Kent Community Health
NHS Foundation Trust

Agenda and Papers

for the

Formal meeting of the

Kent Community Health NHS Foundation Trust Board

In Public

to be held at 10am on

Thursday 21 May 2020

Virtual meeting via MS Teams Live Event

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held at 10am on Thursday 21 May 2020
Virtual meeting via MS Teams Live Event

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		**10.00**
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 6 February 2020	Trust Chair	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 6 February 2020	Trust Chair	
1.6	To receive the Trust Chair's Report • Board Assurance during COVID-19	Trust Chair	
1.7	To receive the Chief Executive's Report • Update on the Trust's response to COVID-19 • Integrated Care Partnership reports	Chief Executive	
2.	**BOARD ASSURANCE/APPROVAL**		**10.25**
2.1	To receive the Service Impact Story	Chief Nurse	Presentation

2.2	To receive the Board Assurance Framework	Corporate Services Director	
2.3	To approve the Standing Financial Instructions	Director of Finance	
	Board Committee Reports		**10.45**
2.4	To receive the Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee	
2.5	To receive the Quality Committee Chair's Assurance Report	Chair of Quality Committee	
2.6	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	
2.7	To ratify the Committees' Terms of Reference	Chairs of the Committees	
	Planning and Performance 2019/20		**11.00**
2.8	To receive the Integrated Performance Report	Director of Finance Executive Directors	
2.9	To approve the 2019/20 Annual Report and Accounts	Director of Finance	
2.10	To receive the Reset Plan for 2020/21 including (i) Strategic Priorities – for approval (ii) Quality Priorities	Chief Operating Officer Director of Strategy and Partnerships Chief Nurse	**11.15**
3.	**REPORTS TO THE BOARD – for noting**		**11.35**
3.1	To receive the Learning From Deaths Report	Medical Director	
3.2	To receive the Freedom To Speak Up Report	Corporate Services Director	
3.3	To receive the Emergency Planning and Business Continuity Annual Report	Corporate Services Director	

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4.	**ANY OTHER BUSINESS**		**11.50**
	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**		**11.50**
6.	**DATE AND VENUE OF NEXT MEETING**		

Thursday 6 August 2020
University of Kent, Canterbury

Kent Community Health NHS Foundation Trust

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

Present:	John Goulston, Trust Chair (Chair) Sola Afuape, Non-Executive Director Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Pauline Butterworth, Chief Operating Officer Peter Conway, Non-Executive Director Gordon Flack, Director of Finance / Deputy Chief Executive Louise Norris, Director of Workforce, Organisational Development and Communications Dr Sarah Phillips, Medical Director Gerard Sammon, Director of Strategy and Partnerships Bridget Skelton, Non-Executive Director Dr Mercia Spare, Chief Nurse Jen Tippin, Non-Executive Director Nigel Turner, Non-Executive Director
In Attendance:	Natalie Davies, Corporate Services Director Theresa Addison (agenda item 2.1) Gina Baines, Committee Secretary (minute-taker) Ann Edridge (agenda item 2.1)

06/02/01 Introduction by Chair

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

06/02/02 Apologies for Absence

Apologies were received from Prof. Francis Drobniewski, Non-Executive Director.

The meeting was quorate.

06/02/03 Patient Story

Ms Theresa Addison and Ms Ann Eldridge joined the meeting to present

their story to the Board.

The story related to their family's experience of local NHS care and social services support when their mother Mrs Patricia (Pat) McCarthy was initially admitted to the acute hospital in July 2019 and who subsequently died at home on 26 August 2019. They explained the difficulties they experienced as their mother was moved through the system and the distressing challenges the family had to cope with as they tried to do their best for their mother.

Dr Spare apologised for the poor communication between the various agencies which had affected the quality of Mrs McCarthy's care. She agreed that the family's experience underlined how the NHS and social care needed to improve 24 hour care, seven days a week and that the current system was disjointed. Ms Ann Eldridge questioned what patients who were in a similar situation but did not have any family could expect in terms of the quality of care and social services support in the current system. The family offered to work with the various agencies in order that no other family should have a similar experience. Mr Bentley highlighted that he had been in communication with the family following their formal complaint to the Trust and reiterated his apology, on behalf of the Board for the experience that they had had. He emphasised that the Trust was learning from their experience and suggested that he would like to update on progress in six months' time.

Ms Theresa Addison and Ms Ann Eldridge left the meeting.

Ms Barber commented that the Quality Committee had received assurance that agency nurses were able to see care plans in the patient's home and she was pleased that this was being revisited. She asked for clarification regarding documentation that was kept in the home. With regards to the Rapid Response Service, she wished to know how many people were waiting for the service. At a system level, she was concerned about the family's experience with the hoist in the home and suggested that there should be a small number of hoists that all relevant staff across the system were trained to use. She asked that this was shared with other agencies with a view to being implemented. Dr Spare indicated that she would take the story to the Kent and Medway Sustainability and Transformation Partnership (STP) Clinical Leads Forum which was attended by all the clinical leads from across the local system. It was agreed that the Quality Committee would include the story as an agenda item at its meetings in order to monitor the Trust's response to the issues that had been highlighted.
Action – Dr Spare

Dr Spare confirmed that the number of trusted assessors had increased which would help with communication.

In response to a question from Ms Afuape regarding the follow up with the family in six months' time, Mr Bentley confirmed that he had made that commitment to the family. He and the Board would receive assurance

through the Quality Committee. Ms Butterworth added that she would like to take the story to the Chief Operating Officers meeting in east Kent to discuss the issues it raised and what changes could be made to improve the experience of the patient and their carers. During the first few weeks in her new role, she had already identified that there were too many hand offs and agencies in the discharge process and the family's experience would help everyone to understand the problems they needed to address.

The Board **RECEIVED** the Patient Story.

06/02/04 Declarations of Interest

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

06/02/05 Minutes of the Meeting of 28 November 2019

The minutes were read for accuracy.

The Board **AGREED** the Minutes.

06/02/06 Matters Arising from the Meeting of 28 November 2019

28/11/14 Integrated Performance Report – Mr Flack confirmed that in the latest Integrated Performance Report for December 2019, the Trust had been compliant on Referral To Treatment waiting times for consultant services. It was anticipated that compliance would continue for January 2020.This would allow the Trust to request a change in status in segmentation from NHS England/Improvement (NHSE/I) which would be led by Ms Butterworth.

The other actions were closed.

The Board **RECEIVED** the Matters Arising.

06/02/07 Trust Chair's Report

Mr Goulston presented the report to the Board for information and assurance.

At the Council of Governor's meeting on 15 January 2020, there had been a presentation on the Trust's aspirations with regards to improving its environmental sustainability. The Board agreed that it would welcome a report on the Trust's strategy and it was agreed that a date would be confirmed for its inclusion at a future Board meeting.
Action – Ms Davies

Mr Goulston had visited the South East DriveAbility Service the previous week. The service was a clinically-led service which carried out assessments and gave advice on driving, driving tuition and car adaption. He had been impressed by the important clinical service that the therapists

provided the public.

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

06/02/08 Chief Executive's Report

Mr Bentley presented the report to the Board for information.

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

06/02/09 Board Assurance Framework (BAF)

Ms Davies presented the report to the Board for assurance.

With regards to a potential risk from the coronavirus infection, entries to date had been made on some local risk registers rather than the BAF.
Ms Norris confirmed that the Strategic Workforce Committee had reviewed and amended some of the individual actions against Risk 102 (workforce). These changes had not affected the overall risk rating.

In response to a question from Ms Tippin as to whether the Trust was assessing the impact of the coronavirus on its supply chain of goods imported from China, Ms Davies confirmed that work had started on this. The system had previously mapped the supply chain in preparation for Brexit and this was the starting point for a coronavirus supply chain analysis. Dr Spare confirmed that at this time, the Trust and the system had identified that the equipment it needed was still readily available. It was agreed that the annual refresh of the BAF would be completed and brought to the May Board meeting following scrutiny by the Audit and Risk Committee.
Action – Ms Davies

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

06/02/10 Board of Directors Committee Membership and Designations Report

Mr Goulston presented the report to the Board for approval.

The report would be presented to the Council of Governors for approval at its next meeting in April 2020. With regards to the recommendation to recruit at least one associate non-executive director, approval of the principle was sought at this stage. Mr Goulston and Mr Bentley would work with the Executive Team to develop the proposal which would then be presented to the Nominations Committee for approval. Mr Bentley highlighted that there had been an omission in the report; Dr Phillips had been a member of the Strategic Workforce Committee and this would continue.

Mr Goulston thanked Ms Tippin for her role as the Freedom To Speak Up Guardian and confirmed that Ms Afuape would take over the role when Ms Tippin stood down from the Trust at the end of February 2020.

In response to a question from Dr Phillips regarding why Mr Bentley and Ms Davies were not included in the membership of Board committees list, Mr Bentley explained that for good governance he should not be a standing member on the committees. For Ms Davies, her role as Trust Secretary required her to maintain neutrality around governance.

Mr Flack highlighted that he was a member of the Charitable Funds Committee. It was agreed that the report would be amended for the Council of Governors meeting.
Action – Mr Goulston

The Board **APPROVED** the Board of Directors Committee Membership and Designations Report, subject to the amendment.

06/02/11 East Kent Frailty Strategy

Dr Phillips presented the report to the Board for approval.

In response to a question from Ms Skelton that she would like more focus on the patient in the strategy rather than the system, Dr Phillips responded that the commissioners were taking part in designing pathways which were being mapped into the pre-consultation business case and also tied in to contract discussions.

In response to a question from Mr Conway as to whether the strategy would lead to the provision of a principle point of contact for patients and carers to improve communication, a need highlighted in that day's patient story, Dr Phillips agreed to feed his comment back to the clinical commissioning group (CCG) who had drafted the strategy.
Action – Dr Phillips

In response to a question from Mr Flack as to whether the innovative working of the multi-disciplinary teams and the philosophy of the Transforming Integrated Care in the Community (TICC) could be more explicit in the strategy, Dr Phillips agreed to feed his comment back to the CCG.
Action – Dr Phillips

In response to a question from Ms Barber as to whether there was an action plan for each of the agencies and who would be monitoring it for delivery and effectiveness, Dr Phillips stated that the delivery plans tied to the local care model would be helpful in the absence of a specific action plan. In the meantime, the Trust was working with GPs and the GP federations to establish who was providing what services in the future.

In response to a question from Ms Barber regarding who was being trained on frailty in the Trust, Dr Phillips agreed that she would clarify. Services were well placed to deliver the Frailty Strategy but it needed greater awareness.
Action – Dr Phillips

In response to a question from Mr Flack as to whether the integrated care partnerships (ICPs) engagement groups could use frailty to work on whole system commitment, Dr Phillips agreed that that would be helpful. She would like to see patients and staff involved as routine in service co-design. Dr Spare confirmed that falls reduction work was discussed at each of the quality forums in the ICPs. Frailty training was being embedded in services and was beginning to have an impact.

Ms Afuape commented on the lack of reference to health inequalities in the strategy.

Mr Flack commented that turning the strategy into reality would come through agreeing contractual obligations. He and Ms Butterworth were talking to the Trust's CCG partners and the outcome of those discussions would come to the Finance, Business and Investment Committee.

The Board **APPROVED** the East Kent Frailty Strategy.

06/02/12 Draft Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24

Mr Bentley presented the report to the Board for information and endorsement.

In response to a question from Ms Skelton as to how the Trust's strategic priorities aligned to the plan and the other parts of the system, and to what extent Kent County Council (KCC) was part of the plan, Mr Bentley explained that the Executive Team was increasing its involvement with all four ICPs and its leverage with KCC. In addition, KCC was helping all four ICPs. Mr Goulston added that borough councils were also important in delivering health. Ms Skelton reflected that the patient story that day had highlighted that KCC played a critical part in the patient pathway in delivering social care. It was agreed that Mr Bentley and Mr Goulston would provide a further briefing to the Board on the role of KCC in the plan. **Action** – Mr Goulston

In response to a question from Mr Conway as to how the Board could get assurance that the plan was succeeding collectively and individually, Mr Bentley suggested that the ICPs could provide regularly reporting. It was agreed that at the May 2020 Formal Board meeting a summary of each of the four ICPs operational plan would be included in the Trust 2020/21 Operating Plan to provide the assurance.

In response to a question from Mr Turner as to whether any early improvements in performance could be seen, Mr Bentley reflected that a better and more cohesive alignment between NHS England and NHS Improvement was beginning to emerge. Having a strong provider voice was also improving cultures. Mr Goulston highlighted the large number of health issues that the NHS faced and the challenge of prioritising them nationally and locally. Mr Sammon added that the document had been written for NHSE/I. The next step was to make the document real for patients, staff and local communities.

In response to a question from Ms Afuape as to how the plan benchmarked against the best, Mr Bentley commented that because of the size and scale of the complexities of the STPs in the south east it was difficult to make an accurate comparison, This was compounded because not published comparison was available.

Mr Bentley confirmed that the national guidance had been published which set out the plan submission process. He agreed to include the ICP reports on the May Board agenda.
Action - Mr Bentley

The Board supported and endorsed the plan.

The Board **RECEIVED** the Draft Kent and Medway Strategy Delivery Plan 2019/20 to 2023/24.

06/02/13 Audit and Risk Committee Chair's Assurance Report

Mr Conway presented the report to the Board for assurance.

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

06/02/14 Charitable Funds Committee Chair's Assurance Report

Ms Tippin presented the report to the Board for assurance.

In response to a question from Ms Skelton regarding the legacy of £140k that had been left to Tonbridge Cottage Hospital, Mr Flack confirmed that an update on how the legacy would be spent would be provided at the Committee's meeting in July 2020.
Action – Mr Flack

With regards to contact with the family of the legacy, Ms Tippin confirmed that there was no family to contact. The Trust had had contact with the solicitor who was the executor for the estate to confirm that the instructions set out in the legacy would be followed. Ms Davies confirmed that Tonbridge Cottage Hospital was one of four properties that the Trust was seeking to repatriate from NHS Property Service (NHSPS) which would simplify the process of utilising the legacy.

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

06/02/15 Quality Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.
In response to a question from Mr Conway relating to the discussion between Mr Bentley and KCC regarding delayed transfers of care (DTOC), Mr Bentley confirmed that the Chief Executive of Maidstone and Tunbridge Wells NHS Trust and the Accountable Officer of West Kent CCG had been

involved in the discussions as well. A formal application had now been submitted for extra investment to reduce DTOCs. Performance had been good but it had been agreed that a further injection of funds would be helpful to ensure that performance did not slip to the end of the financial year.

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

06/02/16 Strategic Workforce Committee Chair's Assurance Report

Ms Skelton presented the report to the Board for assurance.

With regards to considering equality issues in the reports that were presented to the Committee, a new section on the front sheet had been introduced and it was suggested that this should be adopted by the other committees. Ms Barber confirmed that she had discussed this with Dr Spare, Executive Lead for the Quality Committee and it had been agreed that it would be adopted.

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

06/02/17 Integrated Performance Report

Mr Flack presented the report to the Board for assurance.

It was a strong performance that month but in the context of the issues that had been raised in that day's patient story, he commented that the scorecard charts relating to integrating services showed the weakest metrics, in particular around patient 'hand offs' in east Kent. He suggested that these could be strengthened and given a higher profile in the report. He would discuss how this would be done with Ms Butterworth.
Action – Mr Flack

Dr Spare commented that she was working with Ms Norris and Ms Butterworth around monitoring temporary staff fill rates to ensure that they were correct. Ms Butterworth added that the levels of temporary staff varied geographically and this needed to have greater visibility for the Board to ensure that the overall rates were not misleading.

In response to a comment from Ms Barber that there was geographically variation around new birth visits performance, it was agreed that the Quality Committee would undertake a deep dive.
Action – Ms Butterworth

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

06/02/18 Learning From Deaths Report

Dr Phillips presented the report to the Board for assurance.

Ms Barber commented that the Quality Committee had received a more in-depth report at its meeting the previous month. It was important for the Board to see that the themes were reducing. Documentation however was a recurring theme. Dr Spare responded that the work that Dr Scobbie, Deputy Medical Director was undertaking on the policy documents should lead to better documentation outcomes. This would be audited to assess how well it was embedding.

In response to a question from Ms Afuape as to whether there was an opportunity for families to be involved when deaths were reviewed, Dr Phillips confirmed that families had been involved previously. However, this had ceased as they had felt that they were not adding anything to the review, which by design was an assurance process. She would like to improve their experience as she felt that they had a contribution to make.

In response to a comment from Mr Goulston as to whether that day's patient story was within the scope of the reviews, Dr Phillips suggested that the learning that came out of the reviews was shared with the right groups who could action and monitor it.

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

06/02/19 Minutes of the Charitable Funds Committee meeting of 29 November 2019

The Board considered the minutes of the meeting.

The Board **RECEIVED** the Minutes of the Charitable Funds Committee meeting of 29 November 2019.

06/02/20 Any Other Business

There was no other business to report.

06/02/21 Questions From Members of the Public Relating to the Agenda

Ms Jan Allen, Staff Governor Corporate Services reflected on the patient story and offered her assistance to the Trust in its response to the issues that had been raised. In response to a question from her as to what work-related bereavement support was provided to staff, Dr Spare confirmed that clinical staff received clinical supervision which would cover these experiences but she would like to address how support staff were supported. Ms Ruth Davies, Public Governor Tonbridge and Malling supported Ms Jan Allen in offering her assistant to the Trust in response to the patient story.

In response to a further question from Ms Ruth Davies regarding which committee would scrutinise the Trust's environmental sustainability performance it was confirmed that it would be the Audit and Risk Committee.

In response to a comment from Ms Ruth Davies that the Board of Directors Committee Membership and Designations Report might be included in the governor induction packs, it was agreed that this would be arranged. **Action** – Ms Davies

On behalf of the Board, Mr Goulston thanked Ms Tippin for the considerable contribution she had made to the Board, the Trust and as Chair of the Charitable Funds Committee during her time in office. She would be missed.

The meeting ended at 12.25pm.

06/02/22 Date and Venue of the Next Meeting

Thursday 21 May 2020; This will be a virtual meeting held via Ms Teams Live Event.

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 6 FEBRUARY 2020 (PART ONE)

Minute number	Agenda Item	Action	Action Owner	Status
06/02/03	Patient Story	To include the Patient Story as an agenda item at Quality Committee in order to monitor the Trust's response to the issues that had been highlighted.	Dr Spare	This is a standing agenda item at Quality Committee meetings. The latest update was received at the May Committee meeting. Action closed.
06/02/07	Trust Chair's Report	To bring the Trust's environmental sustainability strategy to a future Board meeting. Date to be confirmed.	Ms Davies	The date is yet to be agreed.
06/02/09	Board Assurance Framework (BAF)	To bring the refreshed BAF to the May 2020 Board meeting following scrutiny by the Audit and Risk Committee.	Ms Davies	Agenda item. Action closed.
06/02/10	Board of Directors Committee Membership and Designations Report	To amend the report regarding Mr Flack's membership of the Charitable Funds Committee for the Council of Governors meeting	Mr Goulston	Action complete. Action closed.

Minute number	Agenda Item	Action	Action Owner	Status
06/02/11	East Kent Frailty Strategy	• To feed back the comments of the Board to the clinical commissioning group. • To clarify who was being trained on frailty in the Trust.	Dr Phillips	Action complete. All the ACPs working in the Frailty teams, the Trust's four consultant geriatricians, two trust specialist doctors, complex care nurses in West Kent, all community hospital staff as part of board rounds and team meetings usually led by geriatricians, Trust specialty doctors or qualified ACPs. Other staff groups include pharmacists and pharmacy technicians as part of multi-disciplinary teams (MDT) working with primary care networks (PCNs), also delivered by frailty team.
06/02/12	Draft Kent and Medway Strategy Delivery Plan 2019 to 2023/24	To provide a further briefing to the Board on the role of Kent County Council (KCC) in the plan.	Mr Goulston	Kent County Council has a new leader of the County, Roger Gough. At this point, the KCC role within the Kent and Medway Sustainability and Transformation Partnership (STP) and its Long Term Plan remain unchanged from 2019 i.e. KCC is a partner to the STP and its plan. Action closed.
06/02/12	Draft Kent and Medway Strategy Delivery Plan	To include the Integrated Care Partnerships (ICPs) reports on the May 2020 Board agenda.	Mr Bentley	Will be included as part of the next Chief Executive's Report to the Board.

Minute number	Agenda Item	Action	Action Owner	Status
06/02/14	Charitable Funds Committee Chair's Assurance Report	To provide an update on how the Tonbridge Cottage Hospital legacy would be spent at the Committee's meeting in July 2020.	Mr Flack	Agenda item.
06/02/17	Integrated Performance Report	• To discuss with Ms Butterworth how to strengthen and raise the profile of the Integrating Services metrics in future reports. • To arrange for the Quality Committee to undertake a deep dive of the new birth visits performance	Mr Flack Ms Butterworth	The Integrated Performance Report has been reviewed by the Executive Team and will be coming to the Board. Action complete. Action closed. Action complete. Action closed.
06/02/21	Questions From Members of the Public Relating to the Agenda	To include the Board of Directors Committee Membership and Designations Report in the governor induction packs.	Ms Davies	Action complete. Action closed.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	1.6
Agenda Item Title:	Trust Chair's Report - Board Assurance during COVID-19
Presenting Officer:	John Goulston, Trust Chair

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

Report Summary
This paper covers the principles of Board assurance and governance that Kent Community Health NHS Foundation Trust will follow during the period that we are faced with emergency planning and response because of COVID-19.

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.

John Goulston Trust Chair	Tel: 01622211900
	Email: j.goulston@nhs.net

Kent Community Health NHS Foundation Trust

Governance and Assurance during Covid-19

1. Introduction and Purpose

This paper covers the principles of Board assurance and governance that Kent Community Health NHS Foundation Trust will follow during the period that we are faced with Emergency Planning and Response because of covid-19.

The starting point is that within the rapidly changing environment, the Executive Directors, Senior Management Team and staff are under significant and long term sustained pressure and the Non-Executive Directors need and want to support them as much as possible but without adding to their burden. At the same time the NEDs need to ensure we support them with a governance and assurance framework that is streamlined and supportive (including from an emotional health and wellbeing perspective).

2. Principles of Governance and Assurance during covid-19

The principles that the Kent Community Health NHS Foundation Trust will follow during this period are as follows;

2.1. Overall streamlined approach -the Board will adopt a simple, supportive and streamlined approach to Governance during the period of the coronavirus emergency, stripping back to the essentials.

2.2. Risk Appetite - the Board acknowledges that its risk appetite and tolerance of risks will need to rise. The BAF has new risks added for covid-19 and these will be reviewed regularly by the Board via its Committees as required (formal review on monthly basis as a minimum).

2.3. Authority in an environment of rapid decision making – the Board will operate based on ‘’the Executive has permission" to facilitate rapid response to the fast-changing environment. The Executive should feel empowered to make decisions without reference to the Board unless;

- they want a second opinion and/or
- they feel they need the ‘air cover’ and formal approval.

2.4. Board and its Committees - in order to free up Executive and their senior staff from the “usual” governance and assurance (i.e. preparing papers, attending meetings and taking forward actions) the following changes will take place;

2.4.1. Board of Directors – formal, virtual monthly meeting of no more than 90 minutes with the Chair and CEO agreeing the substantive items. At the virtual Board meeting on 23 April, we will review the best way to undertake (or cancel) the Board meeting in public scheduled for 21 May The next phase of the Board development programme is delayed until 16 July 2020 (to be reviewed in June).

2.4.2. Combining Board Committees – the following combining of the Board Committees will further free up Executives and their teams;

2.4.3. Finance, Business and Investment and Audit and Risk Assurance Committees should be combined forthwith and meet on an ad hoc basis as needed and judged by the 2 Committee Chairs, Peter Conway and Paul Butler and the CFO & Deputy CEO, Gordon Flack.

2.4.4. Quality and Workforce should be combined forthwith and meet on an ad hoc basis as needed and judged by the Chairs of the Committees, Pippa Barber and Bridget Skelton and the CNO, Mercia Spare and the Director of Workforce, Louise Norris.

2.4.5. All Board and Committee papers should be kept brief, as only critical issues / points need to be brought to the attention of the Board or Committee. The reports will cover the following;

1. Purpose
2. Decision required
3. Summary of the problem / issue / risks
4. Proposed actions / mitigations
5. Residual risks after actions / mitigations
6. Escalation or communication required with the Kent & Medway STP/CCG, Kent County Council or NHSE/I
7. SRO / lead for actions / next steps
8. Follow up – report back to Board or Committee or CEO by date and method - i.e. Skype meeting or email.

2.5. Council of Governors - the next meeting of the Council of Governors is scheduled for 29 April. This will be reviewed 2 weeks prior to the meeting. The Chair and Corporate Services Director will keep the Governors informed as required. For example, the Governors will be forwarded a copy of this paper after it is approved by the Board on 26 March. The Chair will also contact the lead and deputy lead Governors as required to keep them in the picture.

2.6. Weekly Skype meetings

2.6.1. The Chair and CEO will have a weekly Skype meeting (or more frequently as required). If necessary, the vice chair and the Senior Independent Director will join part or all the meeting as required.

2.6.2. The NEDs will meet virtually with the Chair, CEO and Deputy CEO once a week by Skype for no more than 30 minutes (or more frequently if the Chair and CEO require). The CEO will ask other Executives to attend as required. The virtual meetings will have an agenda but **no other papers** unless the CEO decides otherwise. Minutes will be taken by a NED (by rotation)

2.7. The Chair will email to the NEDs important emails, documents that are received from DHSC/ NHSE/I and or NHS Providers.

2.8. Buddying - NEDs with Executives
Executive Directors s will have the option to 'buddy' with a NED on an informal basis so there is someone there for them to bounce ideas off and act as counsel/supporter.

2.9. NED behaviour will consist of only asking critical and urgent questions of the Executive, at the same time being supportive, behaving appropriately for the situation and acting as a sounding board when required. Outside of the virtual meetings, NEDs should raise any questions / queries / concerns that they have with the Chair in the first instance.

2.10. Appraisals – as agreed last week, all appraisals of the NEDs and executives are delayed by 2 months. Chair and NED appraisals are now due in May 2020, this timeline will be reviewed after Easter.

2.11. All other extant governance is suspended (some may need to be re-introduced by exception).

3. Recommendation

The Board is asked to approve the above proposed Governance and Assurance "Lite" measures which will be implemented in full from 30 March 2020.

23 March 2020

John Goulston

Chair

Kent Community Health NHS Foundation Trust

My thanks to Peter Conway, Vice chair, Bridget Skelton, SID and Paul Bentley, CEO for the support in drafting this document

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	1.7
Agenda Item Title:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive

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

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

Proposals and /or Recommendations
To note the report.

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

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

CHIEF EXECUTIVE'S REPORT
May 2020

Since the last time the board met in public (February 2020) the country and the NHS has been seriously challenged and occupied by the response to the COVID-19 outbreak. Consistent with my previous reports I have detailed the Trusts response in the following categories patients, our people, and partnerships. I also do wish to highlight that the Trust has been involved in issues other than the response to the pandemic but I hope the board will understand the emphasis of this report is orientated towards Covid 19 and how the Trust has responded.

Patients

Whilst significant energy has been used in responding to the pandemic it is important to note that 31 March 2020 marks the end of the previous year. The Board will today will receive the final accounts of the year 2019/2020 but do I want to record the significant achievements in improving and sustaining the quality of care to the people we service, noting significantly the Trust achieving the outstanding rating as assessed by the Care Quality Commission.

As related to managing the pandemic the Trust moved rapidly to scale down tier 2 and tier 3 clinical services (those that provide important but non-life threatening healthcare), in line with national guidance the emphasis was placed on ensuring suitable staffing was available in life threatening services. Since that time the Trust has seen an increase in patients with COVID-19 who have been looked after by the health care teams of KCHFT. Whilst the demands of the pandemic has been profound on the whole the quality of care provided by KCHFT has remained high with a large number of our patients and their loved ones observing how team members have gone above and beyond the call of duty in delivering care.

Although the peak of the pandemic has been reached we are now experiencing the greatest levels of demand upon community services since the pandemic commenced. The Trust will continue to take all necessary steps to ensure the people we serve are well cared for and treated throughout all our services.

Our People

The once in a lifetime demands of the pandemic have been highly effectively met by all teams member in KCHFT. This has included the temporary relocation of nearly 500 staff from their regular roles into life threatening services, it is also seen all

members of the team have access to a range of really important support at a unnerving time but I would like to record the extraordinary service of all team members and take the opportunity for all Board members to thank them for their service.

Partnerships

Throughout the response to the pandemic the Trust has worked as a full partner with other parties across Kent and Medway to ensure the quality and availability of services has been maintained. Initially this took the form of working across the 4 geographical integrated care partnerships across Kent and Medway to provide an integrated service between health, public health and adult social healthcare and in more recent times the trust has turned its attention to exiting the first phase of the response to the pandemic and exploring safe and manageable ways to return to a more comprehensive provision of community health services and other health services. The Board will scrutinise the reset plan adopted by the Trust to provide assurance that the processes already taken place are correct. However I anticipate by the time the Board meets again in public the plan will be fully enforced with the majority of the services taking place again.

Conclusion

The toll which the pandemic has taken on Kent and Medway and further afield that we serve has been significant, each person that had died or has been unwell has a family and friends who themselves have been impacted during this period. Given the societal changes which have been required very few people in the country have not been affected by the response to the pandemic. Whilst the response of the NHS generally and KCHFT specifically has been remarkable I do wish to take the opportunity to share the Trusts condolences and wishes for a speedy recovery to all those impacted by the pandemic, and to thank the public for their heartfelt and enduring support to the NHS during this time.

