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 6 August 2020

Virtual meeting via MS Teams Live Event

Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford Kent TN25 4AZ and Unit G, Hermitage Court, Hermitage Lane, Maidstone, Kent, ME16 9NT

Kent Community Health
NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust (KCHFT) Board
to be held at 10am
on Thursday 6 August 2020
in
Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford Kent TN25 4AZ and Unit G, Hermitage Court, Hermitage Lane, Maidstone, Kent, ME16 9NT

and virtually by MS Teams Live Event

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		**10.00**
1.1	Introduction by Trust 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 21 May 2020	Trust Chair	
1.5	To receive Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 21 May 2020	Trust Chair	
1.6	To receive the Trust Chair's Report	Trust Chair	Verbal
1.7	To receive the Chief Executive's Report • Pre-Consultation Business Case (PCBC)	Chief Executive	

1.8	To approve the Kent Community Health NHS Foundation Trust Board Governance Refresh Report	Trust Chair Chief Executive	
2.	**BOARD ASSURANCE/APPROVAL**		**10.25**
2.1	To receive the Service Impact Story	Chief Nurse	
2.2	To receive the Board Assurance Framework • NHS Improvement/England Board Assurance Framework for COVID-19 (KCHFT)	Corporate Services Director Chief Nurse and Director of Infection Prevention and Control (DIPC)	
	Board Committee Reports		**10.45**
2.3	To receive the Charitable Funds Committee Chair's Assurance Report	Chair of Charitable Funds Committee	
2.4	To receive the Quality Committee Chair's Assurance Report	Chair of Quality Committee	
2.5	To receive the Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee	
	Planning and Performance		**11.00**
2.6	To receive the Integrated Performance Report	Director of Finance / Executive Directors	
2.7	To approve the 2019/20 Quality Account	Chief Nurse	
2.8	To receive the 2020/21 Trust Strategy	Director of Strategy and Partnerships	
2.9	To receive the joint paper from Kent Community Health NHS Foundation Trust (KCHFT) and Kent and Medway NHS and Social Care Partnership Trust (KMPT)	Chief Executive (KCHFT) Executive Director of Strategy and Partnerships / Deputy Chief Executive (KMPT)	

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3.	**REPORTS TO THE BOARD – for noting**		**11.40**
3.1	To receive the Learning From Deaths Report	Medical Director	
3.2	To receive the Freedom To Speak Up Index Report	Corporate Services Director	
3.3	To receive the approved Minutes of the Charitable Funds Committee meeting of 17 January 2020	Chair of Charitable Funds Committee	
4.	**ANY OTHER BUSINESS**		**11.55**
	To consider any other items of business previously notified to the Trust Chair	Trust Chair	
5.	**QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA**		
6.	**DATE AND VENUE OF NEXT MEETING**		

Thursday 5 November 2020
To be confirmed

Kent Community Health NHS Foundation Trust

UNCONFIRMED Minutes
of the Kent Community Health NHS Foundation Trust Board Meeting
held at 10am on Thursday 21May 2020

Virtual Meeting via MSTeams Live Event

Present:	John Goulston, Trust Chair (Chair) Sola Afuape, Non-Executive Director Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Paul Butler, Non-Executive Director Pauline Butterworth, Chief Operating Officer Peter Conway, Non-Executive Director Prof. Francis Drobniewski, 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 Nigel Turner, Non-Executive Director
In Attendance:	Natalie Davies, Corporate Services Director Gina Baines, Committee Secretary (minute-taker)

21/05/01 Introduction by Chair

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

For safety reasons due to COVID-19, the meeting was being held virtually rather than in public. The Board would be discussing a number of issues that were sensitive and might also be personal to the situations that many patients, carers and staff were having to face at this time. Therefore, the public were requested that the meeting was not recorded. The minutes would be made available on the Trust website.

21/05/02 Apologies for Absence

There were no apologies.

The meeting was quorate.

21/05/03 Declarations of Interest

Mr Goulston confirmed that his appointment as interim chair of the Kent and Medway Sustainability and Transformation Partnership (STP) had been extended until the substantive chair was appointed in March 2021.

21/05/04 Minutes of the Meeting of 6 February 2020

The minutes were read for accuracy.

The Board **AGREED** the Minutes.

21/05/05 Matters Arising from the Meeting of 6 February 2020

The Board **RECEIVED** the Matters Arising.

21/05/06 Trust Chair's Report

Mr Goulston presented the report to the Board for assurance.

With regards to the interim Board governance arrangements during the COVID–19 crisis, the recommendations in the report had been agreed at the Board's meeting in March. The report described the way that the Trust had been operating its governance over the preceding two months and how this would continue for the time being. A governance paper which proposed new governance arrangements had been drafted by Mr Conway, Ms Skelton, Ms Barber and Mr Goulston and would be considered in due course.

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

21/05/07 Chief Executive's Report

Mr Bentley presented the report to the Board for information.

With regards to the Trust's response to COVID-19, Mr Bentley reflected on the toll it had taken on patients and their families. Each patient and family that had been affected was an individual trauma and staff had kept this at the forefront of their minds as they delivered compassionate care in very challenging circumstances.

With regards to the flooding that had taken place at Tonbridge Community Hospital two days previously, Mr Bentley confirmed that all affected patients had been moved to Sevenoaks Hospital. There had been no harms to patients or staff in the incident. A full assessment of the damage would take place. He praised the calm and measured response of the staff involved. Because the damage was significant, there would be no inpatient beds at the unit for the time being. Additional round-the-clock security had been put in place to make staff using other areas of the site feel safer. The Board would be kept updated on developments.

Ms Barber commented that the non-executive directors have been well briefed on the incident and she thanked the staff who had been involved in containing the incident. Dr Spare had informed Ms Barber of the incident promptly and had also confirmed to her that staff had accompanied the patients when they were transferred to Sevenoaks Hospital with their families being kept informed of events.

With regards to the Kent and Medway integrated care partnerships (ICPs), Mr Bentley presented the report on progress to the Board for information. It was agreed that this item would continue as a standing item in future reports.

In response to a question from Mr Turner as to whether the COVID-19 emergency would impact on the implementation of ICPs and the agreed timescales and milestones of their development, Mr Bentley indicated that it was inevitable that there would be some adjustment to the timeframe. However, as services moved forward into a new business as usual, it was important that their delivery and commissioning reflected the way clinicians had so positively responded to the emergency. For example, moving suitable clinical patient consultations to a digital platform was here to stay. There was also a strong argument to accelerate the transfer of the commissioning of services from clinical commissioning groups (CCGs) to the integrated care system (ICS). Clinicians had driven the response to the crisis, finding creative solutions to the challenges they had faced. This should not be lost in the new environment that the Trust and the ICPs found themselves in.

In response to a question from Ms Afuape regarding the ICPs and their future relationship with the voluntary sector and other external bodies, Mr Bentley commented that a strong relationship was already in place with a number of them, for example Public Health, but there was a desire to make this even more inclusive. With COVID-19 bringing the role of the ICPs into sharp focus, they were actively responding to and agreeing their priorities. For example, the West Kent ICP had agreed its priorities the previous week and had identified the role of the voluntary sector and other external organisations as its first priority.

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

21/05/08 Service Impact Story

Dr Spare presented the video to the Board for assurance.

The video related to the Rough Sleeper project that had been commissioned by Maidstone Borough Council. Originally a Quality Improvement project, it had now received long-term funding to provide healthcare services to this hard to reach group.

Prof. Drobniewski congratulated the team on the success of the project which he noted highlighted how a single point of contact linked to a wider multidisciplinary healthcare team could bring real health benefits to a

neglected and vulnerable group in the community.

Mr Sammon added that this type of project provided powerful learning that could be harnessed by the various ICPs across the county.

The Board **RECEIVED** the Service Impact Story.

21/05/09 Board Assurance Framework (BAF)

Ms Davies presented the report to the Board for assurance.

Mr Goulston confirmed that the Executive Team was reviewing the BAF on a weekly basis during the COVID–19 emergency. The committees of the Board also received the BAF as a standing agenda item. It was noted that the scores relating to COVID–19 (risk 107 and 108) remained significant.

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

21/05/10 Standing Financial Instructions

Mr Flack presented the report to the Board for approval.

The Board **APPROVED** the Standing Financial Instructions.

21/05/11 Audit and Risk Committee Chair's Assurance Report

Mr Conway presented the report to the Board for assurance.

The Audit and Risk Committee (ARC) had reviewed the 2019/20 accounts at its meeting the previous week and it congratulated the Finance Team for its work in preparing them to such a high standard. Although some items were yet to be finalised, the Committee recommended that the accounts were approved by the Board subject to receipt of final comments from Grant Thornton, the external auditors. Once these had been received, Mr Bentley, the Trust's Accountable Officer, would sign the accounts.

With regards to cyber security, the Committee continued to scrutinise this risk closely and provide assurance to the Board. Its risk profile had increased but mitigation was in place. As the Committee would not meet again until late August, Mr Conway suggested that the Board could receive an interim update on cyber security risk mitigation or monitor it through the BAF which it received regularly.

Mr Turner reflected that this was a significant risk as cyber-attacks on organisations continued to remain high. Mr Conway reflected that as the BAF was updated regularly and circulated to the Board, he was confident that it was an effective way for Board members to retain oversight of the risk. The Board agreed to monitor the risk through the BAF.

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

21/05/12 Quality Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.

The Committee had met four times since the last Board meeting in February.

With regards to the impact of COVID-19 on preparing the 2019/20 Quality Account, national guidance had been published which had extended the deadline for the report's submission. However, the Trust had made good progress with compiling the data and the final report would be brought to the Board for approval at its next meeting in public in August. The Extraordinary Quality Committee had met on 3 April 2020 to ratify a number of documents that had had to be amended to support the Trust's response to COVID-19. The Committee had received good assurance at its meeting in May that risks were being reviewed and that robust processes were in place to manage the risks.

With regards to the patient story that had been presented to the Board at its meeting in February, the Committee had received a detailed report on how the Trust and system-wide services were responding.

With regards risk 105 (referral to treatment waiting times) on the BAF, the Trust had put in additional service capacity in response to the increased number of unaccompanied asylum seeking children arriving in Kent who required initial health assessments.

With regards to the annual Infection Prevention and Control Declaration this had been approved at the March Committee meeting.

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

21/05/13 Strategic Workforce Committee Chair's Assurance Report

Ms Skelton presented the report to the Board for assurance.

The Trust had put in place a series of workforce initiatives to support staff during the COVID-19 emergency. Sickness absence among staff had been minimised. Good practice around the use of personal protective equipment (PPE) had been in evidence. A programme of regular engagement with staff through a number of communications initiatives had been put in place including a daily Q and A on Flo to answer questions from staff. Work was ongoing around risk assessments for all black, Asian and minority ethnic (BAME) staff to support them. A raft of new health and well-being initiatives had been introduced.

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

21/05/14 Committees' Terms of Reference

Mr Goulston presented the report to the Board for ratification.

The committees would be reviewing their terms of reference in light of the proposal to refresh the Board's governance arrangements when the approach described earlier in the meeting was agreed.

The Board **RATIFIED** the Committees' Terms of Reference

21/05/15 Integrated Performance Report

Mr Flack presented the report to the Board for assurance.

Although the COVID-19 emergency had had an impact on a small number of the Trust's key performance indicators (KPIs) at the end of March, overall the 2019/20 year-end review of the Trust reflected a strong performance. Some of the data in the final report for the year had been cleansed which had had a positive impact on some services' performance. Further cleansing would continue. The Trust's continued good performance in meeting its referral to treatment waiting times KPI had led to a recommendation within NHS England/Improvement (NHSE/I) for the Trust to move to segment one of the Single Oversight Framework.

The integrated performance report would have its annual refresh following the recent review of all the KPI metrics by the Executive Team.

Mr Bentley observed that the report showed a strong set of performances particularly with regards to workforce but not exclusively. Services had delivered sustained high quality and compassionate care throughout the year and ongoing during the COVID-19 crisis.

Ms Barber commented that the Quality Committee would support changes to Friends and Family Test reporting. She also looked forward to seeing the results of system-wide conversations around patient experience and transfers of care between organisations.

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

21/05/16 2019/20 Annual Report and Accounts

Mr Flack presented the report to the Board for assurance

The Quality Account had not been required at this time but would be presented to the Board at a later date. The ARC had reviewed the accounts, the annual report and the annual governance statement. The accounts have been prepared to the original timetable set out by NHSE/I which had extended the deadline for completion of the external audit to the end of June. Once this was completed the auditors would provide their opinion. COVID-19 had impacted on the preparation of the accounts in two areas. Firstly, there was a national issue for auditors that was yet to be

concluded around the going concern assumption. Secondly, with regards to the regular five yearly valuation of the Trust's properties, the current instability in the economy could affect the wording of the external auditors' opinion. In conclusion, the auditors had undertaken the testing of the accounts and had found no errors. There was no change from the month 12 Finance Report. With regards to Note 24, this should read that the Trust had no borrowings. With regards to the remuneration report, all relevant information had now been received which would lead to a minor change in the numbers reported. Mr Flack highlighted a further amendment with regards his pension and a benefit for a lease car.

Mr Conway added that the prime responsibility of the ARC was to scrutinise the accounts and receive the opinions of the internal and external auditors. The Committee had met on more than one occasion to undertake this and was content with the accounts. The minor amendments and the issue with regards to the Going Concern assumption would not make a significant difference. The Committee was happy to recommend the annual report and accounts to the Board for approval subject to the amendments.

With regards to the remuneration report, although the ARC had not reviewed it, it had been circulated to Mr Conway and he was happy to recommend it to the Board.

Mr Goulston highlighted that there was an error in the Board attendance table which would be corrected after the meeting.

The Board **APPROVED** the 2019/20 Annual Report and Accounts, subject to the amendments.

21/05/17 2020/21 Reset Plan including

(i) Strategic Priorities – for approval

(ii) Quality Priorities – for information

Ms Butterworth presented the 2020/21Reset Plan to the Board for assurance.

Mr Sammon presented the 2020/21 Strategic Priorities to the Board for approval.

Mr Sammon added that the 2020/21 Strategic Priorities had been agreed by the Management Committee at its meeting in February. However, a fifth priority had been added subsequently to address the issues of COVID-19. This additional priority had been agreed by the Executive Team.

Dr Spare presented the 2020/21 Quality Priorities to the Board for information.
Dr Spare confirmed that the Board had seen a draft version of the priorities previously. They had been discussed at the Quality Committee and the Trust had consulted widely with its stakeholders and taken note of their feedback. The Quality Committee would receive regular updates on

progress with each of the priorities including the learning disabilities priorities and the psychological safety indicators. The full list would be published in the 2019/20 Quality Account.

In response to a series of questions from Prof. Drobniewski regarding whether the Trust should commit to COVID-19 antibody testing for all staff, whether it was planning to have a comprehensive swab testing programme for all staff, and with regards to the flu vaccination whether this should be made compulsory for staff, Dr Spare clarified that at this time it was not mandatory for staff to have a flu vaccination and that this policy was unlikely to change. A similar policy would apply for a COVID-19 vaccination when it became available. For the 2020/21 Staff Flu Vaccination programme, stocks had been ordered and would be increased in response to COVID-19.

With regards to antibody testing and swab testing, Dr Phillips commented that how a programme of regular testing of staff for the infection could be implemented and the resources required was being considered. With regards to the current antibody test, there were still unanswered questions around its efficacy and this would impact on how the Trust would employ it strategically.

In response to a question from Ms Afuape regarding how the Trust would model and map the emerging picture of COVID-19 infections and immunity, Mr Goulston indicated that the ICPs were looking at this. Mr Bentley added that although much was still unknown, the Trust was keen to take a leadership role in the ICS and ICPs in shaping their response. With regards to how the Trust would shape its services, internal decisions would continue to be driven by the core values of the Trust as a major and best employer.

It was agreed that the Reset Plan, Strategic Priorities, Quality Priorities and the Chief Executive's Report on the ICPs (agenda item 1.7) would be circulated to the Council of Governors.
Action – Ms Davies

The Board **RECEIVED** the 2020/21 Reset Plan and Quality Priorities and **APPROVED** the 2020/21 Strategic Priorities.

21/05/18 Learning From Deaths Report

Dr Phillips presented the report to the Board for assurance.

Dr Phillips added that the report preceded the COVID-19 emergency which would affect the number of reported deaths in the next quarter's report. The report had been scrutinised by the Quality Committee.
In response to a question from Ms Afuape regarding whether the Trust would be collecting data to understand trends with particular patient profiles, Dr Phillips clarified that the Trust reviewed all deaths in the community hospitals and a sample of deaths in the community. With regards to quantitative date relating to ethnicity, the dataset in Kent and

Medway was too small to be meaningful. Therefore, the Trust linked with Dr Foster for the national picture which as yet had not drawn any conclusions.

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

21/05/19 Freedom To Speak Up (FTSU) Report

Ms Davies presented the report for assurance**.**

Ms Afuape had been appointed as the Freedom To Speak Up non-executive director lead. She had taken the opportunity to meet with the Trust's FTSU Guardian to discuss the forward plan.

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

21/05/20 Emergency Planning and Business Continuity Annual Report

Ms Davies presented the report for assurance noting the extraordinary year and the particular efforts of the Resilience team and the Head of Emergency Planning.

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

21/05/21 Any Other Business

There was no other business to report.

21/05/22 Questions From Members of the Public Relating to the Agenda

In response to a question from Miles Lemon, Public Governor Swale as to whether the staff on the Rough Sleeper project had become aware of an increase in domestic violence due to the COVID-19 lockdown, Dr Spare responded that the Safeguarding Team monitored this across the whole organisation. Although there had been an increase in the sale of alcohol during the period, there had been no significant rise in the reported cases of domestic violence. However, this would continue to be monitored.

In response to a question from Ms Ruth Davies, Public Governor Tonbridge and Malling regarding what mechanisms would be available to staff to contribute to the reset process, Ms Butterworth explained that there would be a number of mechanisms. Each directorate would be involved in identifying what had gone well and locking in those changes. Clinical directors were being tasked to engage with their teams and those people who could support the transformation. Patient experience also had a contribution to make and services would be listening to them to identify and lock in the positive experiences they had had. Key public health specialists would be utilised in resetting services as well. The Q and A function on Flo had also been successful and it was the intention to continue with it to support the reset plan. Ms Norris added that the

Executive Team was considering a repeat of The Big Listen (which had first taken place in June 2018) to capture what had gone well and not so well. Staff experience would feed into the refreshed People Strategy for 2020/21.

In response to a question from Mr Brian Varney, Public Governor Ashford regarding how the A&E departments at the acute hospitals were preparing for a surge in attendance once the pubs opened after lockdown, Mr Bentley confirmed that there was planning in hand across all the trusts in Kent and Medway. The clear message from the government to the public to stay at home had reduced attendance at A&E over the previous weeks. Trusts were working hard to come up with workable arrangements for members of the public to wait to enter A&E departments and urgent care centres as lockdown eased. Managing A&E to ensure they did not become overwhelmed was being looked at across the system as a whole rather than individually by trusts.

Mr Goulston added that the next Council of Governors meeting would take place on 23 July. It was yet to be agreed whether this would be held virtually or physically. Details would appear on the Trust's website nearer the time. In the meantime, there would be a meeting with the governors in the second half of June to discuss the reset plan and the governance arrangements.

On behalf of the Board, Mr Goulston thanked all the staff of the trust for the extraordinary work they had undertaken in the last two months which had shown innovation, resilience and compassion.

The meeting ended at.11.52am.

21/05/23 Date and Venue of the Next Meeting

Thursday 6 August 2020; Virtual meeting via MS Teams Live Event and Rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent TN25 4AZ and Unit G, Hermitage Court, Hermitage Lane, Maidstone, Kent ME16 9NT.

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM BOARD MEETING OF 21 MAY 2020 (PART ONE)

Minute number	Agenda Item	Action	Action Owner	Status
21/05//17	2020/21 Reset Plan including Strategic Priorities and Quality Priorities	To circulate the 2020/21 Reset Plan and Strategic Priorities; and the 2020/21 Quality Priorities to the Council of Governors.	Ms Davies	Action complete.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 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
Not applicable.

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

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

CHIEF EXECUTIVE'S REPORT
August 2020

Since the last time the board met in public (May 2020) the country and the NHS has continued to meet the challenges of responding to the COVID-19 outbreak, whilst this has occupied a significant amount of capacity my report covers the wider scope of issues which the Trust is addressing. Consistent with my previous reports I have detailed the Trusts response in the following categories patients, our people, and partnerships.

Patients

1. COVID-19 update

In March 2020, in response to the first phase of the NHS response to COVID19, KCHFT took the following actions impacting on operational services:

· Risk Stratification of all operational services in to Tier 1 (high priority /urgent care), Tier 2 and 3 (planned services)

· Reduction or re-modelling of all non- urgent services and identification of core workforce requirements to maintain Tier 2 & 3 services at a reduced level

· Identification and redeployment of Tier 2 and 3 staff to support Tier 1

With the exception of School Public Health service; School-aged Immunisations service and elements of Health Improvement service, all Tier 2 and 3 services have maintained either a reduced or full service offer, working in a different way using a 'virtual by default' approach, this is the use of digital technology to maintain service whilst minimising physical interaction with patients. All services have maintained access for new referrals via triage processes to which has also minimised the need for face to face consultations, identify high risk patients and address urgent needs. All services have put in place processes for virtual consultations and follow-up for on-going care needs. Where clinically indicated services have continued to offer face to face home visits and clinic appointments following telephone triage.

A reset working group was established as the Trust moved into phase two of our response to COVID 19 to ensure that the reset of services was and continues to be undertaken in a structured, consistent, phased and safe way. This work continues as

we move into phase three and embed the transformation we have seen during this time. As we reset our staff are returning to their substantive roles and we are capturing the learning from their experiences which will be essential to inform our response to a possible second wave and winter surge.

2. Finance

Since 1st April NHS England/Improvement has put in place different financial arrangements whereby the Trust is paid on a block basis for all NHS contracts based on the December 2019 expenditure position. The Trust submits additional monthly claims for covid19 costs to ensure the Trust can breakeven and these costs are approved by me before submission to NHSEI. The Trust has incurred £1,176k in June on covid19 related expenditure and £3,903k in the year to June, and a further £806k of costs on the hospital discharge programme which have been invoiced directly to Kent & Medway CCG.

This overall system is set to change for the second part of the year. It will continue to be based on block arrangements but giving more local system discretion to distribute the covid19 related funds. It is however a fixed total and therefore will not automatically enable organisations to breakeven although that would be the reasonable expectation in the determination of these fixed amounts. Details of these values are not yet available and the Finance, Investment and Business Committee will scrutinise the details of this new scheme when available, and report to the board accordingly.

Our People

1. Wellbeing of our staff

The health and wellbeing our staff is always important however we gave additional focus during the pandemic to ensure that all team members felt supported during these unprecedented times. Below are some of the services we provided:

- Counselling: This service was already available to staff during normal office hours however during the height of the pandemic we extended the service to 24/7. In addition we were able of offer trauma support services which were provided by colleagues from KMPT.

- Wellbeing apps: A number of companies have provided NHS staff with free access to their wellbeing apps including: unmind and headspace and Catalyst 14 is offering free online mindfulness sessions.

- Guides/advice: this included advice sheets and videos on emotional, physical and mental wellbeing (and a range of links to useful websites), how to deal with isolation, top tips for working from home, self-care, managing anxiety and how to find the right advice about the current situation with tips on dealing with the media coverage.

- Managing relationships at home: we recognised that COVID-19 was placing extraordinary pressure on individuals and families and may be really testing people's relationships and wellbeing; guides were made available to signpost them to a wide range of external organisations who could provide support.

Wobble rooms had been set up in locations where it was physically possible. This is a room to enable staff to take time out and have a 'wobble' moment. Virtual wobble rooms had also been set up for colleagues working virtually.

Support pack were developed for colleagues who were temporarily redeployed and welcome back packs have been developed as colleagues return to their permanent roles.

2. Rio implementation

The roll out of our new Electronic Patient Record system, Rio continues. We had a successful and on plan 'go live' for cohort 2 on the 28th June 2020, this enabled Children's services to join Specialist and elective services in using the new system. Team members are feeding back they were happy with the support from the project team, in particular the floorwalkers, who were on hand every day for the first 3 weeks to guide staff through any issues they encountered. A 'lessons learned' questionnaire had been circulated, early feedback has been positive highlighting the 'user friendliness' of Rio and any areas of improvement will be incorporated into the next Cohorts.

We have revised the plan to complete the installation of the new product and as such we will combine Cohorts 3 & 4 with a 'go live' date of 18th October 2020 for these large cohorts. This includes all our adult services in east and west Kent. The team are focussed on ensuring we have the correct capacity to prepare for Cohorts 3 & 4, particularly in the area of data cleansing and clinical leadership. Additional support is being provided to the clinical operational leads from the project team, the training team and bank staff. All teams will have moved over to Rio in time for this winter bringing considerable benefits to teams. I would like to recognise the hard work and dedication of all involved in this Trust wide transforming programme of work

Partnerships

1. System leadership

As previously reported the Clinical Commissioning Group for Kent and Medway came into being on 1 April. The Group has commenced on the process of appointments to the new roles and this process will continue for some months. I hope that over time the fragmented nature of the relationship with the Group will start to ease as a single NHS body responsible for commissioning takes shape. I do recognize that this change was enacted at the same time as the service reacted to the pandemic placing significant demands on the CCG.

One of the most important relationships the Trust has is with Kent County Council and on 1 April the council appointed Richard Smith as Director for Adult social care, the response of KCC has been crucial during the pandemic and the council is reviewing many elements of how they operate. Pauline Butterworth is leading on a very important joint work program with KCC on hospital discharge.

The last four months have challenged the NHS is a way we have not seen before; the teams in KCHFT continue to respond to those challenges with compassion, integrity and creativity consistent with the values of the Trust. I want to share with the Board how grateful and proud I am of the way the teams have responded.

Paul Bentley
Chief Executive
August 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	6 August 2020
Agenda Item:	1.7
Subject:	East Kent Pre-Consultation Business Case (PCBC)
Presenting Officer:	Paul Bentley, Chief Executive

Action - this paper is for:	Decision	☒	Assurance	☐

Report Summary

In March 2020 the Board supported the submission of the draft pre-consultation business case (PCBC) regarding the reconfiguration of acute hospital services in east Kent.

The document set out the case for more than £400million investment in East Kent Hospitals University NHS Foundation Trust services and described a model of integrated care hospital(s). The integrated care hospital(s) will be a critical element of the east Kent whole system clinical model and include investment in community services.

Following the submission of the draft document to NHSE/I a further iteration is being produced by the Project Management Office in East Kent on behalf of the Kent and Medway Clinical Commissioning Group. This document will require the support of relevant organisations in East Kent before submission.

However, the document is not yet ready and the required timescale mean that approval will be needed prior to the next Board meeting.

Recommendation:

It is therefore proposed that the Board approves the delegation of authority to a number of Board members to review the changes which have been included in the new draft since the Board supported the document. This review and conclusion will be reported to the Board at the next meeting. It is proposed that the authority is delegated to the Chair, Chief Executive, Deputy Chief Executive and Chair of the Finance, Business and Investment Committee.

The Board is asked to approve the recommendation.

Proposals and /or Recommendations:
To approve the delegation of authority
Relevant Legislation and Source Documents:
Draft PCBC
Has an Equality Analysis been completed?

No. High level position described.

Paul Bentley, Chief Executive	Tel: 01622 211900

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	1.8
Agenda Item Title:	Kent Community Health NHS Foundation Trust Board Governance Refresh Report
Presenting Officer:	John Goulston, Trust Chair Paul Bentley, Chief Executive

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

Report Summary

The Board of Directors wishes to take the opportunity to refresh its Board governance arrangements, building on the experience of governance during COVID-19 phase one (Board governance paper approved at the Board meeting on 23 March 2020). The proposals in the paper build on both existing governance arrangements and those put in place to meet the challenges of COVID-19 and explicitly commit the Board to not return as governance in the way it had undertaken it pre COVID-19.

Proposals and /or Recommendations

To approve the proposed governance refresh as detailed in the paper.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

Not applicable.

John Goulston, Trust Chair	Tel: 01622 211903
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Kent Community Health NHS Foundation Trust

KENT COMMUNITY HEALTH NHS FOUNDATION TRUST (KCHFT) BOARD OF DIRECTORS GOVERNANCE REFRESH

Revised draft post 16 July Part 2 meeting – draft 20July 2020

1. Introduction and Purpose

The Board of Directors wishes to take the opportunity to refresh our Board Governance arrangements, building on the experience of Governance during COVID phase 1 (Board Governance paper approved at the Board meeting on 23 March).
The proposals in the paper build on both existing governance arrangements and those put in place to meet the challenges of COVID-19 and explicitly commit the board to not return as governance in the way we had undertaken it pre COVID). The proposals also build on the outputs to date from Board's Development programme.

Given the proposed focus of the Board as detailed in section three of this paper, we have the opportunity to review what work currently going to the Board's Committees can be stopped so that the Committees focus on areas they need to examine to support the delivery of KCHFT's strategy and plans whilst ensuring that the assurance which the board must provide is delivered. In this way, there should not be duplication between the work of the Committees and the work of the Board.

2. Principles underpinning the Governance Refresh;

- It is the role of the executive to formulate Strategic Plans, ensure accountability, shape culture and manage risk in a focused and time efficient manner. The role of the Board of Directors includes
    - approving strategic plans; and
    - assuring that our services and finances comply with the regulatory quality and economic standards

- Ensure Board and Committee papers are focused and appendices are used for reference or for noting without presentation

The Board recognises that how we do things is as important as what we do.

3. Board of Directors

3.1. **Agenda –** the agenda for part one and part two Board meetings should focus through six headings;

1) Strategy – strategic assessment, plan development and delivery of strategic goals and enablers (including business cases for approval which require the support of the board as defined in the standing orders of the Trust).

2) External Influencing (Wider system issues) - ICS, ICPs, PCNs plus national developments together with how KCHFT fits in and /shapes these.

3) Priorities for the year - progress, issues and next steps (the milestones in delivering our strategy.

