impact on survival rates
- **Earlier and faster diagnosis** – we have a multi-faceted approach including awareness campaigns, a primary care education strategy, reviewing and improving our diagnostic service provision (for both cancer and diagnostics broadly, recognising that issues with diagnostics do not just impact patients with cancer but with a wide range of conditions).
- **Treatment and care** – our strategy includes a number of strands to ensure that patients can access appropriate and specialist treatment, including specialised surgical care available alongside modern radiotherapy and chemotherapy services
- **Personalised care and support** – we will ensure that all patients have access to personalised care including a care plan, access to health and wellbeing information and support, stratified pathways of care, and provision of psychological support

By 2023/24, Kent and Medway will have:

- Significantly increased uptake and coverage of the National Cancer Screening Programmes
- Networked Diagnostic Services for streamlined turnaround and reporting of tests
- Implemented the Faster Diagnosis Standard so that patients get a diagnosis of cancer within 28 days of referral by a GP (85%)
- Implemented Targeted Lung Health Checks based on national piloting and recommendations
- Established a Radiotherapy Network with colleagues at Guys & St Thomas's NHS Trust which has fully implemented the new national service specifications
- Ensured that all cancer patients will have access to personalised care, including needs assessment, a care plan and health and wellbeing support and provision
- Extensive genomic testing available to patients who are newly diagnosed with cancers
- Developed plans with ICPs to improve early cancer diagnosis of patients in their localities and significantly increased the number of people diagnosed at stages 1 & 2 – by 23/24 c61% of cancers will be diagnosed at stages 1 & 2

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Mental Health

We all have mental health and, just like our physical health, our mental health goes up and down over time. We experience different things in life, our circumstances change, and we move through different stages of life. In fact, over half of us will have a problem with mental health during our lifetime and about a quarter of us do at any one time. So, just like we look out for our body, we need to look out for our mind.

Common mental health problems, such as depression and anxiety, are increasing both nationally and here in Kent and Medway. The co-existence of mental health problems with other issues such as smoking and alcohol misuse is also increasing. People with a serious mental health illness die on average 25 years earlier than people without a mental illness.

Prevention, early diagnosis and support for children is essential, because half of all lifetime mental disorders start by the age of 14 and 75% by the mid-20s . Our work to help prevent MH problems in children and provide earlier diagnosis and support, needs to be linked to a wider set of actions on deprivation, adverse childhood events and other risk factors for MH problems in children. The NHS and education will need to work even more closely in the future, including mental health support teams in schools.

In Kent and Medway, specialist mental health services for adults and older people are delivered by Kent and Medway NHS and Social Care Partnership Trust (KMPt) and for children and young people by North East London NHS Foundation Trust (NELFT). Additionally, KCC and Medway Council provide MH social work and AMHP provision, as well as commissioned social care mental health services. We also have a range of IAPT providers and additional primary care mental health practitioners. These providers are coming together to form a K&M Mental Health Collaborative.

Since 2016, we have had in place a system programme for Mental Health within our Kent and Medway Sustainability and Transformation Partnership. This programme has focused on delivering the Five Year Forward View for Mental Health, promoting mental wellbeing, and integrating physical and mental health care. Our Mental Health Workstream Oversight Group meets monthly and comprises a wide range of partners including Healthwatch, CCG commissioners, Local Authority social care mental health and public health representatives, KMPt and NELFT.

Progresses and successes to date include:

- A reduction in the rate of death by suicide
- A higher than the national target number of CYP with a diagnosable mental illness accessing specialist mental health services
- We significantly expanded specialist community perinatal mental health services, serving pregnant women and new mums
- A higher than the national expected proportion of people recovered after receiving IAPT / primary care psychological therapies
- Nearly ¾ of people referred with suspected first episode of psychosis engaged with the Early Intervention in Psychosis service within two weeks of referral
- All adults who were acutely unwell were placed in local acute inpatient mental health beds, except women needing psychiatric intensive care
- All CCGs met the Mental Health Investment Standard for 2019/20
- We have secured so far in 2019/20 c£5m Central Transformation Funding for local community crisis care services, Liaison Mental Health Services, and schools-based Mental Health Support Teams

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Mental Health continued

Our Plan

We will support Kent and Medway's population to have good habits for looking after our minds as a normal part of living a healthy life. Where children, young people and adults have problems with their mental health or a mental health illness, we will ensure that the right mental health care is simple to access, close by. Our overriding principle for mental health support is 'no wrong door' – that staff across health and social care will feel comfortable talking to a person about mental health and be able to signpost to the right care and support.

We are taking up the big challenges to give mental health equal priority to physical health, address equity of health outcomes for people with a mental illness, reduce the treatment gap in mental health care, and have excellent mental health services.

Our strategic priorities are:

- Improving the mental health and wellbeing of the population including developing resilience – we will implement a Mental Health Wellbeing Campaign

- Ensuring 'no wrong door' for accessing mental health support – through partnership working and integration we will ensure that anyone who needs support for their mental health needs will be able to access it

- Developing a working collaborative of K&M Mental Health service providers to optimise the mental health contribution to PCNs and ICPS
- Developing and implementing a Mental Health Impact Assessment to carve mental wellbeing into local NHS policy, pathways redesign and complex change delivery at the outset

- Increasing the proportion of children and young children accessing timely support for their mental health or in relation to a mental illness
- Improving mental health service outcomes for young people aged 18-25 years

- Working to increase and sustain positive outcomes for people with common mental health illness
- Transforming core community mental health services so that people with lived experience report them as 'services without borders'
- Addressing the inequity in health outcomes for people with severe mental illness, especially targeted actions for improved physical health
- Enhancing urgent and emergency pathways for people with a mental illness, including community-based alternatives to A&E and more tailored NHS 111 and Ambulance services
- Ensuring that 75% to 100% of our general hospitals with an A&E department have on-site liaison mental health services that satisfy national 'Core 24' standards
- Improving dementia diagnosis rates and the range of services available to support people with dementia and their families and carers
- Increasing community support (including out of hours) to ensure that people with dementia can remain in their usual place of residence at a time of crisis. This will include support to care homes

To support the transformation of mental health services, CCG planned investment this year is £278m and will continue to meet Mental Health Investment Standard in future years.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Maternity and neonatal

Giving babies and children a healthy start in life is one of our key priorities. Our approach to maternity and neonatal care includes a focus on prevention and promoting healthy behaviours, continuously improving neonatal care, and supporting women during pregnancy and beyond.

- The rate of smoking in pregnancy in Kent and Medway is 14.2%, with the aim to reduce this to 6% by 2022. Stopping smoking is the single most important change a woman can make to avoid unnecessary complications. Smoking in pregnancy is associated with a wide range of problems, including complications during labour, increased risk of stillbirth, miscarriage, premature birth, low birthweight and sudden unexpected death in infancy. It also increases the risk of infant mortality by 40%.
- One in five pregnant women in Kent and one in four in Medway were obese in 2017, a 1% and 2% increase from 2015. Obesity during pregnancy impacts on the infant's weight in childhood and increases the infant's predisposition to type 2 diabetes in childhood.
- Infant mortality has been decreasing in Kent and Medway over the past 15 years, however, over the last six years in Kent this has increased from 3.5 per 1000 to 3.8 per 1000 while rates in Medway remain unchanged at 3.7

- UK breastfeeding rates at 6-8 weeks compare unfavourably with other countries in Europe. In Kent and Medway we have variation in breastfeeding rates across the county. We will develop and implement a tailored breastfeeding strategy to ensure that women have the advice, information and support they need, when they need it, and ultimately improve local rates of breastfeeding initiation and continuation. Improving the UK's breastfeeding rates would have a profoundly positive impact on child health.

In February 2016 the national Better Births Maternity Review* set out a compelling future for maternity services: *we should work together across organisational boundaries in larger place-based systems to provide a service that is kind, professional and safe, offering women informed choice and a better experience by personalising their care*. Achieving this requires local leadership and action and this is achieved by commissioners, providers and service users coming together to create a Local Maternity System (LMS) to deliver local transformation. The LMS is a collaborative of organisations and partners. The LMS Maternity System Transformation plan has been approved by the NHSE Regional Team and was endorsed by the K&M STP prior to submission. In addition, the 0-25 Health and Wellbeing Board in Kent and the Health and Wellbeing Board in Medway also endorsed the plan as the respective Boards are committed to improving health in pregnancy and early childhood.

Our strategic priorities for the next five years are:

- Safer maternity care
- Tackling smoking in pregnancy
- Delivering continuity of carer
- Improving perinatal mental health services
- Access to maternity records and digital support

* <https://www.england.nhs.uk/matt-transformation/>

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Maternity and neonatal continued

Safer maternity care

The second version of the national care bundle includes a greater emphasis on continuous improvement and addresses variation by bringing together **five** key elements of care based on best available evidence and practice in order to help reduce stillbirth rates. The priorities for the Kent and Medway LMS are:

- Reducing smoking in pregnancy
 - Risk assessment, prevention and surveillance of pregnancies at risk of foetal growth restriction (FGR)
 - Raising awareness of reduced foetal movement (RFM)
 - Effective foetal monitoring during labour
 - Reducing preterm birth from 8% to 6% by 2025
- There is significant commitment in this second version of the Saving Babies' Lives Care Bundle to meet the national ambition of 50% reduction in stillbirth, maternal mortality, neonatal mortality and serious brain injury and a reduction in preterm birth rate, from 8% to 6%, by 2025.

Smoking during pregnancy

The new Tobacco Control Plan 2017-2022 defines an ambition to achieve a 'tobacco free generation' by 2022. To realise this vision, we must harness our efforts to ensure babies and children are not exposed to tobacco use. The Tobacco Control Plan seeks to further reduce maternal smoking in England to 6% or less by 2022. Our work will involve working with Public Health colleagues and our STP Prevention Programme on smoking cessation during pregnancy. We will target interventions in communities with the highest maternal rates.

Delivering of continuity of carer

Continuity of carer is associated with significant improvements in the safety, personalisation and experience of maternity care including:

- Seven times more likely to be attended at birth by a known midwife
- 16% less likely to lose their baby and 19% less likely to lose their baby before 24 weeks.
- 24% less likely to experience pre-term birth
- 15% less likely to have regional analgesia and 16% less likely to have an episiotomy

In K&M, the LMS are working to ensure that most (>51%) women are receiving continuity of carer by March 2021. All Trusts are developing and implementing Continuity of Carer pathways.

Perinatal mental health services

The NHS Long Term Plan includes a commitment to establish Maternity Outreach Clinics to integrate maternity, reproductive health, and psychology therapy for women experiencing mental health difficulties. This community based model of care will compliment specialist inpatient services and psychological therapy services. The LMS in K&M is bidding to national bodies to be an early implementer for this new community based care. By 23/24, some 2,000 women will receive perinatal MH support.

Access to maternity records and digital support

Three of our four Trusts have received funding from NHS Digital to enable women access to their own maternity records. The LMS is funding the development of electronic personal health records at the remaining Trust to ensure that all women have this option. The LMS will be participating in work at the level of Kent, Surrey and Sussex clinical network to ensure that women are guided to a small number of recommended apps to form their digital toolkit. Via this toolkit, women will be able to express their choices and receive personalised care.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Children and young people (CYP)

Across Kent and Medway, whilst there are some exemplar services in place for CYP, there is not yet an over-arching strategic plan for the commissioning and delivery of Children's Services. As a result, the level of service delivery and clinical/care outcomes vary considerably and are a material contributory factor to the inequalities children and young people experience across the county.

Current challenges

- The recent CQC/Ofsted Inspection of services for children with Special Educational Needs and Disabilities in Kent identified areas of significant weakness. Medway's inspection also identified similar challenges
- There is a high number of women who smoke during their pregnancy (13.8% in Kent and 17.1% in Medway)
- Children in their early years do not have adequate vaccination coverage

Next Steps

- 1 in 5 primary school children are obese or overweight
- The rate of teenage pregnancies is above the regional average in Kent and Medway
- Around 10% of children and young people have a mental health issue and there is a particular concern for looked after children
- 12% of children in Kent and 17% of children in Medway have a special educational need
- There is minimal local provision of cancer care and hospice care for children

Action taken to date

A Joint Committee of K&M CCG's has been established to oversee improvements. The Joint Committee supported the immediate priorities to oversee the delivery of the Kent and Medway SEND action plans including the imminent Medway re-inspection and to support the development a Kent and Medway multi-agency plan for Children and Young People (0-25). They recognised that this will identify further system priorities and will be developed in line with the Long Term Plan.

- We have produced SEND Improvement Plans which are agreed with CQC and Ofsted which focus on 5 areas of improvement:
1. Parental confidence, engagement and coproduction
 2. Inclusive practice, outcomes, progress and attainment of children and young people
 3. Quality of education, health and care plans
 4. Joint commissioning and governance
 5. Service provision

The development of a system-wide priorities document by December 2019 which will describe system:

- Principles
- Priorities
- Strategic Aims and Objectives
- Success Measures

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Learning disabilities and autism

The rate of children with the autism in Kent and Medway is significantly higher than the England average. It is also higher than Kent's statistical neighbour Essex. The rate of children with ASD known to schools is 19.7 per 1,000 in Kent and 20.5 per 1,000 in Medway. The prevalence of the primary SEN type ASD is much greater amongst children and young people with SEN support (9.7 % in Kent, 5.7% in England) and amongst children and young people with an Educational Health Care Plan (EHCP) at 39.7% in Kent, and 28.2% in England. We also know that 24.5% of the 14-18 year olds with a Learning Disability are prescribed hypnotic medication without having a diagnosis of a serious mental health disorder and 15.7% are prescribed anti-psychotics.

In February 2018, an analysis of Autism & ADHD data confirmed, within the adult population of Kent, 14,600 people are estimated as being undiagnosed for Autism (7,118) and or ADHD (7,482). Medway data for these cohorts showed within the adult population of Medway 8,061 people are estimated as being undiagnosed for Autism (1,001) and or ADHD (7,060).

Kent & Medway adult's data evidences a significant undiagnosed population when compared to expected prevalence rates for this cohort. Therefore, the demand for adult diagnostic service provision is unlikely to diminish over the next 5-10 years.

Only around 40% of our learning disability population across Kent and Medway, registered with a GP and aged over 14, years are accessing annual health checks and for our adults, aged 19 and older, 20.8 % with a Learning Disability are prescribed a hypnotic without having a diagnosis of a serious mental health disorder and 25% prescribed anti-psychotics.

Our service model for LD & Autism

Commissioning

Learning Disability services for Kent and Medway have been commissioned via a Section 75 Partnership Agreements between all Kent CCGs and Kent County Council, and between Medway Council and Medway CCG. There is also an established Integrated Commissioning Team for Kent Learning Disability, and an integrated Pooled Budget, which are hosted by Kent County Council. From 1st April 2019 the scope for the Kent Partnership Agreement was expanded to include Autism, and it was clarified that the current Section 75 Agreement is not age limited. We have also developed and agreed a plan to stop the over medication of people with a learning disability (STOMP).

Kent and Medway health and social care are currently working together to review and jointly commission a co-designed neuro developmental pathway, recognising the gaps in community service provision for people with autism that result in poorer outcomes for individuals and their families and have adverse economic consequences for the health and social care system.

For clients across Kent and Medway with Learning Disability or autism who are currently accessing in-patient care and are part of the previously named Transforming Care programme, there is a dedicated programme, with a system wide SRO to focus on recovery of the current inpatient numbers. Whilst the numbers of CYP inpatients is within acceptable limits, improvements to the admission and discharge processes are being made with specific reference to reducing both the number of inpatients and out of area admissions. The numbers for adult inpatients are far in excess of that expected for our population and a recovery plan is in place which focuses on discharge planning to deliver the 19/20 trajectory of 63 adults, reducing long lengths of stay and out of area placements, mobilisation and delivery of community and the forensic infrastructure business case and CTR/CeTR assessment capacity.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Learning disabilities and autism continued

Learning disability and autism services are currently provided by a range of providers including:

- Kent & Medway NHS & Social Care Partnership Trust
- Kent Community Health NHS Foundation Trust
- Medway Community Healthcare
- East Kent Hospitals NHS Foundation Trust
- North East London NHS Foundation Trust
- Kent County Council has a well-established specialist adult social care 'Autistic Spectrum Conditions' (ASC) team covering Kent. Providing statutory assessments, care and support packages for those eligible under the Care Act 2014. The ASC team has recently redesigned its service in preparation for integration with health in 2020 and it is anticipated that the service will expand its specialisms to include other neurodevelopmental conditions such as ADHD. Medway have already changed their social care model of delivery to a generic function but retains specialisms amongst its workers
- The inpatient secure and non-secure capacity is provided by a range of NHS and private specialist providers. In addition, the PBS Framework enables access to 14 Providers who successfully showed, through the tender process, that they have, or are, developing the right approaches, competencies and capability to support people with the most complex needs. Providers with the right skills and organisational infrastructure are key to co-producing solutions for people with complex needs, particularly those with learning disability and/or autism within the remit of need defined by the Transforming Care Programme

Priorities for improvement

- To review and co-design a new neuro developmental pathway for Kent & Medway by April 2020
- To ensure people with Learning Disabilities access annual health checks and screening to support improved physical health by December 2020 with 80% people receiving
- To eliminate the back log of Learning Disabilities Mortality Reviews and to ensure learning informs future commissioning plans by October 2020
- To ensure the appropriate prescribing of anti-psychotic medications for people with Learning Disabilities by April 2020. The current uptake is low with the NHS plan target being 75%
- Provide more community based and forensic support for people with LD & autism who are at risk of, or are, accessing inpatient secure care by December 2020
- To significantly reduce the number of CYP and adults requiring in-patient secure care by 2025 in line with national expectations
- To better develop the specialist community care market via the PBS framework which is ongoing
- To ensure K&M delivers the necessary CTR/CeTR capacity
- To develop host commissioner arrangements for secure inpatient facilities by April 2020
- Provide more personalised care for people with LD & autism and their families, listening to their care needs and their life goals by working with clients and families with learned experience
- To work specifically with main stream education providers to enable them to provide timely support to people with autism and ADHD

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Stroke

Stroke prevalence across Kent and Medway is around the national average of 1.7% with some areas of higher prevalence. It is estimated that there are currently nearly 1.2 million adults across the area that have two or more unhealthy lifestyle behaviours, such as smoking and obesity, which increase their risk of avoidable disease and disability such as stroke. Each year, an average of 3,054 strokes are treated for patients in the Kent and Medway catchment area. Stroke care accounts for about 4.5% of total spending on healthcare in Kent and Medway with an average of £7,000 per year spent on people who have had a stroke, (compared to an average £2,700 per year for those who have not).

Kent and Medway providers have continuously struggled to meet the quality standards of the national Stroke Sentinel National Audit Programme. Most scores are below average and although there have been some improvements since June 2014, this has been slow and is inconsistent. This indicated a clear need to improve the quality of stroke care in Kent and Medway.

The Kent and Medway Stroke Review was instigated in 2014 by local healthcare professionals, including senior doctors, nurses and care professionals. The national guidance for stroke states that the quality of a stroke unit is the single biggest factor that can improve a person's outcome following a stroke, and developing these is the main objective of the stroke review. Successful stroke units, hyper-acute stroke units (HASUs) and acute stroke units (ASUs), are built around a stroke-skilled multi-disciplinary team that is able to meet the collective needs of the patient. The proposal was therefore to establish HASUs and ASUs operating 24 hours a day, 7 days a week, to care for all stroke patients across the Kent and Medway area. This will deliver many benefits for patients, most notably more people will survive stroke and with improved quality of life and independence.

Our five year strategic priorities for Stroke include:

- Taking a range of preventative actions on diet, physical exercise, obesity and smoking as outlined in section 5 of this plan
- Implementing targeted interventions in primary care such as detection and monitoring of Atrial Fibrillation (AF) to reduce the number of AF related strokes
- Developing a stroke prevention business case, that will incorporate both of the above
- Implementing the model of hyper acute stroke units and acute stroke units across K&M, in line with national policy
- Support the development and delivery of an intra-arterial thrombectomy centre for stroke patients within Kent and Medway (currently, thrombectomy is not consistently available and there is a need to travel outside of the county for intervention compromising the benefits associated with early recanalisation)
- Developing a rehabilitation business case to ensure that community services meet the national and local specifications and to reduce variation

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Diabetes

In Kent and Medway, there are at least 123,000 people with diabetes of which around 90% are adults are living with Type 2 diabetes. Approximately 75% of people with diabetes go on to develop cardiovascular disease. Prolonged exposure to raised blood glucose levels can also damage the eyes, kidneys and nerves. Diabetes is the leading cause of blindness in people of working age, the largest single cause of end stage renal failure and the second most common cause of lower limb amputation. This places a significant burden on health and social services. Life expectancy is reduced, on average, by more than 20 years in people with Type 1 diabetes and by up to 10 years in people with Type 2 diabetes. More recently, a greater number of children are being diagnosed with Type 2 diabetes, as a secondary condition to being overweight. Increasing physical activity, maintaining good diet and reducing the obesogenic environment are key strands of our prevention strategy (see section 4). These preventative actions will be critical to reducing the number of people who develop diabetes.

Our five year priorities

- Kent and Medway's ambition for diabetes can be broken down into three overarching priorities:
 - Prevention of type 2 diabetes** – Increase referrals and attendance at the National Diabetes Prevention Programme (NDPP). We will work with practices and all partners across the STP to ensure there is sustained referrals and understand the barriers/issues to referral rates and subsequent attendance. We will also develop the opportunities to improve referrals through the Primary Care Networks. By 23/24, some 6,500 people will have been supported by the Diabetes Prevention Programme.
 - Reduce the variation in commissioning** – A Kent and Medway CCG would set Integrated Care Partnerships with clear standards to be achieved supplemented with national pathways and support people who are newly diagnosed to manage their own health by further expanding provision of structured education and digital self-management support tools. This will include expanding access to HeLP Diabetes an online self-management tool for those with type 2 diabetes. We will procure a K&M Diabetes Education Service that will increase access and attendance to structured education programmes
 - Reconfigure diabetes services** – Developing primary care/community services, improving interfaces between primary/community and secondary care ensuring resource/work force are aligned accordingly and developed and ensure diabetes alignment with the wider CVD LTP deliverables. We will enable more people to achieve the recommended diabetes treatment targets and drive down variation between CCGs and practices to minimise their risk of future complications

Current service provision

Historically, variation has existed in the commissioning arrangements for diabetes services across Kent and Medway which has led to variation in care and outcomes for people with diabetes. A key priority is addressing this variation in diabetes prevention, management, treatment and care/support, with a focus on achieving the three nationally recommended treatment targets. Addressing variation and meeting the national standards is the purpose of the Diabetes Oversight Group. This group membership comprises of STP diabetes Leads including Clinical, STP Prevention leads, 8 CCG commissioning leads, acute provider and community provider leads in diabetes, Public Health, Diabetes UK, voluntary sector and patient representative. The purpose of the group is to oversee the implementation of the NHS Long Term Plan for diabetes.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan in clinical and service areas

Cardiovascular disease (CVD)

The NHS Long Term Plan identifies cardiovascular disease as a clinical priority and the single biggest condition where lives can be saved by the NHS over the next 10 years. The Plan sets the ambition for the NHS to help prevent over 150,000 heart attacks, strokes and dementia cases over the next 10 years and outlines how we, and partners in the voluntary and community sector and in other national organisations, will meet this.

The national CVD Prevention programme has been set up to develop targeted interventions to optimise care by maximising diagnosis and treatment to minimise both individual risk factors, and population risk.

In K&M, although prevalence of CVD is lower than the England average, it is the biggest cause of premature mortality and a significant cause of disability in K&M. The number of hospital admissions in K&M for heart failure is increasing, particularly in Medway where the gap to England is also increasing.

Our five year priorities

1) A step change in our prevention efforts including rolling out the national CVDPprevent initiative

The chapter on prevention outlines our ambitions and plans to prevent or mitigate some of the risk factors for cardiovascular disease, smoking, obesity, alcohol, lack of activity and high salt consumption. Our aim is to ideally prevent bad habits forming but also to identify people whose habits or behaviours would benefit from and be amenable to an intervention that will decrease their future risks. Our approach is to work with people to understand their personal risks and what could be done to reduce these, taking a holistic person centred approach

2) Identification of patients at risk followed by targeted interventions

We will be supporting the HealthChecks programme to both ensure that it is being accessed and is accessible to those most at risk, and that those identified risks are then acted upon. We will also be working with pharmacists and pharmacies to support them in identifying patients at risk, for AF through the use of AliveCor, for BP through the use of BP monitoring and for Cholesterol through point of care screening.

We are already piloting an audit in primary care to support the CVDPprevent initiative in some parts of Kent & Medway. This provides prompts in the patients' clinical record which are visible during a consultation, reports at a practice level identifying individual patients and reports at a system level showing performance at a practice level. The plan is to have this aligned to the CVDPprevent rules once they are finalised and role out this support to primary care across the whole of Kent and Medway.

3) Monitoring the impact of interventions

The primary care CVDPprevent audit will also help us improve identification and management of patients with risk conditions, and allow us to monitor near real time improvements and the impact of interventions. We would use the Kent Integrated Dataset (KID) as a means of monitoring this on a near real time basis, and identifying where interventions should be targeted.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

Respiratory disease

Respiratory disease affects one in five people in England and is the third biggest cause of death, with hospital admissions for respiratory disease remaining a major factor in the winter pressures faced by the NHS.

Nationally, there is a correlation between incidence and mortality for respiratory disease with social deprivation due to higher levels of smoking, poor housing, and higher levels of air pollution. Kent and Medway is recognised as having several areas of high deprivation.

One in five people in England are affected by respiratory disease and only cancer and heart disease cause more deaths. For under-75 mortality due to respiratory disease, Kent on average, fares better than England, though areas such as Thanet and Medway are comparatively worse.

The three cornerstones of the Long Term Plan for respiratory are:

- Prevention
- Earlier diagnosis
- Pulmonary rehabilitation

Community Respiratory services are provided across Kent and Medway (with the exception of Dartford, Gravesend and Swanley) delivering care at home, in community clinics and in acute hospitals dependent on need. They also provide an "unwell service" which offers, where appropriate, same day appointment, helping to treat acute episodes promptly and preventing unnecessary admission to hospital.

There is some inconsistency in provision across Kent and Medway, for example community respiratory as above. There are also challenges in workforce, with a lack of staff and poor retention. There is a lack of access to smoking cessation services and poor standardisation and interpretation of spirometry.

Our ambition for respiratory

Key actions to achieve the ambitions for respiratory:

Reduction in smoking rates across all categories – including children, pregnant women, and older age, through better education to prevent initiation of smoking and improvement in smoking cessation services

Improvement in diagnosis and identification of respiratory disease by case finding, improvement in spirometry services and interpretation, as well as encouraging 'at risk but well' patients to engage with opportunistic spirometry, brought in via community screening sessions

Improved access to pulmonary rehabilitation services by increasing referral rates, including through QOF, increasing places for pulmonary rehabilitation courses and working towards alternative means of engaging patients who work or who are otherwise unable to attend courses

Ensuring 100% of patients within K&M are able to access community respiratory services, including during exacerbations, providing long-term management, psychological support, education and palliative care in addition to smoking cessation, pulmonary rehabilitation and pharmacological treatment.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

End of Life care in Kent and Medway

We live in an ageing society. In England around 500,000 people die each year. This will increase by 15% by 2035. The number of people with long term conditions (LTCs) is rising (by 2025 number of people with at least one LTC will rise from 15 million to 18 million; those with two or more LTCs will rise from 5 million to 6.5 million), leading to more complex end of life care for some of these patients.

In 2017, 46% of people died in hospital in England and 68% were admitted to hospital in the last 90 days of their life, with 7.4% of those having 3 or more admissions. Whilst data for Kent and Medway shows a downward trend with 43% dying in hospital, admittance to hospital in the last 90 days of life was higher than the national average in 6 out of 8 Kent and Medway CCGs.

End of Life and palliative care in Kent and Medway is provided by a variety of specialist, acute, community, primary care, and voluntary sector organisations. There are eight specialist hospices. Six of these (Pilgrims Hospice Canterbury, Pilgrims Hospice Margate, Pilgrims Hospice Ashford, Heart of Kent hospice, Hospice in the Weald, and Wisdom hospice) provide services solely for adults. Ellener Hospice provides services for all ages and Demelza Hospice is a specialist children's hospice. Community care is provided by a range of NHS and voluntary organisations, and includes community nurses, district nurses, specialist nurses, health care and therapy assistants.

Our ambition is for everyone approaching end of life to receive high quality care that reflects their individual needs, choices and preferences. We strive to provide high quality and equitable end of life and palliative care to everyone, regardless of their life limiting condition, care setting, social circumstances, lifestyle choices, culture or religion.

Challenges for End of Life Care

The challenges in Kent and Medway reflect many of those experienced nationally. A lack of standardised care planning documentation and shared IT platforms can result in confusion among providers about treatment plans and ceilings of care, potentially leading to patients receiving poor care and ultimately a negative experience. Similar issues occur through the lack of a standardised electronic care record. There is a lack of standardised documentation both nationally and at a system level. This can create difficulties for patients and their carers, particularly at points of transfer of care. Patients at end of life frequently transfer between acute, primary and community sector as well as care homes and hospices.

There is a challenge to ensure all staff are adequately trained to enable them to identify and care for patients approaching the end of life and to ensure there is an understanding that end of life treatment encompasses the last 12 months of a person's life, rather than the last few weeks or days. In order to support this, it is vital end of life care is embedded into primary and community care. We need to address inequalities in end of life care, for those with learning disabilities, working with specialist commissioning to support prisoners, travellers, LGBTQ+ and the homeless.

End of Life care for children and Young People

Rates of life limiting and life threatening conditions (LLCs) amongst children and young people have significantly increased in K&M since 2014/15 whilst death rates from LLCs have been declining since 2008. The need for services is growing year on year owing to advances in diagnosis and management of LLCs. The national picture can also be seen in Kent and Medway where a complex and fragmented system is sometimes ill equipped to cope with this, particularly in the provision of 24 hour EOL care.

Strategic Objective 1) – Improving care quality and patient experience

Delivering the Long Term Plan for clinical and service areas

End of Life care continued

Our priorities for the next five years

We recognise the need for a strategy and implementation plan for Kent and Medway and will be working with colleagues to establish this. In the development of the strategy we will consider the following areas:

- Expansion of services for children with life limiting conditions and terminal illness, in line with the national priority of the LTP and as indicated by our K&M Health Needs Assessment, reducing unwarranted variation and the delivery of care closer to or in the child's home
- Review of provision of home based EoL care, reflecting our commitment to support people to be cared for and die in their preferred place including support for their informal carers
- Standardisation of care and support planning and documentation across providers and wider organisations involved in a person's end of life care to include advance care planning and tools such as RESPECT
- Working more closely with voluntary sector to maximise the value that they can bring to EoL and bereavement care

Section Four

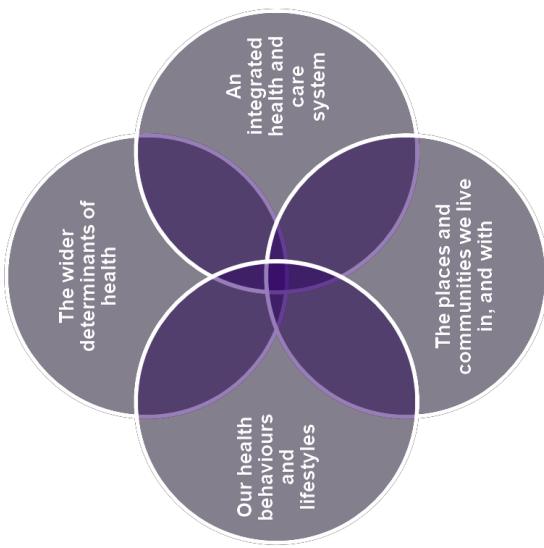
Strategic Objective 2) – An increased focus on population health and prevention

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to population health

Population Health is an approach aimed at improving the health of an entire population. The concept of population health is not new: there is existing knowledge across the system and specific expertise within our Public Health teams. However, the term ‘population health’ helps to create a collective sense of responsibility across partner organisations and individuals, in addition to public health professionals. Population health management (PHM) uses data to guide the planning and delivery of evidence-based interventions to achieve maximum improvement of population health within the resources available.

The King’s Fund defines population health as having four key pillars rooted in what drives our health, and what can improve and maintain it over time. Population health can only be delivered through a coherent, joined up system. A population health system recognises the interconnectedness of the four pillars of population health management, maximising the activity in the overlapping areas, as well as ensuring a balance of activity across the four pillars.



Defining population health management in Kent and Medway

The Kent and Medway system have been working on aspects of PHM for a number of years, such as the Kent Integrated Dataset (KID). This work has been further supported by the STP. However, a programme to develop a *Roadmap for Population Health Management in Kent and Medway* has now been established as part of the development towards an Integrated Care System. The programme will involve all parts of the Integrated Care System, including commissioners, ICPs, PCNs, upper tier Local Authorities as well as Public Health England and the Kent, Surrey and Sussex Academic Health Science Network.

Case studies from the NHSE/I Population Health Development Programme show that one of the first steps on the roadmap to embedding a PHM approach is to develop a consistent understanding and vision of PHM across place and system leadership. Nationally, PHM is defined as improving population health by “...*data driven planning and delivery of proactive care to achieve maximum impact. It includes segmentation, stratification and impactability modelling to identify local ‘at risk’ cohorts - and, in turn, designing and targeting interventions to prevent ill-health and to improve care and support for people with ongoing health conditions and reducing unwarranted variations in outcomes.*”

Locally, we aim to develop a simplified definition that resonates with our stakeholders, patients and the public, and broaden its scope, recognising that clinical care and health behaviours account for only 50% of health outcomes. Our Kent and Medway definition, agreed with our local stakeholders, will reflect our collaborative approach to PHM, explicitly incorporating prevention and improving well-being. This definition will be underpinned by a vision and values statement, articulating our aims for PHM and aspirational future state.

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to population health continued

Maturity and progress to date

An initial assessment against the population health management maturity matrix indicates that overall, Kent and Medway's arrangements are 'Developing' against the infrastructure, intelligence and interventions domains. In some areas of the Intelligence domain, we are 'Maturing', for example: the development of the Kent and Medway Care Record using linked data to segment and stratify the local population starting to map and understand the system's analytical workforce.

There is the potential to rapidly move to 'Maturing' overall once specific Infrastructure and Intelligence elements are agreed or established, e.g., joint data controller arrangements, linking remaining care datasets within Kent Integrated Dataset or its successor. As part of the programme, we will also consider the development of system-wide leadership behaviours (i.e. supporting action across the four pillars of population health) and workforce development requirements.

The maturity assessment will be adapted and continue to be tested with stakeholders to ensure that it accurately reflects our progress, in order to helpfully inform the development of our PHM arrangements.

Support for Primary Care Networks

The 2019/20 planning guidance states that 'STPs/ICSSs must ensure that Primary Care Networks (PCNs) are provided with primary care data analytics for population segmentation and risk stratification...to allow Primary Care Networks to understand in depth their populations' needs for symptomatic and prevention programmes including screening and immunisation services'. Kent and Medway's Public Health Teams are in the process of drafting PCN health profiles to support local understanding of health and care needs. Medway Council's Public Health team is also producing PCN-level children and young people's profiles to support work on developing a system-wide, intelligence-led children and young people's strategic plan

Next steps

By April 2020, we plan to have an agreed Population Health Management Strategic Plan in place, which outlines our PHM arrangements at each level of the system, the infrastructure, intelligence and intervention capabilities that will support these arrangements and how we will continue to strengthen and enhance population health management during the lifetime of this Strategy Delivery Plan to become a 'thriving' population health system.

Our immediate priorities for 2019/20 are to:

Q3:

- Agree local PHM definition and supporting vision and values statement
- Establish population health management as a system-wide work programme, with agreed governance arrangements and dedicated resources
- Agree Analytics Strategy
- Complete PCN-level health and children & young people's profiles

Q4:

- Run further stakeholder workshops to inform strategic plan development

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention

- The importance of prevention in impacting health and wellbeing**

The Kent and Medway Health Needs Assessment, produced jointly by Kent County Council and Medway Council, sets out a compelling case for the role of prevention in supporting the needs of our population.

There are many major health conditions that are preventable and amenable to targeted interventions, particularly those that are linked with smoking, diet (including salt consumption), obesity, alcohol and substance misuse, and air pollution. Some headlines from the K&M Health Needs Assessment from a prevention perspective are shown below:
- Cancer** - Cancer remains the leading cause of premature death in K&M. In 2017, 4,893 people died from cancer in K&M, accounting for 29% of all deaths and 40% of deaths for under 65s. Over recent years, cancer mortality rates for Medway have remained consistently higher than the England average. While mortality rates in Kent are in line with national average, they have been increasing in recent years. There is more to be done on prevention, screening and earlier diagnosis. Continued preventative action on smoking, diet and physical activity will reducing the risks of developing specific types of cancer including lung and colon cancer
- Respiratory disease** - One in five people in England are affected by respiratory disease and only cancer and heart disease cause more deaths. There is a significant link between respiratory disease and deprivation, associated with smoking, poor living environments and air quality. While K&M fares better than England as a whole, we have pockets where under 75 mortality due to respiratory disease is significantly higher than the England average - in Dover, Thanet, Swale, and Medway
- Stroke** is the fourth single leading cause of death and the single largest cause of complex disability. There is a strong evidence base for the case finding of atrial fibrillation and subsequent anti-coagulation treatment in the prevention of stroke. Unhealthy lifestyle choices such as smoking and obesity increase the risk of stroke.
- Type 2 diabetes** is increasing in prevalence and is often associated with being overweight. It can have devastating effects on the eyes, kidneys, nerves, and limbs. In Kent and Medway, there are at least 123,000 people with diabetes of which around 90% of adults with Type 2 diabetes
- Mental Health** – there is a strong case for prevention in Mental Health. Half of all lifetime mental disorders start by the age of 14 and 75% by the mid-20s. Efforts to positively impact the mental health and wellbeing of children need to considered alongside wider actions relating to deprivation and adverse childhood events such as family breakdown. Suicide rates in K&M are higher than the national average, particularly in men, and there are large co-occurrences with substance misuse and self-harm
- Frailty and multi-morbidity** – Frailty doesn't just affect the elderly and having more than one long term condition increases a person's risk of becoming frail. Additionally, ageing does not necessitate becoming frail. Therefore, targeted action on maintenance of wellbeing and independence is essential. There also needs to be a greater alignment between interventions for frailty and dementia.

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Health Inequalities in Kent & Medway

Health inequalities are avoidable differences in the health and wellbeing of individuals due to factors such as, where they live and whether they have good quality employment. The past decade has seen mortality falling across Kent and Medway, however, the gap in deaths between the most and least deprived areas continues to increase, i.e. there are widening health inequalities. For example, over the last five years in Medway, life expectancy has increased by 2.6 years in Cuxton and Halling, while it has only increased by 0.3 years in Chatham Central, leading to an increase in the gap in life expectancy from 5.1 years to 7.4 years. In Kent, over a six-year period, female life expectancy has decreased by 0.5 years in Folkestone and Hythe and increased by 1 year in Sevenoaks. Male life expectancy in Canterbury has not changed, whilst male life expectancy in Thanet has improved by 1 year over the same time period.