Whilst responding to the pandemic has been highly challenging I would invite the Board to take this opportunity to thank each member of the team of KCHFT for their remarkable response and I would like to thank the executive team for their leadership and the support of the non-executives of the Board on their support to the executive.

Paul Bentley
Chief Executive
May 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 20
Agenda Number:	2.2
Agenda Item Title:	Board Assurance Framework
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary

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

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

The full BAF as at 13 May 20 is shown in Appendix 1.

Proposals and /or Recommendations

The Board is asked to note this report.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

High level position described and no decisions required.

Natalie Davies, Corporate Services Director	Tel: 01622 211900
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Kent Community Health
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

1. Introduction

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

1.2 The BAF is therefore comprised of high risks. Refer to section 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 13 May 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 two new risks identified against the strategic objectives.

BAF ID 107 ‘Risk that the organisation’s services may suffer significant challenges and become compromised as a result of the impact of the COVID-19 pandemic’.

BAF ID 108 ‘Risk that the availability of staff could impact on the delivery of tier one services during the COVID-19 pandemic potentially due to illness or isolation, and/or morale amongst staff’.

2.2 Since the BAF was last presented to the Board there has been one risk removed.

BAF ID 106 ‘Risk that the organisation’s services may suffer significant challenges as result of the impact of winter pressures’.

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.

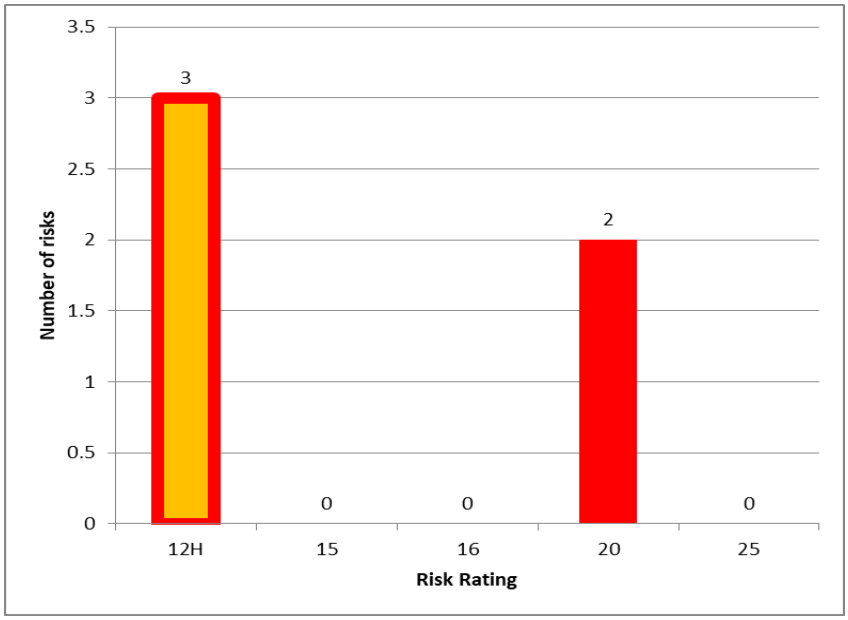
		← *Impact / Severity* →				
		Insignificant	Minor	Moderate	Major	Catastrophic
↓Likelihood ↓		**1**	**2**	**3**	**4**	**5**
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

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

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

4. Organisational Risk Profile

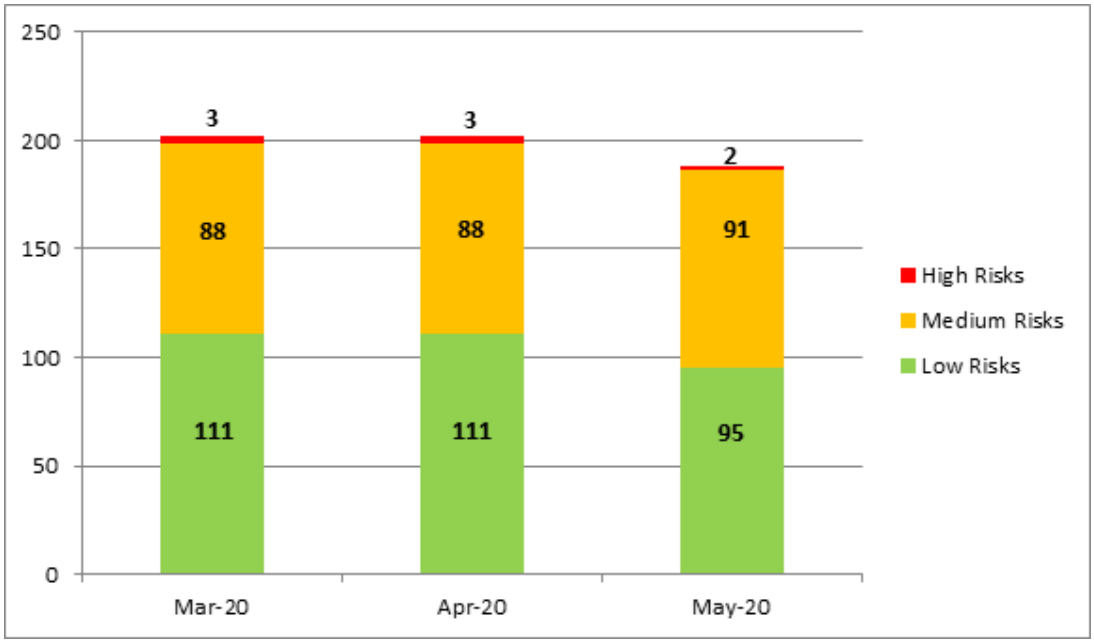
4.1 Figure 2: BAF Risk Profile



5. Risk Overview

5.1 The total number of open risks within the Trust stands at 188 this is comprised of 95 low risks, 91 medium risks and two high risks. Figure 3 (below) provides a visual representation. There are currently 0 out of date risks and 0 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.

5.2 Figure 3: Organisational Risk Profile.



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 and Sustainability
13 May 2020

NHS
Kent Community Health
NHS Foundation Trust

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

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

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

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

Action status key:

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating C	Initial rating L	Initial rating Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	Current rating C	Current rating L	Current rating Rating	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target Date (end)
Prevent ill health																			
107	Mar 2020	Paul Bentley	Risk that the organisation's services may suffer significant challenges and become compromised as a result of the impact of the COVID19 pandemic. Board Committee Lead on Assurance: **The Board**	5	4	20	Weekly setting and review of organisational priorities Exec meeting 7 days a week Covid 19 Response Plan Incident Control Centre in action SIRO and Deputy SRO appointed Operational Response SRO appointed Incident Team appointed On-call structure extended and implemented Membership of LHRP Established Battle rhythm reporting and communications plan Trigger and escalation framework established	Internal and External Reporting Executive sit-reporting daily Department of Health Response confirmation Operational KPIs LRF area ratings nationwide and local		4	5	20	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	Medium	**May 2020**
													Continuation of ICC, daily update calls and representation at region	All	On-going	A			
													Trigger document finalised and disseminated	Pauline Butterworth	27 March 2020	G			
													Escalation of supply shortages as required	Mercia Spare	29 May 2020	A			
													Re-deployment of further staff to tier 1	All execs Gordon Flack	18 April 2020	G			
													Framework of Recovery Strategy and Plan drafted	Gerard Sammon Pauline Butterworth	24 April 2020	G			
													On-call structure to be reviewed	Natalie Davies Pauline Butterworth	03 April 2020	G			
													To assess the impact of the CAS alert on reusable PPE and issue guidance as necessary	Mercia Spare	01 May 20202	G			
													Ethics Committee review of use of PPE to make recommendation to Executive	Sarah Phillips	01 May 20202	G			
													To complete the trust response and projections to the latest Kent and Medway Modelling	Gordon Flack	01 May 20202	G			
108	Mar 2020	Paul Bentley	Risk that the availability of staff could impact on the delivery of tier oner services during the Covid19 pandemic potentially due to illness or isolation, and/or morale amongst staff Board Committee Lead on Assurance **The Board**	5	4	20	Covid 19 Response Plan Incident Control Centre in action SIRO and Deputy SRO appointed Operational Response SRO appointed Incident Team appointed On-call structure extended and implemented Membership of LHRP Established Battle rhythm reporting and communications plan	Internal and External Reporting Executive sit-reporting daily Department of Health Response confirmation Operational KPIs LRF area ratings nationwide and local		4	5	20	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	Medium	**May 2020**
													Staff welfare package: continued co-ordination and expansion	Louise Norris	On-going	A			
													Executive daily blog / message	Paul Bentley	On-going	A			
													Chief Nurse/Medical Director Question and Answer	Mercia Spare Sarah Phillips	On-going	A			
													Re-deployment of further staff to tier 1	All execs	24 April 2020	G			
													Induction programme established for re-deployed staff	Natalie Parkinson	03 April 2020	G			
105	May 2019	Pauline Butterworth	Challenges in meeting the referral to treatment waiting time target could impact on patient experience and the trust segmentation rating Board Committee Lead on Assurance: **Quality Committee**	4	3	12H	• Access policy includes harm risk assessment for pts waiting over 18 weeks	• Regular reports IPR • SPC chards • Quality committee review of areas of concern • QI approach to service improvement	• Increase in demand raised with CCG's but no decisions	4	3	12H	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Pauline Butterworth	Medium	**Mar 2020**
													Consultant led 18 week pathways: • Develop demand & capacity tools	Pauline Butterworth	May 2020	A			
Develop Sustainable Services (Strategic Objective Enablers)																			
Deliver High Quality Care at Home and in the Community																			
99	Jan 2019	Gordon Flack	Implementing a clinical system including double running with the existing obsolete system . The significant tasks relate to the associated data extraction and import of large and complex records to 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 to design the input window functions ensuring consistent and streamlined records which minimises clinical input time whilst running the old system as is. This is also taking 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.	4	3	12H	• Governance structure & project plan in place • Engagement with the project team delivering the Kent Care Record • Project Leadership team job descriptions • Expertise from NELFT • Phase implementation plan and resourcing appropriately • Communication plans developed with stakeholders Inc. commissioners. • Operational risk and mitigations log	• Regular Board reports linked to other projects • Project Group report to Management Committee, Exec Team and Board	• Timescales to implement new system • Comprehensive programme plan for replacement system to be developed in response to emerging timescales	4	3	12H	Resource assessment on-going as part of the project governance structure.	Sarah Phillips	May 2020	A	Gordon Flack	High	**May 2020**
													Data Archive Strategy	Sarah Phillips	May 2020	A			

				Initial rating						Current rating									
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	C	L	Rating	Planned Actions and Milestones				Action owner	Confidence Assessment	Target Date (end)
			training. Board Committee Lead on Assurance: **Finance, Business and Investment Committee**																
103	Jan 2019	Paul Bentley	Changes to the system architecture and continued financial instability may provide uncertainty in the future delivery of integrated services Board Committee Lead on Assurance: **Board**	4	3	12H	• Sustainability and Transformation Plan (STP) Programme •Board TORs and membership • TORs for: Local Care Boards; Frailty Group; Chief Executives Forum • STP Governance Structures • West Kent Improvement Board terms of reference • East Kent Transformation Board terms of reference NHS I/E system meeting terms of reference • Chief Executive as SIRO for East ICP • Chair as Chair for West ICP • System transformation governance structure • West Kent integrated care partnership development board's terms of reference • East Kent integrated care partnership development board's terms of reference	• Local Care Investment received for both east and west Kent - Hospital at Home and Rapid Transfer of Care scheme. • Community Care Funding increase in financial settlement • Chief Exec report to the board • Regular Strategic development update to the board • Non executive membership of the STP board. • Director of strategy report to the Management Committee		4	3	12H	**Individual Actions** 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	**Owner** Paul Bentley Paul Bentley Gerard Sammon	**Target Completion** (end) May 2020 May 2020 May 2020	**Status** A A A	Paul Bentley	Low	**May 2021**

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.3
Agenda Item Title:	Standing Financial Instructions
Presenting Officer:	Gordon Flack, Director of Finance / Deputy Chief Executive

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

Report Summary

The Standing Financial Instructions have been updated to reflect:

- The new organisational forms for NHS England and NHS Improvement and NHS Counter Fraud Authority and change in name of the NHS Oversight Framework.
- Removing references to out of date guidance.
- Updated to comply with the DHSC transparency guidance (paragraph 7.11) and the use of the national Contracts Finder portal and removing reference to a list of approved firms.
- The Invitation to Tender section (7.14) has been updated to reflect the use of the Trust's e-procurement system.
- The admissibility of tenders has been updated to include a nominated officer of the Chief Executive.
- Acceptance of tenders (7.17.2) has been expanded to state that the lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary *i.e. there is specific evaluation criteria stipulating basis of award*.
- That orders are not required for approved purchase order exceptions such as rates, council tax and agency costs.

Proposals and /or Recommendations

The Board is asked to approve the updated Standing Financial Instructions.

Relevant Legislation and Source Documents

Monitor NHS Foundation Trusts Annual Reporting Manual
NHS Manual for Accounts 2014-15

Has an Equality Analysis (EA) been completed?

No ☒ High level position described and no decisions required.

Gordon Flack, Director of Finance / Deputy Chief Executive	Tel: 01622 211934
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Kent Community Health
NHS Foundation Trust

Standing Financial Instructions

1 Introduction

1.1 General

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

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

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

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

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

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

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

1.2 Responsibilities and delegation

The Board of Directors

1.2.1 The Board exercises financial supervision and control by:

1.2.1.1 formulating the financial strategy;

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

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

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

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

The Chief Executive and Director of Finance

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

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

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

The Director of Finance

1.2.6 The Director of Finance is responsible for:

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

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

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

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

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

1.2.6.4.1 the provision of financial advice to Directors and Officers;

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

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

1.2.7 **Directors and Officers**

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

1.2.7.1 the security of the property of the Trust;

1.2.7.2 avoiding loss;

1.2.7.3 exercising economy and efficiency in the use of resources;

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

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

Contractors and their employees

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

2 Audit

Audit and Risk Committee

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

2.1.2 overseeing internal and external audit services;

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

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

2.1.5 monitoring compliance with SOs and SFIs;

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

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

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

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

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

2.4 Director of Finance

The Director of Finance is responsible for:

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

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

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

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

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

2.4.4.2 major internal financial control weaknesses discovered;

2.4.4.3 progress on the implementation of internal audit recommendations;

2.4.4.4 progress against plan over the previous year;

2.4.4.5 strategic audit plan covering the coming 3 years; and

2.4.4.6 a detailed plan for the coming year.

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

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

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

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

2.5.4 explanations concerning any matter under investigation.

2.6 Role of internal audit

Internal audit will review, appraise and report upon:

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

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

2.6.3 the suitability of financial and other related management data;

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

2.6.4.1 fraud and other offences;

2.6.4.2 waste, extravagance, inefficient administration;

2.6.4.3 poor value for money or other causes.

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

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

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

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

2.10 External audit

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

Fraud and corruption

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

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

2.13 The LCFS shall report to the Director of Finance and shall work with staff in the NHS Counter Fraud Authority (CFA) in accordance with the NHS Counter Fraud and Corruption Manual and associated guidance.

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

Security management

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

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

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

Finance, Business and Investment Committee (FBI)

2.18 The FBI committee has responsibility for the following ;

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

2.18.2 Monitor performance against Cost Improvement Plans;

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

2.18.4 Approve treasury management policy and scrutinise implementation.

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

Preparation and approval of plans and Budgets

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

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

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

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

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

3.2.2 accord with workload and manpower plans;

3.2.3 be produced following discussion with appropriate Budget Holders;

3.2.4 be prepared within the limits of available funds; and

3.2.5 identify potential risks.

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

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

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

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

3.7 Budgetary delegation

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

3.7.1.1 the amount of the Budget;

3.7.1.2 the purpose(s) of each Budget heading;

3.7.1.3 individual and group responsibilities;

3.7.1.4 authority to exercise virement;

3.7.1.5 achievement of planned levels of service; and

3.7.1.6 the provision of regular reports.

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

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

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

3.11 Budgetary control and reporting

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

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

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

3.11.1.2 movements in working capital;

3.11.1.3 movements in cash and capital;

3.11.1.4 capital project spend and projected outturn against plan;

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

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

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

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

3.11.4 monitoring of management action to correct variances; and

3.11.5 arrangements for the authorisation of Budget transfers.

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

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

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

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

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

3.12 Capital expenditure

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

3.13 Monitoring returns

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

4 Annual accounts and reports

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

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

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

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

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

4.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the NHS Foundation Trust Annual Reporting Manual.

5 Bank and Government Banking Service (GBS) accounts

5.1 General

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

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

5.2 Bank and GBS accounts

The Director of Finance is responsible for:

5.2.1 bank accounts and GBS accounts;

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

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

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

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

Banking procedures

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

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

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

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

Tendering and review

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

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

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

Income systems

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

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

Fees and charges

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

6.4 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by NHS England and NHS Improvement or by Law. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered, the Trust's local policy on Standards of Business Conduct and Conflicts of Interest shall be followed.

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

Debt recovery

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

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

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

Security of cash, cheques and other negotiable instruments

6.9 The Director of Finance is responsible for:

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

6.9.2 ordering and securely controlling any such stationery;

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

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

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

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

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

7 Tendering and contracting procedure

7.1 Duty to comply with SOs and SFIs

The procedure for making all contracts by or on behalf of the Trust shall comply with the SOs and these SFIs.

7.2 EU Directives governing public procurement

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

7.3 Reverse eAuctions

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

7.4 Other Department of Health and Social Care guidance

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

Formal competitive tendering

7.5 General applicability

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

7.5.1.1 the supply of goods, materials and manufactured articles;

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

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

7.5.1.4 for disposals of tangible and intangible property (including equipment and intellectual property).

7.6 Health care services

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

Exceptions and instances where formal tendering need not be applied

7.7 Formal tendering procedures need not be applied where:

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

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

7.7.3 regarding disposals as set out in SFI 7.25 below;

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

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

7.8.2 where the requirement is covered by an existing contract;

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

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

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

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

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

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

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

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

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

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

7.11 Fair and open procurement process

In line with the Department of Health and Social Care procurement transparency guidance, the Trust shall ensure that all contract opportunities with a contract value of £25,000 and over are advertised on the national Contracts Finder portal. For contract opportunities with a contract value under £25,000, the Trust shall ensure fair and adequate competition by selecting a sufficient number of suppliers, and in no case less than 2 suppliers for evaluation, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.12 Building and engineering construction works

7.12.1.1 Suppliers awarded contracts shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person and shall act in accordance with the law and for the avoidance of doubt this includes all relevant employment legislation and guidance and the Bribery Act 2010.

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

7.13 Items which subsequently breach thresholds after original approval

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

7.14 Contracting/tendering procedure

Invitation to tender

7.14.1 All invitations to tender shall state the date and time as being the latest time for the receipt of tenders and that all tenders must be submitted via the Trust's e-procurement system. On receipt, completed tenders are received into a sealed mailbox, which can only be accessed by a Nominated Officer on expiry of the tender deadline.

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

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

Receipt and safe custody of tenders

7.14.4 All tenders will be received electronically via the Trust's e-procurement system and will not able to be accessed until the expiry of tender deadline. Access is strictly controlled via password protection and an audit trail of access maintained.

7.14.5 The Trust's e-procurement system records the date and time of receipt of each tender.

Opening tenders and register of tenders

7.14.6 As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, the Procurement team will remove the electronic seal to allow formal compliance review of the tenders received and the Trust's tender evaluation procedures to commence. The Trust's e-procurement system maintains an audit trail of all tenders received and actions taken.

7.14.7 Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders (see SFI 7.16).

7.15 Admissibility

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

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

7.16 Late tenders

7.16.1 Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his Nominated Officer decides that there are exceptional circumstances.

7.16.2 Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Trust's Procurement team or if the process of evaluation and adjudication has not started.

7.16.3 While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall not be accepted and reviewed.

7.17 Acceptance of formal tenders

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

7.17.2 The lowest tender, if payment is to be made by the Trust, or the highest, if payment is to be received by the Trust, shall be accepted unless there are good and sufficient reasons to the contrary i.e. there is specific evaluation criteria stipulating basis of award. Such reasons shall be set out in either the contract file, or other appropriate record.

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

7.17.3.1 experience and qualifications of team members;

7.17.3.2 understanding of client's needs;

7.17.3.3 feasibility and credibility of proposed approach;

7.17.3.4 ability to complete the project on time.

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

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

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

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

7.17.6.2 that best value for money was achieved.

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

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

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

7.18 Quotations: competitive and non-competitive

7.18.1 **General position on quotations**

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

7.18.2 **Competitive quotations**

7.18.2.1 Quotations should be obtained from at least 3 suppliers based on specifications or terms of reference prepared by, or on behalf of, the Trust.

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

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

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

7.18.3 **Non-competitive quotations**

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

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

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

7.18.3.3 miscellaneous services, supplies and disposals;

7.18.3.4 where the goods or services are for building and engineering maintenance the responsible works Officer must certify that the first two conditions of this SFI (SFIs 7.18.3.1 and 7.18.3.2 above) apply.

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

Competitive quotation need not be applied where:

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

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

7.18.5 **Quotations to be within financial limits**

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

7.18.6 **Authorisation of tenders and competitive quotations**

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

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

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

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

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

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

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

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

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

7.19 Preferred procurement route

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

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

7.20 Private finance for capital procurement

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

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

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

7.20.3 the proposal must be specifically agreed by the Board.

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

7.21 Compliance requirements for all contracts

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

7.21.1 the Trust's SOs and SFIs;

7.21.2 EU Directives and other statutory provisions;

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

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

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

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

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

7.22 Personnel and agency or temporary staff contracts

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

7.23 Health care services agreements

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

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

7.24 Disposals

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

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

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

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

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

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

7.25 In-house services

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

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

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

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

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

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

7.25.4 The evaluation team shall make recommendations to the Board.

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

7.26 Applicability of SFIs on tendering and contracting to Funds Held on Trust

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

8 NHS service agreements for provision of services

8.1 Service Contracts

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

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

8.1.2.1 the standards of service quality expected;

8.1.2.2 the relevant national service framework (if any);

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

8.1.2.4 the NHS Oversight Framework; and

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

8.2 Reports to Board of Directors on Service Contracts

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

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

9.1 Remuneration and terms of service

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

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

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

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

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

9.1.2.1.3 arrangements for termination of employment and other contractual terms;

9.1.2.2 making such recommendations to the Board on the remuneration and terms of service of Directors and senior Officers to ensure they are fairly rewarded for their individual contribution to the Trust -

having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

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

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

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

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

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

9.2 Funded establishment

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

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

9.3 Staff appointments

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

9.3.1.1 authorised to do so by the Chief Executive; and

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

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

9.4 Processing payroll

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

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

9.4.1.2 the final determination of pay and allowances;

9.4.1.3 making payment on agreed dates; and

9.4.1.4 agreeing method of payment.

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

9.4.2.1 verification and documentation of data;

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

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

9.4.2.4 security and confidentiality of payroll information;

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

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

9.4.2.7 methods of payment available to various categories of Officers;

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

9.4.2.9 procedures for the recall of cheques and bank credits;

9.4.2.10 pay advances and their recovery;

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

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

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

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

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

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

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

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

9.5 Contracts of employment

The Board shall delegate responsibility to an Executive Director for:

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

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

10 Non-pay expenditure

10.1 Delegation of authority

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

10.1.2 The Chief Executive will set out:

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

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

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

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

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

10.3 System of payment and payment verification

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

10.4 The Director of Finance will:

10.4.1 advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders

must be obtained; and, once approved, the thresholds should be incorporated in the SOs and SFIs and/or Scheme of Delegation (as appropriate) and regularly reviewed;

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

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

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

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

10.4.4.2 certification that:

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

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

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

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

10.4.4.2.5 the account is arithmetically correct;

10.4.4.2.6 the account is in order for payment;

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

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

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

10.5 Prepayments

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

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

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

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

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

10.6 Purchase orders

Purchase orders for goods and/or services must:

10.6.1 be consecutively numbered;

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

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

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

10.7 Duties of Officers

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

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

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

10.7.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the

Department of Health and Social Care and NHS England and NHS Improvement;

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

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

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

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

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

10.7.5.3 the Code of Conduct for NHS Managers 2002; and

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

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

10.7.5.6 all goods, services, or works are ordered on a purchase order except works and services executed in accordance with a contract and purchases from petty cash and for certain type of purchases as per the Trust's approved Purchase Order exceptions;

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

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

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

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

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

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

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

11 External borrowing

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

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

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

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

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

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

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

12 Investments

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

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

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

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

13.1 Capital investment

The Chief Executive:

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

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

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

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

13.2.1 that a business case is produced setting out:

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

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

13.2.1.3 appropriate project management and control arrangements;

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

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

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

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

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

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

13.6.1 specific authority to commit expenditure;

13.6.2 authority to proceed to tender;

13.6.3 approval to accept a successful tender.

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

13.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and

valuation for accounting purposes. These procedures shall fully take into account any current delegated limits for capital schemes.

13.9 Private finance

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

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

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

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

13.10 Asset registers

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

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

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

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

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

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

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

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

13.10.6 Where a full valuation of assets has not been undertaken, the value of each material asset shall be indexed to current values in accordance with the most up-to date BCIS Index (Building Cost

Information Service of RICS). The BCIS Index fulfils the requirement of being current and is approved by the Royal Institution of Chartered Surveyors. Where the BCIS Index is not appropriate for a class of asset i.e. Land, an assessment of current valuation will be provided by an approved External Chartered Surveyor. Non-Property assets, those assets which have short useful lives or low values (or both) are not re-valued.

13.10.7 The value of each asset shall be depreciated using methods applicable to the Department of Health and Social Care Government Accounting Manual and relevant International Accounting Standards.

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13.11 Security of assets

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

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

13.11.2.1 recording managerial responsibility for each asset;

13.11.2.2 identification of additions and disposals;

13.11.2.3 identification of all repairs and maintenance expenses;

13.11.2.4 physical security of assets;

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

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

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

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

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

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

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

14 Stores and receipt of goods

14.1 General position

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

14.1.1 kept to a minimum;

14.1.2 subjected to proper control and recording; and

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

Control of stores, stocktaking, condemnations and disposal

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

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

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

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

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

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

14.8 Goods supplied by NHS Supply Chain

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

15 Disposals and condemnations, losses and special payments

Disposals and condemnations

15.1 Procedures

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

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

15.1.3 All unserviceable articles shall be:

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

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

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

Losses and special payments

15.2 Procedures

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

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

15.2.3 The Director of Finance must notify the NHS Counter Fraud Authority and the external auditor of all frauds.

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

15.2.4.1 the Board of Directors; and

15.2.4.2 the external auditor.

15.2.5 Within delegated limits, the Management Committee shall approve the writing-off of losses.

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

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

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

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

15.2.10 All losses and special payments must be reported to the Audit and Risk Committee on a quarterly basis unless a significant loss has been incurred.

16 Information technology

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

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

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

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

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

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

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

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

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

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

16.4.1 details of the outline design of the system; and

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

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

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

16.6 Risk assessment

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

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

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

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

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

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

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

17 Patients' property

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

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

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

17.2.2 hospital admission documentation and property records; and

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

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

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

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

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

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

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

18 Funds held on trust

18.1 Corporate trustee

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

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

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

18.2 Accountability to Charity Commission and Secretary of State

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

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

18.3 Applicability of SFIs to funds held on trust

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

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

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

The Director of Finance shall ensure that all staff are made aware of the Trust policy on acceptance of gifts and other benefits in kind by staff. This policy follows the guidance contained in the guidance "Managing Conflicts of Interest in the NHS Guidance for staff and organisations" issued by NHS England and NHS Improvement and is also deemed to be an integral part of the SOs and SFIs.

20 Retention of records

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

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

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

21 Risk management and insurance

Programme of Risk Management

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

21.2 The programme of risk management shall include:

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

21.2.2 engendering among all levels of staff a positive attitude towards the control of risk;

21.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

21.2.4 contingency plans to offset the impact of adverse events;

21.2.5 audit arrangements including; internal audit, clinical audit, health and safety review;

21.2.6 a clear indication of which risks shall be insured; and

21.2.7 arrangements to review the risk management programme.

21.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a Statement of Internal Control within the annual report and accounts as required by current NHS Improvement guidance.

21.4 Insurance: risk pooling schemes administered by NHS Resolution

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution or self-insure for some or all of the risks covered by the risk pooling schemes. If the Board decides not to use the risk pooling schemes for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme this decision shall be reviewed annually.

21.5 Insurance arrangements with commercial insurers

The Trust, as a Foundation Trust, can enter into insurance arrangements, for areas not covered by the risk pooling schemes, with commercial insurers. The Board will approve commercial insurance arrangements.

21.6 Arrangements to be followed by the Board in agreeing insurance cover

21.6.1 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that documented procedures cover these arrangements.

21.6.2 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. The Director of Finance will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.6.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the "**Deductible**"). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the Deductible in each case.

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.4
Agenda Item Title:	Audit and Risk Committee Chair's Assurance Report
Presenting Officer:	Peter Conway, Chair of Audit and Risk Committee

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

Report Summary
The paper summarises the Audit and Risk Committee meetings held on 12 February and 13 May 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:

Kent Community Health
NHS Foundation Trust

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

This report is founded on the Audit and Risk Committee meeting held on 12 February 2020.