4) Current Year Performance

   a) Triangulating evidence with Patient and staff experience - including Patient and or Staff story for part one meetings.

   b) Integrated Performance Report (IPR- the Deputy Chief Executive is leading the review of the IPR based on the principles of;
      i) Key performance indicators / data - quality and operational performance, workforce and finance) related directly to the delivery of in year priorities,
      ii) data 'for information' should be provided by way of appendix, and
      iii) extant SPC charts should remain the basis for Performance reporting but with better balance and less duplication between those going to Committee and those to Board.

5) Enablers - people, digital, sustainability and system leadership, these will be reported by the board committees which provide the assurance on each one, with exception reporting undertaken by the Chair of the relevant committee of the board.

6) Governance, Risk Management and Compliance - including the Board Assurance Framework.

3.2 Board Meeting Practices

- The overall thrust is to spend more time on strategic issues and less time on reports and assurance.
- More outward looking through considering the Kent and Medway health economy and national developments.

- Most of the detail stays with the Executive and Board Committees with relevant items coming to board for noting or endorsement where applicable / required. This requires a standardised and consistent approach across the Committees.

3.3. Annual make up of 11 Board of Directors meetings (no meetings in August) as follows;

- Part One meetings - quarterly (up to two hours split broadly 1.0 hours on first three items and 1.0 hours on remaining three items) including approving strategy and plans followed by Part Two - (maximum of 90 mins) Part One meetings times to include IPR for the quarter (e.g. July or Sep Q1, Nov for Q2, Feb for Q3, May Q4,).

- Part Two only Board meetings - three per year (up to three hours) – including refining and delivering strategy and plans; six month review of Board and Committee effectiveness / review of Governance refresh.

- Remuneration Committees where possible will be on the same date as Board meetings.

- Board Development – quarterly focusing on behavioural effectiveness (these can take place on the same day as Board Meetings if appropriate). These will be preceded where required by a part two (one hour) Board meeting.

- NED meetings – up to 60 minutes after the Board meeting but not after Board development sessions (unless required on exception basis).

- Annual NED only meeting – in March or April 2021.

3.4. Board Reports

- All Board reports to be focused, supportive data to be included as appendices for reference only. The Board will have a standard guide to create more uniformity on Board papers.

- Front sheets to be restyled and reduced to three boxes -

    1. What is the purpose of the paper and the ask of the Board (including reference to any prior Board Committee review and recommendations on report / proposals);

    2. Summary of key points

    3. Equality Impact assessment (EIA)

- The front cover should say whether it has been to a Board committee so that if key questions have not been raised at Committee others get a chance to raise issues.
- Re-order papers so the flow improves - relevant Executive reports to appear after NED Chairs' Committee reports under agenda items 4) and 6).
- All Annual Summaries and NHSI compulsory items to be taken through appendices without presentation, where possible, on the basis that Committees have already scrutinised them as part of their Terms of Reference (ToR).
- All items in Part One unless items comply with the legislation for part two items.

4. Board Committees

Given the proposed focus of the Board as detailed in section three of this paper, we will review what work currently going to the Board's Committees and identify what will cease so that the Committees focus on areas they need to examine to support the delivery of KCHFT's strategy and plans. In this way, there should not be duplication between the work of the Committees and the work of the Board.

- The agendas for Board Committees should follow the Board agenda sequence in section 3.1 so that Committees first consider strategic issues within their remit (see below table as agreed at the part two Board meeting on 16 July).

Goal or enabler	Proposed Executive director / lead	Proposed Board / sub-committee reporting
Prevent ill health	Ali Carruth /	Quality
	Mercia Spare	
High quality care	Mercia Spare /	Quality
	Sarah Phillips	
Integrate services	Pauline Butterworth /	Strategic Workforce
	Gerard Sammon	
Sustainable services	Gordon Flack /	Quality
	Louise Norris	

Goal or enabler	Proposed Executive director / lead	Proposed Board / sub-committee reporting
People	Louise Norris /	Strategic workforce
	Pauline Butterworth	
Digital	Sarah Phillips / Gordon Flack	Finance, Business and Investment
System leadership	Executive Team	Trust Board
Environmental sustainability	Natalie Davies / Ali Carruth	TBC

- Consider ways that FBI, ARAC and Charitable Funds could be better aligned and brought closer together.
- After agreement between the committee chair and the lead executive all Committee ToRs to be reviewed for
    - post COVID-19 relevancy,
    - what can be stopped and
    - what is the specific ask by the Board - is it clear and transparent?
- The revised approach agreed above will be reported to and endorsed by the board.

5. Board and Committee Effectiveness - enhancing the individual and collective contribution

Initially there will be a review of Board effectiveness in early 2021/21. This will take into account a review of these revised Board governance arrangements and will reflect on the outcomes from the next phase of the Board's development programme.

Evaluate Committee effectiveness by ensuring each Committee has the right ToRs (see above) and then asking how well are they carried out.

6. Learning from Others

Finally, the Chair and Company Secretary should consult with NHSE&I, CQC and NHS Providers to find out if there are any exemplars in terms of Board governance / Well Led effectiveness and learn from them.

7. Recommendation

The Board is asked to approve the proposed Governance Refresh as detailed above with a review in early 2021/22 given the pace of change of post COVID phase 1 and the evolving health and care system in Kent and Medway.

John Goulston, Chair and Paul Bentley, Chief Executive
27 July 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
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 30 July 2020 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.

Ben Norton, Head of Transformation and Sustainability	Tel: 01233667744
	Email: ben.norton@nhs.net

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 30 July 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 109 – 'Risk that the balance of factors, including safety, operational effectiveness, patient need and engagement, to consider as part of reset may impact our ability to stand up all services'

BAF ID 110 – 'System and partner plans to reset and restart could be insufficient to meet the demand resulting in the system being overwhelmed'

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

BAF ID 105 – 'Challenges in meeting the referral to treatment waiting time target could impact on patient experience and the trust segmentation rating'

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.

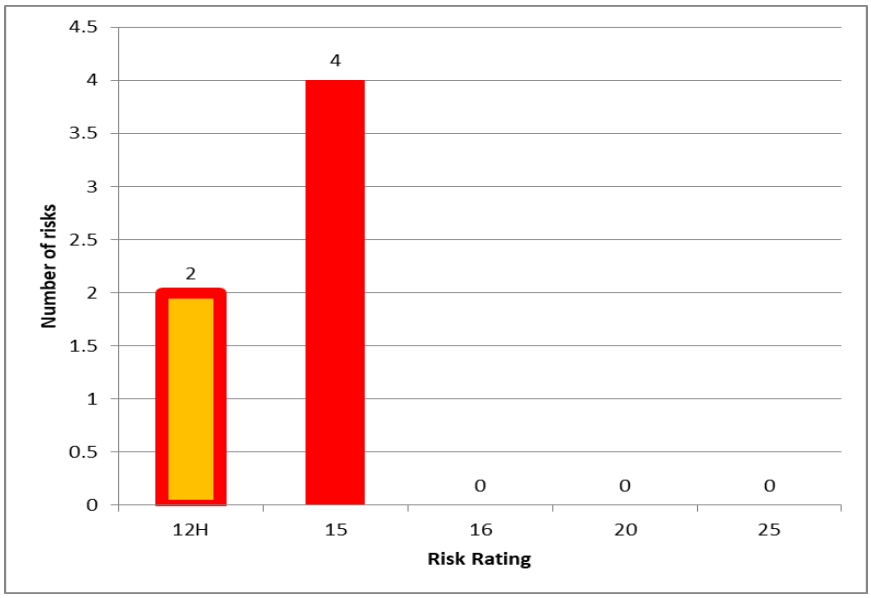
		← *Impact / Severity* →				
		Insignificant	Minor	Moderate	Major	Catastrophic
↓Likelihood ↓		**1**	**2**	**3**	**4**	**5**
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

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

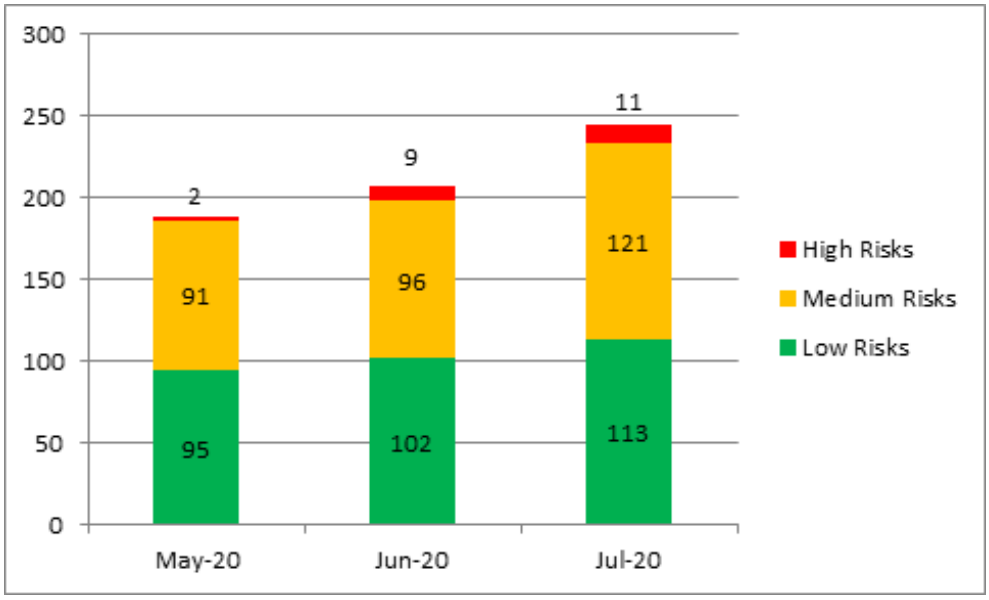
4.1 Figure 2: BAF Risk Profile



5. Risk Overview

5.1 The total number of open risks within the Trust stands at 245 this is comprised of 113 low risks, 121 medium risks and 11 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 Executive Team should review the Board Assurance Framework within Appendix 1 to ensure sufficient mitigating action is in place to address the risks.

Ben Norton
Head of Transformation & Sustainability
30 July 2020

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

Kent Community Health NHS Foundation Trust

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

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

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

Action status key:

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating C	Initial rating L	Initial rating Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	Current rating C	Current rating L	Current rating Rating	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target Date (end)
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; current outbreak and future peaks. Board Committee Lead on Assurance: **The Board**	5	4	20	Organisational priorities reviewed and established Coved 19 Response Plan Incident Control Centre in action SIRO and Deputy SRO appointed Operational Response SRO appointed Incident Team appointed On-call structure reviewed and amended to support current COVID activity 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		5	3	15	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	Medium	**October 2020**
													Continuation of ICC, twice weekly update calls and representation at region	All	July 20	G			
													Escalation of supply shortages as required	Mercia Spare	July 20	G			
													Establish integrated management meeting for twice weekly overview of COVID and seasonal surge including delegated authority	Pauline Butterworth	August 20	G			
													Extension of IPC and PPE teams	Mercia Spare	October 20	A			
108	Mar 2020	Paul Bentley	Risk that the extended and on-going response to COVID including isolation, test and trace and morale could result in increased stress levels and reduced productivity and morale that may impact our ability to deliver services. Board Committee Lead on Assurance **The Board**	5	4	20	COVID 19 Response Plan SIRO and Deputy SRO appointed Operational Response SRO appointed Incident Team appointed 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		5	3	15	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	Medium	**October 2020**
													Staff welfare package: continued co-ordination and expanded	Louise Norris	September 20	A			
													Executive blog / message	Paul Bentley	August 20	G			
													All executive Director Question and Answer	All Execs	August 20	G			
													Big Listen 2 - Results analysed and action planned	All Execs	September 20	A			
109	Aug 2020	Paul Bentley	Risk that the balance of factors, including safety, operational effectiveness, patient need and engagement, to consider as part of reset may impact our ability to stand up all services. Board Committee Lead on Assurance: **The Board**	5	3	15	Organisational priorities reviewed and established Return to buildings and working from home ToR established 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 Cross directorate working and membership	Internal and External Reporting Executive sit-reporting daily Department of Health Response confirmation Operational KPIs LRF area ratings nationwide and local		5	3	15	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	Medium	**October 2020**
													Stablemen of reset group and associated work streams, linked to IMM	Pauline Butterworth	August 20	G			
													Return to buildings and working from home weekly assurance and escalation report to rest group	Mercia Spare	August 20	G			
													Data reset dashboard to be finalised	Pauline Butterworth	September 20	A			
													Data reset to be reviewed weekly	Pauline Butterworth	September 20	A			
110	Jul 2020	Pauline Butterworth	System and partner plans to reset and restart could be insufficient to meet the demand resulting in the system being overwhelmed Board Committee Lead on Assurance: **Quality Committee**	5	3	15	System led COVID response and recovery plans SIRO and Deputy SRO appointed Operational Response SRO appointed Integrated management team meeting introduced Daily Sit rep reporting - Locally and Nationally Operational risk and controls logs Membership of LHRP Kent and Medway COVID plan	System response through LHRP/NHSE Internal and external reporting LRF area ratings	• Plan for discharges to nursing and homes not fully articulated • Backlog of 1600 CHC assessment to be completed by system	5	3	15	**Individual Actions**	**Owner**	**Target Completion** (end)	**Status**	Pauline Butterworth	Medium	**October 2020**
													ICS/CCG Governance structure proposal	Paul Bentley	October 20	A			
													Development of the East Kent discharge model with KCC	Pauline Butterworth	October 20	A			
													Development of ICP boards and its impact	Paul Bentley	October 20	A			
													Continuation of influence and negotiation at system meetings	All Execs	September 20	A			
													West Kent frailty model options paper agreed	Sarah Philips	September 20				
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 risk is achieving this before the CIS contract end November 2020 and before winter pressures adversely impact the adults teams.	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	• 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	Data Archive Strategy - Cohort 1 live (CYP)	Sarah Phillips	February 20	G	Gordon Flack	High	tember 2020
													Data Archive Strategy - Cohort 2 live (SES)	Sarah Phillips	June 20	G			

				Initial rating							Current rating								
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Positive Assurances	Gaps in control or Negative Assurance	C	L	Rating	Planned Actions and Milestones				Action owner	Confidence Assessment	Target Date (end)
			Board Committee Lead on Assurance: **Finance, Business and Investment Committee**				• Phase implementation plan and resourcing appropriately • Communication plans developed with stakeholders Inc. commissioners. • Operational risk and mitigations log						Data Archive Strategy - Cohorts 3 & 4 (Adults) - merger of the last two go live dates to maximise learning and ensure implementation prior to winter	Sarah Phillips	October 20	G			**Sep**
													Resource assessment on-going as part of the project governance structure.	Sarah Phillips	September 20	A			
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**	**Owner**	**Target Completion** (end)	**Status**	Paul Bentley	Low	**July 2021**
													Joint Board and Management Committee meeting to agree forward plan.	Paul Bentley	October 20	A			
													Continue to influence at STP level	Paul Bentley	March 21	A			
													Programme to manage the transition of PCNs into the new system architecture	Gerard Sammon	March 21	A			

Kent Community Health NHS
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.2
Agenda Item Title:	Infection Prevention and Control - Board Assurance Framework – COVID-19
Presenting Officer:	Dr Mercia Spare, Chief Nurse and Director of Infection Prevention and Control (DIPC)

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

Report Summary
The is the NHSI/E IP and C Board Assurance Framework for COVID-19, demonstrating compliance to The Hygiene Code, with specific reference to new recommendations for preventing the spread of COVID-19. Where gaps in assurance are highlighted, mitigations are documented.

Proposals and /or Recommendations
Report for assurance

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

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

Kent Community Health NHS
NHS Foundation Trust

NHSI/E Board Assurance Framework for COVID-19

Kent Community Health NHS Foundation Trust

July 2020

Compliance with the Health and Social Care Act (2008) Code of practice on the prevention and control of infections and related guidance is routinely collected and monitored via HealthAssure and reported to the IP&C committee, Quality Committee and to the Board.

1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • infection risk is assessed at the front door and this is documented in patient notes • patients with possible or confirmed COVID-19 are not moved unless this is appropriate for their care or reduces the risk of transmission • compliance with the PHE national guidance around discharge or transfer of COVID-19 positive patient • patients and staff are protected with PPE, as per the PHE national guidance • national IPC PHE guidance is regularly checked for updates	• Screening assessment in place at all entry points to our services • Patient risk is established as part of clinical assessment • Only patients requiring transfer for deteriorating health or essential care are transported from community hospitals • Standardised discharge letter incorporating date of positive swab, and advice for 14-day isolation, information for patients and household members circulated and available on trust intranet (flo) • RNA PCR testing in place as per PHE guidance, and	• As per Community SOP – 'hot and cold' clinics in place where required, in outpatient departments, assessments undertaken and zoning in place.	• Community SOP reviewed. • Dental services have a hot and cold model in place. • Zoning used in MIU and OPDs Podiatric surgery has a green pathway in place for elective surgery

and any changes are effectively communicated to staff in a timely way • changes to PHE guidance are brought to the attention of boards and any risks and mitigating actions are highlighted • risks are reflected in risk registers and the Board Assurance Framework where appropriate • robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens	changed in accordance with updated guidance • PPE provided as per PHE guidance. Fit testing in place for all staff undertaking or working in areas where APGs are performed. • All guidance reviewed daily, discussed at incident management team meeting (IMT). Changes implemented through internal cascade system, as well as on internal intranet. • All changes communicated and supported with updated guidance within 24 hours of publication.		

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • teams with appropriate training care for and treat patients in COVID-19 isolation or cohort areas	• E-learning updated to incorporate COVID-19 information, donning and doffing, viral swabbing, and face to face fit test training		• Staff wear PPE and treat all patients and clinical areas as assumed to be COVID-19 positive, therefore enhanced cleaning in place throughout.

• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas. • Decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE national guidance • increased frequency of cleaning in areas that have higher environmental contamination rates as set out in the PHE national guidance • linen from possible and confirmed COVID-19 patients is managed in line with PHE • national guidance and the appropriate precautions are taken • single use items are used where possible and according to Single Use Policy	including AGP PPE donning and doffing • Domestic staff have received training, and where appropriate have been fit tested also. Insufficient staff to allocate to cohort and non-cohort. • All linen is segregated as per guidance. • Local SOPs written and circulated for decontamination and re-use of eye protection where required, clear guidance on all other PPE being single use / sessional use • Environmental decontamination is carried out in line with PHE guidance and National standards of cleanliness. • Single use items are used in line with requirements. Discussion has taken place with relevant services relating to decontamination and use		• Cohort area clearly defined to ensure staff are aware of COVID-19 positive, step-down positive and negative patients are located.

• reusable equipment is appropriately decontaminated in line with local and PHE • national policy	of specialist consumables where relevant i.e. dental services and respiratory services.		
3. Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and process are in place to ensure: • arrangements around antimicrobial stewardship are maintained • mandatory reporting requirements are adhered to and boards continue to maintain oversight	• IPCAS has continued throughout the pandemic (virtually). Antimicrobials reviewed in light of current guidance, and first line treatments changed to doxycycline – monitoring in place on compliance. • Medicines optimisation committee has continued to meet during COVID-19 and assurance reported to the quality committee.		
4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:	• Visiting restriction implemented as per guidance		

• implementation of national guidance on visiting patients in a care setting areas in which suspected or confirmed COVID-19 patients are where possible being treated in areas marked with appropriate signage and where appropriate with restricted access • information and guidance on COVID-19 is available on all Trust websites with easy read versions • infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved	and local determination on resuming visiting has been addressed through a series of principles for local managers to apply to ensure safety of visitors is paramount. • All patients in inpatient units cohorted or in siderooms as per IPC guidance. In non-inpatient areas, specific rooms / streaming in place for segregation of potential 'hot and cold' sites • Available on Internet and Intranet – easy read version in development. • Electronic discharge note clearly identifies COVID status, date of swab and date of the end of isolation.		
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:	• As per Community SOP – 'hot and cold' clinics in place where required, in outpatient		

• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms to minimise the risk of cross-infection • patients with suspected COVID-19 are tested promptly • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately	departments/MIU/UTC's, assessments undertaken and zoning in place • All new patients swabbed on admission; day 5-7, if they develop symptoms and on discharge if going to care home / another care facility. This is all clearly identified in a swabbing flow chart. • Screening questions are asked at all entry ports and patients, clients, service users managed accordingly.		
6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure: • all staff (clinical and non-clinical) have appropriate training, in line with latest PHE	• E-learning updated to incorporate COVID-19 information, donning and doffing, viral swabbing, and face to face fit test training including AGP related PPE		

guidance, to ensure their personal safety and working environment is safe • all staff providing patient care are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it • a record of staff training is maintained • appropriate arrangements are in place that any reuse of PPE in line with the CAS alert is properly monitored and managed • any incidents relating to the re-use of PPE are monitored and appropriate action taken • adherence to PHE national guidance on the use of PPE is regularly audited • staff regularly undertake hand hygiene and observe standard infection control precautions • staff understand the	donning and doffing • Education and Workforce Department (EWD) hold and maintain records for staff training including Fit testing • PPE reuse SOP in place to enact if global supply shortage. This is supported by a set of principles for assessing the need to reuse. Supported by ethical committee and Board. To date this has not been enacted. • SOP for re-use of eye protection in place and enacted. • IPC team are 90% outward facing with operational staff to support compliance with PPE guidance, hand hygiene and IP&C policies and procedures. • All COVID related incidents recorded on DATIX, investigated and reported daily to IMT and via Patient Safety Clinical Risk Group to		

requirements for uniform laundering where this is not provided for on site • all staff understand the symptoms of COVID-19 and take appropriate action in line with PHE national guidance if • they or a member of their household display any of the symptoms.	Quality Committee. • IPC team visit regularly and monthly local audits • Laundering guidance provided through Intranet and executive Q&A via trust intranet. • All guidance on Intranet, and enforced by managers. • IP&C and HR manage advice and support for staff presenting with symptoms. This is reinforced through communications on trust intranet. • Staff impacted with COVID-19 or by family members is collected via e-roster and monitored via internal sitrep daily at IMT.		
7. Provide or secure adequate isolation facilities			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure:			

• patients with suspected or confirmed COVID-19 are where possible isolated in appropriate facilities or designated areas where appropriate • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring appropriate patient placement	• All patients are managed by COVID-19 status in isolation or cohorts. This is supported by Cohort and isolation flowcharts, outbreak and isolation policy. • Trust COVID-19 escalation framework in place to support RAG rating of risk relating to safe patient management. This is monitored via IMT.		
8. Secure adequate access to laboratory support as appropriate			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
There are systems and processes in place to ensure: • testing is undertaken by competent and trained individuals • patient and staff COVID-19	• Staff trained on how to screen for COVID-19 • Screening flowcharts in place to support staff • All other screening and testing has continued, and	• There has been limited capacity currently to routinely screen for all infections relating to community services as	• Clinical review of patients/clients and treatment provided as per guidelines. Supportive other diagnostic tests can be undertaken to help identify infection, and treat

testing is undertaken promptly and in line with PHE national guidance • screening for other potential infections takes place	audited.	laboratory capacity has been focused on COVID-19. This includes other respiratory viruses and some sexual health related infections, this is currently resolving	accordingly.
9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Systems and processes are in place to ensure that: • staff are supported in adhering to all IPC policies, including those for other alert organisms • any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff • all clinical waste related to confirmed or suspected COVID-19 cases is handled,	• Trust intranet and internal communication flows have been increased to daily bulletins during the pandemic, there has been a live executive Q&A predominantly manned by the Chief Nurse, Medical Director and Director of HR. This has included all executives recording videos on a variety of topics to support staff well-being and safety. • Changes in guidance have been communicated to staff		

stored and managed in accordance with current PHE national guidance • PPE stock is appropriately stored and accessible to staff who require it	within 24 hours and supported by update guidance and resources. • Staff provided with training and resources as required or stipulated in the guidance • All waste streams appropriate as stipulated by PHE and this is audited. • Central ordering and oversight of stock reported daily to IMT. Monitored as part of daily sitrep		
10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection			
Key lines of enquiry	**Evidence**	**Gaps in Assurance**	**Mitigating Actions**
Appropriate systems and processes are in place to ensure: • Staff in at risk groups are identified and managed appropriately including ensuring their physical and psychological wellbeing is supported	• All risk assessments undertaken for staff with known underlying health conditions and those who identify as BAME. National risk assessment used to support this. All bank staff included and agencies contacted for assurance that		

• staff required to wear FFP reusable respirators undergo training that is compliant with PHE national guidance and record of this training is maintained. • staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing • staff that test positive have adequate information and support to aid their recovery and return to work.	their workers have been risk assessed. Actions taken on results of risk assessments, reported to Board. • The trust has embraced and implemented the national resources to support staff health and wellbeing. This is led through HR. • • Fit testing undertaken for all staff that undertaking AGP's and recorded via EWD • IP&C and HR manage advice and support for staff presenting with symptoms. This is reinforced through communications on trust intranet. • Staff impacted with COVID-19 or by family members is collected via e-roster and monitored via internal sitrep daily at IMT. • Staff are fully supported from presentation of symptoms, testing, self-isolation and on return to duty.		

Kent Community Health NHS
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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.3
Agenda Item Title:	Charitable Funds Committee Chair's Assurance Report
Presenting Officer:	Prof. Francis Drobniewski, Chair of Charitable Funds Committee

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

Report Summary
The paper summarises the Charitable Funds Committee meeting held on 8 July 2020.

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

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

Prof. Francis Drobniewski , Non-Executive Director	Tel: 01622 211906
	Email:

Kent Community Health NHS Foundation Trust

CHARITABLE FUNDS COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Charitable Funds Committee meeting held on 8 July 2020.

Agenda item	Assurance and Key points to note	Further actions and follow up
Minutes and matters arising from the meeting of 17 January 2020	Minutes agreed subject to minor corrections re page three obtaining three pre-budget quotes re Heron ward work. Matters arising table agreed with proposed closure confirmed for all but two items - residual Sensory Room appeal fund. Non-Executive Director (NED) composition of Committee confirmed with Chief Nurse taking on Executive responsibility (although Mr Flack would continue to attend).	Assistant Financial Accountant confirmed bid to buy additional toys were on order leaving approx. £1.5k in fund. She would additional toys/equipment could be purchased by them to close out the fund.
Relevant feedback from other committees	The Committee noted the Board Assurance Framework (BAF). National NHS Charity funds needed to be considered within the overall COVID-19 BAF but not considered to need specific risk rating.	
2019/20 Annual accounts statement	Report presented for assurance by the Assistant Financial Accountant. Income increased over 2019/20 across all funds (£172k) mainly from donations (£28K-largely due to transfer to Kent Community Health NHS Foundation Trust (KCHFT) of two unrestricted funds, £15k from HIV Medway	Agreed to continue strategy of keeping open unrestricted funds with different initiatives to maximise income to them via targeted action e.g. marketing communications to highlight and support key funds at different times of the year.

Agenda item	Assurance and Key points to note	Further actions and follow up
	and £9k from Kent County Council (KCC) for the Benenden East Unit at West View, bank interest (£4k) and legacy (£140k) to Tonbridge Cottage Hospital. Income in 2020/21 likely to be increased due to NHS COVID-19 related donations. As expected spending from unrestricted funds occurring appropriately but no expenditure on some restricted funds and difficulty with others.	Restricted funds aim to spend as quickly as possible in line with wishes of donor (see later regarding key specific funds).
2020/21 Quarter One Finance Update	Presented by the Assistant Financial Accountant. Noted that some funds were small but agreed that we would endeavour to rapidly spend and close restricted funds. Wide variation in amounts in community hospital restricted funds e.g. Tonbridge, Faversham, Deal large sums, others such as Sevenoaks tiny.	First time presentation of quarterly reports Agreed very helpful in monitoring income and spend with more agility and would continue. Make known as widely as possible that some funds are available for bids e.g. HIV fund.
Tonbridge Cottage Hospital (TCH) Legacy	The fund manager was not able to attend in person but a detailed paper was submitted. Discussion regarding careful expenditure so as not to incur tax liability. Also that TCH legacy was not to be spent on what should be provided by NHS directly e.g. all repairs. Refurbishment following on from water leak.	Agreement that combined therapy/dementia garden was appropriate spend (£30k approx.) and that it should proceed as quickly as practicable (by mid-August in any case when refurbishment of TCH was complete). Other possible spends deferred to November meeting.
Mermikides Fund Update	The fund manager presented an update. Report confirms earlier accounts that limited spend from fund on Heron Ward upgrade-due to loss of project manager, NHS Property Services backlog, then COVID-19 situation; Also potential change to allocation of works; the League of Friends had originally planned to provide a sensory garden but now	Current work specification, tender drawings and pre-tender costings for Heron Ward refit to be done now and followed with full tender process commencing December 2020 with commissioning of works in April 2021. KCHFT would fund a sensory garden and external doors

Agenda item	Assurance and Key points to note	Further actions and follow up
	preferred to pay for replacement of external door sets (£109k).	initially and engage with the League of Friends to see what they would wish to fund and adjust accordingly. The fund manager to discuss with commissioners/ East Kent Hospitals University NHS Foundation Trust (EKHUFT) Heron Ward temporary closure for six weeks of works and management strategy.
Charitable Funds Marketing Report: Annual marketing objectives and plan; Annual marketing review	Report received. Discussion around what could be done to assist regarding current COVID-19 situation.	Plans to launch community gardens campaign, promote COVID-19 funding for spending on staff health and welfare, promote legacy giving by producing new materials and ongoing advertising in Community Health magazine focusing on funds to give specific exposure; more promotion of success stories on flo/team briefs. Encourage fund managers to consider how funds might be deployed through discussion with relevant staff groups. Aim for funds to support supporting equitable access to Trust services (particularly as we embrace digital transformation).
NHS Charities Together	Three COVID-19 related blocks: (1)KCHFT donations and Community Heroes – KCHFT Just Giving page (2) NHS One Million Claps appeal (£2.8k KCHFT share (3) NHS Charities Together- First tranche of national funds received (£35,000).	Staff asked opinion regarding expenditure and top three suggestions selected by Executive (mindful to avoid tax issues).Whole list to come to Committee. Seek clarity on how second tranche is to be

Agenda item	Assurance and Key points to note	Further actions and follow up
		distributed – seems by bidding process.
eTapestry Essential business proposal	Maidstone and Tunbridge Wells NHS Trust (MTW) campaigns co-ordinator approached KCHFT to join in purchase of software to hold contacts of donors, issue thank you communications, solicit donations. Cost linked to number of members (entries) onto database. Upfront year one costs and then annual costs to retain cloud-based database.	Limited time for discussion but the Head of Campaigns and Digital requested to discuss with colleagues pros and cons of this database e.g. initial data entry. Potential role for Foundation members/governors to support creation of database and promote charitable giving. Paper regarding pros/cons and decision at November meeting.
Forward Plan	Standard items for November and agreed that the Committee effectiveness would be in November now as forms were not sent out due to current demands on the executive. Also for November: Charity reports and accounts, quarterly statement funds and accounts, charitable funds marketing report, fund manager presentations, annual financial statement and reserves policy, Tonbridge Cottage hospital legacy. Forward plan approved.	Forms to be sent out with time for response to be presented in November. Agreed to try and align with the Finance, Business and Investment (FBI) Committee meeting in November (or other meeting).
Next meeting	Friday 27 November 2020	

Prof. Francis Drobniewski
Chair, Charitable Funds Committee
10 July 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.4
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Pippa Barber, Chair of Quality Committee

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

Report Summary
The paper summarises the Quality Committee (Part One) meeting held on 21 July 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 Part One meeting held on 21 July 2020.