In Kent and Medway, men living in the most deprived areas have, on average, a 7 to 8 year life expectancy gap when compared with men living in the least deprived areas. While the trend is similar for women, the absolute gap is smaller (4.4 years for Kent and 5.4 years for Medway). Cancer is the largest cause of premature mortality overall. But in the more deprived areas, an increasing proportion of deaths are caused by cardiovascular, respiratory and gastrointestinal (GI) disease.

Many inequalities are amenable to being reduced through earlier detection of disease and preventative measures, such as lifestyle modification and management of long-term health risks.

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

More action on prevention

A critical overarching theme throughout our five year plan is the importance of more action on prevention. To deliver prevention at scale, the NHS needs to work with other local partners, specifically local government, to maximise the use of resources to deliver better outcomes. Local government has a strong role to play to create the physical and cultural environment in which health can be protected and improved. In K&M, we have a compelling vision for joined up action on prevention between the NHS, local authorities, the voluntary sector and our communities. Prevention is everyone's responsibility and it is never too early or too late in the life cycle to focus on prevention.

The K&M Health Needs Assessment stresses the importance of these factors and the critical role of prevention in positively impacting outcomes. This has driven our proposed prevention strategic priorities:

Prevention across the life course:

- A strong start in life
- Working age adults
- Ageing well

Prevention across the system

- Reducing health inequalities
- Tackling modifiable disease risk factors by:
 - Stopping smoking
 - Reducing obesity
 - Reducing alcohol consumption
- Protecting health
 - Improved screening
 - Improved vaccination
 - Improved infection control
 - Reducing antimicrobial resistance (AMR)
- Improving chronic disease management and secondary prevention
 - Cardiovascular disease/stroke, respiratory disease, diabetes
 - Improving mental health
 - Improving air quality

Embedding Prevention across the system

Extending the reach of prevention across the system through all levels and in all pathways will be a priority over the 5 years of the strategic plan. Alongside the work on population health management, there is a clear opportunity to set clear ambitions and scope of work. To ensure consistency and consensus, a set of principles have been developed which are being proposed for the ICS as a commitment to drive prevention across the system:

- Prevention will be owned by the whole Kent and Medway system. All partners have a clear understanding of prevention and of their role within the system
- Prevention and its role in reducing health inequality and variation will be a priority across the system, making the best use of a proportionate approach
 - All clinical pathways will begin with prevention
 - Tackling prevention as an system will be a whole system approach. The wider determinants of health will be tackled alongside clinical health in a partnership approach making the most of partner specialisms
- There is parity in the importance of good physical health alongside mental wellbeing
- The system will take a life course approach embedding prevention alongside all life events. It's never too early or too late for prevention.
- Children and young people will be a priority, embedding prevention at the earliest opportunity. Schools and other education settings will be fully involved to shape the future of children and young people
- Systems thinking will underpin all work, using an intelligence led, evidence based approach to developing and evaluating interventions
- Interventions will be implemented at scale in a coherent and consistent way across the system to achieve the best outcomes
- Services will be co-commissioned to ensure prevention is fully embedded across the system. Every commission must be published with a section on prevention

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

- **Current delivery priorities for 1920 into 20/21**
- **NHS Health Check:** The NHS Health Check outreach programme introduced in 2019/20 is designed to increase the number of patients diagnosed with hypertension through a specific programme focused on vulnerable members of the population of Kent and Medway. This programme will overlap into the early stages of 20/21 and will enable identification of risk factors particularly for CVD
- **Obesity:** Kent and Medway provide a range of well established weight management services through ‘One You Kent’ and ‘A Better Medway’ respectively. Obesity prevalence is heavily influenced by the wider determinants of health and for this reason tackling obesity involves changing a complex system of interrelated factors and relationships at multiple levels for interventions to be effective. Equally, as is demonstrated in the data, prevalence of obesity is higher in disadvantaged communities leading to health inequality and the requirement for a place-based approach. In light of the publication of the guidance on the Whole Systems Approach to Obesity, the Prevention Workstream is currently reviewing the opportunity to embed the whole systems approach in our work to tackle obesity across K&M
- **Smoking cessation:** Services for smoking cessation are well developed across Kent and Medway and offer services to support people to quit smoking through the ‘One You Kent’ offer and the ‘A Better Medway Programme’. The range of services available are designed to offer the service in a way that suits the needs of individuals. Services include digital and online services, face to face and telephone support. There is public facing ‘walk in’ provision in both central Chatham and Ashford offering convenient and approachable support. The number of adults across Kent and Medway who smoke continues to fall and the current trajectory will need to be maintained to meet the aspiration set out in the Tobacco Control Plan of 12% or less adults who smoke by 2022
- **Smokefree environments:** Achieving a Smokefree environment at each of our Trust sites is a key focus in 2019/20. Trusts have come together to develop consistency in policy and actions to facilitate full implementation of their Smokefree commitment. Actions are being implemented including wording in appointment letters, signage and speaker systems
- **Smoking during pregnancy:** Specialist smoking cessation midwives in each of the acute trusts have supported pregnant women in Kent to quit smoking since 2016. STP funding in the financial year 2019/20 has enabled extension of this service to Medway. Smoking cessation midwives have a key role in ensuring carbon monoxide testing of pregnant women at the time of booking and making referrals to stop smoking services as appropriate. The latest data for 2018/19 shows that 14.2% of women across Kent and Medway smoke during pregnancy, although this is falling, there is a steep trajectory to reach the Local Maternity System Target of 6% by 2022. It is intended that the work of the specialist midwives will continue into 2020/2021 alongside a range of services provided by Kent and Medway Public Health Teams
- **Reducing alcohol consumption:** Reducing alcohol consumption services across Kent and Medway fall under the following main areas
 - Identification and brief advice - Know your score ('One You Kent' campaign) and lower your drinking ('A Better Medway' campaign)
 - Making Every Contact Count training for frontline staff
 - The Blue Light project in Medway supports those facing severe and multiple disadvantage (substance misuser, involvement in the criminal justice system and homelessness) by way of a multi-agency team
 - Moving forward into 20/21 the Kent and Medway aspiration is to create better links between hospitals and treatment services and to ensure vulnerable dependant drinkers have access to MDT teams via local care

Strategic Objective 2) – An increased focus on population health and prevention

Our approach to prevention continued

Current delivery priorities for 1920 into 20/21

- **Air Quality:** The Kent and Medway Energy and Low Emissions Strategy Consultation sets out a clear vision for reducing emissions and, therefore, improving air quality across the footprint. The aim of the strategy is that by 2050 emissions in the county of Kent have been reduced to Net-Zero and it is benefiting from a competitive, innovative and resilient low carbon economy, where no deaths are associated with poor air quality. The outcome of the consultation and the strategy will guide the ongoing work through the lifetime of the plan.

- **Health Protection (including antimicrobial resistance):** The scope of the STP Prevention Workstream has been extended to include Health Protection. This strand of work includes oversight of antimicrobial resistance (AMR), outbreak control, infection prevention and control, sexual health and immunisation and screening (non-cancer). A Task and Finish Group has been set up to develop a work plan to guide the work of this strand through the period of the plan.

Section five

Strategic Objective 3) – Driving efficiency and productivity

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Investing in the delivery of the Long Term Plan

Kent & Medway has been allocated £166m of Long Term Plan fair share funding over the five years. The categories of spend for each of these categories of investment are set out at high level in the table below. Throughout the development of this Strategy Delivery Plan, we have brought together clinicians, service managers, subject matter experts and finance professionals to continue to stress test the affordability of plans at a high level. Work will continue on this with each year's operational and financial planning to ensure that funding is allocated to the commitments outlined in this plan. Where required, the STP/ICS will make decisions regarding the prioritisation of initiatives.

	LTP Funding Allocation Summary				
	Plan 2019/20	Plan 2020/21	Plan 2021/22	Plan 2022/23	Plan 2023/24
Mental Health					
<i>Children and Young People's services</i>	1,604	1,732	6,278	12,640	17,009
<i>Adult and older adult Crisis Resolution Home Treatment Teams and Crisis Alternatives</i>	-	84	1,926	2,984	4,928
	-	1,648	896	1,203	1,572
<i>Serious Mental Health Issues</i>	-	-	3,456	8,453	10,508
Primary Medical and Community Services	12,952	14,366	16,474	21,160	25,506
a) Primary Care	12,952	13,405	14,231	14,612	14,485
b) Ageing Well	-	961	2,244	6,548	11,021
Cancer	3,754	2,915	2,276	2,183	2,185
Other	1,226	1,305	3,020	4,396	13,252
LTP funding allocation, total	19,536	20,318	28,048	40,379	57,952

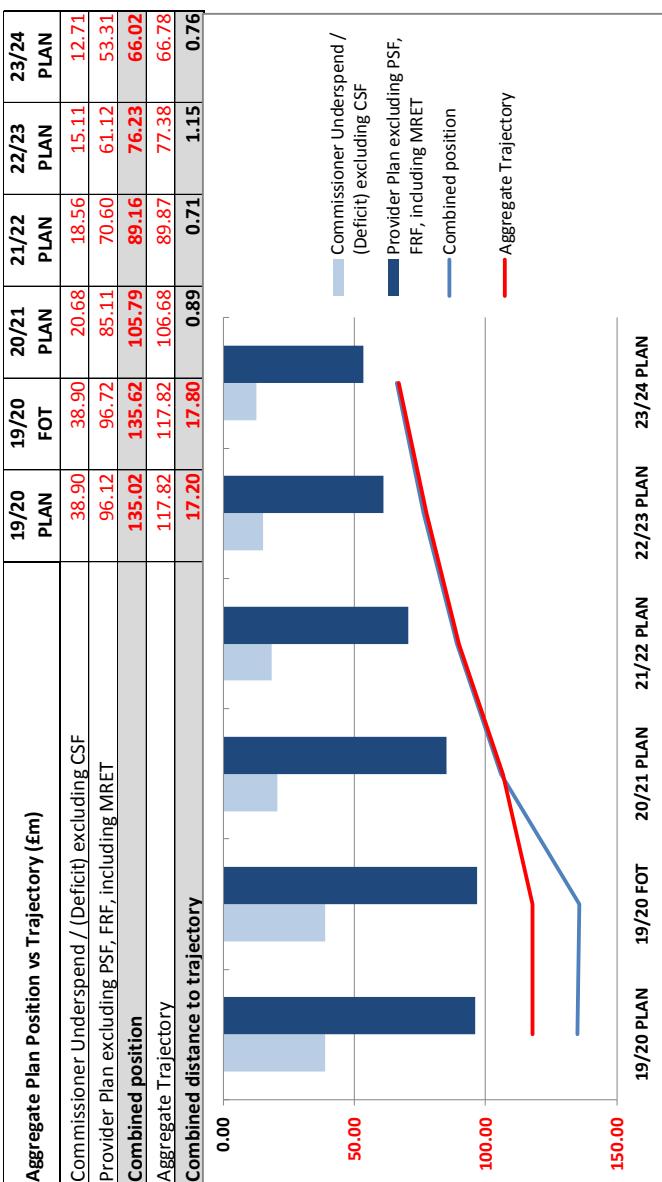
The NHS Long Term Plan implementation framework states that targeted funding will be available for selected systems to act as pilot or test sites in implementing certain aspects of the LTP earlier than other systems. The system is actively bidding for targeted funding in relation to a number of areas. These include PCN development, new Local Care models, diabetes, mental health, and Cancer innovation fund. Ageing Well funding will be applied to deployment of home-based and bed-based elements of the Urgent Community Response model, development of Community Teams, and Enhanced Health in Care Homes. 'Other' covers the LTP funding available to support implementation of the LTP for Prevention, CVD, Stroke & Respiratory, CYP & maternity, Learning Disabilities and Autism.

This does not represent the total funds that K&M will invest in these areas, as we anticipate receiving additional targeted funding through successful bids to national bodies as well as re-prioritising our baseline budget according to the priorities outlined in this plan. This will see a shift in investment over the next five years to prevention, out of hospital services and integrated care. Prioritisation and impact on other services will continue to be assessed through the 2021 operational planning process

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Delivering finance balance

The five year projections have been prepared with acknowledgement to financial improvement trajectories. Separate work is ongoing in respect of medium to long term financial planning to deliver long term clinical and financial sustainability through a range of measures including transforming out of hospital care, managing demand, reducing unwarranted variation, driving efficiency and productivity and making best use of capital. K&M STP has made significant progress in addressing a 19/20 £479m do-nothing financial challenge presented in October 2017. The current forecast is for a £135m net deficit in 19/20 (after sustainability funding). All organisations are forecasting financial balance against their trajectories for the 3 year period 2021/22 to 2023/24. However Dartford & Gravesham Trust and East Kent Hospitals Trust are currently forecasting plans adverse to their trajectories for 2020/21. To balance the system this pressure manifests in a £6m additional QIPP requirement in CCG plans and therefore delivering collectively above the expected trajectories by the £6m for the CCGs. Finance leaders have agreed to share this additional challenge across the system and have agreed to develop an appropriate approach to this. Through our Finance Group and Finance & Activity Modelling Group (FAM Group) we will conduct an exercise to confirm the £6m position and to understand the key opportunities across all four Integrated Care Partnerships. Additionally, work has been initiated to develop proposals for how income will be apportioned across the system for 20/21 and how we will move to alliance based contracts.



The table and graph show the trajectory of the system is moving towards financial balance over the five year period. Contingent on achievement of agreed trajectories, the receipt of Financial Recovery Funding of £107.7m in 20/21 would take the system to an aggregate surplus position which continues through to 2023/24. In line with the long term plan expectations, the number of organisations in deficit within Kent and Medway reduces over the planning period from 10 to 8 (of 12) organisations before FRF and from 3 to 0 after the application of FRF with all organisations planning to be in surplus from 2022/23 after FRF. Work is continuing across the system to the ambition of a quicker trajectory to financial balance.

Number of Deficit Organisations	Before FRF		After FRF	
	CCGs	Prov	CCGs	Prov
2019/20	5	5	1	2
2020/21	4	5	0	1
2021/22	4	5	0	1
2022/23	4	5	0	0
2023/24	3	5	0	0

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Driving efficiency and productivity

The K&M Productivity programme was established in 2016. The programme has focused on delivering efficiencies that are enabled by working in partnership at a 'system level'. A 'Productivity Executive Board' and 'Working Group' governance structure have been set up with finance and subject matter expert leads assigned to each workstream embedding a collaborative culture and ownership to deliver. A clear reporting structure and governance has been created with an Executive SRO. This programme has delivered savings of £1.2m in 2017/18, £2.9m in 2018/19, and forecast delivery of £11.67m of saving in 2019/20.

The key areas of focus for 19/20 delivery are:

- £8.99m in Bio-Similar switching
- £250k in continence formulary
- £1.86m in Temporary Staffing
- £555k in Pathology

These programmes of work align with the Carter Efficiency Guidance and the NHS Long Term Plan (LTP).

The STP will follow due process for "stress-testing" of all programmes ensuring the assumptions underpinning them are credible and the outcomes are deliverable.

The plans for 19/20 and the forward planning for the next 5 years, in line with the LTP, will support a trend towards achievement of financial balance. Model Hospital is supporting the STP to realise an opportunity of c £53m to c £90m over 5 years. Teams are completing a desktop exercise with Model Hospital against internal datasets to confirm a degree of confidence with the opportunity.

The Model Hospital opportunities include:

- **Developing a workforce to deliver 21st century healthcare** - This workstream focuses on maintaining agency staff in accordance with NHSL cap rates for Nursing, AHP and Admin staff and working in partnership with agencies for Medical Locums making Kent & Medway NHS the best place to work. Alongside this, K&M STP are driving forward a technology driven collaborative bank system which embeds with existing banks systems. This will enable K&M to develop a new operating model for workforce which will override all workforce gaps and costs. Model Hospital demonstrates workforce holds an opportunity of c£16m - £26m."
- **By 2023, K&M will align with the diagnostic imaging networks vision** - to enable the rapid transfer of clinical images from care settings close to the patient to the relevant specialist clinician to interpret. The programme is currently undertaking a diagnostic review and will develop the initiatives in collaboration with the Cancer Alliance plan and the Elective Care Transformation and Digital plans.
- **Tackle clinical variation across health improving providers' financial and operational performance** – Kent & Medway recognises that further unwarranted clinical variation exists, particularly within Geriatric Medicine, Emergency Medicines and Orthopaedic & Spinal Surgery with an opportunity of c£11m – c£13m, c£10m- c£14m and c£8m – c£14m respectively. Kent & Medway have plans in place by utilising Rightcare, Model Hospital and GIRFT data and support from local and central NHSE/I to deliver opportunities where they exist.
- **Estates and Facilities is a key priority with opportunity ranging from c£8.2m - £23.4m**- This workstream holds plans for a review of Linen & Laundry, Medical Records Storage and Transport. These plans are a stepping stone towards maximising best value within K&M's existing Estate. Capital planning has started and in many places is already in progress with regards to prioritisation, improving utilisation of clinical space, ensuring build and maintenance is done sustainably, improving energy efficiency and releasing properties now needed to support the government's target of building new homes.

Strategic Objective 3) – Driving financial balance, efficiency and productivity

Driving efficiency and productivity

- **Further efficiencies in NHS admin costs across providers and commissioners both nationally and locally** - Productivity will be part of this priority which sits with CCG and Providers at tackling reducing management costs. The STP recognises efficiency in consolidating corporate services, thereby reducing the cost and improving the quality of services. Focus areas are currently within scope; temp staffing such as developing a Collaborative Bank and reviewing structures across organisations such as HR and Legal. Further plans will include standardisation of internal procedures/processes (to reduce variation and enable prospects of pooling/sharing of resources) and pooling of high cost/specialist resource within a system to maximise utilisation

Areas which Model Hospital exclude but where the STP will realise opportunity are:

- In the future, a **single pathology service in Kent and Medway** will be established with a single Laboratory Information Management System, Managed Service Contract, referred diagnostic contract and standardised operating procedures; which, together with potential efficiency gains through strategic partnership/s and management/workforce redesign. This workstream is well established and a final business case (FBC) is currently being developed. The potential annual saving for this initiative across Kent and Medway is **£5.6 million annual saving** on current costs

- **Delivering value from the £16bn spend on medicines**- Kent & Medway Medications Optimisations Group have agreed a set of priorities which will deliver 'system level' working and 'local level' working for the next 5 years. The focus points are Workforce, System Aseptic Review, Dispensing, Medicines Information, Centralised Stock Holding, 'Direct to ward', Vaccination Supply & Management and a centralised admin function, whilst other priorities will be maintained at a local partnership level such as Clinical Services, Educational & Training and Governance
- **Improved efficiency in community health, mental health and primary care through integrated care models** – productivity opportunity will hold a wider 'lens' focusing on the improved efficiency in the new partnership ways of working model. Keys focus points will be on supporting all Community staff, Primary Care Networks and Mental Health. The collaborative working of these priority STP workstreams will model and track the changes to ensure we are measuring improved productivity at a wider level
- **Engage with local intelligence at a population health level**- Kent & Medway is committed to **achieving cash releasing productivity growth**. Productivity will continue to plug into national support and datasets and initiate further work with Public Health Intelligence to gain a niche understanding of the population needs. By triangulating all of these sources, productivity growth will accelerate and impact benefits realisation in specific areas of deprivation.

Strategic Objective 3) – Driving financial balance, efficiency and productivity

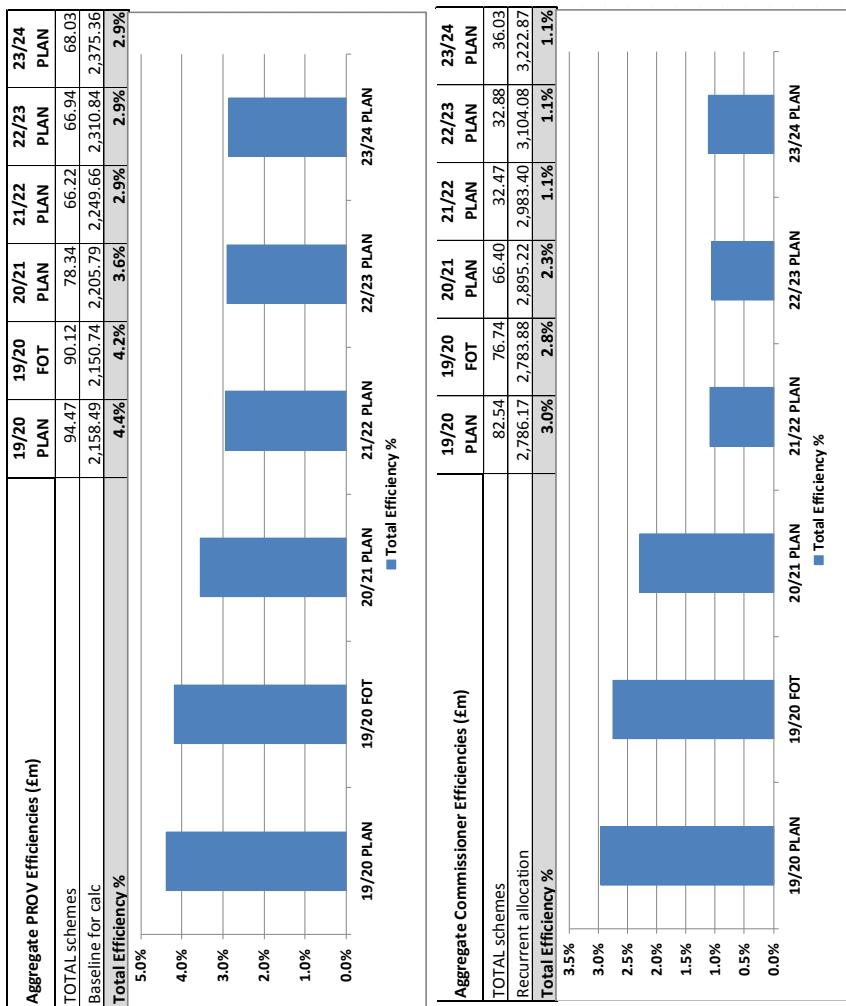
Reducing growth in demand through integration and prevention

We have set out in sections 3 and 4 of this plan our plans for prevention and integrated services. The full financial impact of these new models of care is not yet fully quantified, in line with the LTP implementation framework statement that all new systems will be in a position to quantify this as part of the Strategy Delivery Plan. Understanding the impact of prevention and integration on the cost of services is necessarily complex. Work has started across our ICPs to understand the medium term cost impact of key interventions being taken in Local Care and Primary Care (i.e. integrated care). However, more work is required on this.

Understanding the impact of prevention would need to be evaluated over a longer term timeframe (potentially in excess of 10 years). We will look to learn from NHSE/I and more advanced Integrated Care Systems as to the most appropriate method for long term financial planning of this nature.

Achieving cash-releasing productivity growth of at least 1.1% per year

Through all of the efficiency and productivity schemes, the organisations within Kent and Medway are planning on delivering in excess of 1.1% cash releasing productivity growth. The profiling of the efficiencies required and planned show the higher ask in the first two years of the plan.



Making best use of capital investment

The K&M Estates Strategy contains 117 projects, with capital investment values varying from under £500k to £363m. The suite of projects totals £821m. The STP have an agreed assurance and governance process for the Programme Management of all Capital projects. The STP has initiated programme management of the disposals programme with regular reporting from the property owners and escalation of blockers and issues. The estates workstream is embedded as an enabler into all other workstreams – including the Estate/Capital requirement to deliver the services.

Please see Section 6 for details of our estates strategy

Section Six

Strategic Objective 4) – Transformation of critical enablers

Strategic Objective 4) – Transformation of our workforce and infrastructure

Making K&M a great place to live, work and learn

In Kent and Medway, we know that at the heart of our health and care services are our people and that is why we are committed to making Kent and Medway a great place to live, work and learn. The [workforce transformation strategy](#) focuses on our commitment to work together to prioritise actions that will have the biggest impact on addressing our workforce challenges. We strongly believe this focus will support the system-wide transformation needed to provide the people of Kent and Medway with a better quality of life and a better quality of care. We have developed the strategy with the aims for our:

Workforce to work together across health and social care, enjoy their work, learn in their jobs and be empowered, engaged and developed to be good at what they do.

Employers to work together to attract and retain the right supply of health and social care workforce through talented and capable leadership and the offer of attractive, flexible and interesting careers

Population to have the skills and support to help them manage their own health and care with confidence and, where needed, with the right support to achieve their health, social and community outcomes and goals

To deliver this ambition and address critical workforce challenges we will develop a **Kent and Medway Academy for Health and Social Care** working collectively to:

- Promote Kent and Medway as a great place to work
- Maximise supply of health and social care workforce
- Create lifelong careers in health and social care
- Develop our system leaders and encourage culture change
- Improve workforce wellbeing, inclusion and address workload to increase retention

As set out in the interim NHS People Plan, and aligned to our transformation plan, we need more staff working across health and social care over the next five years; system actions identified in our strategy will both address existing shortages and deliver the improvements set out in the Long Term Plan.

Our workforce context

In Kent and Medway we employ around 78,141 FTE workforce across Kent and Medway in over 350 careers across health and social care organisations.

	Workforce (FTE)	March 19 (actual)*
Acute	18,960	
Community	5,372	
Mental health	3,175	
Primary care	4,030	
Ambulance (Total SECAMB)	3,427	
CCG (* 19/20 FOT)	619.	
Social care (* 2018)	31,700	
Pharmacy (* 2017)	2,012	
Dentistry	1,086	
Ophthalmology (* 2018)	414	
Vacancies	7,346	
Total	78,141.	

It is recognised that across K&M, there have been long term workforce challenges with workforce supply for most staff groups being behind national growth averages, except for pharmacists and health visitors.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Some of workforce challenges include:

- Limited pipeline of skilled and qualified workforce in Kent and Medway
- Limited system digital capability and digital skills of our workforce hindering new ways of working and creating inefficiencies
- Trust shortage of key specialty workforce and staff groups including consultants (61.79 FTE by 20/21), adult, community and mental health nursing, junior doctors and allied health professionals
- Shortage of GP and primary care workforce is exacerbated by the primary care age profile – 25% of GPs and 55% of general practice nurses approaching possible retirement. In order to meet the retirement gap, we would need to increase the GP workforce to 222.4 full-time equivalent (FTE) and grow our nursing workforce to 287.9 FTE
- Not enough stroke workforce to provide hyper acute stroke services on the current sites. The revised workforce gap analysis across the preferred sites will require an estimated additional 135.5 FTE to 264 FTE staff, including the filling of a range of new and enhanced roles
- Shortages of key mental health professional workforce including, psychiatrists and nurses, and a required total growth in the mental health practitioner workforce by 2024 of 1577 FTE
- Significant unregistered and non-statutory workforce for intellectual disabilities supporting a complex and extremely diverse group of people with support required being highly individualised with the potential for variability in terms of workforce engagement and development support
- A 90 FTE gap between forecast supply and demand in cancer workforce by 2022. Particular areas of concern are: Gastroenterology, histopathology, clinical and diagnostic radiology amounting to 84% of the identified gap.
- Shortage of skilled social care workforce providing direct care and support in local communities, with over half of all vacancies in Kent and Medway within social care – estimated vacancy rate of 8.7%.

The Kent and Medway Local Workforce Board (LWAB) which oversees the delivery of the workforce transformation plan have identified five key strategic system workforce risks:

- Collective inability to attract, recruit and retain sufficient numbers of high quality staff may result in a continued dependency on temporary staff and unsafe staffing levels, affecting quality of care, costs and may also impact on the health and wellbeing of staff
- Limited national and regional supply of workforce will not meet demand in Kent and Medway which may result in an increased vacancies now and in the future
- Reliance on temporary staffing may lead to quality issues and impact on the improvement plan for financial sustainability
- Lack of consistent funding alignment for growth in workforce expected may result in not achieving expected growth in workforce
- Should there be a deterioration of staff engagement due to lack of workforce confidence, this may lead to worsening morale and subsequent increase in turnover.
- Limited system digital capability and digital skills of our workforce hindering new ways of working and creating inefficiencies

The Workforce Transformation plan aims to mitigate these risks and address our system wide workforce challenges. Key actions include activities to attract, recruit and retain the right staff, actions to maximise current supply through workforce redesign, using digital and new and enhanced roles, investment in cross sector apprenticeships, a collaborative approach for harmonising temporary staffing costs and agency conversion, working with our partners to identify recurring workforce funding streams.

We have been working together as a workforce board to understand the collective challenges and opportunities in Kent and Medway. We successfully supported our universities to campaign for a **medical school for Kent and Medway** to increase our supply of potential doctors and attract wider professionals into the county.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Our Transformation Strategy

To deliver our ambition and address critical workforce challenges we will develop a **Kent and Medway Academy for Health and Social Care** working collectively to:

- **Promote Kent and Medway** as a great place to work through social media, a [dedicated website](#), and recruitment campaigns for roles such as GPs and primary care. We are developing a joint attraction offer and will undertake joint international recruitment activities; maximising the use of apprenticeships including health and care rotations and streamlining the recruitment process through the implementation of staff passports

- **Maximise supply** of health and social care workforce acknowledging that we have a limited workforce supply. We will launch a Kent & Medway Academy and introduce a Kent & Medway Medical School in 2020, undertake redesign through competency workforce planning, maximise the use of current skills through new and enhanced roles such as care navigation and through the use of social prescribing, introduce a skills hub and improve the digital capability of our staff

- Create **lifelong careers** in health and social care by providing work experience, pre-employment health and care courses, promoting careers through school and employment events. We are also supporting flexible and part time working and using new technologies to support staff such as our [Help4Carers app](#)

- **Develop our system leaders** and encourage culture change. We have been working together to introduce an [OD toolkit](#) for local care team collaboration, introducing a Kent and Medway Talent Board for hard-to-recruit roles and senior roles across health and social care, developing our own leaders of the future from the existing workforce, and equip current leaders with the skills they need to help transform our local systems. These actions will be supported by the introduction of a system OD strategy later this year

- **Improve workforce wellbeing, inclusion and address workload** to increase retention through Best Place to work retention programmes, by developing programmes which support staff with health and wellbeing activities, staff resilience projects, professional development and retirement planning. We are working on the implementation of an inclusion strategy and improving rostering in all our organisations

Our workforce transformation strategy provides an overview of our work to date including:

- A Kent and Medway Medical School which will have 500 students by 2025, with a focus on growing our future workforce aligned to our care models
 - Kent and Medway social care recruitment campaign
 - Launching the 'Take a Different View' website and social campaign for hard to recruit roles
 - Upskilling education programmes for health and care in the community
 - Supported 237 individuals through pre-employment and Prince Trust courses and engaged with 8900 individuals through careers activities Launched an OD toolkit for multidisciplinary team working
 - Invested in system leadership development programmes
 - Investment in retention programmes for GPs
- Our workforce transformation plan identifies key activities that are being undertaken between 19/20 to 21/22 for our STP priority areas. These include:
- Ensuring cross system placement readiness for the Kent and Medway Medical School, with 100 medical students starting in September 2020
 - Working with education partners to increase the number of trainee placements
 - Working with PCNs and ICPs to undertake localised workforce planning and redesign including promotion of career development and new and enhanced roles
 - Developing our health and social care staff to be digitally ready through training, access to education platforms and use of digital champions
 - Working together to recruit a number of international doctors enrolling onto the Kent and Medway Global Learners Programme by March 2021. This would make a difference to hard to recruit areas such as interventional radiology, surgery, Anaesthetics, ED and Elderly Care including Stroke

Strategic Objective 4) – Transformation of our workforce and infrastructure

• Implementation of our primary care workforce plan through our Training Hubs with a focus on developing multidisciplinary learning

and working within PCNs, retention of our workforce (at all career stages), workforce redesign including introduction of new roles, OD and leadership development and primary care recruitment campaigns

• Working with providers to implement the stroke workforce plan including actions on recruitment, workforce redesign, introduction of new and enhanced roles and upskilling through the stroke competency framework and education programme and retention

• Growing the mental health workforce with an expansion target for growing the workforce by 2021 of 498 WTE - we are currently over performing and would meet this target

• Investment in community learning disability and neuro-development teams, introduction of a Positive Behaviour support team and attractive pay rates for providers on the PBS framework

• Co-production of a Kent and Medway workforce plan, building on sessions being run to identify key actions to address the shortage of hard to recruit roles and a Kent and Medway recruitment campaign

• Social care sector recruitment campaign, continued sector engagement and events to develop a care sector workforce strategy, rollout of ESTHER coaching, supporting new roles including apprenticeships and introduction of the [Help4Careers app](#).

Delivery of the Workforce Transformation plan is monitored through the Workforce Board with progress reported to the Partnership Board. The Workforce Board has four key workstream groups which include engagement from primary care, social care, HR Directors and Directors of Nursing. The implementation plan is being updated to include actions up to 23/24 with a revised workforce monitoring dashboard.

• Responding to the Interim People Plan

In Kent and Medway we recognise the importance of the national, regional, local system and organisational actions needed to address the workforce challenge and welcome the recommendations made as part of the Interim People Plan, focused on four key themes of:

- Making the NHS the best place to work
- Improving leadership culture
- Holistic approach to workforce transformation and workforce growth – ‘more people, working differently’
- Changing the workforce operating model within the context of ICS working

We have reviewed our transformation plan against the key local system recommendations from the Interim People Plan and are encouraged that these recommendations, in the most part, are already underway or planned as part of our activities.

• Making the NHS the best place to work to Improve workforce wellbeing, inclusion and address workload.

We have a number of organisational and system initiatives to improve retention including two Trust providers on the Best Place to Work scheme and a number undertaking the NHSE/I retention programmes, Training Hubs leading retention initiatives for the ‘First Five, Last Five’ programmes for primary care (£192,850 awarded by NHSE/I) and local authorities working with the care sector to develop a workforce strategy for the wider care sector utilising support and expertise from Skills for Care. Shared inclusion and health and wellbeing commitments and activities will be further developed using best practice from our organisations and from the wider health and care systems.

Strategic Objective 4) – Transformation of our workforce and infrastructure

- **Improving leadership culture to Develop our system leaders and encourage culture change.** We have programmes underway to support the leadership development within primary care, social care providers and system leaders through Practice Manager and Registered Manager development programmes, *Leading through Kent and Medway* system leadership programme and the development of Communities of Practice. Clinical Director and PCN development offers are planned for later this year.
- We are developing an ICS OD strategy, including working with our system leaders to develop shared values and behaviours and bring together the system plans and actions.
Holistic approach to workforce transformation and workforce growth – ‘more people, working differently’, alignment to promote Kent and Medway and maximise supply. Working together to grow the workforce supply by promoting Kent and Medway whilst also using our current workforce differently. Examples of this include:
 - Buurtzorg community teams
 - Local and system workforce redesign (using competency based system workforce planning)
 - Upskilling current staff (for example, care navigation and stroke competency framework)
 - Maximising new and enhanced roles (such as Nurse Associates, apprenticeships, Advanced Clinical Practitioners, Physician Associates)
 - Digital (upskilling, improved rostering, shared systems and use of telecommunications to reduce inefficiency)
 - Empowering our population and their carers to self- care and self-management through the use of technology such as the [Help4Carers app](#) and training and support for self- monitoring
- Changing the workforce operating model within the context of ICS working- including the development of a Kent and Medway Academy for health and social care to create lifelong careers in health and social care. In Kent and Medway we have been developing our operating model for workforce for the future including the development of a Kent and Medway Academy and Workforce Board.
- We have been working together to develop our strategic approach to key challenges in primary care, social care and, more recently, the nursing challenge, led by senior system leaders from health and social care and overseen by LWAB. The Academy will build on the workforce transformation plan and the good relationships we have with partners such as HEE and NHSE/I. There will be a focus on workforce planning, career development, work experience, engagement with education, role development and redesign, and workforce assurance. The Academy will also play a key role in engagement and development of a network of volunteers and peer support.
- Part of our evolving governance arrangements will be localising workforce activities where these are best undertaken at an integrated care partnership, primary care network or organisational level whilst continuing to share learning and best practice.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Delivering a digital transformation

Digital must be regarded as a golden thread running throughout our plan. This includes utilising digital technology to enable service transformation, to harness the power of modern technology and approaches to allow health and care to be delivered in new ways not previously possible. Delivery needs to be enacted through a strong and mature platform that keeps our data both secure and accessible. We need to ensure that digital care delivery is safe and seamless as we become ever more reliant on technology for both every day delivery of health and care and long term strategic planning. We can use digital to keep our population healthier for longer, intervene earlier when needed and to enable the use of our NHS resources more effectively in caring for our population.

Kent and Medway is committed to learning from best practice from other areas and to gain maximum advantage from national products and solutions, such as the NHS App and NHS Login. For example, the STP is linked into the Global Digital Exemplar (GDE) and local health care record programmes and is seeking to apply learning from the GDE blueprints, where appropriate, to STP priorities.

The Kent and Medway digital strategy has the ambition to help people achieve the best possible health and well-being outcomes, living independent and fulfilling lives in their own homes and communities by using digital innovation and technology. The digital workstream aims to co-design solutions; working proactively with all relevant stakeholders to deliver the right solutions and outcomes. The Kent and Medway digital strategy contains seven core components as detailed in the table opposite.

Digital strategy core components	Vision
Universal care record	Health and care professionals have immediate access to all relevant information about a patient's care, treatment, diagnostics and previous history, for all patients across Kent & Medway, with each digital footprint area determining their own delivery approach. This will be delivered through the Kent and Medway Care Record (More information on slide 74)
Universal Care Professional Access	Health and care professionals can operate in the same way independent of their geographic location. This is the infrastructure layer and includes providing HSCN connections to all sites with GovRoam access to support sharing of information, and meeting cybersecurity standards
Universal transactional services (eCare Navigation)	Health and care professionals can access a common directory of services and make arrangements for the appropriate referral to the next stage of the care pathway
Shared management information	Health and care professionals have the management information they require to run an efficient and effective service for patients e.g. details of bed occupancy and compliance with targets
Online patient services	Patients can access their own medical and social care records online and use other online services e.g. book a GP appointment or ask a clinician a question.
Expert systems	Health and care professionals and patients have access to knowledge bases to support the care processes
Personal digital healthcare	Patients can use personal technology to support their healthcare e.g. a device can automatically send data to alert their GP. This can be collated and used to inform population health management

Strategic Objective 4) – Transformation of workforce and our infrastructure

Delivering a digital transformation continued

This strategy is delivering:

- A digital infrastructure based on care/clinical themes and their associated outcome measures (cross reference to clinical transformation sections)
- County wide processes for sharing data safely and securely
- Focus on data quality and consistent coding
 - The development of digital maturity with care provider organisations is based on creating core capabilities across the organisation covering
 - Administration
 - Records Assessments and Plans
 - Transfers of Care
 - Medicines management
 - Order communications and results management
 - Remote and assistive care
 - Decision support
 - Clinical and business intelligence
 - Asset & resource optimisation

Page 122 of 254

Kent and Medway Care Record

We are developing the Kent and Medway Care Record (KMCR) to achieve the following:

- Enable health and care professionals involved in an individual's care to view near real-time electronic patient records currently held in numerous Provider point of care systems. A view of an individual's KMCR will be accessed via an integrated solution
- Enable a citizen to access their own consolidated record and to receive support and guidance to promote self-care
- Support the use of the rich dataset to drive intelligence, both in terms of near real time operational management of the Health and Social Care system plus longer term strategic planning and population health management (utilising depersonalised subset of data)

KMCR facilitates the NHS Long Term Plan aspiration to provide a Local Health Care Record for Kent and Medway. Subject to business case approval, the Kent and Medway Care Record will deliver a significant transformational change for the health and social care system in terms of shared information between providers and with citizens. This will provide a better patient experience and improve clinical safety as all relevant information will be available in one place. KMCR will also provide a platform for Kent and Medway citizens to access their health and care records and provide a consolidated platform to support population health intelligence.