Area	Assurance	Items for Board's consideration and/or next steps
Risk Management	Board Assurance Framework - positive assurance. Committee noted clustering of action plan dates at financial year end, the prevalence of 12H scores and that the system architecture/integrated services risk no longer reflects current 5 year plan/STP/Trust risks Risk Management Policy - update agreed including outline risk appetite statement	-Risk (103) needs to be refreshed -Action target dates and risk scores to be revisited -Risk Appetite to be further developed and agreed by the Board
Third party assurances	TIAA Internal Audit - No current issues, all work on schedule. Plan for 2020/2021 agreed (160 days of activity, no change year on year) Counter Fraud - positive assurance External Audit - audit plan for this year agreed with suggested fee increase (for main audit, not Value for Money or Charitable Funds) because of Financial Reporting Council requirements	-the purpose, scope and timing of some of the individual audits will need further consideration (eg. Kent Care Record, Self-Managed Teams and Patient Involvement). Mr Flack, Director of Finance to agree fee with Grant Thornton following member feedback out of committee

Governance and internal assurances	Freedom to Speak Up - positive assurance STP governance - general discussion CARM - positive assurance on a wide range of issues Legal Report - positive assurance (including hopefully the end of the Provision/plasma TV screens saga)	Single page flow diagram needed to help staff navigate all the current escalation routes (Joy has in hand) ARAC to consider ICS and ICP governance, assurance and risk management in September based on the proposals in the recently agreed STP Plan ARAC to follow through liability/provision implications in Annual Accounts 2019/20
Financial reporting and controls	Single Tender Waivers, Retrospective Requisitions, Losses, Special Payments and Write Offs - positive assurance 2019-2020 Annual Report and Accounts Process, Timetable and Accounting Policies - plan agreed	-Impact of new IFRS 16 standard for leases considered. Issues being covered off by Exec including where we have not been able to agree leases with Property Services. Revenue impact estimated about -£300k, Balance sheet +£67m. NB accounting changes only no behavioural or spending impact on Trust
Focus items	Cyber Security - positive assurance (amber-green overall rating) and continuing good progress including achieving the right balance between control of risks and agility	Board to note some simple but positive user experience enablers going live this year eg. single sign on and Govroam.

	Committee Forward Plan - reviewed	-Kent Care Record assurance to be regular item for Finance, Business and Investment (FBI) Committee -Sustainability assurance (strategy, plans and progress) to be considered by ARAC in September -assurance on future IFRS 16 investment impacts to go to FBI Committee

Peter Conway
Chair, Audit and Risk Committee
February 2020

Kent Community Health
NHS Foundation Trust

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

This report is founded on the Audit and Risk Committee meeting held on 13 May 2020.

Area	Assurance	Items for Board's consideration and/or next steps
2019/20 Accounts	Accounts completed (again) to a very high standard by the Finance Team. External Auditors have a longish list of items still to complete before they can give an unqualified** (but see below) opinion. The to do list stems from the COVID-19 challenges. None are show-stoppers but may prevent Grant Thornton's final opinion being given in time for Board on 21 May 2020. **There are two national/systemic items that could give rise to qualification and/or an emphasis of matter paragraph in the Accounts: 1) going concern: as central COVID-19 financial support has been received for 3 months forward only, the Auditors cannot reach a conclusion for the full year ahead (as required by audit standards) because NHSI have not yet said anything about the	ARAC recommends that the Accounts should be signed. In terms of the of the two items detailed, as both are issues beyond the Trust's ability to resolve, the ARAC recommends the Board accepts whatever the final outcomes are and the consequences for Grant Thornton's opinion

Area	Assurance	Items for Board's consideration and/or next steps
	remaining 9 months 2) Land and Buildings (£5.6m) have been externally valued as required every 5 years. The Valuer has declared a ''material valuation uncertainty'' because of COVID-19 and because of this, the Auditors have to include an emphasis of matter paragraph (unless the amount is below materiality levels which is still under consideration).	
2019/20 Annual Report (AR)	The ARAC was not able to consider the AR as a final and complete version was not available. The Annual Governance Statement was reviewed and endorsed for Paul to sign	ARAC members will review the AR for consistency (particularly the Remuneration Report which has been delayed by the necessary Pensions information) hopefully prior to the next Board meeting
Financial reporting and controls	An update on single tender waivers (STWs), retrospective waivers and special payments was given with detail provided on the already advised increase in STWs because of COVID-19	
Cyber Security	An updating report was received describing a heightened risk profile largely because of the new and innovative ways of working. There are 2 red risks which are currently being addressed	As the next ARAC is not until late August, the Board may wish to receive interim assurance by way of a one off report or rely upon the Board Assurance Framework (BAF) in the event that cyber risks escalate there

Peter Conway
Chair, Audit and Risk Committee
May 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.5
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Pippa Barber, Chair of Quality Committee

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

Report Summary
The paper summarises the Extraordinary Quality Committee meeting held on 18 February 2020, the Quality Committee (Part One) meetings held on 17 March and 13 May 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 ☒ High level position described and no decisions required.

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

Kent Community Health
NHS Foundation Trust

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report follows the Quality Committee meetings held in February (Extraordinary - Cost Improvement Programme (CIPs)), March 2020 and May 2020. Part one:

Agenda item	Assurance and key points to note	Further actions and follow up
Quality Account 2019/20 (May)	Following amendments to the national regulations the 2019/20 Quality Account is no longer required to be submitted as part of the Trust Annual Report with a review by external auditors. The timescale for completion has also been extended. It is important the Trust is able to record the significant work that has been undertaken and a report has been prepared. The draft account was presented to the Committee for comments. It will also be shared with stakeholders for comment.	The Quality Account will come to the Committee in July for a recommendation of approval by the Board at the August meeting.
Extraordinary Quality Committee (3 April)	A virtual meeting was held to approve and ratify the following documents to support the Trust's response to COVID-19: Documents related to supplementary prescribing; once daily gentamicin; virtual mortality review process; just in	

Agenda item	Assurance and key points to note	Further actions and follow up
	case medicines; Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR); treatment escalation plans; and the Anticipating Prescribing Policy.	
Patient Safety and Clinical Risk Group Chair's Assurance Report (May)	Key risks are being reviewed. Assurance received that there is a robust process in place during this time and that risks can and are being raised, reviewed and managed.	
Extraordinary Quality Committee to consider CIP deep dives (February)	Assurance received on 49% of CIP schemes in February. Deep dives to be undertaken by non-executive directors (NEDs) on identified schemes from quarter two onwards with the majority of visits in quarter three and four. These will be reported back to the Quality Committee. Further estates schemes were considered in March. No quality risks were identified that required deep dives from the Committee. Further quality impact assessments (QIA) risk scores will be considered at future meetings when completed.	NED deep dives identified and will be reported back to the Committee from quarter two onwards.
Patient story to the Board (March)	The Chief Nurse advised that system issues were being shared with commissioners. The Trust has taken internal actions. A request to the Quality Committee from the Governors to feedback on how assurance has been sought on the	A written report on actions taken will be provided to the Quality Committee at the earliest opportunity and it will be an agenda item in May as part of the Committee feedback.

Agenda item	Assurance and key points to note	Further actions and follow up
	issues raised has been made.	
Patient story to the Board (May)	A formal report was provided at the May meeting on actions taken to date and further work that is progressing. The team are working with the family. Wider issues were identified in the more recent complaint, including; seven day working. Assurance was received that actions have been taken with the specific team and this is being considered as part of the reset plan. End of life care (EOLC) there are processes in place within the Trust that are rapidly changing as a result of COVID-19 , Wider system issues.	Further assurance on outstanding areas will be provided in July.
Board Assurance Framework (BAF) (March)	Significant assurance received on actions in place to support the Trust's response to COVID-19.This is a rapidly changing picture with significant changes for Trust services and staff. Minutes circulated to the Board separately	The BAF score being considered by the Executive Team and updates as needed following ongoing review and discussion.
Board Assurance Framework (May)	Updates were received on the following risks Risk 107 and 108. Updates and assurance given on the work to source and provide guidance and support to staff on personal protective equipment (PPE). This will remain a focus as further services are bought on line. Actions	

Agenda item	Assurance and key points to note	Further actions and follow up
	taken to provide a prompt response to staff questions have had a positive impact on providing confidence to staff. Further updates and assurance given on processes in place with the senior team working internally and how they are working as part of the wider system. Risk 105. Referral to Treatment waiting time (RTT) targets have been maintained. Changes to working practices as a result of COVID-19 include a virtual offer which is being considered where appropriate as part to the reset plans. Risks to maintaining the achievement of the initial health assessments (IHAs) for unaccompanied asylum-seeking children were highlighted due to increasing demand. Mitigated by virtual health assessments is being completed where they can and additional staffing has been sourced. This remains an ongoing area of focus for the team.	Further updates will be available in the Integrated Performance Report (IPR).
Quality Report (March)	Discussion and assurance on Falls work taking place with teams in the Trust. Additional falls prevention coordinators have been recruited.	Deep dive presentation to take place at May Quality Committee. The End of Life Care (EOLC) plan data must be included in the report.

Agenda item	Assurance and key points to note	Further actions and follow up
Quality Report (May)	It was agreed that the Deep Dive on Falls will take place in July Assurance was received on the work at West View Integrated Care Centre to support the introduction of additional beds over winter and to monitor and enhance patient safety and experience. Assurance was received on the incident process put in place to identify and support COVID-19 related incidents.	May update on EOLC: these are now included and some good progress is being made. Progress will continue to be monitored
2019/20 and 2020/21 Quality priorities (March)	The working list of priorities for 2020/21 was considered. These will come back for final agreement in May. The plan for their development was supported by the Committee. The 2019/20 Quality priorities: The achievement of the target on number of patient and service users completing Quality Improvement (QI) fundamental training will not be reached.	The Quality Committee will need to have sight of further work on the development of care plans and holistic assessments as these are not quality priorities and remain learning from Serious Incidents (SIs). The staff experience suggested for 2020/21 will be shared with the Strategic Workforce Committee for comment.
Annual Infection Prevention and Control (IPC) Declaration (March)	This was considered by the Committee and assurance received that effective systems were in place. The annual IPC Declaration on compliance was approved by the Committee.	

Agenda item	Assurance and key points to note	Further actions and follow up
Medicines Optimisation Report (March)	Good progress and assurance given on QI process in place, particularly on reducing avoidable insulin incidents in both community and community hospitals. Rates are reducing for the last two quarters.	QI process will continue in both inpatient and community settings. A request for data to be presented in SPC charts going forward.
Health Visiting Service New Birth Visits (March)	Following review of the Integrated Performance Report (IPR) at the Board a deep dive paper was considered and assurance given on performance. Particularly focusing on district performance. Assurance was received on improving work force metrics with vacancy rates remaining a focus for the service. The service was able to demonstrate that it now has active systems in place to track and monitor district performance and provide support and additional capacity if needed. This is currently targeted in three areas.	The team will continue to monitor targets at district level.
Terms of Reference (March)	Agreed subject to the following amendments: A review of the membership. Removal of Chief Executive (in line with agreed governance). Add Director of Quality, Improvement and Patient Experience as a member. Consideration of strengthening the equality component and setting out deputy chair arrangements.	

Pippa Barber
Chair, Quality Committee
13 May 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.6
Agenda Item Title:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Chair of Strategic Workforce Committee

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

Report Summary
The paper summarises the Strategic Workforce Committee meeting held on 18 March and 13 May 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 ☒ High level position described and no decisions required.

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

Kent Community Health
NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE (SWC) CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on Wednesday 18 March 2020.

Agenda item	Assurance and key points to note	Further actions and follow up
Feedback from Quality Committee Coronavirus Workforce update Assurance and Planning	Assurance from Dr Spare, Chief Nurse and Ms Norris, Director of Workforce, Organisational Development on workforce planning for COVID-19 including the role of the Incident Control Team, the Trust's approach to staff resourcing as we move from delay to suppression, how staff will work safely out of scope, training plans for staff, how we are maintaining services to protect patients whilst being clear on the level of care absolutely necessary. Explored effectiveness of communication and ability to do further testing with the extended family. Reported on tracking of staff daily sick, working from home, isolated due to family members, looking at how we protect our own at risk staff, use of extreme measures like the use of hotels as well as the importance of maintaining resilience and peer support. We are planning for 40 per cent staff absence due to COVID-19 at any one time due to combination of staff sickness and isolation at home with likely school closures.	

Agenda item	Assurance and key points to note	Further actions and follow up
Workforce Report	Workforce statistics pre-COVID-19 continued to be strong but clearly COVID-19 will significantly change them most seriously in sickness levels. The positive state of the workforce statistics is clearly to be recognised and appreciated. More importantly we can be demonstratively assured we start this COVID-19 challenge from a very strong 'colleague-foundation' Recruitment efforts are being enhanced and creative ways of conducting interviews explored.	The Board Assurance Framework (BAF) to reflect the seriousness of the risk to staff is being drafted for the Board meeting on 26 March 2020.
Significant Employee Relations Report	No new suspensions since January 2020.	
Equality and Diversity Strategy		Feedback from Ms Afuape, Non-Executive Director to be incorporated in new version of E, D & I Strategy paper for the May SWC meeting.
Effectiveness of HR / OD function roles	Amazing amount achieved by Organisational Development/Human Resources (HR) Team this year with fantastic qualitative and quantitative evidence to illustrate the significant effectiveness of the team.	Improvements or changes/development required to be built into the 2020 – 2025 plan to reflect the need to work more strategically, greater attention to E, D & I, as well as mechanisms for enhancing system working at STP, ICP and PCN level, as well as the role of technology.
Academy Update	Exploring how we can bring students back to support core staff. Impact on autumn cadre unknown.	

Agenda item	Assurance and key points to note	Further actions and follow up
Self-directed Teams	Current Transforming Integrated Care in the Community (TICC) programme of four teams will continue supported. Roll out of further teams paused although concept of small teams working closer together albeit supported may be a model used to tackle aspects of patient care.	Time line of decisions in future plan would highlight what is required by when to better understand scale, criteria and decision points/people.
Operational Workforce Report	Covered in the Quality Committee update.	
Automation in HR (Bots)	IT continues to develop bot use and recruit a bot builder.	
Advanced Practitioners Assurance Report	No concerns reported verbally. A revised report will be presented at the SWC May Committee meeting.	Advanced Practitioners Assurance Report to be completed for the May SWC meeting.
People Strategy Action Plan	Final Year of 2020/21 Strategy completion nearly achieved. Development of Workforce Strategy stalled.	
Staff Survey	Excellent results, illustrating the success of many initiatives introduced by HR and the Executive to engage and value staff.	Feedback on quality of appraisals to feed into action planning on Appraisal Policy plan. Survey data on WRES and WDES need to triangulate with E, D & I Strategy and Workforce Strategy.
Draft Workforce Plan	Received People Plan detailing numbers with some still at risk with commissioners.	Development of People Plan (numbers) to triangulate with development of Workforce Strategy (Goals and plan)
Gender Pay Gap	Main learning included how differently the winter pressure incentive impacted on bank staff compared to substantive staff.	

Agenda item	Assurance and key points to note	Further actions and follow up
Appraisal Policy	Drafting of a one page document to ensure managers understand new requirements including the need for consistent objective setting, to help improve the survey score ‘being valued’, plus clear objectives will ensure we are able to judge fairly whether someone has met criteria to be awarded pay increment.	

Bridget Skelton
Chair, Strategic Workforce Committee
18 March 2020

Kent Community Health
NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE (SWC) CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on 13 May 2020.

Agenda item	Assurance and Key points to note	Further actions and follow up
Workforce Report	Reviewed positive overall assurance from March data. Three are in a negative position all directly attributable to the emergency response for COVID-19. Absence has been well managed supported by good management of PPE using principles and regular communication using Q&A. To minimise the backlog of Data the pause on leave has been lifted where possible. Work is ongoing to support potential COVID-19 risk to Black, Asian and Minority Ethnic (BAME) staff with guidance given and support provided. New key performance indicators (KPIs) were noted before going back to the Executive Team.	The Executive Team to discuss and agree principles for who gets tested in Phase Two of COVID-19 and which committee gets assurance on that. Key KPIs to be highlighted against Trust Strategy and the refreshed People Strategy.
Operations Workforce Report – hotspots and mitigation	Challenges covering needs of 60+ extra asylum children in East Kent. Risks associated with redeployment of over 500 staff. Vacancy levels in west Kent in Community Nursing.	

Agenda item	Assurance and Key points to note	Further actions and follow up
Health and Wellbeing Report	Excellent set of existing and new initiatives to support wellbeing of staff. Qualitative feedback collected to determine which most beneficial to continue or develop. Further work scheduled with Kent and Medway NHS and Social Care Partnership Trust (KMPT) on how to support staff post COVID-19.	
Annual Leave, reset after lock down, resuming services and ending redeployment	A reset plan is being devised to allow annual leave, and restore services that locks in transformational change whilst doing so safely and ensuring personal protective equipment (PPE) is available where needed.	
Workforce Initiatives impacted by COVID-19 and plan to resume	Noted all workforce initiatives paused and the impact of doing so, as well as the timescales to restart. Occupational Health provider to develop a catch-up programme.	Appraisal process to be additionally used to thank and value staff as well as incorporate a question on self-reflection to inform objective setting and development planning.
Any other Business		Ms Norris, Director of Workforce, Organisational Development and Ms Skelton to produce draft of forward plan to include items postponed from March, cut from May and new items of importance for the Committee.

Bridget Skelton
Chair, Strategic Workforce Committee
13 May 2020

NHS
Kent Community Health
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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.7
Agenda Item Title:	Board Committees' Terms of Reference
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary

The Terms of Reference for each of the following committees has been reviewed and approved.

- Audit and Risk Committee
- Charitable Funds Committee
- Finance, Business and Investment Committee
- Quality Committee
- Remuneration and Terms of Service Committee
- Strategic Workforce Committee

Proposals and /or Recommendations

The Board is asked to ratify the Terms of Reference.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

High level position described.

Natalie Davies, Corporate Services Director	Tel: 01622 211906
	Email: Natalie.davies1@nhs.net

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

AUDIT AND RISK COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	21.03.11	Craig Sharples	New Document
1.1	Draft	26.01.12	Craig Sharples	Minor amends to reflect organisational change
2.0	Final	26.09.12	Craig Sharples	Update administrative section of TOR. Update references to CFSMS to NHS Protect in TOR. Explicitly reference relationship with the Finance, Business and Investment Committee in TOR.
2.1	Draft	05.02.13	Anthony May	Added section 7, expanded section 5 to state frequency of attendance required and amended requirement for a quorum
2.2	Draft	Aug 2014	Natalie Davies	Clinical Audit and Counter Fraud
2.3	Draft	March 2015	Rob Field	Updated to reflect Foundation Trust Status
2.4	Draft	March 2015	Rob Field	Amendment to Section 1.2 Objectives Trust Governance. Reallocation of delegated decision-

				making from ARC to FBI Committee. Amendment to Section 5.3 Membership, Removal of reference to attendance.
2.5	Draft	February 2017	Gina Baines	Minor amendments: Trust logo updated. Job titles updated.
2.6	Draft	February 2018	Gina Baines	Removed reference to resourcing of the clinical audit function in Section 1.2 Objectives. Inclusion of Strategic Workforce Committee in the list of 5.4 Key Relationships Removal of Section 5.11 Confidentiality.
2.7	Draft	September 2018	Gordon Flack	Add assurance reviews on the application of Standing Financial Instructions to the Financial Reporting Section.
2.8	Draft	February 2019	Gina Baines	1.2 Governance Risk Management and Internal Controls – Addition of cyber security controls; and physical security legal compliance. Deletion of clinical audit assurance. This has been transferred to the Quality Committee. Amendment of External Audit reference from 'Audit Commission rules' to 'ethical standards'. Addition of consideration of any published external reviews which relate to the Trust's services. 5.1 Governance – Chair. Wording amended to clarify who is responsible for appointing the Committee Chair.
2.8	Draft	July 2019	Gina Baines	1.2 Trust Governance – addition of oversight of specific risks on the Board Assurance Framework.

2.9	Draft	February 2020	Gina Baines	1.2 Objectives. Amendment of wording: changes from NHS Internal Audit Standards to NHS public sector standards

Review

Version	Approved date	Approved by	Next review due
1.0	4 April	KCHT Board	April 2012
1.1	26.01.2012	KCHT Board	April 2012
2.0	Sept 2012	Audit and Risk Committee	Sept 2013
2.0	Sept 2012	KCHT Board	Sept 2013
2.1	Feb 2013	Audit and Risk Committee	Sept 2013
2.2	Sept 2014	Audit and Risk Committee	Sept 2015
2.3	March 2015	KCHFT Board	April 2016
2.4	March 2015	KCHFT Board	April 2016
2.4	February 2016	Audit and Risk Committee	May 2017
2.5	February 2017	Audit and Risk Committee	February 2018
2.5	May 2017	KCHFT Board	May 2018
2.6	February 2018	Audit and Risk Committee	February 2019
2.6	May 2018	KCHFT Board	May 2019
2.8	February 2019	Audit and Risk Committee	February 2020
2.8	May 2019	KCHFT Board	May 2020
2.9	February 2020	Audit and Risk Committee	February 2021

1. Role

The Audit and Risk Committee is a non-executive committee of the Board with delegated decision-making powers specified in these Terms of Reference.

1.1 Purpose:

The purpose of the Audit and Risk Committee is to:

- Seek assurance that the financial reporting, risk management and internal control principles are applied;
- Maintain an appropriate relationship with the Trusts auditors, both internal and external; and
- Offer advice and assurance to the Trust Board about the reliability and robustness of the process of internal control.

The Board may request the Audit and Risk Committee to review specific issues where it requires additional assurance about the effectiveness of systems of internal control or areas where risk management reports highlight concerns.

It is incumbent upon the Audit and Risk Committee to work closely with other committees of the Trust Board to ensure that all issues relating to finance, risk management and internal control are considered in a holistic and integrated way.

1.2 Objectives:

<u>Governance, Risk Management and Internal Control</u>

The committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities that supports the achievement of the organisation's objectives.

In particular, the committee will review the adequacy of:

- All risk and control-related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commissions Essential Standards), together with any accompanying Head of Internal Audit statement, external audit opinion or other independent assurance, prior to endorsement by the Board

- The underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements

- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements

- The policies and procedures for all work related to fraud and corruption as set out in the Secretary of State Directions and as required by NHS Protect.

- Cyber security controls

- Physical security legal compliance - lone working, fire safety, building security, health and safety

In undertaking such review the Committee provides assurance to the Chief Executive and to the Board about fulfilment of the responsibility of the Trust's Accounting Officer, who under the terms of the National Health Service Act 2006 is held responsible to Parliament by the Public Accounts Committee for the overall stewardship of the organisation and the use of its resources.

In carrying out this work, the committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these audit functions. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

The committee shall ensure that there is an effective internal audit function established by management that meets mandatory NHS public sector standards and provides appropriate independent assurance to the Audit and Risk Committee, Chief Executive and Trust Board. This will be achieved by:

- Consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal

- Review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the Assurance Framework

- Considering the major findings of Internal Audit work (and management's response) and ensure co-ordination between the Internal and External Auditors to optimise audit resources

- Ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the organisation

- Annual review of the effectiveness of Internal Audit

External Audit

The committee shall review the work and findings of the External Auditor and consider the implications and management's responses to their work. This will be achieved by:

- Consideration of the independence, appointment and performance of the External Auditor

- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan, and ensure coordination as appropriate, with other External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee

- Review of all External Audit reports, including the report to those charged with governance, the annual audit letter before submission to the Trust Board and any work in the nature of audit work carried out outside the annual audit plan, together with the appropriateness of management responses

The committee shall provide an opinion to the Council of Governors on the appointment of the external auditor at the end of the contracted period for its consideration.

Counter Fraud

The committee shall review the effectiveness and impact of Counter Fraud operations within the Trust. This will be achieved by:

- Review of independent assessments of the Counter Fraud service
- Consideration, agreement and monitoring for assurance purposes of an annual programme of work balancing the need for proactive and reactive work
- Review of Counter Fraud Service reports and recommendations determining whether appropriate management responses have been received

Trust Governance

- Oversee the maintenance of an effective system of internal controls, assurance framework and management reporting and ensure that the Board is provided with evidence that risks are being appropriately identified, assessed, addressed and monitored
- Monitor the implementation of Board policies on standards of business conduct
- Consider the content of any report involving the Trust issued by the Public Accounts Committee or the Comptroller and Auditor General and review the management responses before presentation to the Board
- The Committee will also consider any published external reviews which relate to the Trust's services within the scope of the committee
- Have oversight of specific risks on the Board Assurance Framework as assigned by the Board.

Financial Reporting

The committee shall review the Annual Report and Financial Statements before submission to the Trust Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices
- Unadjusted mis-statements in the financial statements
- Major judgmental areas
- Significant adjustments resulting from the audit

The committee shall review reports on any exceptions applied to Standing Financial Instructions for assurance.

Review of the completeness and accuracy of financial information provided to the Trust Board

2. Accountability

The Audit and Risk Committee is accountable to:
KCHFT Board.

And accountable for:
The Audit and Risk Committee has no sub committees.

3. Decision Making

The Audit and Risk Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control.

4. Reporting Arrangements:

The Audit and Risk Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively possible.

5. Governance

5.1 Chair: One Non-Executive Director will be appointed as Chair of the Committee by the Trust Board.

5.2 Secretariat:
The Corporate Services Director will act as Secretariat to the Audit and Risk Committee.

5.3 Membership:
The committee shall be appointed by the Board from amongst the non-executive directors of the Trust and shall consist of not less than 3 members. One of the members will be appointed chair of the committee by the Trust Board. The Chairman of the Trust should not be a member of the Audit and Risk Committee.

The Head of Internal Audit, Head of External Audit and the Local Counter Fraud Specialist, or their deputies, shall normally attend meetings. Other individuals with specialist knowledge may attend for specific items with the prior consent of the Audit and Risk Committee Chairman.

At least once a year the committee should meet privately with the External and Internal Auditors and the Local Counter Fraud Specialist.

The Chief Executive and other executive directors should be invited to attend, particularly when the committee is discussing areas of risk or operation that are the responsibility of that director.

The Chief Executive should be invited to attend, at least annually, to discuss with the Committee the process for assurance that supports the Annual Governance Statement.

5.4 Key Relationships:
Quality Committee
Finance, Business and Investment Committee
Strategic Workforce Committee
The Executive Committees

5.5 Quorum:
The meeting will be quorate if two Non-Executive Directors are in attendance.

5.6 Frequency of Meetings:
Meetings will be held not less than three times a year.
The Chair of the Committee can call extra-ordinary meetings as necessary.

5.7 Notice of Meetings:
Meetings of the Audit and Risk Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

5.8 Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

5.9 Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

5.10 Minutes of Meetings:
The secretariat will record the minutes of the Audit and Risk Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Audit and Risk Committee shall be circulated promptly to all members by the secretariat.

6. Approval and Review of Terms of Reference

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

7. Monitoring Compliance

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Following each meeting.
Frequency of attendance	Attendance register of each meeting	Corporate Services Director will report to the Committee Chair	Annually

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
0.1	Draft	11.01.12	Craig Sharples	New Document
0.2	Draft	12.01.12	Craig Sharples	Revised following Charitable Funds Committee meeting – Submitted to Board for ratification
0.3	Draft	16.03.15	Rob Field	Amended to reflect Foundation Trust status
0.4	Draft	March 2016	Gina Baines, Assistant Trust Secretary	Amended to include Governor as a member.
0.5	Draft	April 2017	Gina Baines, Assistant Trust Secretary	Amended point 5 attendance to include Fund Managers and Assistant Director of Communications and Marketing. Trust logo. Updated job titles
1.4	Draft	27.04.2018	Gina Baines, Assistant Trust Secretary	Section 5 – Confidentiality – to change to 'The minutes… shall be made available to the public, through the Formal Board Part One papers'

Version	Draft/Final	Date	Author	Summary of changes
1.5	Draft	30.01.2019	Gina Baines, Assistant Trust Secretary	1. Role – Amended to reflect that the Committee is a sub-committee of the Board and membership is wider than non-executive directors.
1.6	Draft	07.06.2019	Gina Baines, Assistant Trust Secretary	Objectives – Addition of consideration of published external reviews relating to Trust services *and* oversight of specific risks on the Board Assurance Framework as assigned by the Board. 5. Governance – Amendment to appointment of Chair of Committee
1.6	Draft	01.03.2020	Gina Baines Assistant Trust Secretary	5.1 Membership amended to include a second non-executive director and formalise the Deputy Chair arrangements

Review

Version	Approved date	Approved by	Next review due
1.0	26.01.2012	KCHT Board	April 2012
1.1	26.03.2015	KCHFT Board	April 2016
1.2	March 2016	Charitable Funds	April 2017
1.3	April 2017	Charitable Funds	April 2018
1.3	May 2017	KCHFT Board	May 2018
1.4	April 2018	Charitable Funds	April 2019
1.4	May 2018	KCHFT Board	May 2019
1.5	January 2019	Charitable Funds	January 2020
1.5	May 2019	KCHFT Board	May 2020
1.6	January 2020	Charitable Funds	January 2021

1. ROLE

The Charitable Funds Committee is established as a Committee of the Board of Kent Community Health NHS Foundation Trust (the Trust) with delegated decision-making powers specified in these Terms of Reference to

Purpose:

The Charitable Funds Committee will act on behalf of the Corporate Trustee, in accordance with the Kent Community Health NHS Foundation Trust Standing Orders to oversee the charity's operation and to ensure that the administration of charitable funds is distinct from its exchequer funds.

The committee is authorised by the Board to obtain reasonable external, legal or other independent professional advice, and to secure the attendance of outsiders with relevant experience or expertise, if it considers this to be necessary.