Agenda item	Assurance and key points to note	Further actions and follow up
Quality Account 2019/20	Following amendments to National Regulations, the 2019 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 that the Trust is able to record and recognise the significant hard work that has been undertaken during the year in which the Trust was rated Outstanding by the Care Quality Commission. The Quality Priorities for 2020/21 build on the work achieved during 2019/20 and enable areas that require ongoing focus and work to be carried out .Importantly the strategy underpinning all of the work will include quality improvement methodologies.	The Quality Committee recommends approval of the Quality Account by the Board. An update on progress with 2020/21 priorities will be considered by the Quality Committee in November.

Agenda item	Assurance and key points to note	Further actions and follow up
Board Assurance Framework (BAF) General	Discussion took place on the increasing number of online consultations now taking place as part of our offer and if this was a risk that should currently be on the BAF.	
	Assurance was received that work is underway reviewing this service by service and a digital task and finish group is in place reviewing the digital intervention during the COVID-19 period and going forward. Evaluation metrics are being developed and there is work in place to look at the impact of digital poverty on the offer being provided.	Assurance was sought that where services were considering this it is on their risk registers if needed.
	The Committee recognised this was work in progress. It was an area that would need to be considered by the digital work stream for our strategy going forward and as part of that work identify any risks including if there was a BAF risk.	An area for further consideration by Finance Business and investment Committee as part of our Digital Strategy going forward.
BAF (Infection Prevention and Control (COVID-19)	The Committee received and considered the Infection Prevention and Control COVID-19 BAF. This is a national tool enabling all organisations to consider risks and mitigations in place for this critical area.	
	Assurance was received on areas contained within the report with further discussion on the mitigations in place. The BAF was noted subject to some specific comments	The updated version will be submitted to the August Part One Board meeting

Agenda item	Assurance and key points to note	Further actions and follow up
	(type of testing, updates on wider testing capacity for all infections, and staff testing of vulnerable groups).	
Quality Report	Discussion and assurance sought on avoidable medication incidents. Work on this is ongoing. It was suggested and agreed a deep dive would be undertaken and reported back to the Committee to ensure we were identifying all of the learning on reducing incidents. Pressure Ulcer action plan is in place .This has and remains a focus for the Trust There are a number of actions outstanding from the Trust wide action plan and this is now a focus for the teams. End of life care has been a significant part of the care provided by some teams over the previous months .Good systems and support were put in place early on to support patients and staff.	Pharmacy deep dive to be undertaken and reported back to the September Quality Committee For assurance to be received on organisational learning and actions on the last open actions. To be updated to the Committee in September. Further assurance is being sought on completion of Trust data into the National Audit of Care at the End of Life (NACEL).
Quality Impact Assessments	An update paper was provided, Detail on achievement of schemes will be overseen by the Finance, Business and Investment Committee (FBI). The non-executive director (NED) deep dives into quality impact assessments (QIAs) were reviewed with timescales, (which may be pushed back) due to the impact of COVID-19.	

Agenda item	Assurance and key points to note	Further actions and follow up
We Care Reviews during COVID-19	These visits have been suspended during the COVID-19 incident. The Committee considered and approved a proposal for restarting these with a revised COVID-19 appropriate approach from September.	
Infection Prevention and Control (IPC) Annual Report	The Committee received the annual report and noted the significant work that has been undertaken both before and during the COVID-19 pandemic. Significant progress has been made during the year. Highlights included; • No cases of MRSA bacteraemia attributable to Kent Community Health NHS Foundation Trust (KCHFT) this year .No cases of acquisition of MRSA in our hospitals and 100% of podiatric surgery patients and 97% of in patients were screened according to the policy. • During 2019/20 there was a 17% reduction in rates per occupied bed days of UTIs and a 31% reduction in rates per occupied bed days of CAUTIs compared to the previous years. • 60% of patient-facing staff received their flu vaccine, a good improvement on previous years. The Committee acknowledged this and also recognised that there was further improvement that needed to be achieved when bench marking with	Assurance on the staff flu plan will be given to either the Strategic Workforce Committee or the Quality Committee in September.

Agenda item	Assurance and key points to note	Further actions and follow up
	some other organisations. • The annual IPC audit of inpatient departments provided significant assurance of compliance with the Hygiene Code. The Committee thanked the teams for their hard work and excellent leadership across the year and particularly over the last few months.	
Clinical Effectiveness Group Chair's Assurance Report	The Committee received and noted the work of the group. This included an update on the significant work that has been put in place to continue to support End of life Care.	Further assurance was sought and a request for a more detailed update next time on the re start of the Quality Improvement training/approach to support the restart work.
Learning From Deaths Report	The Committee discussed the report. Assurance was sought on the process of mortality reviews by newer NEDs, assurance was given. The impact of COVID-19 on the numbers of deaths was noted as was the fact that all reviews were still being undertaken, although in a revised approach. Assurance was also sought on shared learning with system partners as part of the review. Good practice that has been identified and shared was noted. The recruitment of an end of life care (EOLC) Nurse consultant was seen as a positive measure to support implementation of EOLC best practice.	Further assurance will be provided to the September Committee meeting on the implementation of personalised care plans with the introduction of Rio to adult services. This and EOLC documentation more widely remains the biggest ongoing area of learning internally for the Trust.

Agenda item	Assurance and key points to note	Further actions and follow up
Falls Reduction Report	This was considered by the Committee .Assurance given on the Falls Strategy in place and the refocus on falls coordinators to support this work .Assurance was also given on the strategies being put in place in inpatient units, and with patient transfers, to support vulnerable pts with the increased time taken by staff to 'don and doff' personal protective equipment (PPE).	
Annual reports	The following annual reports were received and noted by the Committee ; • Safeguarding Annual report and declaration: The Committee noted the significant work undertaken in the year and thanked the team for their leadership of the Trust in this important area. The Committee noted the Annual Safeguarding Declaration. • Patient Experience Annual Report and Patient Experience during COVID -19:The Committee noted the very positive changes that had been made to the patient experience during this time with the use of technology where appropriate in receiving feedback on our services and in helping our inpatients keep connected to loved ones. • Complaints Annual Report • Medicines Optimisation Annual Report • Clinical Audit Programme and Annual Report	

Agenda item	Assurance and key points to note	Further actions and follow up
	• All of the reports had excellent examples of Quality Improvement (QI) methodologies being used to learn and improve.	
Implications for back log following restart of services	A verbal update was given on the process being undertaken to review assessments and interventions on a pathway. A task and finish group is in place .Each service is considering this as part of its restart work referral to treatment (RTT) and audiology are achieving targets. Where services do have a back log as a result of COVID-19, trajectories and recovery plans will be put in place.	The process for under taking harm reviews as part of reviewing any service backlogs will be finalised by the Chief Nurse and circulated to the Committee.

Pippa Barber
Chair, Quality Committee
Date July 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.5
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 27 July 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 27 July 2020.

Agenda item	Assurance and Key points to note	Further actions and follow up
Workforce Report Board Assurance Framework (BAF) Risk 73	Pleasing set of June data despite challenges of COVID-19. 13/18 metrics stable, Turnover the lowest for two years at 13.9%Virtual interviewing was working well and well as digital induction. BAF remains at 12 with mitigations being addressed albeit the development work on People Strategy was parked during COVID-19. Big Listen had an amazing 22.5% participation rate. Key positives during COVID-19 being communication and staff wellbeing, including virtual 'wobble rooms'. Issues for learning and lessons include the trauma caused to some with redeployment.	
Operational Workforce Report	Albeit vacancy levels are down, there are pockets of concern in West Kent where staff have many more opportunities open to them including London; and in Thanet where we struggle to find the skills we need. Some areas have suffered greater pressure than others during COVID-19 i.e. Long Term Conditions with pathway organisations not being as visible or present.	The Director of Workforce, Organisational Development and Communications and the Chief Operating Officer to explore how best to bring assurance to the Committee on 'Integrate Services' to demonstrate progress, and

Agenda item	Assurance and Key points to note	Further actions and follow up
	Visits and support are being put into place to mitigate this stress. Lessons have been learnt with business continuity, highlighting the need to respond quicker, lessons will be used with winter pressures. Recovery planning is well underway to tackle the backlog that exists and prioritise attention to those most in need especially podiatric surgery and new-born visits. New ways of working are being explored as part of each service resetting.	highlight issues that need resolving to make progress and achieve our strategic goals.
Equality and Diversity Intent	Good response to recruitment of workforce Equality, Diversity, and Inclusion (ED&I) member of staff. Equality, Diversity and Inclusion Strategic Intent document describing the ongoing effort to raise the profile of these important issues. A baseline assessment will be one of the first tasks undertaken to collect qualitative data to enhance our energy in key areas, as well as the Board role modelling this by addressing the issue at Board development.	Encourage ED&I philosophy to become everyone's responsibility.
Significant Employee Relations Report	There are no staff currently suspended. Since the beginning of 2019 to date the Trust has successfully defended all four of the tribunal cases. 'Just and Learning' culture has been embedded which supports a case conference approach involving more parties earlier, speeding up decisions and improving communication.	
Workforce Race Equality Standards and Workforce Disability Equality Standards	Objective and thorough report which describes some progress but not as much as we would have liked given attention to support recent initiatives. Comparison with other Trusts is positive. Our base line work will give us rich data to support this report from which we	

Agenda item	Assurance and Key points to note	Further actions and follow up
	can prioritise the most urgent actions.	
Leadership, Talent and Succession Planning	Education and Workforce Development has redeveloped leadership and management training to be delivered virtually. Leadership Circles developed nationally through COVID-19 will continue. The Leadership Academy sets out on Flo areas of development and specific training opportunities. Career conversations have been encouraged as part of the appraisal process. Mapping key data from appraisal conversations is underway.	Map key people to roles for succession planning by summer 2021 and use data and learning for ED&I work.
Transformation of Workforce Quality Improvement (QI) (self-directed teams, digital, APR)	Self-directed teams were paused during COVID-19, being relaunched with teams being empowered with managers coaching rather than managing. Some issues around purity of model due to commissioning of Care Staff. A road map for widening this way of working is being explored. Advanced Clinical Practitioners (ACP) - good progress – five new recruits, eight more planned for 2021. Digital – significant online e learning has been rolled out. Teams deployed to support home working and virtual patient clinics. Robotic process automation is being restarted in Human Resources (HR), and DocuSign being procured to enable documents to be signed.	Reconsideration of the Trust wide Digital Strategy to include technical skill development and how to handle potential emotional stress arising from working practices that result from home working or running of virtual clinics.

Bridget Skelton
Chair, Strategic Workforce Committee
27 July 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.6
Agenda Item Title:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance 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.

This report contains the following sections:

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

Historic data has been provided to show trends, with the SPC charts being used to show a rolling 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 10 KPIs moving favourable in month and 7 moving unfavourably whilst 20 are in normal variation.

There are 3 KPIs consistently failing target (target outside of control limits) which are:

- KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%. Currently at 14.6% against 0% target, now in normal variation.
- KPI 5.3 Turnover (planned and unplanned) at 13.19% against revised 20-21 14.47% target. Moving favourably below the lower control limit and below the target

- KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more) moving favourably at 87.4% but 87% target is still marginally above the upper control limit.(86%)

Of the 7 indicators not measured by SPC charts, 6 (85.7%) are achieving target

Quality

- Four lapses in care were identified within the trust acquired incidents during April and May 2020.
- During April and May 2020, 162 falls were reported across the trust. This is an increase compared with 150 falls reported in February and March 2020. Of the 162 falls, five were considered avoidable of which two resulted in a fractured neck of femur and were declared as serious incidents (including the aforementioned COVID-19 related incident).
- At the time of writing this report, a total of 193 COVID-19 related incidents had been reported. Of the 193 incidents reported, 19 happened in our care and were considered avoidable following investigation; 17 no harm incidents; one low harm incident and one severe harm to the patient.

Workforce

- 100% of the identified BAME risk assessments have been completed to date
- Turnover in June 2020 continues on a downward trajectory to 13.19%, a 1.19% decrease from May 2020 (14.38%). With this performance, turnover rates remain below average and below the new target of 14.47%. This is the metric's lowest level across the reporting period
- Since the last reporting period we have experienced the highest sickness absence rate the organisation has reported in the last 24 months. In April 2020 the sickness absence rate peaked to 5.14%. June 2020 has however returned to below the target and below the mean to 3.32%. The sharp spike was COVID-19 related. 73 employees were recorded as sick in June due to exhibiting COVID-19 symptoms, this accounts for 11.7% of the total number of staff (626) off sick in the month.
- The Vacancy Rate has been on a continual downward trajectory below the mean since September 2019. In June 2020 the Vacancy rate is at its lowest for the reporting period of 24 months at 3.6%. This is a decrease of 2.48% since the last reporting period in March 2020.

Finance

- The Trust achieved a break even position in the month, including £747k top up funding. The plan was a surplus of £12k and so there is an adverse variance against the plan of £12k. The cumulative position is break even, including £3,381k year to date top up funding. Cumulatively pay and non-pay have overspent by £266k and £1,468k respectively. Depreciation/interest has underspent by £75k and income has over-recovered by £1,621k.
- £1,027k of CIP savings has been achieved to the end of June meeting the YTD target in full. The cumulative position includes £365k of travel savings which have been recognised non-recurrently while the Trust works through

reset plans.

- Capital spend to June was £1,119k, against a YTD plan of £1,702k (66% achieved). The YTD spend includes £72k relating to a Capital COVID-19 claim which has received regional approval and awaits national approval. The full year forecast is £7,956k and the Trust expects to utilise this in full. The full year forecast includes a further £198k Capital COVID-19 claim, which has again received regional approval and awaits national approval. It is therefore expected that the Trust will receive £270k of PDC funding relating to the Capital COVID-19 claims submitted. Since June reporting closed the Trust has been made aware of additional funding being made available to the Kent and Medway system and the Trust will receive an additional £900k.

Operations

- Health Checks has dropped to 0 for Months 1-3 due to the service being paused as a result of the COVID-19 pandemic. 85% of activity is delivered via Primary Care and 15% KCHFT core delivery. Primary Care could not deliver NHS Health Checks because of other critical clinical care.
- COVID-19 hit referrals to the Stop Smoking service which reduced significantly. The major challenge is that 60% of clients are usually seen via community pharmacy and general practice. Additional capacity has been sought and reallocation of roles explored but this will need to be increased.
- New birth visits - Issues relating to data migration to RIO have now been resolved which is reflected in the strong performance in 2020/21 Months 1-3.
- RTT - The proportion of patients on a consultant-led Referral to Treatment (RTT) pathway at month end who are waiting less than 18 weeks is continuing to perform positively above the upper control limit (last 4 months) and the Month 3 position being at 98.4%.
- 6 week diagnostics waits for paediatric audiology is now in normal variation following a dip in Month 1 to marginally below the mean, achieving 100% in M2 and M3
- KCHFT's target for delayed transfers is to achieve an average of 7 per day in both east Kent and west Kent, which equates to around 9.5% as a rate of occupied bed days. Performance had improved in Month 1 and 2 although we had started to see the impact of the COVID-19 pandemic and the reduced occupancy during this initial period. However with increased acute activity in Months 2 and 3 and a revert of the patient transfer process to the CAB team (Community Assessment Beds) the rate for Month 3 has gone back up.
- Looked After Children Initial Health Assessment (IHA) performance is showing normal variation and is achieving target most months.
- Bed Occupancy has traditionally shown a varying trend with no periods of special cause variation, however April-June 2020 has been affected by the COVID-19 pandemic and the readying of wards for the expected demand for

COVID-19 patients. As a result the occupancy levels were considerably lower to ensure there was capacity when needed. However the levels into July have increased back up and expected to be much higher for month 4 reporting.

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

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

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Kent Community Health
NHS Foundation Trust

Integrated Performance Report 2020/21

August 2020 report

Part One

we care

Kent Community Health
NHS Foundation Trust

Contents

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Kent Community Health
NHS Foundation Trust

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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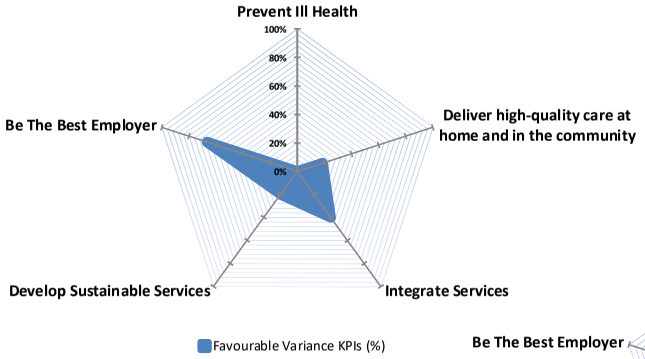
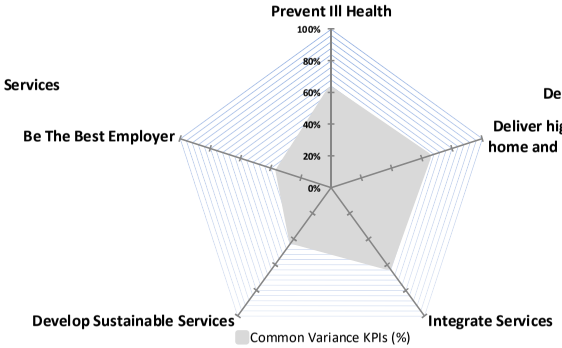
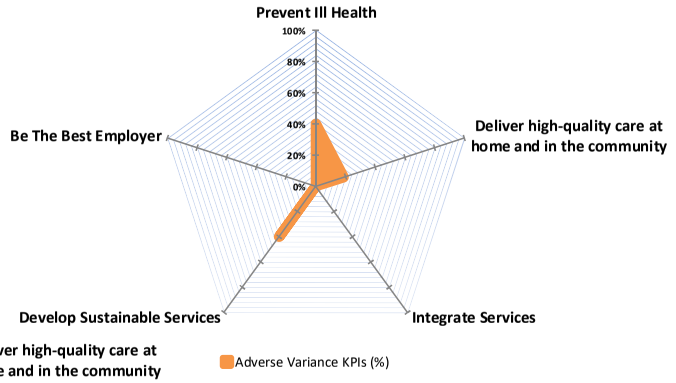
1.0 Assurance on Strategic Goals





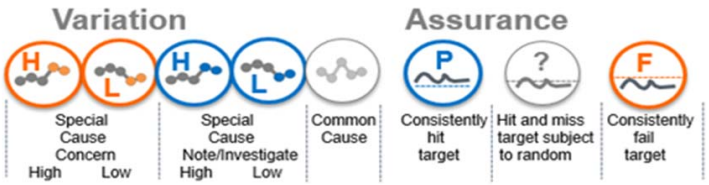


NHSI have confirmed that we will be moved back to segment 1 of NHS Improvement's Single Oversight Framework ("maximum autonomy") should we achieve the RTT 92% standard for 2 consecutive months, which we have done. We are currently waiting for this move to be confirmed

Overall, of the 37 indicators that we are able to plot on a statistical process control (SPC) chart, **27% are experiencing favourable in-month variation (10, KPIs 2.12, 2.13, 2.14, 3.3, 3.5, 4.3, 5.1, 5.3, 5.5, and 5.6), 18.9% are showing in-month adverse variance (7, KPIs 1.1, 1.2, 2.5, 2.7, 2.8, 4.1 and 4.2)** and the remaining **54.1% (20) are showing normal variation.**

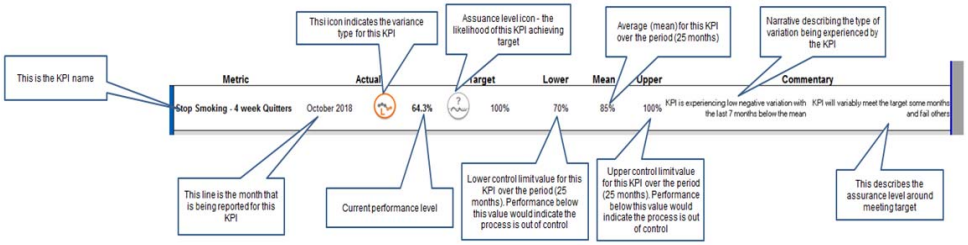
21.6% of the KPIs are consistently achieving target **(KPIs 1.5, 2.5, 2.9, 2.11, 2.15, 2.18, 2.20, and 5.4),**
8.1% (KPIs 4.5, 5.3 and 5.6) are consistently **failing (i.e. target outside control limits negatively),**
with the remaining **70.3% variably achieving target** with no trend of consistent achievement/failure.

Of the 7 indicators where an SPC chart is not currently appropriate, **85.7% (6) 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. KPIs highlighted in RED are those most adversely affected by the Covid-19 Pandemic

	Metric	Actual		Target		Lower	Mean	Upper	Commentary	
1. Prevent Ill Health	KPI 1.1 Stop Smoking - 4 week Quitters	May 2020	8.8%		100%	76%	95%	115%	KPI is experiencing a period of negative positive special cause variation as the referrals into the service have dropped due to Covid-19	KPI will variably meet the target some months and fail others
	KPI 1.2 Health Checks Carried Out	June 2020	0.0%		100%	55%	85%	114%	KPI is experiencing a period of positive special cause variation as the service was stopped in Q1 due to Covid-19	KPI will variably meet the target some months and fail others
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	June 2020	94.3%		90%	89%	92%	95%		KPI will mostly achieve target but the control limits indicate that failing the target is a possibilty within the current process
	KPI 1.4 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	June 2020	94.6%		90% (year end)				KPI is cumulative through the school year	KPI has met target for the year
	KPI 1.5 LTC/ICT - Admissions Avoidance (using agreed criteria)	June 2020	6255		5257	5290	6585	7881		KPI is consistently achieving the target with the target below the lower control limit
	KPI 1.6 % LTC/ICT patients that had at least one visit which Avoided a Hospital Admission	June 2020	16.6%		15.0%	14.6%	17.8%	20.9%		KPI will variably meet the target some months and fail others

	Metric	Actual		Target		20/21 YTD Actual	20/21 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	June 2020	0		1	5	3	There have been 5 Amber/Red ratings for the financial year to date
	KPI 2.2 (N) Never Events	May 2020	0		0	0	0	No never events experienced this year. Last event in December 2016
	KPI 2.3 (N) Infection Control: C.Diff	May 2020	0		0	0	0	Last case in January 2019
	KPI 2.4 (N) Infection Control: MRSA cases where KCHFT provided care	May 2020	0		0	0	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. KPIs highlighted in RED are those most adversely affected by the Covid-19 Pandemic**

	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**	May 2020	H	**0.21**	P	0.19	-0.06	0.04	0.13	KPI is experiencing a period of negative special cause variation with current month performing above the upper control limit	KPI is consistently achieving the target with the target marginally above the upper control limit
	KPI 2.6 Avoidable Pressure Ulcers - Lapses in Care	May 2020		**2**	?	1	-1.3	1.9	5.1		KPI will variably meet the target some months and fail others.
	KPI 2.7 Contractual Activity: YTD as % of YTD Target	June 2020	L	**77.4%**	?	100.0%	92.2%	96.4%	100.6%	KPI is experiencing a period of positive special cause variation with activity levels affected by Covid-19 and the stopping/reduction of services	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	June 2020	H	**4.7%**	?	4.0%	2.8%	3.5%	4.2%	KPI is experiencing a period of positive special cause variation above the upper control limit with DNA levels affected by Covid-19	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)	June 2020		**97.9%**	P	95.0%	96.0%	97.7%	99.4%		KPI is consistently achieving the target with the target marginally below the lower control limit
	KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance	June 2020		**98.5%**	?	95.0%	92.8%	96.9%	101.0%		KPI will variably meet the target some months and fail others
	KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	June 2020		**99.7%**	P	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	June 2020	H	**98.4%**	?	92.0%	89.0%	93.3%	97.5%	KPI is experiencing high positive variation, with the last 4 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)	June 2020	L	**24**	?	532	105	420	736	KPI is experiencing low positive variation, with the last 3 months 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)	June 2020	H	**94.8%**	?	92.0%	89.0%	92.7%	96.4%	KPI is experiencing high positive variation, with the last 9 months performing above the lower control limit	KPI will variably meet the target some months and fail others
	KPI 2.15 (N) Access to GUM: within 48 hours	June 2020		**100.0%**	P	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)	June 2020		**19.2**	?	21.0	14.7	20.0	25.3		KPI will variably meet the target some months and fail others
	KPI 2.17 Research: Participants recruited to national portfolio studies (19-20 Year to Date)	May 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. KPIs highlighted in RED are those most adversely affected by the Covid-19 Pandemic

	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	June 2020		85.1%		80.0%	81.4%	88.3%	95.2%	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	June 2020		96.5%		95.0%	94.0%	96.7%	99.4%	KPI will variably meet the target some months and fail others
	KPI 2.20 (N) NICE Technical Appraisals reviewed by required time scales following review	May 2020		100.0%		100.0%	100.0%	100.0%	100.0%	Consistently meeting target. Failure to meet target would be considered a chance event without a process change. Has met target for the last 5 years
	KPI 2.21 (N) 6 Week Diagnostics	June 2020		100.0%		99.0%	90.9%	97.8%	104.6%	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	June 2020		17.9%		9.5%	5.6%	12.6%	19.5%	KPI will variably meet the target some months and fail others
	KPI 3.2 Home First impact - reduction in average excess bed days (West Kent)	June 2020		0.24		0.20	-0.19	0.25	0.68	KPI will variably meet the target some months and fail others
	KPI 3.3 Average Daily Medically Fit for Discharge Patients (MFFD) - West Kent	June 2020		46		75	62	87	111	KPI is low positive variation, with the last 3 months performing below the lower control limit
	KPI 3.4 Rapid Transfer impact - reduction in average excess bed days (East Kent)	June 2020		0.09		0.20	-0.19	0.25	0.69	KPI will variably meet the target some months and fail others, although seems to be moving towards the upper control limit
	KPI 3.5 Average Daily Medically Fit for Discharge Patients (MFFD) - East Kent	June 2020		91		100	92	127	161	KPI is low positive variation, with the last 3 months performing below the lower control limit
	KPI 3.6 East Kent Rapid Transfer Service - Average Commissioned Discharges per day	June 2020		25.3		30				Data building to allow SPC reporting — Affected by Covid-19 and reduced bed base in EKHUFT

Kent Community Health NHS Foundation Trust - Corporate Scorecard

***NOTE: National Targets are denoted by (N) in the KPI name. KPIs highlighted in RED are those most adversely affected by the Covid-19 Pandemic**

	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	June 2020		73.3%		92.0%	77.6%	86.9%	96.2%	KPI is experiencing low adverse variation, with the last 3 months below the lower control limit (affected by Covid-19)	KPI will variably meet the target some months and fail others
	KPI 4.2 Income & Expenditure - Surplus (%)	June 2020		0.0%		1.0%	0.83%	1.2%	1.7%	KPI is experiencing low adverse variation, with the last 15 months performing below the mean	KPI will variably meet the target some months and fail others
	KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	June 2020		100.0%		100.0%	71.6%	87.1%	102.7%	KPI is experiencing high positive variation, with the last 11 months performing above the mean	KPI met the target for 19-20
	KPI 4.4 External Agency spend against Trajectory (£000s)	June 2020		£594,893		£491,250	£202,613	£523,005	£843,397		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%	June 2020		14.6%		0%	9.2%	16.4%	23.6%		KPI is consistently failing the target with the target below the lower limit. This suggest achieving target without a process change will be down to chance.