The KMCR will initially prioritise the needs of Urgent and Emergency Care settings where patient data is required instantaneously, then extend to other areas including care homes. The development of specific KMCR requirements, including design and mobilisation, will be led by our Citizen User Group and Clinical Reference Group.

The specification that has underpinned the KMCR procurement has been based on national best practice. We continue to discuss our plans for the KMCR with NHSE/I to ensure that all national best practice is utilised.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Future digital structures and priorities

The merger of our CCGs provides an opportunity to review and invest in digital leadership through the establishment of a Chief Information Officer (CIO) at a system level. This role is key in reviewing and agreeing a refreshed digital strategy and implementation plans for K&M. With the imminent merger of the eight CCGs, there is an opportunity to develop extended capability in a range of functions including digital. We are moving to develop integrated management structures in order to streamline, remove duplication and pool talent.

It is suggested that Kent and Medway needs to improve its digital planning and delivery capability to ensure that digital developments are able to support strategic and delivery aspirations. The new leadership and management structures would be pivotal to this. Guidance from NHSE/I emphasises the need to establish either Chief Clinical Information Officers (CCIO) or Chief Information Officers (CIO) as board level appointments. Regardless of the specific approach adopted, both clinical and technical leadership is required

Through this approach we need to focus on:

- **Oversight of the system architecture:** Ensure oversight and coherence of enterprise architecture services, solutions architecture and design, application and data architecture, architecture and information governance, and assurance and consulting
- **Strategic development and planning:** Understanding the challenges, issues and opportunities of the emerging digital landscape in Kent and Medway and developing system strategies and associated plans that align opportunities to local requirements
- **Technology Architecture:** Ensuring focused Information Management & Technology (IM&T) expertise and advice is in place to ensure all significant IT investments have a solid business case and are consistent with established IT architectural standards

- **IM&T Programme & Project Management:** Scalable and adaptable delivery of digital initiatives to ensure significant commitments are delivered within time and budget constraints and to agreed specification. This can be through delivery of an intelligent customer role linked to the commissioning of external support or through the direct management of internal resources as agreed with the CCG or system
- **Digital Procurement, Contract & Vendor Management Services:** Managing 3rd party suppliers end-to-end to ensure high quality and compliant service provision as well as ongoing value for money
- **Systems Accreditation & Testing:** Providing assurance that updated or new externally provided systems meet the business / contractual specifications and that the inter-operability of systems is assured
- **Information governance and cyber security:** Strengthen our resilience and ensure the ongoing safeguarding of data
- **Business Intelligence:** Our system has a strong focus on population health intelligence and we are developing a K&M health and care analytics strategy to build on our extensive experience with linked data sets, most notably the Kent Integrated Data set (KID). The strategy is due for completion in autumn 2019 and will cover the following themes:
 - Understanding and predicting the health needs of the population and understanding the impact of interventions on population health, reducing health inequalities, improving patient experience, efficiency, and workforce wellbeing
 - Examining the wider determinants of health and the impact of work across the system
 - Supporting the shift from reactive care to anticipatory care
 - Providing information and intelligence for our citizens
 - Driving innovation by working with research and industry partners
 - Developing whole system demand and capacity intelligence for integrated care management
 - Developing intelligent business support for clinicians and care teams

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Across Kent and Medway we harnessing technology to transform services and personalise care. We have outlined some examples of the innovations being tested, piloted and implemented across Kent and Medway. Through our Digital Transformation Group we will evaluate the cost and benefits of various innovations and we will look to spread the most impactful innovations.

Supporting cancer diagnosis using technology

Darent Valley Hospital are harnessing machine learning and use of artificial intelligence (AI) software to identify abnormal chest x-rays. If an abnormality is detected AI will be able to detect this within 40 seconds allowing patients requiring further investigations to be fast tracked for a CT scan.

There is opportunity to adopt AI supported diagnostic technology for other tumour groups as this area of work develops. Using AI we can ensure that we can support early diagnosis through a more efficient turnaround of x-rays for those patients on a cancer pathway. We will evaluate the impact of this pilot and consider its further application across Kent and Medway.

Kent and Medway is the only cancer alliance nationally that has a networked cancer information system across all of its providers, the next phase of this journey is to develop a integrated cancer care record for patients in Kent and Medway. The benefit of this solution would mean that no matter which hospital, GP surgery or clinic you are at, your full care record relating to your cancer diagnosis and treatment will be available to the relevant clinician. The system will draw a diagnostic scan, blood tests and reports from the various local systems through IT interfaces to allow it to be seen in one place.

We are currently looking to implement a network diagnostic service where scans can be reported by a clinician remotely irrespective of where a scan was performed, removing unnecessary delays.

Unlocking the future of digital primary care

Kent and Medway is embarking on an exciting period of change with additional digital functionality being made available for practices and patients.

Over the next few years we will be embarking on a transformational change in how patients service their primary care needs:

- Underpinning online consultations as a core element of the primary care offer, enabling patients to access primary care at their convenience, and where deemed clinically appropriate, rollout of these services will start in 2019 / 20.
- Using digital technology to enable practices to operate at scale and develop patient facing models of care that are utilising technology such as apps an wearables.
- Wider integration between providers and system suppliers to join up pathways and patient journeys. Creating seamless and safe handoffs between systems allowing patients to flow between care settings.

There is significant investment that is being made in primary care and a fundamental change in the way we are harnessing technology to improve patient access and experience.

Strategic Objective 4 – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Digital Primary Care First East Kent Digital First Unscheduled Care Accelerator

Moving to a digital based primary care sector is a key aspiration of the STP and we are fortunate to have one of the national digital accelerator projects within the county; the East Kent Digital First Unscheduled Care Accelerator (EK UCA). This will deliver agreed outcomes within our unscheduled care pathways. This will ensure patients and professionals can access appropriate services in a timely and consistent manner, reducing unwarranted variation around experience (patient and professional). It is expected that the solutions that are being implemented in East Kent will be extended to the rest of the county

East Kent was awarded accelerator funding due to two specific challenges:

- GP to patient ratio** – East Kent has some of the lowest GP to patient ratios in England, currently **1:2520** in Thanet. The NHS mean is **1:1724**.

Significantly higher ageing and associated acuity in the Thanet locality, which places additional unscheduled demand pressure on the unscheduled care pathway, particularly around care homes.

Phase 1: Funding will develop and test new ways of working enabled by Digital First solutions. Margate Primary Care Network (PCN) (4 GP Practices / 17 Care Homes) and Hythe (8 GP Practices) will be our original test of change sites. East Kent will adopt a Quality Improvement Making Data Happen approach and focus on three areas of the unscheduled care pathway

- Patient access (on the day primary care demand)** - Ensuring patients flow down the right channels via the NHS App (where possible) to the appropriate whole system professional in a safe and timely manner

- Digitally enabling Care Homes** – Ensure a more proactive approach with rapid response by appropriate professionals delivered in a more effective manner, reducing GP visits enabling GPs to have more capacity for continuity of care around complex patients. This will also ensure the right step up in care – when required.

- UEC/111 interoperability** – The ability to ensure that professionals can have safe and timely access to almost real time information to make the right pathway decisions. The ability to directly book patients to the appropriate professional e.g. GP practice or Urgent Treatment Centre We will build on learning from our online consultation partner e Consult around efficient delivery of ‘on the day’ GP services, a PCN hub based approach to maximise on efficient and effective use of GP time. The aim being that GPs focus on the patients that need their expertise – between **20-30%** of daily demand. The other **70%** channel shifting to administration support, social prescribing, practice pharmacists and nursing staff. This will also impact positively on Emergency Department walk-ups.

Our core aim is to:

Enable the East Kent Unscheduled Care system to use their time more effectively to reduce unwarranted variation in health outcome and patient, carer and workforce experience.

A core requirement is to blueprint our approach and spread it in a prioritised manner – based on findings from our QI Making Data Happen platform for example conveyance (over 75s) rate per 1000 GP practice patients or demand and capacity work using operational data to both baseline the current position and measure improvement.

We fully understand that this system transformation requires appropriate levels of business change management and programme management. This is not about product – it’s about digitally enabling new models of care that can spread and sustain on a local and national basis.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Avoiding unnecessary visits to hospital by channel shifting

There are a number of pilot solutions in place across Kent & Medway to utilise video conferencing solutions to provide virtual consultations, including the Attend Anywhere project at Maidstone & Tunbridge Wells.

It is our ambition to extend these pilots across the whole of Kent and Medway leading to the provision of up to 30% of follow-up outpatient appointments virtually by the end of the long term plan period.

- Use of online advice and guidance services to provide specialist clinical advice to generalists
- The use of remote monitoring telehealth devices to support safe, early discharge
- Supporting self-care by the provision of online information to patients, removing the need for unnecessary follow-up appointments

Unlocking the future of digital mental health care

The future of Mental Health provision will benefit from digital technology and solutions in a number of areas, these include:

- The adoption of a population health intelligence approach to looking at the mental health and emotional well-being of our population
- The provision of online services to support direct access to a range of IAPT services
- Making crisis care plans available to care professionals that need them across the urgent care pathway
- Supporting the “no wrong door” aspiration through the provision of a shared care record (KMCR) Patient access to their records, including their care plan, is expected to become available in year two of this development and will facilitate the provision of data by patients from wearables, home hospital devices, and Internet of Things (IoT) devices.
- Provision of online advice and guidance between care professionals
- The use of video-conferencing as an option for consulting with patients
- We have identified a range of artificial intelligence applications covering patient engagement, administration support, alert management, coding and classification, predictive forecasting, record summarisation, and information governance. There is much work still to do on this agenda but already we can see opportunities and benefits across the board from patient safety, through quality improvement, clinical outcomes, productivity, satisfaction, and sustainability.

Strategic Objective 4) – Transformation of workforce and our infrastructure

Developing a digital transformation continued

Supporting digital maternity

Better Births Maternity Review set out a digitally enabled future for the provision of maternity services and it is our ambition to meet this aspiration by providing every woman with access to her personal health record to support her through her pregnancy. We anticipate that this will be delivered through the citizen access component of the Kent and Medway Care record and will be accessed through the NHS App utilising NHS Login.

We will further support this by the provision of apps to provide targeted and relevant information to women throughout their pregnancy.

Through the Local Maternity System (LMS) maternity services will be well represented within web resources for Kent & Medway, providing a single point of access and directory of services for women and families accessing maternity and neonatal services. The first iteration of this website is planned to go live in April 2020, and development of the resource to meet the needs of a modern maternity service will be ongoing, with innovation, development and maintenance being handed over as business as usual by March 2021.

East Kent Hospitals University Foundation Trust have an advancing digital maternity transformation programme underway, with colleagues from maternity, IT and business intelligence working well together to deliver benefits for the service. Kent & Medway LMS will support the spreading of this best practice across the footprint. The MOMA app being developed in East Kent will be developed and adopted across Kent & Medway in line with the Better Births vision for women to have a digital tool for maternity. This work also forms part of the personalisation and choice mainstream as the app becomes a digital Personal Health and Support Plan for the maternity journey. It will enable clinicians to tailor care to each woman based on what is important for her.

Community Services

- Supporting the wider partnership arrangements for the delivery of health and social care services to patients, we will develop digital solutions in the following areas:
 - Preventing ill health:
 - Signposting patients to information via smartphone apps and other digital resources
 - Supporting patients with self management of long-term conditions through wearable technology, online support services and tailored apps
 - Integrating services:
 - Sharing patient data and information across the care management team through the KMCR and supporting technologies
 - Providing online support, guidance and training for clinicians on condition specific issues
 - Delivering high quality care at home and in the community:
 - Providing teams with live, interactive resourcing tools that will allow teams to respond to real-time patient demands
 - Supporting teams to undertake remote consultations and liaison with patients and carers
 - Developing sustainable services:
 - Provide digitally enabled services to remove duplication, speed patient access to services and reduce complexity
 - Supporting digital access for clinicians and patients to clinical information and service access points

Strategic Objective 4) – Transformation of our workforce and infrastructure

Our estates strategy

The Kent & Medway STP (K&M STP) fully acknowledge the importance of having the right estate to deliver its clinical aspirations and intentions. This includes ensuring the estate is future proofed to meet the demands of the large housing growth which will occur over the next 10 years within Kent and Medway resulting in an additional c. 400,000 or c.23% increase in population by 2031 according to Kent & Medway Growth & Infrastructure Plan 2018.

This population growth, combined with the aging population within Kent and Medway will have a significant impact on the demand for services, the location the services are required to be delivered from and how the services are delivered. In response to this, the system submitted a forward thinking Estates Strategy in July 2019 to NHS I focusing on how the estate will be an enabler to the K&M STP objectives, how the accessibility of the estate will improve to the benefit of the patient and how we will ensure that the estate is fit for purpose and future proofed. Following a review and roundtable discussion with NHS I, the Estates Strategy for Kent and Medway has now been rated as 'Good'.

The Strategy focuses on the transformation of how the estate is viewed and used – to shift perspective from individually owned properties to a shared, co-located estate which can be used by all organisations within the STP. This alignment of the estate will focus primarily on opportunities that will benefit the patient, by making the services more accessible and in fit-for purpose facilities. Through shared costs and improved utilisation of the estate – paying particular adherence to the Carter Metrics and ERIC/model hospital data - it is hoped that revenue saved can be re-invested either into the estate to improve its condition and capacity and/or patient services.

Within the Primary/Local estate, the system will undertake locality reviews to seek to utilise the existing estate to its full potential – by reducing void spaces and increasing shared desk spaces, open to all organisations, including the Local Authorities. Through working with the digital workstreams and the Kent and Medway Care Record, we will seek to improve connectivity within all buildings regardless of organisation – to allow more time spent on work productivity and less time on travelling to siloed office locations.

We will also be working closely with the new ICP's in their development of Primary Care Networks, and with the Acute Trusts as clinical service requirements and locations are agreed for out of hospital services to best serve patient needs. An example of which may be Cancer or Integrated Urgent Care Services, as the locations to deliver these will impact on the development of the PCN's, the size of the estate necessary and any requirements on the accessibility of the estate. Emphasis will be on utilising the existing estate in the most efficient way to reduce void costs, with shared clinical service space throughout the day wherever possible to reduce the amount of void space/redundant rooms when a service is not running.

As demonstrated in the Estates Checkpoint Submission contained within the appendices, the K&M STP have a robust disposals pipeline working towards the £85.4m Naylor Fair Share target that was allocated. Currently, organisations within K&M have delivered £51m of receipts, with an additional £28m of properties on our disposals pipeline to be delivered within the Naylor timescales. Through the locality reviews that are being undertaken, it is expected that currently unknown disposal opportunities will arise from a reduction in void spaces/improved utilisation within the current estate – which will enable other properties to be sold.

Strategic Objective 4) – Transformation of our workforce and infrastructure

Our estates strategy continued

Although the existing estate will be used whenever possible, there will also be instances where a new build is required, or significant capital required to tackle backlog maintenance issues to ensure continuity of services. Therefore, we will continue to work on developing its capital projects pipeline and prioritisation of projects for different funding amounts. By regularly updating and understanding the priority of each project, resources and internal assurance can be given to business cases to be developed in line with strategic need or greatest impact. This will ensure that they are available or close to completion for future capital bidding rounds as they become available, and that the capital expenditure is efficiently targeted to projects with the best return to the system.

A high level summary of our mid/long term capital investment requirement broken down per STP clinical initiative shows investment of:

- Stroke Services Reconfiguration - £27.7m
- East Kent Acute Redesign - Option 1 = £351m, Option 2 = £363m Acute bids - £224m (excluding the EK Redesign)
- Local Care including primary care
- £211m Mental Health - £31m

Without this integrated health system approach and without additional capital investment, there is a risk that the current estate may not able to meet the patient needs now and also in the future, which will have an impact on the patients health and wellbeing. It is imperative that the K&M Estate has sufficient pro-active investment to the housing and population growth, so it has the resilience to provide the additional clinical services that will be required, as well as appropriate environments for staff to deliver services from before and during the housing growth, not after.

Section Seven

Strategic objective 5) A new Integrated Care System delivery model

Strategic objective 5) A new Integrated Care System delivery model

An Integrated Care System for Kent and Medway

To achieve ‘Quality of Life, Quality of Care’ we know that we need to organise our system differently to remove duplication and enable collaboration and integration. We are creating an Integrated Care System to support the delivery of joined up and personalised care, to drive consistency of services, and to address unwarranted variation.

- **Primary care networks (PCNs):** GP practices working as networks, as outlined in the NHS Long Term Plan and enabled through the new GP contract. PCNs will enable delivery of primary care at scale, with an extended primary care team. We will have 42 Primary Care Networks in K&M, all of which have a Clinical Director who is responsible for leading the PCN’s development.
- **Four integrated care partnerships (ICPs):** Partnerships of NHS providers and other key partners working together to deliver joined up care by collaborating within their local geography. They will determine and secure the delivery of care through integrated working, operating across populations of around 250,000 to 700,000. Our four ICPs are:
 - East Kent Integrated Care Partnership
 - Dartford, Gravesham and Swansley Integrated Care Partnership
 - Medway and Swale Integrated Care Partnership
 - West Kent Integrated Care Partnership
- **One Single System Commissioner:** The establishment of a single K&M CCG covering our population of circa 1.8 million. A single CCG would not simply be a coming together of the current CCGs with the same responsibilities but would set strategic direction, establish the financial framework for the system and have an assurance function. Its focus would be on population needs as outlined in the table below.

This signals significant transformation of health and social care commissioning and provision to drive collaboration and integration. The development of strong relationships and partnerships across providers in different settings and sectors form a critical part of the success of delivering this change. The ability to work as a whole system, both commissioning and provision, will strategically strengthen the planning of services in response to population needs and expected outcomes, as well as the management of resources and its deployment. It is anticipated that the ability to work as a system will also offer opportunities to preside over key activities such as financial arrangements and incentives, in line with single control totals.

Benefits for patients arising from Primary Care Networks:

- Extended access to primary care at different practices/facilities outside of traditional opening hours and with more care, advice and support offered outside of the GP’s consulting room
- Patients discover a new confidence in primary care teams – recognising that sometimes the most effective help and support is found outside of the consulting room and with a pharmacist, social prescriber, nurse or mental health professional
- You’ll only need to tell your story once – shared records will mean that patients no longer have to tell their story to multiple individuals or teams
- Prevention and early intervention are key drivers to help people stay well, prevent avoidable illness, and to make the right decisions for their health and wellbeing
- Joined-up care for those with complex conditions, treating the whole person and what’s important to them will be the cornerstone of care
- By creating bigger, more integrated teams allows professionals to work under the primary care ‘umbrella’, rather than in isolation, offering more holistic and personalised care. With other highly qualified health professionals able to focus on care and support to patients, GPs will have more time to deal with the complex cases that need their attention and focus on bringing their medical knowledge and expertise where it is most needed.

Strategic objective 5) A new Integrated Care System delivery model

Benefits of creating Integrated Care Partnerships

- ICPs will work together rather than in competition with each other to deliver local care. We expect their role will include:
 - Focusing on the specific health needs and challenges of their local population and developing and delivering services that improve the health and wellbeing of local people
 - Driving integration by breaking down barriers between organisations, enabling more joined-up working, less duplication and a more seamless experience for patients
 - Assuring and overseeing the quality of care and services that local people receive, reporting on performance and ensuring that the highest quality standards are adhered to
 - Local clinicians and teams at the forefront of designing and delivering patient pathways that deliver the highest quality care and best patient outcomes with the support of local people
 - Making best use of available budget and managing contracts with local providers to ensure that care and support represents true integration and value for money.

To achieve ICS status by April 2021, we need to deliver the following:

Key actions for remainder of 19/20

- Develop ICS system model and governance structure for transition including the agreement of ICS system functions and interim operating model
- Confirm future ICS leadership arrangements that includes the appointment of the permanent Accountable Officer and senior management team for single CCG, building upon current joint working arrangements
- Confirm future functions and roles across ICPs, CCG and ICS responsibilities.
- Appoint Independent Chair for ICS and CCG Clinical Chair
- Develop the Medium Term Financial strategy across K&M system (links to merger application)
- Approval of the K&M Analytics Strategy

Actions for 20/21

Merger of 8 CCGs into single CCG by April 2020

- Further development of future financial allocations
- Develop a long term strategic approach to embedding prevention in all policy, commissioning and delivery of services
- An agreed Population Health Management Strategy outlining our PHM arrangements at each levels of the system, including the infrastructure, intelligence and intervention capabilities

The table overleaf shows our K&M position against the key national components of an integrated Care System.

Benefits of creating a Kent and Medway CCG

- The Kent and Medway CCG would focus on health needs of the whole population and would set out what integrated care partnerships need to do to meet them
- The CCG could also commission some specialist services for the whole of Kent and Medway, for example, cancer care and children's services
- The CCG would set the standard of what we want to see for everyone in Kent and Medway, how funding flows and hold the whole system to account

Key requirements for an ICS from the LTP implementation framework	Kent and Medway current position
<p>A partnership board, representing commissioners, trusts, primary care networks, and – with the clear expectation that they will wish to participate - local authorities, voluntary and community sector and other partners</p>	<ul style="list-style-type: none"> Recently undergone a major STP/ICS Partnership Board governance refresh, resulting in the streamlining of our governance ensuring alignment to clinical forums and Health and Wellbeing Boards System Transformation Executive Board will oversee the delivery of the system commissioner, ICPs and PCNs across Kent and Medway and has broad representation from across the sectors Developed, and have in place, joint working relationships with both of our upper tier Local Authorities and we are continuing to develop our ways of working with the voluntary sector
<p>A non-executive chair (locally appointed, but subject to approval by NHS England and NHS Improvement) and arrangements for involving non-executive members of boards/ governing bodies</p>	<ul style="list-style-type: none"> A NEDs Oversight Group that sits alongside the STP/ICS Partnership Board and successfully received funding from NHS Confederation to be a pilot site for effective NED / Lay member engagement A System Commissioner Governance Oversight Group made up of CCG Lay members to oversee the development of a single CCG. The STP currently has an interim chair and we will recruit a permanent independent chair for the ICS
<p>Sufficient clinical and management capacity drawn from across their constituent organisations to enable them to implement agreed system-wide changes</p>	<ul style="list-style-type: none"> A clear system transformation infrastructure in place with good clinical leadership and close working with Local Govt A single Accountable Officer structure across the 8 CCGs with direct reports holding portfolios with shared responsibility Shared leadership by way of a senior management team across the 8 CCGs to enable joint working Dedicated PMO capacity within the STP working on large scale change programmes across the system We will be appointing a Kent and Medway Chief Nursing Officer and Chief Financial Officer
<p>Full engagement with primary care, including through a named accountable Clinical Director of each primary care network</p>	<ul style="list-style-type: none"> Developed primary care strategy that is owned by primary care professionals, including our PCN Clinical Directors. We have worked directly with the Clinical Directors through surveys, workshops and 1:1s to understand what support they want and need to develop their roles within ICPs and the ICS, as well as to develop their own PCN. This directly contributed to how we allocated our PCN development funding and to the design of our support offer, which is centrally coordinated but delivered within ICP footprints Appointed a Senior Primary Care Advisor to sit on our System Transformation Executive Board to support the design and development of PCN representation
<p>Clinical leadership aligned around ICSs to create clear accountability to the ICS. Cancer Alliances will be made coterminous with one or more ICS, ICSs and Health and Wellbeing Boards will also work closely together</p>	<ul style="list-style-type: none"> An established Clinical and Professional Board (CPB) has a specific mandate through its terms of reference to promote clinical and professional engagement and leadership in the delivery of STP programmes and the transition to an integrated care system Each of the four ICPs has established local clinical and professional boards to build on this model and lead the delivery of our clinical and professional vision. As we transition to an ICS we will use the CPB to support the development of these local arrangements as well as advising on the design of an ICS that remains as firmly clinically and professionally led as our STP has been since its inception. This will ensure that we continue to provide care model frameworks and support and challenge at system level, while enabling local programmes and pathways to be developed within ICPs Through the Kent and Medway Cancer alliance (which is already coterminous with our STP), we have a strong focus on improving cancer performance against national standards and preparing to meet new standards for faster diagnosis and diagnosis at stages 1 & 2

Strategic objective 5) A new Integrated Care System delivery model

The case for a K&M system commissioner through a single Clinical Commissioning Group

Our eight clinical commissioning groups (CCGs) have successfully applied to become a single commissioner with effect from 1 April 2020. This will enable the NHS in Kent and Medway to build on, and accelerate, joint working to address some of our key local challenges, unlocking short and long term benefits for the people who use our services and for our workforce.

A single clinical commissioning group will:

- Free up staff and GP time to improve care for local people
- Have less complex structures and a clearer framework for clinical decision making
- End duplication of committees, meetings and effort, saving time and money, not just for the clinical commissioning group, but also for the NHS trusts and other organisations that provide NHS services and partners, such as social care
- Enable faster decision making, meaning improvements to patient care can happen sooner
- Agree health outcomes for Kent and Medway, reducing unacceptable difference in health and life expectancy – these will be delivered by integrated care partnerships and will be tailored to their local populations
- Use detailed data to achieve a bird's eye view of the health of specific groups or communities, underpinning the development of health outcomes
- Reduce the number of buildings needed for staff in the longer term and IT running costs
- Improve staff recruitment and retention through a joined-up approach to workforce issues and opportunities
- Use its substantial buying power to increase value for money for the taxpayer
- Continue to involve local people in shaping health and care services
- Accelerate clinically-led innovation

The GPs who chair the current CCGs led the drive to create a single CCG, after rigorously assessing all the possible options for a system commissioner. They undertook extensive engagement including with the GPs who make up our current CCGs, staff, patients, the public, health and social care partners, local authorities and MPs.

A recurring theme has been concern about the potential loss of local input into a single CCG. To address this concern, the following has been integral to the proposed design of a single CCG:

- The new CCG will always be GP-led, with a GP governing body majority including a GP from each current CCG until at least April 2022 and clinical representation or leadership as appropriate on all committees
- A full and robust development programme for primary care networks enabling effective leadership within the emerging integrated care system
- Strong local patient and public representation running from the CCG governing body to individual primary care networks, linking all patient and public involvement forums, and creating a citizens' panel and an insight bank, to significantly strengthen the use of patient experience and insight across the system
- GP members and governing bodies of the existing eight CCGs all approved the merger. NHSE/I approved the merger application in October 2019
- We have also developed a 'One Team' model which sets out how health and social care will work together in a more joined-up way, drawing expertise together from across organisations to address the key challenges, and improve quality of life and quality of care for patients

Strategic objective 5) A new Integrated Care System delivery model

ICS Organisational Development

We have been working as a system to develop our organisational development (OD) approach through our System Leadership and OD group. We have developed a set of OD activities to support PCNs and to enable our CCG teams to transition to a single system commissioner. We are scoping the OD needs of our ICPs. An OD strategy that brings these elements together to support Kent and Medway to transition to an ICS is to be developed, building on current and future system OD needs, activities and actions. This will support us as a system to have an agreed set of system priorities, a common language, development of our system leaders to lead this change and a shared OD methodology to transform our system. As the new system will be evolving over the next five years, with different parts developing at different rates, this strategy itself is emergent and will adapt and change as new elements of the system develop and mature.

Immediate priorities are focused on the development of the ICS OD strategy, transition plan for the system commissioner, and the clinical leadership and development offer for the PCNs.

- Development of the ICS OD strategy
- Undertaking development of our senior leaders with the objective of co-producing a vision, values, behaviours and strategic direction and prioritising strategic activities for the ICS
- Implement the senior leadership structure that is aligned to the delivery of the vision of the ICS including appointment to the permanent AO/system leader
- Developing cohorts of leaders (including clinical leaders) in system working, building on the Leading across Kent and Medway pilot
- Implement the Workforce and OD plan for the CCG
- Rollout of the PCN development offer including clinical leadership development, rollout of the OD toolkit to support team collaboration
- Scoping of OD needs with ICPs
- Develop new models of care that work effortlessly across boundaries

ICS Operating Model

As the Integrated Care System develops, there will be a number of functions that we will need to operate at a system level. These functions will include:

- **System Planning:** This year has seen the development of a System Operating Plan for 19/20 and the creation of this five year Strategy Delivery Plan 19/20 to 23/24. There is further work to do on our long term outcomes and benefits, linked with future operational planning at all levels of the ICS
- **System Resilience:** In 18/19, Kent and Medway were asked to provide some support to winter planning at a system level; this was expanded to also lead on EU Exit planning for the system. We have established a team at a Kent and Medway level to lead on system resilience and planning
- **Assurance and delivery:** With the changes at NHSE/I, and the expectation that ICSS will take more of a responsibility for assurance, STPs/ICSS will be invited to join the regulators' system assurance meetings and Intensive Support work with ICPs in 19/20
- **Quality:** The NHSE/I feedback on the SOP noted the lack of a Quality strategy at a Kent and Medway level. We have set out in Chapter 4a) Our approach to quality how this is being addressed

NHSE/I will be rolling out a “one team” approach with STPs/ICSS on delivering national programmes in 19/20. In some areas, the STP has pre-existing programmes and already works with NHSE/I, but STPs/ICSS will take on more responsibility for overseeing national programmes across systems. This will include Primary Care, Cancer, Mental Health, Continuing Healthcare, Maternity, Learning Disabilities and Autism, Digital, Diabetes, Variations and New Pathways, Urgent and Emergency Care, Elective.

In Kent and Medway, we have developed an interim operating model which describes the integrated working arrangements across the emergent ICS and outlines the key relationships between commissioners, healthcare providers (including PCNs) and local authorities - the key partner organisations within the new system. It reflects the need to focus on the system and sub-systems rather than the individual organisations, drawing expertise together from across organisations in order to address the key challenges, and realise opportunities for patient through integration of care delivery.

Strategic objective 5) A new Integrated Care System delivery model

Specialised commissioning

As we move to become an Integrated Care System, we will continue to work with NHSE/I to plan and deliver specialised services as locally as possible and to join up care pathways from primary care through to specialised services with the overall goal of improving patient outcomes and experience. We will work with NHSE/I to understand the national parameters within which ICS can take on more responsibility and the associated resource implications.

We will support NHSE/I to repatriate services that are currently being provided outside of the South East where it is in the best interests of patients and supports sustainability of South East providers. This will be in support of the drive to move care closer to home.

We will work with NHSE/I on the implementation of Long Term Plan commitments as outlined elsewhere in this plan:

- Improving bowel, breast and cervical screening uptake
- Implementing the HPV vaccination programme for boys
- Roll out of FIT 120
- Roll out of HPV Primary Screen in the cervical screening programme
- Taking forward the findings of Sir Mike Richards review into Cancer screening
- Designing screening and vaccination programmes to support a reduction in health inequalities
- Improvements in child immunisation levels
- Implementation of the digital child health record ‘e-book’

Specific areas for Kent and Medway include:

- *Mechanical Thrombectomy* – the geography of Kent makes it important to have a mechanical thrombectomy centre in Kent to ensure equitable access. Currently it is envisaged that it will be at William Harvey site based on analysis conducted by NHSE/I. It is important looking ahead that there is a joined up approach to planning all vascular intervention which would include thrombectomy for stroke and vascular services
- *Kent and Medway Vascular Network* – continuing to drive the establishment of a vascular network across Kent and Medway to secure the long-term provision of vascular services and support equity of access for all patients in Kent and Medway (as outlined earlier in this plan on page 41)
- *Clinical Frailty* – East Kent have successfully achieved a place in the National Clinical Frailty Pilot for Vascular services. The improvement work developed at this site will be used as an exemplar for other specialised service teams to improve their services for people with frailty, as well as shaping national policy
- *Cardiology* – We will work closely with specialised commissioning colleagues to establish an appropriate network to improve the outcomes and experience of people accessing these services and ensure fast access to life-saving stroke treatments
- *Enhanced Supportive Care* - Promote the expansion of Enhanced Supportive Care, and take a leadership role in sharing learning, to enable patient choice and informed decision-making. Specialised Commissioning have pump-primed investment in Maidstone and Tunbridge Wells NHS Trust to achieve this.
- ⋮

Strategic objective 5) A new Integrated Care System delivery model

Innovation

As we move to become an ICS, we will need to consider where leadership and capability for research and innovation should sit, with a need to consider innovation alongside our approach to quality improvement and digital given the close interactions between these areas.

In order to spread innovation faster and wider, Kent and Medway STP supported the establishment of the Innovation Collaborative. The collaborative consists of the Kent Sussex and Surrey AHSN, and the Design and Learning Centre who have a remit to accelerate the uptake of health and social care innovations in Kent and Medway. The Design and Learning Centre was initially developed as part of the NHS Integrated Care Pioneer Programme which aimed to explore new and innovative ways of delivering health and social care in an integrated way. The Innovation Collaborative seeks to identify, select and support the adoption of innovations that improve clinical outcomes, deliver better patient experiences, drive down the costs of care and stimulate wealth creation locally and regionally.

In line with the ambitions of the Long Term Plan, the Kent and Medway STP Clinical and Professional Board (C&PB) set a challenge for the collaborative to find new and innovative ways to support people with a number of conditions including asthma, cardiovascular disease, chronic obstructive pulmonary disease and diabetes. The group will report back to the Clinical and Professional Board during Q4 of 2019/20.

- Key deliverables for the Innovation Collaborative in 19/20 are:
- Organising user / citizen innovation sessions to support programmes such as Local Care and Digital
 - Evaluation and Research Network supporting the Clinical & Professional Board including the link with ARC and the Health Analytics Board
 - ESTHER training and briefing sessions for Dartford Gravesham and Swale and Swale
 - ESTHER and Buurtzorg: EU management and implementation of the new models of care
 - Care Sector Workforce : facilitating conferences and engagement
 - Medication Innovation programme : digital MAR sheets and joint pharmacy programme
 - International and national funding applications including for the Innovation Lab, Workforce Academy, Digital innovation supporting health and social care
- Future arrangements for innovation will be considered as part of the wider ICS operating model design

Strategic objective 5) A new Integrated Care System delivery model

The role of the voluntary sector and volunteers

In Kent and Medway, we are committed to working closely with the voluntary sector, recognising the invaluable and under exploited role of the voluntary sector to support new models of care.

Social isolation has a major impact on both physical and mental health and as a system we are committed to working with our communities, with the voluntary sector, volunteers and local businesses to continue to find new and innovative ways to tackle loneliness and isolation. We also recognise that there is a significant role for business, community, voluntary sector organisations and volunteers to support prevention. As we embed prevention across all of our pathway, we will actively consider new and expanded ways of working with these organisations and individuals.

As part of the Kent and Medway STP, the local care model for older people and adults with long term conditions has been developed. Through this new model, new roles for care navigators, case managers and peer supporters are being developed. Peer supporters will usually be volunteers, with similar conditions or challenges to give the patient the support they need. They might also act as mediators. Some of our volunteers already provide a sign-posting role by staffing information desks, but the new local care model provides opportunities for the role of peer supporters to be further developed and recruited.

Through the Home First scheme, the NHS and social care in Kent is working more closely together to get more people home from hospital safely and sooner. Part of this involves commissioning and partnering with organisations, such as Age UK, to provide a meet and greet service for patients returning home from hospital. We will explore opportunities for volunteers to form part of a befriending scheme to help tackle social isolation among patients who are returning home from hospital and support sign-posting as part of the multidisciplinary team.

Befriending services are in place across much of our geography, mainly for isolated older people, delivered by local organisations including Age UK, carers' organisations, volunteer bureaux and community groups. Most are specific to a geographical location such as isolated rural areas or to a specific client group, for example phone befriending for carers, or visits to people with dementia. Arrangements for funding of befriending services by KCC are moving from grants to contracts and as a result, a number of befriending services are forming a Kent-wide consortium to tender for this work. We will explore way of working with any future consortium to help build befriending into our care pathways. We will support promotion of the befriending scheme to increase referrals from our staff.

We will utilise local business and community networks to promote volunteer recruitment and create corporate fundraising and volunteering opportunities for local businesses. A good example of where this has already worked well is where Maidstone Lions supported Kent Community Health Foundation Trust's charity 'i care' to launch a sensory room in Maidstone

Volunteers make a unique and valuable contribution to patients, carers, visitors and staff. As well as having a positive impact on healthcare services and the volunteer, volunteering is widely recognised as a powerful tool for promoting healthy communities. Volunteers are an essential resource in helping us achieve our vision,

In Kent and Medway we recognise that volunteering can help to:

- Improve quality of life: The Royal Voluntary Service, in May 2012, found volunteering in later life decreased depression and social isolation and boosted quality of life.
- Improve an individual's ability to cope with ill health: Volunteering can help people come to terms with their illness and provide a form of distraction to one's own problems

Strategic objective 5) A new Integrated Care System delivery model

- Lead a healthier life: Smokers who volunteer in stop-smoking services, often give up and students who binge-drink, drink less when volunteering.
- Improve mental health: Volunteering helps people to improve self-esteem and gives a sense of purpose. This can be vital for people who might be isolated.

Across Kent and Medway, provider Trusts utilise the valuable service of volunteers in over 37 different types of roles many of which are patient focused including volunteers who assist with mealtimes, ward exercise rehabilitation, ward trolley rounds, reception and admin support, hospital shops, and governors. Additionally, we have a vibrant network of volunteers in primary care carrying out activities such as volunteer driving.

We are developing and innovative and integrated youth volunteering offer in partnership with Pears Foundation and NHS/E during 20/21 and 21/22 that increases the number of young people aged 16-25 actively participating in volunteering within the sector and widens the breadth of volunteering opportunities available to young people, building a cross sector network that works together to embed this work within the wider health and care volunteering and career development system. We are also working in partnership with the Princes to Trust to support Young People aged 16-30 yrs old into health and care careers and planning to expand these type of employability model with other voluntary sector organisations to widen participation and diversify our workforce.

As we become an Integrated Care System, there is an opportunity to look at ways of engaging and partnering with business, community, and voluntary sector organisations as a system, to support and augment the work that is happening with individual organisations and at a local level.