Objectives:

The committee is delegated by the Board to undertake the following duties and any others appropriate to fulfilling the purpose of the committee (other than duties which are reserved to the Board alone):

- To ensure the Kent Community Health NHS Foundation Trust Charitable Fund is being managed and accounted for within the terms of its declaration of trust and Department of Health policy, including all legal and statutory duties, and in compliance with Charity Commission regulations. As a committee of the Board, in so far as it is possible to do so, most of the sections of the Standing Financial Instructions will apply to the management of charitable funds.
- To approve any new funds, the name and terms of reference of a Fund, and identify the nominated Fund Holder.
- To set and annually review the charity's reserves policy.
- To manage the investment of funds in accordance with the Trustee Act 2000.
- To determine the charitable fund's investment policy, including the selection of appropriate investment advisers and banking service provider.
- To monitor the performance of Investment Managers if appointed.
- To ensure funding decisions are appropriate and are consistent with Kent Community Health NHS Foundation Trust's objectives, to ensure such funding provides added value and benefit to the patients and staff of the Trust, above those afforded by the Exchequer funds.
- To receive regular monitoring reports on the utilisation of charitable funds by nominated fund budget-holders and take action to ensure Trust policy is implemented.
- To review and monitor Charity appeals and receive regular reports on the performance of all charitable fundraising activities.
- To implement as appropriate, procedures to ensure that accounting systems are robust, donations received are coded as instructed and that all expenditure is reasonable, clinically and ethically appropriate.

- To examine financial statements of the Charity and approve the annual accounts and report and ensure that relevant information is disclosed.
- To ensure that the Charitable Funds Committee membership is such that undue reliance is not placed on particular individuals when undertaking the duties of the Charitable Funds Committee Terms of Reference.
- To assure the Board that charitable funds are being managed and accounted for in terms with Trust and wider Charity Commission and Department of health policy.
- To consider any published external reviews which relate to the Trust's services within the scope of the committee.
- To have oversight of specific risks on the Board Assurance Framework as assigned by the Board.

2. ACCOUNTABILITY

Accountable to:
KCHFT Board

Accountable for:
The Charitable Funds Committee has no sub committees.

3. DECISION MAKING

The Charitable Funds Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for the corporate governance and internal control on the management of charitable funds.

4. MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The Charitable Funds Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its subcommittees as soon as administratively possible.

5. GOVERNANCE

Chair:
One Non Executive Director will be appointed as Chair of the committee by the Trust Board.

Secretariat:
The Corporate Services Director will provide the Secretariat to the Charitable Funds Committee.

Membership:
The Committee shall be appointed by the Board to ensure representation by non-executive and executive directors.

Members will include:

Chair	Non Executive Director
Other Members	Two Non-Executive Directors Chief Nurse Governor
In Attendance	Staff Side Representative Fund Managers Assistant Director of Communications and Marketing

5.1. The Deputy Chair, one of the non-executive directors and appointed by the Board will deputise in the absence of the Chair.

Key Relationships:
Audit and Risk Committee
The Executive Committees
The Charity Commission

Quorum:
The quorum necessary for the transaction of business shall be two members, one of which must be a Non-Executive Director.

Frequency of Meetings:
Meetings will be held not less than twice a year.
The Chair of the Committee can call extra-ordinary meetings as necessary

Notice of Meetings:
Meetings of the Charitable Funds Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:
The secretariat will record the minutes of the Charitable Funds Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Charitable Funds Committee shall be circulated promptly to all members by the secretariat.

Confidentiality:
The minutes (or sub-sections) of the Charitable Funds Committee, unless deemed exempt under the Freedom of Information Act 2000, shall be made available to the public, through the Formal Board Part One meeting papers.

7. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice.

Terms of Reference V.6

Finance, Business and Investment Committee

Document Control

Version No.	Draft / Final	Date	Author	Summary of Changes
V.1	Draft	1st Oct 2012	Gordon Flack	First draft of ToR for discussion at inaugural meeting of the FBI Committee on 12/10/12.
V.2	Draft	12th Oct 2012	Gordon Flack	ToR amended with minor changes agreed at FBI Committee on 12.10.12.
V.3	Draft	25th Oct 2012	Gordon Flack	ToR amended with change to clause on frequency of meetings agreed at Informal Board meeting on 25th October 2012.
V.4	Final	29th Nov 2012	Gordon Flack	ToR ratified at formal Board meeting on 29th November but quoracy changed from four members to three, including at least one NED.
V.5	Draft	15th Mar 2013	Gordon Flack	Proposed decision rights delegated by Board
V5.1	Final	15th May 2013	Gordon Flack	Amends following FBI to recognise capital projects within overall approved budget and E&D
V6	Final	15th February 2014	Gordon Flack	Amended to allow FBI to sign off Reference Costs return.
V6.1	Draft	16th March 2015	Rob Field	Amended to reflect Foundation Trust status
V6.2	Final	25th March 2015	Rob Field	Amendment to point 6.1 Finance, point 7. Additional point added to 6.1 Finance regarding procurement
V6.3	Draft	April 2016	Gina Baines	Amendment to point 4.2. any Board member could request a meeting.
V6.4	Draft	29 March 2017	Gina Baines	Updated Trust logo, job titles and reference to Monitor changed to NHS Improvement.
V6.5	Draft	28 March 2018	Gordon Flack	Amendment to point 2.1 with regards to inviting Executive Directors to meetings quarterly Amendment to point 2.2 - A quorum shall be three members, including at least two non-executive directors. Amendment to point 6.1 Finance regarding model contracts Amendment to point 6.3 Investments regarding bank mandates Amendment to point 7.3 with regards timing.
V6.6	Draft	June 2019	Gordon Flack	1.2 – addition of consideration of published external reviews which relate to the Trust's services *and* oversight of specific risks on the Board Assurance Framework as assigned by the Board.

Version No.	Draft / Final	Date	Author	Summary of Changes
V6.7	Draft	March 2020	Gordon Flack	Section 2 – Membership. Updated. Four non-executive directors; the Chief Executive is no longer a member; the Director of Strategy and Partnership is a new member.

Review

Version No.	Approved Date	Approved By	Next Review Date
6.1	March 2015	Board	April 2016
6.2	March 2015	Board	April 2016
6.3	April 2016	Finance, Business and Investment Committee	March 2017
6.4	March 2017	Finance, Business and Investment Committee	March 2018
6.4	May 2017	KCHFT Board	May 2018
6.5	March 2018	Finance, Business and Investment Committee	March 2019
6.5	May 2018	KCHFT Board	May 2019
6.6	May 2019	Finance, Business and Investment Committee	May 2020
6.6	July 2019	KCHFT Board	May 2020
6.7	March 2020	Finance, Business and Investment Committee	March 2021

FINANCE, BUSINESS AND INVESTMENT COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

1.1. The Board hereby resolves to establish a Committee of the Board to be known as the Finance, Business and Investment Committee (The Committee), which is to be directly accountable to the Board.

1.2. The overall objectives of the Committee are to:

- Scrutinise current financial performance and future financial plans (Annual Plan and Budget and Long Term Financial Model);
- Monitor performance against Cost Improvement Plans;
- Scrutinise the development and implementation of Service Line reporting and Service Line Management;
- Monitor decisions to bid for business opportunities and approve those up to £15m contract turnover in line with Trust Strategy and reviewing and then referring and recommending larger and novel bids to the Board for approval;
- Review and approve capital investment decisions between £1m to £3m within capital budget and the overall capital programme development, refer with recommendation, larger cases to the Board for approval;
- Review and approve revenue business cases between £1m to £3m annual value and refer with recommendation, larger cases to the Board for approval;
- Approve treasury management policy and scrutinise implementation;
- Promote good financial practice throughout the Trust;
- To consider any published external reviews which relate to the Trust's services within the scope of the committee;
- The Committee will be allocated appropriate Board Assurance Framework (BAF) risks by the Board to lead on assurance related to financial and business risks. The Committee will seek assurance on the actions being taken and the control system in place for the risks in question.

1.3. All procedural matters in respect of conduct of meetings shall follow the Trust's Standing Orders.

2. MEMBERSHIP

2.1. The members of the Committee shall be as follows:

- Four Non-Executive Directors
- Director of Finance/Deputy Chief Executive
- Chief Operating Officer
- Director of Strategy and Partnerships

The Medical Director and Chief Nurse to be invited to attend the committee on a quarterly basis.

2.2. A quorum shall be three members, including at least two non-executive directors.

2.3. The Chair of the Committee shall be one of the non-executive directors and shall be appointed by the Board. The Deputy Chair, one of the non-executive directors and appointed by the Board will deputise in the absence of the Chair.

3. ATTENDANCE AT MEETINGS

3.1. Executive directors and senior service leads will be invited to attend when the Committee is discussing issues relating to their area of responsibility.

3.2. All non-executives in addition to the members will be invited to every meeting of the committee and the full board will receive all papers.

4. FREQUENCY OF MEETINGS

4.1. The Committee will initially meet on a monthly basis and subsequently at least four times a year, when the Committee feels it is appropriate to reduce the frequency of meetings.

4.2. Any Board member may request a meeting if they consider that one is necessary.

5. AUTHORITY

5.1. The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by the Committee.

5.2. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

6. DUTIES

The duties of the Committee can be categorised as follows:

6.1. Finance:

- To scrutinise current financial performance and assess adequacy of proposed recovery plans to bring performance in line with plan (where necessary);
- To scrutinise projected financial performance with particular reference to reviewing sustainability against Board objectives on risk ratings and liquidity;
- To scrutinise annual financial performance and current projections;
- To review budget control framework, including budget setting and guidelines;
- To scrutinise proposed budgets (revenue and capital) and recommend adoption of final budgets by the Trust Board;
- To review strategic assumptions underpinning the Long Term Financial Plan and review the development of this plan;
- To review the contract negotiations framework with main commissioners, and development of contractual models;
- To assess, periodically, impact of different financial assumptions on the future financial position of the Trust, and to assess adequacy of mitigating actions to protect the future financial position of the Trust;
- To assess the adequacy of Treasury and Management Accounting reporting;
- To advise on the development of financial policies including service line reporting and associated costing and development of tariff;

- To review implications of national financial policies, and changes therein, on the Trust;
- To review the Trust Cost Improvement Programme and assess whether the Trust has established robust PMO arrangements to ensure delivery and with regular reporting from the Trust CIP group meeting;
- To review and approve business cases between £1m and £3m within capital budget or annual revenue investment and recommend approval by the Trust Board for larger cases and subsequently review benefits realisation;
- To scrutinise decisions with reference to their impact on equality using resources such as the "Equality Analysis Toolkit";
- To approve the annual Reference Costs return on behalf of the Board;
- To scrutinise and review procurement activity.

6.2. Business

- To assess whether adequate systems are in place to ensure that financial considerations are properly incorporated within capital investment decisions;
- To scrutinise capital investment proposals for financial implications and consistency with strategic service plans;
- To review the Trust's Annual and Strategic Business Plans;
- To receive, scrutinise and approve (£1m to £3m per annum) proposed service developments, including enhancements to existing contracts, to ensure proper financial evaluation including impact on the future risk ratings, making recommendations to the Board where larger than £3m per annum;
- To review the commercial strategy and individual bids and acquisitions, to ensure proper financial evaluation and approve those with a contract turnover up to £15m and in line with Trust Strategy and otherwise make recommendations to the Board;
- To review, periodically, market analysis undertaken on behalf of, or by, the Trust.

6.3. Investments

- To monitor adequate safeguards on investment of funds by approving:
    - List of institutions with whom funds can be placed;
    - Appointment of bankers and brokers;
    - Investment limits for each institution;
    - Investment types.
- To approve cash management and investment policies and test compliance with such policies;
- To approve any draw down of Working Capital Facility or Prudential Borrowing Limits;
- To review investment performance and risk.

7. REPORTING

7.1. The minutes of the Committee meetings shall be formally recorded and submitted to the following private or informal Board meetings.

7.2. The Chair of the Committee shall draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action.

7.3. The Committee will take feedback from other committees verbally from members and consider any issues relevant including risks identified on the Board Assurance Framework.

8. ADMINISTRATION

8.1. The Committee will be supported administratively by the office of the Corporate Services Director, whose duties in this respect will include:

- Agreement of agenda with Chair and attendees and collation of papers;
- Taking the minutes and keeping a record of matters arising and issues to be carried forward;
- Advising the Committee on pertinent areas;

8.2. The agenda for each meeting will be circulated seven days in advance, together with any supporting papers and will be distributed by the Secretariat.

8.3. The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

9. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference and assess performance against these at least once each year to reflect changes in NHS requirements or best governance practice.

The Committee will maintain a forward plan for the year of agenda items and review this regularly.

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

QUALITY COMMITTEE

Document Control

Version	Draft/ Final	Date	Author	Summary of changes
0.1	Draft	13 10 2011	Karen Proctor Director of Nursing and Quality	
0.2	Draft	17 01 2012	Stephen Robinson Director of Corporate Services	Format into KCHT Template. Amend to clarify role as Assurance Committee role.
0.3	Draft	12.7.2012	Karen Proctor Director of Nursing /Quality	Addition of groups reporting to committee and membership
0.4		27.09.2012	Director of Nursing/Quality	Changed membership and committee groups
0.5		27.09.2012	Director of Nursing/Quality	Changed reasonability for accountability to assurance
0.6		29.01.2013	Head of Risk Management	Amended to reflect NHSLA requirements
0.7		14.02.2013	Corporate Secretary	Amended Head of Health and Wellbeing to Health and Wellbeing Director
0.8	Draft	10.12.13	Corporate Secretary	Amended secretarial references Addition of reference to Finance, Business and Investment Committee Updating of HR Director title

Version	Draft/ Final	Date	Author	Summary of changes
0.9	Draft	5.5.14	Director of Nursing/Quality	Amended to reflect changes and assurance
1.0	Draft	16.3.15	Assistant Director of Assurance	Amended to reflect Foundation Trust status
1.1	Draft	07.03.2017	Gina Baines, Assistant Trust Secretary	Amended Trust logo, job titles.
2.0	Draft	06.06.2017	Ali Strowman, Chief Nurse	Full revision
2.1	Draft	March 2018	Ali Strowman, Chief Nurse	Membership section – to add Deputy Chief Nurse. Confidentiality section removed from Section 5. Strategic Workforce Committee added to Section 5 Governance – Key Relationships.
2.2	Draft	February 2019	Dr Mercia Spare, Chief Nurse (Interim)	Transfer of responsibilities for clinical audit from Audit and Risk Committee Terms of Reference to Quality Committee Terms of Reference.
2.2	Draft	06.06.2019	Gina Baines, Assistant Trust Secretary	Objectives – addition of role in considering any published external relevant reviews related to Trust services and oversight of specific risks on the Board Assurance Framework. 5.0 Governance Standard agenda - removal of reference to red flags and EWTT; inclusion of a number of new regular agenda items. Frequency of meetings changed to 'no more than eight meetings a year.'
2.3	Draft	29.04.2020	Gina Baines, Assistant Trust Secretary	4.0 Monitoring and Reporting - Amended to reflect changes to Board and committee governance arrangements 5.0 Governance – standard agenda- changed for accuracy

Version	Draft/ Final	Date	Author	Summary of changes
				5.0 Governance Membership – Amended to reflect changes to Board and committee governance arrangements 7.0 – Frequency – change to quarterly

Review

Version	Approved date	Approved by	Next review due
0.2	26.01.2012	KCHT Board	April 2012
0.5	27.09. 2012	Quality Committee	September 2013
0.9	03.06.2014	Quality Committee	June 2015
1.0	26.03.2015	KCHFT Board	April 2016
1.0	08.03.2016	Quality Committee	March 2017
1.1	07.03.2017	Quality Committee	March 2018
1.1	25.05.2017	KCHFT Board	March 2018
2.0	12.09.2017	Quality Committee	March 2018
2.0	28.09.2017	KCHFT Board	May 2018
2.1	17.04.2018	Quality Committee	March 2019
2.1	24.05.2018	KCHFT Board	May 2019
2.2	19.03.2019	Quality Committee	March 2020
2.2	14.05.2019	Quality Committee	March 2020
2.2	25.07.2019	KCHFT Board	May 2020
2.3	17.03.2020	Quality Committee	March 2021

1.0 ROLE

Purpose:

The Quality Committee is established as a Committee of the Board of Kent Community Health NHS Foundation Trust (the Trust). The aim of the Quality Committee is to provide assurance to the Board of Directors that there is an effective system of risk management and internal control across the clinical activities of the organisation that support the organisation's objectives and the Trust's ability to provide excellent quality care by excellent people.

Objectives:

Specific responsibilities of the Quality Committee include:

Providing assurance that the risks associated with the Trust's provision of excellent care are identified, managed and mitigated appropriately. In doing so, the Quality Committee may consider any quality issue it deems appropriate to ensure that this can be achieved.

Providing assurance to the Board by:

- Ensuring that the strategic priorities for quality assurance are focused on those which best support delivery of the Trust's quality priorities in relation to patient experience, safety of patients and service users and effective outcomes for patients and service users;
- Reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the CQC, NHSLA and the NHS Performance Framework.
- Reviewing quality risks which have been assigned to the Quality Committee and satisfying itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances;
- Reviewing the Annual Quality Report ahead of its submission to the Board for approval.
- Overseeing 'Deep Dive Reviews' of identified risks to quality identified by the Board or the Committee, particularly "Serious Incidents" and how well any recommended actions have been implemented.
- Considering any published external reviews which relate to the Trust's services within the scope of the Committee.
- Having oversight of specific risks on the Board Assurance Framework as assigned by the Board.

The Committee may also initiate such reviews based on its own tracking and analysis of quality trends flagged up through the regular performance reporting to the Board.

Reviewing how lessons are disseminated, learnt and embedded in KCHFT.

<u>Clinical Audit</u>

The Committee shall ensure there is an effective clinical audit function established by management.

This will be achieved by:

- Consideration of the Clinical Audit Strategy and Annual Plan to determine the scope, scale and focus of the plan meets Trust identified risk priorities

- Assessment of the timeliness and effectiveness of management responses to clinical audit reports, drawing any deficiencies to the attention of the Quality Committee

Overseeing the ratification of clinical policies and any other formal clinical document where mandatory compliance is required.

2.0 ASSURANCE

Assurance to:
KCHFT Board.

Groups:
Patient Safety and Clinical Risk Group
Clinical Effectiveness Group
Patient Experience Group

3.0 DECISION MAKING

The Quality Committee is directly accountable to the Board of Directors. At each formal meeting the Chairman of the Quality Committee will report to the Board. Minutes of committee meetings will be reported directly to the Board of Directors.

The Quality Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Quality Committee.

The Quality Committee is further authorised by the Board to obtain external independent professional advice and to secure the attendance of specialists with relevant experience and expertise if it considers this necessary.

4.0 MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
The minutes of each Committee meeting will be reported to the Board of Directors. A summary of the minutes of each meeting will be included in the next Board meeting agenda.

Where a significant risk emerges either through a report or through discussion at a Committee meeting, this will be reported to the Board by the Committee Chair. The outcomes of any 'Deep Dive Reviews' will be reported to the Board and any follow up action kept under review by the Committee.

The Quality Committee has three formal sub-groups- the Clinical Effectiveness Group; the Patient Safety and Clinical Risk Group and the Patient Experience Group and will receive reports from these groups each meeting.

5.0 GOVERNANCE

Chair:
One Non-Executive Director will be appointed as Chair of the committee by the Trust Board.

Secretariat:
The Secretariat function will be provided by the Corporate Services Director.

The agenda will be prepared for the Committee Chair with input from the Committee members and other regular attendees, who may propose items for inclusion in the agenda. Items for inclusion in the agenda will be submitted a minimum of two weeks prior to the meeting. The agenda with associated meeting papers will be distributed to members of the Committee one week prior to the meeting. The date for the next meeting will be arranged and distributed to all members within one month of the meeting. The date for the next meeting will be arranged and distributed to all members with the draft minutes.

A standard agenda as follows will be used by the Quality Committee may include the following items:

- Apologies for absence
- Declarations of interest
- Minutes of last meeting
- Action log
- Presentation from a service on a quality improvement initiative
- Progress against Quality Priorities
- Summary assurance report from Clinical Effectiveness Group
- Summary assurance report from Patient Safety and Clinical Risk Group
- Summary assurance report from Patient Experience Group
- Committee reports for assurance
- Areas of concern highlighted in the Integrated Performance Report
- Published external reviews relating to the Trust's services within the scope of the committee
- Non-executive director led deep dives
- Updates from service visits
- Feedback from other committees including the Board Assurance Framework
- Ratification of policies
- Any other business
- Date of next meeting

Membership:
The Members of the Quality Committee shall comprise four Non-Executive Directors, one of whom will be Committee Chair; , the Chief Nurse, the Medical Director, Chief Operating Officer and Deputy Chief Nurse. In the absence of the Committee Chair, the Vice Chair of the Committee, a nominated Non-Executive Director will chair the meeting.

Executive Directors along with any other appropriate attendee will be invited to attend by the Committee Chair when the Committee is discussing areas of risk or operation that fall under their direct responsibility.

Key Relationships:
Audit and Risk Committee
Finance, Business and Investment Committee
Strategic Workforce Committee
Executive Committee
Management Committee

Quorum:
The quorum shall be four members, of which at least two must be Non-Executive Directors and two must be Executive Directors.

Frequency of Meetings:
The Quality Committee will hold no more than eight meetings each year to ensure it is able to discharge all its responsibilities.

Notice of Meetings:
Meetings of the Quality Committee, other than those regularly scheduled as above, shall be summoned by the Corporate Services Director at the request of the Committee Chair.

Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Corporate Services Director.

Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:
The Assistant Trust Secretary will record the minutes of the Quality Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Quality Committee shall be circulated promptly to all members by the Assistant Trust Secretary. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

6.0 APPROVAL / REVIEW OF TERMS OF REFERENCE

The Quality Committee will review these Terms of Reference on an annual basis as part of a self- assessment of its own effectiveness. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Board of Directors approval.

7.0 MONITORING COMPLIANCE WITH THESE TERMS OF REFERENCE

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Quarterly to public Board
Frequency of attendance	Attendance register of each meeting	Assistant Trust Secretary will report to the Committee Chair	Annually

Kent Community Health
NHS Foundation Trust

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST

REMUNERATION COMMITTEE

TERMS OF REFERENCE

1. ROLE

1.1 The Remuneration Committee is constituted as a standing committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference. Its constitution and terms of reference are set out below and can only be amended with the approval of the Trust Board.

2. PURPOSE

2.1 The Remuneration Committee shall have delegated authority from the Trust Board to set the remuneration, allowance and other terms and conditions of office for the Trust's Executive Directors and Senior managers not employed on national terms and conditions and to recommend and monitor the structure of remuneration.

2.2 In setting the remuneration and conditions of service for the Chief Executive, other Directors and Senior managers, the committee shall take into account all factors which it deems necessary including relevant legal and regulatory requirements, the provisions and recommendations the Foundation Trust Licence and associated guidance from Monitor.

2.3 When required the committee will oversee the appointment of Executive Directors in accordance with Standing Orders.

3. DUTIES

3.1 To agree and keep under review the overall remuneration policy of the Trust.

3.2 To set the individual remuneration, allowances and other terms and conditions of office (including termination arrangements) for the Trust's Executive Directors and other Senior Managers reporting to the Chief Executive.

3.3 To recommend and monitor the structure of remuneration, including setting pay ranges.

3.4 To monitor and evaluate the performance of the Trust's Chief Executive against objectives and previous year and note forward objectives. Act as 'grandparent' to Executive Directors performance. Performance of other senior managers will be monitored and evaluated by their line managers.

3.5 To ratify where appropriate actions taken between meetings by the Chair of the Committee using delegated authority.

3.6 In determining remuneration policy and packages, to have due regard to the policies and recommendations of NHS improvement and the wider NHS, and to adhere to all relevant laws and regulations.

3.7 To keep abreast of executive level remuneration policy and practice and market developments elsewhere in the NHS and in other relevant organisations, drawing on external advice as required.

3.8 To scrutinise and where appropriate authorise those Compromise Agreements, Settlements and Redundancy Payments which require the final approval by HM Treasury as well as any proposed termination payment to the Chief Executive or an Executive Director.

3.9 To receive regular reports on other Compromise Agreements, Settlements and Redundancies approved in accordance with Trust policies.

3.10 To receive an annual report on the outcome of the employer-based (local) Clinical Excellence Awards round.

3.11 In relation to other employees of the Trust, the Committee is responsible for:

- Approving any non-contractual payments that have to be reported to the HM Treasury (via Monitor);

- Approving any business cases for redundancy for any staff reporting directly to the Chief Executive or any other Executive Director, or where the value exceeds £100k, or where the business case requires reporting to HM Treasury;
- The structure, payment criteria and targets for any bonus or incentive scheme proposed by the executive;
- Approving the terms and conditions for any staff outside of nationally agreed pay frameworks;

- Considering and approving any payments in settlement of an employment tribunal claim

3.12 To undertake any other duties as directed by the Trust Board.

4. ROLE OF THE COUNCIL OF GOVERNORS

4.1 The Council of Governors is required to approve the appointment of the Chief Executive.

5. ACCOUNTABILITY

5.1 The Remuneration Committee is accountable to the Kent Community Health Foundation Trust Board.

5.2 **Accountable for:**
The Remuneration and Terms of Service Committee has no sub committees.

Kent Community Health NHS Foundation Trust

TERMS OF REFERENCE

STRATEGIC WORKFORCE COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	29.09.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	
1.1	Draft	03.10.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	Reformatted into Trust template
1.1	Final	22.11.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	Language in purpose revised and inclusion of Ratification of Policies and membership to include Finance added.
1.2	Final	30.01.2019	Louise Norris, Director of Workforce, Organisational Development and Communications	3. Decision Making - Addition for Committee to oversee the approval of workforce policies

Review

Version	Approved date	Approved by	Next review due
1.1	14.11.2017	Strategic Workforce Committee	March 2018
1.1	30.11. 2017	Board	March 2018
1.2	30.01.2019	Strategic Workforce Committee	March 2020
1.2	25.07.2019	Board	May 2020
1.2	18.03.2020	Strategic Workforce Committee	March 2021

1. ROLE

The Strategic Workforce Committee is a committee of the Board with delegated decision-making powers specified in these Terms of Reference.

1.1 Purpose:

- The Strategic Workforce Committee (The Committee) is an assurance Committee. It will provide assurance to the Board on the organisational priority of creating and maintaining Kent Community NHS Foundation Trust as the place where people want to work, delivering high quality care to our patients.

- To keep abreast of the strategic context in which the Trust is operating in, the consequences and implications on the workforce.

1.2 Objectives:

The Committee is delegated by the Board to undertake the following duties and any others appropriate to fulfilling the purpose of the committee (other than duties which are reserved to the Board alone) in order to provide assurance on the following:

- Overseeing the development and implementation of the Trust's people strategy, ensuring that the Trust has robust plans in place to support the on-going development of the workforce;

- Reviewing the Trust's plans to identify and develop leadership capacity and capability within the Trust, including talent management;

- Ensuring that there is an effective workforce plan in place, to ensure that the Trust has sufficient staff, with the necessary skills and competencies to meet the needs of the Trust's patients and services users;

- Ensuring that the Trust continually reviews its workforce models, to reflect new roles and new ways of working to support delivery of the Trust's contractual obligations;

- Receiving and provide assurance that the Trust has an appropriate pay and reward system that is linked to delivery of the Trust's strategic objectives, outcomes and desired behaviours;

- Ensuring that the training and education provided and commissioned by the Trust is fully aligned to the Trust's strategy;

- Ensuring that there are mechanisms in place to support the mental and physical health and well-being of the Trust's staff

- Receiving information on strategic themes relating to employment issues, ensuring they are understood and actioned;

- Ensuring that the Trust is compliant with relevant legislation and regulations relating to workforce matters.

- Ensure that the Trust has appropriate workforce policies in place.

2. ACCOUNTABILITY

Accountable to:
KCHFT Board.

Accountable for:
The Strategic Workforce Committee has an Operational Workforce sub group that reports to it.

3. DECISION MAKING

The Strategic Workforce Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for strategic workforce issues.

The Strategic Workforce Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Strategic Workforce Committee.

The Strategic Workforce Committee is further authorised by the Board to obtain external independent professional advice and to secure the attendance of specialists with relevant experience and expertise if it considers this necessary.

The Strategic Workforce Committee is further authorised to oversee the approval of workforce policies as required.

4. MONITORING AND REPORTING

4.1 Monitoring Arrangements:

To ensure the Strategic Workforce Committee complies with its Terms of Reference, compliance will be monitored through the following methods:

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of Trust workforce strategy	Annual Board report	Board	Annual
Frequency of attendance	Attendance register of each meeting	Committee Secretary will report to the Committee Chair	Annually

4.2 Reporting Arrangements:

The Strategic Workforce Committee will ensure that the minutes of its meetings are submitted to Kent Community Health NHS Foundation Trust Board following each meeting and will report to the Board following each meeting. Any items of specific concern or which require Kent Community Health NHS Foundation Trust Board approval will be the subject of separate ad-hoc reports. The Committee will receive Chair-approved formal minutes from each of its sub committees as soon as they are approved by the subcommittee.

5. GOVERNANCE

5.1 Chair:
One Non Executive Director will be appointed as Chair of the committee by the Trust Board.

5.2 Secretariat:
The meetings will be minuted by the Committee Secretary. All other administrative matters will be coordinated by the PA to the Director of Workforce.

5.3 Membership:
The Committee shall be appointed by the Board to ensure representation by non-executive and executive directors.

Members will include:

Chair	Non Executive Director
Other Members	Non Executive Director Director of Workforce, Organisational Development and Communications Chief Operating Officer Chief Nurse Medical Director Deputy Director of Workforce Deputy Director of Finance

Other officers will attend as required.

In the absence of the Chair, another Non-Executive Committee member will perform this role.

5.4 Key Relationships:
Audit and Risk Committee
The Executive Committees
Quality Committee

5.5 Quorum:
The quorum necessary for the transaction of business shall be three members, one of which must be a Non-Executive Director.

5.6 Frequency of Meetings:
Meetings will be held bi-monthly.
The Chair of the Committee can call extra-ordinary meetings as necessary.