	Metric	Actual			Target		Lower	Mean	Upper	Commentary	
5. Be The Best Employer	KPI 5.1 Sickness Rate	June 2020		3.32%		4.20%	3.43%	4.32%	5.20%	KPI is experiencing low positive variation with the current month performing below the lower control limit	KPI will variably meet the target some months and fail others
	KPI 5.2 Sickness Rate (Stress and Anxiety)	June 2020		1.06%		1.15%	0.90%	1.19%	1.48%		KPI will variably meet the target some months and fail others
	KPI 5.3 Turnover (planned and unplanned)	June 2020		13.19%		14.47%	15.64%	16.90%	18.16%	KPI is experiencing low positive variation with the last 11 months performing below the mean.	KPI will consistently fail 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 5.4 Mandatory Training: Combined Compliance Rate	June 2020		95.4%		85.0%	95.2%	95.8%	96.4%		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)	June 2020		3.6%		8.0%	6.4%	8.2%	9.9%	KPI is experiencing low positive variation with the last 9 months performing below the mean	KPI will variably meet the target some months and fail others
	KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	June 2020		87.4%		87.0%	83.6%	84.8%	86.0%	KPI is experiencing high positive variation with the last 12 months performing above the mean	KPI will consistently fail the target as the upper limit is below the target. This suggests performance is unlikely to decrease to meet target without a process change

2.0 Quality Report

2.1 Assurance on Safer Staffing

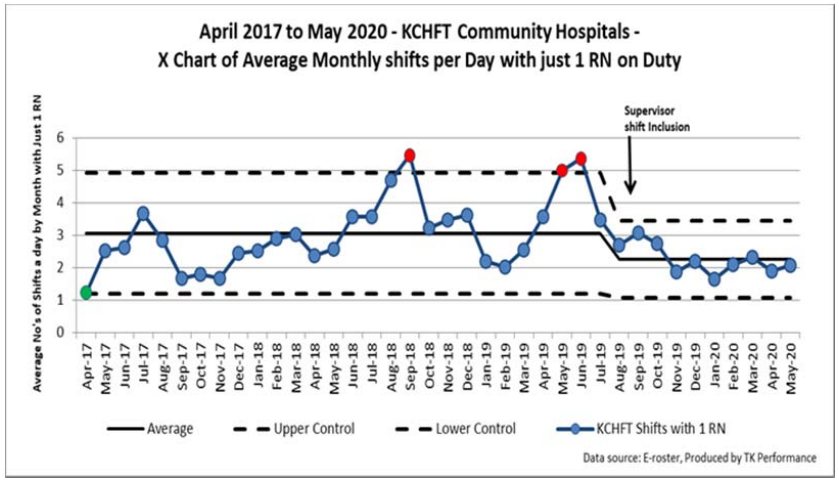
During April and May only Sevenoaks had an RN fill rate below 90% in its April staffing,

1.1 RN and HCA staffing Community Hospital April 2020	Day Fill Rate %		Night Fill Rate %	
	RN's	HCA's	RN's	HCA's
Faversham	164.2%	128.9%	105.0%	138.3%
Deal	130.8%	122.8%	105.0%	103.3%
QVMH	169.2%	135.0%	95.0%	115.0%
Whit &Tank	158.3%	141.3%	101.7%	130.0%
West View	137.5%	82.1%	96.7%	63.3%
Edenbridge	129.2%	87.5%	96.7%	73.3%
Hawkhurst	147.5%	118.9%	101.7%	83.3%
Sevenoaks	136.7%	76.1%	86.7%	73.3%
Tonbridge	185.8%	99.4%	121.7%	89.2%
Total	151.0%	108.6%	101.1%	93.3%

1.1 RN and HCA staffing Community Hospital May 2020	Day Fill Rate %		Night Fill Rate %	
	RN's	HCA's	RN's	HCA's
Faversham	267.7%	123.7%	109.7%	154.8%
Deal	150.8%	115.1%	108.1%	108.1%
QVMH	186.3%	136.0%	98.4%	138.7%
Whit &Tank	164.5%	187.7%	106.5%	129.0%
West View	125.8%	89.5%	106.5%	62.4%
Edenbridge	129.0%	107.3%	116.1%	83.9%
Hawkhurst	164.5%	121.0%	116.1%	130.6%
Sevenoaks	168.5%	89.8%	95.2%	84.9%
Tonbridge	159.7%	139.2%	91.9%	60.5%
Total	168.5%	122.0%	105.4%	98.8%

The additional Nursing demands in response to Covid-19 has seen Nursing Capacity increase over the standard planned levels. Additional RN staffing has generally been around 1 extra RN for day shifts (including Supervisory hours). At Faversham in May this has increased to 3 additional RN's including supervisory hours. Where there are HCA shifts with less than 65% fill rate there has been a RN fill rate of over 90% and deemed safe based on the acuity of patients.

During the pandemic 87 clinical staff were redeployed to community hospital inpatient services.



2.2 Covid-19 Incidents

At the time of writing this report, a total of 193 COVID-19 related incidents had been reported. Of the 193 incidents reported, 19 happened in our care and were considered avoidable following investigation; 17 no harm incidents; one low harm incident and one severe harm to the patient. The severe harm related to a patient who had a fall on the community hospital ward and sustained a fracture. This was declared as a serious incident and a complaint was also raised and as such a root cause analysis investigation is underway. It is recognised that COVID-19 positive patients are at higher risk of falls due to less routine staff movement into the cohort bays and delays entering due to donning and doffing PPE.

COVID-19 Related Incidents Reported on Datix	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Total
Incidents Reported	4	9	50	58	24	145
Patient Deaths in Community Hospitals	0	0	24	20	4	48
Total	4	9	74	78	28	193

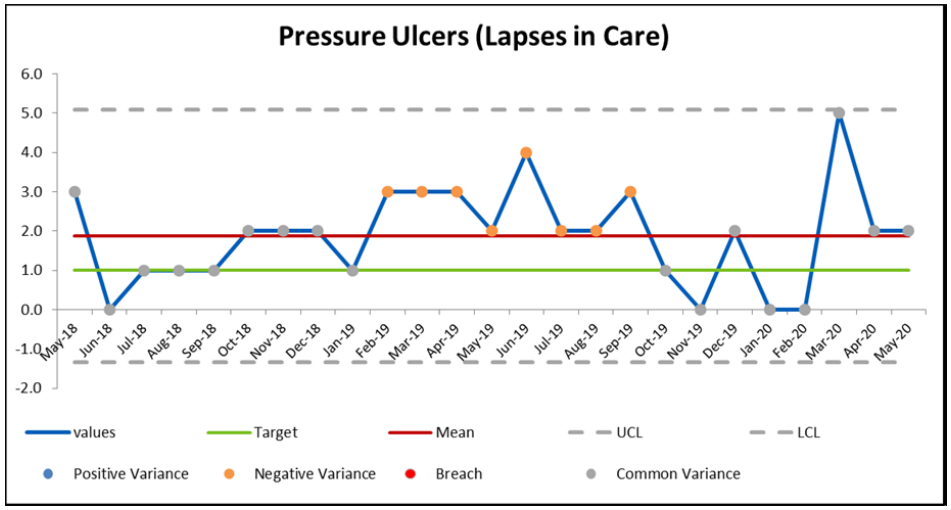
With regards the low harm incident, arrangements were made to transfer a patient to a care home, however when they came to be assessed they had died, however the team continued to work on this placement as they had not been informed. The process in place now ensures community hospitals email the Community Assessment Bed (CAB) team formally when a patient in a community hospital has passed away. This was raised as a complaint.

There have been 48 Covid-19 related patient deaths as of 29th July in community hospitals, of these 42 people were end of life care patients.

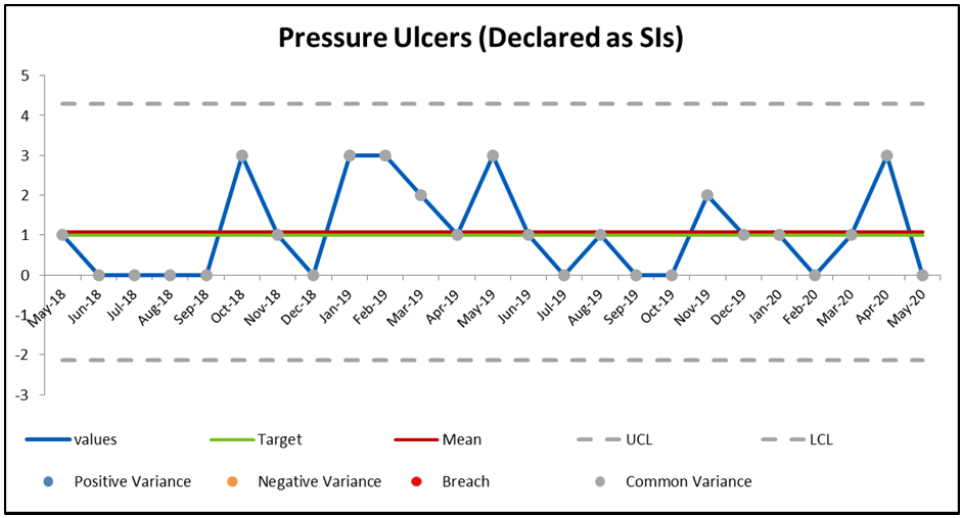
2.3 Assurance on Pressure Ulcers

The national Stop the Pressure Programme led by NHS Improvement has developed recommendations for trusts in England. These support a consistent approach to defining, measuring and reporting pressure ulcers. The aim is to provide an accurate profile of pressure damage so it can improve quality by reducing the harm patients experience. The recommendations are designed to be consistent but also raise the profile of 'hidden' categories of pressure ulcer damage. With this in mind, KCHFT will measure data under the following criterion: lapses in care (formerly category 2 pressure ulcers, in addition to category 3 and above that are under investigation to determine whether they meet the SI criteria); serious incidents (pressure ulcers declared as) and pressure ulcers caused by medical device.

Four lapses in care were identified within the trust acquired incidents during April and May 2020. These related to four patients that developed category 2 pressure damage resulting in low harm. Key themes identified were a lack of holistic assessments, timely provision and monitoring of equipment.



Three incidents were reported whereby two separate patients developed an ungradable pressure ulcer and a third developed a category 3 pressure ulcer. These have been declared as a serious incidents and as such full root cause analyses will be undertaken. A lapse in care is when an act or omission in pressure area care that has impacted skin breakdown and could have been preventable.

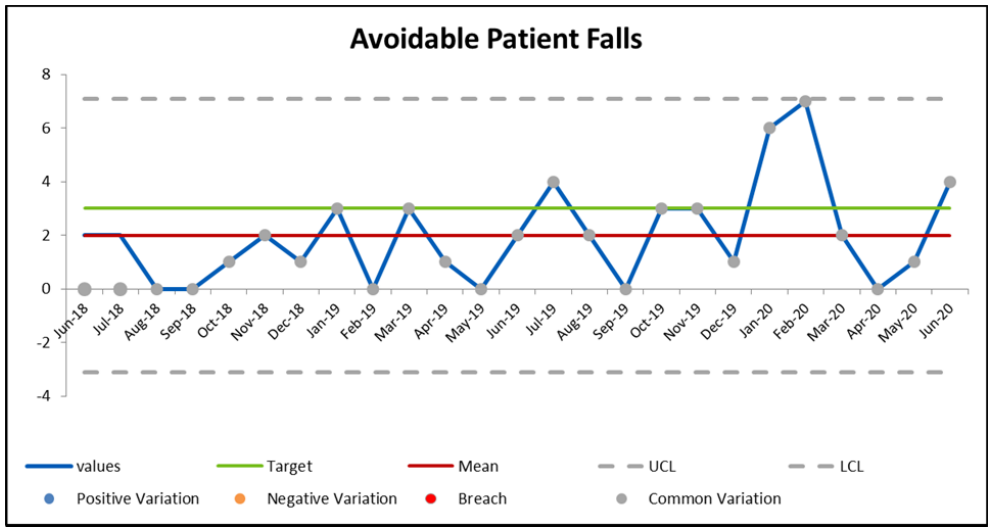


2.4 Assurance on Falls

During April and May 2020, 162 falls were reported across the trust. This is an increase compared with 150 falls reported in February and March 2020. Of the 162 falls, five were considered avoidable of which two resulted in a fractured neck of femur and were declared as serious incidents (including the aforementioned Covid-19 related incident).

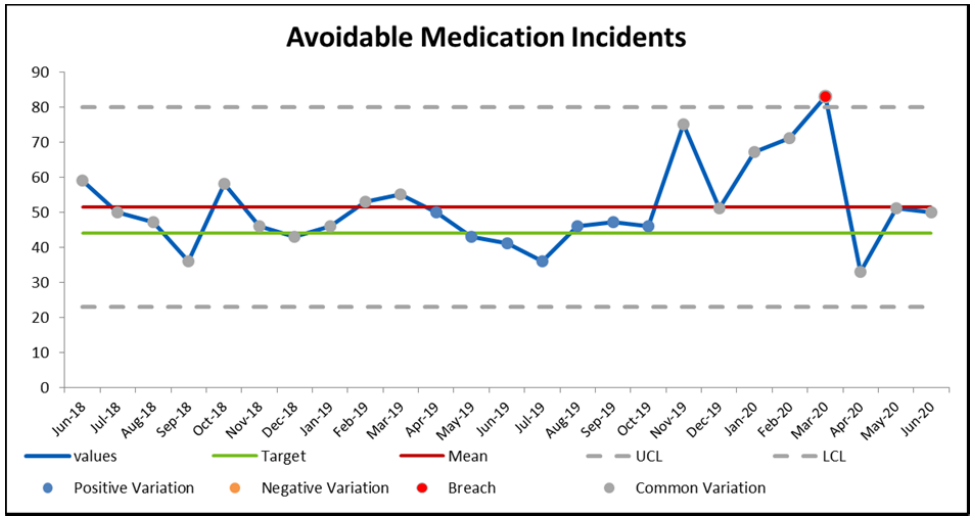
The remaining three incidents resulted in no harm to the patient. Two incidents occurred when two separate patients in Covid positive bays fell, one patient used a table as a walker and the second patient mobilised from the chair to the bed without using their call bell.

The third occurred when a patient was readmitted to the community hospital ward to her previous bed area which was not observable from the nurses station. The patient had developed delirium following surgery so an observable bed would have been more suited. The patient had an unwitnessed fall and on assessment no injury was sustained.



2.5 Assurance on Medication incidents

There were 139 medication related incidents reported during April and May 2020 of which 101 (73%) were considered avoidable. 50 of the 101 (49.5%) were from community nursing team and 31 (30.7%) from community hospitals. The other 20 were across a number of services, the highest in Sexual Health (5) and Rapid Response (4). There has been an increase in the number of incidents reported from the same period last year due to the introduction of incident reporting webinars for all new starters in the Trust in August last year. More staff are now reporting incidents, demonstrating the success of the training.



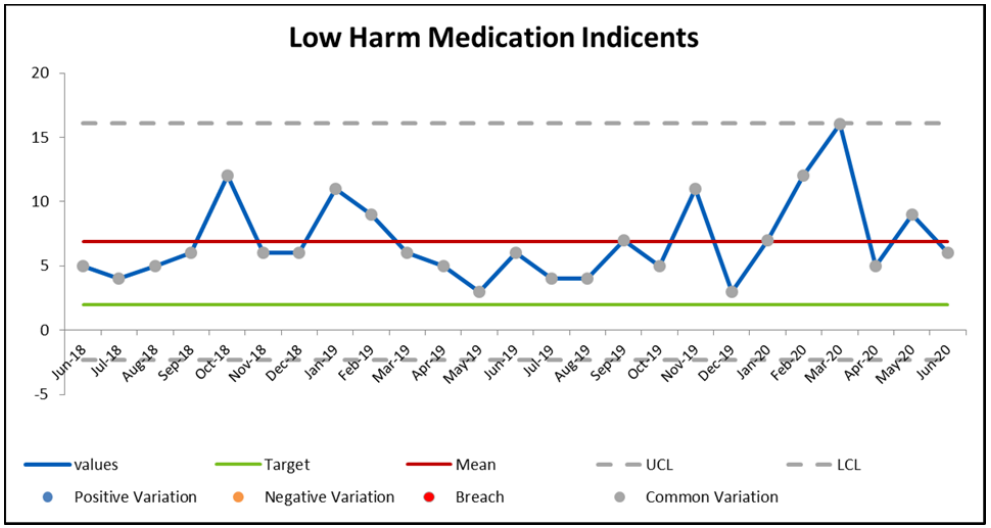
The themes were;

Omitted medication; No harm incidents 29 (20.8%), Low harm incidents 3 (2.2%). 1 in 3 of all omitted medication incidents reported were from the community nursing teams.

Wrong quantity; No harm incidents 14 (10.1%), Low harm incidents 5 (3.6%)

Wrong method of preparation/supply; No harm incidents 10 (7.2%), Low harm incidents 3 (2.2%)

There were 34 (24.5%) low and no harm controlled drug incidents. Of the 34, 11 were omitted doses, 9 wrong quantities and one omitted dose was for an end of life care patient. The others were due to wrong method of preparation/supply



2.6 Assurance on Patient Experience

2.6.1 Meridian Patient Experience survey results

2,545 surveys were completed by patients, relatives and carers with a strong combined satisfaction score of 95.5%. Survey volumes continue to be low due to Covid-19, with an increase seen in May, as a result of the introduction of the 'Remote' survey (602 completions).

Overall satisfaction survey percentages trust wide from April to May 2020 show a 1% reduction compared with the previous two months, as a result of the decrease seen in May.

PALS dealt a total of 833 contacts; 770 telephone calls, 44 on-line forms via the public website and 19 queries via text message..

2.6.2 The NHS Friends and Family Test (FFT)

1,786 FFT questions were completed during April and May. The FFT recommend score was 97.3%.

1.15% (21) of our patients chose not to recommend the service they received by answering poor or very poor. 13 of the 21 were from people who had been triaged over the telephone by the dental service. They felt they did not get the help they needed, due to the tight restrictions on the availability of clinical based appointments at the current time. The other 8 negative responses were for a variety of services, showing no particular themes.

2.7 Assurance on Clinical Audit and Research

2.7.1 Clinical Audit Reporting

All national audits paused due to Covid-19

All clinical audit staff redeployed to support Tier 1 services.

Trust wide audit programme put on hold. Continued submission by services to ad hoc record keeping audit at reduced level.

Necessity provides additional impetus to refocus the audit programme.

2.7.2 Research

70@70 national community nursing project

The project is to deliver a James Lind Alliance (JLA) Priority Setting Partnership (PSP) in Community Nursing. The project was initiated by KCHFT's 70@70 nurse

Part funding received from the Applied Research Collaborative (ARC) in Oxford. Northumbria ARC have recently offered contribution too. KSS have yet to make an offer.

2.7.4 National Institute for Clinical Excellence (NICE)

NICE Guidance dissemination halted temporarily. Process for dissemination and review has restarted with pause on review of all non-urgent guidance (including overdue guidance).

NICE issued 34 COVID-19 rapid guidelines (number includes updates). Only 11 rapid guidelines relevant to KCHFT and then mostly only incidentally applicable and disseminated for information/awareness rather than full review.

2.8 Infection Prevention and Control

2020/21 Infection prevention and control trust objectives	April 2020	May 2020	YTD (Apr- March)
No cases of *Clostridium difficile* infection (CDI) where level 3 lapses in care were identified by KCHFT staff (i.e. the infection was deemed avoidable, caused by a failures in care or failure to follow policy/protocol). This year, cases of CDI will be reviewed and attributed in relation the following 4 categories: Hospital onset healthcare associated Community onset healthcare associated Community onset indeterminate association Community onset community associated	1 HOHA (attributed to Acute Trust)	3 COHA(attributed to Acute Trust	4 3 COHA 1 HOHA
There will be no KCHFT attributed cases of MRSA bacteraemia in 2020/2021	0	0	0
100% of patients admitted for podiatric surgery, or to our community hospitals will be screened for MRSA	There has been podiatric surgery 100% inpatient unit	There has been podiatric surgery 100% inpatient unit	Currently surgery suspended due to COVID 100% on wards
There will be a reduction of acquired urinary tract infections and catheter associated urinary tract infections compared to 2018/19	8 UTI's 1 CAUTI	5 UTI's 1 CAUTI's	13 UTI's 2 CAUTI's
Prevent ongoing transmission COVID within Community Hospitals Total No. COVID +ve patients in inpatient wards at end of month No. of those who tested positive in month, and meet the definition: hospital onset – probable or definitely healthcare acquired (data collection commenced May)	61	67 10	Total COVID+ve patients cared for in inpatient wards since March 2020: **213**

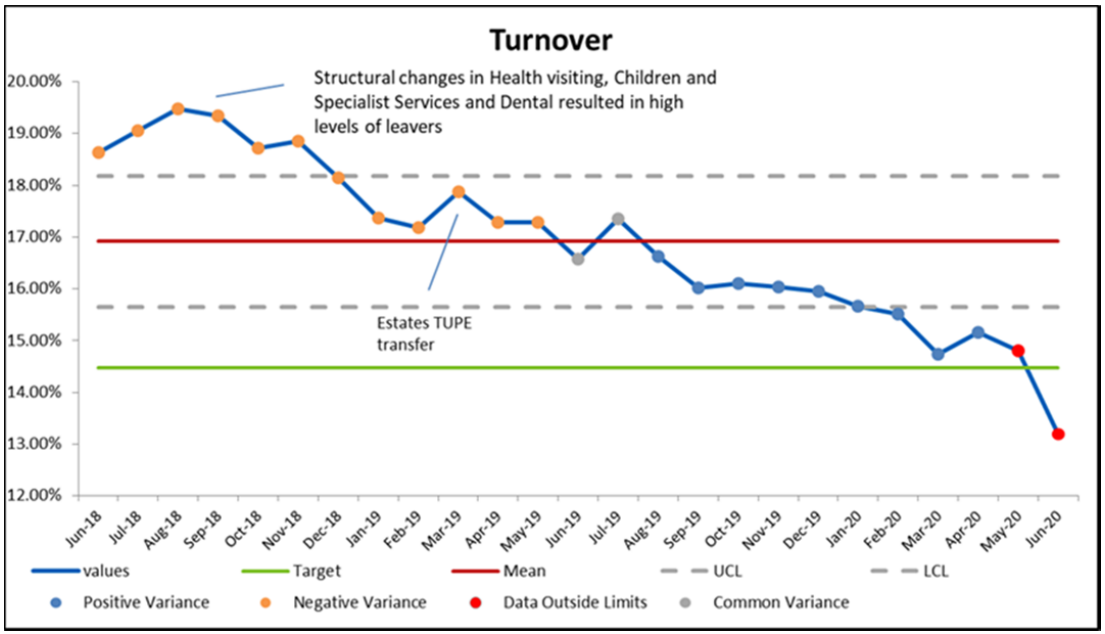
3.0 Workforce Report:

100% of the identified BAME risk assessments have been completed to date

3.1 Assurance on Retention

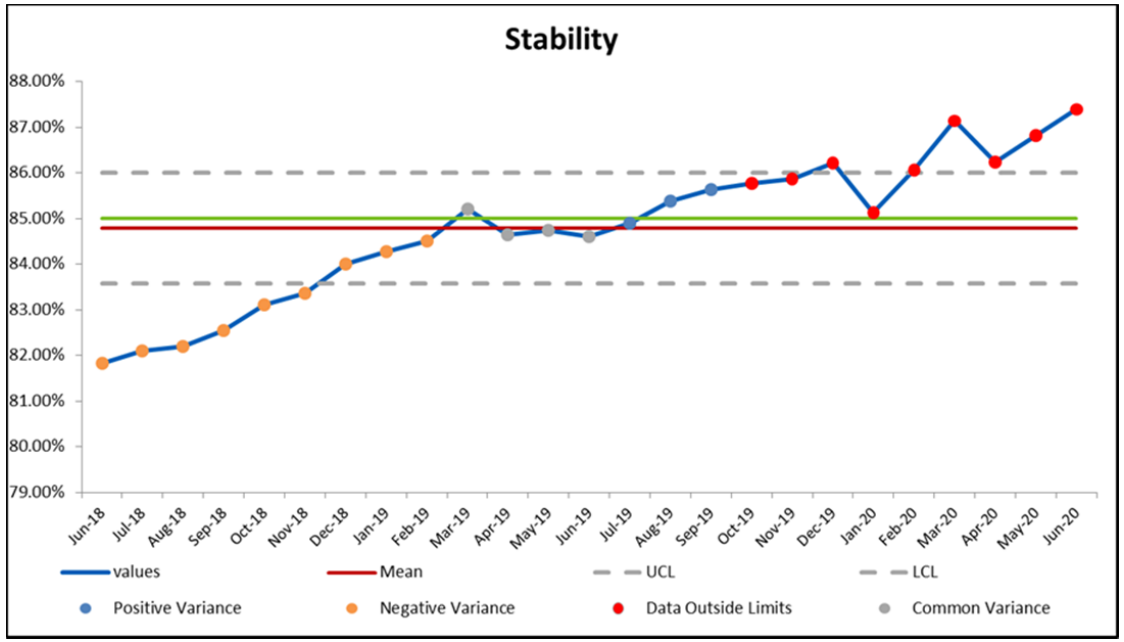
3.1.1 Turnover

Turnover in June 2020 continues on a downward trajectory to 13.19%, a 1.19% decrease from May 2020 (14.38%). With this performance, turnover rates remain below average and below the new target of 14.47%. This is the metric's lowest level across the reporting period.



3.1.2 Stability

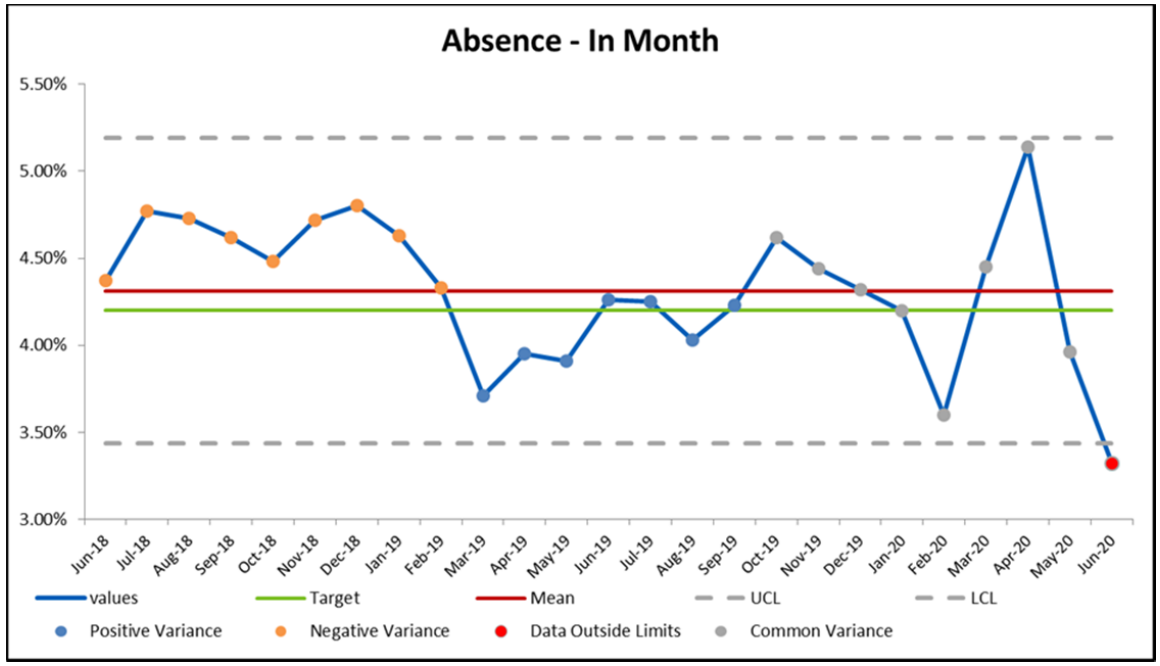
Stability continues to perform above the mean and target for the last 11 consecutive months. We continue to report outside the limits of this metric, and as of June 2020 at 87.39% it is the highest rate of stability across the reporting period and 2.39% above the Target rate of 85%.



3.2 Assurance on Sickness

3.2.1 Sickness Absence

Since the last reporting period we have experienced the highest sickness absence rate the organisation has reported in the last 24 months. In April 2020 the sickness absence rate peaked to 5.14%. June 2020 has however returned to below the target and below the mean to 3.32%. The sharp spike was COVID-19 related (see further information below).



COVID-19 Related Absence

73 employees were recorded as sick in June due to exhibiting COVID-19 symptoms, this accounts for 11.7% of the total number of staff (626) off sick in the month.

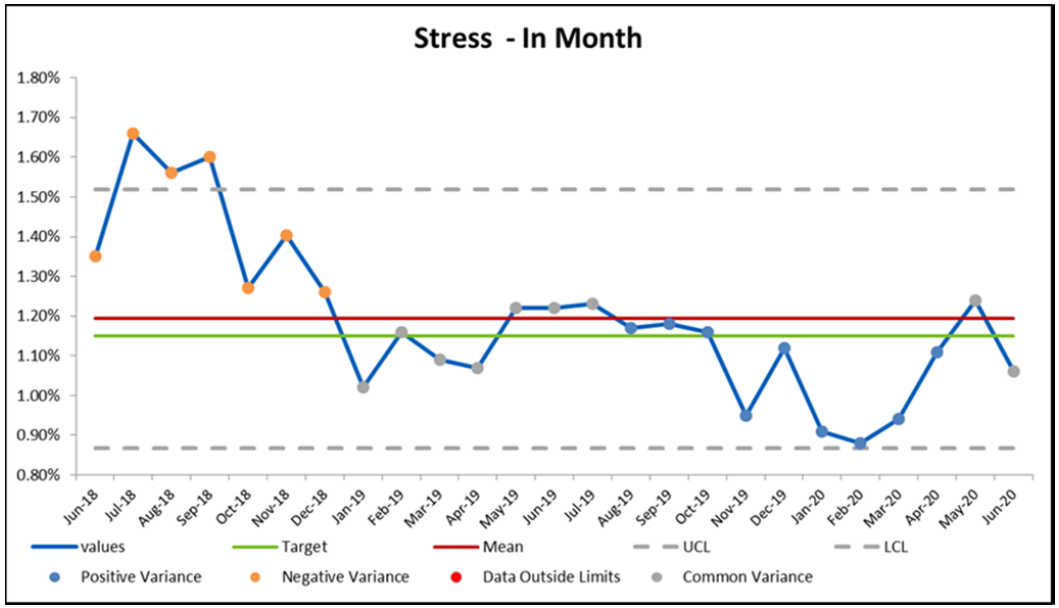
Through the HealthRoster system managers have also been recording staff that are requiring isolation due to being symptomatic, someone in their house being symptomatic and those individuals that have been identified as being in a vulnerable group.

Individuals identified as being in a vulnerable group have had a risk assessment completed which determines whether they can continue in their current position or need adjustments made. These might include working in an alternative role, working from home or in a handful of cases shielding at home with no option for work.

3.2.2 Stress Absence

In-month stress absence figures for June 2020 (1.06%) have seen a decrease from May of 0.18%. Following a peak in May to 1.24% which was above the mean and the target. The financial year-to-date figure for June 2020 is 1.14%.