Section Eight

Monitoring delivery of this plan

Monitoring delivery of this plan

Governance

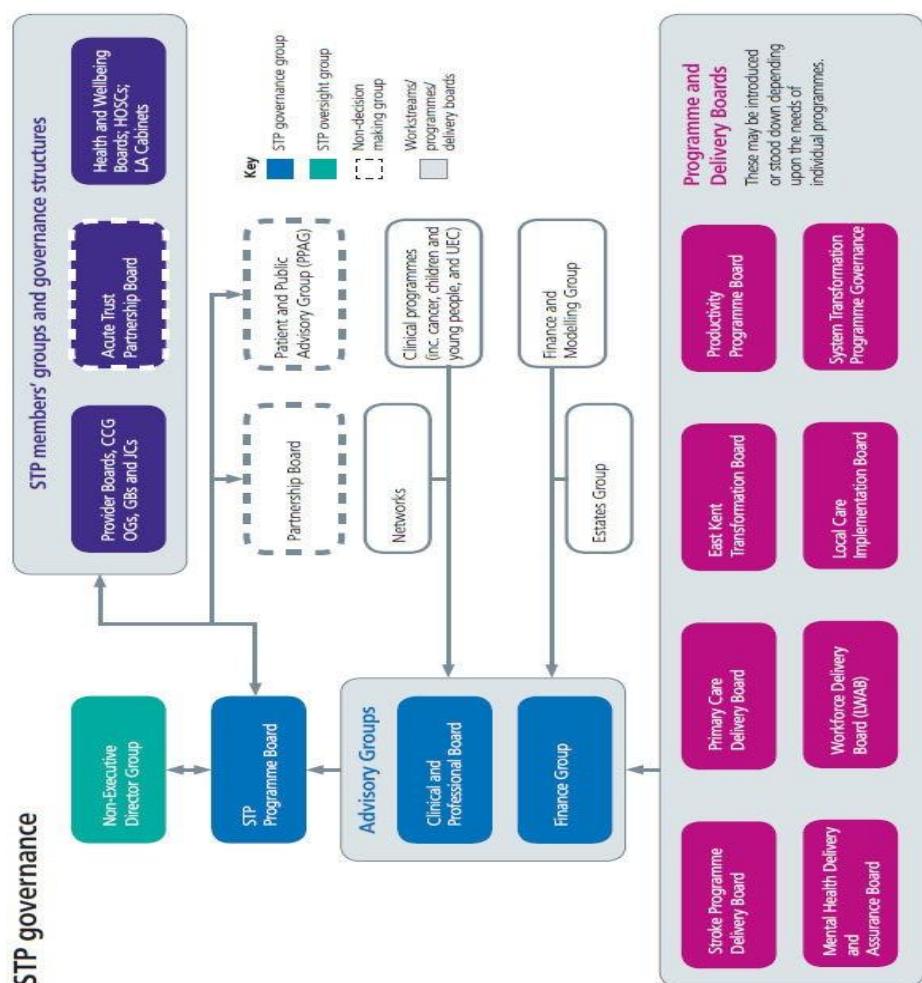
Our Kent and Medway Sustainability & Transformation Partnership (STP) has established system governance to support delivery of our STP Programmes and provide the foundation for delivery of the Strategy Delivery Plan (see governance structure right). In 2018, the STP refreshed the system governance with individual Programme Boards set up to support delivery, and a Non-Executive Director Group established with membership from NHS commissioners and providers as well as the Local Authorities to support oversight and connection to statutory organisations and their Boards and Committees.

However, as we move to become an Integrated Care System, we will need to transition to a new set of ICS governance arrangements, ascertaining what is required at the system level and what will need to operate at the level of the Integrated Care Partnerships.

In the immediate future, we will continue to utilise our existing STP governance, individual organisational governance, and ICP partnership boards. Our existing arrangements are already changing incrementally to support the move to an ICS, for example with the STP Programme Board evolving into an ICS Partnership Board.

Alongside the creation of new governance for a single CCG, a wider governance review will be instigated to look at the levels of accountability between the CCG and the ICPs including where accountabilities sit for quality governance and quality assurance (as outlined in section three of this plan on 'Our approach to Quality'). Additionally, a key focus of the new governance arrangements will be the importance of clinical leadership, GP representation and patient representation. It is likely that we will need to develop and evaluate a series of options for the future ICS arrangements.

Once new arrangements are agreed, we will ensure a smooth transition from the existing legacy STP arrangements to the ICS governance model.



Monitoring delivery of this plan

Supporting delivery

The established system governance and programme delivery is supported by a PMO team that has been set up as part of the STP team, and has been in place since 2017. The PMO team lead the management of the STP programmes with SROs and workstream leads and ensures an appropriate programme management approach is used. The PMO team also manage the system governance to support the focus on delivery and oversight. As we move to become an ICS, the emergent Integrated Care Partnerships will provide the infrastructure for partners to work together on delivery as well as the local governance to track progress with the delivery of plans.

Assurance

Kent and Medway's vision for an Integrated Care System will support delivery and ensure appropriate monitoring across the different levels of the system. NHSE/I are supporting this model with assurance focusing on the ICP level in 2019/20 with the STP invited to attend assurance discussions. The Single Oversight Framework for providers and the CCG Improvement and Assessment Framework are also being brought together to support the move to partnership working. To support further integration, NHSE/I are also inviting STP and ICS leaders to join their South East region Senior Leadership Team meetings every quarter. These are complemented by six-monthly meetings with each STP or ICS leadership team. NHSE/I are also establishing a "One Team" approach with STPs/ICSSs for national programmes that will provide a direct linkage between national and STP programmes and an operating model that supports a whole system approach.

Risk management

The STP has established a risk management approach that is led by programmes and tracked and monitored through the STP. Every STP workstream has a programme board that manages programme risk or escalates to our STP/ICS Partnership Board where required.

As part of our ICS development we are designing a new approach to monitoring system risks across Primary Care Networks, Integrated Care Partnerships and across K&M as a system. This will build on the STP risk management policy that has been signed off by all organisations for monitoring the STP programme. We will report on these risks in our 20/21 System Operating Plan and individual ICP and organisational plans.

Monitoring delivery of this plan

Future engagement on our plans

The STP has engaged with patients, public, and a range of partners and stakeholders to develop and deliver plans since 2016. Our approach was to build on the extensive engagement work already undertaken, which gives us a good understanding of local issues, attitudes, and concerns and has informed our work. To support the development of the Strategy Delivery Plan, listening events were held in each of the ICP areas, as well as targeted engagement with seldom heard groups.

The Kent and Medway STP's Patient and Public Advisory Group (PPAG) has been regularly involved in the development of engagement plans, as well as playing an important role in co-producing and critiquing the actual plans. PPAG members sit on existing STP workstreams representing the patient voice and feed into the co-design of the plans from those workstreams.

As the STP evolves into an ICS, and to support the delivery of plans, we have co-designed a new model of patient and public involvement to ensure that patients continue to have a voice at every level. This includes the creation of a new patient group, supplemented by patient, client and carer-led task and finish groups. These will be drawn together for time-limited focused pieces of work as the workstreams and overall programme of transformation require.

In addition, two new systems will be set up to support these groups. We will launch a virtual citizen's panel - a network of people representative of the Kent and Medway population to ensure a public perspective can be sought on all work programmes. Plus an insight bank to collate and link all the existing intelligence on patient experience gathered by NHS trusts, Healthwatch Kent and Healthwatch Medway, CCGs, ICPs and local authorities. Supplementary groups are also being established at ICP and PCN level to ensure patients have a voice at every level.

While not losing the range of groups and mechanisms we have to support our engagement, we will be using these new groups to facilitate and help monitor our progress. We will continue to share our progress against the ambitions we have set out with our audiences and seek their views on how effective we are being and where we can improve so that the voice of patients and the public remains at the heart of everything we do.

Monitoring delivery of this plan

Next steps

The Strategy Delivery Plan builds on the work of the STP as well as the System Operating Plan for 19/20 to provide a plan for the next five years for Kent and Medway. Following approval of Kent and Medway's Strategy Delivery Plan, we will ensure that this is comprehensively built into programmes with the appropriate governance in the system to monitor progress and support delivery. This will also be hardwired into the development plan for the Integrated Care System in Kent and Medway. Detailed actions for the coming year will be set out in the System Operating Plan for 2021, which will provide further granularity on plans in the next financial year.

The development of Kent and Medway's plans do not stop with our Strategy Delivery Plan. Significant pieces of strategy and plans in development include a shared children's plan, a system wide analytics strategy, a refreshed Digital strategy and an End of Life Care strategy and implementation plan. Additionally, we know that the creation of a single CCG and the development of our Integrated Care Partnerships, including our Primary Care Networks, creates an opportunity to refresh our system vision.

We intend to launch a new ICS vision in spring/summer 2020 that will build on all of the work to date but will look further ahead to the next five to ten years. Our strategic objectives and priorities will be further refined as we develop a Kent and Medway Population Health Outcomes Framework. Additionally, we will develop a commissioning strategy for the new single Kent and Medway CCG. In light of all this, we aim to develop a Strategy Delivery Plan refresh in late 2020. This refresh will take account of any additional targeted funding awarded to K&M to support the implementation of the Long Term Plan.

Annex 1 – STP partners

DRAFT WORK IN PROGRESS

Members of STP Programme Board

1. Ashford CCG
2. Canterbury and Coastal CCG
3. Dartford and Gravesham NHS Trust
4. Dartford, Gravesham and Swanley CCG
5. East Kent Hospitals University NHS Foundation Trust
6. Kent and Medway NHS and Social Care Partnership Trust
7. Kent Community Health NHS Foundation Trust
8. Kent County Council
9. Maidstone and Tunbridge Wells NHS Trust
10. Medway CCG
11. Medway Community Healthcare CIC
12. Medway Council
13. Medway NHS Foundation Trust
14. South East Coast Ambulance Service NHS Foundation Trust
15. South Kent Coast CCG
16. Swale CCG
17. Thanet CCG
18. West Kent CCG
19. Healthwatch Kent and Medway

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	2.6
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	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary

The paper summarises the Audit and Risk Committee meeting held on 11 December 2020.

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.

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

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

This report is founded on the Audit and Risk Committee (ARAC) meeting held on 11 December 2019.

Area	Assurance	Items for the Board's consideration and/or next steps
Risk Management	Board Assurance Framework (BAF) - positive assurance.	The new sub-committee scrutiny is working well. The ARAC to review the relative scoring of the highest net risks given all six of them are 12H.
Third Party Assurances	Internal Audit - Three reports (reasonable assurance) covering Community Information System (CIS) Replacement, Procurement and Health and Social Care Network Project.	A few items to follow through. There is nothing of note for the Board's attention.
	Counter Fraud - positive assurance.	As above
	External Audit - no activity at this stage in the annual cycle.	Regulator and market audit pressures increasing provider costs so Grant Thornton is reviewing its fee levels.
Governance	Corporate Assurance and Risk Management (CARM) Group update - positive assurance.	Increased qualitative assessment of risks requested (e.g. 10 risks overdue out of 222 open....trends, insights, hot-spots??).
Financial Controls	Single Tender Waivers, Retrospective Requisitions, Losses, Special Payments and Write Offs - positive assurance.	Dentistry write-offs not reducing as expected. Recommended that the Director of Dental Services undertake a quick and proportionate review with a

Area	Assurance	Items for the Board's consideration and/or next steps
Financial Controls (continued)		goal of establishing a write off baseline; benchmarking these and then including as cost of provision when negotiating with commissioners. A reporting limit could be introduced to reduce administration.
Focus Items	Cyber Security - positive assurance (amber-green overall rating).	<p>Good progress is being made and the Trust is on target to meet the new Data Protection Toolkit standards and Cyber Essentials Plus by May 2020.</p> <p>Positive assurance on latest phishing test (only four staff clicked on the link) showing significant improvement from levels previously reported.</p> <p>Annual Data Quality Review - positive assurance. Annual Property Risks Review_- positive assurance.</p>

Peter Conway
Chair, Audit and Risk Committee
December 2019



Committee / Meeting Title:	Board Meeting - Part 1 (Public)			
Date of Meeting:	06 February 2020			
Agenda Number:	2.7			
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	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary

The paper summarises the Charitable Funds Committee meeting held on 17 January 2020.

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.

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

CHARITABLE FUNDS COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Charitable Funds Committee meeting held on Friday 17 January 2020.

Agenda item	Assurance and Key points to note	Further actions and follow up
Introduction by Chair	Ms Barber, acting Chair, welcomed everyone present to the meeting of the Charitable Funds Committee meeting, until Ms Tippin joined the meeting via Skype.	
Apologies for Absence	There were no apologies.	
Declarations of Interest	There were no Declarations of Interest in addition to those formally noted on the record.	
Minutes and Matters Arising from the Meeting of 29 November 2019	Minutes were agreed, subject to one amendment. Matters arising were agreed and proposed closure confirmed.	
Charitable Funds Report and Accounts 2018/19	The Committee approved the Annual Report and Accounts.	
Charitable Funds Marketing Report	The Committee discussed the marketing report and the confirmation of the name of the charity.	-
East Kent Charitable Funds Update - Heron Ward (Mermikides) Fund	The Committee discussed the report and agreed to go ahead with the tender.	

Agenda item	Assurance and Key points to note	Further actions and follow up
Terms of Reference Review	The Committee approved the Terms of Reference subject to one small amendment.	
Committee Effectiveness Review	The Committee agreed the Committee effectiveness questionnaire.	Committee Secretary to circulate the template to the Committee.
Forward Plan 2020/21	The Committee discussed the forward plan and agreed updates to be made.	
Any other items of business for discussion	The Committee thanked Ms Tippin for chairing the Committee and discussed the handover to Prof Drobniowski as the new Chair.	

**Jen Tippin
Chair, Charitable Funds Committee
17 January 2020**

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	2.8
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Pippa Barber, Chair of Quality Committee

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary
The paper summarises the Quality Committee meeting held on 21 January 2020.

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 <input checked="" type="checkbox"/>
High level position described and no decisions required.

Pippa Barber, Non-Executive Director	Tel: 01622 211906
	Email:

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report follows the Quality Committee meeting held on 21 January 2020 Part One.

Agenda item	Assurance and Key points to note	Further actions and follow up
Non-Executive Director (NED) Cost Improvement Programme (CIP) Deep Dive East Sussex School Health	<p>Following the visit by Bridget Skelton and Pippa Barber assurance was received on the service re design and wider model review that had as one of its outcomes enabled achievement of the CIP. The redesign was being carried out with commissioners. Some staff expressed concern on the level of engagement they were able to have on the redesign, and knowledge and skills needed for one element of the redesigned service model . This was still being addressed at the time of the visit.</p> <p>Assurance was received at the Committee meeting that further work had been undertaken with the team since the visit to work with the team on the changes and to take forward the recommendations of the visit</p>	<p>Recommendations from the visit will be followed up by the Operations and Quality teams and areas identified will be considered in the next We Care visit to the service.</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
Monthly Quality Report	<p>The report covered data for October and November.</p> <p>Pressure ulcers: Positive assurance on the two data point reductions on lapses in care and no Serious Incidents (SIs) declared in either months for pressure ulcers.</p> <p>Falls: The Committee noted the on-going work in this area and were assured on the actions being taken. However, it was noted that the Trust is marginally above the national benchmark data on the rate of falls per 1000 occupied bed days and considered further focus should continue to be undertaken.</p> <p>Infection control: Assurance was given and received on CAUTIs and UTI rates and MRSA screening. Although the number of CAUTIs and UTIs appeared to be increasing, rates per 100,000 occupied bed days have reduced by 14% for UTIs and 22% for CAUTIs compared to the same time last year.</p> <p>End Of Life Care care plans:</p>	<p>March Quality Committee will consider a deep dive progress report into the Trust wide Pressure Ulcer Action Plan.</p> <p>Actions are being reviewed and a more detailed paper will be considered at the May Quality Committee.</p> <p>These need to added to the Quality Report as agreed at the Board. Assurance was received this will be in place for the March meeting.</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
Progress on the 2019/20 Quality priorities in the Quality Account	<p>A quarter three update was received.</p> <p>An update was received on progress with priorities to date. Risks were identified for two:</p> <p>15 patient and service users to complete the Quality Improvement (QI) Fundamentals training. Currently it is expected six will achieve this by the end of March.</p> <p>Assurance was given that more patients/service users are being recruited to the Patient Experience Group so this may increase.</p> <p>It was recognised that more focused work is needed on this area and the wider area of carer and service involvement in the Trust. This is being taken forward by the new post holder Director of Quality, Improvement and Patient Experience.</p> <p>75% of in patients are able to report they were confident, empowered and supported to undertake their usual activities. Currently 68% against a target of 75%. The team was more confident this target could be achieved by year end with work being undertaken by heads of Quality and Matrons.</p>	<p>A further update will be provided at the March meeting.</p> <p>A further update will be proved at the March meeting.</p> <p>In addition an update was provided advising the goals as worded currently on personalised care plans are subject to a change in wording due to configuration of personalised plans of care templates on the new</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
Seasonal Infection Prevention and control report.	<p>Staff Flu Vaccination:</p> <p>An update was provided and assurance sought on levels and activities being undertaken. Currently reported at 57% Non-patient facing and 55% overall for the Trust.</p> <p>Assurance was received that the peer vaccination programme remains underway and the programme is a significant focus across the Trust. However, the Trust remains below other trusts in the system currently but we are ahead of our own target at the same time last year.</p>	<p>The need for additional peer vaccinators for next year's programme is being considered as part of the 2020/21 plan and further updates on this year's programme will be provided at the March meeting.</p>
Learning from Deaths Report including End of Life Issues	<p>The report was considered by the Committee. Assurance was sought on the progress being made on themes (appendix1) that are helpfully being identified through the review process. The areas were consistent with other reports, largely documentation. Assurance given included recruitment of an End of Life (EOL) Lead Consultant post and setting up a working group to develop End of Life consistent documentation across the Trust.</p>	<p>Further reviews and actions of the themes will be undertaken at the End of Life Care (EOLC) Steering Group.</p> <p>Reviews and monitoring of downward trends by the Quality Committee and Board through the quarterly report.</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
External Regulation and Inspection reports	<p>Further detail was provided on the reports verbally reported at the last committee and reported to the Board. HMP Maidstone and Swaleside dental waiting times have improved. Requirement notices have been lifted.</p> <p>Achievement of improvement has been due to increased capacity funded by the Trust until March 20.</p> <p>Medway Secure Training Centre received a Care Quality Commission (CQC) inspection. The only service the Trust provides is the mobile dental unit. No concerns were found with the dental unit.</p> <p>Public Health England Quality Assurance visit to antenatal and new-born screening services. It was reported that no major concerns were identified but 25 recommendations. An action plan is being developed.</p>	<p>Risk remains for waiting time targets beyond March until an agreement can be reached with the commissioners.</p> <p>The Quality Committee will review the action plan at its March meeting.</p>
Integrated Performance report		<p>Referral To Treatment waiting times (RTT): Delivery of consultant pathways remains fragile, largely Community Orthopaedics. However, December saw delivery of 92% for the first time in eight months due to focused work.</p> <p>Delayed transfers of care (DTOC) currently 12.5%, target is 9.5%. Majority of delays are due to social care.</p> <p>Discussion being undertaken with CEO and Kent County Council (KCC).</p>

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 February 2020
Agenda Number:	2.9
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	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary
The paper summarises the Strategic Workforce Committee meetings held on 27 November 2019 and 29 January 2020.

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 <input checked="" type="checkbox"/> High level position described and no decisions required.

Bridget Skelton, Non-Executive Director	Tel: 01622 211906
	Email:

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on 27 November 2019.

Agenda item	Assurance and key points to note	Further actions and follow up
Workforce Report	<p>The Workforce Report provided positive overall assurance in relation to the workforce dashboard. Two metrics only have moved to a negative position: compliance with agency price cap, and average time to recruit. The latter is due to increased recruitment activity. Turnover has reduced again, after seven positive variations a recommendation is being made to the Executive Team to reduce the turnover target to 16%. Credit needs to go to the Recruitment Team and staff who have worked hard to tackle turnover and bring down absence.</p>	<p>Implement findings from Diversity by Design, examining more creative ways to attract candidates, and learn from work looking at why 10% of candidates with offer letters do not start.</p>
Recruitment Campaign	<p>Kent Community Health NHS Foundation Trust has significant planned growth over the coming years – 552 WTE over the next five years with an additional 150 WTE needed within 2020/21 to cover vacancies. Many innovative ways are being examined to attract candidates: learning from successful initiatives in east Kent, linking further with university placements, designing a training</p>	

Agenda item	Assurance and key points to note	Further actions and follow up
Recruitment Campaign (continued)	programme with the Job Centre for health care assistants, recommending a friend as well as exploring the viability of a recruitment van going out to supermarkets. ‘Diversity by Design’ is looking at creativity too.	
Interim National People Plan	Due to Purdah there has been little progress on the National People Plan.	
Academy Update	The Committee looked at the numbers and spend to date and supported ongoing discussions to find further levies from other organisations unable to spend their allocation. 208 staff are currently enrolled on an apprenticeship with a spend to date of £1,568,461.	
Health and Well Being	The Time to Change initiative is still having a significant impact with another 27 new champions enrolled especially to support the corporate services. Further work on profile building is underway.	
E-Rostering Performance	‘Insight’ an e-rostering module exposed a need for more data cleansing. A December launch timeline will be followed by monthly calls to look at what can be done to improve efficiency and effectiveness with rosters, whilst ensuring quality and safety.	Data to be shared with the Chief Nurse and operational teams to learn from ‘insights’ coming from data once cleansed.
Operational Workforce Report	The Committee discussed winter pressure challenges on workforce. It received assurance on the change to use of beds at Tonbridge Cottage Hospital which is now running as a single unit with 50% beds designed for patients	Governance and challenges embedding self-managed teams in primary care networks (PCN) model to be looked at in March 2020 at the Committee after further

Agenda item	Assurance and key points to note	Further actions and follow up
	having had surgery following fractured neck of femur, giving patients a better care experience and improving bed flow at Maidstone and Tunbridge Wells NHS Trust (MTW).	work on devolved authority and Transforming Integrated Care in the Community (TICC) has been completed.
Contract Management	The Committee received details on all contract management activities to ensure compliance with supplier evaluation, Key Performance Indicators and performance management.	At the next review further assurance to be supplied on where adjustments have been made following a review or value for money assessment.
General Data Protection Regulation (GDPR) Compliance	Following limited GDPR assurance on personal files, all files will have been audited by the end of March 2020 and the business case for an electronic solution will have been taken to the Executive Team for approval.	
Disclosure and Barring Service (DBS) Board Assurance	Full compliance has been met for all director files including DBS checks. Two new non-executive director (NEDs) checks are underway.	
Kent and Medway Long Term Plan and Primary Care Plan - Workforce Planning – Lessons from Lloyds Visit	Expected to produce operational plans for 2020/21 in February 2020, in accordance with the system plan. Working closely with system partners to ascertain what makes sense to work as a whole system and locally. Local planning will think beyond the numbers looking at the new governance of primary care networks (PCNs) and devolved authority, starting to populate the journey of recruiting 500+.	
People Strategy Action	The Committee is sighted on updates to the plan, to be	

Agenda item	Assurance and key points to note	Further actions and follow up
Plan update	refreshed by March 2020 giving equality, diversity and inclusion much more prominence.	
Forward Plan	The Committee added in 'self-managed teams' as a new way of working under the item on devolved authority to the forward plan.	

Bridget Skelton
Chair, Strategic Workforce Committee
27 November 2019

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on Wednesday 29 January 2020

Agenda item	Assurance and Key points to note	Further actions and follow up
Workforce Report	<p>The report provided positive assurance in relation to the workforce dashboard, a good and sustained performance. Some targets (turnover, stability, average time to recruit and stress absence) are being re assessed at the Management Committee in March recognising the need to ensure both stretch and realism.</p> <p>As actions on the Board Assurance Framework (BAF) are green, new actions have been agreed to ensure continued mitigation of risk.</p>	<p>None</p>
Workforce Strategy	<p>Received the Communication and engagement plan for the development of the 2021 - 2026 People Strategy. Discussed the importance of getting a full understanding of what being the best employer meant and ensuring the people strategy enables the Trust Strategy.</p>	<p>Making sure we answer the question 'What workforce imperatives are required to enable the Trust Strategy, Vision and Priorities', in all communications and engagement.</p>
Action Learning Sets / Coaching Network	<p>Positive assurance on quality of delivery and early impact received. Some issues around uptake for action learning sets are being addressed, supported by myths being busted and positive feedback shared from attendees.</p>	<p>Encouragement to attend and communication of benefits to be shared at next Operations meeting.</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
Career Pathways	<p>Received strong evidence of extensive work to provide information for individuals on career options and some clarity on how they might achieve their career aspirations.</p> <p>Professional Leads have agreed to be part of a working group to fully complete and maintain the clinical element of the career pathway.</p> <p>Assured of the necessary steer to support career conversations at appraisal.</p>	<p>None</p> <p>Achievement of work highlighted to ensure consistency and full implementation, as well as developing necessary safeguards on an ongoing basis as we implement self-directed teams and develop integrated system working.</p>
Developing Workforce Safeguards	<p>The committee recommends compliance with delivering workforce safeguards guidance to the Board.</p> <p>The trust remains compliant with the key principles of the NHS Improvement (NHSI) Developing workforce safeguards guidance. However, there remain areas of focus that require ongoing development and a greater consistency in delivery across teams.</p> <p>Much work has been achieved following challenges identified in the previous paper to support delivery of and improve the ease of providing safer staffing information. A Safer Staffing Stakeholder Group implemented, new approaches to ensure full potential of the e-roster, consistency of Meridian application, work with Rio team to enable a unified approach, supervisory role of clinical leads reviewed, safer staffing review for Community hospitals completed using Shelford Safer Nursing Care Tool, being some of the work undertaken.</p>	<p>Criteria to judge suitability.</p> <p>Coaches to collect emotional issues as well as operational for learning about effective</p>
Self-directed Teams	<p>The Trust has identified devolved authority as one of its key objectives to support patient care decisions being made closer to the patient. Received a report setting out the progress of developing self-directed teams based on the Buurzorg model of care, the</p>	

Agenda item	Assurance and Key points to note	Further actions and follow up
Self-directed Teams (continued)	<p>phases of the programme and the enabling actions.</p> <p>Initial focus on the development of self-directed teams within the community nursing service will eventually cover the whole organisation for those teams where the model is suitable. Feedback from the Big Listen identified a key issue for staff was the level of bureaucracy in the organisation. The development of self-directed teams was taken on as a strategic response to this.</p> <p>Pilots in Edenbridge and Charing from Nov 2018, commencing now with four existing community nursing teams in Sevenoaks from Jan 2020, with wider roll out across all community nursing teams from March 2020 to December 2020. 53 (30 East, 20 West Kent) teams placed in the framework by the end of the year albeit not fully functional. Modelling highlights the need for 70 additional staff which Commissioners will need to fund. A business case with benefits evidenced is being drawn up.</p> <p>The move to an organisational culture based on coaching and empowerment is a commitment for the next three to five years.</p>	<p>Implementation.</p> <p>Framework setting the team boundaries and clear KPIs to support the articulation of benefit to patient and staff.</p> <p>Continued triangulation between Quality and Workforce to ensure issues are being addressed.</p>
Operational Workforce Report		

Agenda item	Assurance and Key points to note	Further actions and follow up
Automation in HR (bots)	<p>Approved plans for the purchase of Robotic Process Automation software (more commonly referred to as Bots) with the view to automation of HR processes. The aims of this project include: - 100% accuracy on automated processes - Removal of tedious process job duties from human job roles - Release of time for employees to undertake more rewarding and value adding duties, and the delivery of future CIPs.</p> <p>Initial scoping identifies opportunities for the Bots to be used in Payroll, Finance, Business Information, Procurement, Contracts, Clinical Administration.</p>	None
Deep Sive sickness absence	<p>Received a very positive report with assurance that sickness absence is being managed appropriately and that targeted measures to address the main causes of absence from work are being taken to ensure the Trust's targets and workforce priorities are met.</p> <p>"Anxiety/Stress and Depression" remains by far the highest reason for absence.</p>	<p>None</p> <p>The Trust is in a more positive position both in comparison to its own performance in previous years and against its peer comparators. The absence rate appears to be on a downwards trajectory toward the end of the financial year. There are a number of organisational wide interventions in place to support the management of sickness absence and this is an item high on all services agenda.</p>
Significant employee	There have been no new suspensions since the November 2019 report to the Board.	None

Agenda item	Assurance and Key points to note	Further actions and follow up
relations report	<p>All live cases are complicated but assurance was provided that despite being time consuming due process was being observed in all cases and where any lessons for managers could be learnt they were being shared.</p>	<p>Systems conversations Increasingly decisions are being made at a Systems level that impact on quality, wellbeing and patient care that we need to have an influence over. The Committee has requested an update at each meeting to understand and get assurance that we are supporting system conversations where ever possible, to ensure effective quality of care we give our patients and be the best employer to our staff.</p> <p>Equality Impact assessment (EIA) is only relevant in report writing where a Service or Policy is impacted and therefore most often equality issues not addressed. The Committee has introduced a section headed Equality Issues on its front sheet to ensure every time a paper is written equality is a consideration. EIA will continue as a tick box so we know that an EIA judgement has been accurately made. The committee recommends other committees adopt this approach.</p> <p>Equality and Diversity strategy to be presented at March's Committee meeting.</p>
Any other business – For the Board to note		

Bridget Skelton
Chair, Strategic Workforce Committee
Wednesday 29 January 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)		
Date of Meeting:	06 February 2020		
Agenda Number:	3.1		
Agenda Item Title:	Integrated Performance Report Part One		
Presenting Officer:	Gordon Flack, Director of Finance / Executive Directors		

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary	
The Integrated Performance Report is presented with the use of Statistical Process Control (SPC) charts. 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:	
<ul style="list-style-type: none"> • 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 2 year 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 currently sit within segment 2. This level is categorised as "targeted support offer" (segment 1 is "maximum autonomy"). The move from segment 1 to segment 2 was as a result of deterioration in performance in RTT and 6 week diagnostics. 6 week diagnostics is now meeting target and RTT has now met target in Month 9. NHSI have confirmed that we will be moved back to segment 1 should we achieve the RTT 92% standard for 2 consecutive months, which we are predicting to achieve. See the operations section for more details	
There are 11 KPIs moving favourably in month and 6 moving unfavourably whilst 24 are in normal variation.	
There are 7 KPIs consistently failing target (target outside of control limits) including the two system targets tracked of A&E wait times at MTW and EKUFT. The others are:	
<ul style="list-style-type: none"> • KPI 2.7 Contract activity at 101.1% for Month 8 and moving favourably, but 	

- upper limit still below 100% (99.9%) so achievement not assured.
- KPI 2.20 Friends and Family Test Response Rate for MIU and Community Hospitals is now in normal variation and improving but the previous low performance has resulted in the upper control limit now being below the target
- KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5% currently performing at 20% (0% target)
- KPI 5.3 Turnover (planned and unplanned) at 15.95% against 16.5% target and moving favourably below the lower control limit but target is still below the lower control limit.
- KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more) moving favourably at 86.2% but 85% target is still marginally above the upper control limit.(84.5%)

Of the 10 indicators not measured by SPC charts 9 are achieving target and the one that has not is KPI 2.4 MRSA cases where KCHFT provided care (1 for November)

Quality

- 1 lapse in care was identified within the trust acquired incidents. This related to a low harm incident where the patient developed category 2 pressure damage.
- There were 127 falls reported during October and November 2019, compared to 98 in August and September. The total number of falls has increased for the reporting period, however there were 4 avoidable falls which demonstrates common cause variation. The number of avoidable patient falls is below the mean for November.
- There were 200 medication related incidents reported across KCHFT during October and November 2019, of which 103 were considered avoidable.
- 12,341 surveys were completed by patients, relatives and carers in October and November with a strong combined satisfaction score of 96.6%.
- There was an MRSA bacteraemia reported in East Kent in November where podiatry staff in KCHFT provided care. This case was attributed to the CCG. Learning identified ineffective communication between all providers. KCHFT are currently undertaking actions with other providers to improve communication channels.

Workforce

- Turnover in December 2019 has decreased further since the last report to 15.95%, the lowest rate over the last 2 years. It is now sitting at 0.52% below the target of 16.47%
- Since the last Workforce report was produced the trust has seen drop in sickness absence to below the mean at 4.32%, This is 0.12% above the target rate of 4.2%. Absence levels do usually increase over this winter period. The Financial YTD figure for

- December is 4.22%, 0.02% above the target of 4.2%.
- Following the increase in vacancy rates in April 2019 due to budget setting, levels have been on a continual downward trajectory below the mean. In December 2019 the Vacancy rate is at 7.51%; this is an increase (0.35%) since the last reporting period in October 2019. However, this is still remaining significantly below the target of 9.66%.
- The use of agency staff across the Trust in December 2019 (132.78%) has significantly increased since the last report in October 2019 with a figure of 93.24%. November 2019 reported the highest level it has been across the 26 month reporting period at 143.94%. Therefore, even though there has been a reduction in December it remains significantly above both the Target and the Mean.

Finance

- The Trust achieved a surplus of £2,115k (1.2%) to the end of December. Cumulatively pay and depreciation/interest have underspent by £5,851k and £139k respectively and non-pay has overspent by £3,837k. Income has under-recovered by £1,798k
- £3,849k of savings has been achieved for the YTD against a risk rated plan of £3,971k which is £122k (3.1%) behind target
- Capital spend to December was £3,470k, against a YTD plan of £5,217k (67% achieved). The full year forecast is £7.4m and the Trust expects to utilise this in full.

Operations

- Health Checks is now experiencing special cause variation, following 8 consecutive months performing above the mean. Performance is currently at 101.1% for 2019/20.
- Stop Smoking Performance to month 7 is currently showing as special cause variation with 7 months performing above the mean; however investigation has found that there has been no specific reason attributed to this strong level of performance, which has continued deep into the year
- New birth visits - the target of 90% is generally being achieved and is closely monitored through the monthly district level reports and is showing varying performance across the districts.
- RTT - 92.2% of waits are now below 18 weeks, although there are 10 waits above 36 weeks within Orthopaedics. We are predicting to improve further in the coming months (93.4% in Month 10 and 94.1% in Month 11).
- prison waits are currently experiencing adverse special cause variation at HMP Maidstone, plus in all three cases current performance is above the mean and the target is either below or near the lower control limit, suggesting consistent achievement

<p>of the 6 week target is unlikely to occur in the current environment.</p> <ul style="list-style-type: none"> • Audiology 6 week diagnostics waits for paediatric audiology is experiencing a period of positive special cause variation, with the last 15 months performing above the mean, with the target being achieved for 6 consecutive months. • Delayed Transfers of Care (DTOCs) remains in special cause variation with a period of 9 months above the mean, caused by an increased level of delayed transfers in east Kent. There has been consistently high delays due to availability of social care packages and also delays due to patient choice. The patient choice policy is being reviewed following evaluation of the Lincolnshire model and if this is implemented this should reduce these types of delay. • Looked After Children the Initial Health Assessment is achieving target most months. Performance is variable due to late requests from KCC. The Review Health Assessment has met target and showing normal variation • Bed Occupancy is showing a varying trend with no periods of special cause variation or changes in performance that would be a particular concern.

Proposals and /or Recommendations

The Board is asked to note this report.

Relevant Legislation and Source Documents

Not Applicable

Has an Equality Analysis (EA) been completed?

No

High level position described and no decisions required.

Nick Plummer, Assistant Director of Performance and Business Intelligence	Tel: 01233 667722
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Integrated Performance Report 2019/20

January 2020 report

Part One





Contents

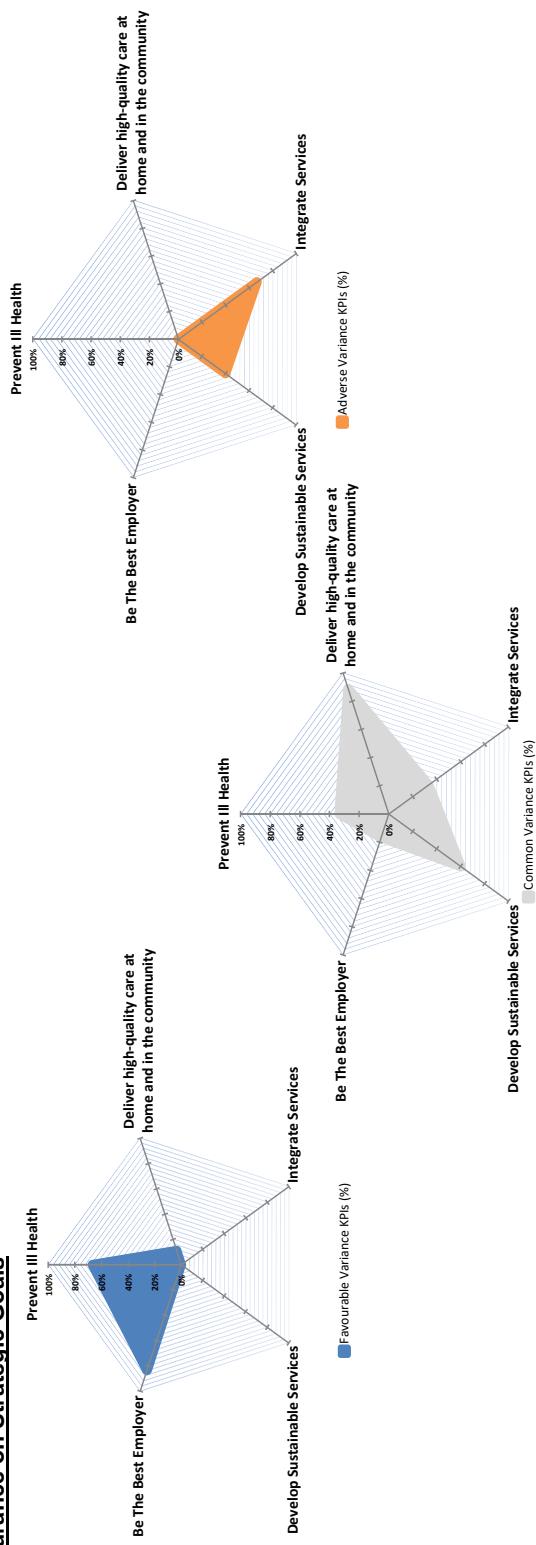
Glossary of Terms	Page 3
Assurance on Strategic Goals	Page 4
Corporate Scorecard	Page 5-8
Quality Report	Page 9-14
Workforce Report	Page 15-20
Finance Report	Page 21
Operational Report	Page 22-37
Appendix 1 – SPC Charts	Page 38



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

1.0 Assurance on Strategic Goals



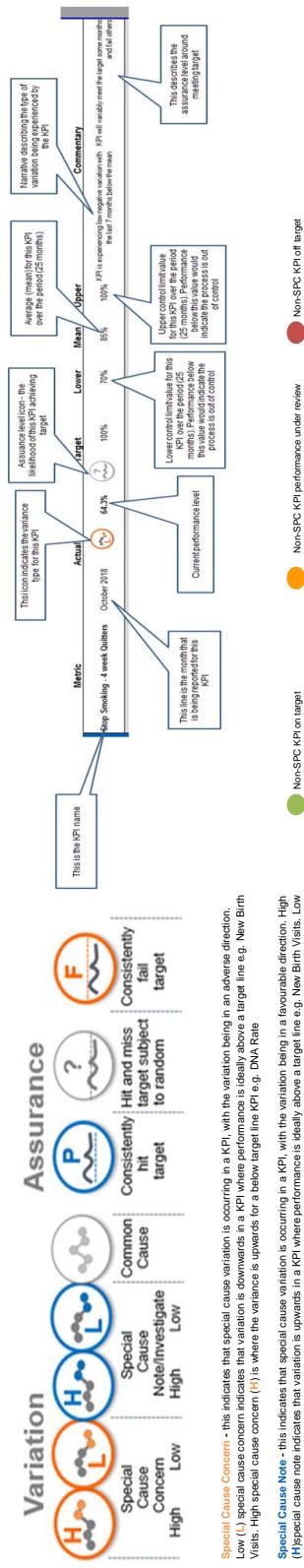
Within NHS Improvement's Single Oversight Framework, KCHFT currently sit within segment 2. This level is categorised as "targeted support offer" (segment 1 is 'maximum autonomy'). The move from segment 1 to segment 2 was as a result of deterioration in performance in RTT and 6 week diagnostics. 6 week diagnostics is now meeting target and RTT has now met target in Month 9. NHSI have confirmed that we will be moved back to segment 1 should we achieve the RTT 92% standard for 2 consecutive months, which we are predicting to achieve.