5.7 Notice of Meetings:
Meetings of the Strategic Workforce Committee, other than those regularly scheduled as above, shall be summoned by the secretariat to the Committee at the request of the Committee Chair.

5.8 Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Secretariat.

5.9 Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

5.10 Minutes of Meetings:
The secretariat will record the minutes of the Strategic Workforce Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Workforce Committee shall be circulated promptly to all members by the secretariat.

6. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice. These Terms of Reference will be approved by the Trust Board.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.8
Agenda Item Title:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance / Deputy Chief Executive Executive Directors

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

Report Summary

The Integrated Performance Report is presented with the use of Statistical Process Control (SPC) charts. 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 and is tabled as a financial year end report.

This report contains the following sections:

- Corporate Scorecard and Summary
- Key Performance Indictors(KPI) SPC Charts

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>

'NHSI have confirmed that we will be moved back to segment 1 of NHS Improvement's Single Oversight Framework ("maximum autonomy") should we achieve the RTT 92% standard for 2 consecutive months, which we have done. We are currently waiting for this move to be confirmed

There are 13 KPIs moving favourable in month and 9 moving unfavourably whilst 19 are in normal variation.

It should be noted that while 2 of the 'Prevent Ill Health' indicators related to the Health Visiting mandatory visits are showing as negative variation (KPIs 1.3 and 1.4) this is a temporary impact of the migration to the new patient record system, RIO. The data migration will have differing levels of impact on services based on their KPIs and data structure, with Health Visiting being one of the more complex.

The implementation has provided a number of challenges in terms of data sitting across 2 data systems for the last 2 months of 2019/20. Also, as this was the first cohort of services to go live, some teething issues were experienced in the

migration of data (including appointments) and this was also coupled with the new system being quite different in design and the way staff are capturing their data. As a result the data for these months is not yet complete and the teams are still working through their data quality issues and will continue to do so until all the required updates have been made. However, RIO provides us with significant advantages in terms of data extraction times and frequency, allowing us to identify gaps and rectify far more swiftly.

There are 4 KPIs consistently failing target (target outside of control limits) including the two system targets tracked of A&E wait times at Maidstone and Tunbridge Wells(MTW) and East Kent Hospital University NHS Foundation Trust(EKUFT). The others are:

- KPI 2.20 Friends and Family Test Response Rate for Minor Injury Units(MIU) and Community Hospitals is particularly low this month but as expected with less focus on patient experience data collection.
- KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5% currently performing at 21.3% (0% target)

Of the 9 indicators not measured by SPC charts, all are achieving target.

Report changes for 2020/21

Recommendations have been presented to and agreed by the Executive Team for changes to the report for the 2020/21 reporting period. The changes agreed are as follows:

- KPI 1.4 – remove from IPR as service key metric already covered (KPI 1.3) but still measured within divisional and commissioner reporting.
- KPIs 1.5 & 1.6 – merger metrics into single measurement
- KPI 2.7 – include data/narrative relating to video consultation within Operational Report
- KPI 2.8 - include data/narrative relating to video consultation within Operational Report.
- KPIs 2.9 & 2.10 – Align targets to new national targets
- KPI 2.11 – include Urgent Treatment Centre(UTC) breakdown in Operational Report.
- KPIs 2.12 & 2.14 – ensure specialities not meeting target are discussed in Operational Report
- Remove KPIs 2.20 and 2.21 as not adding value to report but continue to monitor by Director of Quality, Improvement and Patent Experience and Medical Director respectively.
- Remove KPI 3.2 as no longer relevant
- Suspend KPI 3.3 as Commissioning for Quality and Innovation(CQUIN) guaranteed in most contracts. Look to re-instate when relevant.
- KPIs 3.5 & 3.7 – replace these KPIs with metrics related to Medically Fit for Discharge patients within EKHUFT and MTW as more relevant KPIs for KCHFT
- KPI 4.1 – amend target to 92%
- KPI 5.1 – include detail of Covid-19 self isolation in Workforce Report.

- KPI 5.3 – 2% reduction to target
- KPI 5.5 – amend target to 8%
- KPI 5.6 - 2% reduction to target

Work will continue to develop more outcome measures and in particular looking with partners how the overall patient journey between organisations can measure integration of care.

Proposals and /or Recommendations
The Board is asked to note this report and approve the changes to the Integrated Performance Report (IPR) proposed.

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

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

Kent Community Health
NHS Foundation Trust

Integrated Performance Report 2019/20

May 2020 report

2019/20 Year End

we care

Integrated Performance Report

Kent Community Health
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Contents

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Glossary of Terms

SPC – Statistical Process Control

LTC – Long Term Conditions Nursing Service

ICT – Intermediate Care Service

Quality Scorecard – Weighted monthly risk rated quality scorecards

C.Diff – Clostridium Difficile

MRSA – Methicillin Resistant Staphylococcus Aureus

MIU – Minor Injury Unit

RTT – Referral to Treatment

GUM – Genitourinary Medicine

CQUIN – Commissioning for Quality and Innovation

MTW – Maidstone and Tonbridge Wells NHS Trust

WTE – Whole Time Equivalent

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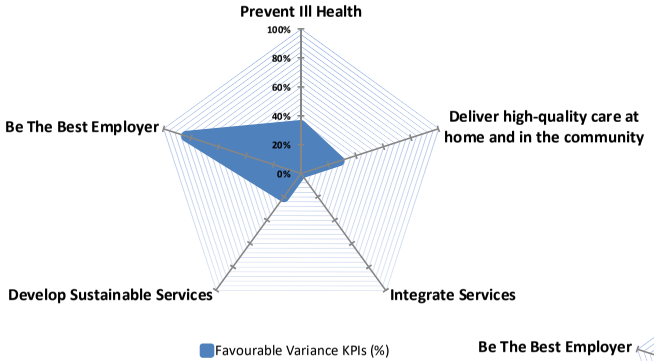
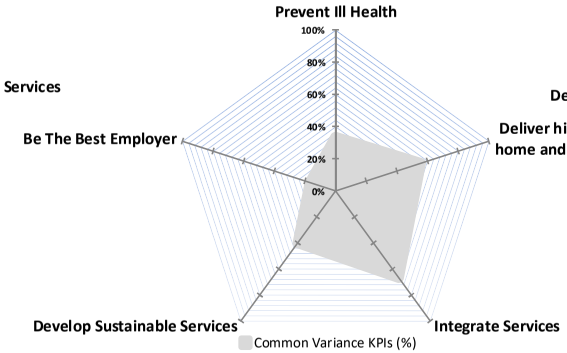
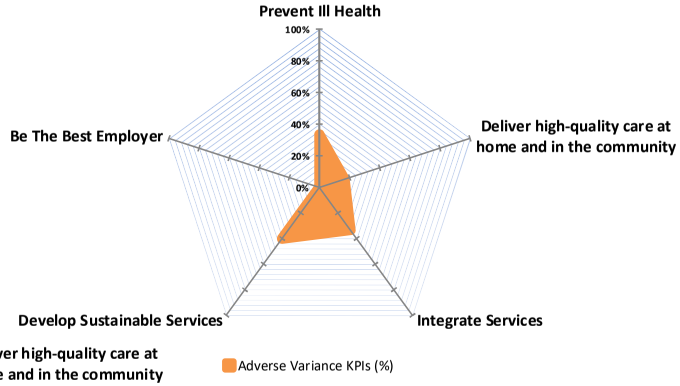
1.0 Assurance on Strategic Goals





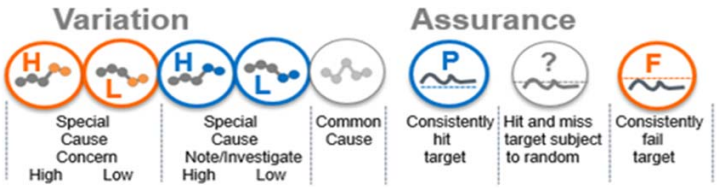


NHSI have confirmed that we will be moved back to segment 1 of NHS Improvement's Single Oversight Framework ("maximum autonomy") should we achieve the RTT 92% standard for 2 consecutive months, which we have done. We are currently waiting for this move to be confirmed

Overall, of the 41 indicators that we are able to plot on a statistical process control (SPC) chart, **31.7% are experiencing favourable in-month variation (13, KPIs 1.1, 1.2, 2.5, 2.12, 2.13, 2.21, 2.23, 4.3, 5.2, 5.3, 5.4, 5.5 and 5.6), 22% are showing in- month adverse variance (9, KPIs 1.3, 1.4, 2.18, 2.19, 2.20, 3.5, 3.7, 4.2 and 4.5)** and the remaining **46.3% (19) are showing normal variation.**

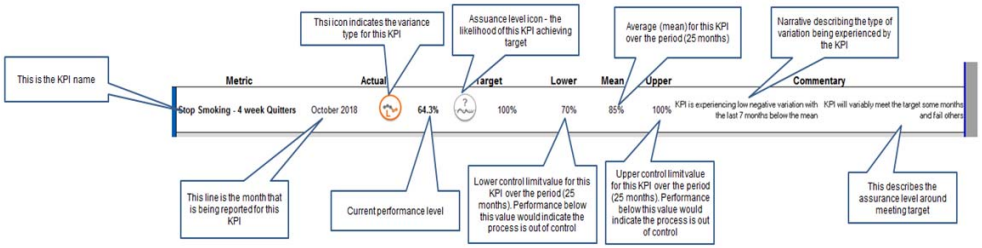
36.6% of the KPIs are consistently achieving target **(KPIs 1.4, 2.9, 2.11, 2.15, 2.18, 2.19, 2.22, 3.2, 4.2, 4.3, 5.2, 5.3, 5.4, 5.5 and 5.6),**
9.8% (KPIs 2,20, 3.5, 3.7, 4.5) are consistently **failing,**
with the remaining **53.7% variably achieving target** with no trend of consistent achievement/failure.

Of the 9 indicators where an SPC chart is not appropriate, **100% (9) 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. Low (L) special cause concern indicates that variation is downwards in a KPI where performance is ideally above a target line e.g. New Birth Visits. High special cause concern (H) is where the variance is upwards for a below target line KPI e.g. DNA Rate

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



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

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	
1. Prevent Ill Health	KPI 1.1 Stop Smoking - 4 week Quitters	March 2020	112.6%		100%	88%	101%	113%	KPI is experiencing a period of positive special cause variation with the last 12 months performing above the mean	KPI will variably meet the target some months and fail others
	KPI 1.2 Health Checks Carried Out	March 2020	97.2%		100%	71%	94%	117%	KPI is experiencing a period of positive special cause variation with the last 12 months performing above the mean	KPI will variably meet the target some months and fail others
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	March 2020	85.2%		90%	88%	91%	95%	KPI is experiencing a period of negative special cause variation with the last 2 months performing below the lower control limit	KPI will mostly achieve target but the control limits indicate that failing the target is a possibilty within the current process
	KPI 1.4 Health Visiting - 6-8 week check undertaken by 8 weeks	March 2020	76.4%		80%	82%	88%	94%	KPI is experiencing a period of negative special cause variation with the last month performing below the lower control limit	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	March 2020	95.0%		90% (year end)				KPI is cumulative through the school year	KPI has met target for the year
	KPI 1.6 (N) School Health - Year 6 Children Screened for Height and Weight	March 2020	94.2%		90% (year end)				KPI is cumulative through the school year	KPI has met target for the year
	KPI 1.7 LTC/ICT - Admissions Avoidance (using agreed criteria)	March 2020	6993		5257	5112	6530	7948		KPI will variably meet the target some months and fail others
	KPI 1.8 % LTC/ICT patients that had at least one visit which Avoided a Hospital Admission	March 2020	17.6%		15.0%	13.4%	17.8%	22.2%		KPI will variably meet the target some months and fail others

	Metric	Actual		Target		19/20 YTD Actual	19/20 YTD Target	Commentary
2. Deliver high-quality care at home and in the community	KPI 2.1 Number of Teams with an Amber or Red Quality Scorecard Rating	March 2020	0		1	8	12	There have been 8 Amber/Red ratings for the financial year to date
	KPI 2.2 (N) Never Events	March 2020	0		0	0	0	No never events experienced this year. Last event in December 2016
	KPI 2.3 (N) Infection Control: C.Diff	March 2020	0		0	0	0	Last case in January 2019
	KPI 2.4 (N) Infection Control: MRSA cases where KCHFT provided care	March 2020	0		0	1	0	There has been one case in November 2019

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	
2. Deliver high-quality care at home and in the community	KPI 2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days	March 2020	0.00		0.19	-0.12	0.05	0.22	KPI is experiencing a period of positive special cause variation with the last 8 months performing below the mean	KPI will variably meet the target some months and fail others
	KPI 2.6 Avoidable Pressure Ulcers - Lapses in Care	March 2020	4		1	-1.4	1.7	4.8		KPI will variably meet the target some months and fail others.
	KPI 2.7 Contractual Activity: YTD as % of YTD Target	March 2020	98.7%		100.0%	97.4%	99.0%	100.5%		KPI will variably meet the target some months and fail others
	KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity	March 2020	3.3%		4.0%	2.9%	3.5%	4.0%		KPI is consistently achieving the target with the target marginally above the upper control limit
	KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)	March 2020	98.5%		95.0%	95.8%	97.5%	99.3%		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	March 2020	97.6%		95.0%	91.4%	96.4%	101.3%		KPI will variably meet the target some months and fail others
	KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	March 2020	99.7%		95.0%	99.3%	99.6%	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	March 2020	97.6%		92.0%	88.0%	92.2%	96.5%	KPI is experiencing high positive variation, with the last 2 months performing above the upper control limit	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)	March 2020	123		532	135	483	831	KPI is experiencing high positive variation, with the last month performing below the lower control limit	KPI will variably meet the target some months and fail others
	KPI 2.14 AHP (Non-Consultant Led) Referral to Treatment Times (RTT)	March 2020	95.4%		92.0%	89.3%	92.6%	96.0%		KPI will variably meet the target some months and fail others
	KPI 2.15 (N) Access to GUM: within 48 hours	March 2020	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)	March 2020	19.9		21.0	15.2	20.7	26.1		KPI will variably meet the target some months and fail others
	KPI 2.17 Research: Participants recruited to national portfolio studies (Year to Date)	March 2020	2202		300				KPI is cumulative for the financial year	KPI is consistently achieving the target of 75 per quarter

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	
2. Deliver high-quality care at home and in the community	KPI 2.18 Percentage of patient goals achieved upon discharge for planned and therapy services	March 2020	L	85.1%	P	80.0%	86.0%	90.0%	94.1%	KPI is experiencing low negative variation, with the last month performing below the lower control limit	KPI is consistently achieving the target as the lower limit is signifcantly above the target. This would mean failure to meet target would likely be due to chance
	KPI 2.19 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT	March 2020	L	92.6%	?	95.0%	94.8%	96.7%	98.6%	KPI is experiencing low negative variation, with the last month performing below the lower control limit	KPI will variably meet the target some months and fail others
	KPI 2.20 Friends and Family Test (Patients surveyed for MIUs & Comm. Hosp) - Response Rate	March 2020	L	10.7%	F	20.0%	11.0%	14.4%	17.7%	KPI is experiencing low negative variation, with the last month performing below the lower control limit	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	March 2020	H	98.0%	?	80.0%	58.3%	83.8%	109.3%	KPI is experiencing high positive variation, with the last 8 months performing above the mean	KPI will variably meet the target some months and fail others
	KPI 2.22 (N) NICE Technical Appraisals reviewed by required time scales following review	March 2020		100.0%	P	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	March 2020	H	98.1%	?	99.0%	85.8%	95.2%	104.5%	KPI is experiencing high positive variation, with the last 12 months performing above the mean	KPI will variably meet the target some months and fail others

	Metric	Actual			Target		Lower	Mean	Upper	Commentary	
3. Integrate Services	KPI 3.1 Delayed Transfers of Care from a Community Hospital bed as a % of Occupied Bed Days	March 2020		13.8%	?	9.5%	6.0%	12.0%	18.0%		KPI will variably meet the target some months and fail others
	KPI 3.2 Percentage of LTC/ICT Referrals coming from within KCHFT	March 2020		19.3%	P	10.0%	14.6%	18.4%	22.2%		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 Q4)	March 2020		95.3%		100%				SPC not appropriate for this metric	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)	February 2020		0.53	?	0.20	-0.19	0.39	0.96		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	February 2020	H	359	F	240	272	327	382	KPI is experiencing high negative variation, with the last 11 months performing above the mean	KPI is consistently failing the target as the lower limit is above the target. This suggests performance is unlikely to decrease to meet target without a process change
	KPI 3.6 Rapid Transfer impact - reduction in average excess bed days (East Kent)	February 2020		0.46	?	0.20	-0.14	0.24	0.62		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	February 2020	H	413	F	240	328	373	418	KPI is experiencing high negative variation, with the last 14 months performing above the mean	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	March 2020		33.0		30				Data building to allow SPC reporting	Met target for 6 consecutive months

Kent Community Health NHS Foundation Trust - Corporate Scorecard

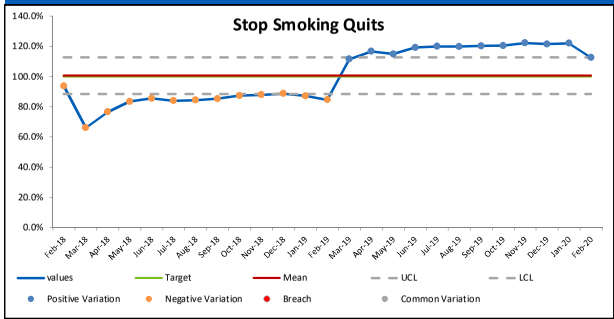
*NOTE: National Targets are denoted by (N) in the KPI name

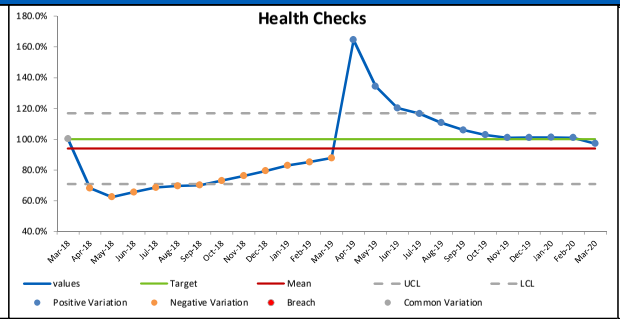
	Metric	Actual			Target		Lower	Mean	Upper	Commentary	
4. Develop sustainable services	KPI 4.1 Bed Occupancy: Occupied Bed Days as a % of available bed days	March 2020		90.8%		87.0%	82.1%	89.0%	95.9%		KPI will variably meet the target some months and fail others
	KPI 4.2 Income & Expenditure - Surplus (%)	March 2020	L	1.0%	P	1.0%	1.02%	1.4%	1.8%	KPI is experiencing low adverse variation, with the last 12 months performing below the mean	KPI is consistently achieving the target as the lower limit is above the target. This suggests performance is unlikely to decrease to below target
	KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	March 2020	H	100.1%	P	100.0%	65.9%	84.7%	103.4%	KPI is experiencing high positive variation, with the last 9 months performing above the mean	KPI has met the target for the year
	KPI 4.4 External Agency spend against Trajectory (£000s)	March 2020		£690,000		£628,000	£191,446	£490,891	£790,337		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%	March 2020	H	21.3%	F	0%	4.4%	14.9%	25.4%	KPI is experiencing high adverse variation, with the last 11 months performing above the mean	KPI is consistently failing the target with the target below the lower limit. This suggest achieving target without a process change will be down to chance.

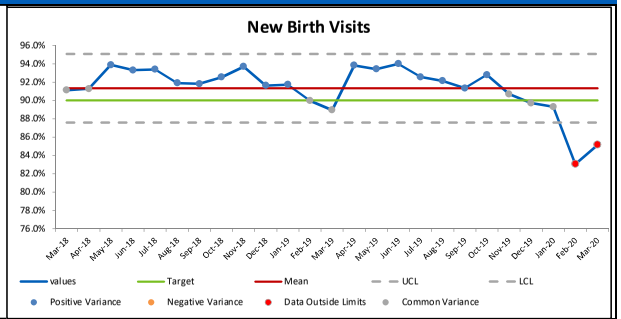
	Metric	Actual			Target		Lower	Mean	Upper	Commentary	
5. Be The Best Employer	KPI 5.1 Sickness Rate	March 2020		4.45%		4.20%	3.64%	4.33%	5.03%		KPI will variably meet the target some months and fail others
	KPI 5.2 Sickness Rate (Stress and Anxiety)	March 2020	L	0.94%	P	1.15%	0.93%	1.20%	1.48%	KPI is experiencing low positive variation with the last 8 months performing below the mean.	KPI has met the target for the year
	KPI 5.3 Turnover (planned and unplanned)	March 2020	L	14.74%	P	16.47%	16.39%	17.41%	18.44%	KPI is experiencing low positive variation with the last 12 months performing below the mean. The last 7 months are also below the lower control limit	KPI has met the target for the year
	KPI 5.4 Mandatory Training: Combined Compliance Rate	March 2020	H	96.5%	P	85.0%	95.1%	95.7%	96.3%	KPI is experiencing high positive variation with the last 8 months performing above the mean	KPI is consistently achieving the target as the lower limit is above the target
	KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce)	March 2020	L	6.1%	P	9.7%	7.0%	8.9%	10.8%	KPI is experiencing low positive variation with the last 9 months performing below the mean	KPI has met the target for the year
	KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	March 2020	H	87.1%	P	85.0%	83.1%	84.2%	85.3%	KPI is experiencing high positive variation with the last 15 months performing above the mean	KPI has met the target for the year

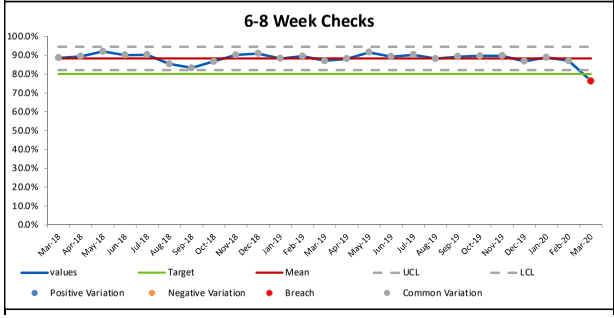
Appendix - Scorecard SPC Charts

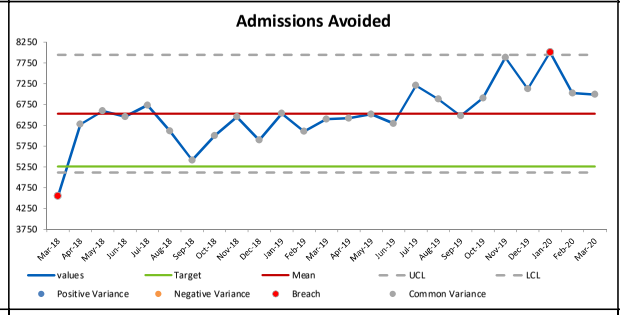
1. Prevent Ill Health

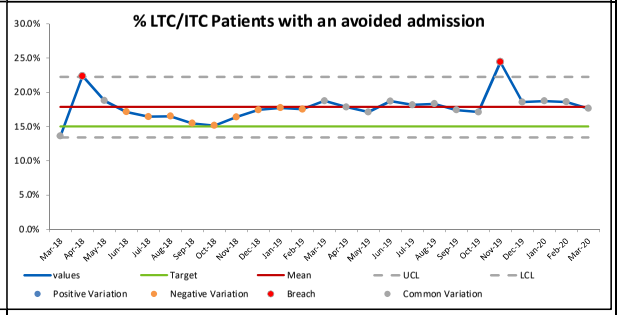






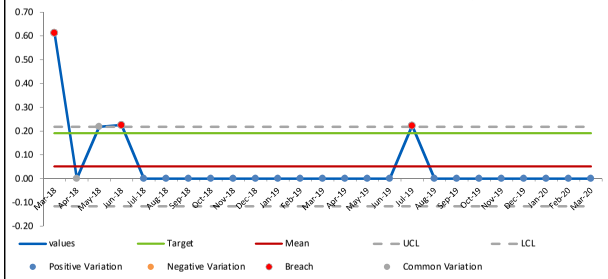




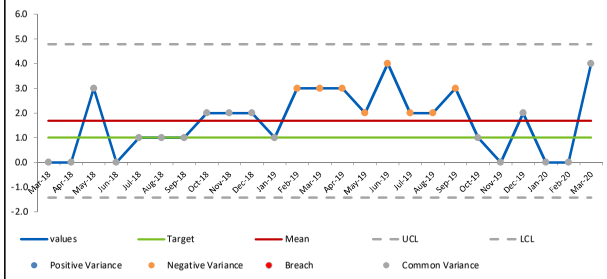


2. Deliver high-quality care at home and in the community

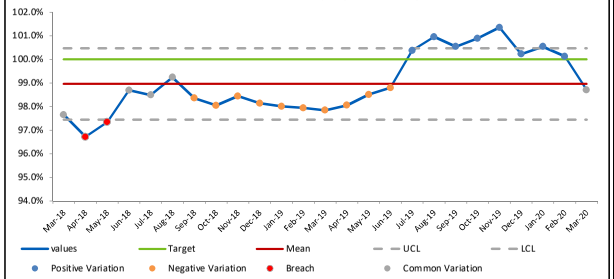
Moderate and Severe falls per 1,000 bed days



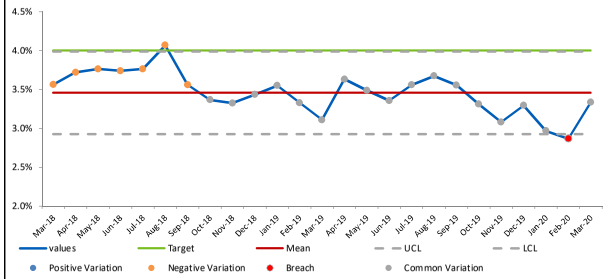
Pressure Ulcers (Lapses in Care)



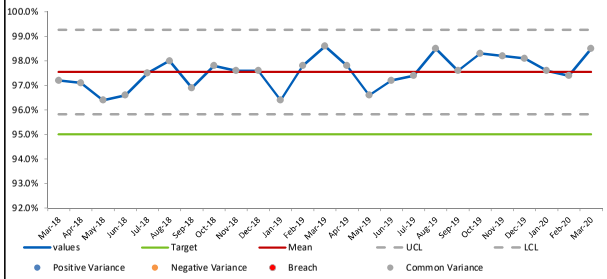
Contractual activity against target



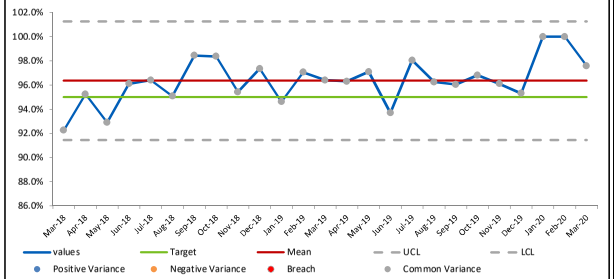
DNA Rate



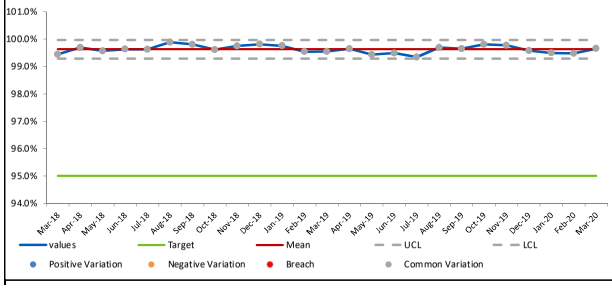
LTC/ICT Response Times Being Met



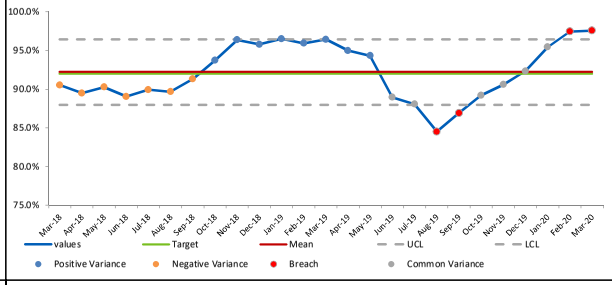
% 2Hr Rapid Responses met



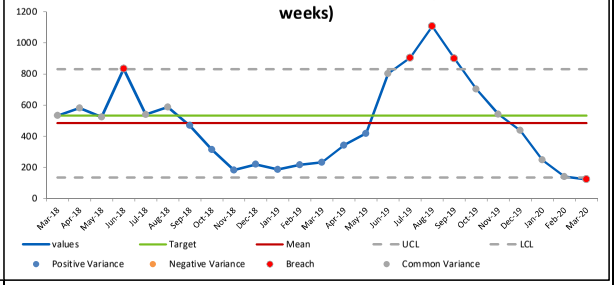
MIU 4Hr Target



Consultant-Led RTT Incomplete Waits

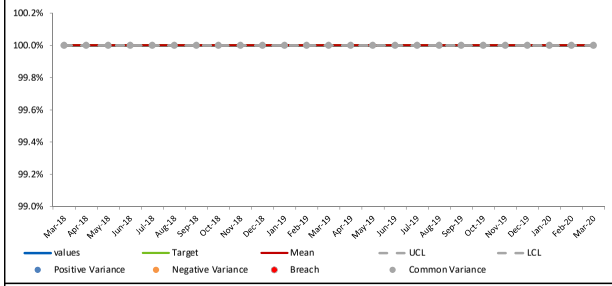


Consultant-Led RTT Incomplete Waits (waiting list size >18 weeks)