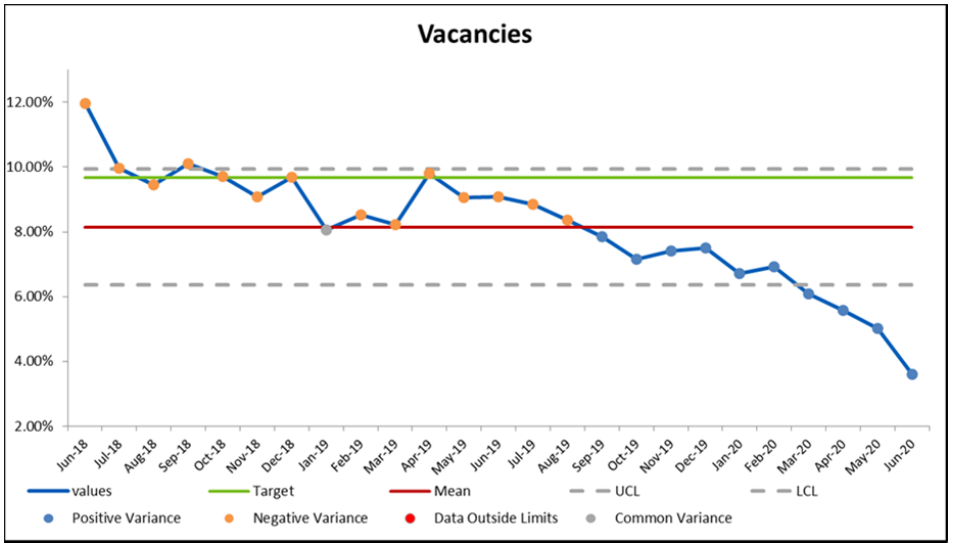
As expected this metric increased over March, April and May as a result of the emergency response to the COVID-19 pandemic. We have implemented multiple measures to mitigate this expected increase and maintained the health and wellbeing of our people.



3.3 Assurance on Filling Vacancies

3.3.1 Establishment and Vacancies

The Vacancy Rate has been on a continual downward trajectory below the mean since September 2019. In June 2020 the Vacancy rate is at its lowest for the reporting period of 24 months at 3.6%. This is a decrease of 2.48% since the last reporting period in March 2020. It has continued to remain significantly below the target of 8%.

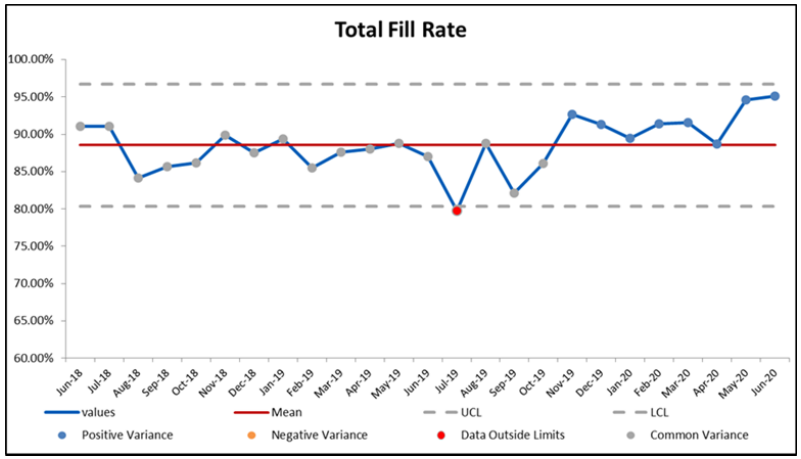


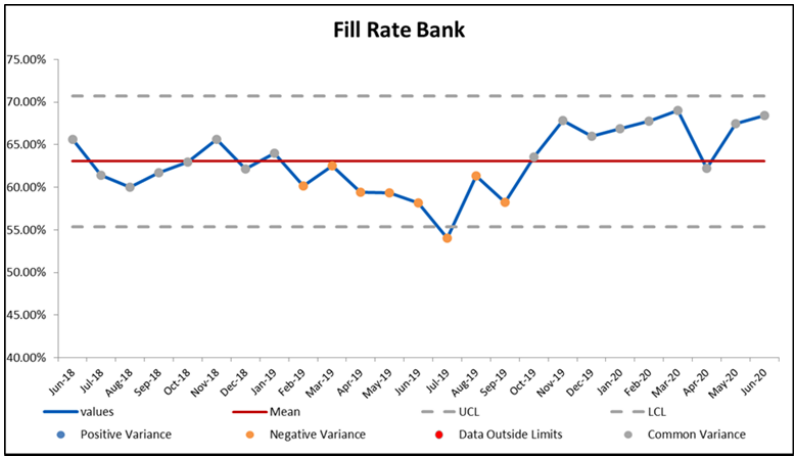
3.3.2 Temporary Staff Usage

The Total fill rate has increased since the last reporting period in March 2020 to 95.07%, this is the highest rate over the reporting period. This is the eighth consecutive month that the total fill rate has remained above the mean.

The Bank fill rate also reports above the mean at 68.44%

Significant recruitment has been undertaken to increase capacity on the Bank to support the emergency response to the COVID-19 pandemic.





4.0 Finance Report:

4.1 Key Messages

Surplus: The Trust achieved a break even position in the month, including £747k top up funding. The plan was a surplus of £12k and so there is an adverse variance against the plan of £12k. The cumulative position is break even, including £3,381k year to date top up funding. Cumulatively pay and non-pay have overspent by £266k and £1,468k respectively. Depreciation/interest has underspent by £75k and income has over-recovered by £1,621k.

Continuity of Services Risk Rating: EBITDA Margin achieved is 1.5%. The Trust scored 1 against the Use of Resources Rating, the best possible score

CIP: £1,027k of savings has been achieved to the end of June meeting the YTD target in full. The cumulative position includes £365k of travel savings which have been recognised non-recurrently while the Trust works through reset plans.

Cash and Cash Equivalents: The cash and cash equivalents balance was £54,482, equivalent to 79 days expenditure. The Trust recorded the following YTD public sector payment statistics 97% for volume and 96% for value.

Capital: Spend to June was £1,119k, against a YTD plan of £1,702k (66% achieved). The YTD spend includes £72k relating to a Capital Covid-19 claim which has received regional approval and awaits national approval. The full year forecast is £7,956k and the Trust expects to utilise this in full. The full year forecast includes a further £198k Capital Covid-19 claim, which has again received regional approval and awaits national approval. It is therefore expected that the Trust will receive £270k of PDC funding relating to the Capital Covid-19 claims submitted. Since June reporting closed the Trust has been made aware of additional funding being made available to the Kent and Medway system and the Trust will receive an additional £900k.

Staff: temporary staff costs for June were £1,232k, representing 7.95% of the pay bill. Of the temporary staffing usage in June, £522k related to external agency and £73k for locums, representing 3.84% of the pay bill. Vacancies reduced to 160 in June which was 3.63% of the budgeted establishment.

4.2 Dashboard

Surplus — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	0	37	-37
Year End Forecast £k	0	150	-150

The Trust is in a breakeven position to the end of June inline with guidance received from NHSEI, which is £37k behind plan.

Pay and non-pay have overspent by £266k and £1,468k respecitvely partly offset by an underspend on depreciation/interest of £75k and an over-recovery of income of £1,621k.

The forecast for 2020/21 is to breakeven.

Use of Resource Rating — Rag rating: Green

	Year to Date Rating	Year End Forecast Rating
Capital Service Capacity	1	1
Liquidity	1	1
I&E margin (%)	2	2
Distance from Financial Plan	1	1
Agency Spend	2	2
Overall Rating	1	1

The Trust has scored overall the maximum 1 rating against the Use of Resource rating metrics for M3 2020-21. The YTD I&E margin % has returned a rating of 2 as a result of the current break-even regime and the YTD Agency spend rating is 2 following an increase in actual agency costs due to Covid-19.

CIP — Rag rating: Green

	Actual	Plan	Variance
Year to Date £k	1,027	1,027	0
Year End Forecast £k	4,210	4,210	0

The Trust achieved CIPs of £1,027k to the end of June against a risk rated plan of £1,027k.

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

The Trust is forecasting to achieve the full plan of £4,210k by the end of the year.

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	54,482	53,294	1,188
Year End Forecast £k		34,064	

Cash and Cash Equivalents as at M3 close stands at £54,482k, equivalent to 79 days operating expenditure.
The Trust recorded the following YTD public sector payment statistics 97% for volume and 96% for value.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	1,119	1,702	583
Year End Forecast £k	7,956	7,686	-270

Capital Expenditure year to date is £1,119k, representing 66% of the YTD plan submitted.
The YTD actual expenditure includes £72k relating to a Capital Covid-19 claim which has received regional approval and awaits national approval. This expenditure will be funded via issued PDC.
The full year forecast is £7,956k and the Trust expects to utilise this in full. The full year variance represents the £72k actual expenditure already incurred relating to Covid-19 and a further £198k Covid-19 expenditure forecast, which is also awaiting national approval and funding issued via PDC.

Agency Trajectories — Rag rating: Green

	M3			YTD		
	Actual £k	Target £k	Variance £k	Actual £k	Target £k	Variance £k
External Agency Excluding Covid-19 Expenditure £k	326	491	165	1,345	1,474	129
External Agency Including Covid-19 Expenditure £k	595	491	-104	1,908	1,474	-434

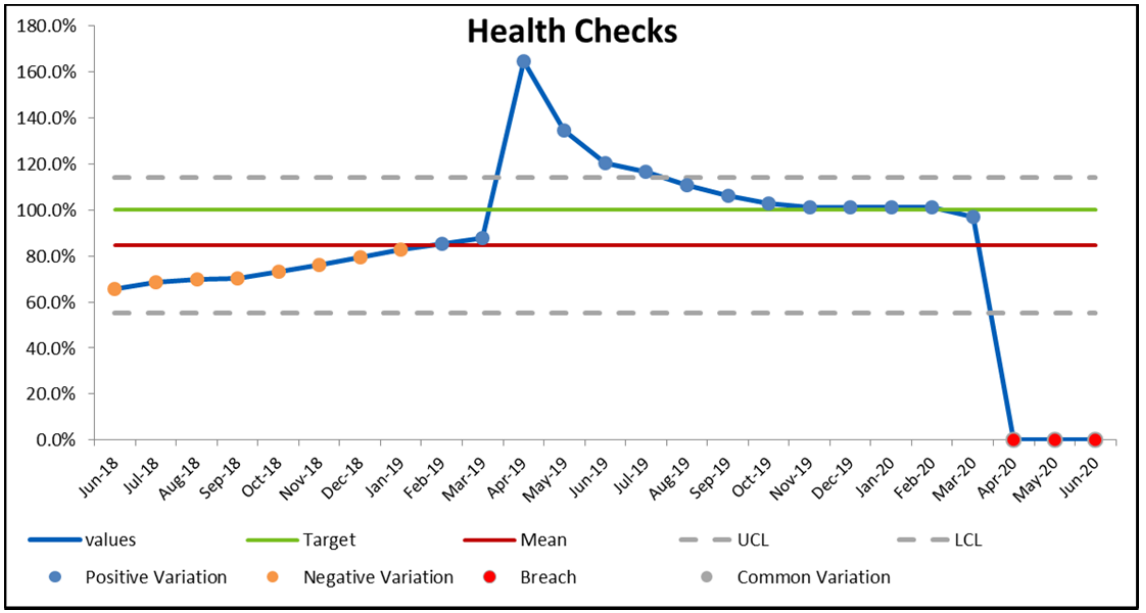
External Agency and Locums excluding Covid-19 expenditure was £326k against £491k target in June. (YTD £1,345k against £1,474k target).
External Agency and Locums including Covid-19 expenditure in June was £595k against £491k target. (YTD £1,908k against £1,474k target).

5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits

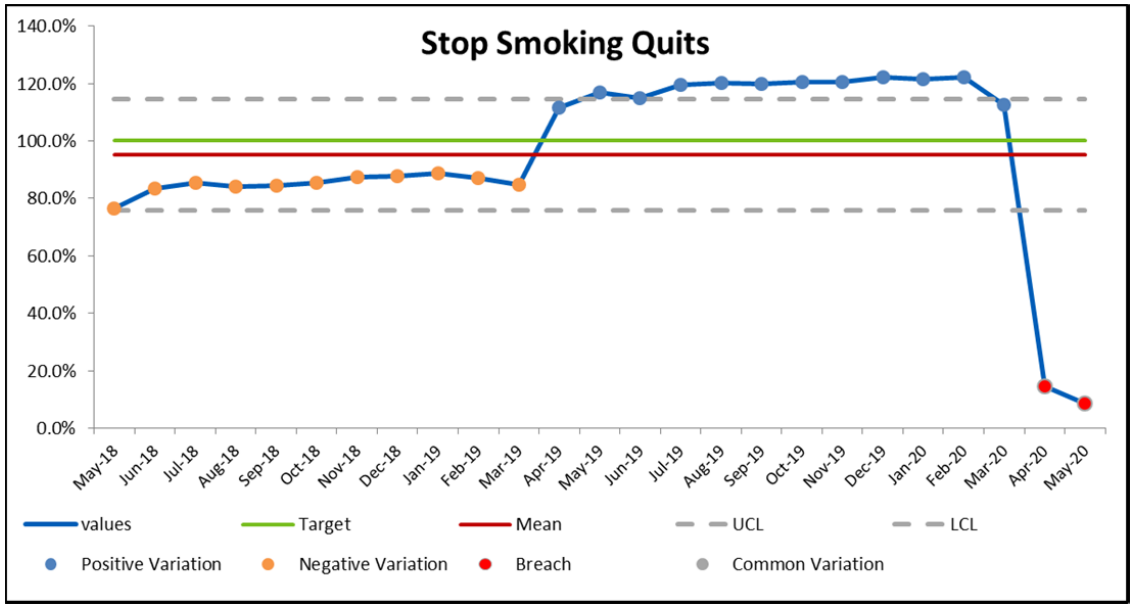
Health Checks



Health Checks has dropped to 0 for Months 1-3 due to the service being paused as a result of the Covid-19 pandemic. 85% of activity is delivered via Primary Care and 15% KCHFT core delivery. Primary Care could not deliver NHS Health Checks because of other critical clinical care. The general public have been diverted away from face to face appointments to manage social distancing and NHS Health Checks cannot be delivered virtually

KCHFT have met with primary care representatives to discuss resetting NHS Health Checks and they have reported that it is unlikely that they will be able to deliver fully until January 2021. KCHFT Adult Health Improvement are undertaking a mapping exercise to see which providers will be able to reset earlier (September) and currently 21 practices are keen to do so.

Stop Smoking Quits



COVID hit referrals to the service which reduced significantly as can be seen in the graph above. 1959 referrals have been received for Smoke Free service since 1st April 2020, 763 received into the service 467 chosen to wait for a face to face contact (Service has offered telephone and video link appointments to the others). Initially the service saw a huge decline in the number of referrals however, seen a steady increase each week since then.

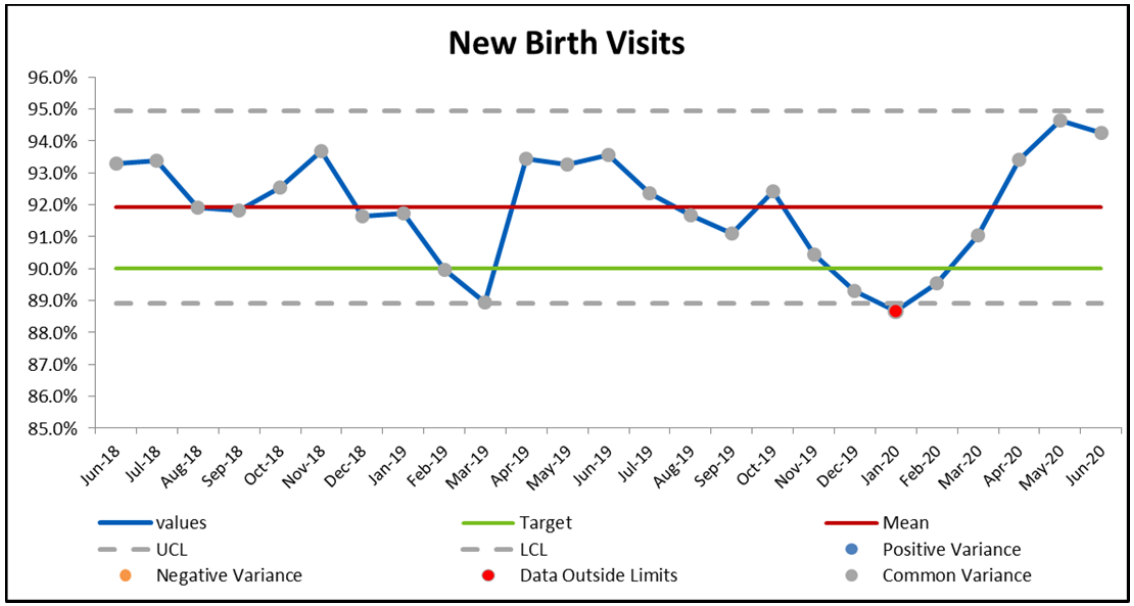
The major challenge is that 60% of clients are usually seen via community pharmacy and general practice. Additional capacity has been sought and reallocation of roles explored but this will need to be increased.

Currently we are mapping service reset with 3rd Party Providers to understand which providers want to reset from September onwards.

5.1.2 Health Visiting

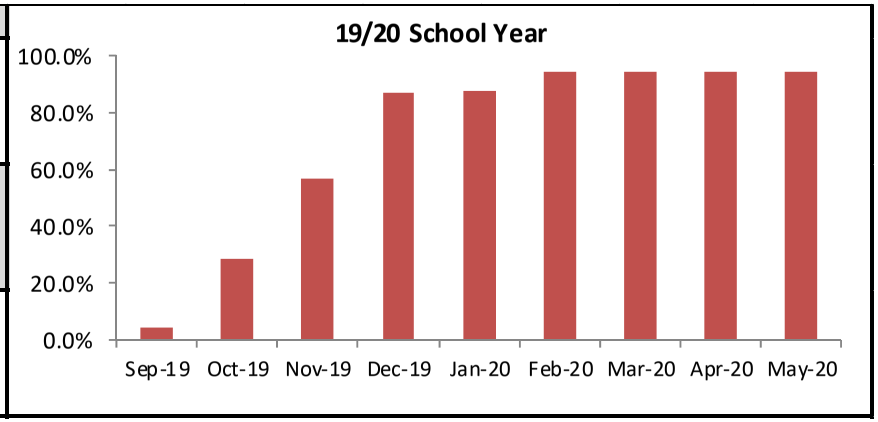
New Birth Visits

Issues relating to data migration to RIO have now been resolved which is reflected in the strong performance in 2020-21 Months 1-3.



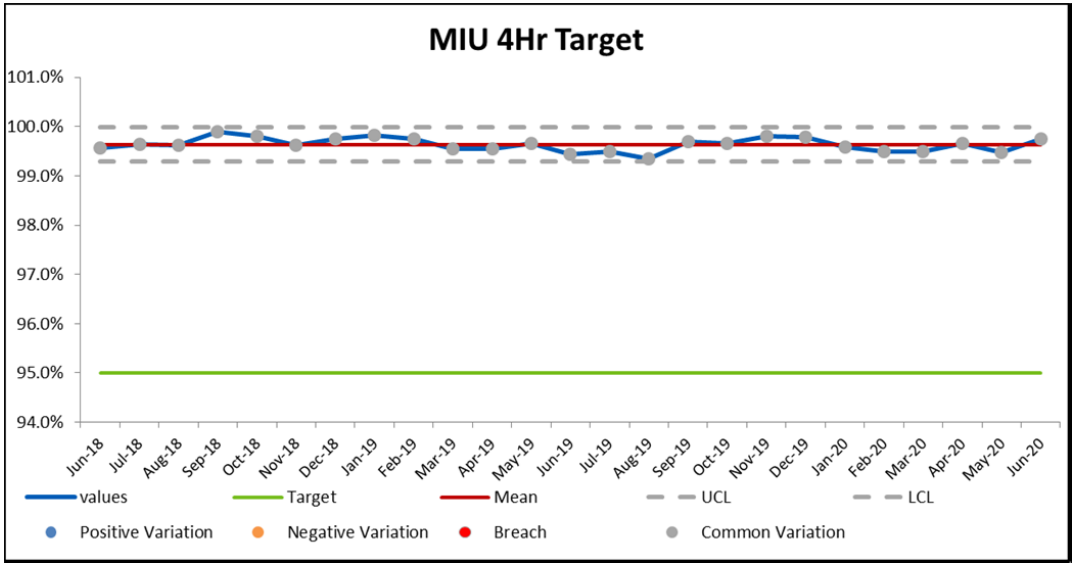
5.1.3 National Child Measurement Programme (NCMP)

	Year R/6
19/20 School Year to May-20	**94.6%**
18/19 School Year	**94.9%**
Annual Target	**90%**



The measurement programme for Year R and 6 pupils has met the trajectory for the 19/20 school year, with both programmes achieving the 90% target for the school year.

5.1.4 Minor Injury Units (MIU) 4 Hour Wait Target



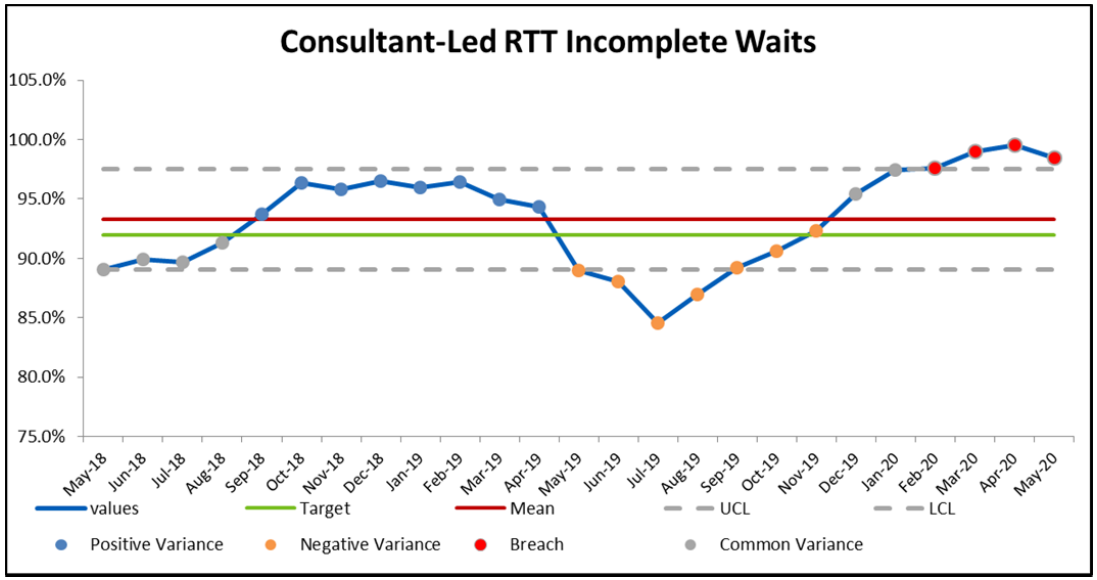
KCHFT's achievement of the 4 hour wait target for Minor Injuries Units has consistently been high, with very little variation from the mean, with the control range suggesting that failing target is highly unlikely to happen.

With activity having decreased in April-June 2020 (-52% compared to 19/20) as a result of the Covid-19 pandemic, there were very few breaches (52 – 0.35%) with the largest number of these being at Gravesham (22 – 0.72%) so still well within target. However it is worth noting that reduced activity does increase the risk of breaching the 95% target as few breaches are needed to bring the compliance below 95%, however the reduced activity does make this unlikely as capacity would be sufficient to keep waiting times low.

5.1.5 GUM 48hr

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

5.1.6 Consultant-Led RTT Incomplete Waits Over 18 weeks



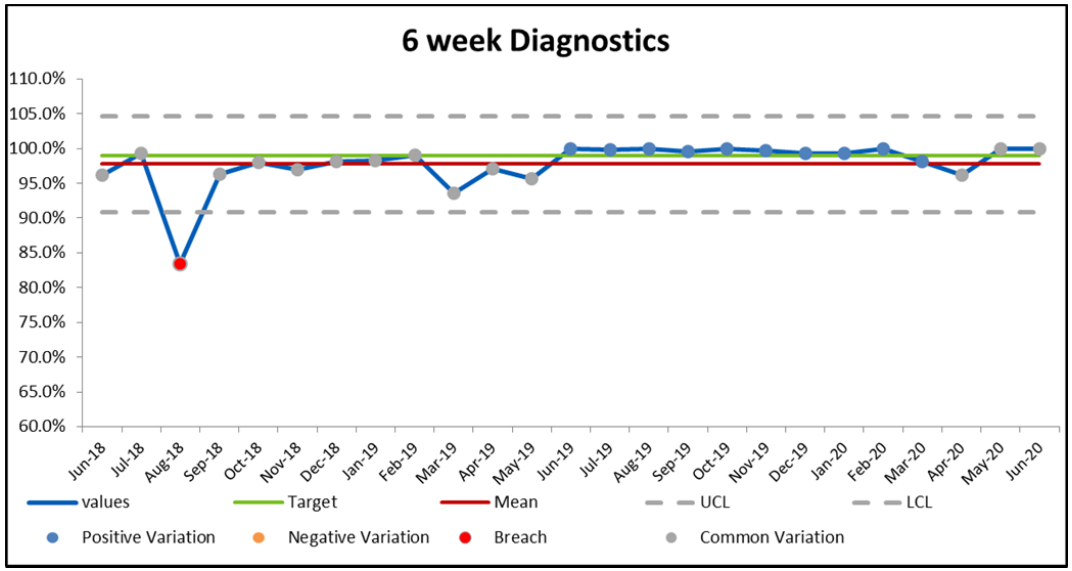
The proportion of patients on a consultant-led Referral to Treatment (RTT) pathway at month end who are waiting less than 18 weeks is continuing to perform positively above the upper control limit (last 4 months) and the Month 3 position being at 98.4%.

	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	426	128	21	0	0	96.3%
Orthopaedics	399	1	0	0	0	100.0%
Children's Audiology	64	0	0	0	0	100.0%
Community Paediatrics	392	84	3	0	0	99.4%
KCHFT Total	1281	213	24	0	0	98.4%

The above table shows the current breakdown of the waiting list for all services on a consultant-led pathway. 98.4% of waits are now below 18 weeks, with no waits above 36 weeks and only 24 above 18 weeks. All consultant-led services are currently meeting target.

NHSI have confirmed that 2 consecutive months of achievement will move KCHFT back to segment 1 of the NHSI Single Oversight Framework and we are awaiting confirmation of this

5.1.7 6 Week Diagnostics (Audiology)



6 week diagnostics waits for paediatric audiology is now in normal variation following a dip in Month 1 to marginally below the mean, achieving 100% in M2 and M3

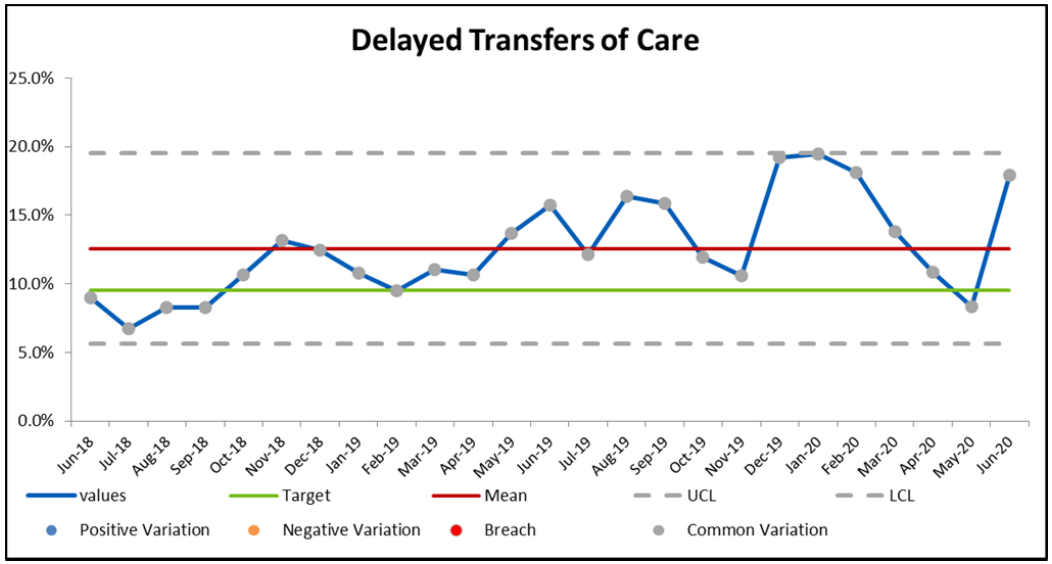
5.1.8 Dental Prisons Waiting Times

There is currently no updated data for April-June 202 as the services in Prisons had not yet resumed.

HMP Swaleside and HMP Standford Hill have no dental activity due to Gold Command in place. However, dental triage is taking place and we are awaiting further instruction form HMP establishment. The dental team are prioritising patients are per the NHSE/I SOP, the patients that have been put on the waiting list by IC24 healthcare staff and patients that received AAA in the past few months during Covid-19.

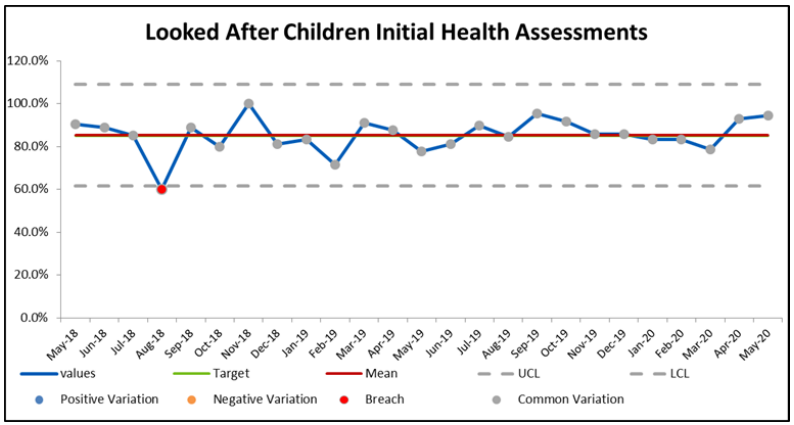
HMP Maidstone – a process was in place to see and treat emergencies however this has now been rescinded by Oxleas. The dental team are prioritising patients and conducting remote triage although this is actually face to face triage as remote telephone access is not possible at HMP Maidstone. Some dental emergencies have been seen with prior agreement from Oxleas but this is now not considered as routine but assessed on a case by case situation with authorisation and agreement from the head of health care at HMP Maidstone.