Overall, of the 41 indicators that we are able to plot on a statistical process control (SPC) chart, 26.8% are experiencing favourable in-month variation (11, KPIs 1.1, 1.2, 1.7, 2.7, 2.23, 5.2, 5.3, 5.4, 5.5 and 5.6), 14.6% are showing in-month adverse variance (6, KPIs 3.1, 3.2, 3.5, 3.7, 4.2 and 4.5) and the remaining 58.5% (24) are showing normal variation.

24.4% of the KPIs are consistently achieving target (KPIs 1.4, 2.9, 2.11, 2.15, 2.18, 2.19, 2.22, 3.2, 4.2, and 5.4), 17.1% (KPIs 2.7, 2.20, 3.5, 3.7, 4.5, 5.3 and 5.6) are consistently failing,

with the remaining 58.5% variably achieving target with no trend of consistent achievement/failure.

Of the 9 indicators where an SPC chart is not appropriate, 89% (8) have achieved the in-month target.



Special Cause Concern - this indicates that special cause variation is occurring in a KPI with the variation being in an adverse direction.

Special Cause Note - this indicates that variation is downwards in a KPI where performance is ideally above a target line KPI e.g. New Birth Visits.

High special cause concern (H) - where the variance is upwards for a below target line KPI e.g. DNA Rate.

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name

Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 1.1 Stop Smoking - 4 week Quitters	October 2019 	116.3% 	100% 	82% 	96% 	KPI is experiencing a period of positive variation with the last 7 months performing above the upper control limit
KPI 1.2 Health Checks Carried Out	November 2019 	101.1% 	100% 	65% 	92% 	KPI is experiencing a period of positive variation with the last 8 months performing above the upper control limit
KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	November 2019 	90.5% 	90% 	89% 	92% 	KPI will mostly achieve target but the control limits indicate that failing the target is a possibility within the current process
KPI 1.4 Health Visiting - 6-8 week check undertaken by 8 weeks	November 2019 	89.3% 	80% 	85% 	90% 	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 (N) School Health - Reception Children Screened for Height and Weight	November 2019 	79.9% 	90% (year end) 	90% (year end) 	KPI is cumulative through the school year	KPI is on target for year end achievement
KPI 1.6 (N) School Health - Year 6 Children Screened for Height and Weight	November 2019 	77.5% 	90% (year end) 	90% (year end) 	KPI is cumulative through the school year	KPI is on target for year end achievement
KPI 1.7 LTC/ICT - Admissions Avoidance (using agreed criteria)	November 2019 	7719 	5257 	4795 	6142 	KPI is experiencing a period of positive variation with the last 9 months performing above the mean
KPI 1.8 % LTC/ICT patients that had at least one visit which Avoided a Hospital Admission	November 2019 	24.5% 	15.0% 	13.4% 	17.2% 	KPI is experiencing a period of positive variation with the current month performing above the upper control limit
1. Prevent ill Health						
Metric	Actual	Target	YTD Actual	YTD Target	19/20 YTD	19/20 YTD
KPI 2.1 Number of Teams with an Amber or Red Quality Scorecard Rating	November 2019 	0 	1 	4 	8 	There have been 4 Amber/Red ratings for the financial year to date
KPI 2.2 (N) Never Events	November 2019 	0 	0 	0 	0 	No never events experienced this year. Last event in December 2016
KPI 2.3 (N) Infection Control: C.Diff	November 2019 	0 	0 	0 	0 	Last case in January 2019
KPI 2.4 (N) Infection Control: MRSA cases where KCCHFT provided care	November 2019 	1 	0 	1 	0 	There has been one case in November 2019
2. Deliver high-quality care at home and in the community						

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name

Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days	November 2019 	0.00 	0.19 	-0.14	0.06	0.26 KPI will variably meet the target some months and fail others
KPI 2.6 Avoidable Pressure Ulcers - Lapses in Care	November 2019 	0 	1 	-1.1	1.6	4.3 KPI will variably meet the target some months and fail others.
KPI 2.7 Contractual Activity: YTD as % of YTD Target	November 2019 	101.1% 	100.0% 	97.5% 	98.7% 	99.9% with the last 5 months performing above the upper control limit KPI will consistently fail the target. This suggests achievement is likely to be down to chance without a process or target change
KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity	November 2019 	3.1% 	4.0% 	3.0% 	3.5% 	4.0% 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 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)	November 2019 	98.2% 	95.0% 	95.4% 	97.3% 	99.2% KPI is consistently achieving the target with the target marginally below the lower control limit
KPI 2.10 Percentage of Rapid Response Consultations started within 2hrs of referral acceptance	November 2019 	91.7% 	95.0% 	89.6% 	95.5% 	101.4% KPI will variably meet the target some months and fail others
KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	November 2019 	99.8% 	95.0% 	99.3% 	99.7% 	100.0% KPI is consistently achieving the target with the target significantly below the lower limit
KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways	December 2019 	92.2% 	92.0% 	87.7% 	91.8% 	95.9% KPI will variably meet the target some months and fail others
KPI 2.13 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Waiting List Size (>18 weeks)	December 2019 	445 	532 	159 	501 	843 KPI will variably meet the target some months and fail others
KPI 2.14 AHP (Non-Consultant Led) Referral to Treatment Times (RTT)	November 2019 	93.5% 	92.0% 	89.2% 	92.8% 	96.3% KPI will variably meet the target some months and fail others
KPI 2.15 (N) Access to GUM: within 48 hours	November 2019 	100.0% 	100.0% 	100.0% 	100.0% 	100.0% Consistently meeting target. Failure to meet target would be 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)	November 2019 	20.4 	21.0 	14.5 	20.4 	26.3 KPI will variably meet the target some months and fail others
KPI 2.17 Research: Participants recruited to national portfolio studies (Year to Date)	October 2019 	2202 	300 			KPI is consistently achieving the target of 75 per quarter

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

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name

Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 2.18 Percentage of patient goals achieved upon discharge for planned and therapy services	November 2019 90.3%	80.0% 	86.4% 	90.4% 	94.4%	KPI is consistently achieving the target as the lower limit is significantly above the target. This would mean failure to meet target would likely be due to chance
KPI 2.19 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT	November 2019 97.5%	95.0% 	95.6% 	97.0% 	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	November 2019 15.2%	20.0% 	10.6% 	14.7% 	18.9%	KPI is consistently failing the target as the upper limit is below the target. This suggests performance is unlikely to increase to meet target without a process change
KPI 2.21 Clinical Audit: % of audit recommendations implemented by deadline	October 2019 90.0%	80.0% 	54.6% 	81.7% 	108.7%	KPI will variably meet the target some months and fail others
KPI 2.22 (N) NICE Technical Appraisals reviewed by required time scales following review	November 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 2.23 (N) 6 Week Diagnostics	November 2019 99.7%	99.0% 	80.2% 	92.7% 	105.2%	KPI is experiencing high positive variation, KPI will variably meet the target some months and fail others
Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 3.1 Delayed Transfers of Care from a Community Hospital bed as a % of Occupied Bed Days	November 2019 10.7%	9.5% 	5.4% 	10.5% 	15.6%	KPI is experiencing high negative variation, KPI will variably meet the target some months and fail others
KPI 3.2 Percentage of LTC/CT Referrals coming from within KCHFT	November 2019 15.2%	10.0% 	15.2% 	18.7% 	22.3%	KPI is experiencing low negative variation, KPI is consistently achieving the target with the target considerably below the lower limit
KPI 3.3 CQUINs (% of CQUIN money achieved to 19/20 Q2)	September 2019 100.0%	100% 				KPI will variably meet the target some months and fail others
KPI 3.4 Home First impact - reduction in average excess bed days (West Kent) Emergency Services	November 2019 0.26	0.20 	-0.18 	0.46 	1.11	KPI will variably meet the target some months and fail others
KPI 3.5 (N) Average wait time (minutes) for MTW Accident and Emergency Services	November 2019 369	240 	271 	322 	374 	KPI is experiencing high negative variation, lower limit is above the target. This suggests performance is unlikely to decrease to meet target without a process change
KPI 3.6 Rapid Transfer Impact - reduction in average excess bed days (East Kent)	November 2019 0.41	0.20 	-0.14 	0.22 	0.59	KPI will variably meet the target some months and fail others, although seems to be moving towards the upper control limit
KPI 3.7 (N) Average wait time (minutes) for EKHUFT Accident and Emergency Services	November 2019 400	240 	318 	372 	425 	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 3.8 East Kent Rapid Transfer Service - Average Commissioned Discharges per day	December 2019 32.6	30 				New metric - data building to allow SPC reporting

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

3. Integrate Services

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name

Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 4.1 Bed Occupancy: Occupied Bed Days as a % of available bed days	November 2019 	91.1% 	87.0% 	81.5% 	88.8% 	96.0% KPI will variably meet the target some months and fail others
KPI 4.2 Income & Expenditure - Surplus (%)	December 2019 	1.2% 	1.0% 	1.1% 	1.5% 	1.9% KPI is experiencing low adverse variation, with the last 9 months performing below the mean
KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	December 2019 	96.9% 	100.0% 	66.1% 	84.7% 	103.3% KPI will variably meet the target some months and fail others, especially early in each financial year
KPI 4.4 External Agency spend against Trajectory (£000s)	December 2019 	£627,703 	£628,000 	£219,929 	£469,664 	£719,399 KPI will variably meet the target some months and fail others,
KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%	December 2019 	20.0% 	0% 	0.7% 	13.3% 	26.0% KPI is experiencing high adverse variation, with the last 8 months performing above the mean
4. Develop sustainable services						
Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 5.1 Sickness Rate	December 2019 	4.32% 	4.20% 	3.77% 	4.44% 	5.12% KPI will variably meet the target some months and fail others
KPI 5.2 Sickness Rate (Stress and Anxiety)	December 2019 	0.94% 	1.15% 	0.98% 	1.26% 	1.53% KPI is experiencing low positive variation with the last 12 months performing below the mean
KPI 5.3 Turnover (planned and unplanned)	December 2019 	15.95% 	16.47% 	16.56% 	17.76% 	18.96% KPI is experiencing low positive variation with the last 9 months performing below the mean. The last 4 months are also below the lower control limit
KPI 5.4 Mandatory Training: Combined Compliance Rate	December 2019 	96.2% 	85.0% 	94.5% 	95.6% 	96.77% KPI is experiencing high positive variation with the last 10 months performing above the mean
KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce)	December 2019 	7.5% 	9.7% 	7.2% 	9.2% 	11.3% KPI is experiencing low positive variation with the last 8 months performing below the mean
KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	December 2019 	86.2% 	85.0% 	82.8% 	83.6% 	84.5% Target is set at 85%. While the target currently sits above the upper control limit, current performance should see the upper limit increase above target
5. Be The Best Employer						

2.0 Quality Report

2.1 Assurance on Safer Staffing

With the inclusion of RN Managers' hours, only Tonbridge had a day fill rate below 90% for RN's in October and in Deal and West View in November.

The average monthly shifts per day with 1 registered nurse is an aggregated number for all of the community hospitals, and this has continued to declined during this period.

1.1 RN and HCA staffing Community Hospital October 19		Day Fill Rate %				Night Fill Rate %			
		RN	HCA	RN	HCA	RN	HCA	RN	HCA
Faversham	98.5%	91.8%	96.7%	99.9%					
Deal	99.2%	91.7%	96.9%	93.5%					
QVMH	95.8%	81.3%	96.8%	84.2%					
Whit & Tank	101.2%	97.2%	99.8%	99.7%					
West View	92.7%	96.3%	96.7%	100%					
Edenbridge	95.6%	85.8%	95.1%	97.7%					
Hawkhurst	100.8%	86.4%	98.1%	92.6%					
Sevenoaks	93.4%	93.3%	98.3%	99.3%					
Tonbridge	89.5%	93.0%	94.6%	95.6%					

1.1 RN and HCA staffing Community Hospital November 19		Day Fill Rate %				Night Fill Rate %			
		RN's	HCA's	RN's	HCA's	RN's	HCA's	RN's	HCA's
Faversham		101.2%	94.8%	98.7%	98.4%				
Deal		82.0%	97.0%	100.0%	97.0%				
QVMH		98.8%	86.3%	98.3%	95.3%				
Whit & Tank		105.0%	98.9%	100.0%	99.8%				
West View		85.0%	96.1%	100.0%	103.3%				
Edenbridge		96.2%	86.8%	100.0%	98.0%				
Hawkhurst		96.6%	90.5%	98.4%	98.3%				
Sevenoaks		98.4%	94.5%	100.0%	99.3%				
Tonbridge		97.8%	84%	96.6%	97.4%				

Safer staffing reviews continue, collaborative work, including the workforce and operational teams to manage the rosters effectively and safely. Further training and monitoring on the use of rosters to improve data access continues to be delivered. During the period in November, at West View, the ward was not full to capacity, between 3 and 5 empty beds and therefore is reflected in the staffing levels

2.2 Assurance on Pressure Ulcers

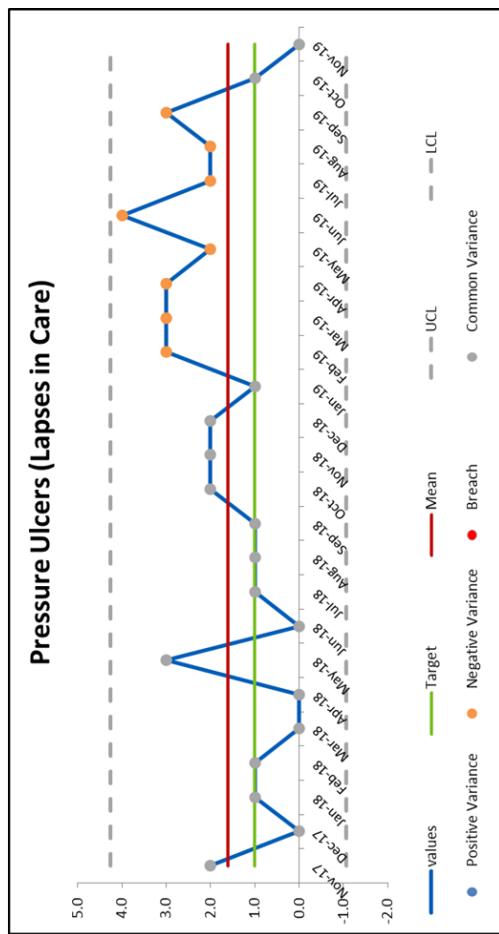
1 lapse in care was identified within the trust acquired incidents. This related to a low harm incident where the patient developed category 2 pressure damage.

A lapse in care is when an act or omission in pressure area care that has impacted skin breakdown and could have been preventable.

There have been no serious incidents reported since September 2019; this is a significant improvement on previous months and is highlighting the impact of the interventions implemented at clinical level to enhance earlier interventions, reduce risks and timely management of skin damage.

The reported incidents remain low in relation to the size of the trust and population when compared to other community trusts.

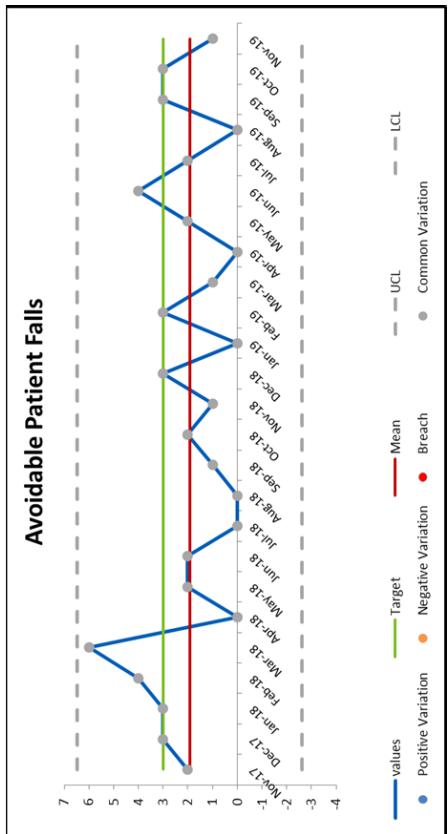
Key Themes from investigations highlight that there is still work to be undertaken in timely interventions with relevant equipment usage and repositioning and escalating the challenges of concordance with carers and patients alike.



2.3 Assurance on Falls

There were 127 falls reported during October and November 2019, compared to 98 in August and September. The total number of falls has increased for the reporting period, however there were 4 avoidable falls which demonstrates common cause variation. The number of avoidable patient falls is below the mean for November.

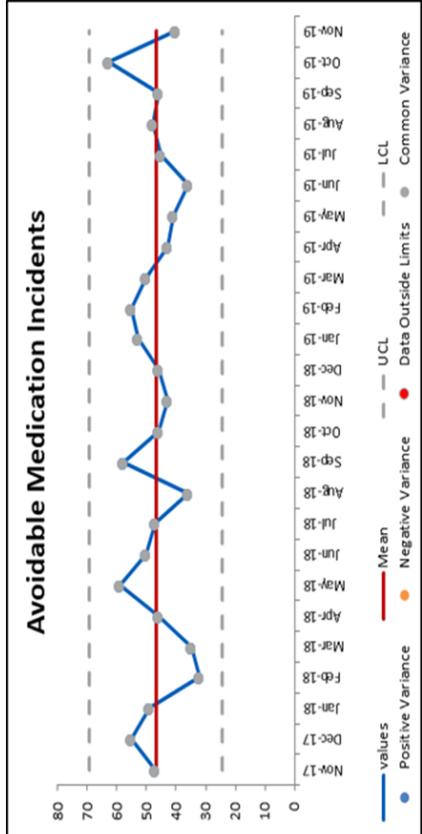
Of the four avoidable falls, two resulted in low harm and two resulted in no harm to the patient. The falls with low harm occurred when a patient was assisted to the floor in their bathroom and sustained 2 skin tears from falling against a shaving mirror having lost strength in her legs. The other occurred when a patient fell whilst reaching for their call bell and the following day pain was noted to their left arm; they were assessed by the GP and x-rays were taken. The x-ray showed no fracture. The falls with no harm occurred when two patients, one with an undiagnosed cognitive impairment and one with a mental health condition, were left unsupervised in the day room at Faversham and Whitstable and Tankerton hospitals



2.4 Assurance on Medication incidents

There were 200 medication related incidents reported across KCHFT during October and November 2019, of which 103 were considered avoidable.

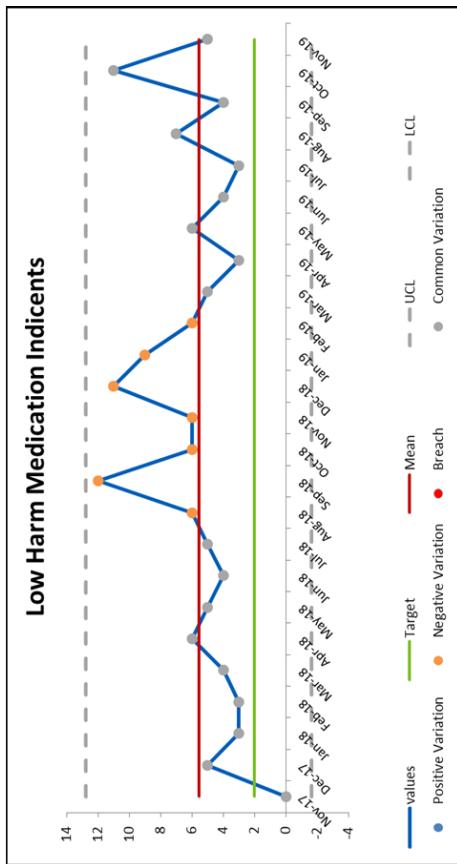
The top themes were omitted medication (44 no harm incidents, 7 low harm incidents); wrong quantity (17 no harm incidents, 1 low harm incident and 1 moderate harm (declared as an SI) and wrong frequency (10 no harm incidents). There were 16 low and no harm control drug incidents, the top theme was omitted doses. There was an increase in avoidable medication incidents in October, however analysis of data showed an increase in reporting trust wide rather than a specific service or location. Avoidable low harm medication incidents have reduced in November from October.



All medication incidents are reviewed by the Pharmacy Team who are undertaking targeted work with the specific teams. The increase in incidents does not correlate to specific teams or services, but increased reporting overall.

The Pharmacy Team are working alongside operational services on Quality Improvement Projects and use Medsavvy meetings to identify issues with omitted doses and medicine rounds and ideas to promote patient safety.

The Pharmacy team will continue to promote peer checking and self-checking in community hospitals and provide training on completing drug charts.



2.5 Assurance on Patient Experience

2.5.1 Meridian Patient Experience survey results

12,341 surveys were completed by patients, relatives and carers in October and November with a strong combined satisfaction score of 96.6%.

PALS received a total of 1,238 calls and dealt with 48 contacts received via the on-line form on the public website. Only two complaints were forwarded to the Patient Experience Team for formal investigation.

Overall satisfaction survey percentages trust wide from December 2018 to November 2019 have remained consistently good with fluctuations of less than 1% from month to month.

2.5.2 The NHS Friends and Family Test (FFT)

11,559 FFT surveys were completed during October and November. The FFT recommend score from 11,240 of our patients was 97.2%. 0.7% (77) of our patients chose not to recommend the service they received by answering unlikely or extremely unlikely.

2.6 Assurance on Clinical Audit and Research

2.6.1 Audit

The annual KPI target is 95% of clinical audit recommendations to be implemented. This is achieved via a stepped target during the year. The target for November was achieved.

KPI Actions	Target %	October >80%	November >80%
Due audit recommendations implemented – KPI 4.6	93%	90%	
Actions overdue by more than 3 months – KPI 36 Target <=10%	0%	0%	
Actions overdue by more than 6 months – KPI 37 Target <=5%	0%	0%	

2.6.2 Clinical Audit Reporting

Clinical Audit Actions – All three KPI actions achieved

KPI Reporting	Target % (Annual Target 80%)	October	November
Receipt of clinical audit dashboard within 30 days of analysis	Achieved 74% Target 60%	Achieved 72% Target 65%	
Receipt of clinical audit full report within timeframe (timeframe dependent on assurance level)	Achieved 95% Target 70%	Achieved 96% Target 70%	

2.6.3 Research

We have exceeded our annual recruitment pledge to the Clinical Research Network (CRN KSS). The previous recruits from the dental study that were withdrawn have been returned. Awaiting confirmation from the CRN as to whether or not they will be counted toward next year's funding allocation

Research Portfolio recruitment Target 300 (annual)	Q 1	Q 2	Q 3	Q 4	Achieved
Portfolio recruitment 75 per quarter	59	2161	2202		Significantly over achieved

2.6.4 National Institute for Clinical Excellence (NICE)

545 pieces of NICE Guidance have been issued since 2017. Only 122 are applicable to KCHFT. Of these 11 (9%) remain under initial review and have exceeded our 3 month target to complete the baseline assessment. Was 16%

2.7 Infection Prevention and Control

The Trust cases of CAUTI's and UTI's - There were 17 healthcare associated urinary tract infections (UTI) and 3 catheter associated urinary tract infections (CAUTI) reported.

There was an MRSA bacteraemia reported in East Kent in November where podiatry staff in KCHFT provided care. This case was attributed to the CCG. Learning identified ineffective communication between all providers. KCHFT are currently undertaking actions with other providers to improve communication channels.

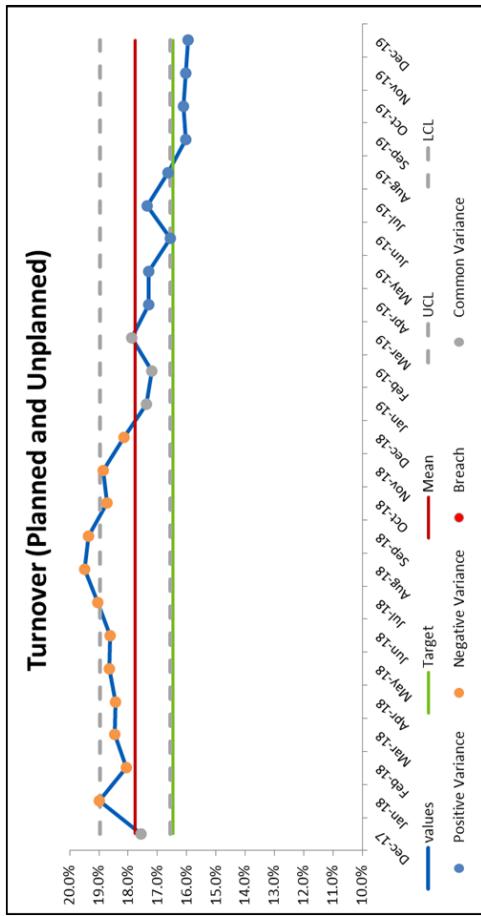
There has been 1 COHA and 1 COIA Clostridium difficile infections – attributed to the Acute Trust and CCG, with no learning for KCHFT

3.0 Workforce Report:

3.1 Assurance on Retention

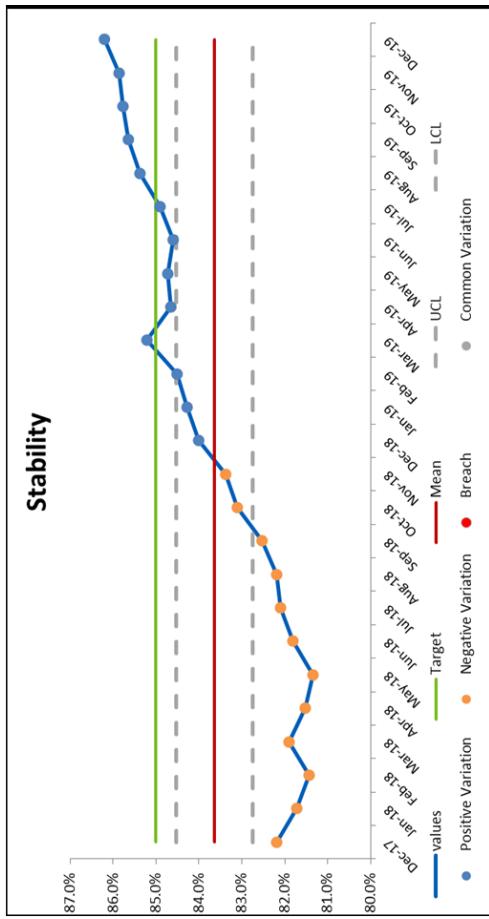
3.1.1 Turnover

Turnover in December 2019 has decreased further since the last report to 15.95%, the lowest rate over the last 2 years. It is now sitting at 0.52% below the target of 16.47%.



3.1.2 Stability

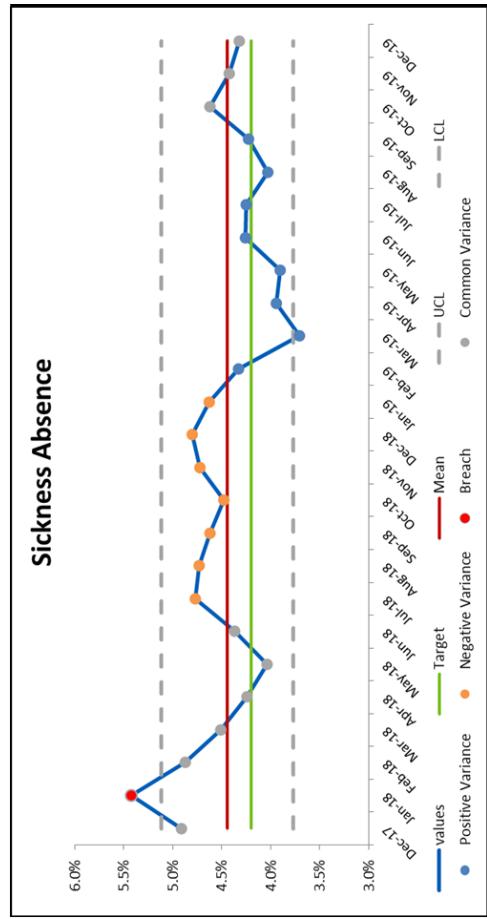
Stability continues to positively perform above the mean and the target, it has recovered the small drop reported in March 2019, and is sitting at 86.21%, 1.21% above the 85% target.



3.2 Assurance on Sickness

3.2.1 Sickness Absence

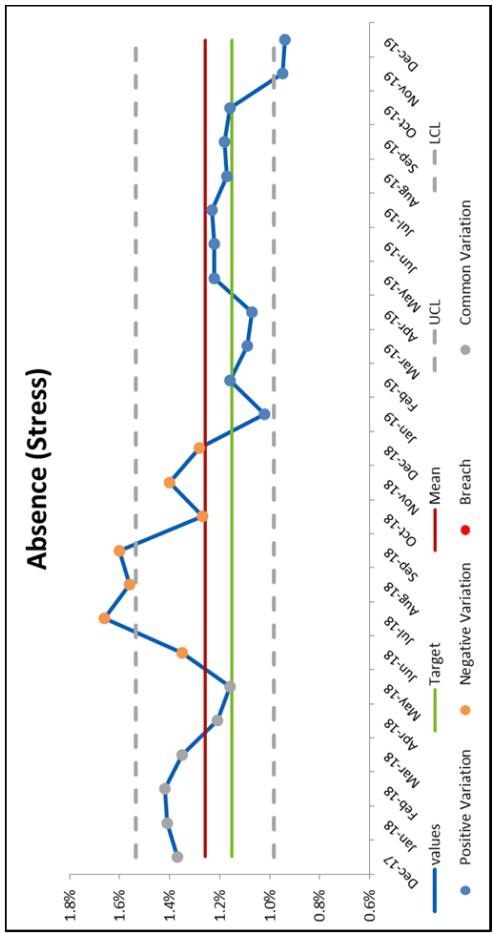
Since the last Workforce report was produced the trust has seen drop in sickness absence to below the mean at 4.32%, This is 0.12% above the target rate of 4.2%. Absence levels do usually increase over this winter period. The Financial YTD figure for December is 4.22%, 0.02% above the target of 4.2%.



3.2.2 Stress Absence

In-month stress absence figures for December 2019 have seen a decrease of 0.22% since the last reporting period in October 2019. Following a period where the levels of absence were varying around the target of 1.15% this is the lowest rate of absence since the beginning of the calendar year and the lowest rate in the reference period. The financial year-to-date figure for October 2019 is 1.12%, just a slight decrease from the last reported figure in October of 1.15%.

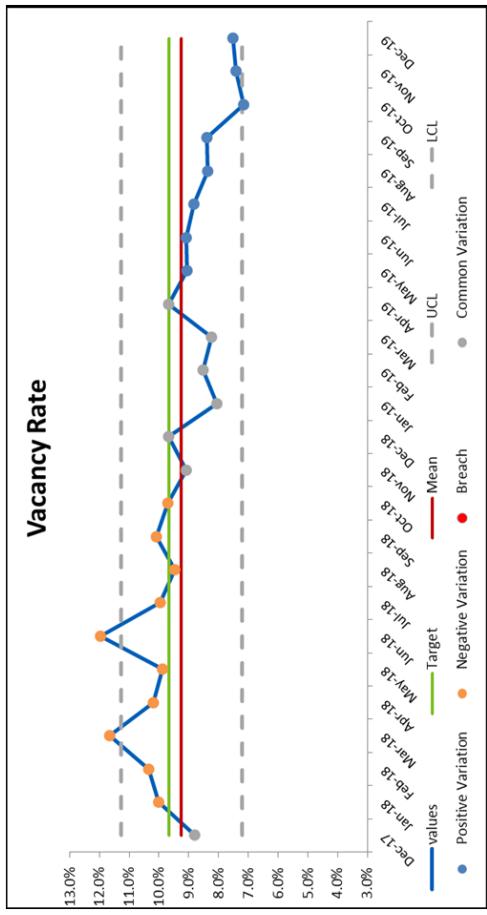
The continued trend of improved performance below the mean in stress absence has now been in place for 12 months (since December 2018). This has triggered a special cause variation flag, indicating that a significant improvement in the performance of this metric is now in place. This will continue to be monitored in the coming months to ensure this level of performance is maintained.



3.3 Assurance on Filling Vacancies

3.3.1 Establishment and Vacancies

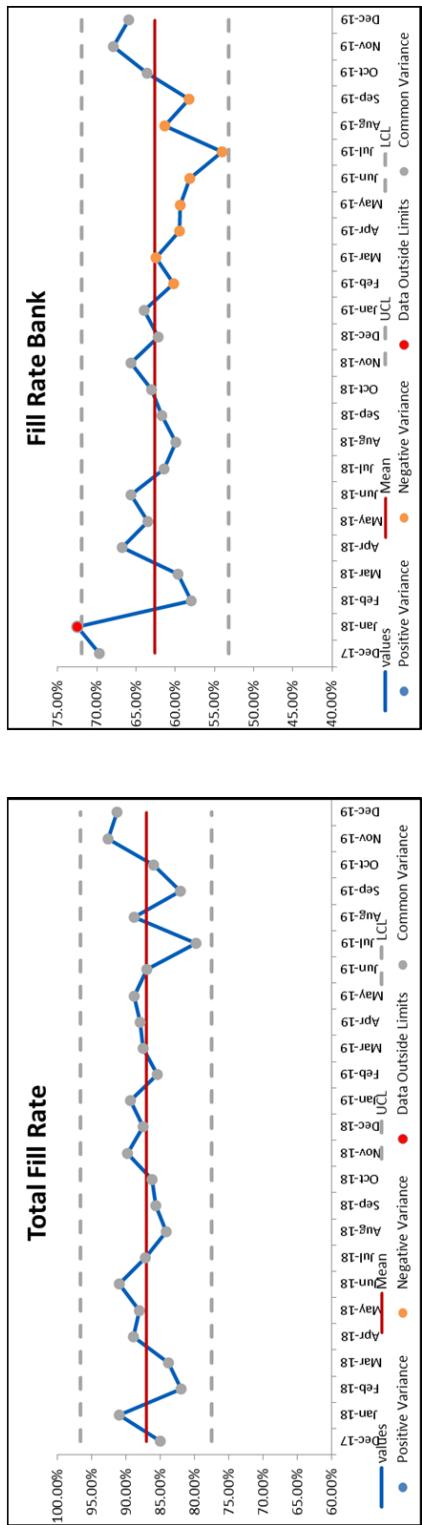
Following the increase in vacancy rates in April 2019 due to budget setting, levels have been on a continual downward trajectory below the mean. In December 2019 the Vacancy rate is at 7.51%; this is an increase (0.35%) since the last reporting period in October 2019. However, this is still remaining significantly below the target of 9.66%.



3.3.2 Temporary Staff Usage

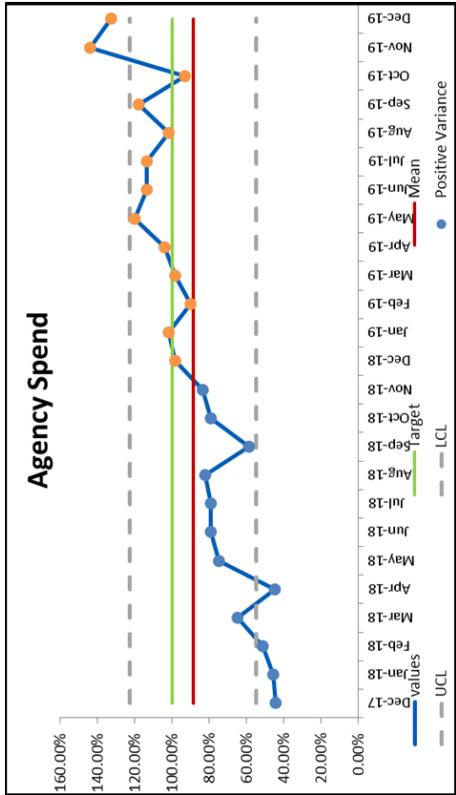
Both Bank and Total fill rates have increased since the last reporting period in October 2019. At 92.7% the Total Fill rate in November 2019 saw a significant increase to the highest levels since January 2018. December 2019 decreased by 1.37% to 91.33%, however this remains above the mean and the Bank fill rate is above the mean for the third consecutive month.

As previously reported the fill rate is being increased by the significant increase in demand. We are working with our STP partners looking at a system that will enable vacant shifts to be shared.



3.3.3 Agency Spend

The use of agency staff across the Trust in December 2019 (132.78%) has significantly increased since the last report in October 2019 with a figure of 93.24%. November 2019 reported the highest level it has been across the 26 month reporting period at 143.94%. Therefore, even though there has been a reduction in December it remains significantly above both the Target and the Mean.



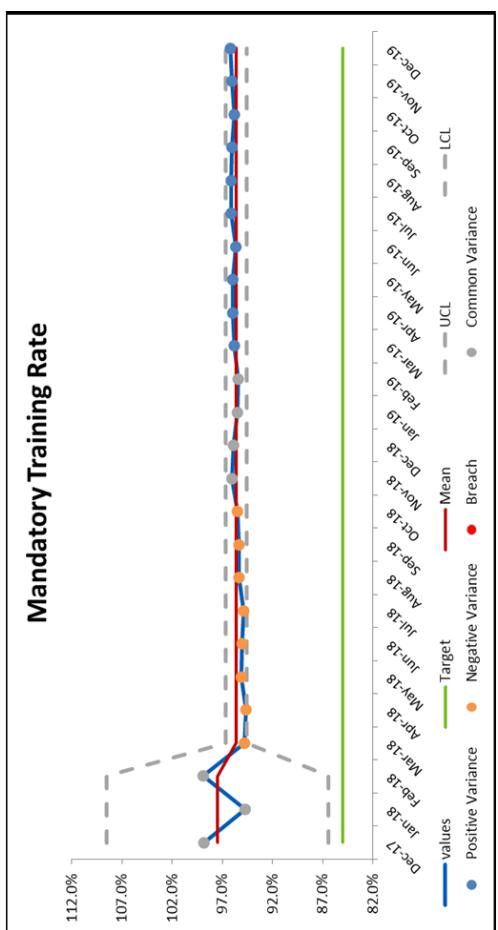
3.4 Assurance on Training Compliance

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.

Following a dip in October 2019 (95.85%), November and December 2019 have reported an increase of 0.36% to 96.21% in compliance. Overall there have been no negative changes in the topic based RAG ratings.

Moving and handling level 4 has moved from amber to green this month and assuming all those booked to attend in November and December do attend this will remain above target coming into the pressure of January. There are also an additional 23 spaces not currently being utilised over those months. There is a risk that whilst there are sufficient spaces in January, February and March 2020 (420) to accommodate all staff out of date, should bad weather hit or the traffic disruptions anticipated from Brexit occur, then there will not be enough of a cushion to keep compliance above the targeted 85%.



4.0 Finance Report:

4.1 Key Messages

Surplus: The Trust achieved a surplus of £2,115k (1.2%) to the end of December. Cumulatively pay and depreciation/interest have underspent by £5,851k and £139k respectively and non-pay has overspent by £3,837k. Income has under-recovered by £1,798k.

Continuity of Services Risk Rating: EBITDA Margin achieved is 2.5%. The Trust scored 1 against the Use of Resources Rating, the best possible score.

CIP: £3,849k of savings has been achieved for the YTD against a risk rated plan of £3,971k which is £122k (3.1%) behind target.

Cash and Cash Equivalents: The cash and cash equivalents balance was £41,544k, equivalent to 65 days expenditure. The Trust recorded the following YTD public sector payment statistics 98% for volume and 96% for value.

Capital: Spend to December was £3,470k, against a YTD plan of £5,217k (67% achieved). The full year forecast is £7.4m and the Trust expects to utilise this in full.

Staff: Temporary staff costs for December were £1,324k, representing 9.2% of the pay bill. Of the temporary staffing usage in December, £499k related to external agency and £129k to locums, 4.4% of the pay bill. There were gross vacancies of 338 WTE, a decrease of 21 compared to November, and 7.6% of the budgeted establishment.