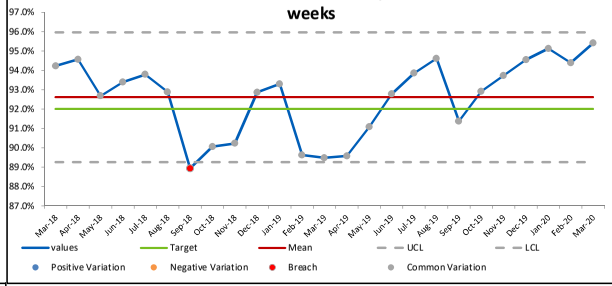


2. Deliver high-quality care at home and in the community

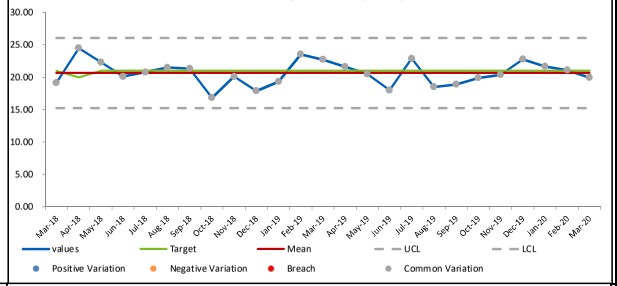
GUM Access within 48Hrs



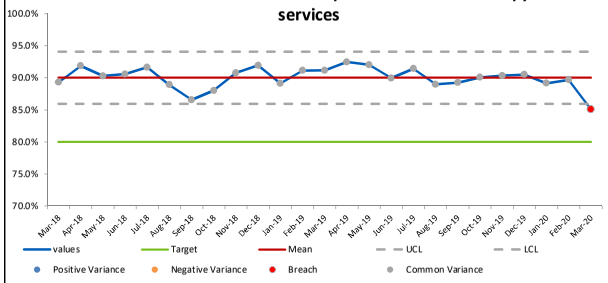
AHP Non Consultant-led 18 Week complete waits within 18 weeks



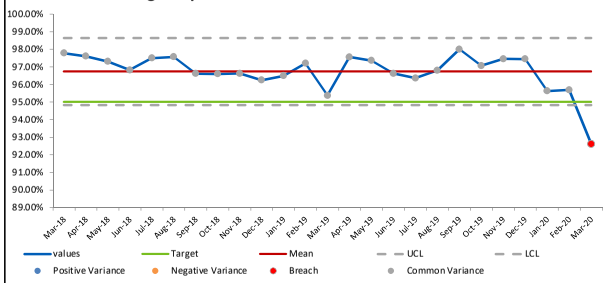
Median length of stay (days)



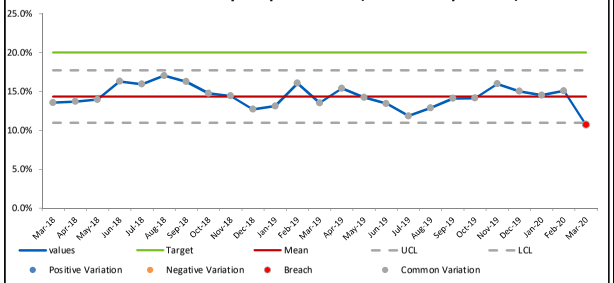
Positive outcomes achieved for planned care and therapy services



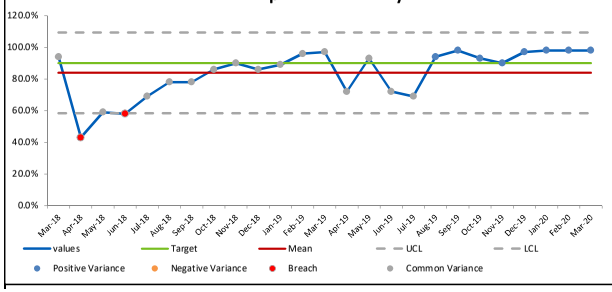
Percentage of patients who would recommend our services



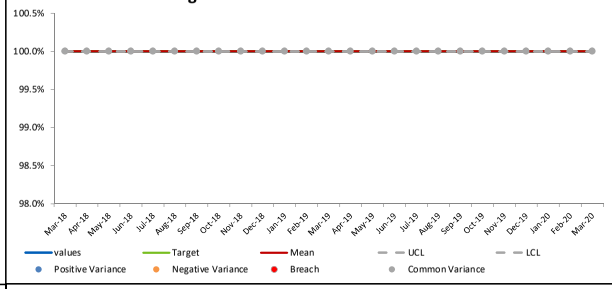
Friends and Family Response Rate (MIU and Inpatients)



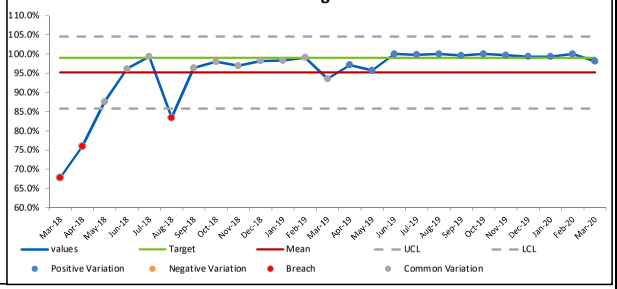
Clinical Audit Implementations by deadline



NICE guidance reviewed within timescales

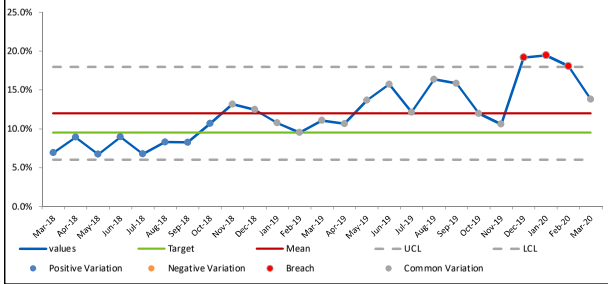


6 week Diagnostics

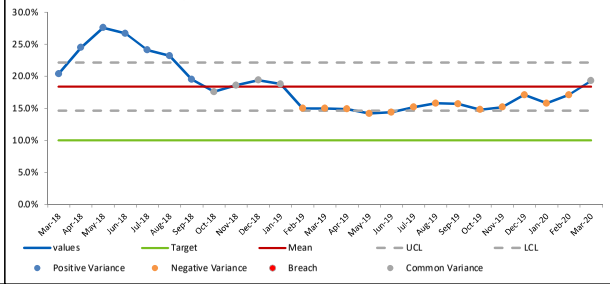


3. Integrate Services

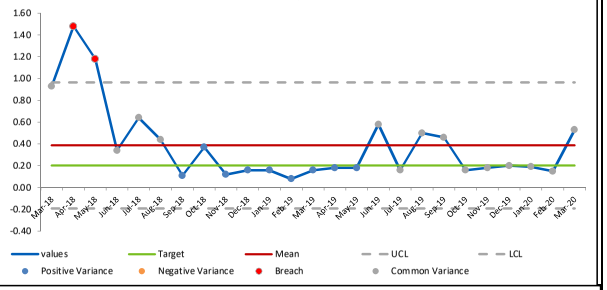
Delayed Transfers of Care



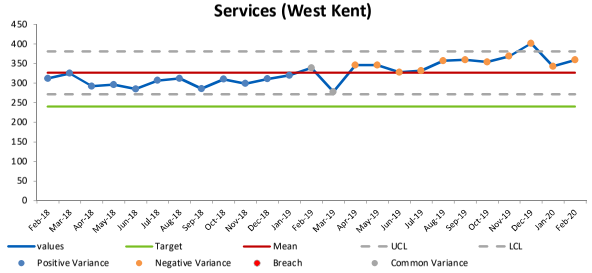
Percentage of ICT/LTC Referrals from within KCHFT



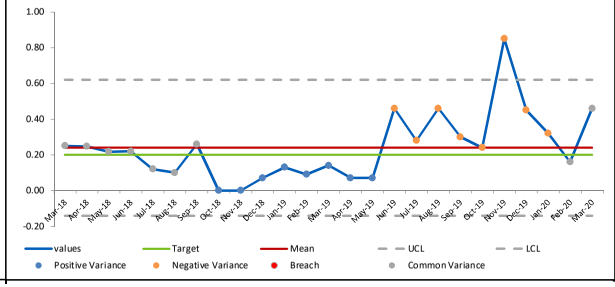
Excess Bed Days - West Kent



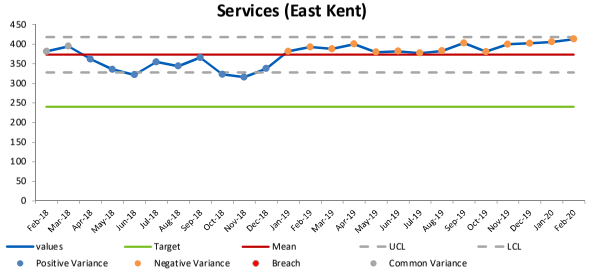
Average wait time (minutes) for Accident and Emergency Services (West Kent)



Excess Bed Days - East Kent

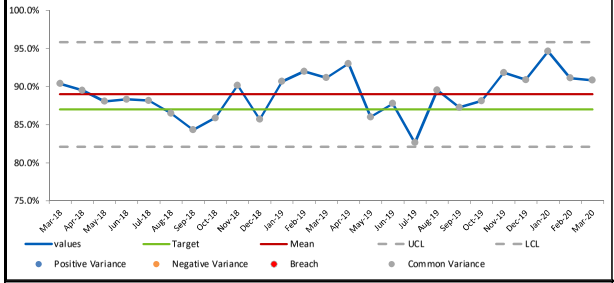


Average wait time (minutes) for Accident and Emergency Services (East Kent)

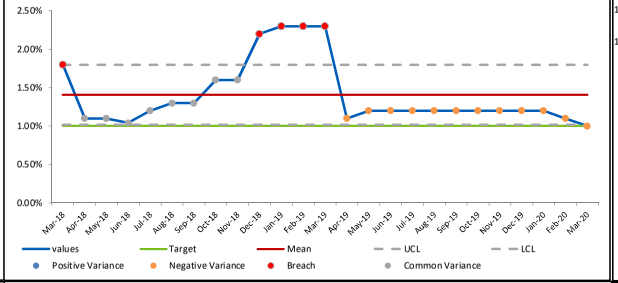


4. Develop sustainable services

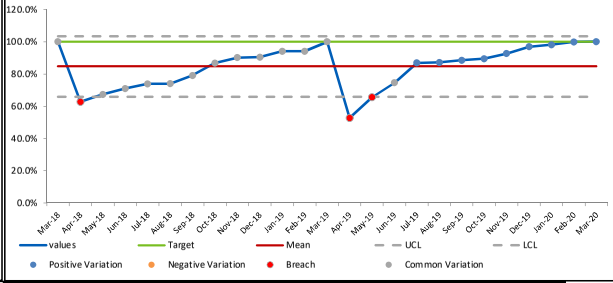
Bed Occupancy



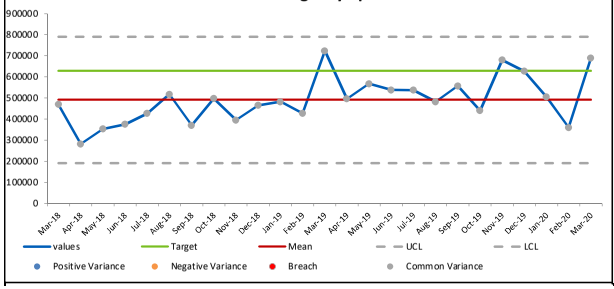
Income and Expenditure Surplus vs plan



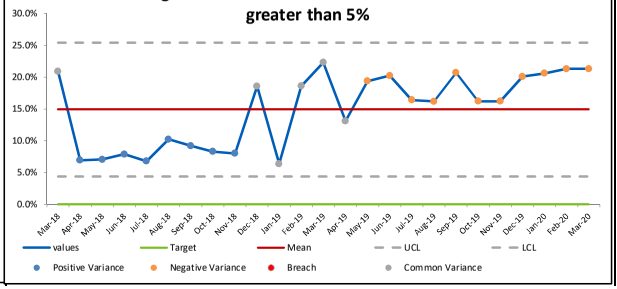
CIP Achieved Against Plan



External Agency Spend

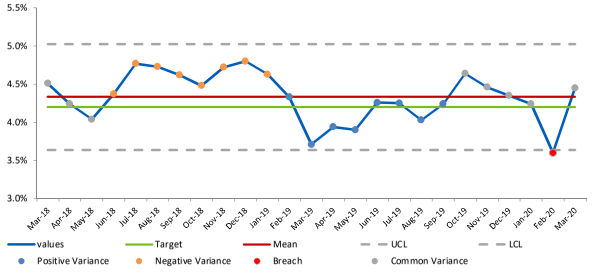


Percentage based on value of Service Lines with deficits greater than 5%

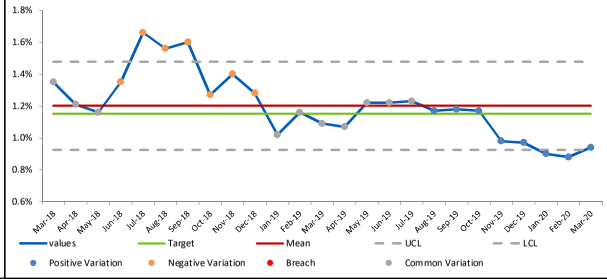


5. Be The Best Employer

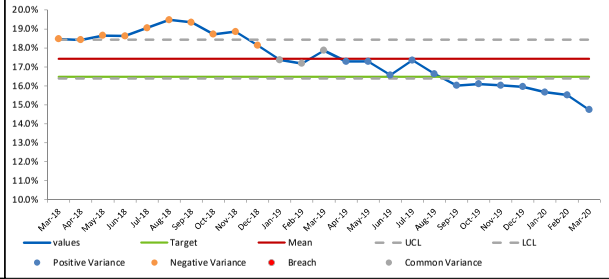
Sickness Absence



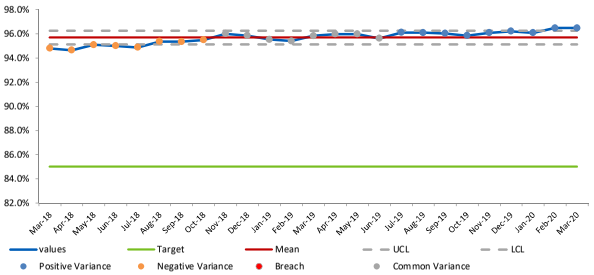
Absence (Stress)



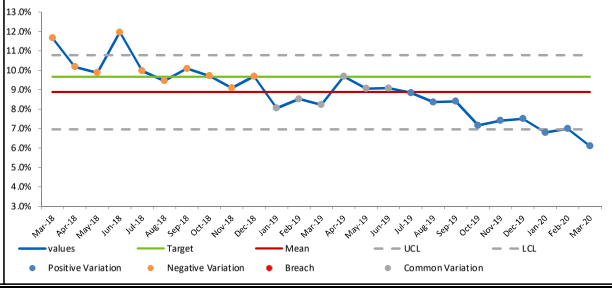
Turnover (Planned and Unplanned)



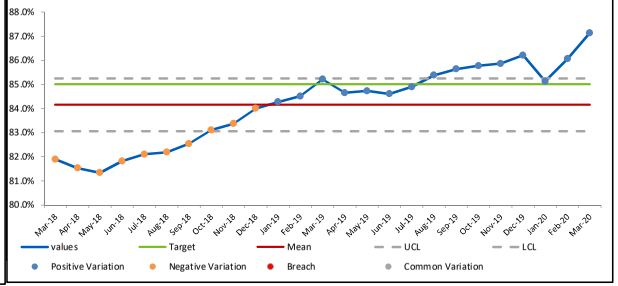
Mandatory Training Rate



Vacancy Rate



Stability



Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.10
Agenda Item Title:	Reset Plan
Presenting Officer:	Pauline Butterworth, Chief Operating Officer Gerard Sammon, Director of Strategy and Partnerships

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

Report Summary
This paper sets out the approach, work completed to date and next steps in the development of a COVID-19 reset plan. It includes a set of principles and ambitions as well as the broad framework for a programme of work.

Proposals and /or Recommendations
The Board is asked to note the reset plan and the next stages it proposes.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
An initial EA with the contents of the current reset plan inserted has been submitted to the engagement team for examination. Further content (which is due to be inserted into the programme of work as part of the proposed next stages) is needed to allow the EA to be completed.

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

Kent Community Health
NHS Foundation Trust

RESET PLAN

1. Introduction

1.1. This paper describes the Trust's approach and next steps in the development of a covid-19 reset plan. It includes a set of principles and ambitions as well as the broad framework for a programme of work.

2. Background

2.1. National guidance has started to emerge modelling the future demand of covid-19 and the approach to reinstating services.

2.2. The national approach set out restoration and recovery phases and the Trust has responded accordingly, most recently to the requirements of what is deemed the second phase of the NHS response (see appendix one and two). However we will be adopting the term reset for the purposes of our own Trust's plan. This reinforces our intention to not merely return to a pre-covid-19 state but to build on the many positive changes we have seen and to learn from our experiences.

3. Assessment

3.1. Our approach and key principles to guide the reset are that we will:

- **Be bold, innovative and ambitious**
- **Sustain the positive changes and transformation already made and quickly establish them as our new normal.**
- **Ensure that the reset is universally adopted across all parts and tiers of the organisation.**
- **Adopt a safe and evidence based approach**
- **Actively lead, partner and collaborate as roles and relationships within the system are retuned.**

3.2. The Trust's values have supported us to deliver a strong response to covid-19 and they will continue to guide us. Our ambition for 'what' will be achieved in our programme of work will therefore be aligned to our values of Caring, Aspirational, Responsive and Excellence and is attached as appendix three.

4. Programme Framework

4.1. The broad content of the reset programme has been considered in three strands: **capacity** for patients and service users**, changes –** both **sustaining newly established models** and **progressing new opportunities,** and **system transformation**. A detailed work programme has begun to populate the framework and is currently in production.

5. Next stages

In addition to the steps outlined above governance is being established that will ensure there are clear links with the business planning cycle and overarching work through the Trust's strategy refresh. A further update will be provided to the Trust Board at its next meeting.

APPENDIX ONE

Skipton House
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From the Chief Executive Sir Simon Stevens
& Chief Operating Officer Amanda Pritchard

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers
GP practices and Primary Care Networks
Providers of community health services
NHS 111 providers

Copy to:
NHS Regional Directors
Chairs of ICSs and STPs
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Local authority chief executives and directors of adult social care
Chairs of Local Resilience Forums

29 April 2020

Dear Colleague,

IMPORTANT - FOR ACTION - SECOND PHASE OF NHS RESPONSE TO COVID19

We are writing to thank you and your teams for everything you have achieved and are doing in securing the remarkable NHS response to the greatest global health emergency in our history.

On 30th January the first phase of the NHS's preparation and response to Covid19 was triggered with the declaration of a Level 4 National Incident. Then in the light of the latest SAGE advice and Government decisions, on 17th March we wrote to initiate what has been the fastest and most far reaching repurposing of NHS services, staffing and capacity in our 72-year history.

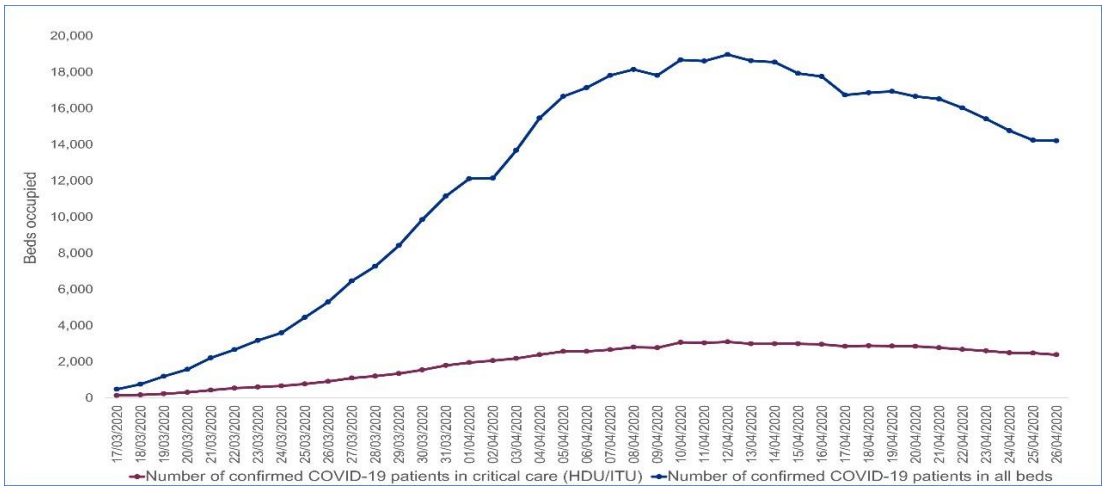
This has enabled us in the space of the past six weeks to go from looking after zero such patients to caring for 19,000 confirmed Covid19-positive inpatients per day, many of whom have needed rapidly expanded critical care support. Alongside this, the majority of patients the Health Service has continued to look after have been receiving care for other important health conditions. Despite real concern going in to the pandemic – following difficult international experience – every coronavirus patient needing hospital care, including ventilation, has been able to receive it.

This has largely been possible as a result of the unparalleled commitment and flexibility of NHS staff, combined with the public's 'social distancing' which remains in

place to cut the spread of the virus. We have also been greatly strengthened by over 10,000 returning health professionals; 27,000 student nurses, doctors and other health professionals starting their NHS careers early; 607,000 NHS volunteers; and the work of our partners in local government, social care, the military, the voluntary sector, hospices, and the private sector.

Sadly coronavirus looks set to be with the us for some time to come, so we will need continuing vigilance. We are, however, now coming through this peak of hospitalisations, as seen by the drop of nearly 5,000 in the daily number of confirmed Covid19-positive patients in hospitals across England over the past fortnight.

Patients with confirmed Covid19 in hospital beds, England



As the Prime Minister set out on Monday, we are therefore now entering the second phase in the NHS's response. We continue to be in a Level 4 National Incident with all the altered operating disciplines that requires. NHS organisations therefore need to fully retain their EPRR incident coordination functions given the uncertainty and ongoing need. The purpose of this letter is to set out the broad operating environment and approach that we will all be working within over the coming weeks.

Based on advice from SAGE, we still expect to be looking after several thousand **Covid19-positive patients**, though hopefully with continuing weekly decreases. This means:

- Ongoing and consistent application of PHE/NHS Infection Prevention and Control guidance in all NHS organisations, with appropriate cohorting of Covid/non-Covid patients (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control).

- In response to the global shortage, DHSC and the Cabinet Office together with BEIS (for UK manufacture) and DIT (for international suppliers) continue to expand the sourcing and procurement of HSE/PHE-recommended PPE for the NHS, social care and other affected sectors of the UK economy, but it is likely that current Covid-specific logistics and distribution arrangements will need to continue for the time being.

- Increased lab capacity now enables testing of all non-elective inpatients at point of admission, the introduction of pre-admission testing of all elective patients, testing prior to discharge to a care home, as well as expanded testing for staff. The corollary is the operational importance of fast turnaround times for test result reporting.

The pressure on many of **our staff** will remain unprecedented, and they will need enhanced and active support from their NHS employers to ensure their wellbeing and safety.

- Increased testing capacity means that we will now be able to extend the offer of regular testing to asymptomatic staff, guided by PHE and clinical advice. This approach is being piloted in a number of acute, community and mental health providers this week, which will inform further roll out from next week.

- As set out in our letter of 17th March, NHS organisations should continue to assess staff who may be at increased risk - including older colleagues, pregnant women, returnees, and those with underlying health conditions - and make adjustments including working remotely or in a lower risk area. Educational material, training and appropriate protection should be inclusive and accessible for our whole workforce, including our non-clinical colleagues such as cleaners and porters.

- Emerging UK and international data suggest that people from Black, Asian and Minority Ethnic (BAME) backgrounds are also being disproportionately affected by Covid19. Public Health England have been asked by DHSC to investigate this. In advance of their report and guidance, on a precautionary basis we recommend employers should risk-assess staff at potentially greater risk and make appropriate arrangements accordingly.

- Now more than ever a safety and learning culture is vital. All our staff should feel able to raise concerns safely. Local Freedom to Speak Up Guardians are able to provide guidance and support with this for any concerned member of staff. As we know, diverse and inclusive teams make better decisions, including in the Covid19 response.

- Employers are also asked to complete the process of employment offers, induction and any necessary top-up training within the next fortnight for all prospective ‘returners’ who have been notified to them.

We are going to see increased demand for Covid19 aftercare and support in **community health services, primary care, and mental health.** Community health services will need to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing health support. High priority actions for mental health providers in this next phase are set out in the Annex. General practice will need to continue to stratify and proactively contact their high-risk patients with ongoing care needs, including those in the ‘shielding’ cohort to ensure they are accessing needed care and are receiving their medications.

Given the scale of the challenges they face, we must also continue to partner with **local authorities** and Local Resilience Forums (LRFs) in providing mutual aid with our colleagues in **social care**, including care homes. This includes:

- Continuing to ensure that all patients safely and appropriately being discharged from hospital to a care home are first tested for Covid19; care homes can also check that these tests have been carried out.

- Under the direction of the LRF, local authority public health departments and CCG infection control nurses can help 'train the trainers' in care homes about PHE's recommended approach to infection prevention and control - particularly focusing on those care homes that lack the infrastructure of the bigger regional and national chains.

- To further support care homes, the NHS will bring forward from October to May 2020 the national roll out of key elements of the primary and community health service-led Enhanced Health in Care Homes service. Further detail will be set out shortly.

- Opportunities to support care homes should also be provided to younger health professional 'returnees' and public volunteers who have offered to help (subject to appropriate personal risk assessment, as described above).

As also seen in a number of other countries, **emergency activity** has sharply reduced in recent weeks. Last week emergency hospital admissions were at 63% of their level in the same week last year. This is likely due to a combination of: a) changed healthcare seeking behaviour by patients, b) reductions in the incidence of some health problems such as major trauma and road traffic accidents, c) clinical judgements about the balance of risk between care in different settings, and d) some NHS care being provided through alternative access routes (eg ambulance 'see and treat', online appointments).

There is therefore considerable uncertainty as to the timing and extent of the likely rebound in emergency demand. To the extent it happens, non-elective patients will potentially reoccupy tens of thousands of hospital beds which have not had to be used for that purpose over the past month or so.

This means we need to retain our demonstrated ability to quickly repurpose and **'surge' capacity** locally and regionally, should it be needed again. It will also be prudent, at least for the time being, to consider retaining extra capacity that has been brought on line - including access to independent hospitals and Nightingale hospitals. The national Nightingale team will work with Regions and host trusts to develop and assure regional proposals for the potential ongoing availability and function of the Nightingale Hospitals. Independent hospitals and diagnostics should be used for the remainder of the current contract which runs to the end of June. Please also start now to build a plan for each STP/ICS for the service type and activity volumes that you think could be needed beyond the end of June, which can inform discussions during May about possible contract extensions with the independent sector.

Over the next six weeks and beyond we have the opportunity to begin to release and redeploy some of the treatment capacity that could have been needed while the number of Covid19 patients was rising so sharply.

This means we are now asking all NHS local systems and organisations working with regional colleagues fully to step up **non-Covid19 urgent services** as soon as possible over the next six weeks, including those set out in the Annex. This needs to be a safe restart with full attention to infection prevention and control as the guiding principle.

In addition, you should now work across local systems and with your regional teams over the next 10 days to make judgements on whether you have further capacity for at least some **routine non-urgent elective care**. Provisional plans will need to factor-in the availability of associated medicines, PPE, blood, consumables, equipment and other needed supplies. We will continue to provide new ventilators to trusts over the coming weeks so as to sustain critical care 'surge' capacity should it again be needed in future, while progressively returning operating theatres and recovery suites to their normal use.

We should also take this opportunity to **'lock in' beneficial changes** that we've collectively brought about in recent weeks. This includes backing local initiative and flexibility; enhanced local system working; strong clinical leadership; flexible and remote working where appropriate; and rapid scaling of new technology-enabled service delivery options such as digital consultations.

In terms of wider action that will also be underway, DHSC will be designing and establishing its new 'Test, Track & Trace' service. The leadership and resourcing of local authority public health departments will be vital. Trusts and primary care networks should continue to support clinicians to enrol patients in the three major phase III clinical trials now underway across the NHS, initially testing ten potential Covid19 treatments. In addition, at least 112 Covid19 vaccines are currently in development globally. We also expect an expanded winter flu vaccination campaign alongside a school immunisation 'catch up programme'.

Looking forward, at the right time and following decision by Government, we will then need to move into the NHS's phase three 'recovery' period for the balance of the 2020/21 financial year, and we will write further at that point.

In the meantime, please accept our personal thanks and support for the extraordinary way in which you and your staff have risen to this unprecedented global health challenge.