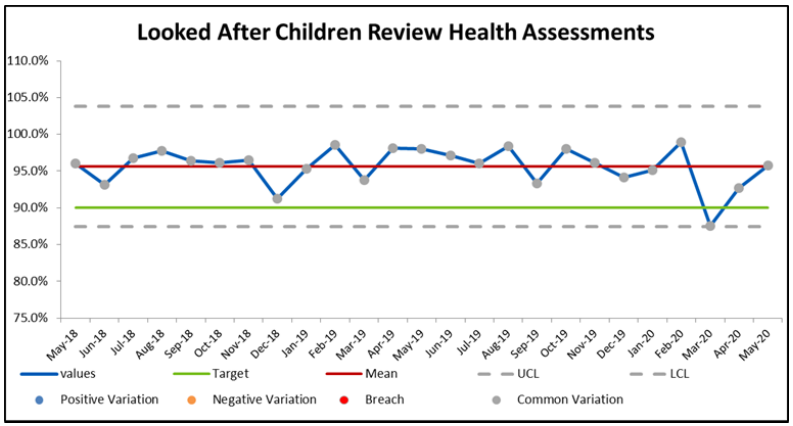
5.1.9 Delayed Transfers of Care (DTOCs)



KCHFT's target for delayed transfers is to achieve an average of 7 per day in both east Kent and west Kent, which equates to around 9.5% as a rate of occupied bed days. Performance had improved in Month 1 and 2 although we had started to see the impact of the Covid-19 pandemic and the reduced occupancy during this initial period. However with increased acute activity in Months 2 and 3 and a revert of the patient transfer process to the CAB team (Community Assessment Beds) the rate for Month 3 has gone back up.

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





Initial Health Assessment (IHA) performance is showing normal variation and is achieving target most months. Performance can still be variable and liable to failing target some months, due to late requests. We continue to work with KCC to ensure timely requests. We have an additional KPI to ensure that we complete the IHA within 23 days of receipt of the referral which achieves target most months.

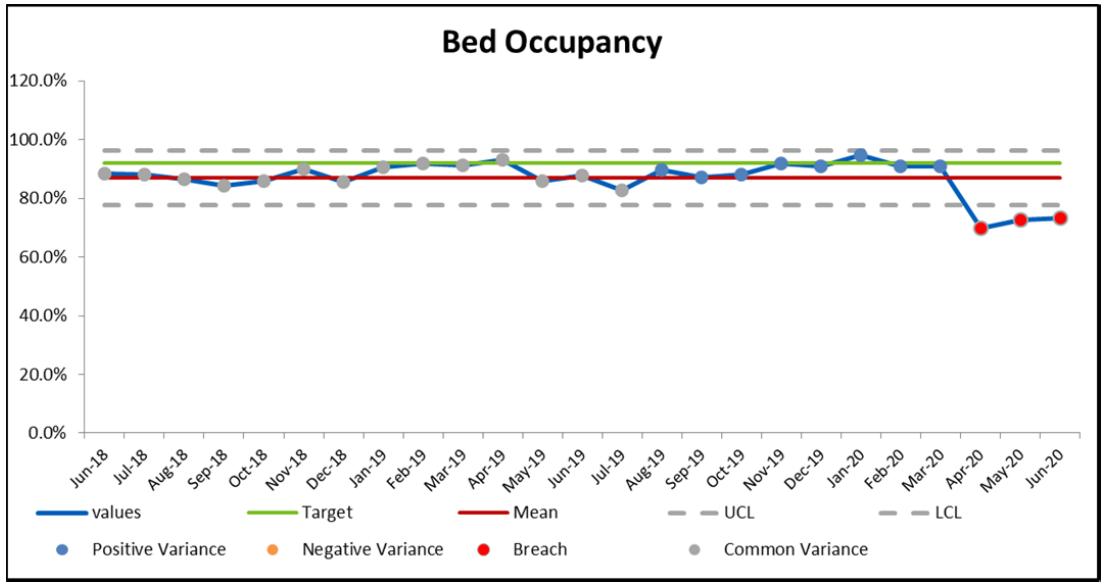
Compliance with the Review Health Assessment target is now showing normal following a dip in March 2020. Frequent monitoring through the team weekly calls continues to occur.

5.1.11 NHS Number Completeness

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

5.1.12 Bed Occupancy

Bed Occupancy has traditionally shown a varying trend with no periods of special cause variation, however April-June 2020 has been affected by the Covid-19 pandemic and the readying of wards for the expected demand for Covid-19 patients. As a result the occupancy levels were considerably lower to ensure there was capacity when needed. However the levels into July have increased back up and expected to be much higher for month 4 reporting



5.1.13 CQUIN

CQUIN programme currently paused due to the Covid-19 pandemic.

5.2 Assurance on activity and productivity

5.2.1 Activity

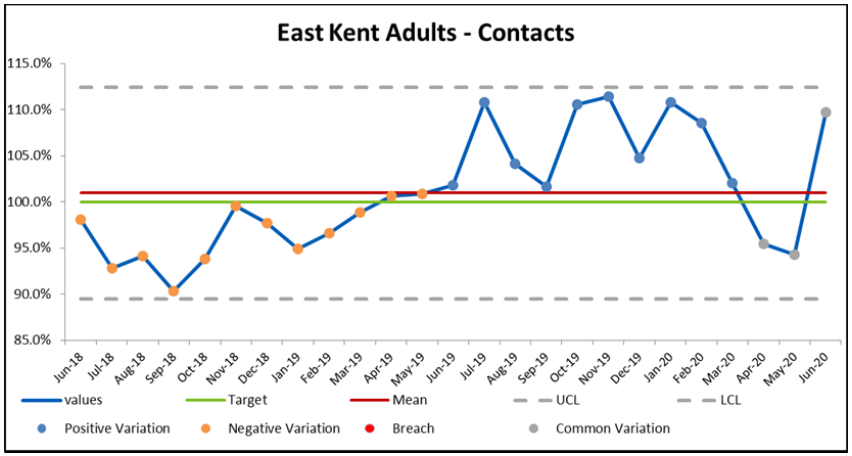
During Month 3 (June 2020) KCHFT carried out 141,179 clinical contacts, of which 7,177 were MIU attendances. For the year to June 2020 KCHFT are 22.6% below plan for all services (some services have contractual targets, some are against an internal plan), predominantly due to the impact of the Covid-19 pandemic. The largest negative variances are within MIUs (-45.5%), Public Health Services (-53.5%) and Adult Specialist Services (-39.6%).

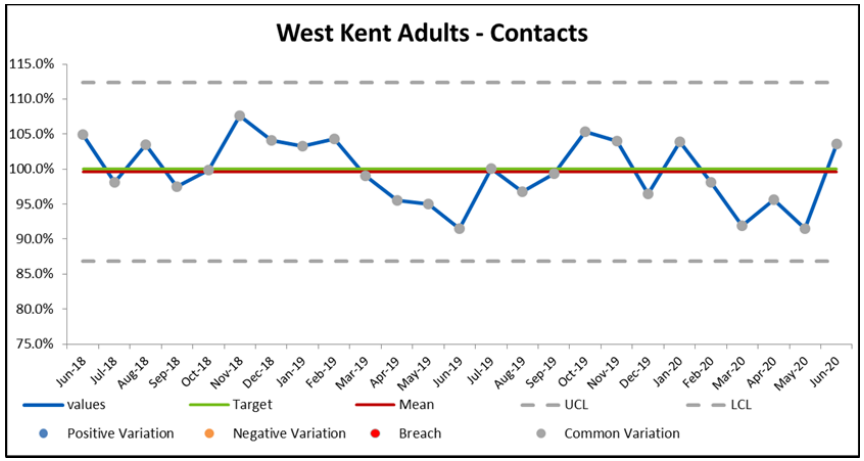
Service Type	M3 Actual	YTD Actual	YTD Plan	YTD Variance	Movement	Internal BRAG	Contract BRG
East Kent Adults - Contacts	57,893	159,694	160,096	-0.3%	Positive		
East Kent Adults - MIU	2,723	7,649	11,490	-33.4%	Negative		
East Kent Adults - Admissions	120	420	233	80.3%	Negative		
West Kent Adults - Contacts	25,896	73,420	75,806	-3.1%	Positive		
West Kent Adults - MIU	4,454	10,280	21,382	-51.9%	Positive		
West Kent Adults - Bed Days	1,723	5,387	5,554	-3.0%	Negative		
Specialist and Elective Services	15,859	49,919	82,610	-39.6%	Negative		
Children's Specialist & Adult LD Services	14,213	43,698	55,792	-21.7%	Positive		
Public Health Services	18,298	46,489	100,077	-53.5%	Positive		
Dental Service	0	0	0	N/A	Positive		
Trust Total Activity against plan	**141,179**	**396,956**	**513,039**	**-22.6%**	Static		

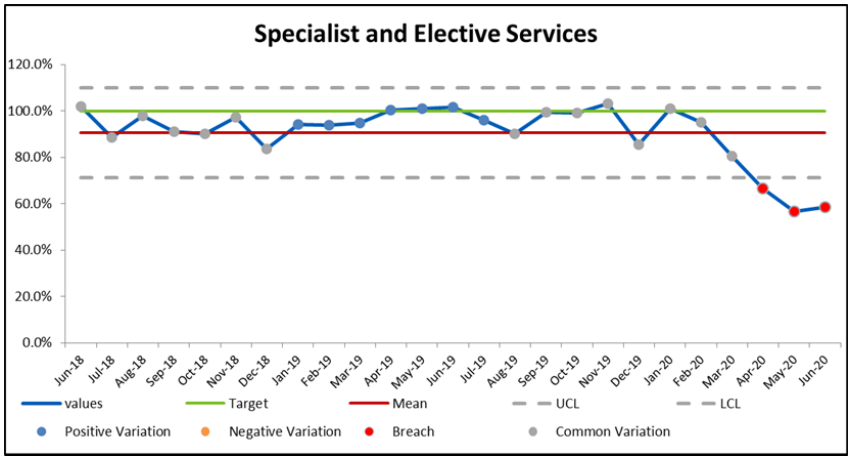
	Internal	Contract
	>+5%	>+10%
	>-5%	>-10%
	+/- 2.5-5%	n/a
	<+/- 2.5%	<+/- 10%
		No Target

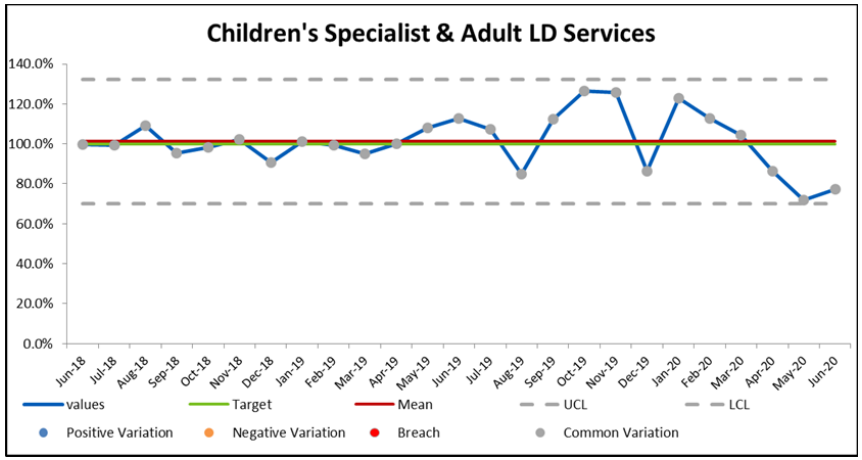
*these figures are not included in the table totals as they don't have a contractual target

The following charts show the monthly activity against target for East and West Kent Adults, Specialist and Elective Services and Children's Specialist & Adult LD Services, with Adult Specialist Services showing a period of negative special cause variation with performance below the lower control limit. However in all the below charts it is clear to see that the reset and recovery is taking effect with increased levels of activity in June 2020

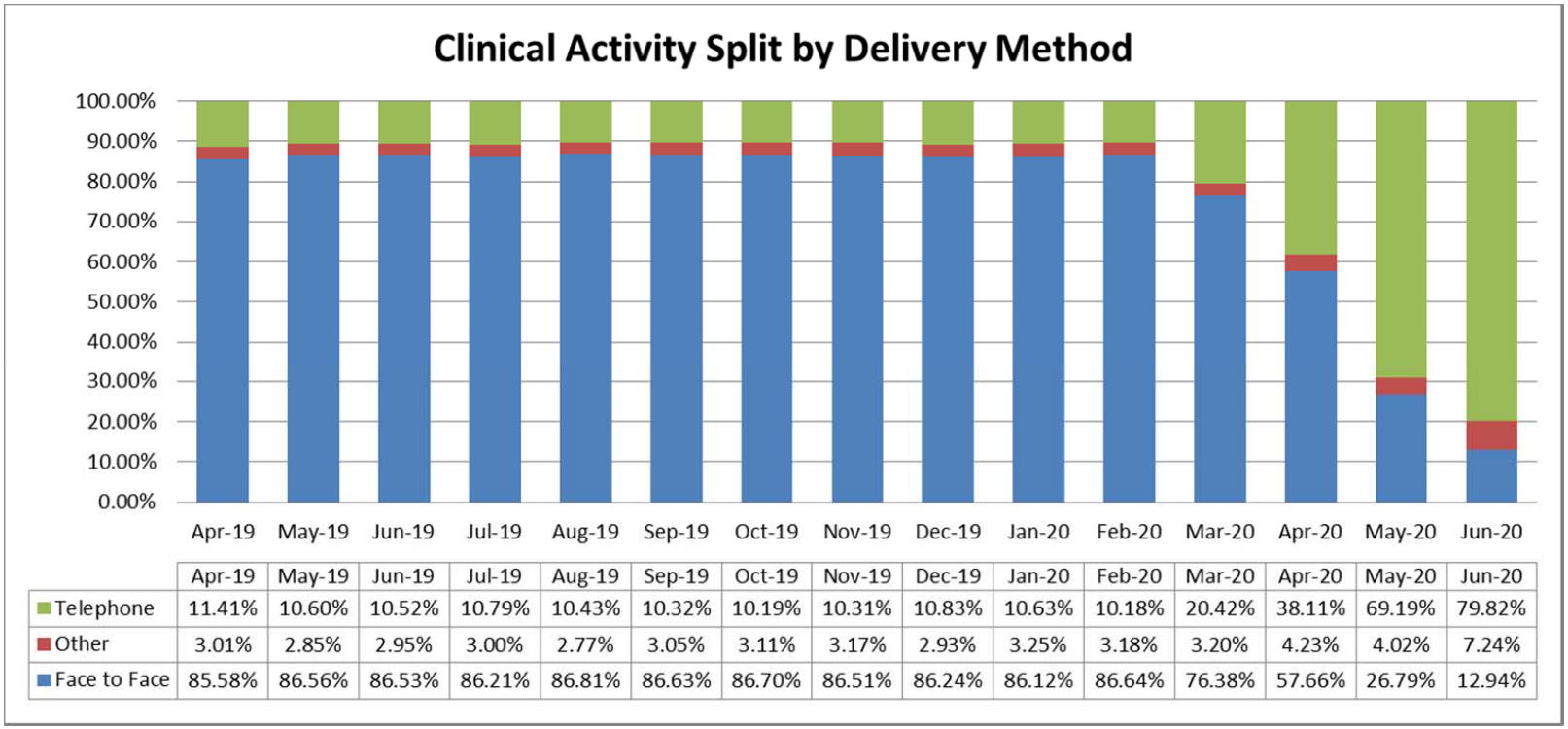






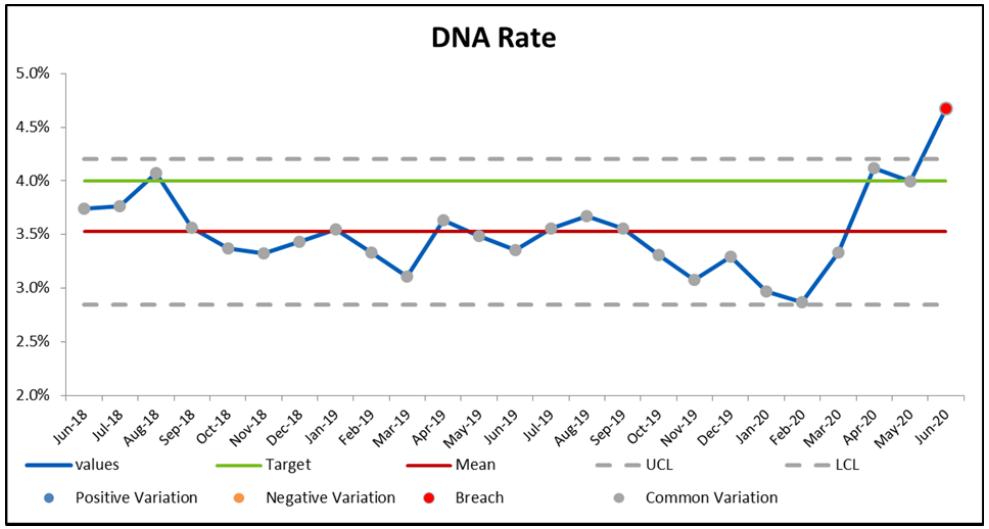


While activity has decreased in Months 2-3 as a result of the Covid-19 pandemic, a number of services have looked at re-configuring their service delivery with a large part of this the implementation of a larger number of telephone or virtual consultations. As you can see from the below the method of activity delivery had shifted in March 2020 and further by June 2020 towards telephone and “other” methods of delivery to shift away from face to face to adapt services to the national picture. Non face to face activity accounted for 87.1% of all activity delivered in April 2020 compared to only 14.4% for April 2019.



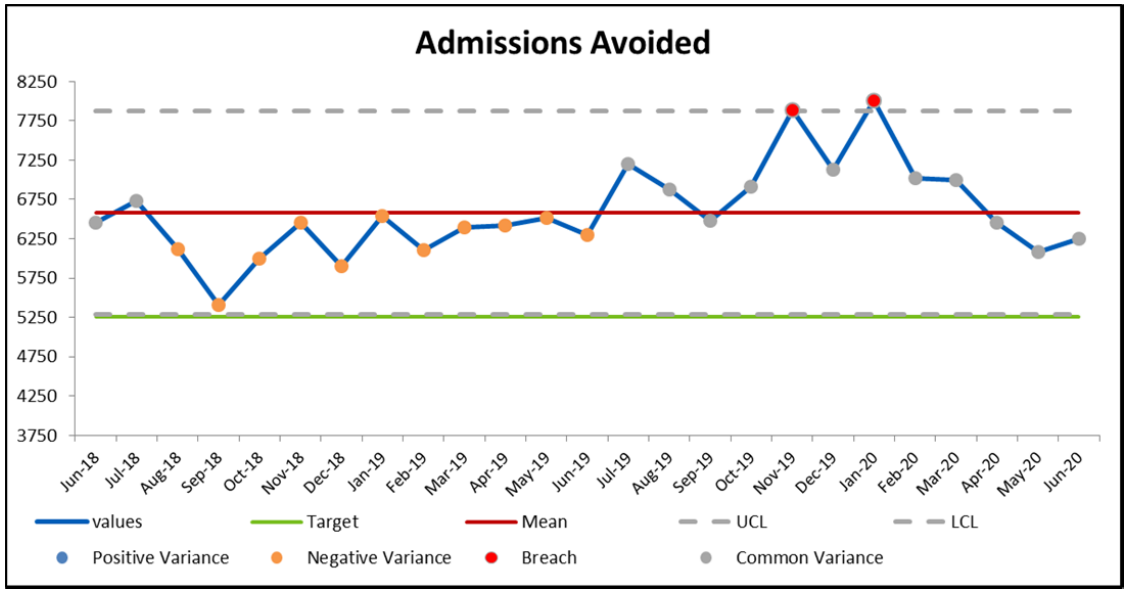
	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Telephone	11.41%	10.60%	10.52%	10.79%	10.43%	10.32%	10.19%	10.31%	10.83%	10.63%	10.18%	20.42%	38.11%	69.19%	79.82%
Other	3.01%	2.85%	2.95%	3.00%	2.77%	3.05%	3.11%	3.17%	2.93%	3.25%	3.18%	3.20%	4.23%	4.02%	7.24%
Face to Face	85.58%	86.56%	86.53%	86.21%	86.81%	86.63%	86.70%	86.51%	86.24%	86.12%	86.64%	76.38%	57.66%	26.79%	12.94%

5.2.2 DNA rates



DNA rates have traditionally fallen below the target of 4%, although there has been an increase in months 1-3 to above the upper control limit as a result of Covid-19 pandemic. This should stabilise and reduce as services are reworked and more appointments delivered in alternative ways but current levels remain higher than usual

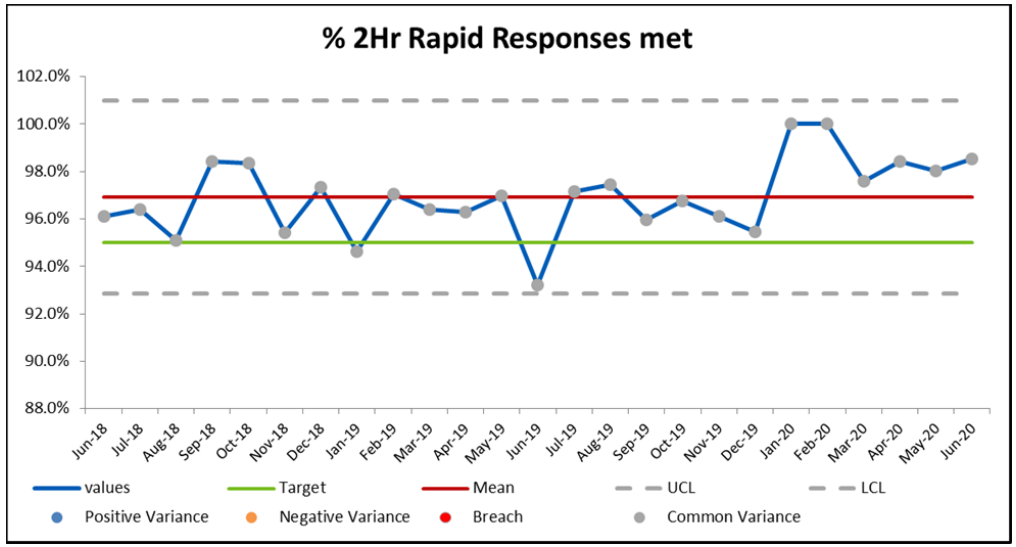
5.2.3 Admissions Avoided



The above chart indicates that performance is experiencing normal variation following a period of increased admissions avoided. Performance against target is favourable with the target below the lower control limit, suggesting the monthly target should always be achieved.

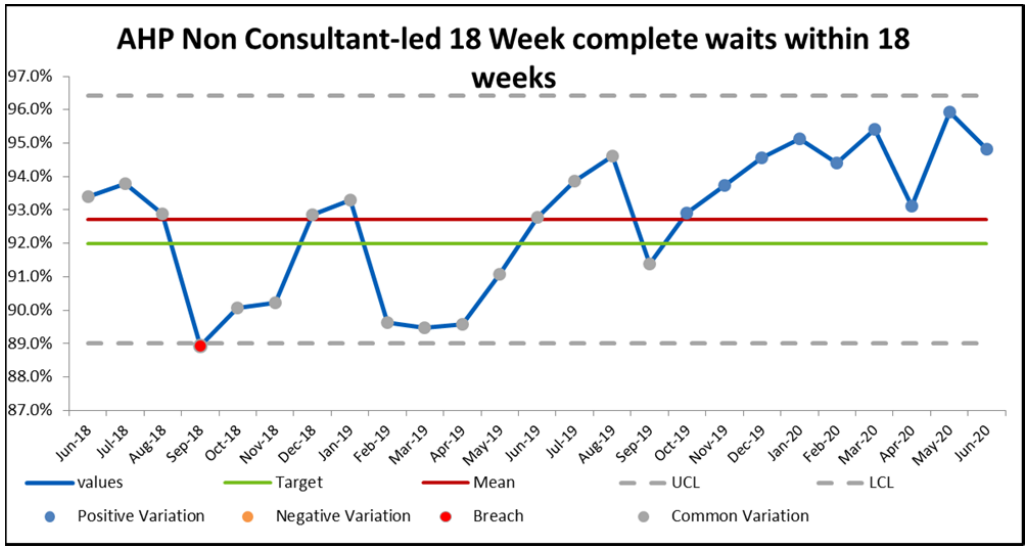
5.2.4 Rapid Response referrals seen within 2 hours

The mean level of performance is sitting above the target level of 95%, with performance in normal variation but performing well, above both the target and mean. However, given the volatility and the high 95% target, it's unlikely the control limits will fully move above the target level in the near future to give full assurance of continual achievement.



5.3 Assurance on Local Wait Times

Completed wait times for all non-consultant-led AHP services are now showing positive special cause variation with an improving trend above the mean as most of the initial appointment backlog has now been cleared and performance is consistently hitting the target

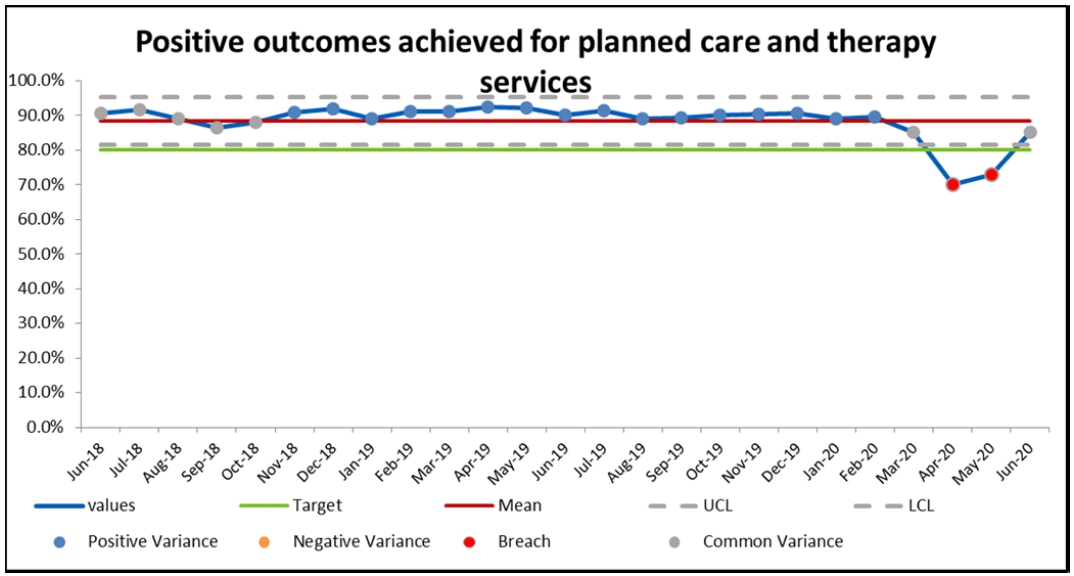


5.4 Covi-19 Related Backlogs

Specialist and Elective services have continued to work virtually and by carrying out home visits during the Covid-19 pandemic which has kept the national referral to treatment times low. However capacity has been reduced to accommodate all government and Trust requirements such as social distancing. Children's Services similarly provided virtual consultations and kept a number of clinics to ensure those children with high risk needs were seen and managed e.g. ADHD medication, audiology hearing loss. RTT was maintained in Children's community paediatrics, audiology at 100% with a drop in children's therapies RTT associated with staff redeployment. In some services delivery was very restricted e.g. podiatric surgery, group work, MSK injection therapy and provision within schools. Trajectories for recovery have been developed and shared with the Trust's recovery task and finish group. Plans are in place to increase face to face clinic access following approval by the reset working group and all services have recovery plans in place which are reviewed by the SES CSDs, Performance managers and Heads of Service.

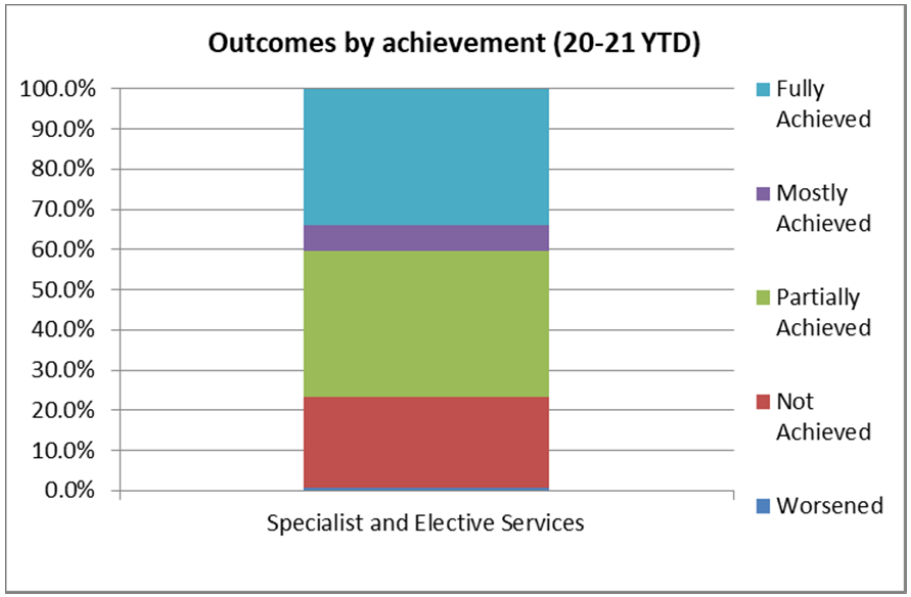
5.5 Outcomes

Aggregate outcomes are currently reported for Adult Specialist and Children's Therapy services (Adults only so far in 20/21 as Children's Therapies have moved to RIO and reporting being developed), with patients receiving a favourable outcome in the vast majority of cases on a consistent basis. However the below is showing negative special cause variation in Months 1 and 2, with the cause as a result of the Covid-19 pandemic and a period of stopping/change within some services. Positively, as services have been reworked in terms of delivery, outcomes have improved into June 2020. The below chart does show that achievement of target is always likely to occur unless a process change or significant event occurs (as has caused the recent drop), as the control limits indicate the range of performance varying month to month should not fall low enough to breach target.