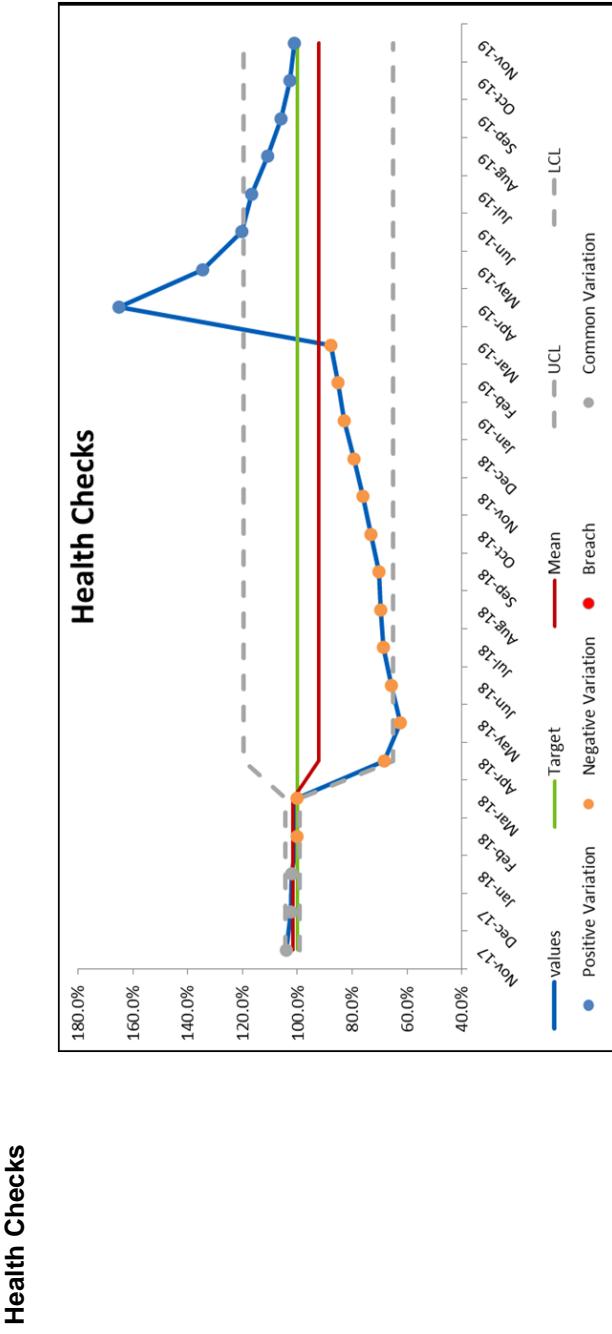
4.2 Dashboard

Surplus	Rag rating: Green			Rag rating: Green			Rag rating: Green					
	Actual	Plan	Variance	Use of Resource Rating	Year to Date Rating	Year End Rating	Year to Date £k	Year End Forecast £k	Actual £k	Plan £k	Variance £k	
Year to Date £k	2,115	1,760	355	Capital Service Capacity Liquidity I&E Margin (%)	1	1			3,849	3,971	-122	
Year End Forecast £k	2,463	2,350	113	Distance from Financial Plan Agency Spend Overall Rating	1	1			5,299	5,299	0	
The Trust achieved a surplus of £2,115k to the end of December. Pay and depreciation/interest have underspent by £5,851k and £139k respectively and non-pay has overspent by £3,837k. Income has under-recovered by £1,798k.												
The Trust has scored the maximum "rating against the Use of Resource rating metrics for M9 2019-20.												
The forecast is to deliver a surplus of £2,463k which is £113k ahead of the plan for the year, due to additional provider support funding received in 2018/20 but relating to 2018/19 of £113k.												
Rag rating: Green			Rag rating: Amber			Rag rating: Green			Rag rating: Green			
Actual	Forecast	Variance	Capital Expenditure	Actual/Forecast	Plan	Variance	M9	YTD	Actual £k	Trajectory £k	Variance £k	
Year to Date £k	41,544	38,016	3,528	YTD Expenditure £k	3,470	5,217	1,747		External Agency Expenditure (inc. Locums) £k	628	628	0
Year End Forecast £k		36,543		Year End Forecast £k	7,372	7,654	282		Locum Expenditure £k	129	106	-23
Cash and Cash Equivalents as at M9 close stands at £41,544k, equivalent to 65 days operating expenditure. The Trust recorded the following YTD public sector payment statistics 98% for volume and 96% for value.												
Capital Expenditure year to date is £3,470k, representing 67% of the YTD initial plan submitted. The full year forecast is £7,372k and the Trust expects to utilise this in full.												
External agency expenditure (including locums) was £628k against £628k trajectory in December (YTD £4,928k against £5,652k trajectory).												
Locum expenditure in December was £129k against £108k trajectory.												
(YTD £603k against £564k trajectory).												

5.0 Operational report:

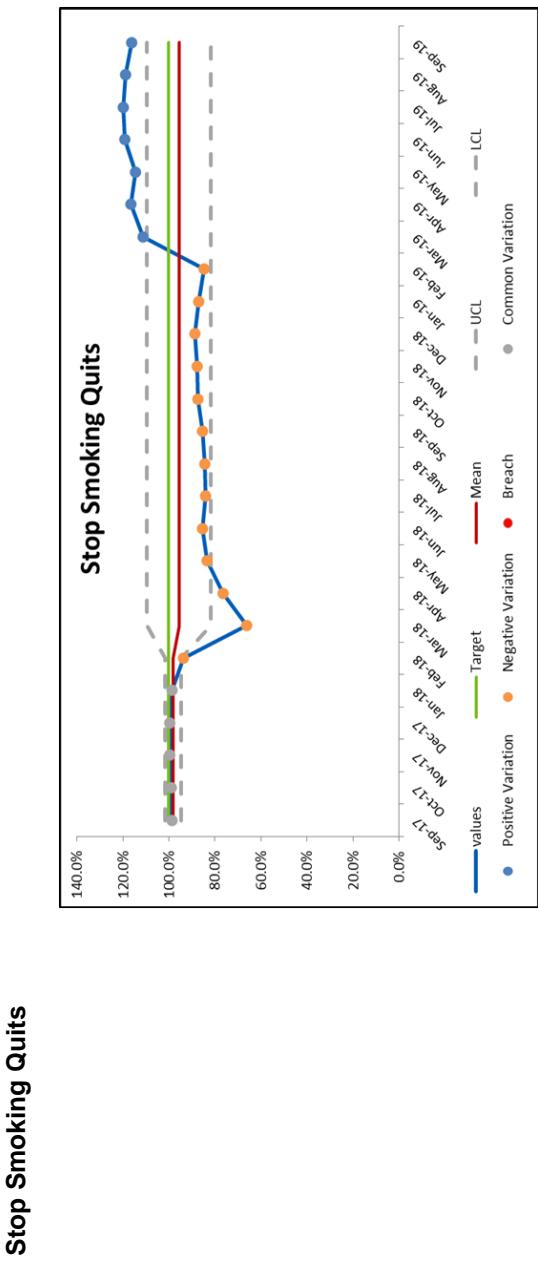
5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits



Health Checks is now experiencing special cause variation, following 8 consecutive months performing above the mean. Performance is currently at 101.1% for 2019/20

The special cause resulting in the increased performance is related to the problems last year with the introduction of the new IT system and late invites, causing a higher number of checks completed during this period. This was resolved and performance is now more stable following abnormally high levels of checks is M1 and M2



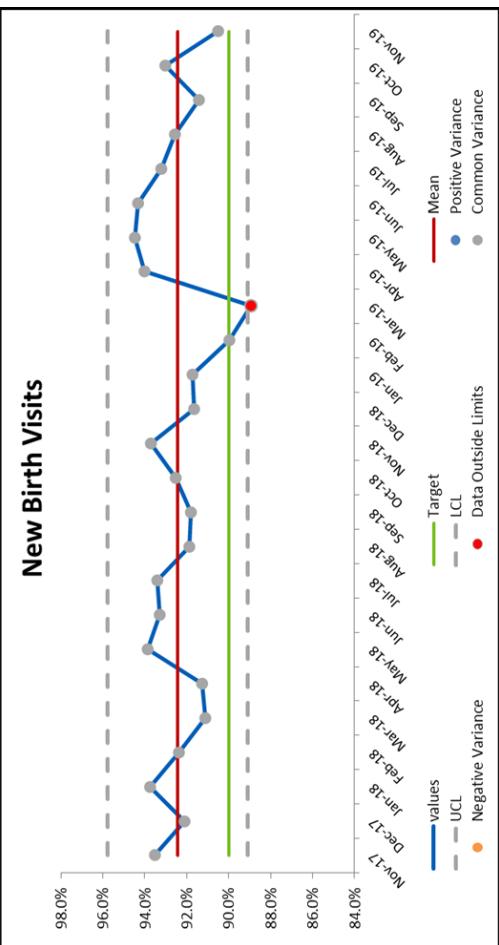
Performance to month 7 is currently showing as special cause variation with 7 months performing above the mean; however investigation has found that there has been no specific reason attributed to this strong level of performance, which has continued deep into the year.

National smoking prevalence continues to move in a downwards trend. With the successful outcomes of the Home Visits for pregnant mums, KCC and KCHFT have met to discuss new approaches to engaging the county's toughest and hardest to reach smokers.

5.1.2 Health Visiting

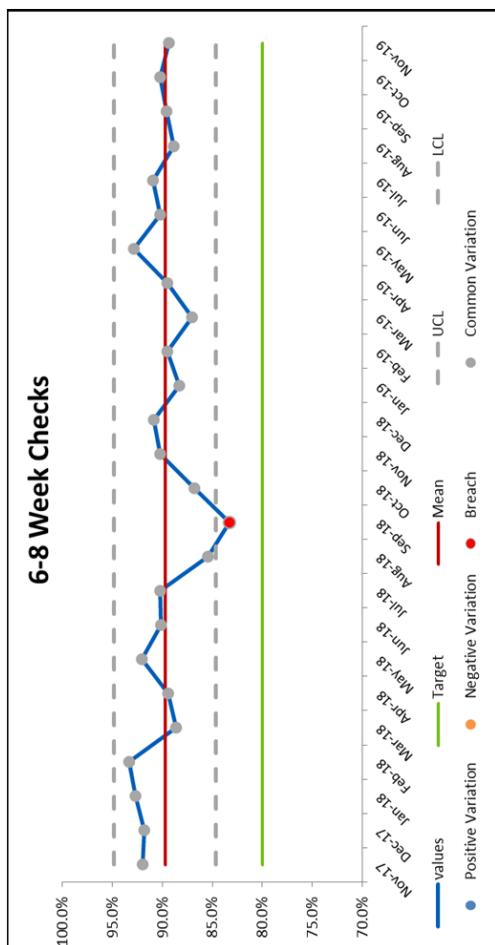
New Birth Visits

Months 1-4 were above both target and the mean and although there has been a slight dip since then, performance looks stable. The data cleanse continues to occur monthly and involves teams receiving a patient level list of children who have had no visit, DNA or refusal recorded for them to ensure their status is recorded correctly, which generally improves the most recent month upon refresh. The target of 90% is generally being achieved and is closely monitored through the monthly district level reports and is showing varying performance across the districts.

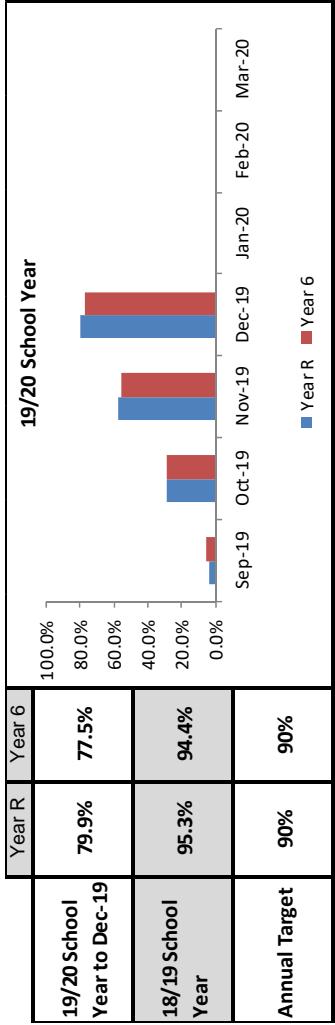


6-8 Week Checks

Performance is stable, with the target being consistently achieved. Monthly processes continue to be in place for localities to drill down into any adverse trends and improve the data quality where issues are identified.

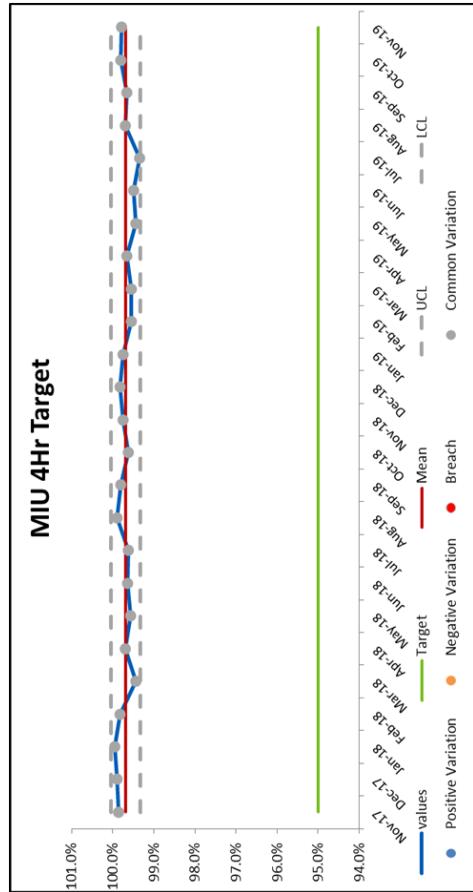


5.1.3 National Child Measurement Programme (NCMP)



The measurement programme for Year R and 6 pupils met the trajectory for the 18/19 school year, with both programmes achieving the 90% target for the school year. The 19/20 programme is fully on track

5.1.4 Minor Injury Units (MIU) 4 Hour Wait Target

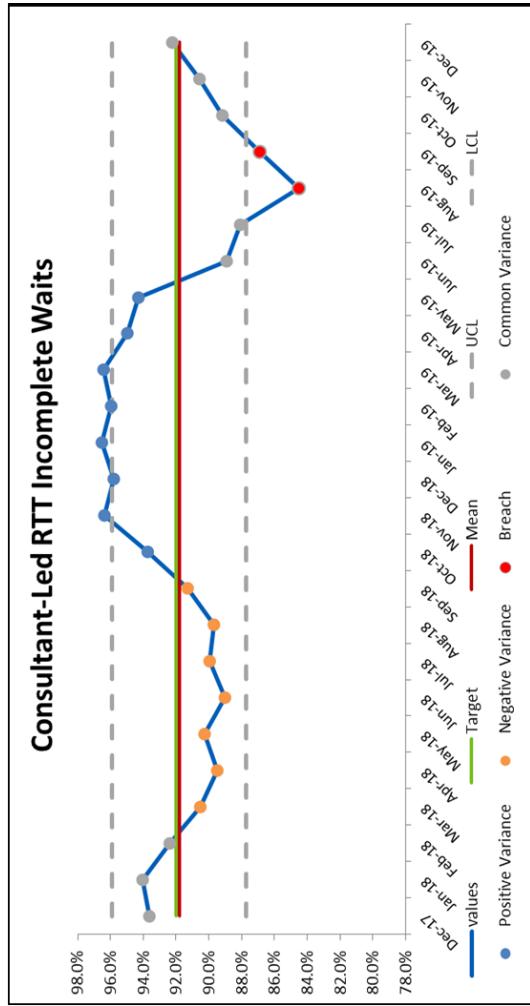


KCHFT's achievement of the 4 hour wait target for Minor Injuries Units has consistently been high, with very little variation from the mean, with the control range suggesting that failing target is highly unlikely to happen. However, there had been a period of variation showing a dip below the mean with a few extra breaches caused by the increased demand in the summer months (as noted by increased activity), which has now improved and performance is stable.

5.1.5 GUM 48hr

Access to GUM clinics within 48 hrs 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 is now showing normal variation and improving following negative special cause variation below the lower control limit. This was caused by increased waits in Orthopaedics which are a large portion (c.70%) of the Trustwide RTT position. Under normal conditions, Orthopaedics would need to achieve at least 90% (90.1% in Month 9) within 18 weeks to ensure the Trustwide position met the 92% target.

In comparison to 2018/19, there has been an increased referral rate of 22.1% for Consultant-Led RTT services which has led to an increase by 20.9% in incomplete waits at month end. The proportion of those within 18 weeks has dropped by 3.2% in comparison to 2018/19 as a result of this increased referral rate.

As a result a recovery plan was developed within Orthopaedics and a forecast trajectory constructed to support oversight and senior management conversations internally and with commissioners.

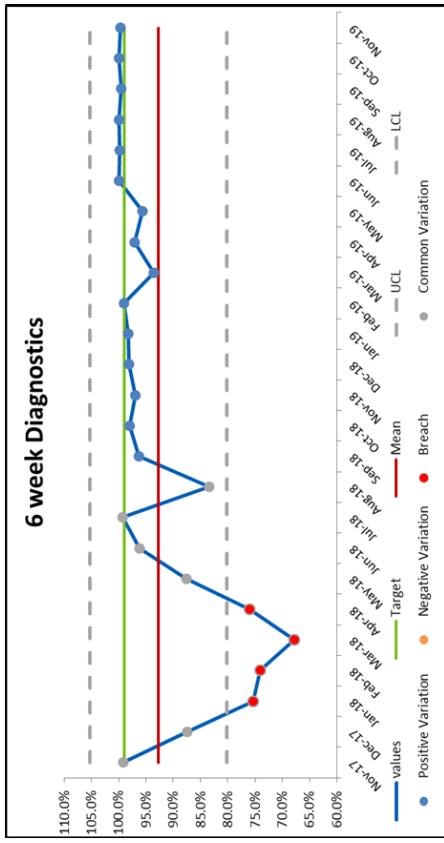
This recovery plan included a range of short term measures and using trajectories, available data and assumptions, as anticipated orthopaedics has improved to ensure that we are RTT compliant for complete and incomplete waits at Trust level by the end of December. Previous estimate of end of November was not met due to the impact of staff availability.

NHSI have confirmed that 2 consecutive months of achievement will move KCHFT back to segment 1 of the NHSI Single Oversight Framework

	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	581	12	6	0	0	99.0%
Orthopaedics	2854	721	384	10	0	90.1%
Children's Audiology	288	2	0	0	0	100.0%
Community Paediatrics	686	145	45	0	0	94.9%
KCHFT Total	4409	880	435	10	0	92.2%

The above table shows the current breakdown of the waiting list for all services on a consultant-led pathway. 92.2% of waits are now below 18 weeks, although there are 10 waits above 36 weeks within Orthopaedics. We are predicting to improve further in the coming months (93.4% in Month 10 and 94.1% in Month 11).

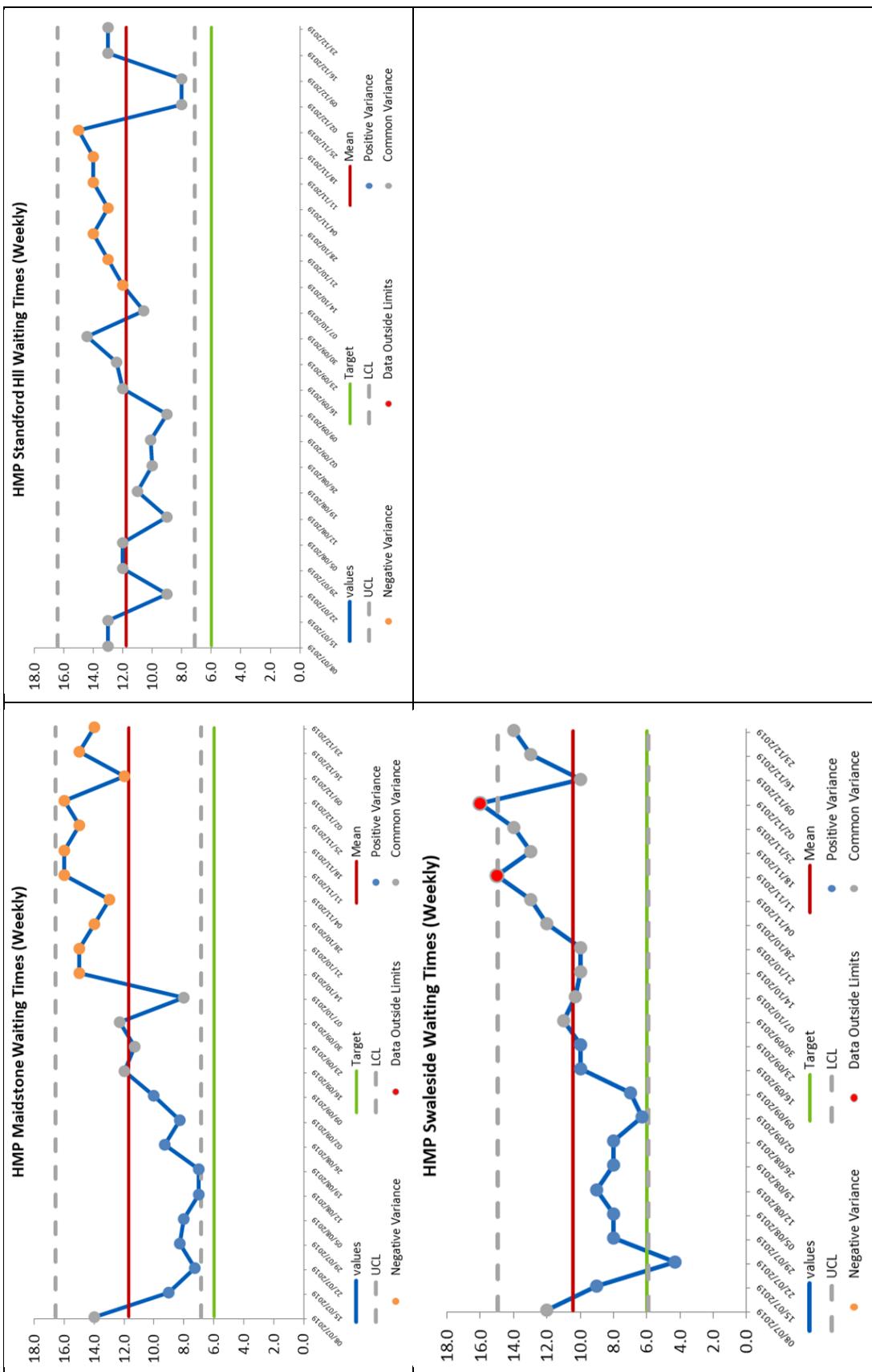
5.1.7 6 Week Diagnostics (Audiology)



6 week diagnostics waits for paediatric audiology is experiencing a period of positive special cause variation, with the last 15 months performing above the mean, with the target being achieved for 6 consecutive months.

The Service has moved to business as usual and going forward if the referral rates remain within the normal parameters of between 300 and 400 per month, the service will continue to be fully compliant with the 99% target within six weeks. Weekly teleconferences continue to ensure that we maximise clinical capacity to meet demand.

5.1.8 Dental Prisons Waiting Times



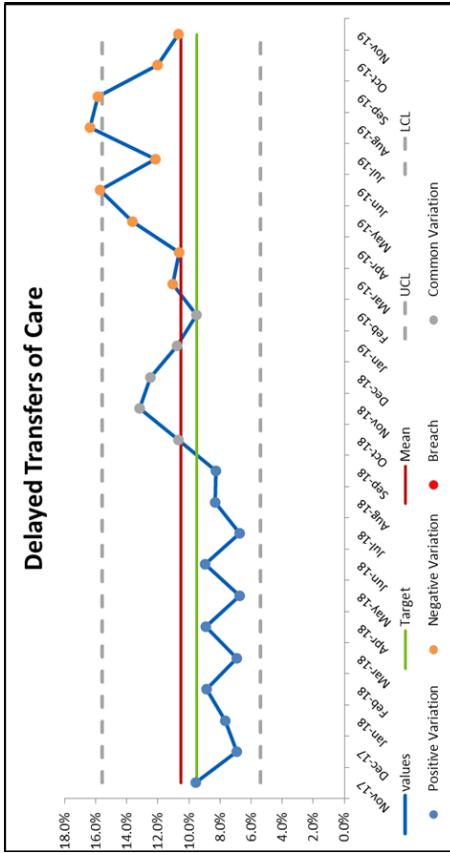
The above charts show that prison waits are currently experiencing adverse special cause variation at HMP Maidstone, plus in all three cases current performance is above the mean and the target is either below or near the lower control limit, suggesting consistent achievement of the 6 week target is unlikely to occur in the current environment.

The Dental prison service had been providing additional sessions within prisons at our own cost to manage waiting times which had been masking the true contractual level of performance. A business case is with NHS England to fund the additional sessions required to bring the waiting times to an average of 6 weeks. This has been re-reviewed on the 9th January 2020 to be tabled with the senior committee on the 5th February.

In the meantime all prison health services in Kent are being market tested including the dental element. The model is a lead provider with sub-contractors which would include dentistry. The delay this has caused is creating more uncertainty and risk of long term breaching of waiting times.

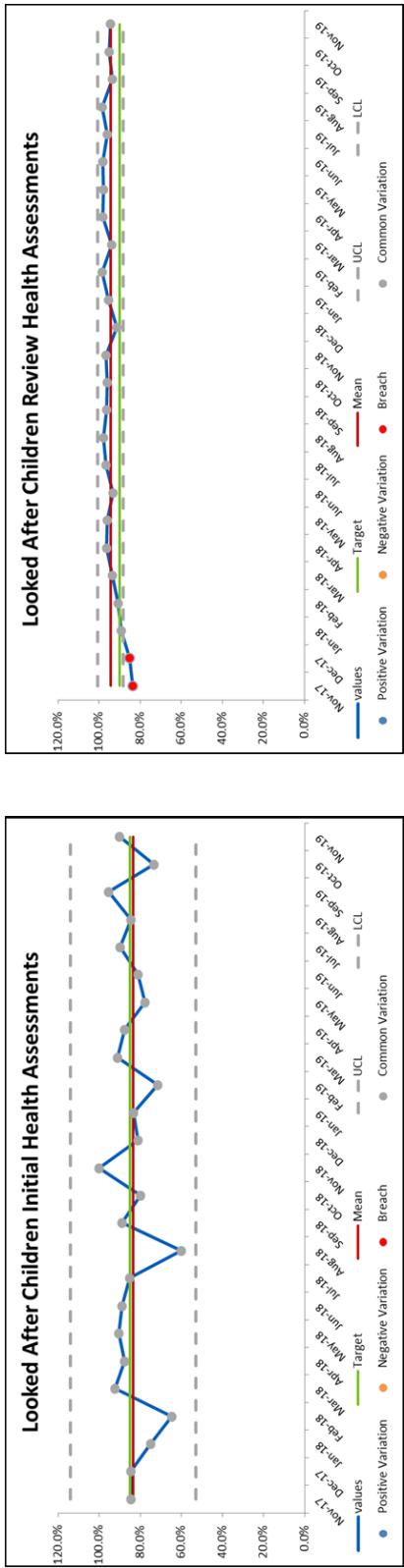
Current performance at 13th January 2020 indicates an increase in average wait time performance across all facilities since October 2018 to on average 10.7 weeks.

5.1.9 Delayed Transfers of Care (DTOCs)



KCHFT's target for delayed transfers is to achieve 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. Performance had improved in month 4 but remains in special cause variation with a period of 9 months above the mean, caused by an increased level of delayed transfers in east Kent. There has been consistently high delays due to availability of social care packages and also delays due to patient choice. The patient choice policy is being reviewed following evaluation of the Lincolnshire model and if this is implemented this should reduce these types of delay.

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. Performance can still be variable and liable to failing to meet target some months, due to late requests being received from KCC. We are working with KCC to ensure timely requests. 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.

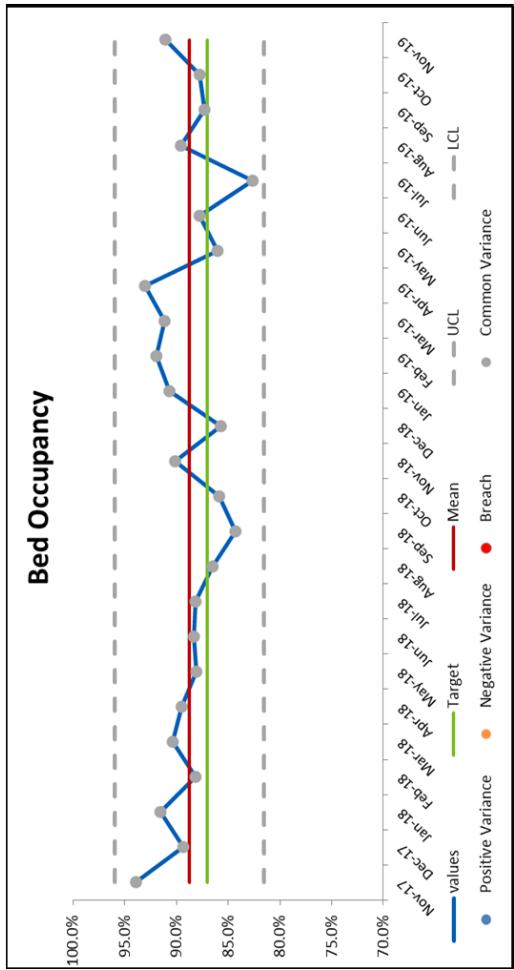
Compliance with the Review Health Assessment target is also now showing normal variation and meeting target.

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, currently performing above the target and mean.



5.1.13 CQUIN

The 2019-20 Q2 CQUIN achievement (% of potential income) is at 100%, although the national CQUINs are more highly weighted to the end of the year

5.2 Assurance on activity and productivity

5.2.1 Activity

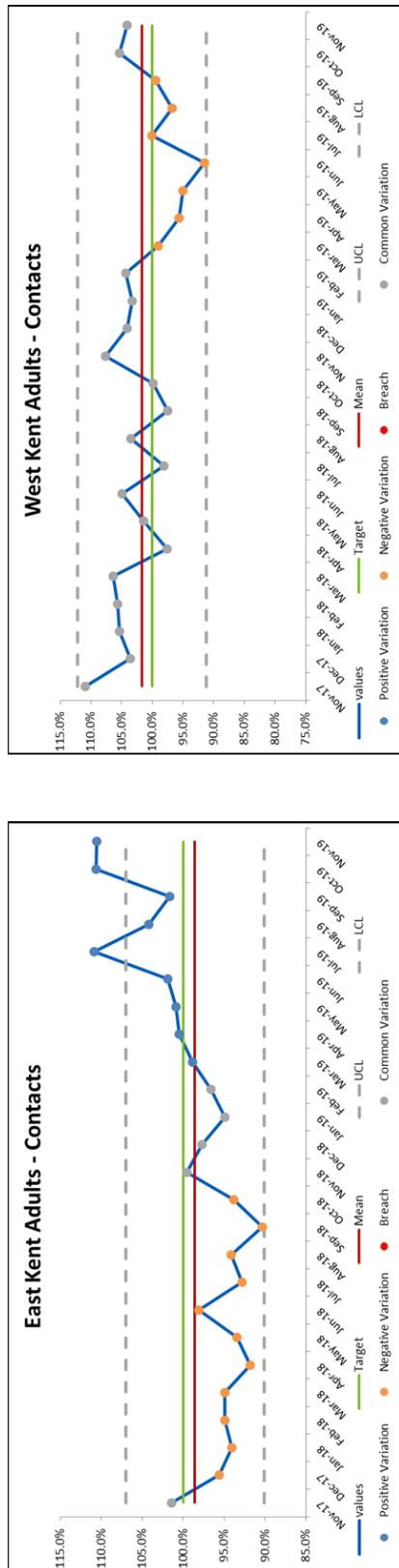
During November 2019 KCHFT carried out 188,478 clinical contacts, of which 9,790 were MU attendances. For the year to November 2019 KCHFT are 1.1% above plan for all services (some services have contractual targets, some are against an internal plan), a slight improvement on the M7 position. The largest negative variances are within Public Health Services (-6.3%) and Adult Specialist Services (-1.9%). Public Health services activity is an internal only plan based on 18/19 activity and while activity levels within Health Visiting has been impacted by staffing challenges, this has not negatively impacted achievement of the national KPIs related to mandatory checks.

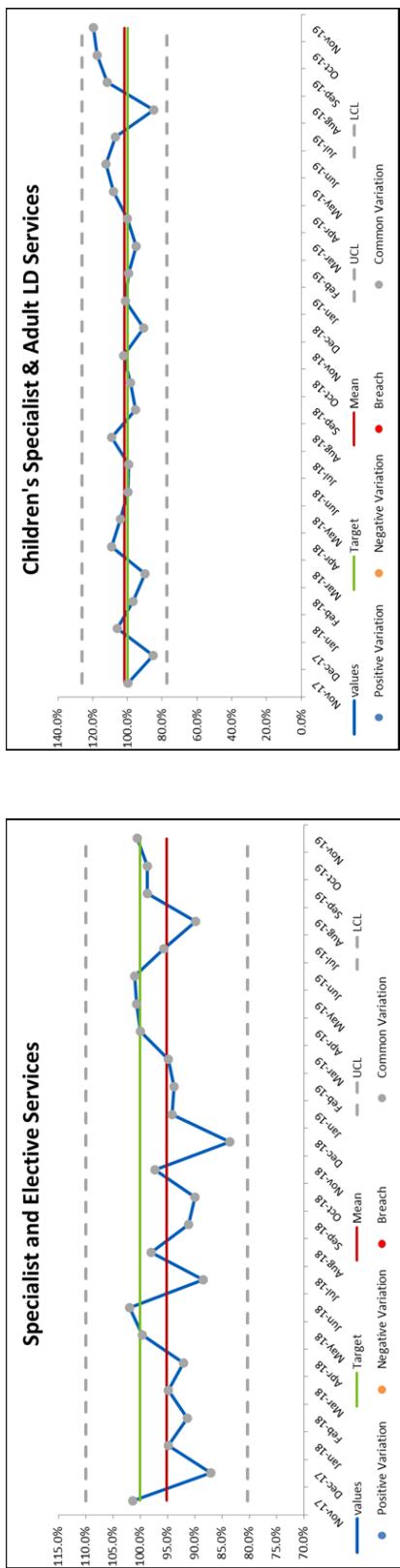
Specialist and Elective Services are still recovering following lower activity levels in July and August which has caused the YTD underperformance. There is a large variance in Pulmonary rehab which is predicted to improve following recruitment.

Service Type	M&B Actual	YTD Actual	YTD Plan	YTD Variance	Movement	Internal BRAG	Contract BRG
East Kent Adults - Contacts	58,339	451,318	429,267	5.1%	Negative		
East Kent Adults - MUU	3,440	31,494	30,807	2.2%	Negative		
East Kent Adults - Admissions	106	908	625	45.4%	Negative		
West Kent Adults - Contacts	26,024	200,197	203,261	-1.5%	Negative		
West Kent Adults - MUU	6,350	57,953	57,331	1.1%	Negative		
West Kent Adults - Bed Days	2,736	21,918	17,765	23.4%	Negative		
Specialist and Elective Services	28,779	227,281	231,765	-1.9%	Negative		
Children's Specialist & Adult ID Services	21,906	158,832	147,394	7.8%	Negative		
Public Health Services	30,975	246,360	262,959	-6.3%	Negative		
Dental Service	9,823	82,505	82,100	0.5%	Negative		
Trust Total Activity against plan	188,478	1,478,766	1,463,273	1.1%	Static		

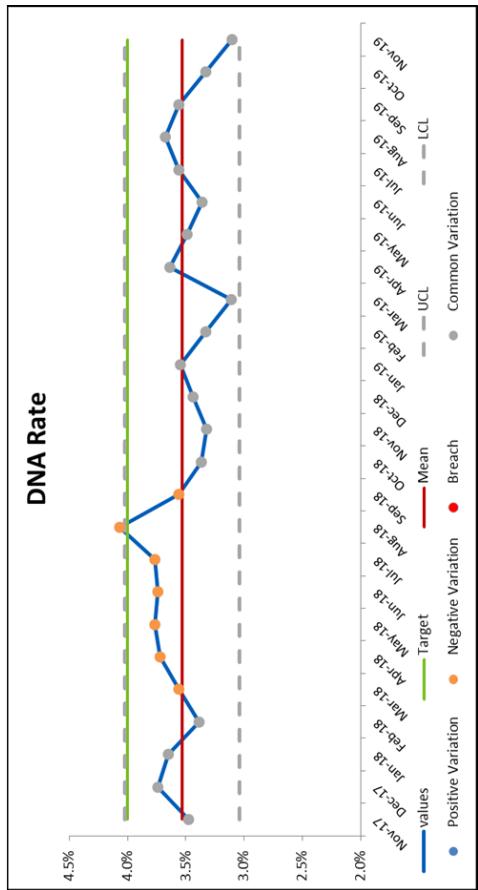
*these figures are not included in the table totals as they don't have a contractual target

The following charts show the monthly activity against target for East and West Kent Adults, Specialist and Elective Services and Children's Specialist & Adult LD Services, with East Kent showing a period of special cause variation with a shift above the mean, and West Kent now showing normal variation following a negative shift.



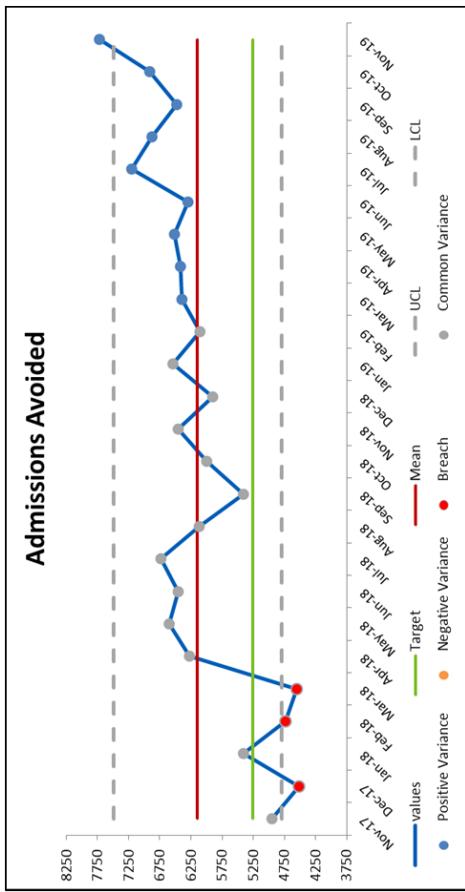


5.2.2 DNA rates



DNA rates continue to fall below the target of 5%, although are higher within some services, particularly children's therapies. This KPI is now experiencing normal variation with a slight downwards shift. The target is close to the upper control limit indicating that it is unlikely that levels would increase above target.