With best wishes,

Simon Stevens
NHS Chief Executive

Amanda Pritchard
NHS Chief Operating Officer

ANNEX

ACTIONS RECOMMENDED FOR URGENT CLINICAL SERVICES OVER THE NEXT SIX WEEKS

Urgent and routine surgery and care

- Strengthen 111 capacity and sustain appropriate ambulance services 'hear and treat' and 'see and treat' models. Increase the availability of booked appointments and open up new secondary care dispositions (SDEC, hot specialty clinic, frailty services) that allow patients to bypass the emergency department altogether where clinically appropriate.
- Provide local support to the new national NHS communications campaign encouraging people who should be seeking emergency or urgent care to contact their GP, go online to NHS 111 or call 999 if necessary.
- Provide urgent outpatient and diagnostic appointments (including direct access diagnostics available to GPs) at pre-Covid19 levels.
- Ensure that urgent and time-critical surgery and non-surgical procedures can be provided at pre-Covid19 levels of capacity. The Royal College of Surgeons has produced helpful advice on surgical prioritisation available at: (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0221-specialty-guide-surgical-prioritisation-v1.pdf)
- In the absence of face-to-face visits, primary and secondary care clinicians should stratify and proactively contact their high risk patients to educate on specific symptoms/circumstances needing urgent hospital care, and ensure appropriate ongoing care plans are delivered.
- Solid organ transplant services should continue to operate in conjunction with the clinical guidance developed and published by NHS Blood and Transplant.
- Where additional capacity is available, restart routine electives, prioritising long waiters first. Make full use of all contracted independent sector hospital and diagnostic capacity.
- All NHS acute and community hospitals should ensure all admitted patients are assessed daily for discharge, against each of the Reasons to Reside; and that every patient who does not need to be in a hospital bed is included in a complete and timely Hospital Discharge List, to enable the community Discharge Service to achieve safe and appropriate same day discharge.

Cancer

- Providers have previously been asked to maintain access to essential cancer surgery and other treatment throughout the Covid19 pandemic, in line with guidance from the Academy of Medical Royal Colleges and the NHS (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf and https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf). An exception has been where clinicians consider that for an individual patient the risk of the procedure at the current time outweighs the benefit to the patient.

- Local systems and Cancer Alliances must continue to identify ring-fenced diagnostic and surgical capacity for cancer, and providers must protect and deliver cancer surgery and cancer treatment by ensuring that cancer surgery hubs are fully operational. Full use should be made of the available contracted independent sector hospital and diagnostic capacity locally and regionally. Regional cancer SROs must now provide assurance that these arrangements are in place everywhere.
- Referrals, diagnostics (including direct access diagnostics available to GPs) and treatment must be brought back to pre-pandemic levels at the earliest opportunity to minimise potential harm, and to reduce the scale of the post-pandemic surge in demand. Urgent action should be taken by hospitals to receive new two-week wait referrals and provide two-week wait outpatient and diagnostic appointments at pre-Covid19 levels in Covid19 protected hubs/environments.
- High priority BMT and CAR-T procedures should be able to continue, where critical care capacity is available.

Cardiovascular Disease, Heart Attacks and Stroke

- Hospitals to prioritise capacity for acute cardiac surgery, cardiology services for PCI and PPCI and interventional neuroradiology for mechanical thrombectomy.
- Secondary care to prioritise capacity for urgent arrhythmia services plus management of patients with severe heart failure and severe valve disease.
- Primary care clinicians to continue to identify and refer patients acutely to cardiac and stroke services which continue to operate throughout the Covid19 response.
- Hospitals to prioritise capacity for stroke services for admission to hyperacute and acute stroke units, for stroke thrombolysis and for mechanical thrombectomy.

Maternity

- Providers to make direct and regular contact with all women receiving antenatal and postnatal care, explaining how to access maternity services for scheduled and unscheduled care, emphasising the importance of sharing any concerns so that the maternity team can advise and reassure women of the best and safest place to receive care.
- Ensure obstetric units have appropriate staffing levels including anaesthetic cover.

Primary Care

- Ensure patients have clear information on how to access primary care services and are confident about making appointments (virtual or if appropriate, face-to-face) for current concerns.
- Complete work on implementing digital and video consultations, so that all patients and practices can benefit.
- Given the reduction of face-to-face visits, stratify and proactively contact their high-risk patients with ongoing care needs, to ensure appropriate ongoing care and support plans are delivered through multidisciplinary teams. In

particular, proactively contact all those in the ‘shielding’ cohort of patients who are clinically extremely vulnerable to Covid19, ensure they know how to access care, are receiving their medications, and provide safe home visiting wherever clinically necessary.

- To further support care homes, the NHS will bring forward a package of support to care homes drawing on key components of the Enhanced Care in Care Homes service and delivered as a collaboration between community and general practice teams. This should include a weekly virtual ‘care home round’ of residents needing clinical support.
- Make two-week wait cancer, urgent and routine referrals to secondary care as normal, using ‘advice and guidance’ options where appropriate.
- Deliver as much routine and preventative work as can be provided safely including vaccinations immunisations, and screening.

Community Services

- Sustain the Hospital Discharge Service, working across secondary care and community providers in partnership with social care. Includes daily reviews of all patients in a hospital bed on the Hospital Discharge List; prompt and safe discharges when clinically and in line with infection control requirements with the planning of ongoing care needs arranged in people’s own homes; and making full use of available hospice care.
- Prepare to support the increase in patients who have recovered from Covid and who having been discharged from hospital need ongoing community health support.
- Essential community health services must continue to be provided, with other services phased back in wherever local capacity is available. Prioritise home visits where there is a child safeguarding concern.

Mental Health and Learning Disability/ Autism services

- Establish all-age open access crisis services and helplines and promote them locally working with partners such as local authorities, voluntary and community sector and 111 services.
- For existing patients known to mental health services, continue to ensure they are contacted proactively and supported. This will continue to be particularly important for those who have been recently discharged from inpatient services and those who are shielding.
- Ensure that children and young people continue to have access to mental health services, liaising with your local partners to ensure referral routes are understood, particularly where children and young people are not at school.
- Prepare for a possible longer-term increase in demand as a consequence of the pandemic, including by actively recruiting in line with the NHS Long Term Plan.
- Annual health checks for people with a learning disability should continue to be completed.
- Ensure enhanced psychological support is available for all NHS staff who need it.
- Ensure that you continue to take account of inequalities in access to mental health services, and in particular the needs of BAME communities.

- Care (Education) and Treatment Reviews should continue, using online/digital approaches.

Screening and Immunisations

- Ensure as a first priority that screening services continue to be available for the recognised highest risk groups, as identified in individual screening programmes.
- Increase the delivery of diagnostic pathways (including endoscopy) to catch up with the backlog of those already in an active screening pathway, followed by the rescheduling of any deferred appointments.
- Antenatal and Newborn Screening Services must be maintained because this is a time critical service.
- Providers and commissioners must maintain good vaccine uptake and coverage of immunisations. It is also likely that the Autumn/Winter flu immunisation programme will be substantially expanded this year, subject to DHSC decision shortly.

Reduce the risk of cross-infection and support the safe switch-on of services by scaling up the use of technology-enabled care

- In response to Covid19, general practice has moved from carrying out c.90% of consultations with patients as face-to-face appointments to managing more than 85% of consultations remotely. 95% of practices now having video consultation capability live and the remaining few percent in the process of implementation or procurement of a solution. GP Practices should continue to triage patient contacts and to use online consultation so that patients can be directed to the most appropriate member of the practice team straight away, demand can be prioritised based on clinical need and greater convenience for patients can be maintained.
- Referral streaming of new outpatient referrals is important to ensure they are being managed in the most appropriate setting, and this should be coupled with Advice and Guidance provision, so that patients can avoid an outpatient referral if their primary care service can access specialist advice (usually via phone, video too).
- All NHS secondary care providers now have access to video consultation technology to deliver some clinical care without the need for in-person contact. As far as practicable, video or telephone appointments should be offered by default for all outpatient activity without a procedure, and unless there are clinical or patient choice reasons to change to replace with in-person contact. Trusts should use remote appointments - including video consultations - as a default to triage their elective backlog. They should implement a ‘patient initiated follow up’ approach for suitable appointments - providing patients the means of self-accessing services if required.

APPENDIX TWO

Kent Community Health NHS Foundation Trust

Submission made by the Trust in response for action requested in the letter dated 29th April *(from the NHS Chief Executive Sir Simon Stevens & Chief Operating Officer Amanda Pritchard)*

KCHFT Second Phase Response to COVID-19

When the revised COVID-19 national modelling was shared showing a much reduced peak in demand with a sustained period of activity expected KCHFT began to develop a reset plan. This sets out our approach and the principles underpinning how we will restore services in a way that locks in the positive transformational change we have seen during COVID-19. The Second Phase letter from NHS England on the 29th of April sets out the operating environment and approach that we will be working within over the coming weeks. We have been asked to work with regional colleagues to fully step up non-COVID-19 urgent services as soon as possible with full attention to cohorting and infection prevention & control. In addition over the next 10 days we have been asked to make judgements on whether there is further capacity for routine non-urgent elective care to resume. A number of recommended actions were identified to begin the Second Phase. Those relevant to us as an organisation are outlined below along with our approach to each.

- **Ensure appropriate cohorting in Inpatient and Outpatient Areas**

  This is fully embedded in all community hospitals. MIUs have implemented zoning for patients who fit the case definition and those who do not. As outpatient activity is restored we will adopt a virtual by default approach to ensure departments can be zoned to manage the patients who require face to face appointments.

- **Testing for patients being admitted to bed based services and on discharge to a care home**

  This is in place, monitored and will be/is reported on our sitrep.

- **Regular access to testing for staff even if they are asymptomatic**

  We have a robust COVID19 testing process for staff in place. All staff or members of their household who are asymptomatic are invited for a test 3 days after their symptoms develop, in line with the national guidance. This includes weekends. Once the results are received the member of staff in telephoned. An email is sent to their line managers to confirm if the member of staff is able to

return to work or the period that they are required to remain off. This will be an ongoing process.

- **Supporting vulnerable staff to take appropriate precautions**

  We have robust risk assessment arrangements in place and support our vulnerable staff to work from home where required.

- **Risk assess our BAME employees**

  We are conscious of the new and emerging evidence that BAME colleagues may be disproportionately affect by COVID 19. To this end we are risk assessing all of our BAME colleagues. In addition we are holding bi weekly calls with our BAME network to ensure that colleagues feel supported and are able to raise any concerns that they may have

- **Ensure we have a learning culture and support speaking up**

  The Freedom to Speak Up Guardian helps to raise the profile of raising concerns in the trust and provides confidential advice and support to staff, agency workers employed by KCHFT or volunteers about concerns they have and/or the way their concern has been handled.
  We have also introduced a Q&A section on the Trust intranet to enable staff to ask any question of the Executive. This has been well used to date.

- **Enhance psychological support for staff**

  The Trust has provided extended out of hours counselling and wellbeing apps have been made available to all staff alongside our usual wellbeing support.
  Our focus is now being given to the recovery phase of the pandemic as the evidence suggests that health care professionals often supress trauma for a period before they access support. The Trust has a work stream looking at 'what the new normal will be for KCHFT' and underpinning that will need to be staff support into the recovery phase. There will be a national offer to support this including resources on trauma and decompression but we are sharing our 'Recovery' template on lessons learnt with the STP and together we will consider any common themes to work on collectively.

- **Complete recruitment for our returners over the next 2 weeks**

  This work is underway and will be complete

- **Restore routine non urgent elective activity**

A number of staff who usually work in these services have been redeployed to support Tier 1 delivery. A measured approach will need to be taken to support this over the coming weeks moving staff in a way that does not destabilise Tier 1 delivery.

- **Lock in the benefits of the transformation of services where possible**

  A reset group has been established. This will work to ensure that transformation will be retained and built on as we restore our services to normal activity levels in both planned and urgent care. As a Trust we understand that a large piece of system work around transformation will be taking place and we are keen to help drive this forward at pace.

- **Plan for immunisation catch up to ensure good uptake and coverage**

  Detailed plans are being finalised to share with NHSE/PHE commissioners to catch up on the missed school-based immunisations. In addition we have developed plans to maximise uptake of the flu vaccination programme moving towards autumn/winter 2020.

- **Maintain the approach to discharge to ensure patient flow is maximised**

  KCHFT has led the hospital discharge process ensuring patients who are medically fit are discharged promptly. We will continue to work with the system to undertake this work recognising that as non covid services are restored and redeployed staff need to return to their original service there may need to be rebasing of the workforce to support this as a new normal approach.

- **Plan for an increase in patients requiring ongoing community care following hospital discharge**

  We are modelling weekly with our Business Intelligence colleagues to gain a better understanding of the emerging demands across the system. Using this information we will be working with system colleagues to create the appropriate capacity to support patients.

- **Prioritise home visiting where safeguarding is a concern**

  In place and will be stepped up moving forward. KCHFT's Children and Young Peoples services are working proactively as part of the system with children's social care, education and early help providers.

- **Complete antenatal and newborn screening services**
  This has continued throughout.

- **Video and telephone consultation to be offered by default unless there is a clinical reason for people to be seen face to face**

  Significant change has been delivered across a number of our services to accommodate social distancing guidelines. We will adopt a virtual by default approach as we begin restoration.

The Trust will proactively collaborate as roles and relationships with system partners are reset as the 'new world' emerges. A key focus for us will be working locally to maximise the opportunity for system transformation and improved patient outcomes. Our new approach to virtual consultations may well drive efficiency and provide an enhanced ability to work with hard to reach communities. Care home support has been challenging during this time. The clinical model now outlined in the letter received this weekend challenges us to deliver real local change over the next 2 weeks. Our Frailty Teams and Community Nursing Teams have offered considerable support to this sector and we would like to build on this working with PCNs and the CCG.

APPENDIX THREE

Our values have guided our ambition for the reset plan;

Caring

- Relationship with patients and service users will be redefined as partners through the creation of 'experts by experience', 'peer support workers' and accelerating our recruitment to the Trust 'Peoples Network'. This will accelerate our practice of co-design, co-production, community engagement and involvement of carers.
- Prevention will be categorised as a tier one service, capitalising on the changed public response to the NHS and need to stay healthy. Key system stakeholders will be lobbied to promote a unified and up scaled Kent and Medway campaign.
- Provision of proactive staff health and wellbeing packages of support during and after the pandemic to reduce the risk of fatigue and moral injury.
- Digital communication initiatives will both continue and be expanded.
- Recruitment activity and use of, and engagement with, volunteers will be widened. Inclusion will be promoted, digital and home working opportunities optimised.
- Our system leadership will set the pace advancing work with partners and building opportunities to unite around.

Aspirational

- Digital and agile working by default will be adopted - 80% of first contacts with patient and service users will be digitally enabled and 20% of our workforce's base will be at home.
- Service provision that is deemed to have added value will be retained and that which doesn't dissolved.
- Successful innovations will continue, for instance, the use of 'wobble' rooms.
- Closure of some estate will remain with a 20% reduction in the overall footprint.

Responsive

- Adoption of a proactive approach towards patients who are now fearful of accessing health care services, due to covid-19, as well as those who are at risk of requiring healthcare who have been 'silent' during the pandemic. This may include frail elderly, or those with long term health conditions.
- Prime concern for our provision of services will be hard to reach groups and populations with existing health and broader inequalities. Lessons from the national review of evidence concerning the impact on people black, Asian and *minority ethnic (BAME) backgrounds will be rapidly implemented.*
- Clinical facing time for all professionally registered clinical leaders will be a feature of our new normal.
- Continue to act as the system leader for managing and coordinating patient care following an acute episode.
- Digitally delivered workforce induction and education deemed to be appropriate will be maintained and evolve.

Excellent

- Work more as one and across geographical and internal organisational boundaries to standardise care and improve our interoperability. There will be a resulting reduction in variation in our offering for patient and service users.
- Delayering of structures and our existing self-directed teams programme will be accelerated.

- *Outstanding care will be redefined including provision of more time for human contact with patients and service users.*
- Change will always use Quality Improvement.

In addition there is a need to review our **governance** with the following ambitions:

- Decisions are, and will be, made quickly, with a lighter and accelerated governance system.
- Red tape will remain cut and governance deemed non-essential will remain removed.
- The best of the Incident Control Centre's inter organisational and multi-disciplinary governance will be incorporated into our way of working.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.10
Agenda Item Title:	Strategic Priorities 2020/21
Presenting Officer:	Gerard Sammon, Director of Strategy and Partnerships

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

Report Summary
The annual refresh of the Trust's priorities has been undertaken and this paper summarises the process used to develop them and proposes what they should be for 2020/21.

Proposals and /or Recommendations
The Board is asked to approve the strategic priorities for 2020/21.

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

Gerard Sammon, Director of Strategy and Partnerships	Tel: 01622211938
	Email: Gerard.sammon@nhs.net

Kent Community Health
NHS Foundation Trust

STRATEGIC PRIORITIES 2020/21

1. Introduction and background

1.1. The Trust's strategic priorities are updated annually at the end of the planning cycle, based on business plans, to reflect services' aims for the year ahead. This process also provides an opportunity to ensure alignment between our organisational strategy and local objectives.

1.2. For the year 2020/21 this exercise was completed pre Covid19, and in advance of the outcome of the Trust's strategy refresh, and was approved by the management committee to inform the 2020/21 annual plan.

2. Assessment

2.1. The service objectives for the year 2020/21 continued to broadly group into what were the Trust's existing four strategic priorities and therefore no change was made. To take into account our response to Covid19 a new priority has been added.

2.2. The priorities to inform the 2020/21 annual plan are set out below:

- **Improve quality** – innovate, improve and learn – so everyone gets the best health and wellbeing outcomes.
- **Support our people** – engage, develop and value our people so they deliver high-quality care throughout long, rewarding careers.
- **Join-up care** – progress partnerships so people feel supported by one multi-skilled team.
- **Develop our digital ways of working** – invest in technology and training to give more time to care, better access to services and the power of information to all.
- **Respond to Covid19** – continue our strong response by developing our approach and plan for a reset that meets the changing demand across our services, builds on positive changes and transforms system working.

3. Recommendation

3.1. The Trust Board is asked to approve the strategic priorities for 2020/21.

Rachel Jennings
Deputy Director of Strategy

Gerard Sammon
Director of Strategy and Partnerships

May 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	2.10
Agenda Item Title:	Quality Priorities 2020/21
Presenting Officer:	Dr Mercia Spare, Chief Nurse

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

Report Summary
Every Quality Account must contain the trust's priorities for improvement to be achieved in the following year. This paper presents Kent Community Health NHS Foundation Trust's (KCHFT) 2020/21 Quality Priorities.

Proposals and /or Recommendations
The Board is asked to note the Quality Priorities for 2020/21.

Relevant Legislation and Source Documents
NHS Improvement – Detailed requirements for quality reports (2019/20)
Has an Equality Analysis (EA) been completed?
No ☒ High level position described.

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Kent Community Health NHS Foundation Trust

QUALITY PRIORITIES 2020/21

1. Executive Summary

Every Quality Account must contain the Trust's priorities to be achieved in the following year. The Detailed requirement for quality reports 2019/20 states that the indicators be selected by the board in consultation with stakeholders and must include:

- at least three indicators for patient safety
- at least three indicators for clinical effectiveness and
- at least three indicators for patient experience

Kent Community Health NHS Foundation Trust (KCHFT) has added a fourth dimension to ensure that this extends to staff experience.

This report describes the consultation and engagement process undertaken and the rationale for selecting the quality priorities for the 2020/21 Quality Account.

2. Quality Priorities 2020/21 Consultation

The 2020/21 quality priorities for KCHFT have been identified and selected through a robust consultation and engagement process (see table 2.1)

The 12 indicators selected are not the sum total of the quality portfolio for 2020/21; these have been selected based on the consultation with our stakeholders. The quality strategy for 2020-2025 is being developed and will detail the organisation's quality objectives and action plan to deliver high quality care and continuous improvement.

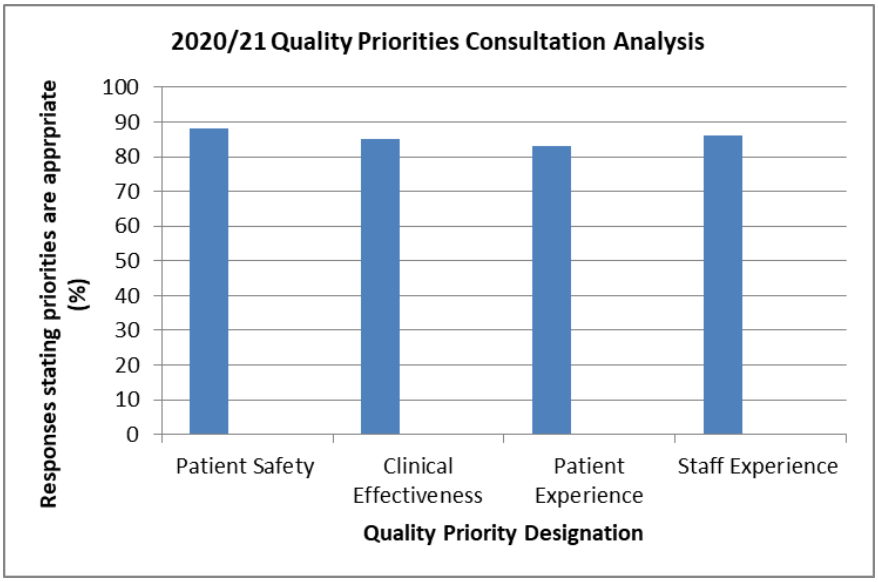
Table 2.1 development and consultation process for 2020/21 quality priorities

Timeline	
January 2020	Long list of potential quality priorities was constructed based on current risks, national priorities, strategies and reviews, operational business plans and the NHS Long Term Plan.
February 2020 – March 2020	The long list of potential quality priorities was presented to the board and amendments based on comments were made. The long list was agreed for consultation (Appendix 1) The revised long list of potential priorities was sent for consultation through the development of a consultation paper and electronic survey to KCHFT staff and stakeholders.
March 2020	The consultation closed on 13 March 2020.

2.2 The 2020/21 quality priorities long list was consulted on via a survey produced by the KCHFT Communications team and shared via Flo and Flomail, Team Brief, the public facing webpage, CCG, 1183 foundation trust members and a marketing list of 1000 stakeholders that included commissioners and GP. 147 responses were received.

2.3 The consultation survey analysis identified respondents agreed that the long list of quality priorities for 2020/21 we appropriate (table 2.3) and very strong comments received included "BRILLIANT to see learning disabilities being so highlighted", "transition from children's to adult services is very important" and "great principle to use QI: gives time for changes to show." The nature of other comments was mixed.

Table 2.3 2020/21 Quality Priority Consultation Analysis



3. KCHFT Final Quality Priorities 2020/21

3.1 The consultation survey provided data which supported the development of the final 12 quality priorities for the 2020/21 Quality Account. These data, in conjunction with feedback from the Senior Leaders conference that took place on 11 February 2020 and work already in train, led to the identification of the following themes:

3.2 Learning Disabilities

These quality priorities were selected based on the strong feedback received in the consultation survey and the identification of further work required for the learning disability improvement standards.

In 2018, NHS Improvement commissioned the NHS Benchmarking Network to undertake an annual benchmarking exercise to measure the quality of care provided to people with a learning disability, autism or both. NHSI require the universal standards to be applied to all NHS funded care by 2023. Each of the learning disability quality priorities for 2020/21 aligns to the gaps identified against specific standards in the 2019 learning disabilities standards review. The implementation of these quality priorities will

expedite the progress of the work already in train to meet the standards by 2023 by placing the patient and carer experience as a primary objective as well as recognising the importance of how the trust listens, learns and responds in order to improve care for people with a learning disability.

3.3 Improving Outcomes

These indicators were selected based on 100% positive feedback for those quality priorities contained within the long list that related to improving outcomes for our patients. Similarly, feedback from the Leaders Conference in February 2020 highlighted the importance of improved outcomes in the quality, system leadership and self-directed teams working groups. The opening of a research study in collaboration with an NHS acute trust aligns to system changes within Kent and Medway and will support the progression of partnerships across the local health economy. The indicators also support the trust's strategic goals of preventing ill health and delivering high quality care at home and in the community.

It is more important than ever that NHS workplaces become environments that support staff wellbeing and morale; indeed there is evidence that good staff health, wellbeing and engagement can lead to improvements in patient experience. Achievement of the proposed quality priority for staff experience in this sector would identify KCHFT as 4.7% above average and 1.2% from best based on 2019 community trust comparator data.

3.4 Psychological Safety

The National Patient Safety Strategy (NHS Improvement, 2019) illustrates that when people feel psychologically safe, they will hear, learn and act more to improve care. A culture of psychological safety allows for kindness, compassion and fairness, but it has also been seen that where teams feel psychologically safe, they are highly motivated and empowered to lead improvement.

The psychological safety indicators measured by the NHS Staff Survey relate to the equality, diversity and inclusion and safety culture themes. Achievement of the proposed quality priority for feeling secure reporting unsafe clinical practice would identify KCHFT 2.5% above average and 1.5% from best. Achievement of the proposed quality priority regarding discrimination from colleagues would identify KCHFT as 1.9% above average and in line with best based on 2019 community trust comparator data.

3.5 Draft 2020/21 Quality Priorities

For each of the themes a quality priority was assigned for patient safety, clinical effectiveness, patient experience and staff experience. (Table 3.5)

Quality Priorities	**Improving the safety of the people we care for:** Build on the foundations of a patient safety culture and a patient safety system to respond to patient needs and priorities	**Improving clinical effectiveness:** Improve patient outcomes Use QI, research and innovation to improve our care and services	**Improve the experience of the people we care for:** Improve the feedback, design and delivery of our services increasing accessibility and the voice of the patient	**Improving the experience of our people:** Engage, develop and value our people to deliver high quality care and maintain personal wellbeing
Learning Disabilities	Implement the *Ready, Steady, Go* framework for children and young people transitioning to adult learning disability services	Improve outcomes using research and innovation enabling prevention of ill health through increased recognition of infection related deaths in patients with a learning disability	Fully implement the requirements of "Ask, Listen, Do" and good practice resources to improve feedback, concerns or complaints for children, young people and adults with a learning disability	Identify LD Champions in general services to increase the knowledge and expertise of working with people with a learning disability
Improving Outcomes	90% of patients in community core services with a NEWS2/PEWS score of 2 or more which is elevated from their baseline, will be reviewed by a registered healthcare professional to detect patients at risk of clinical deterioration or death	Open one research study in collaboration with an acute NHS Trust to enable the delivery of research that follows the patient pathway and is not restricted by organisational boundaries	The Patient/Carers Council to support, over the next 2 years, 100% of services to have an identified patient/carer voice in the delivery of care. In the first year, 50% of services will have an identified patient/carer voice in the delivery of care	A 2% reduction in staff reporting "During the last 12 months have you felt unwell as a result of work related stress"
Psychological Safety	A 3% positive response increase to staff survey question 18b "I would feel secure raising concerns about unsafe clinical practice"	Continue to empower employees to actively engage in quality improvement, 50% of QSIR Practitioners are actively involved in or sponsoring QI project(s) 6 month after achieving practitioner status	A total of 5 Schwartz rounds to have taken place with evaluation shared with Quality Committee. There will be a well-established and functioning steering group	Create and maintain a culture where people feel included in the workplace by 1.3% decrease in the number of staff reporting discrimination from colleagues in the annual staff survey

4. Governance and Reporting

4.1 The 2020/21 quality priorities will be developed into quality improvement programmes by identifying SMART outcomes and a baseline from which to measure improvement. The quality priorities for patient safety, clinical effectiveness and patient experience will be monitored quarterly at their respective governance groups and at Quality Committee. The quality priority for staff experience will be reported on at the Strategic Workforce Committee and Quality Committee.

4.2 The 2020/21 quality priorities will be published in the 2019/20 Quality Account and will include the priorities, their rationale for inclusion and how they will be measured and reported.

5. Recommendations

The Board is asked to approve the quality priorities for the 2020/21 Quality Account.

Dr Mercia Spare
Chief Nurse
April 2020

Appendix 1

Quality Priorities 2020/21 long list and the rationale for inclusion

1. Patient safety (We are safe)

Suggested priorities	Rationale for inclusion
Patient Safety Strategy – Safety Systems Reduce Pressure Damage The implementation and completion of the 2020 pressure ulcer improvement plan to reduce lapses in care and pressure damage. **Metric** X% increase in Purpose T assessments within 24 hours of admission.	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients (July 2019) – Safety issues that particularly affect older people.
Patient Safety Strategy – Safety Systems NEWS 2 Utilise NEWS2 in all community core services to detect patients at risk of clinical deterioration or death, prompting a more timely clinical response, with the aim of improving patient outcomes. **Metric** 100% of patients scoring $\geq$ 2 NEWS2/PEWS are reviewed by a registered professional.	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients (July 2019) – Preventing deterioration in a patient's condition wherever they are being cared for.
Patient Safety Strategy – Safety Systems 100% Compliance for all national patient safety alerts KCHFT will audit 100% of all completed national patient safety alerts in 2020/21 in line with the requirements of the National Patient Safety Alert Committee. **Metric** 100% of relevant patient safety alerts are embedded in practice as shown in an audit.	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients (July 2019) – Implementation of the National Patient Safety Alerts Committee.
Patient Safety Strategy – Safety Systems Children and Young People are safe in their transitions to adult services Ensure that there are clear pathways for transition from children and young people to adult services that are based on evidence based guidelines and assessments.	The learning disability improvement standards for NHS Trusts (2018) – The improvement measures: what trusts need to be doing to meet this standard.

Metric 100% of children and young people transitioning into adult care have a named worker to support them.	
Patient Safety Strategy – Safety Culture **Support staff to feel psychologically safe, encourage openness and support for learning.** Utilise staff survey metrics about fairness and effectiveness of reporting, and staff confidence and security in reporting to understand the safety culture within the trust. **Metric** A 3% positive response increase to staff survey question 18b *I would feel secure raising concerns about unsafe clinical practice.*	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients (July 2019) – Features of a patient safety culture, Psychological safety for all staff.
Patient Safety Strategy – Safety Culture **Include patients, carers and families as patient safety partners.** Equip staff and partners with skills and opportunities to improve patient safety. Include two patient safety partners on patient safety related Clinical Governance committees or equivalent by April 2021 who will have required training by April 2022. **Metric** Increase the patient voice in serious incidents and solutions.	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients (July 2019) – Patients, carers, families and lay people as partners: patient safety partners.
Patient Safety Strategy – Safety Culture **Ensure that people with a learning disability are more visible; that they are listened to and that reasonable adjustments are made to ensure that they have better access to healthcare.** Further roll out of the LD Champions to increase knowledge and expertise of general services working with people with a learning disability. **Metric** X% compliance to reasonable adjustments made for patients and service users with a learning disability.	The NHS Patient Safety Strategy Safer culture, safer systems, safer patients (July 2019) – Safety and learning disabilities.