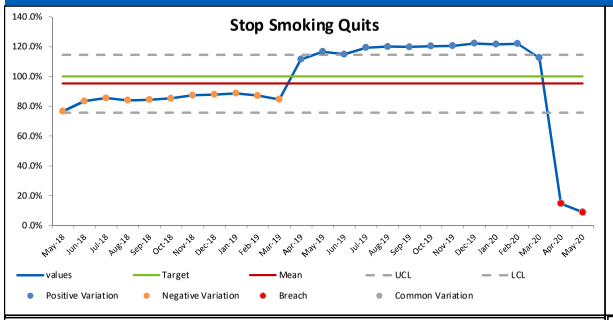
The following table and chart shows the proportion of the grading of each outcome for the year to date. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised. Currently reported as Adults only until reporting is finalised from RIO for Children's Therapies

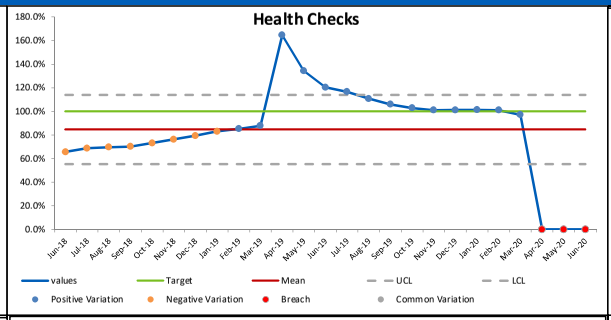
	Specialist and Elective Services
Worsened	0.8%
Not Achieved	22.4%
Partially Achieved	36.5%
Mostly Achieved	6.5%
Fully Achieved	33.9%

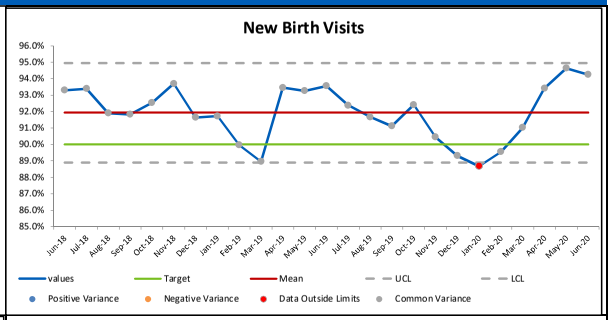


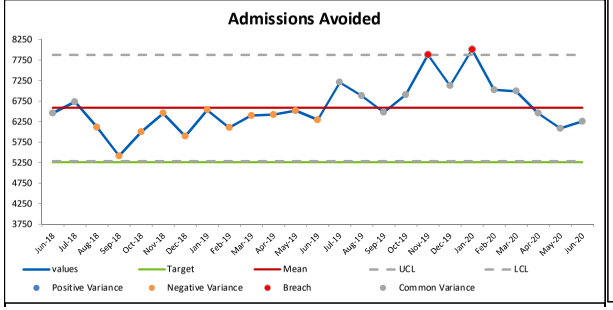
Appendix - Scorecard SPC Charts

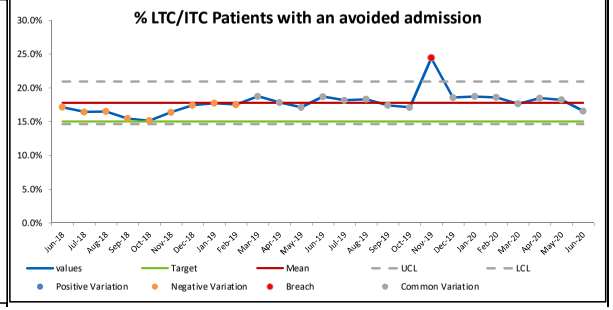
1. Prevent Ill Health





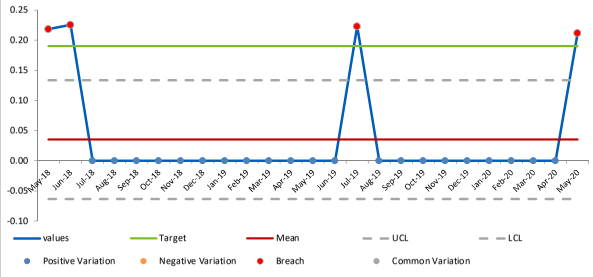




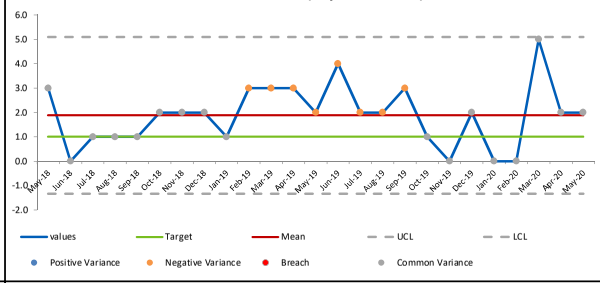


2. Deliver high-quality care at home and in the community

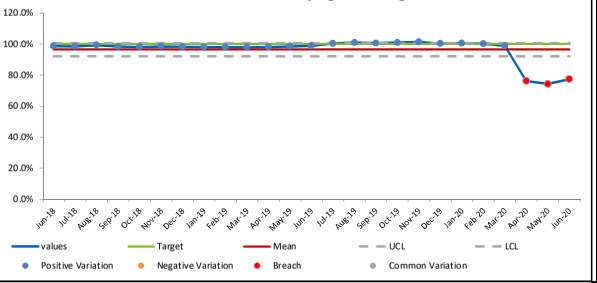
Moderate and Severe falls per 1,000 bed days



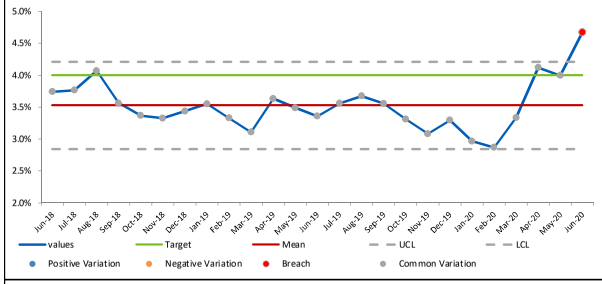
Pressure Ulcers (Lapses in Care)



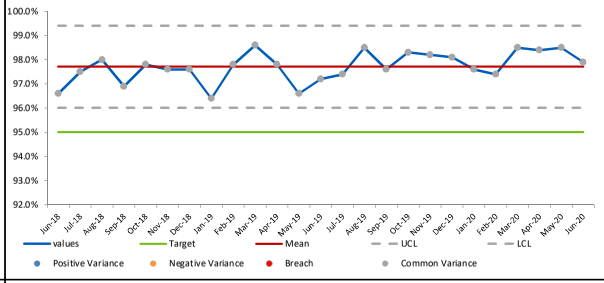
Contractual activity against target



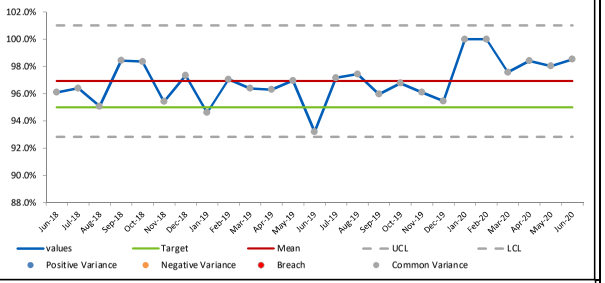
DNA Rate



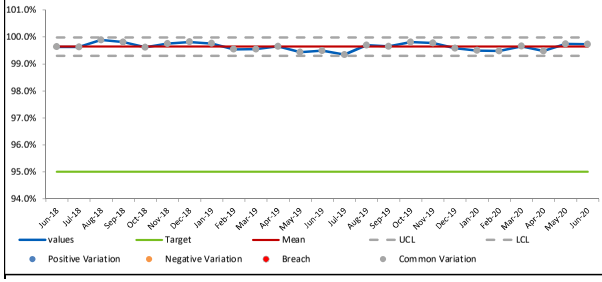
LTC/ICT Response Times Being Met



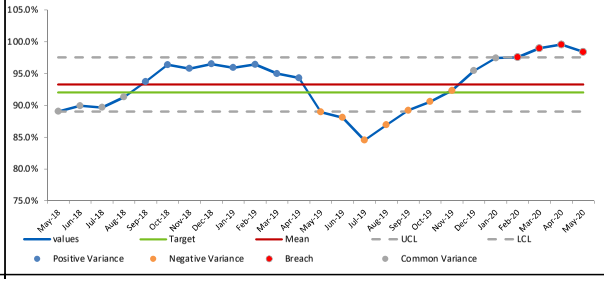
% 2Hr Rapid Responses met



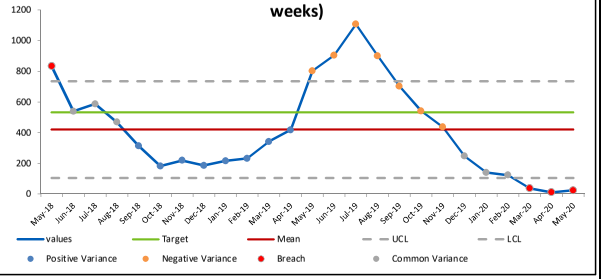
MIU 4Hr Target



Consultant-Led RTT Incomplete Waits

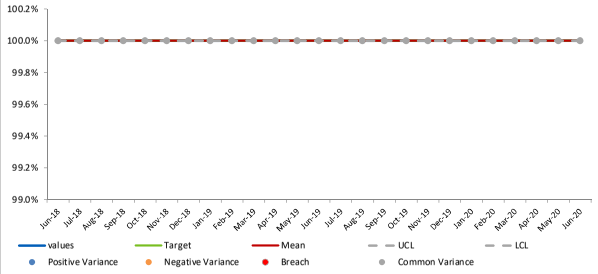


Consultant-Led RTT Incomplete Waits (waiting list size >18 weeks)

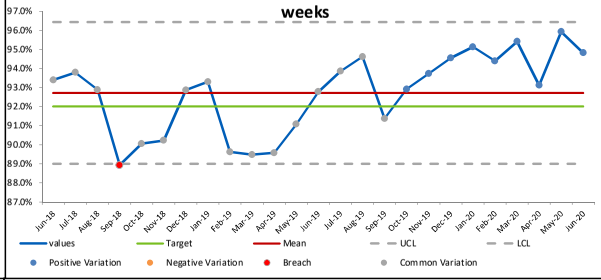


2. Deliver high-quality care at home and in the community

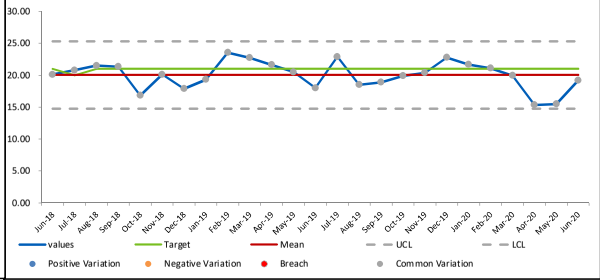
GUM Access within 48Hrs



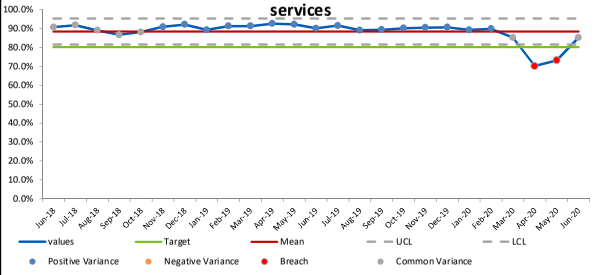
AHP Non Consultant-led 18 Week complete waits within 18 weeks



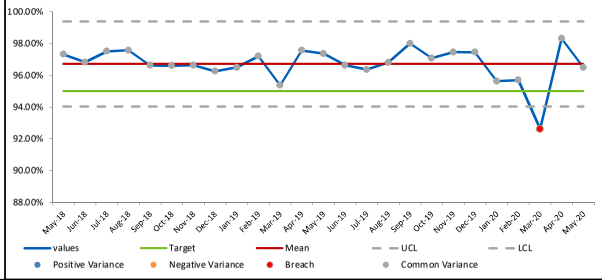
Median length of stay (days)



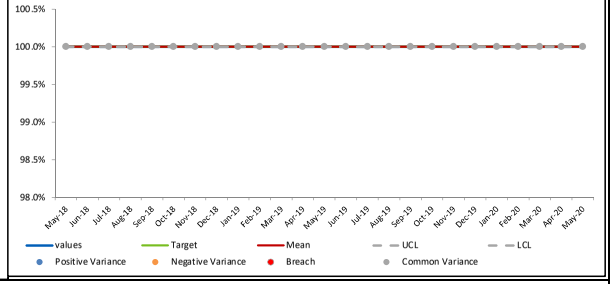
Positive outcomes achieved for planned care and therapy services



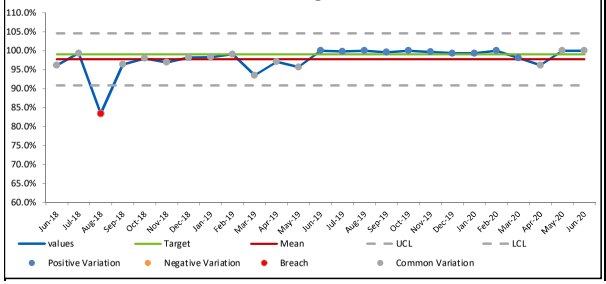
Percentage of patients who would recommend our services



NICE guidance reviewed within timescales

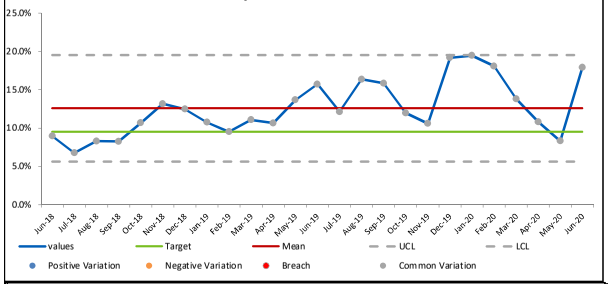


6 week Diagnostics

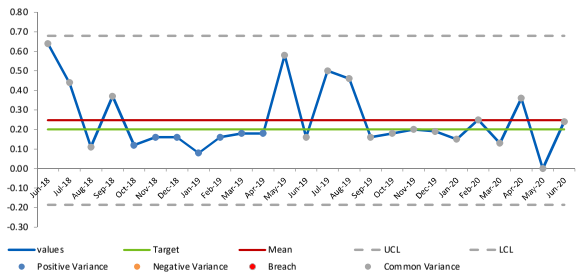


3. Integrate Services

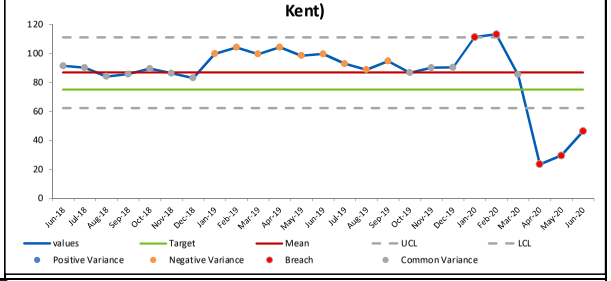
Delayed Transfers of Care



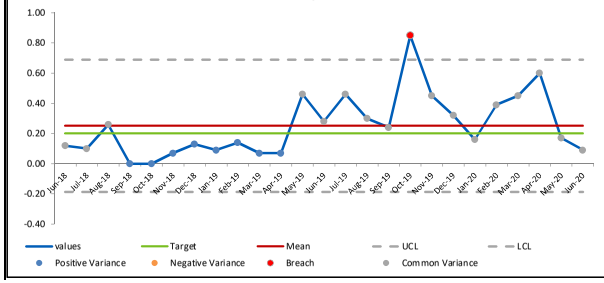
Excess Bed Days - West Kent



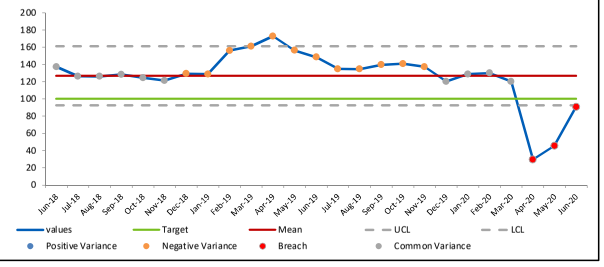
Average Daily Medically Fit For Discharge (MFFD) - (West Kent)



Excess Bed Days - East Kent

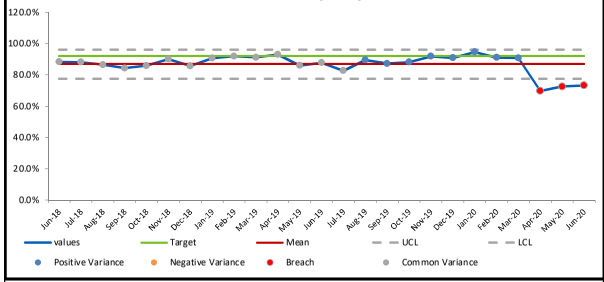


Average Daily Medically Fit For Discharge (MFFD) - (East Kent)

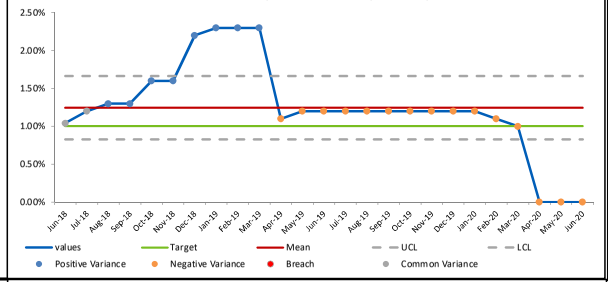


4. Develop sustainable services

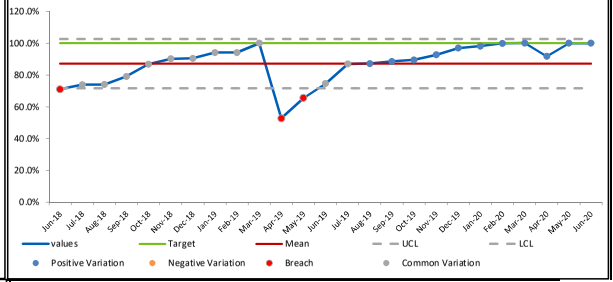
Bed Occupancy



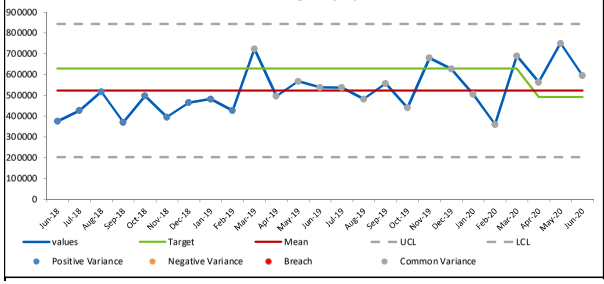
Income and Expenditure Surplus vs plan



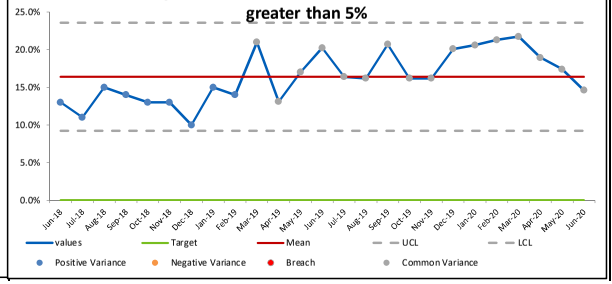
CIP Achieved Against Plan



External Agency Spend

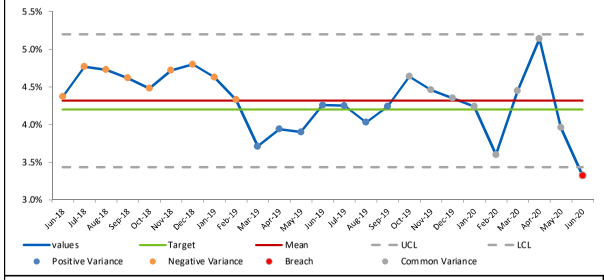


Percentage based on value of Service Lines with deficits greater than 5%

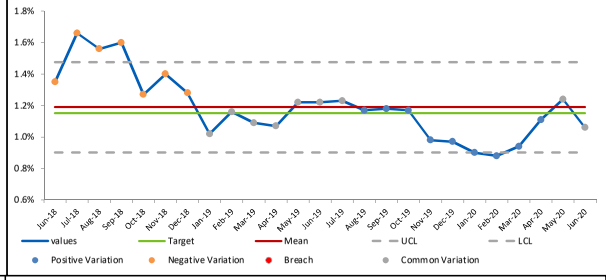


5. Be The Best Employer

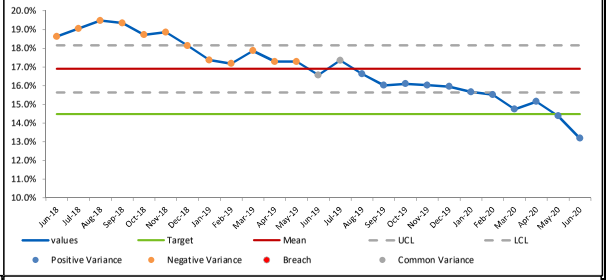
Sickness Absence



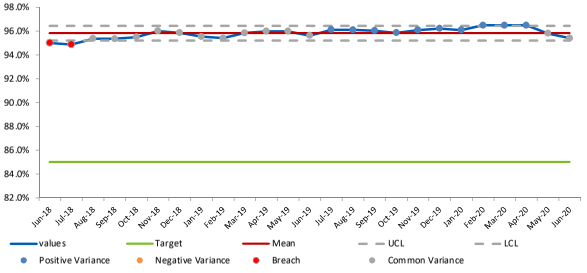
Absence (Stress)



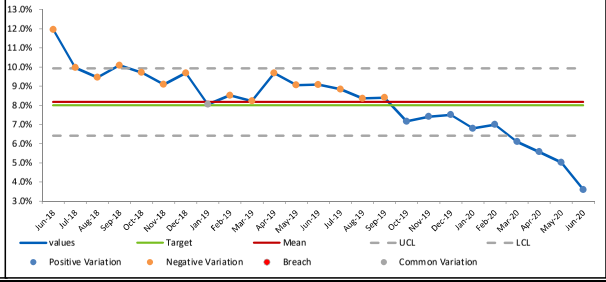
Turnover (Planned and Unplanned)



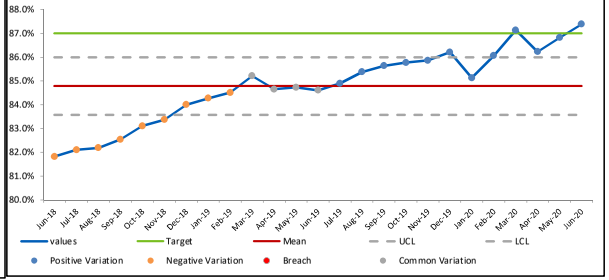
Mandatory Training Rate



Vacancy Rate



Stability



Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.7
Agenda Item Title:	2019/20 Quality Account
Presenting Officer:	Dr Mercia Spare, Chief Nurse

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

Report Summary

Patients want to know they are receiving the very best quality of care. Providers of NHS healthcare are required to publish a quality account each year.

This report describes and delivers assurance of the view of quality of relevant health services provided or subcontracted by Kent Community Health NHS Foundation Trust (KCHFT) during 2019/20. It details the quality of care in relation to the 2019-20 priorities and the quality goals for 2020/21.

It has been prepared in accordance with the NHS Improvement's annual reporting manual and supporting guidance (which incorporates the quality account regulations)

Amendments to regulations for the 2019/20 quality accounts are now in force; NHS providers are no longer expected to obtain assurance from their external auditor on their quality accounts and NHS foundation trusts are no longer required to include a quality report in their annual report for this year.

Proposals and /or Recommendations

The Board is asked to approve the 2019/20 Quality Account.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?

No ☒

High level position described and no decisions required.

Dr Mercia Spare, Chief Nurse	Tel: 07384878317
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NHS
Kent Community Health
NHS Foundation Trust

Quality account

2019 to 2020

we care

Contents page

Part one: Introduction

Statement on quality from the chief executive

Welcome to the quality report for Kent Community Health NHS Foundation Trust for 2019/20.

Patients, service users and the people we care for have always been – and always will be – at the heart of everything we do at the trust. While the response to the COVID-19 pandemic was very late in the year, which this report covers, it reinforced the importance of continuing to deliver outstanding patient care to the most vulnerable in our communities.

The year has been a significant one for KCHFT. The trust was inspected and rated as outstanding by the Care Quality Commission; recognition of the dedication and compassion of colleagues working across the organisation.

Our people are how we deliver outstanding care and we are committed to nurturing home grown talent in our academy and across the trust. A second cohort of student nurses joined the programme in February 2020; they will be supported to develop their careers while continuing to work in their substantive positions within the trust. We also extended and invested in occupational therapy apprenticeships and, in the past year, we launched the Admin Academy, which aims to further develop the skills of admin colleagues across the organisation.

Patient safety is the cornerstone of the care we deliver. In 2019/20, our Patient Safety Team successfully led and delivered a number of projects to support colleagues to maintain the safety of people who use our services. These include a programme of investigator training, which has enabled us to improve the quality and consistency of investigations.

The trust also implemented and trained staff in use of the NEWS2 tool in all our community hospitals. The tool provides an early warning score, which has improved the early recognition of patients who deteriorate. We continued to work with colleagues to drive further improvement though our active membership of Kent, Surrey and Sussex Deterioration Collaborative.

An important part of patient experience is helping people to feel confident, empowered and supported to resume or carry out their usual daily activities. I'm proud to report that in patient satisfaction surveys, 98 per cent of our patients said they felt involved and supported during their community hospital stay to build the confidence to carry out their usual activities, while 99 per cent of patients felt that community nursing visits had a positive impact on their health and wellbeing. This feedback is crucial and allows us to continually improve the services we deliver by helping us to learn how we can do better.

An example of this was a patient who said there were insufficient mirrors in our community hospital bathrooms, so now patients have access to handheld mirrors. During the COVID-19 pandemic, we restricted visiting to community hospitals as one of many steps to make the hospitals as safe as we could; however we invested in in a number of handheld computers so that patients could stay connected with their loved ones virtually. This has proven very popular with patients, carers and staff, albeit we recognise that nothing replaces seeing a loved one in person.

Caring for patients at the end of their life remains a key focus for the trust. In 2019/20, we worked with the Kent and Medway health and social care system and the Point of Care Foundation to implement the Sweeney programme. The aim of this two-year programme is to support the trust to understand and improve the experience of patients at the end of their life and that of their families. The programme's tools help healthcare professionals recognise the impact of their own routines and practices through the experience of service users and supports them to modify or change what they do to enhance patient experience.

Our quality improvement programme has continued

to gather momentum in 2019/20, with a further 82 people completing the five-day QSIR practitioner course and 324 colleagues attended a one-day quality improvement fundamentals course. The attendance for both programmes has exceeded our targets for the year, meaning we have more people innovating and improving how they deliver care, co-designing with service users wherever possible.

We understand and value the importance of research within a community setting. This year, our research champion programme engaged a further 10 clinical members of staff who went on to carry out their own clinical investigation, spreading research confidence across the organisation, making improvements to clinical care and encouraging colleagues to do the same.

Our people are our most important asset and their health and wellbeing is paramount if we are to continue to deliver outstanding care. The trust has continued to develop a comprehensive health and wellbeing package, which includes our Time to Change programme, members of our team who provide mental health understanding and support.

Other wellbeing initiatives include fast track physio, counselling, in-house sports teams including football, netball and a walking challenge called flo fit. We also have health checks with our own One You service, gym discounts, the wellness passport, cycle to work scheme, a menopause awareness network and a focus on the importance of taking a lunch break.

We will continue to listen to the needs of staff and act accordingly.

While we strive to get things right every time, I recognise we do, on occasion, fall short. We have overt and transparent channels for staff and patients' feedback and I strongly value everyone who takes the time to offer their thoughts, so we can learn, change and make improvements for the future.

.....

Paul Bentley, Chief Executive Officer

Date .....

Part two: Our quality priorities

Priorities for improvement and statements of assurance from the Board

Priorities for improvement

About our trust

We provide wide-ranging NHS care for people in the community, in a variety of settings including people's own homes; health clinics; community hospitals; minor injury units; nursing homes and in mobile units.

Kent Community Health NHS Foundation Trust (KCHFT) is one of the largest NHS community health providers in England, serving three million people; 1.5million living in Kent and 1.5million people outside of Kent. We employ more than 5,000 staff, including doctors, community nurses, allied health professionals, domestics, drivers, administrators and many other essential healthcare workers. We became a foundation trust on 1 March 2015.

Vision

Our vision is a community that supports each other to live well.

Mission

Our mission is to empower adults and children to live well, be the best employer and work with our partners as one.

Values

We have four values:

1. **Compassionate** – we put patients and our service users at the heart of everything we do. We're positive, kind and polite. We understand diversity. We're respectful, patient and tolerant.

2. **Aspirational** – we feel empowered and we empower our patients. We strive to improve. Our focus is on research and generating ideas and innovations. We're open, transparent and we think creatively.

3. **Responsive** – we listen. We act. We communicate clearly. We do what we say we will. We take account of the opinions of others.

4. **Excellent** – we strive to deliver the best care we can. We grow a culture of excellence in our teams. We challenge complacency.

Our goals are:

1. prevent ill health
2. deliver high-quality care at home and in the community
3. integrate services
4. develop sustainable services.

Our quality strategy 2017 to 2020

Our organisational strategy recognises the importance of providing high-quality services and is central to our vision, mission and values. This is enshrined in our quality strategy.

It places quality at the heart of everything we do to deliver services we are proud of and that make a positive difference to the communities we serve.

Improving quality is the role of every single employee and we wish to partner with patients and carers, where possible, to bring about quality improvements to our services.

We aim to embed quality at all levels and to deliver demonstrable improvements in patient care by:

- enhancing patient experience
- improving population health by improving patient outcomes, clinical effectiveness and national benchmarks, improving safety and reducing harm
- improving staff experience at work
- reducing cost and increasing value for money to increase efficiency.