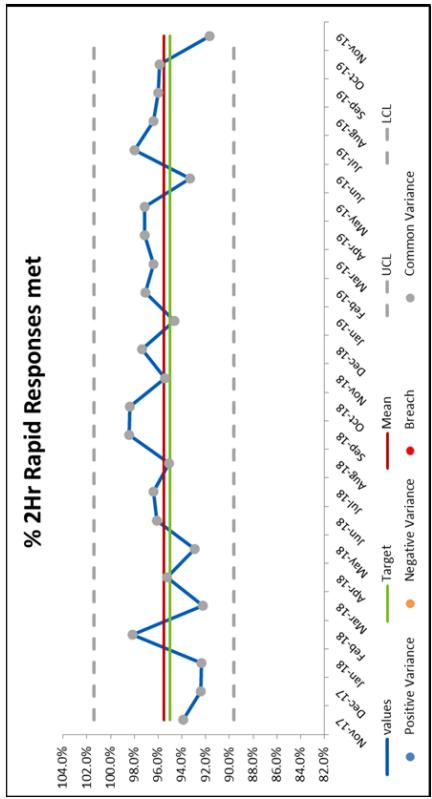
5.2.3 Admissions Avoided



There have been a higher level of admissions avoided in the last 9 months, with the above chart indicates that performance is experiencing special cause variation. This special cause is believed to be related to the work within local care that has led to increased referrals for admission avoidance, as well as increased nursing activity generally. Performance against target is favourable, although with performance being variable, achieving the target monthly is not always guaranteed.

5.2.4 Rapid Response referrals seen within 2 hours

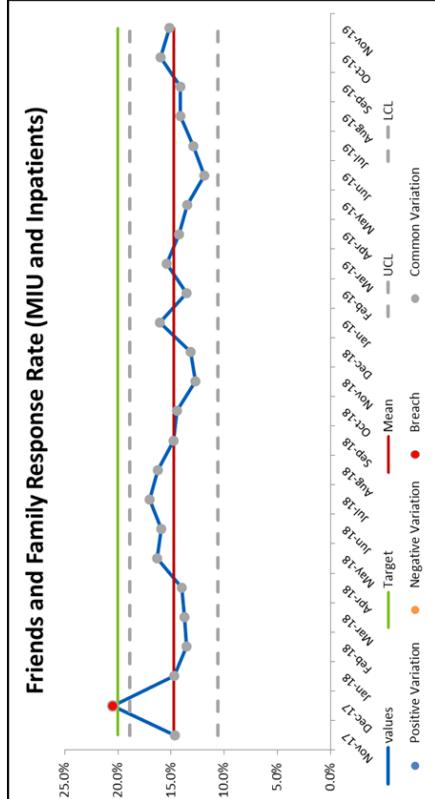
The mean level of performance is sitting marginally above the target level of 95%, with performance stable other than a slight dip in M8. Given the volatility and the high 95% target, it's unlikely the control limits will fully move above the target level in the near future to give full assurance of continual achievement.



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

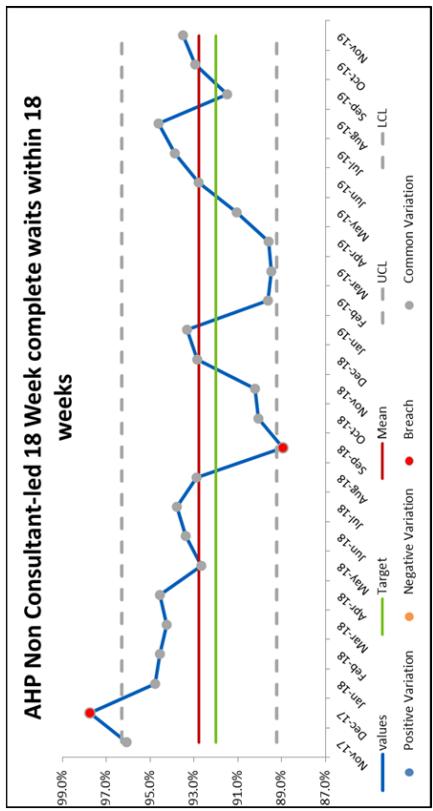
While the level of performance is showing normal variation, the target is now marginally above the upper control limit. Patients are asked to complete the surveys before they leave our Minor Injury Units but once they have been seen the uptake is difficult to achieve. Occasionally patients complete the surveys whilst they are in the waiting room but this is not a reflection of their visit just the booking in process. Emailing the link to the survey has been trialled but this has not worked.

The low levels are mainly due to decreased surveys being completed at Sittingbourne, Sheppey, Sevenoaks and Edenbridge. However current performance is now above the mean, there appears to be the start of an improvement although this will need to be monitored to see if this is a continuing trend or a chance event.



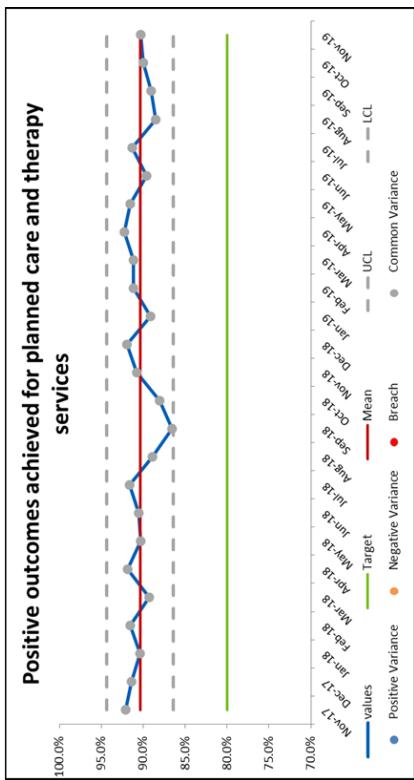
5.3 Assurance on Local Wait Times

Completed wait times for all non-consultant-led AHP services are now showing normal variation and signs of an improving trend as some of the backlog has now been cleared and performance is showing improvement.

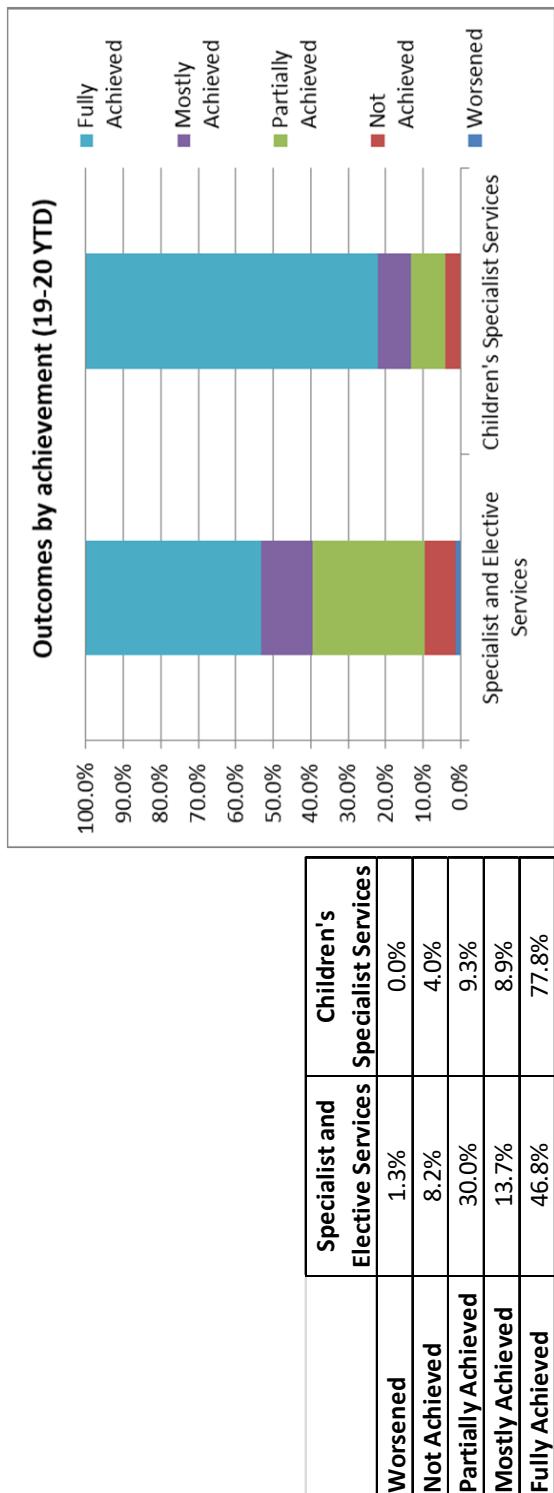


5.4 Outcomes

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 normal 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.

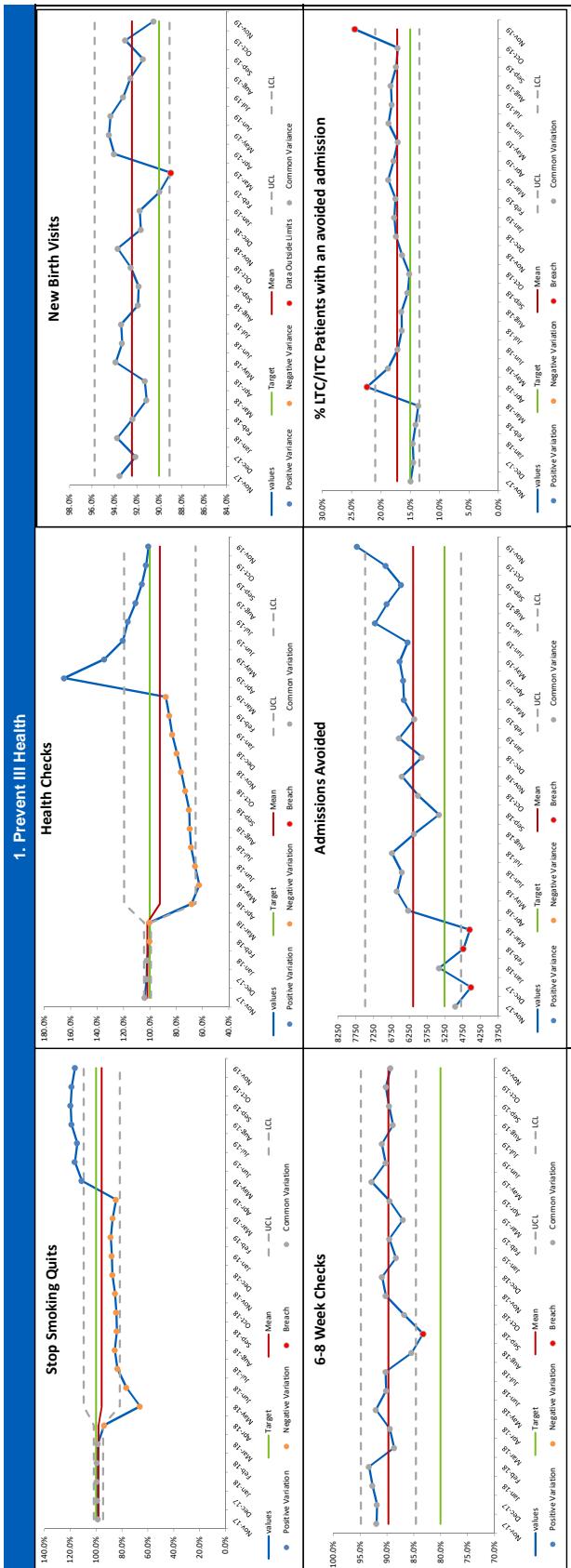


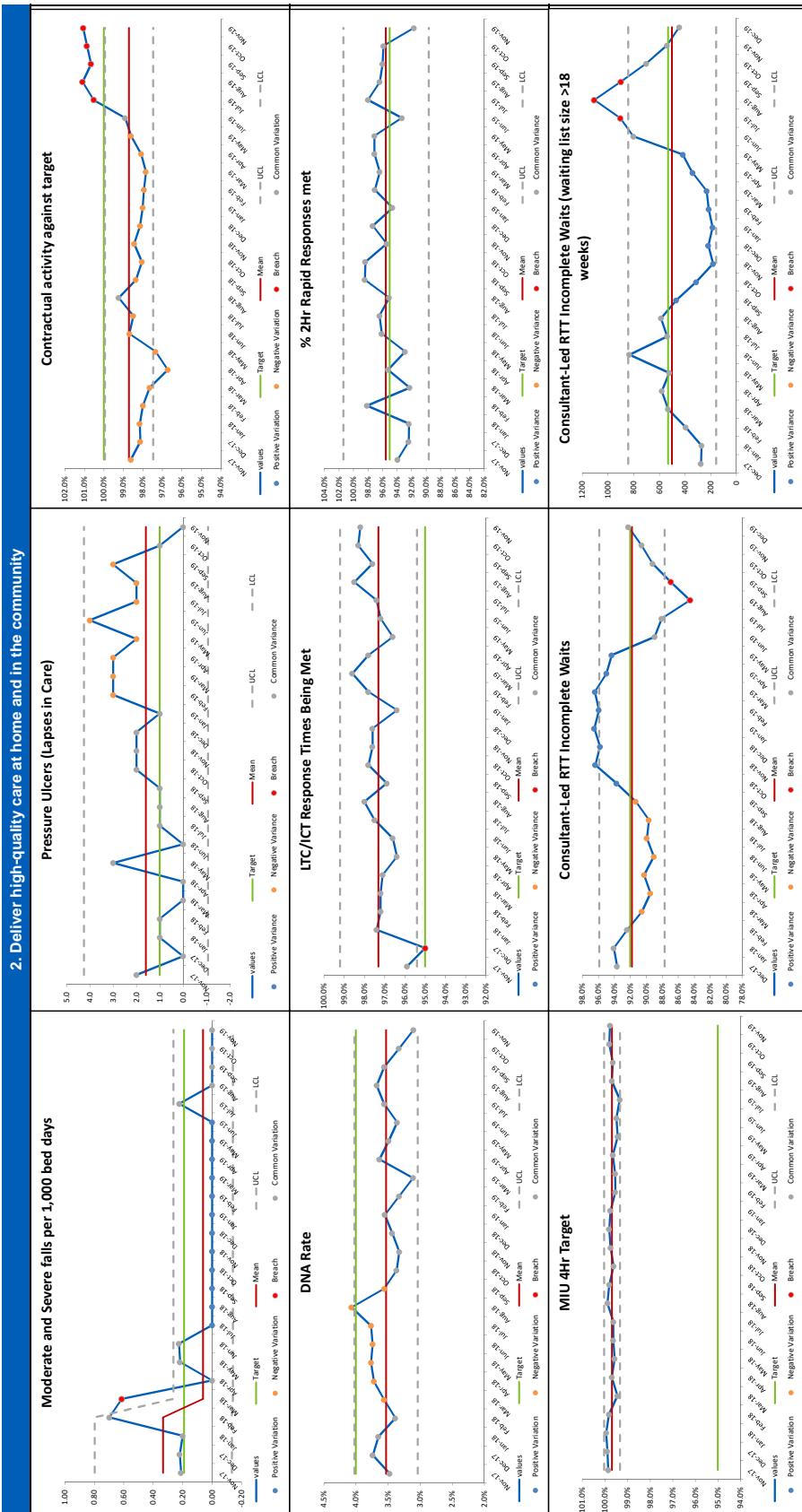
The following table and chart shows the proportion of the grading of each outcome for the year to date, split by service type for further detail on outcomes. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised.



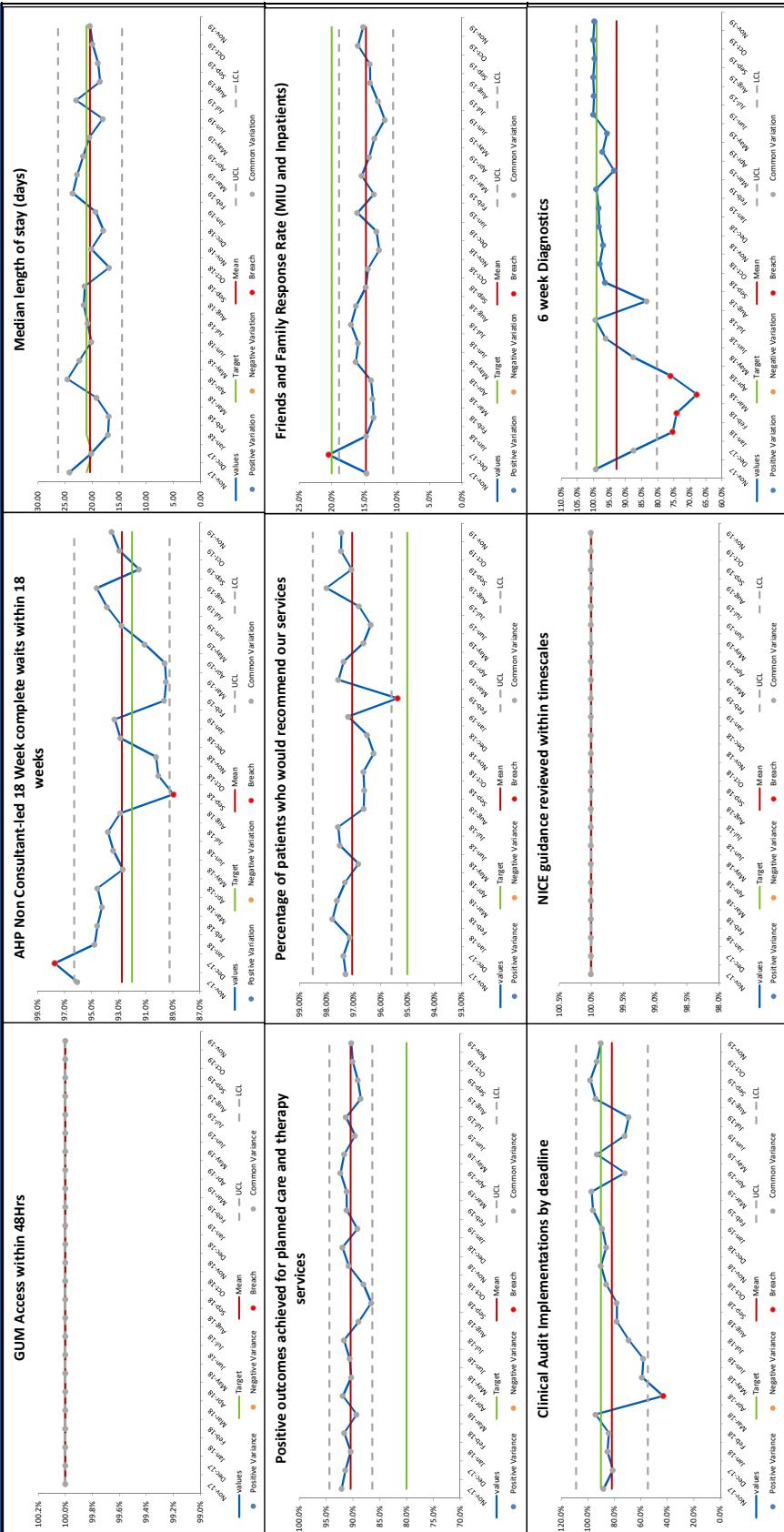
At present, this metric is only available for Children's Therapies within Children's Specialist Services, who are achieving a high level of outcomes. Within Adult Specialist and Elective Services the outcomes are not as high which is likely a result of a greater number of services included in the calculation, with varying levels of achievement.

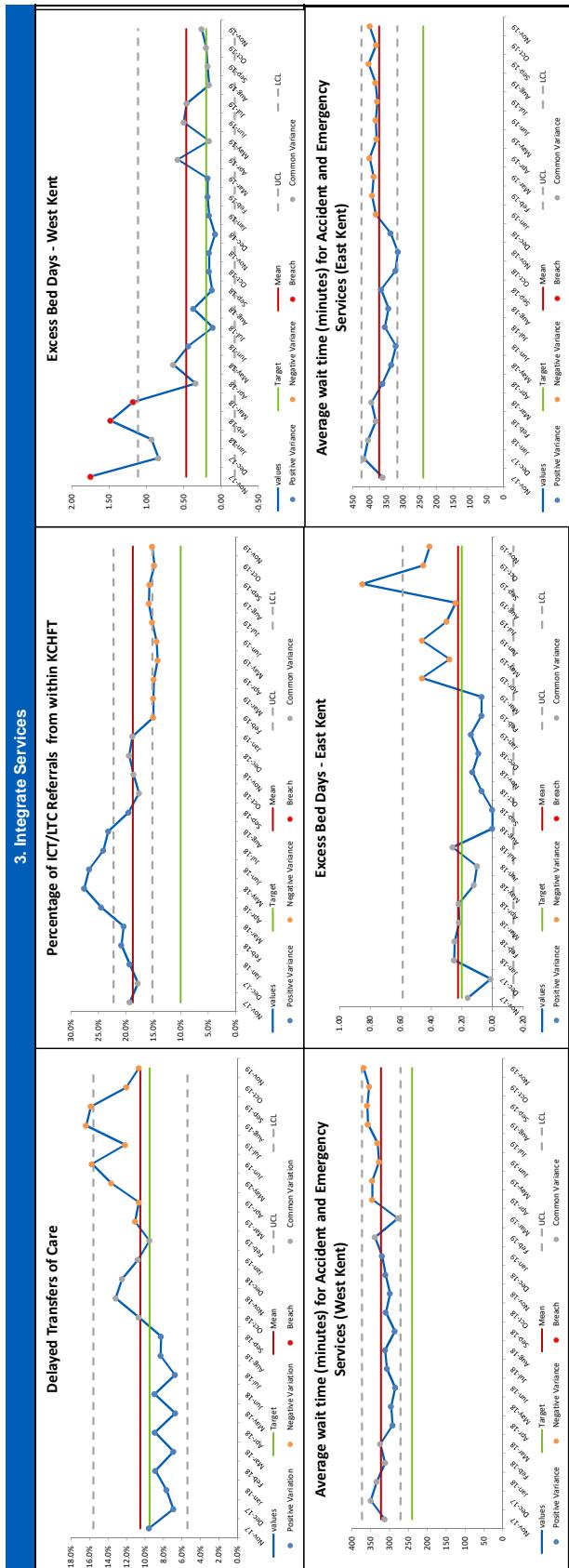
Appendix - Scorecard SPC Charts

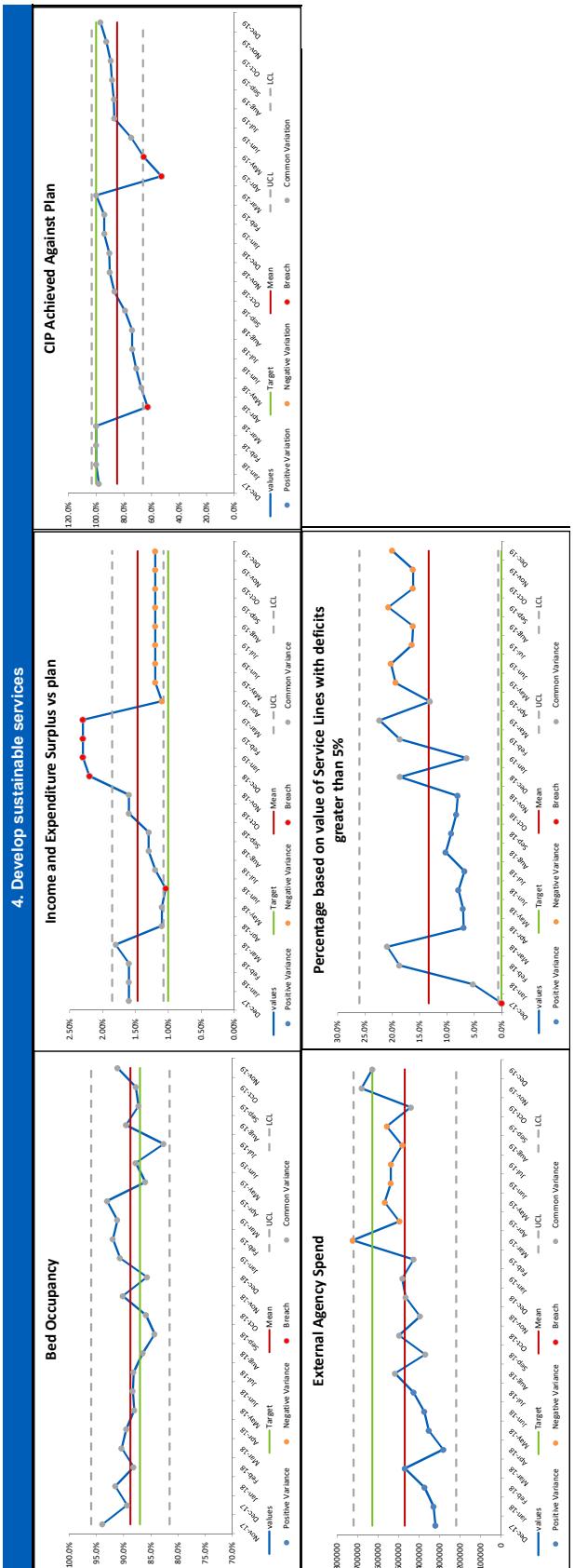


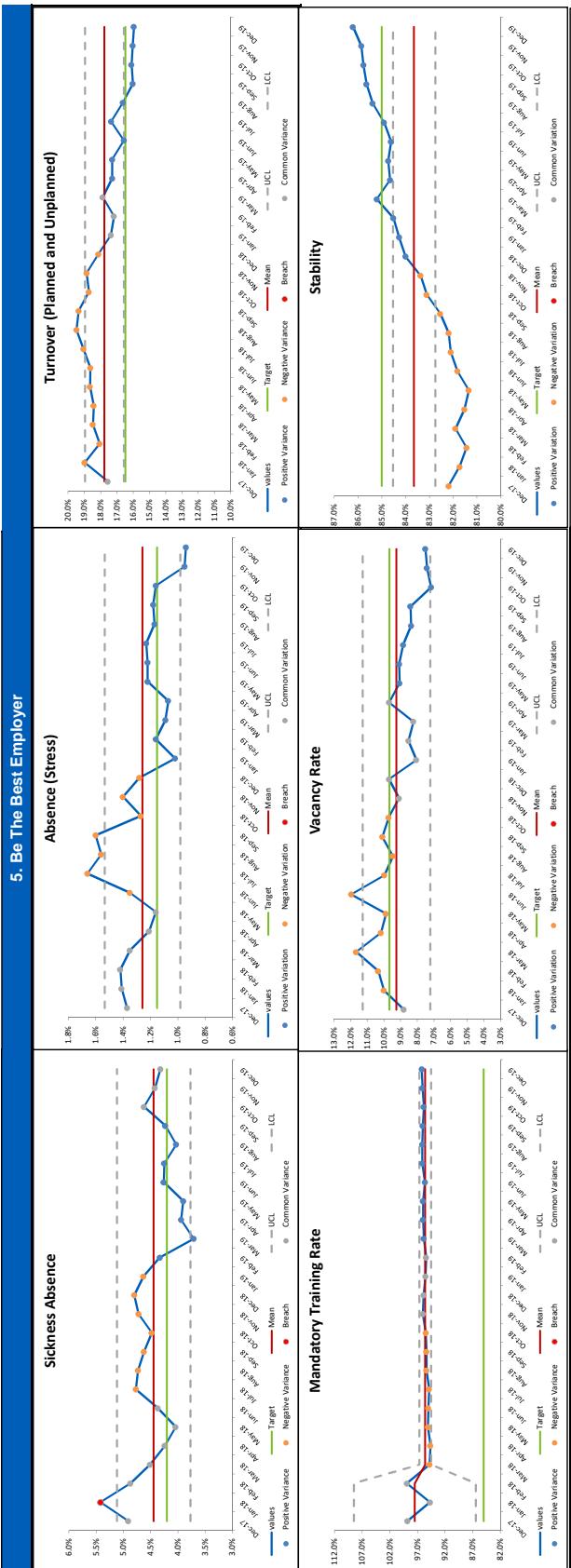


2. Deliver high-quality care at home and in the community









Committee / Meeting Title:	Board Meeting - Part 1 (Public)		
Date of Meeting:	06 February 2020		
Agenda Number:	3.2		
Agenda Item Title:	Learning from Deaths Quarterly Report		
Presenting Officer:	Dr Sarah Phillips, Medical Director		

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary	
<p>In line with national guidance on learning from deaths, Kent Community Health NHS Foundation Trust (KCHFT) collects and publishes mortality data quarterly via a paper to Quality Committee and Public Board, which must include mortality data and learning points. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths reviewed, the Trust must report how many deaths were judged more likely than not to have been due to problems in care.</p> <p>Mortality reviews are conducted through a centralised process where the review team is made up of a doctor, a ward matron or other senior clinical staff member, a pharmacist, a quality lead and centralised administrative support. Members rotate monthly to maintain a degree of independence. An internal process for reviewing deaths of patients with Learning Disabilities is in place alongside the national Learning Disability Mortality Review (LeDeR) process for additional assurance, best practice and to meet the Trust's ethical obligations. Learning from these reviews is submitted to the Mortality Surveillance Group.</p> <p>As defined in the Policy, the Trust Board has overall responsibility for ensuring compliance with all legal and statutory duties, along with best practice including having oversight of mortality review processes and awareness of the learning emerging from reviews that drive improvements in care. The focus of trust mortality review is on quality improvement and sharing meaningful learning.</p> <p>The Mortality Review and Responding to Deaths policy has recently been reviewed to ensure it reflects current processes which have evolved over the past year, and is now in the updated Trust policy template. Comments from the Mortality Surveillance Group have been sought and incorporated into the new document and will be submitted to Clinical Effectiveness Group (CEG) in February 2020.</p>	
Proposals and /or Recommendations <p>To note the report.</p>	
Relevant Legislation and Source Documents	

Has an Equality Analysis (EA) been completed?

Yes

The Equality Analysis found a positive impact for age, disability, pregnancy and maternity as the policy makes specific reference to reviewing deaths of patients under 18, those with severe mental illness and learning disabilities, and that the Trust would assist in reviews of maternity deaths if required.

Dr Sarah Phillips, Medical Director	Tel: 01622 211922
	Email: sarahphillips4@nhs.net

LEARNING FROM DEATHS REPORT (October to December 2019)

1. Introduction

- 1.1 In line with national guidance on learning from deaths, Kent Community Health NHS Foundation Trust (KCHFT) collects and publishes mortality data quarterly via a paper to Quality Committee and Public Board, which must include mortality data and learning points. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths reviewed, the Trust must report how many deaths were judged more likely than not to have been due to problems in care.

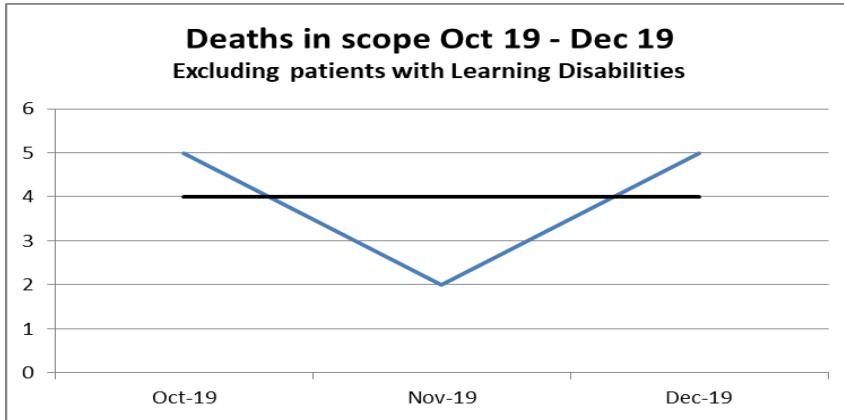
2. December Dashboard

- 2.1 The dashboard below has been based on national suggested format. Deaths in scope include all community hospital inpatient deaths, any deaths where a complaint or potential SI has been raised, and a small sample of deaths in the community.

Total Number of Deaths in Scope		Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month	Last Month	This Month		Last Month	This Month	Last Month
5	2	4*		5	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
12	18	15		19	0	0
This Year (YTD)	Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
69	77	65		69	0	0

*Deaths reviewed in a calendar month may exceed the number of deaths reported that month, as the figure includes deaths taking place in the previous month, but falling into the next month for review; this also applies to those occurring in one year e.g. December, but reviewed in January of the next.

- 2.2 The graph below shows the number of inpatient deaths in community hospitals this quarter by month, along with the average.



3.0 Themes from Mortality Reviews

- 3.1 The tables below outline key areas of good practice along with areas for learning identified in reviews completed this quarter, along with the actions taken. These are also reviewed in the monthly Mortality Surveillance Group (MSG).
- 3.2 All areas of good practice and areas for learning are reported at monthly matrons' meetings in East and West Kent, and wider dissemination to all ward staff is encouraged. A report is also reviewed at the bi-monthly End of Life Steering Group.
- 3.3 The three most common themes in good practice emerging this quarter, aligned to the Five Priorities for Care of the Dying Person:
- Excellent examples of patient-centred care and documentation evidencing respect for patients' wishes. Examples are response to food preferences, working hard to keep patients on the ward in cases where they did not want to be transferred to a care home, and well documented, sensitive conversations with families. **Involve, Communicate & Support**
 - In the majority of cases, all relevant assessments are completed within 24 hours of admission, and there is good cross-team working with dietetics, physiotherapy, OT, SALT and Safeguarding as appropriate. **Plan & Do**
 - Although there is scope for improvement in advance care planning, ceilings of care are being affirmed early in many cases and well documented. Medications are reviewed and stopped appropriately at end of life **Recognise**
- 3.4 The three most common themes in areas for improvement emerging this quarter, and actions to take forward:

Themes	Comments/Actions
Documentation <ul style="list-style-type: none"> - Documentation continues to emerge as a recurring theme, with 	This reflects ongoing Trust-wide work with documentation standardisation

<p>particular issues around Personalised Care Planning. PCPs frequently read like treatment plans and miss the holistic overview and patient voice. The combination of paper and electronic notes are difficult to navigate to get a clear overview at times.</p> <ul style="list-style-type: none"> - There are sometimes out of date documents or forms being used. - At one community hospital, medical notes have been noticed to be frequently unsigned and undated, with an illegible signature. Notes are also printed from a dictation machine and stuck into the paper records. 	<p>and care plans generally. It is hoped that PCP formats can be reviewed as part of the Rio documentation rationalisation.</p> <p>A working group is being set up to develop an End of Life bundle to take forward consistency of documentation across the Trust.</p> <p>This is not in line with the Trust Record Keeping Policy. The issue has been fed back to the ward matron for sharing with the doctor and wider team. Advice has also been obtained from the Trust legal team with regard to record keeping standards, and ongoing concerns have been escalated to Dr Sarah Phillips and the relevant line managers.</p>
<p>Medicines Issues</p> <ul style="list-style-type: none"> - Drug charts are sometimes unclear and cancelled drugs are not always signed and dated. When a drug is unavailable, records do not always clearly explain why this was and what actions were taken as a result. - In one case, breakthrough doses of oramorph were insufficient for pain relief. The consolidated oxycodone did not seem in keeping with the regular dose of morphine. 	<p>All medicines feedback is sent to the Chief Pharmacist as well as the ward team, for awareness and monitoring.</p>

Policies, Processes & Transfers of Care	
<ul style="list-style-type: none"> - A pattern is emerging of staff confusion around verification and certification of death, which has led to delays in several cases. There are sometimes challenges in communicating with GP surgeries to request certification. - In one case it was noted that a VTE assessment had been completed on admission, but there should have been another assessment before the decision to stop Clexane was made, giving evidence for the rationale. - There have been system-wide transfer of information issues, with fragmented information and lack of consistency between the GP, the acute hospital and the community. In one case, there was no discharge summary from the acute hospital, and in another case, despite clear recognition while at the acute that the patient was for palliative care, there was no end of life care plan or advance care plan sent with the patient to the community hospital. 	<p>A workshop is being held on 28 January to review three recent cases where there has been delayed verification or certification, with participation from the teams involved, to gain learning and unpick the issues. Work is also ongoing to clarify the Care After Death policy to improve staff understanding and confidence.</p> <p>This is not a criticism of the ward team, but will be taken forward to address Trust-wide with regard to a potential update of the VTE policy.</p> <p>It is recognised that these are not localised care issues and will be addressed through the Transfers of Care Task and Finish Group, discussion with other providers, and looking at our own processes and documentation as part of the Rio implementation.</p>

Dr Lisa Scobbie, Deputy Medical Director and Melissa Ganendran, Mortality Review Project Lead

on behalf of
Dr Sarah Phillips, Medical Director
January 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)				
Date of Meeting:	06 February 2020				
Agenda Number:	3.3				
Agenda Item Title:	Approved Minutes of the Charitable Funds Committee Meeting				
Presenting Officer:	Jen Tippin, Chair of Charitable Funds Committee				

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report Summary

The paper presents the confirmed Minutes of the Charitable Funds Committee meeting of 29 November 2019.

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.

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

**CONFIRMED Minutes of the Charitable Funds Committee
held on Friday 29 November 2019
in the Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming,
Maidstone Kent ME16 9NT**

Dial in Skype – Conference ID 3793586

Present: Jen Tippin, Non-Executive Director (Chair) (By Skype)
Pippa Barber, Non-Executive Director
Carol Coleman, Public Governor, Dover and Deal
John Goulston, Trust Chair
Stephanie Rhodes, Head of Service Long Term Services West Kent (agenda item 2.3) (By Skype)
Jane Thackwray, Strategic Delivery Manager (agenda item 2.3) (By Skype)

In Attendance: Gina Baines, Committee Secretary/Assistant Trust Secretary (note-taker)
Jo Bing, Assistant Financial Accountant
Jo Treharne, Head of Campaigns (agenda item 2.2)
Carl Williams, Head of Financial Accounting (agenda items 2.1 and 2.4)

026/19 Introduction by Chair

Pippa Barber, Acting Chair welcomed everyone present to the meeting of the Charitable Funds Committee meeting.

027/19 Apologies for Absence

Apologies were received from Victoria Cover, Head of Clinical Services Urgent Care and Hospitals West Kent; Paul Ducker, Acting Convenor Staff Side; Gordon Flack, Director of Finance; Brenda Hollier, Senior Clinical Nurse Specialist; Jane Kendal, Community Services Director; Claire Poole, Community Services Director Public Health/Deputy Chief Operating Officer and Lesley Strong, Chief Operating Officer.

The meeting was quorate.

028/19 Declarations of Interest

There were no declarations of interest given apart from those formally noted on the record.

029/19 Minutes and Matters Arising from the Meeting of 26 July 2019

The Minutes were **AGREED**.

The Matters Arising Table Actions Closed was **AGREED**.

The outstanding actions were discussed and updated as follows:

020/19 Marketing the Charitable Funds Report (Two actions) - Awaiting a decision of the Committee around the branding of the charity before progressing this action. Action open.

022/19 Annual Financial Statement – Jo Bing confirmed that there was a new fund for the Benenden Unit which was a designated unrestricted fund. Carly Edmed, Advanced Nurse Practitioner/complex care (Inpatients) had been appointed as its fund manager and advised of the procedure for accessing funds. The first funds were received in September 2019. With regards to the community hospitals restricted funds there had been two amounts received for legacies: £139447.80 for Tonbridge Cottage Hospital and £300 for Sevenoaks Hospital. These funds have been added to fund number 200 and are managed by Victoria Cover, Head of Clinical Services Urgent Care and Hospitals. Action closed.

022/19 Annual Financial Statement – Awaiting a decision from the Committee around the branding of the charity before progressing this action. Action open.

023/19 Forward Plan – Action open.

023/19 Forward Plan – A piece of equipment has been identified to be purchased. Quotes are outstanding at present and have been chased. It is anticipated that the cost will use up all the outstanding monies in the fund. Action open.

All other outstanding actions were closed.

Jen Tippin joined the meeting and took over as Chair.

030/19 Relevant Feedback from Other Committees

There was nothing to report from the other recent committee meetings.

There were no comments regarding the Board Assurance Framework.

031/19 Draft Charitable Funds Report and Accounts 2018/19

Carl Williams presented the report to the Committee for assurance.