2. Patient Experience (We are Caring/Compassionate and Responsive)

Suggested priorities	Rationale for inclusion
Experience based co design Introduce Patient / Carers Council to bring patients, carers and staff together to share the role of improving care and redesigning services to support strategy delivery. **Metric** X% of our services has an identified patient/carer to support the patient/carer voice in the delivery of care.	KCHFT Quality Strategy alignment with equality objectives: using co-design principles to work with our patients and their families to improve access to services and patient and family experience of healthcare.
Making feedback, concerns and complaints easier for children young people and adults with a learning disability, autism or both, their families and carers. Further implement the requirements of "Ask, Listen, Do" and good practice resources to improve feedback concerns and complaints for children, young people and adults with a learning disability. **Metric** Full implementation of the Ask Listen Do good practice resources.	The learning disability improvement standards for NHS Trusts (2018) – Trusts must demonstrate that they learn from complaints, investigations and mortality reviews, and that they engage with and involve people, families and carers throughout these processes.
Increase the volume of feedback received from children accessing services **Metric** X% increase in "You said, we did" for children and young people services	To increase the number of children and young people who say they feel informed, involved and valued.
Develop a pathway approach from prospective planning to bereavement support for End of Life Care. Develop bereavement surveys to improve end of life care and the experiences of those left behind and support families and carers with bereavement. **Metric** X% increase in bereaved people saying they had a positive experience of end of life services.	KCHFT End of Life Strategy - To support people who are important to each patient.
The introduction of Schwartz rounds The introduction and implementation of Schwartz round reflective practice forums.	The Point of Care Foundation It is essential that organisations support their staff in order to create a strong, open culture where high quality and compassionate care can flourish. Staff who regularly attend Schwartz Rounds feel

Metric A total of 5 Rounds to have taken place with evaluation shared with Quality Committee. There will be a well-established and functioning steering group.	less stressed and isolated at work and listening to colleagues describe the challenges on their work helps normalise emotions. Patients will also benefit if staff feel supported by their organisations.
Accessible service Improve the visibility and location of accessible access signage in trust community hospitals. **Metric** To be confirmed	People should be able to easily enter and exit premises and find their way around easily and independently. This is a requirement of the Patient Led Assessment of the Care Environment (PLACE)
Patient Experience across a pathway of care Develop an outcome based patient experience survey capturing feedback for rapid transfer patients discharged from an acute hospital and accessing community services. **Metric** X% decrease in incidents associated in transfer of care on Datix.	To support a climate for change by across partnerships and systems.

3. Clinical Effectiveness (we are Effective/Excellent and Aspirational)

Suggested priorities	Rationale for inclusion
End of Life Continue to improve the end of life experience by undertaking anticipatory medicine and rapid discharge audits. **Metric** X% of patients have anticipatory medicines in place.	2019 CQC Inspection Recommendation.
Quality Improvement Continue the roll out of the Quality Strategy and implementation of QI training and resources • 80% of QSIR Practitioners are actively involved in or sponsoring QI project(s) 6 month after achieving practitioner status.	Quality Strategy Quality objective 2: Continue to empower employees at all grades to take ownerships of the quality agenda by actively engaging in quality improvement.
Quality Improvement Deliver services to meet the needs of our patients by reducing repeated assessments and increase by the number of single holistic assessments.	Ensure the delivery of organisational and clinical goals are influenced and informed by the impact on patient experience.

Metric X% of relevant patients or service users have a single holistic assessment	
New models of care Build on our strengths of innovation by delivering services in a way to meet patient needs to further develop frailty models using the comprehensive geriatric assessment. **Metric** X% of relevant patients over the age of 60 have a CGA recorded.	NHS Long Term Plan To extend the independence of an ageing population and those living with complex conditions.
Improve Patient Outcomes- Prevention Improve patient outcomes using research and innovation enabling prevention of ill health, earlier diagnosis, more effective treatments, better outcomes and faster recovery. • x% increase of children with a completed EHC assessments completed with statutory timeframes. • x% increase of people who have an annual CD4 count test. • Increased recognition of infection related deaths in patients with a Learning Disability.	NHS Long Term Plan Secondary prevention and early detection to prevent the deterioration of health and reduce symptoms to improve the quality of life.
Research that responds to and meets the needs of the local population KCHFT's research activity is integrated closely with the Applied Research collaborative, so that there is mutually beneficial learning and growth of research activity in line with community trust priorities. **Metric** Undertake two Research Interest Group topics a year, following that of the Applied Research Collaborative themes.	NHS Long Term Plan – Research and innovation to drive future outcomes improvement.
Research that responds to and meets the needs of the local population Increase the research capabilities of our clinical staff across the organisation, bridging the gap between where our staff are with research skills and local and national opportunities for development. **Metric** Support at least 30 individuals a year to further their research capabilities and interests	NHS Long Term Plan – Research and innovation to drive future outcomes improvement.

Research that responds to and meets the needs of the local population To mobilise an increased number of research ready Principle Investigators in different clinical areas to broaden the areas of research delivery. **Metric** Identify and work with at least 3 new Principal Investigators a year, opening research studies for the population KCHFT services	NHS Long Term Plan – Research and innovation to drive future outcomes improvement.
Research that responds to and meets the needs of the local population Increase the number of research ready staff to deliver research. **Metric** At least 15 members of staff to complete the Introduction to Good Clinical Practice	NHS Long Term Plan – Research and innovation to drive future outcomes improvement.
Research that responds to and meets the needs of the local population Enable delivery of research that follows the patient pathway and is not restricted by organisational boundaries. **Metric** Open one research study in collaboration with an acute NHS Trust	NHS Long Term Plan – Research and innovation to drive future outcomes improvement.

4. Staff Experience (we are Caring/Well Led/Responsive and Aspirational)

Suggested priorities	Rationale for inclusion
Workforce Inclusion Create and maintain a culture where people feel included in the workplace. **Metric** X% decrease in the number of staff reporting discrimination from colleagues in the annual staff survey.	NHS Staff Survey comparator.
EDI Strategy Develop an Equality Diversity and Inclusion Strategy **Metric** Staff survey questions 15a, 15b, and 15c on	NHS Staff Survey comparator.

discrimination	
Career Opportunities Enhance opportunities for staff to progress their careers and further develop skills. **Metric** X% increase in staff who say they understand options for career development.	NHS Staff Survey comparator.
People Strategy Engaging with our people to develop our people strategy for 2022-2027 **Metric** To be confirmed	Organisational priority.
Health and Wellbeing Improve our people's health and wellbeing **Metric** 2% reduction in the staff reporting *During the last 12 months have you felt unwell as a result of work related stress**?***	NHS Staff Survey comparator.
Appraisals Improve the quality of appraisals **Metric** 5% increase of staff reporting that appraisal helped improve how they do their job.	NHS Staff Survey comparator.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	3.1
Agenda Item Title:	Learning from Deaths Report
Presenting Officer:	Dr Sarah Phillips, Medical Director

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

Report Summary

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.

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 Disabilities 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.

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.

Proposals and /or Recommendations

To note the report.

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.

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Kent Community Health NHS Foundation Trust

LEARNING FROM DEATHS REPORT

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.

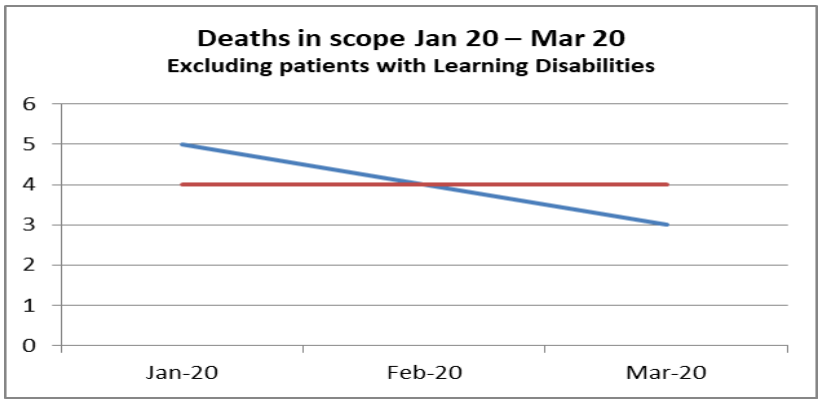
2. March Dashboard

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**
3		4	3*		3	0	0
This Quarter (QTD)		**Last Quarter**	**This Quarter (QTD)**		**Last Quarter**	**This Quarter (QTD)**	**Last Quarter**
12		11	7		15	0	0
This Year (YTD)		**Last Year**	**This Year (YTD)**		**Last Year**	**This Year (YTD)**	**Last Year**
81		77	73		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 bi-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 but these meetings are currently suspended due to COVID-19

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 continue to be seen. A good example seen was the clearly documented decision not to move a patient to a side room when actively dying but responsive because of the recognition of their dementia specific needs and marked positive response to being place near to the nurse's station. Appropriate use of and understanding of mental capacity assessments has also been documented. ***Involve, Communicate & Support***

- In the majority of cases, all relevant assessments continue to be completed within 24 hours of admission. ***Plan & Do***

- Although there is scope for improvement in advance care planning, ceilings of care continue to be affirmed early in many cases and are 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 Documentation has continued as a recurring theme in some cases. The combination of paper and electronic notes remains difficult to navigate to get a clear overview of care at times. Version control and documentation standards have also been raised in some cases.	This reflects ongoing Trust-wide work with documentation standardisation and care plans generally. PCP formats have been reviewed as part of the Rio documentation rationalisation and these issues will continue to be monitored as RiO implementation progresses.
Medicines Issues 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. Correlation between prescribing of venous thrombo-prophylaxis and the completion of a VTE assessment is not always clear. In one case issues raised by medicines reconciliation relating medication concerns were not acted on and there is no evidence that the medical team were made aware of these concerns	All medicines feedback is sent to the Chief Pharmacist as well as the ward team, for awareness and monitoring. Work is ongoing to promote the datixing of any drug related issues. This information was fed back the medicines management via the chief pharmacist for action
Policies, Processes & Transfers of Care A themed review session was carried out to address recurrent issues relating to verification of death procedures. This included cases form June 2019 onwards	Bespoke training from the EoLC and palliative care lead was arranged and process put in place for liaison with other local teams and escalation to on call managers if capacity issues arise. The trust Verification of expected death guidance has been reviewed to align with national guidance and training packages updated to reflect this. In response to COVID-19 further supplementary special edition guidance for the

Themes	Comments/Actions
Issues have arisen due to lack of DNACPR decision making when patients are receiving end of life care. In one case this led to resuscitation being attempted for a patient at the end of life.	emergency period has been provided to staff and liaison with other providers to enable collaborative and consistent practice across the Kent and Medway region The issues relating to these scenarios are often complex and relate to handover issues with transfer of care. The discharge pilot scheme operating in the services in the East has already made some positive impact on quality of transfer information. Work has also been completed to revise the trust DNACPR policy and implement new staff training resources regarding DNACPR.

COVID-19 update The first community hospital death related to COVID-19 was recorded on the 2 April 2020. In the month of April, 37 community hospital death datix reports were received (last updated 5 May 2020). Due to the pandemic restrictions these reviews are currently being completed via a virtual review process.

Dr Lisa Scobbie, Deputy Medical Director
On behalf of
Dr Sarah Phillips, Medical Director
May 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	3.2
Agenda Item Title:	Freedom To Speak Up (FTSU) Report
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary
The report provides a summary of concerns raised by staff between 1 October 2019 and 31 March 2020 (Quarter 3 and Quarter 4).

Proposals and /or Recommendations
To note the report.

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

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Kent Community Health NHS Foundation Trust

FREEDOM TO SPEAK UP GUARDIAN REPORT

1. Introduction

1.1 There are now more than 500[1] Freedom to Speak Up Guardians across NHS organisations in England. Some of these are full-time posts, some part-time and some are added to people's day job. In the period from 1 October 2019 to 31 December 2019 (Quarter 3), they had dealt with 4,120 concerns, 915 of which related to patient safety issues and 1,496 included elements of bullying and harassment[2]. At the time of writing, the Quarter 4 data had not been released by the National Guardian's Office.

1.2 Sir Robert Francis QC has urged NHS Boards and managers to welcome staff raising concerns (whistleblowing), in the same way as staff are encouraged to report incidents. Kent Community Health NHS Foundation Trust's (KCHFT) policy is in line with the national Freedom to Speak Up (Whisteblowing) policy. This says that staff should initially try to raise concerns with their manager or a more senior manager, but if this does not lead to satisfactory action (for example an investigation) or if the staff member feels uncomfortable for whatever reason, they can contact the Freedom to Speak Up Guardian for advice and support. It is all in support of creating a more open culture that puts patient and staff safety at the heart of what we do.

1.3 No-one should experience discrimination or be victimised for speaking up, but we know fear of this can prevent staff from doing so. Those who raise concerns via the Freedom to Speak Up process can expect to receive support and advice from the Trust's Freedom to Speak Up Guardian, as will managers with whom the concerns are raised. The role of the Freedom to Speak Up Guardian is to be impartial and ensure that a fair and timely investigation into concerns takes place and that outcomes, actions and learning are shared.

1.4 This report covers the period 1 October 2019 to 31 March 2020 (Quarter 3 and Quarter 4).

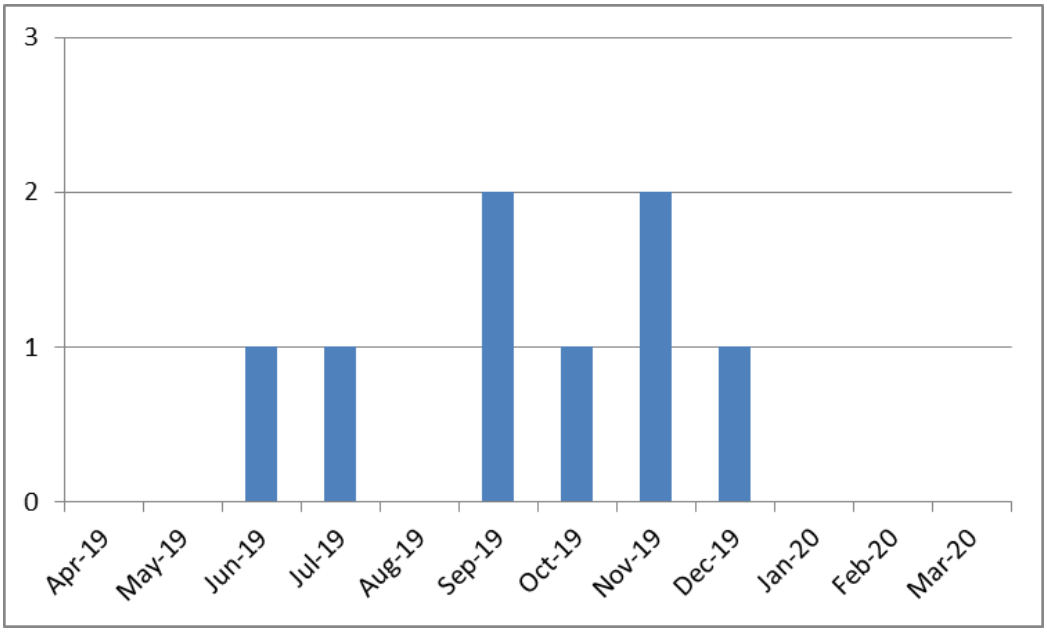
2. Summary of cases

2.1 Four cases were opened during the period of 1 October 2019 to 31 March 2020. All four cases are now closed. A summary of the categories covered is below:

- Patient safety
- Perceived detriment

[1] Source: Freedom to Speak Up Index Report 2019
[2] Source: National Guardians Office Website

2.2 In total, eight new cases were opened during 2019/20. The graph below shows the number of new cases by month.



2.3 Within the data submitted, no cases were raised by staff members going through either the Capability or Disciplinary process.

2.4 The FTSU Guardian has now established a mechanism to obtain feedback on staff experience of speaking up, where it is possible to do so. The FTSU Guardian will provide a summary of staff feedback in future reports.

2.5 The Guardian also offers an informal 3 month follow up of all cases to establish that any changes that have been put into place are sustainable.

3. Fostering a culture of openness

3.1 Since the last report, the number of FTSU Ambassadors within the Trust has increased from 9 to 10.

3.2 Details of the FTSU Guardian has been published on FLO and communicated through FLOMail.

3.3 Contact details for the FTSU Guardian has been communicated regularly to all staff via the daily Coronavirus updates.

3.4 The FTSU Guardian will continue to promote the speaking up culture via regular communications on FLO, distributing leaflets and other promotional material across all sites, as well as attending team meetings when required.

4. Freedom to Speak Up Index Report

In September 2019, the National Guardian's Office published the 'Freedom to Speak Up Index Report 2019'. The Index identified the view of staff on the speaking up culture in all NHS Trusts and NHS Foundation Trusts across the country.

The index calculations were based on the mean average of responses to four questions in the 2018 annual staff survey. The FTSU Index for Kent Community Health NHS Foundation Trust was set at 81%.

I am pleased to report that the FTSU Index for Kent Community Health NHS Foundation Trust is now **84%**, based on the results of the 2019 staff survey. Please note that this has been calculated by the FTSU Guardian as the 2020 Index Report has not yet been published.

5. Forward Plan

- Undertake a review of the Freedom to Speak Up Policy.
- Arrange a meeting with the Ambassadors to re-evaluate their role within the trust.
- Increase the number of Ambassadors to ensure that there is good representation across the different staff groups and services.
- Strengthen links with Guardians at other NHS organisations, via the regional network and nationally to ensure that best practice is shared and lessons learnt.
- Strengthen the support for the Guardian and Ambassadors including access to peer support, counselling and professional development.
- Maintain the FTSU Index score by continuing to promote the role of the FTSU Guardian and embed a positive culture of speaking up across the trust. This will be undertaken by publicising on the staff intranet site, blogs, attending team meetings and staff network meetings.
- Target the staff networks and ensure that all staff members and groups access FTSU when requiring the service.
- Develop case studies and continue to report on themes and trends from cases.

An improvement strategy is near completion. This will incorporate a gap analysis against the recommendations from previous case reviews that the National Guardians Office (NGO) has undertaken at other trusts across the country.

6. Recommendation

The Board is asked to note the report.

Joy Fuller
Freedom to Speak Up Guardian
May 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	21 May 2020
Agenda Number:	3.3
Agenda Item Title:	Emergency Planning and Business Continuity Annual Report
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary

This report is to provide assurance to the Board that plans and systems are in place to meet the Trust's obligations with respect Emergency Preparedness, Resilience and Response and relevant statutory obligations under the Civil Contingencies Act 2004. The report sets out the Trusts state of readiness to respond to major incidents and disruptive events that impact on the delivery of services and performance.

Proposals and /or Recommendations

The Board receives assurance of Kent Community Health NHS Foundation Trust (KCHFT) state of preparedness

Relevant Legislation and Source Documents

Civil Contingencies Act 2004. NHS England Emergency Preparedness Framework 2013

Has an Equality Analysis (EA) been completed?

No ☐

High level position described and no decisions required.

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Kent Community Health NHS Foundation Trust

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

ANNUAL REPORT APRIL 2019 – MARCH 2020

1. Introduction

This report describes the work undertaken in 2019/20 on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2015

The Trust has a mature suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the CCA (2004) and current NHS guidance. All plans have been developed in consultation with partner organisations to ensure cohesion with their plans.

The report covers the following;

- The training and exercising programme delivered
- The continuing development of the emergency planning arrangements
- A summary of incidents the Trust has responded to

2. Risk Assessment

The CCA (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, that preparations are undertaken and that response plans exist. Those standing risks currently identified on the Kent Community Risk Register include;

- Influenza-type disease (pandemic)
- Flooding
- Severe Weather
- EU Exit

As a result of risk assessments with internal services there has been progress made across services in pursuing the necessary actions to control and mitigate the risks. The Head of EPRR and the EPRR manager have developed a close working relationship with services and assisted in the development of service level business continuity plans including detailed information on the Recovery Time Objectives and the Maximum Tolerable Period of Disruption for Information Technology across services.

Within this reporting period the Trust has met four times at the combined On Call/EPRR meeting. Attendance by relevant managers/staff at these meetings has

increased throughout 2019 -20, senior management support is in place to ensure appropriate attendance at these meetings.

3. Compliance

EPRR remains a key priority for the NHS and forms part of the NHS Commissioning Board Framework (Everyone Counts; Planning for Patients), the NHS Standard Contract and the NHS Commissioning Board Emergency Planning Framework (2015).

A set of core standards for EPRR have been in place since April 2013. All organisations who receive NHS funding are asked to carry out a self- assessment against the NHS Standards for EPRR. KCHFT completed this exercise in August and NHS England agreed with KCHFT's assessment that it was successful in meeting all of the requirements for 'full' compliance'. This was an improvement on last year's assessment.

4. Partnership working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Kent and Medway Local Health Resilience Partnership (LHRP). The purpose of this group is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England – South, South East.

The LHRP work plan is delivered by the Trust as required. An area of responsibility agreed at the LHRP for the Emergency Preparedness leads across the county is accountability to the local authorities for the medical risk assessment of community events taking place; the Head of EPRR is responsible for the Dover authority.

4.1 Student Placement

The EPRR team in partnership with Maidstone and Tunbridge Wells NHS Trust continues to facilitate an EPRR student placement from August 2019 for a period of one year. The student is experiencing an extensive insight into the role of EPRR within the acute and community settings.

5. Planning

5.1 Major Incident Plan

The Major Incident Plan is reviewed annually to ensure it continues to accurately reflect the role of the Trust in a major incident and how this role fits with the plans of other NHS organisations and the emergency services. The Major Incident Plan was reviewed in August 2019 and ratified by the Corporate Assurance Risk Management Committee on behalf of the Executive Management Team

5.2 Emergency Resilience and Business Continuity Policy and Business Continuity Plans

The Emergency Resilience and Business Continuity Policy outline's how the Trust will continue to discharge core functions in the event of disruption to business operations. Each service has its own Business Continuity Plan which is reviewed annually. There is a rolling programme of review and work completed with the Minor Injury Units and the Community Teams and Hospitals.

Business Continuity Plans are one of the Key Performance Indicators for (EPRR); I am pleased to report all plans are now 100% complete across all tiers of services A data base has been developed to ensure the timely review of plans going forward.

5.3 Heatwave Plan

The Heatwave Plan for the Trust was updated as required for 2019. The Trust received health watch alerts for the period 1 June - 15 September 2019. The plan allows for escalation of operational services, and specific actions would be implemented to safeguard patients and staff as necessary.

5.4 Lockdown Policy

The Trust is required to have lockdown plans for appropriate sites, such as the Community Hospitals. The Head of EPRR developed a Lockdown policy and worked collaboratively with the Head of Health, Safety and Security to embed this in to the Trust. The Trusts several Minor Injuries Units are located on National Health Service Property Services (NHSPS) sites, the aim of each of these is to develop and embed multi occupancy Lockdown Plans, this has proved challenging with lack of engagement from NHSPS.

5.5 EU Exit Planning

The potential impact of the UK leaving the EU with or without a deal was a significant threat to the business continuity of the trust. In preparation for an exit from the European Union (EU) the Trust instigated and embedded far reaching and detailed plans in accordance with the EU Exit Operational Readiness Guidance and local plans which recognised the unique position of the Kent in the potential exit. The national guidance summarised the Government's contingency planning and covered all actions that health and adult social care organisations had to prepare for but these required local adaption for the potential extremely high impact on Kent roads. In accordance with the guidance and in partnership with multiagency partners the Trust has prepared extensively for an EU Exit, this has included a significant focus on the following;

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

The Trust was represented at a large number of exercises and meetings set up in anticipation of the UK's exit from the European Union. Lessons identified and planning required was discussed at the Trust EU Exit exercise facilitated by the Head of Emergency Preparedness Resilience and Response. These exercises allowed these discussions to assist in the formulation of the Trust operational EU Exit plan Strategic meetings took place by weekly, nine work streams reported directly into the strategic meeting.

As part of workforce planning, Vismo was implemented, this software allows the strategic managers a visual representation of the location of staffs home addresses, and identification of individual staff member's skills, these may be required to support the delivery of care of Tier One services if the Trust were to instigate locality management. Much of the work of the preparation for EU exit was utilised as part of the Trust response to Covid-19

5.6 Covid 19

The UK government declared a level 4 incident in response Covid-19 global pandemic on 3 March 2019.The declared Level 4 incident immediately activated Command, Control and Coordination at local and national levels. At each stage, in advance of national directive, the Trust activated its plans in response to Covid-19. Governance structures were set up, including strategic and tactical levels of command and staff were asked to activate working from home. The trust has played a full part in the regional and national cells and actions.

Trust response to the pandemic included the preparation of and then implementation of, the seven day Incident Management Team (IMT) co located at the Incident Coordination Centre Trinity House, Ashford. As part of planning the Trust conducted a review of Strategic On Call arrangements and many staff from Tiers 2 and 3 temporally transferred to Tier 1 services.

At the time of writing this report the pandemic continues and the trust is actively managing its response.

6 Training and Exercising

In order to comply with our obligations the Trust must undertake a number of emergency preparedness activities; these include a robust training programme facilitated by the Head of EPRR, in the current year the Kent Resilience Forum (KRF) facilitated the annual seminar with a focus on response on Recovery of services following major incident. KCHFT was widely represented with attendance from senior managers.
A rolling programme of exercises designed to test and develop our plans are undertaken. These are:

- a communication test every six months
- a desktop exercise once a year
- a major live exercise every three years
- Command Post exercise every 3 years

6.1 Training

Extensive internal training has been delivered to staff throughout the reporting period.

Staffs from KCHFT are encouraged to attend training events provided by the Kent Resilience Forum (KRF); the Head of EPRR was a member of the planning team for the KRF Seminar which was held at the Royal Naval Barracks, Chatham on 14 November. The focus of the seminar was chemical, biological, radiation, nuclear incidents and lessons identified following the incident have been used to enhance Trust plans.

Within this reporting period KCHFT IT staffs have undertaken business continuity awareness training, focusing their awareness of incidents relevant to their service and the command and control processes in place.

6.2 Exercises

Multiple exercises have taken place throughout the reporting period involving staff from differing services; the exercises include the following;

- Skype for Business; the EPRR Team planned regular live no notice exercises focussing on the on call cohorts of staff. Additionally the Trust loggists have participated in two communication exercises.
- A live no notice Lockdown exercise facilitated by the EPRR team took place on 4 October at the Whitstable and Tankerton Hospital, the scenario was a protest external to the building. On site command of the incident was immediate by a KCHFT member of staff, the ward staff immediately ‘locked down', the protestors were not allowed access onto the ward. The debrief identified lessons which were discussed and communicated to colleagues.
- Similar exercises were facilitated at two other Trust sites, Tonbridge Cottage Hospital and Trinity House. Learning on the non - clinical site exposed distinct challenges; these have been discussed at the quarterly EPRR/on call meetings

The Trust has therefore exceeded these requirements in 2019/20.

7. Incidents

Throughout the year there have been a number of incidents across the Trust which has involved implementation of service level business continuity arrangements.

Examples of incidents are documented below

Measles Outbreak

On 14May 2019 KCHFT were informed of an individual diagnosed with Measles in an International Boarding School in Canterbury. Following on from the initial case there were further students diagnosed with Measles. The Trust was requested to vaccinate 600 staff and children with <3 days’ notice. There were challenges for the agencies involved including completion of consent forms and lack of uptake of the vaccine. KCHFT immediately began the preparation for this large cohort of staff/students and

successfully delivered the programme in the required time frame as requested by Public Health England.

Radiation Incident

On 23 May 2019, a patient presented to a KCHFT Minor Injuries Unit with symptoms suggestive of exposure to radiation. Staff on site immediately recognised the signs and symptoms and activated the Radiation plan; the hospital building was locked down. Investigation with the Ramgene monitor demonstrated an abnormal result; the medical physics team at Maidstone Hospital were prompt with their response and advice. Further effective and efficient partnership working with the Hazardous Area Response Team and the Detection, Investigation Monitoring (DIM) Officer resulted in a safe environment for the individual patient, the staff and other patients and staff within the building. The debrief identified both areas for improvement, particularly in response to the primary care training and capacity and good practice which included the training KCHFT staff had received on the CBRN response.

Water Incident

Two protracted incidents relating to water became challenging for all staff concerned at Sevenoaks Hospital. The Out Patient building implemented Business Continuity arrangements in May due to a lack of hot water. A secondary water related incident affecting the main Sevenoaks hospital building was declared in June with a loss of thermal control. Business Continuity arrangements were put in place, through the Incident Management Team. Staff demonstrated resilience, with no staff or patient harm was reported.

8. Summary

The Trust continued to develop its resilience arrangements throughout 2019/20 which was a year of significant challenge in the field of emergency planning. During 2020/21 this work will continue, ensuring the Trust maintains the ability to respond to emergencies and business continuity incidents. Lessons learned and good practice have been identified and shared amongst staff. On-going embedding of the EPRR arrangements remains a key priority.

The focus for the continued development of the service in 2020/21 will be;

- To continue to effectively respond to incidents
- To maintain compliance with the EPRR requirements
- To continue the planned works in respect of Lockdown
- To facilitate exercises for Clinical and Non Clinical Services

The Board is asked to note the progress of the service in 2019/20 and endorse the continued development of the service for 2020/21.

Jan Allen
Head of Emergency Preparedness, Resilience and Response (EPRR)
10 May 2020