There were no changes to the figures that had previously been presented to the Committee. The independent examination by the Trust's external auditors did not indicate any material changes. The final 2018/19 Annual Report and Accounts would be presented to the Committee at its next meeting in January 2020.

In response to a question from Pippa Barber as to who received the final annual report and accounts, Carl Williams confirmed that they were sent to the Charities Commission. John Goulston suggested that from a governance perspective, the annual report and accounts should also be circulated to the Trust Board. It was agreed that they would be received at the Formal Board meeting in February 2020 for information.

Action – Carl Williams/Gina Baines

In response to a question from Jen Tippin as to whether there were any comments from the auditors, Carl Williams confirmed that they had found nothing of concern and that their report would be added to the accounts.

The Committee **NOTED** the Draft 2018/19 Charitable Funds Report and Accounts.

032/19 Charitable Funds Marketing Report

Jo Treharne presented the verbal report to the Committee for assurance.

The Committee discussed the three branding options that had been proposed and it was agreed that the Communications Team would develop Option One, with the caveat that 'Kent Community Health Charitable Fund', the official registered name of the charity was the name that was required to be referred to on branding.

It was confirmed that there had not been a great deal of fund raising activity since August 2019. The charity now had a presence on Facebook which had attracted a small amount of giving. Jo Treharne confirmed that she would be taking on a different role in the Communications Team. The team would be taking on additional resource which would provide support to the charitable fund. In response to a question from Carol Coleman as to whether a volunteer could be appointed to provide the marketing support that was needed, Jo Treharne responded that this was being considered.

Carol Coleman reported that she had seen contactless payment devices in use and wondered if this could be a way of collecting donations. Arrangements appeared to be quite straightforward with a limited outgoing of around £6 a month.

With regards to collecting donations in envelopes and banking them, Carl Williams reflected that the Trust no longer had the administrative resource in place to do this within the community hospitals. The suggestion was made that contactless payment devices could be an alternative. Carl

Williams confirmed that he would be undertaking a review of card terminals in the Trust and he would include the suggestion as part of the review.

Action – Carl Williams

Jo Bing commented that the Trust's Just Giving page needed a review and suggested that this was the ideal way to give to the charity.

Action – Jo Treharne

The Committee agreed that the collection of donations through envelopes would be abandoned and that the Communications Team would look at the more secure options which had been suggested.

Action – Jo Treharne

The annual Christmas Jumper Day would take place on Friday 13 December and the icare charity had been nominated for that day's fundraising. The Trust now had a football team and its cost had been supported by the fund. It would be taking part in the Kent Community Cup in December 2019. In response to a question from Pippa Barber, it was confirmed that there would be an opportunity to fund raise at the event.

The Committee **NOTED** the verbal Charitable Funds Marketing Report.

033/19 Fund Manager presentations

Stephanie Rhodes and Jane Thackwray presented the reports to the Committee for assurance.

Stephanie Rhodes provided an update on the Bow Road Fund. The programme schedule was tabled at the meeting. A copy would be circulated to Jen Tippin and Jane Thackwray.

Action – Gina Baines

In response to a comment from Carl Williams that it was encouraging to see that the fund was now being spent, Stephanie Rhodes indicated she was confident that another £20,000 would be spent. This would leave a residual £15,000 in the fund.

In response to a question from Carol Coleman as to whether any monies should be held back for ongoing maintenance, Stephanie Rhodes agreed she would check with the surgery on this.

Action – Stephanie Rhodes

Stephanie Rhodes left the meeting.

With regards to whether the Committee wished to have further oversight of how the Bow Road Fund was spent, Jo Bing confirmed the process that was in place under the scheme of delegation. The Committee agreed that it did not require any further information.

On behalf of Jane Kendal, Jane Thackwray provided an update on the East Kent Charitable Fund and the Heron Ward (Mermikides) Fund. With regards to using the Mermikides Fund to help with refurbishing Heron Ward at Queen Victoria Memorial Hospital, Herne Bay it was explained that the work had originally been planned for 2019. Unfortunately the project manager had left and the work held back and re-specified. The Trust was reliant on NHS Property Services (NHSPS) and the community hospital's League of Friends to agree the revised schedule before going ahead with the work. The full scheme of works had been reworked and following this the Trust had formally written to NHSPS. It was anticipated that NHSPS and the League of Friends would agree to the revised schedule which would allow work to begin in April 2020; once the ward had moved out of the winter pressures period. The focus of the work would be to upgrade the therapy rooms. In the meantime, some work had been completed in relation to making the patients' environment more dementia friendly, improving the fabric of both the toilets and the day room. Carl Williams requested that a record of the spend so far from the fund should be submitted to the Committee.

Action – Jane Thackwray

Carl Williams highlighted that it was important that the fund should be spent as a priority since the Trust had received the legacy in March 2018. The Trust had a responsibility to the donor to use the money promptly as set out in their wishes.

In response to a question from Pippa Barber, it was agreed that Jane Thackwray would arrange a date to meet with the League of Friends and confirm this with the Committee.

Action – Jane Thackwray

In response to a question from Pippa Barber as to whether the League of Friends supported the project, Jane Thackwray indicated that they did. The delay centred on reaching an agreement about who was paying for what. The loss of the project manager had also impacted on progressing the project.

In response to a question from Pippa Barber as to whether the project manager had been replaced, Jane Thackwray indicated not although a Mr John Upton would be providing support. It was agreed to find out if he was an employee of the Trust.

Action – Jane Thackwray.

It was agreed that the Committee would receive an update in January 2020 with the expectation that the planning would be near completion for work to begin in April 2020.

Action – Jane Thackwray

The Committee agreed that progress was needed quickly so that the fund could be spent promptly.

In response to a question from Carol Coleman as to whether the donor had asked for an update, Carl Williams confirmed that they had not. It was agreed that the donor would be informed of progress once the plans were in place.

Action – Carl Williams

In response to a question from Pippa Barber as to which bids for equipment should be considered by Charitable Funds and which should be considered by the Capital Steering Group, Carl Williams suggested some of the equipment in the bid from the East Kent Fund should go to the latter. He emphasised that for the purchase of medical equipment, it was practice for the Trust's own internal sources of funding e.g. availability of capital funds, to be reviewed prior to sourcing funding from the Charity especially when the piece of equipment was something that the NHS should be funding from its own resources. If there was insufficient capital funding and the Trustee agreed that the purchase of the equipment met the objectives of the Charity, then ultimately the equipment could be funded from Charitable Funds.

In response to a request from Jane Thackwray for more guidance on where bids should be submitted, it was agreed that Jo Bing would advise her.

Action – Jo Bing

The Committee **NOTED** the Fund Manager presentations

034/19 Reserves Policy

Carl Williams presented the report to the Committee for assurance.

The Committee **NOTED** the Reserves Policy and **APPROVED** the continuation of the current reserves policy.

035/19 Forward Plan

Jen Tippin presented the report to the Committee for approval.

For the January 2020 meeting, it was agreed that the 2018/19 Annual Report and Accounts would be presented for approval. The Committee would also receive updates on marketing activity and the Mermikides Fund. It would also discuss the next fundraising campaign.

The Committee **AGREED** the Forward Plan.

036/19 Any Other Business

Jo Bing confirmed that she had been contacted by the Sexual Health Service in Medway. The service had been approached by the HIV charity, Positive Contact Kentwide which was winding up its activities. It had some residual monies which it wished to pass on to a relevant organisation to

spend. The majority of the fund which amounted to £15,000 was being offered to the Trust. The service had a plan and had created a working group to spend the money. It had been decided that it would be a designated but unrestricted fund and the monies were expected by the end of the 2019.

In response to a question from Jen Tippin as to whether the Trust had done something similar before, Jo Bing confirmed that the Mermikides Fund was a transfer. Carl Williams added that the recently received Benenden Fund was also a transfer. With regards to the money from the HIV charity, the Trustees were following good governance procedures and working through the Charities Commission.

Jo Bing confirmed that Tonbridge Cottage Hospital had received a legacy of £140,000. Victoria Cover had been informed of the new restricted fund for the community hospital.

In response to a question from Carol Coleman as to whether the money would be invested, Carl Williams indicated that the Trust's investment plan would be reviewed and amended as necessary.

In response to a question from Jen Tippin as to whether the family had been contacted, Jo Bing explained that the legacy had come from a solicitor. She believed there was no family but she would check.

Action – Jo Bing

Carol Coleman confirmed that with regards to the Sensory Garden at Deal Hospital, she had raised this with the local League of Friends that week. They were interested in the idea and a working group was being set up. A site inspection was planned to identify a suitable area. The intention was to use the Community Hospitals Restricted Fund. Approval would be needed from NHSPS before any work was undertaken.

The meeting ended at 11.05am.

037/19 Date and time of next meeting

Friday 17 January 2020; The Boardroom, The Oast, Unit D, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT

Committee / Meeting Title:	Board Meeting - Part 1 (Public)			
Date of Meeting:	06 February 2020			
Agenda Number:	3.3			
Agenda Item Title:	2018/19 Annual Report and Accounts – Kent Community Health Charitable Fund			
Presenting Officer:	Jen Tippin, Chair of Charitable Funds Committee			

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report Summary	
The 2018/19 Annual Report and Accounts for Kent Community Health Charitable Fund are presented for the information of the Board. The accounts have undertaken an Independent Examination by the Trust's External Auditors and were approved by the Charitable Funds Committee on 17 January 2020. In turn the mandatory annual return submission to the Charity Commission has successfully been completed in line with the 2018/19 submission deadline.	

Proposals and /or Recommendations	
The Board is asked to note the above and the 2018/19 Annual Report and Accounts presented for information.	

Relevant Legislation and Source Documents	
Has an Equality Analysis (EA) been completed?	
No <input checked="" type="checkbox"/>	High level position described and no decisions required.

Carl Williams, Head of Financial Accounting	Tel: 01622 211929
	Email: carl.williams1@nhs.net

Kent Community Health Charitable Fund

Kent Community Health Charitable Fund

**Annual Report and Accounts for the Year
Ended 31 March 2019**

Registered Charity Number: 1139134

Kent Community Health Charitable Fund

Contents

Report of the Trustee.....	3
Independent Examiner's Report.....	9
Statement of Financial Activities.....	12
Balance Sheet.....	13
Statement of Cash Flows.....	14
Notes to the Accounts.....	15

Kent Community Health Charitable Fund

Report of the Trustee for the year ended 31 March 2019

Foreword

The Trustee presents their annual report and the audited financial statements for the period ended 31 March 2019.

The annual report and financial statements comply with the charity's trust deed, applicable Accounting Standards in the United Kingdom and the Statement of Recommended Practice (Charities SORP FRS 102) "Accounting and Reporting by Charities" issued in July 2014 (updated in February 2016) and the Charities Act 2011.

Reference and Administrative Details

Name and address of Charity: Kent Community Health Charitable Fund Trust HQ, The Oast, Unit D, Hermitage Court, Hermitage Lane, Barming, Kent, ME16 9NT Tel: 01622 211929

Registered Charity Number: 1139134

Other Name Used by Charity: i care

Trustee Arrangements:

Kent Community Health NHS Foundation Trust is the Corporate Trustee of the Charity. The Board of Directors (Voting Board Members) who served Kent Community Health NHS Foundation Trust during the year to 31 March 2019 were as follows:

Name	Position on Trust Board	*Additional Info.
David Griffiths	Chairman	to 24/05/18
John Goulston	Chairman	from 1/11/18
Paul Bentley	Chief Executive Officer	
Lesley Strong	Chief Operating Officer/Deputy CEO	
Gordon Flack	Director of Finance	
Ali Carruth	Chief Nurse	
Mercia Spare	Interim Chief Nurse	from 26/11/18
Dr Sarah Phillips	Medical Director	
Louise Norris	Director of Workforce, OD & Communications	
Richard Field	Vice Chairman, Non Executive Director	Acting Chairman between 25/5/18 to 31/10/18
Jennifer Tippin	Non Executive Director	
Peter Conway	Non Executive Director	
Steve Howe CBE	Non Executive Director	
Pippa Barber	Non Executive Director	
Bridget Skelton	Non Executive Director	
Martin Cook	Non Executive Director	from 1/10/18
Francis Drobniowski	Non Executive Director	from 1/10/18
Nigel Turner	Non Executive Director	from 1/10/18

Kent Community Health Charitable Fund

The Board of Directors are also informed by the views of the Council of Governors.

For further information on the Trust's Board of Directors, its full Leadership Team and the Council of Governors please visit www.kentcht.nhs.uk

Bankers: GBS (Government Banking Service),
Southern House,
Wellesley Grove,
Croydon, CR9 1TR

Independent Examiner: Grant Thornton UK LLP,
30 Finsbury Square,
London, EC2P 2YU

Structure, Governance and Management of the Charitable Funds

The charity was created by Trust Deed and is registered with the Charities Commission as Kent Community Health Charitable Fund (Registered Charity No. 1139134). The primary object of the charity, as stated in its governing document, requires the Trustee to 'hold the trust fund upon trust to apply income, and at its discretion, so far as may be permissible, the capital, for the general purpose of Kent Community Health NHS Foundation Trust'.

Kent Community Health NHS Foundation Trust is the Corporate Trustee of the funds held on trust.

The Executive and Non-Executive Directors of Kent Community Health NHS Foundation Trust Board share the responsibility for ensuring that the NHS body fulfils its duties as corporate trustee in managing the charitable funds.

The board of Kent Community Health NHS Foundation Trust, on behalf of the Corporate Trustee, has delegated to the Charitable Funds Committee (CFC) the responsibility to ensure charitable funds held are being managed and accounted for in accordance with the terms of NHS Charities Guidance and Charities Law. Membership of the Committee includes 2 non-executive directors and the Director of Finance and Deputy Chief Executive/Chief Operating Officer. The Chair of the Charitable Funds Committee for 2018-19 was Jennifer Tippin (Non-Executive Director) with Richard Field (Non-Executive Director) as Vice Chair. All members of the CFC have regard to the principles outlined in the Charities Commission's guidance on public benefit and annual bids/spending plans are requested to ensure the most effective use of resources.

Kent Community Health NHS Foundation Trust is committed to providing a first class and comprehensive healthcare service for the people within their area of responsibility. The Trustee is determined that the charity will continue to prosper, and support delivery of improved patient care for both revenue and capital projects.

Kent Community Health Charitable Fund

Financial Review

The net assets of the charity as at 31 March 2019 were £563k (2017-18 £630k)

Income Generation

Income during the year totalled £9k (2017-18 £253k) and includes income from donations and interest earned from bank accounts. Donations in the period totalled £5k (2017-18 £8k). There was no income from legacies in 2018-19 (2017-18 £242k).

The Trustee would like to thank all donors who have made contributions to the charity during the year and is very grateful for the donations received.

Resources Expended

Expenditure during the period totalled £76k (2017-18 £131k), of which £37k was expended on patients' welfare and amenities and £21k on staff welfare and amenities. Headline expenditure values for 2018-19 were as follows:

- Staff Awards £16k
- Medical and other equipment for Bow Road £15k
- Furniture at Faversham Cottage Hospital along with a Bus Stop scene for patients £8.5k
- Investment in dementia care at the Community Hospitals with the purchase of orientation boards, games etc £6k
- Thank you events for Volunteers £1.5k
- Staff Choir £1.5k

Investment powers, policy and performance

The charity's investment powers require funds to be managed by robust financial organisations so as to maximise the return on the funds, whilst minimising risk accordingly and to ensure that the funds are easily accessible for spending in accordance with the charity's objectives.

Charitable Funds are held as cash in Government Banking Service accounts and in the form of short term liquid investments held for a period of 60 days' notice. Where funds are invested in the latter form, the deposit is arranged via the Charities Aid Foundation (CAF) and is therefore exclusively for charitable organisations.

Non NHS Grant making policy

Grants are made, at the discretion of the Trustee, where the spending meets the objects of the charity. No grants were made to Non-NHS organisations during the 2018-19 financial period (2017-18 Nil).

Reserves Policy

The reserves policy agreed by the Charitable Funds Committee is that no minimum level of reserves is maintained.

A scheme of delegation operates through which all grant funded activity and support costs are managed and authorised by relevant seniority thus enabling the facilitation of a fully accountable, effective and efficient management of the funds held. This in

Kent Community Health Charitable Fund

turn ensures sufficient and appropriate controls are in place to prevent the over-commitment of the charitable funds.

Risk Management

At the time of approval of the accounts the Trustee has reviewed the major strategic, business and operational risks to which the charity is exposed.

Trustee Responsibilities

The Trustee is required by charity law to prepare financial statements for each financial year or period which gives a true and fair view of the state of affairs of the charity and of the surplus or deficit of the charity as at the end of the financial period.

In preparing those accounts the Trustee is required to:

- Confirm that suitable accounting policies have been used and applied consistently;
- Make judgments and estimates that are reasonable and prudent; and
- Confirm that applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and that the financial statements have been prepared on the going concern basis.

The Trustee is also responsible for:

Keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the charity and enable them to ensure that the financial statements comply with the Charities Act 2011; and

Safeguarding the assets of the charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

2018/19 Achievements

Charity-funded activity

Community Hospitals



From the legacies we hold for Community Hospitals, this year at Faversham Cottage Hospital we have funded a bus stop scene within the hospital to help patients who are living with dementia to feel less anxious.

In addition and with the continued drive to support dementia care in the Community Hospitals, orientation boards and traditional board games and puzzles were also purchased to further enrich the service provided to dementia patients.

Also at Faversham, four Tuscan reclining chairs were purchased to enhance patients' comfort during the day.

At Tonbridge Cottage Hospital, patient practice steps were purchased for the gym area to help in the rehabilitation of patients preparing them for climbing a full flight of steps prior to discharge home.

Kent Community Health Charitable Fund

Bow Road Property Fund



For the Wateringbury surgery we have this year funded the purchase of ECG and dopplex ability machines. In addition and to improve and streamline the patient experience within the surgery, patient touch check-in screens have been purchased and installed. This has benefitted the patients and staff at the surgery as patients can check themselves in without having to queue at the reception desk and important messages such as flu jab reminders, waiting times and confirmation of contact details can be automated and informed at the point of check-in.

Volunteer thank you events and lunches

We have once again funded various events and lunches throughout the year to say thank you to the fabulous volunteers who support our work.

Our Expert Patient Programme (EPP) and Patient Engagement Network (PEN) volunteer service were given the opportunity to get together to enjoy a free lunch with fellow volunteers and friends. The work of all the trust's volunteers is so important – collectively they give up hours of their time each year to help others. They also help relieve the pressure on our hard-working colleagues on the frontline.

Staff awards



In 2018/19, the charity helped to fund our staff awards evening. The trust is committed to recognising the achievements and initiatives of all colleagues. The aim of the staff awards is to

celebrate those who consistently work above and beyond the call of duty and who always go the extra mile to make sure our patients receive the best care.



As an addition to the awards the funds also paid for four practice sessions and the start-up of the staff choir so they could perform at the awards and perform they did!

Kent Community Health Charitable Fund

Donation methods

We have a just giving page and within this we can set up various pages for each fund/appeal. Just Giving automatically pay donations via text or on the website into our Charitable Fund account on a monthly basis. They also calculate and reclaim any gift aid on our behalf and also pay this directly.

<https://www.justgiving.com/icare>



Donors are still able to send in cheques, made payable to Kent Community Health Charitable Fund. The acknowledgement forms include a wish to gift aid section.

Charity Mission Statement

i care (Kent Community Health Charitable Fund) is a registered charity that helps pay for services and items which enhance patient care, as well as boost patients' and staff morale, but which cannot be funded by the NHS. We support the trust's aim of delivering first-class, comprehensive healthcare while looking after the health and wellbeing of the people providing that service.

A big thank you

On behalf of staff and patients who have benefitted from improved services due to donations and legacies, the Corporate Trustee would like to thank all patients and their relatives and the staff of the Trust who have made charitable donations.

By order of the Trustee

Signed:

Jennifer Tippin, Chair of the Charitable Funds Committee

Date: 17 January 2020

Independent examiner's report to the corporate trustee of Kent Community Health Charitable Fund

I report on the accounts of **Kent Community Health Charitable Fund** (the "charity") for the year ended 31 March 2019, which are set out on pages 11 to 21.

Your attention is drawn to the fact that the charity's trustee has prepared the charity's accounts in accordance with the Statement of Recommended Practice 'Accounting and Reporting by Charities preparing the accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (effective 1 January 2015)' issued in May 2014 in preference to the Statement of Recommended Practice 'Accounting and Reporting by Charities: Statement of Recommended Practice (revised 2005)' issued in April 2005 which is referred to in the Charities (Accounts and Reports) Regulations 2008 but has been withdrawn. I understand that the charity's trustee has done this in order for the charity's accounts to give a true and fair view in accordance with United Kingdom Generally Accepted Accounting Practice effective for reporting periods beginning on or after 1 January 2015.

This report is in respect of an examination carried out under section 145 of the Charities Act 2011. This report is made solely to the charity's trustee, as a body, in accordance with the regulations made under section 154 of the Charities Act 2011. My work has been undertaken so that I might state to the charity's trustees those matters I am required to state to them in an independent examiner's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the charity and the charity's trustee, as a body, for my work, for this report or for the opinions I have formed.

Respective responsibilities of corporate trustee and examiner

The charity's corporate trustee is responsible for the preparation of the accounts. The charity's trustee considers that an audit is not required for this year under section 144(2) of the Charities Act 2011 and that an independent examination is needed.

It is my responsibility to:

- examine the accounts under section 145 of the Charities Act 2011;
- to follow the procedures laid down in the general Directions given by the Charity Commission under section 145(5)(b) of the Charities Act 2011; and
- to state whether particular matters have come to my attention.

Basis of independent examiner's report

My examination was carried out in accordance with the general Directions given by the Charity Commission. An examination includes a comparison of the accounts with the accounting records kept by the charity. It also includes consideration of any unusual items or disclosures in the accounts, and seeking explanations from you as trustee concerning any such matters. The procedures undertaken do not provide all the evidence that would be required in an audit, and consequently no opinion is given as to whether the accounts present a 'true and fair' view and the report is limited to those matters set out in the statement below.

Independent examiner's statement

In connection with my examination, no matter has come to my attention:

- which gives me reasonable cause to believe that in any material respect, the requirements:
 - to keep accounting records in accordance with section 130 of the Charities Act 2011; and
 - to prepare accounts which accord with the accounting records; and
 - to comply with the applicable requirements concerning the form and content of accounts set out in the Charities (Accounts and Reports) Regulations 2008
- have not been met, or
- to which, in my opinion, attention should be drawn in order to enable a proper understanding of the accounts to be reached.



Sarah Ironmonger, CPFA

Grant Thornton UK LLP
Chartered Accountants

110 Bishopsgate, London , EC2N 4AY

27.01.20

Kent Community Health Charitable Fund

Kent Community Health Charitable Fund

Annual Accounts for the year ended 31 March 2019

Kent Community Health Charitable Fund

Statement of Financial Activities for the year ending 31 March 2019

Statement of Financial Activities for the year ended 31 March 2019	Note	2018-19			2017-18
		Unrestricted Funds £000s	Restricted Funds £000s	Total Funds £000s	Total Funds £000s
Income from:					
Donations and Legacies	2.1	5	0	5	250
Investment - Bank Interest	2.2	1	3	4	3
Total Income		6	3	9	253
Expenditure on:					
Charitable Activities	3.1	26	50	76	129
Raising Funds	3.2	0	0	0	2
Total Expenditure		26	50	76	131
Net Income/(Expenditure)		(20)	(47)	(67)	122
Other Recognised Gains/(Losses)		0	0	0	0
Net Movement in funds		(20)	(47)	(67)	122
Reconciliation of funds					
Total funds brought forward		114	516	630	508
Total funds carried forward		94	469	563	630

All results stated in the above Statement of Financial Activities derive from continuing operations.

The notes at pages 15 to 21 form part of this account.

Kent Community Health Charitable Fund

Balance Sheet as at 31 March 2019

	Note	2018-19			2017-18
		Unrestricted Funds £000s	Restricted Funds £000s	Total Funds £000s	Total Funds £000s
Balance Sheet as at 31 March 2019					
Total Fixed Assets		0	0	0	0
Current Assets:					
Cash and cash equivalents	9	94	471	565	632
Total Current Assets		94	471	565	632
Liabilities:					
Creditors: Amounts falling due within one year	8	0	2	2	2
Total Net Assets		94	469	563	630
Funds of the Charity:					
Restricted Income Funds	10	0	469	469	516
Unrestricted Income Funds		94	0	94	114
Total Funds of the Charity		94	469	563	630

The notes at pages 15 to 21 form part of this account.

The financial statements on pages 12 to 14 were approved and authorised for issue by the Trustee on 17 January 2020.

Signed:

Name: Jennifer Tippin

Date: 17 January 2020

Kent Community Health Charitable Fund

Statement of Cash Flows for the year ended 31 March 2019

Reconciliation of net income/(expenditure) to net cash flow from operating activities	2018-19 £000s	2017-18 £000s
Net income/(expenditure) for the reporting period (as per the Statement of Financial Activities)	(67)	122
Adjustments for:		
Dividends, interest and rents from investments	(4)	(3)
(Increase)/decrease in debtors	0	4
Increase/(decrease) in creditors	0	(91)
Net cash provided by (used in) operating activities	(71)	32

	2018-19	2017-18
	Total Funds £000s	Total Funds £000s
Statement of Cash Flows		
Cash flows from operating activities:		
Net cash provided by (used in) operating activities	(71)	32
Cash flows from investing activities:		
Dividends, interest and rents from investments	4	3
Net cash provided by (used in) investing activities	4	3

Change in cash and cash equivalents in the reporting period	(67)	35
Cash and cash equivalents at the beginning of the reporting period	632	597
Cash and cash equivalents at the end of the reporting period	565	632

Analysis of cash and cash equivalents	2018-19 £000s	2017-18 £000s
Cash at bank and in hand	264	331
Notice deposits (less than 3 months)	301	301
Total cash and cash equivalents	565	632

Kent Community Health Charitable Fund

Notes to the Accounts

1 Accounting Policies

1.1 Basis of preparation

The financial statements are prepared on a going concern basis under the historical cost convention with the exception of investments which are held at market value.

The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (SORP 2015) applicable to Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) and effective from 1 January 2015 (issued July 2014 and updated February 2016); the Charities Act 2011 and UK GAAP as it applies from 1 January 2015.

The financial statements have been prepared to give a true and fair view and have departed from the Charities (Accounts and Reports) Regulations 2008 only to the extent required to provide a true and fair view. This departure has involved following Accounting and Reporting by Charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) issued in July 2014 rather than the Accounting and Reporting by Charities: Statement of Recommended Practice effective from 1 April 2005 which has been withdrawn.

Kent Community Health Charitable Fund represents a public benefit entity as defined by FRS 102.

The Trustee considers that there are no material uncertainties that exist with the Kent Community Health Charitable Fund's ability to continue as a going concern.

The principle accounting policies applied in the preparation of the financial statements are set out below. These policies have been consistently applied to all years presented unless otherwise stated.

1.2 Income Recognition

- a) All incoming resources are recognised in full in the Statement of Financial Activities when the following criteria are met:
 - Entitlement – control over the rights or other access to the economic benefit has passed to the charity.
 - Probable – it is more likely than not that the economic benefits associated with the transaction or gift will flow to the charity.
 - Measurement – the monetary value or amount of the income can be measured reliably and the costs incurred for the transaction and the costs to complete the transaction can be measured reliably.
- b) Income from donations is recognised when there is evidence of entitlement to the gift, the receipt is probable and its amount can be measured reliably.

Kent Community Health Charitable Fund

- c) Receipt of a legacy is recognised as an incoming resource when it is probable that the legacy will be received. Receipt is normally probable when:
- there has been grant of probate;
 - the executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and
 - any conditions attached to the legacy are either within the control of the charity or have been met.

1.3 Expenditure Recognition

All expenditure is accounted for on an accruals basis and is recognised when all of the following criteria are met:

- Obligation – a present legal or constructive obligation exists at the reporting date as a result of a past event.
 - Probable – it is more likely than not that a transfer of economic benefits, often cash, will be required in settlement.
 - Measurement – the amount of the obligation can be measured or estimated reliably.
- a) Grants payable are payments made to third parties (including NHS bodies) in furtherance of the charity's charitable objectives. They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive a grant. This includes grants paid to NHS bodies.
 - b) Charitable activities expenditure comprise of all costs incurred in the pursuit of the objectives of the charity. These costs include direct costs and an apportionment of overhead and support costs as reflected in note 4 to the financial statements.
 - c) Raising funds includes the costs attributed to generating income for the charity.
 - d) Support costs are those costs which do not relate directly to a single activity. Support costs include costs associated with finance, governance and other central costs which support or relate to more than one area of activity. These costs are allocated to charitable activities and raising funds on the basis of their proportion of total resource expended.
 - e) Irrecoverable VAT is charged to the category of resources expended for which it was incurred.

Kent Community Health Charitable Fund

1.4 Structure of Funds

Unrestricted funds are resources held which are available for use at the discretion of the Trustee in furtherance of the general objectives of the charity and which have not been designated for other purposes.

Designated funds are a portion of the unrestricted funds that have been set aside by the Trustee for particular purposes, normally reflecting the non-binding wishes of the donors.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by donors or which have been raised by the charity for particular purposes. The cost of raising and administering such funds is charged against the specific fund. The aim and use of each restricted fund is set out in the notes to the financial statements on page 21 (note 10.2).

1.5 Tangible and Intangible Fixed Assets

The Charitable Fund had no tangible or intangible fixed assets for 2018-19 (2017-18 Nil).

1.6 Fixed Asset Investments

Fixed asset investments are held to generate income or for their investment potential, or both. Investment gains and losses arising during the reporting period are recorded in the Statement of Financial Activities. Fixed asset investments in quoted shares, traded bonds and similar investments are measured initially at cost and subsequently at fair value at the reporting date.

Dividend income from fixed asset investments is included in the period in which it is received and is allocated to funds based on the average balance of the funds across the period during which the income accrued.

The Charitable Fund had no fixed asset investments for 2018-19 (2017-18 Nil).

1.7 Realised and Unrealised Gains/Losses

All gains and losses are taken to the Statement of Financial Activities as they arise and allocated to the relevant fund. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (or date of purchase if later). Unrealised gains and losses are calculated as the difference between market value at the year-end and opening market value (or date of purchase if later).

Kent Community Health Charitable Fund

1.8 Cash and cash equivalents

Cash and cash equivalents includes cash held at bank and in hand and short-term highly liquid investments with a maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

Bank interest is allocated to funds in direct proportion to that fund's share of the total bank balance.

1.9 Stocks and Work in Progress

The Charitable Fund had no stocks or work in progress for 2018-19 (2017-18 Nil).

1.10 Transfers between funds

Transfers between funds are made at the discretion of the Trustee. There were no transfers between funds during the reporting period 2018-19. (2017-18 Nil).

2. Analysis of Income

2.1 Donations and Legacies

Donations and Legacies	2018-19			2017-18
	Unrestricted Funds £000s	Restricted Funds £000s	Total Funds £000s	Total Funds £000s
Donations from individuals and groups	5	0	5	8
Legacies	0	0	0	242
Total Donations and Legacies	5	0	5	250

2.2 Gross Income from Investments

Income from Investments and Cash on Deposit	2018-19			2017-18
	Unrestricted Funds £000s	Restricted Funds £000s	Total Funds £000s	Total Funds £000s
Bank and Building Society Interest	1	3	4	3
Total Income from Investments and Cash on Deposit	1	3	4	3

Bank interest is recorded in the period in which it is received and is allocated to funds in direct proportion to that fund's share of the total bank balance.

3. Analysis of Expenditure – Grants payable to NHS Bodies

All grants are made to Kent Community Health NHS Foundation Trust.

Kent Community Health Charitable Fund

3.1 Expenditure on Charitable Activities

Charitable Activities	2018-19	2017-18
	Total Funds £000s	Total Funds £000s
Patients welfare and amenities	37	82
Staff welfare and amenities	21	29
Support costs	18	18
Total Charitable Activities	76	129

3.2 Expenditure on Raising Funds

Raising Funds	2018-19	2017-18
	Total Funds £000s	Total Funds £000s
Support costs	0	2
Total Raising Funds	0	2

4. Allocation of Support Costs and Overheads

Support Costs and Overheads	2018-19			2017-18
	Charitable Activities £000s	Raising Funds £000s	Total Support Costs and Overheads £000s	Total Support Costs and Overheads £000s
Independent Examination - External Audit	2	0	2	2
Administration - Finance	15	0	15	15
Administration - Marketing	0	0	0	2
Other	1	0	1	1
Total Support Costs and Overheads	18	0	18	20

5. Trustee Remuneration, Benefits and Expenses

No representative of the Trustee received any remuneration or re-imbursement of expenses from the Charitable Fund.

6. Analysis of Staff Costs

The charity had no employees for the reporting period 2018-19 (2017-18 Nil) and therefore does not pay any salaries, national insurance and pension contributions direct. Costs for staff incurred by Kent Community Health NHS Foundation Trust are recharged to the Charitable Fund in the form of an administration fee. The administration fee for 2018-19 was a total of £15k (2017-18 £16k).

Kent Community Health Charitable Fund

7. Auditor's Remuneration

External Auditor's remuneration of £2k including VAT (2017-18 £2k including VAT) relates solely to the agreed Independent Examination fee for the 2018-19 Charitable Funds annual report and accounts.

8. Creditors: amounts falling due within one year

	31 March 2019	31 March 2018
Creditors: amounts falling due within one year	Total £000s	Total £000s
Other Creditors	2	2
Total Creditors	2	2

9. Cash and cash equivalents

Cash and cash equivalents relate to those funds held in Government Banking Service (GBS) bank accounts and on short-term investment (60 day notice deposit). The deposit account is provided by Shawbrook Bank Ltd and is made available through the Charities Aid Foundation.

10. Funds of the Charity

10.1 Analysis of Charitable Funds held

	Balance at 1 April 2018	Incoming Resources	Resources Expended	Transfers	Gains and Losses	Balance at 31 March 2019
Restricted Funds	£000s	£000s	£000s	£000s	£000s	£000s
Community Hospitals Restricted	127	1	(18)	-	-	110
Deal Hospital	45	-	(1)	-	-	44
Bow Road Property	95	-	(18)	-	-	77
Sensory Room appeal	3	-	-	-	-	3
Mermikides - Heron Ward	209	2	(7)	-	-	204
NHS Services in Dover	37	-	(6)	-	-	31
Total Restricted Funds	516	3	(50)	-	-	469

	Balance at 1 April 2018	Incoming Resources	Resources Expended	Transfers	Gains and Losses	Balance at 31 March 2019
Unrestricted Funds	£000s	£000s	£000s	£000s	£000s	£000s
Unrestricted Funds	114	6	(26)	-	-	94
Total Unrestricted Funds	114	6	(26)	-	-	94

	Balance at 1 April 2018	Incoming Resources	Resources Expended	Transfers	Gains and Losses	Balance at 31 March 2019
Total Funds	£000s	£000s	£000s	£000s	£000s	£000s
Total Funds	630	9	(76)	-	-	563

Kent Community Health Charitable Fund

10.2 Restricted Funds detail

Name of Fund	Description of the nature and purpose of each fund
Community Hospitals	This fund includes all legacies received for the following Community Hospitals; Faversham Cottage Hospital, Whitstable & Tankerton Hospital, Deal Hospital, Queen Victoria Memorial Hospital and Sheppey Hospital. All legacies are for the general purpose of the hospitals
Deal Hospital	Any charitable purpose relating to NHS wholly or mainly for Deal hospital
Bow Road Property	Community healthcare for the benefit of the residents of Wateringbury and Nettlestead.
Sensory Room	To provide and equip a Sensory Room at Heathside Children's Centre, Maidstone
NHS Services in Dover	For the use and benefit of NHS medical services in Dover
Mermikides - Heron Ward QVMH	To be used for the purpose of Heron Ward at QVMH only

11. Analysis of Net Assets between Funds

The net assets are held for the various funds as follows:

Fund Classification	Tangible Fixed Assets £000s	Fixed Asset Investments £000s	Net Current Assets/(Liabilities) £000s	Long Term Liabilities £000s	2018-19 Total £000s	2017-18 Total £000s
Restricted Funds	-	-	469	-	469	516
Unrestricted Funds	-	-	94	-	94	114
Total Restricted Funds	-	-	563	-	563	630

12. Related Party Transactions

Board members of Kent Community Health NHS Foundation Trust which is the Corporate Trustee of the charity are also members of the committee which is empowered by the Trustee to act on its behalf in the day to day administration of all funds held on trust, which is the Charitable Funds Committee (CFC).

Board members of Kent Community Health NHS Foundation Trust, the Corporate Trustee, and members of CFC ensure that the business of the charity is dealt with separately from that associated with exchequer funds for which they are also responsible.

During the year neither the Corporate Trustee nor members of the key management staff or parties related to it has undertaken any material transactions with or received any remuneration or expenses from the Kent Community Health Charitable Fund.

The charity made revenue payments to the Kent Community Health NHS Foundation Trust to the value of £76k as detailed in note 3. As at 31 March 2019 £2k (2017-18 £2k) was owed to the Kent Community Health NHS Foundation Trust.

13. Commitments

The charity has commitments totalling £16k at 31 March 2019 (2017-18 £17k) arising from approved bids and requisitions placed for which the relevant goods and services have not been received.

14. Events after the end of the reporting period

There are no events after the end of the reporting period.

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 6 February 2020
in The Committee Room, Tonbridge and Malling Council Offices, Gibson Building,
Gibson Drive, Kings Hill, West Malling, Kent ME19 4LZ

This meeting will be held in Public

AGENDA

1. STANDARD ITEMS

- | | | |
|-----|---|-----------------|
| 1.1 | Introduction by Chair | 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 28 November 2019 | Trust Chair |
| 1.5 | To receive the Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 28 November 2019 | Trust Chair |
| 1.6 | To receive the Trust Chair's Report | Trust Chair |
| 1.7 | To receive the Chief Executive's Report | Chief Executive |

2. BOARD ASSURANCE/APPROVAL

- | | | | |
|-----|--|-----------------------------|--------------|
| 2.1 | To receive the Patient Story | Chief Nurse | Presentation |
| 2.2 | To receive the Board Assurance Framework | Corporate Services Director | |

2.3	To receive the Board of Directors Committee Membership and Designations Report	Trust Chair	
2.4	To approve the East Kent Frailty Strategy	Medical Director	
2.5	To receive the Draft Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24	Chief Executive	
	Board Committee Reports		
2.6	To receive the Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee	
2.7	To receive the Charitable Funds Committee Chair's Assurance Report	Chair of Charitable Funds Committee	
2.8	To receive the Quality Committee Chair's Assurance Report	Chair of Quality Committee	
2.9	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	
3.	REPORTS TO THE BOARD		
3.1	To receive the Integrated Performance Report	Director of Finance Executive Directors	
3.2	To receive the Learning From Deaths Report	Medical Director	
3.3	To receive the approved Minutes of the Charitable Funds Committee meeting of 29 November 2019 <ul style="list-style-type: none"> • Charitable Funds Annual Report and Accounts 2018/19 	Chair of Charitable Funds Committee	
4.	ANY OTHER BUSINESS		
	To consider any other items of business previously notified to the Trust Chair	Trust Chair	
5.	QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA		

6. DATE AND VENUE OF NEXT FORMAL BOARD MEETING

Thursday 21 May 2020
Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120
Upper Pemberton, Eureka Park, Kennington, Ashford Kent TN25 4AZ