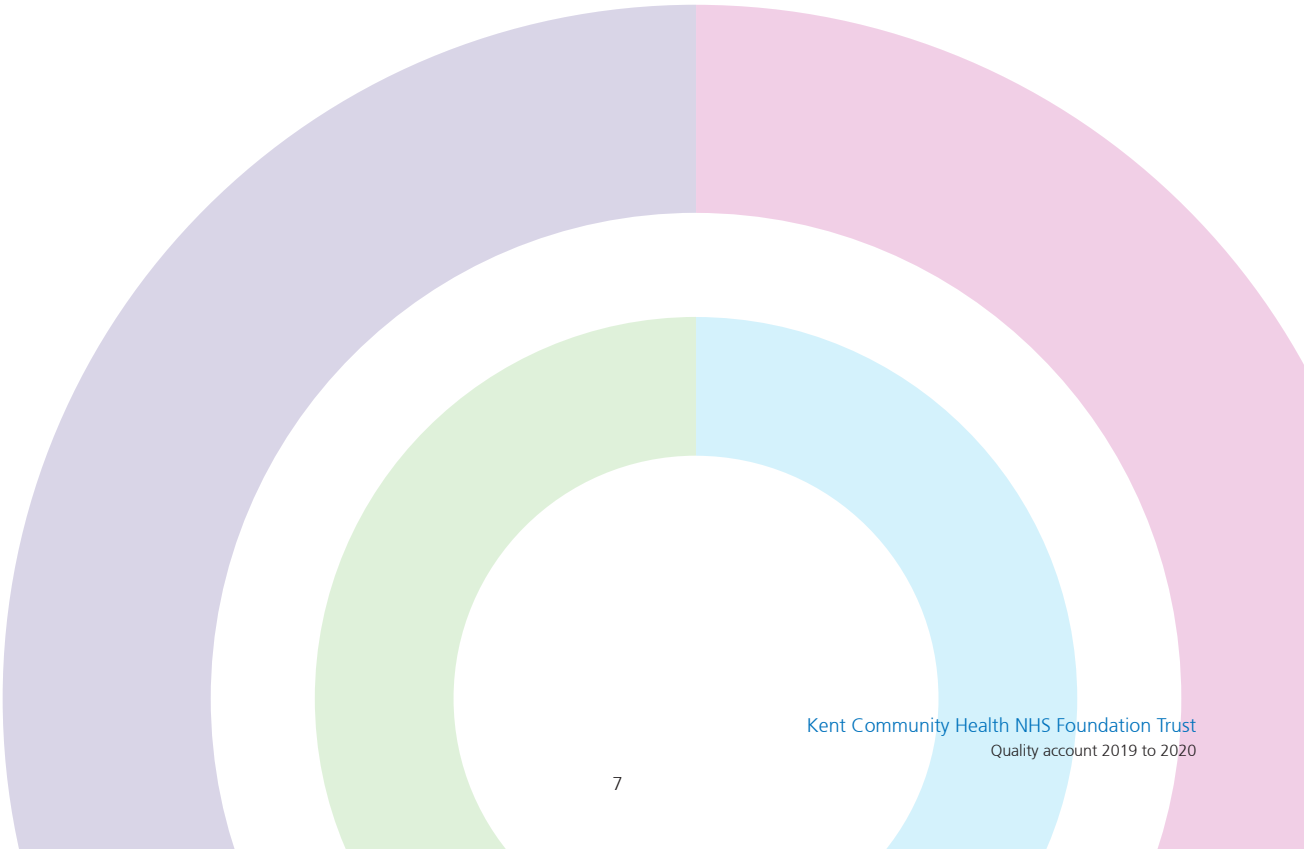
This is known as the quadruple aim.

Quality is central to all we aspire to achieve:

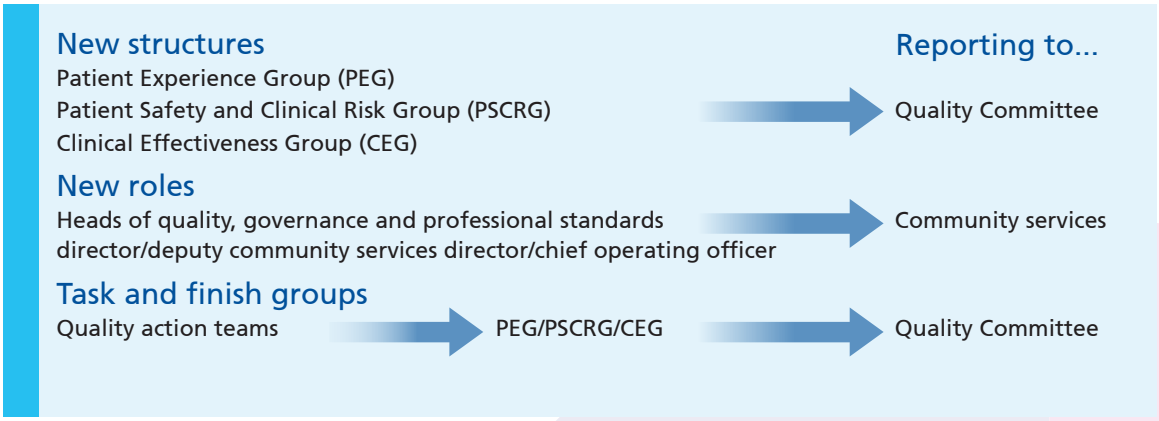
- Patient experience – be nice to me.
- Patient safety – do me no harm.
- Clinical effectiveness – make me better, help me live with my condition and help me die in a way I choose.

Our objectives for quality are:

- visible corporate leadership
- all employees to take ownership
- improved patient experience and increased patient and public engagement and involvement
- clinically and cost effective evidence-based services
- improved patient safety
- organisational learning to enhance quality
- engagement with external partners.



Delivering quality:



We have a comprehensive action plan in place to achieve our quality strategy.

Summary against 2019/20 priorities

Our strategic priorities

Through a robust consultation process four strategic priorities were selected for 2019/20, these were:

- 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.

These strategic priorities were mapped to the 2019/20 quality priorities to make sure there was a clear thread from the organisational strategy to operational service delivery. This enabled the differing requirements placed on our staff delivering the key improvements to be streamlined to benefit our people and our patients.

Our quality priorities for 2019/20 were developed in consultation with our partners, service users and their families. They are shown here:

Patient experience

- 90 per cent of relevant patients report their personal goals were accounted for.
- 15 patient and service users to complete the quality improvement fundamentals training.
- Where able, 75 per cent of patients report they were confident, empowered and supported to carry out their usual activities.

Patient safety

- 15 per cent increase of all relevant patients to have personalised plans of care.
- Increase, by 20 per cent, the number of investigators supported to recognise human factors as a contributing factor.
- To implement and embed NEWS2 across our community hospitals.

Clinical effectiveness

- Participate in the Sweeney programme collaborative to improve the experience of patients at the end of life and their families.
- Continue our quality improvement journey with a total of 100 people completing the QSIR practitioner course and 300 people completing the quality improvement fundamentals course.
- 10 projects with associated reports and poster abstracts will be carried out as part of the Research Champions Programme to develop the research capabilities of our clinical staff.

Staff experience

- 90 per cent of relevant staff state: The personalised plans of care developed meet the needs of the people they care for.
- Work with our staff to increase accessibility and usability of our policies, procedures and guidelines through a quality improvement approach.
- A 35 per cent positive response in the NHS staff survey for 'Does your organisation take positive action on health and wellbeing?'.

Quality achievements 2019/20

We have highlighted below our key achievements during the past year. Section three of this report explains in more detail what we have achieved against our quality priorities and those areas we need to improve upon.

Patient experience

- 69,367 patient experience surveys completed across the trust with an average satisfaction rate of 97 per cent.
- 98 per cent of patients felt supported and involved during their stay to build confidence to carry out their usual activities. This exceeded the 75 per cent target.
- 99 per cent of patients felt that community nursing visits had a positive impact on their health and wellbeing. This exceeded the 75 per cent target.

Patient safety

- KCHFT's Patient Safety Team developed and rolled out investigator training. The number of investigators trained exceeded the target by 17.
- NEWS2 was introduced in all community hospitals. The deteriorating patient audit showed that 94 per cent of patients were appropriately escalated.
- KCHFT was represented at the Kent, Surrey and Sussex Deterioration Collaborative.

Clinical effectiveness

- 150 people completed the QSIR practitioner course and 409 attended the one-day quality improvement fundamentals; this exceeded the target by 50 for QSIR practitioner and 109 for quality improvement Fundamentals.
- As planned, we signed up to the Sweeney collaborative, run by the Point of Care Foundation.
- The research champions programme achieved target and engaged a further 10 clinical members with the Research Team and their own clinical investigation.

Staff experience

- Policies and procedural documents were defined; the number of policies were consequently reduced by 40 increasing their accessibility and usability.
- The number of Time to Change Champions increased from 116 to 175.
- KCHFT's Time to Change programme was named as runner-up in the Kent Chartered Institute of Personal Development's annual awards in October 2019.
- 43.5 per cent positive response rate in the NHS Staff Survey for 'Does your organisation take positive action on health and wellbeing?' compared to a 33.1 per cent positive response rate in comparator trusts.

Our quality priorities for 2020/21

The following table details the three quality improvement projects for learning disabilities, improving outcomes and psychological safety that KCHFT will carry out in 2020/21. These priorities are aligned to the strategic goals and identified based on current risks, national priorities, strategies and reviews, operational business plans and the NHS Long Term Plan.

The 2020/21 quality priorities were determined through a robust consultation process, which included a survey, engagement with services and governance groups, input from staff, stakeholders, patients and their families and carers.

All our quality priorities follow an established governance structure, which monitors and measures performance and progress. Each individual quality priority has a responsible lead who monitors and reports progress each quarter to the Quality Committee, which is a subcommittee of the Board with delegated decision-making powers. The Quality Committee is responsible for providing information and assurance to the board of directors that the trust is safely managing the quality of patient care, the effectiveness of quality interventions and the safety of patients.

To align with our quality strategy objectives and to increase workforce engagement, how we measure and monitor the quality priorities will be based on quality improvement science and methodologies. Each of these priorities will be developed into a quality improvement project.

A summary of next year's quality priorities and what we intend to achieve is shown on the next page.

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 quality improvement, 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 learning disability champions in general services to increase the knowledge and expertise of working with people with a learning disability
Improving outcomes	90 per cent 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 delivery of research follows the patient pathway and is not restricted by organisational boundaries	The Patient/Carers' Council to support, during the next two years, 100 per cent of services to have an identified patient/carer voice in the delivery of care. In the first year, 50 per cent of services will have an identified patient/carer voice in the delivery of care	A two per cent reduction in the annual staff survey of KCHFT staff reporting: 'During the past 12 months have you felt unwell as a result of work-related stress?'
Psychological safety	A three per cent 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 per cent of QSIR practitioners are actively involved in or sponsoring quality improvement project(s) six months after achieving practitioner status	A total of five Schwartz rounds to have taken place with evaluation shared with the 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 per cent decrease in the number of staff reporting discrimination from colleagues in the annual staff survey

Statements of assurance from the Board

During 2019/20 KCHFT provided and/or sub-contracted 53 relevant health services.

KCHFT has reviewed all data available on the quality of care in all of these relevant health services.

The income generated by the relevant health services reviewed in 2019/20 represents 100 per cent of the total income generated from the provision of relevant health services by KCHFT for 2019/20.

During 2019/20, six national audits and one national confidential enquiry covered relevant health services that KCHFT provides. KCHFT participated in 83 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries of those it was eligible to participate in, they are:

- National Diabetes Footcare Audit (NDFA)
- Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life (NACEL)
- Falls and Fragility Fracture Programme/ National Audit of Inpatient Falls (NAIF)
- Long Term Ventilation Study (National Confidential Enquiry into Patient Outcome and Death (NCEPOD))
- Parkinson's UK*(We were unable to resource the requirements to undertake the audit)

The national clinical audits and national confidential enquiries that KCHFT participated in during 2019/20 were:

- National Diabetes Footcare Audit (NDFA)
- Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Cardiac Rehabilitation
- National Audit of Care at the End of Life (NACEL)
  Falls and Fragility Fracture Programme/ National Audit of Inpatient Falls (NAIF)
- Long Term Ventilation Study (National Confidential Enquiry into Patient Outcome and Death (NCEPOD)

The national clinical audits and national confidential enquiries that KCHFT participated in, and which data collection was completed during 2019/20, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases, required by the terms of that audit or enquiry.

- National Diabetes Footcare Audit – no minimum requirement from audit provider (126 cases submitted)
- Sentinel Stroke National Audit Programme (SSNAP) – no minimum requirement for community (278 cases submitted)
- National Audit of Cardiac Rehabilitation – no minimum requirement (803 cases submitted)
- National Audit of Care at the End of Life – 100 per cent
- Falls and Fragility Fracture Programme / National Audit of Inpatient Falls (NAIF) – no minimum requirement (1 case submitted)
- Long Term Ventilation Study (National Confidential Enquiry into Patient Outcome) –100 per cent

The reports of four national clinical audits were reviewed by the provider in 2019/20 and KCHFT intends to take the following actions to improve the quality of healthcare provided:

- The National Audit of Cardiac Rehabilitation Report demonstrated that KCHFT meets the criteria for certification and as such meets all the requirements for a fully comprehensive cardiac rehab programme. However, following review of the report the service have created an online cardiac rehab section to increase patient choice, especially for those unable to attend face-to-face rehab appointments and exercise classes. This is operational and has proved useful in the current climate of needing to limit face to face interaction.
- Sentinel Stroke National Audit Programme (SSNAP) – five CCG locality reports were reviewed. Community teams receive SSNAP reports twice a year – January to June and July to December. The review below relates to the July to December 2019 period as January to June 2020 will not be available until September 2020. The total number of cases submitted was 278 (all localities had one data set except one that had separate early supported discharge and community rehabilitation team data sets). SSNAP does not report on the expected

number of cases for community teams. On reviewing the proportion of patients who require rehabilitation post stroke from other available data it appears as if fewer cases were reported for this six-month period than expected. However, this is because we can only add on to records that have been submitted by the acute hospital. Issues relating to data collection across the pathway are being reviewed and solutions are being explored. In terms of aspects relating to pathway processes and therapy intensity the current stroke development work across Kent and Medway will come with funding that will increase workforce resources. The outcome and any specific aspects of the review will be shared with the service / operational managers.

- Falls and Fragility Fracture Programme / National Audit of Inpatient Falls – report just published. To be reviewed by new falls co-ordinators who will take actions forward.
- The National Audit of Care at the End of Life (NACEL) – while acknowledging the small numbers of patients eligible to be submitted by KCHFT and therefore the difficulties with making decisions and changes to policy based on those small numbers the trust is using the NACEL audit criteria and NICE Guidelines to align our priorities of care to making the NACEL audit tool a meaningful tool to use internally.
- In addition to the named quality account audits, the reports of two national audits were reviewed by the provider in 2019/20 and KCHFT intends to take the following actions to improve the quality of healthcare provided:
- British Association for Sexual Health and HIV (BASHH) National Audit of timeliness to be seen, test results and treatment. Post audit a new national standard was introduced to achieve treatment within three weeks of testing in 85 per cent of cases. This is already being achieved locally. The main action to improve the quality of care is to review service level agreements to ensure that laboratory turnaround times are included in contracts and that there should be provision for local monitoring of this.
- British HIV Association (BHIVA) Management pathways for new HIV diagnoses. National BHIVA audit assessing time from positive HIV test to specialist assessment and time from diagnosis to antiretroviral therapy initiation. Main actions to improve focussed on two out of three sites included in the audit these included raising awareness of peer community support with newly diagnosed individuals and reviewing individuals who have not started antiretroviral therapy within six to eight weeks of diagnosis to identify possible support needs.
- The reports of 57 local clinical audits were reviewed by the provider in 2019/20 and KCHFT intends to take the following actions to improve the quality of healthcare provided:
- Safeguarding audits were carried out in multiple services across the trust, including health visiting, audiology, continence, children's therapies, special schools and short breaks, looked after children, sexual health, dental and adult services. A common theme was for the electronic patient record system to incorporate safeguarding elements. Service specific actions being taken to further enhance quality:
  - Community paediatrics – document for carer to complete when attending clinic to identify their name and relationship and if they have any parental responsibility.
  - School health East Sussex – new named nurse appointment to work on a three month plan of safeguarding supervision in East Sussex, including bespoke training for the team.
  - Health checks – to work with health diagnostics to help health care advisors record if the patient has been signposted to One You services.
  - Children's and adults dental – training to be given for accurate completion of mental capacity forms and accurate recording of consent and for recording of whether children or young people who are patients are on a care protection plan.
  - Sexual health services – audit demonstrated significant assurance. Actions include making sure communication with social worker, where child is subject to child protection plan or child in need, is documented. This is to be monitored through discussion in safeguarding supervision meetings.
- Infection prevention and control audit of nine community hospitals – five hospitals received a green rating of 95-100 per cent compliance. Four hospitals received an amber rating of 89-94 per cent compliance. No hospitals received a red rating of less than 85 per cent. Fortnightly visits to be carried out by infection prevention and control practitioners to

review the status of reports and issues, which centred on making sure awareness of the decontamination form within medical devices policy, adherence to sharps management and disposal in particular use of the temporary closure mechanism on sharps boxes to prevent accidental spillage of contents, if knocked over.

- Prison dental record keeping – audit demonstrated significant assurance with detailed information on reasons for attendance, intra and extra oral examinations, up-to-date charting of existing teeth, filling and cavities recorded, as well as treatment options, risk and benefits of options and treatment plans. Improvements required in relation to recording of NHS number. Actions to improve this include sharing record keeping guidance to staff and reviewing software of excellence (SOEL) examination templates.
- Audit of complaints management – audit demonstrated full assurance and in 100 per cent of cases the tone of correspondence was considered to have shown respect and compassion, offering an appropriate apology. To further improve the process, complaints officers to make sure that 100 per cent of complainants receive a making a complaint fact sheet. The checklist used by the complaints officers is to be updated accordingly to make sure this happens.
- Alcohol and tobacco CQUIN – this quarterly audit was carried out separately in east and west Kent. Results in east and west demonstrated that the screening of patients for both smoking and drinking alcohol above the safe limits was embedded well into clinical practice and provided significant assurance. Actions in the east were focussed on working with all professionally registered staff to make sure they understand and are confident with providing brief advice to all patients identified as smoking or drinking above the low risk levels. By the third quarter, the east had achieved full assurance. Actions in the west were focussed on making sure new starters were trained to assess and support patients in this domain and that holistic assessment was carried out to support patients in managing their risky behaviours.
- Therapy outcome measures audit in East Sussex – task and finish group to propose ways in which the service can make therapy outcome measures part of the conversation with service users. The aim of this is to make sure that staff, parents, carers, service users have a shared understanding of the purpose and scope of therapy and in consequence are better able to collaborate in care planning.
- Peri-mental health audit – to improve the quality of care the perinatal mental health pathway is being updated, staff are receiving training and relevant questions related to perinatal mental health are now mandatory fields in the electronic health record.
- Prevention and management of pressure ulcer audit – actions include embedding the formal assessment tool and template on Rio and updating training.
- Do not attempt cardiopulmonary resuscitation (DNACPR) – DNACPR audits carried out in the community hospitals in east and west Kent. For the east, the actions relate to making sure staff document all discussions with patients/relatives or representatives and detail who the discussion has been carried out with by name and not just their relationship with the patient. In the west, the focus is on reviewing the status of DNACPR forms at transfer and making sure that discussions with patients and relatives regarding DNACPR are documented.
- Handover of Clinical Care Audit – audit reviewed the internal transfer form used to support the transition of children moving within East Sussex from one team to another. Actions included updating the form to reflect the system of planning care. As part of this the standard operating procedure for transfer of care has been updated and includes whose role it is to complete each task in handover.
- Safe management of IV therapy – aim following the audit is to increase the amount of completed IV core care plans from 10 per cent to 60 per cent in nursing notes and increase recording of patient's allergy status in nursing documentation including completed IV risk assessments from 92 per cent to 95 per cent in patients' notes.

- Three high-impact actions to prevent hospital falls (CQUIN) – this CQUIN was carried out quarterly in both adults east and west Kent localities and looked at three criteria: 1) Lying and standing blood pressure, recorded at least once; 2) No hypnotics, anxiolytics or antipsychotics given during stay or rationale for giving documented, 3) Mobility assessment documented within 24 hours of admission stating walking aid not required or mobility/walking aid provided within 24 hours of admission. Both east and west Kent community hospitals achieved significant assurance. The east locality identified trends and themes where assessments were not carried out within 24 hours of admission. In the west locality, improvements were focused on increasing the amount of patients who have a full assessment on admission.

The number of patients receiving relevant health services provided or subcontracted by Kent Community Health NHS Foundation Trust during 2019/20 that were recruited during that period to participate in research approved by a research ethics committee was 210.

A proportion of KCHFT income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between KCHFT and any person or body it entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2019/20 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-19-20/ for the majority of the CQUINs. Further details on agreed goals outside of nationally mandated schemes with NHS England are available on request.

The monetary total for income in 2019/20 conditional upon achieving quality improvement and innovation goals was £1,646,837. The monetary total for income in 2018/19 was £3,433,200.

KCHFT is required to register with the Care Quality Commission and its current registration status is registered without conditions. The Care Quality Commission has taken enforcement action against KCHFT during 2019/20. This was a requirement notice issued in May 2019, at the Dental service, HMP Swaleside relating to regulation nine – person-centred care. KCHFT responded to the requirement notice with a report and action plan and following a review in October 2019, the requirement notice was removed as the CQC found the trust to be compliant.

KCHFT has not participated in any special reviews or investigations by the CQC during the reporting period.

KCHFT submitted 81,363 records during 2019/20 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics, which are included in the latest published data.

The percentage of records in the published data, which included the patient's valid NHS number was:

- 100 per cent for admitted patient care
- 99.56 per cent for accident and emergency care.

which included the patient's valid General Medical Practice code was:

- 99.60 per cent for admitted patient care
- 99.01 per cent for accident and emergency care.

The KCHFT data security and protection assessment reported an overall score of standards met and all mandatory assertions were responded to and evidence provided. The assessment was published on the 17 March 2020 for the period 2019/20. The annual audit of the DSPA was provided by TIAA in February 2020 and the trust was awarded substantial assurance, with no further recommendations. The assessment would be categorised as green, although the RAG status is no longer used within the assessment.

KCHFT was not subject to the Payments by results clinical coding audit during 2019/20 by the Audit Commission.

KCHFT has taken the following actions to improve this percentage, and so the quality of its services:

- by regularly analysing performance
- by regularly reviewing the Data Quality Maturity Index
- reviewing admission and attendance criteria.

During 2019/20, 79 KCHFT patients died. This comprised the following number of deaths, which occurred in each quarter of that reporting period: 16 in the first quarter; 20 in the second quarter; 23 in the third quarter; 20 in the fourth quarter. This figure relates to inpatient deaths in our community hospitals only.

By 31 March 2020, 79 case record reviews and 0 investigations have been carried out in relation to 79 of the deaths included in the previous item.

In no cases a death was subjected to both a case record review and an investigation.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 16 in the first quarter; 20 in the second quarter; 23 in the third quarter; 20 in the fourth quarter.

No patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. No patient deaths relating to this were reported during any quarter in 2019/20.

These numbers have been estimated using a multi-disciplinary review process (RCP) adapted for community use from the RCP structured judgement review form.

Areas of good practice identified during mortality reviews include excellent examples of holistic care, communication with families, thorough documentation and consideration of spiritual needs. Areas for learning include:

- improving consistency with holistic approach to personalised care plans
- improving the use of version controlled documentation to ensure consistent care
- improving understanding of the verification of death and certification procedure
- recognising system wide improvements such as the need for consistently accurate information at handover.

The impact of learning form the mortality review processes has been enhanced by close working with the Patient Safety Team, which has enabled work regarding the verification of death guidance to be available within the trust. Another major intervention has been the implementation of a pilot for discharge planning. This has been introduced to improve the quality of handover and assessment prior to patient transfer into community services. Learning from reviews has also been used to support the work of documentation standardisation and the introduction of holistic personalised care plan processes within the current trust project to update and improve the electronic patient record system.

Trust guidance for verification of death has now been updated to reflect national guidance and enable improved working with other organisations to ensure timely action when a patient dies in the community setting. The patient discharge pilot, while still in its initial phase, has already shown marked improvements in the quality of transfers of care for patients and enabled improved placements for appropriate care. The implementation of the new electronic record system is still in roll out phase, but is anticipated to make marked improvements in the consistency of documentation and the holistic approach to personalised care planning across the trust. Work is also continuing to increase collaboration with partners within the integrated care system – ICS to make sure shared learning and improved collaboration to continue work to maintain high quality patient care.

Three case record reviews and zero investigations were completed after 1 April 2019, which related to deaths which took place before the start of the reporting period

None of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using a multi-disciplinary mortality review process adapted for community use from the RCP structured judgement review form.

None of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

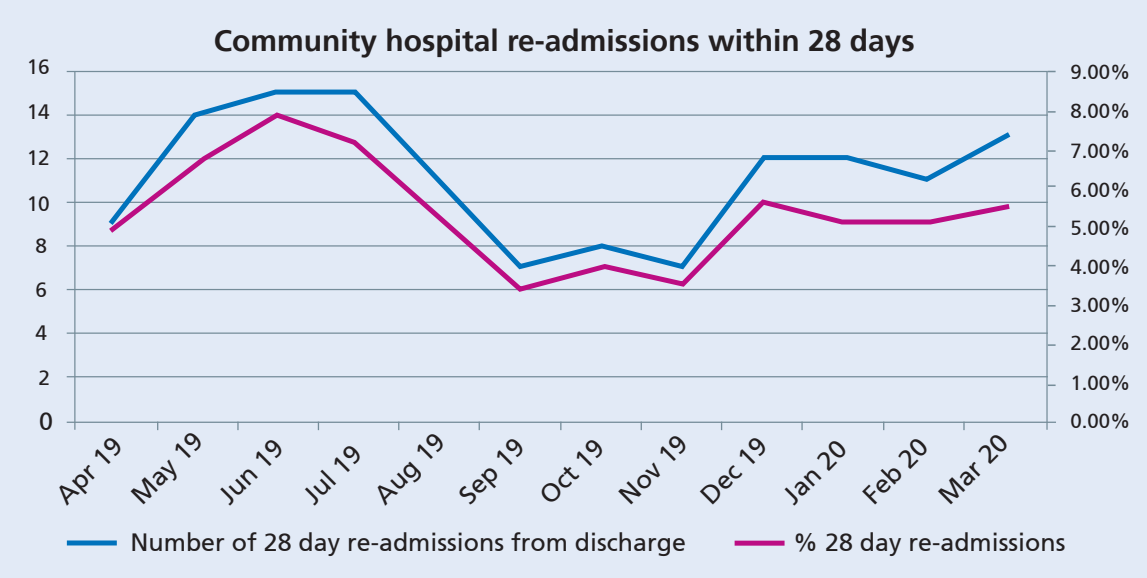
Reporting against core indicators

Indicator 19: Hospital re-admissions

KCHFT is not commissioned to deliver inpatient paediatric care. Therefore, only the percentage of patients aged 15 and over re-admitted to a hospital within 28 days of being discharged from a hospital is shown here:

	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
Number of 28-day re-admissions from discharge	9	14	15	15	11	7	8	7	12	12	11	13
% 28 day readmissions	4.86 %	6.54 %	7.81 %	7.08 %	5.21 %	3.37 %	3.94 %	3.54 %	5.63 %	5.06 %	5.12 %	5.53 %

	2017/18	2018/19	2019/20
Number of 28-day re-admissions from discharge	168	150	134
% 28-day re-admissions	7.21%	6.52%	5.31%



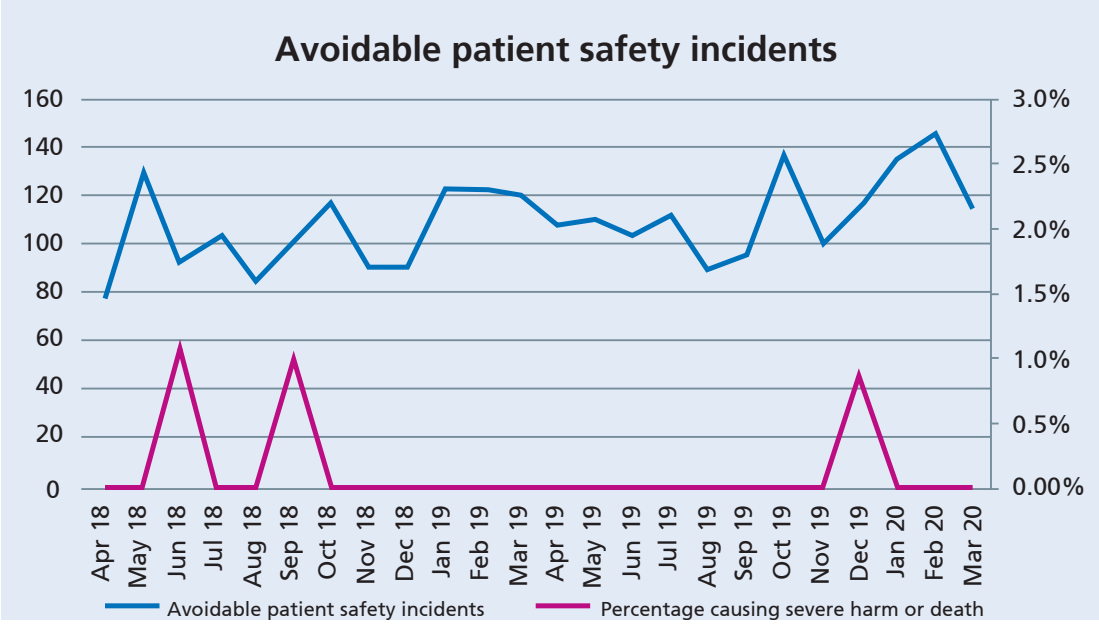
KCHFT considers that this data is as described for the following reasons:

- the data is regularly extracted and checked
- shared with services for validation
- collected at point of delivery in the majority of cases.

Indicator 25: Patient safety incidents

The number, and where available, rate of patient safety incidents reported in the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death are shown here:

	2018/19	2019/20
Avoidable patient safety incidents	1256	1369
Avoidable patient safety incidents (causing severe harm or death)	2	1
Percentage causing severe harm or death	0.16%	0.07%



KCHFT considers this data is as described for the following reasons: As it is captured on the Datix system by the member of staff who discovered the incident, making sure the data is first-hand information.

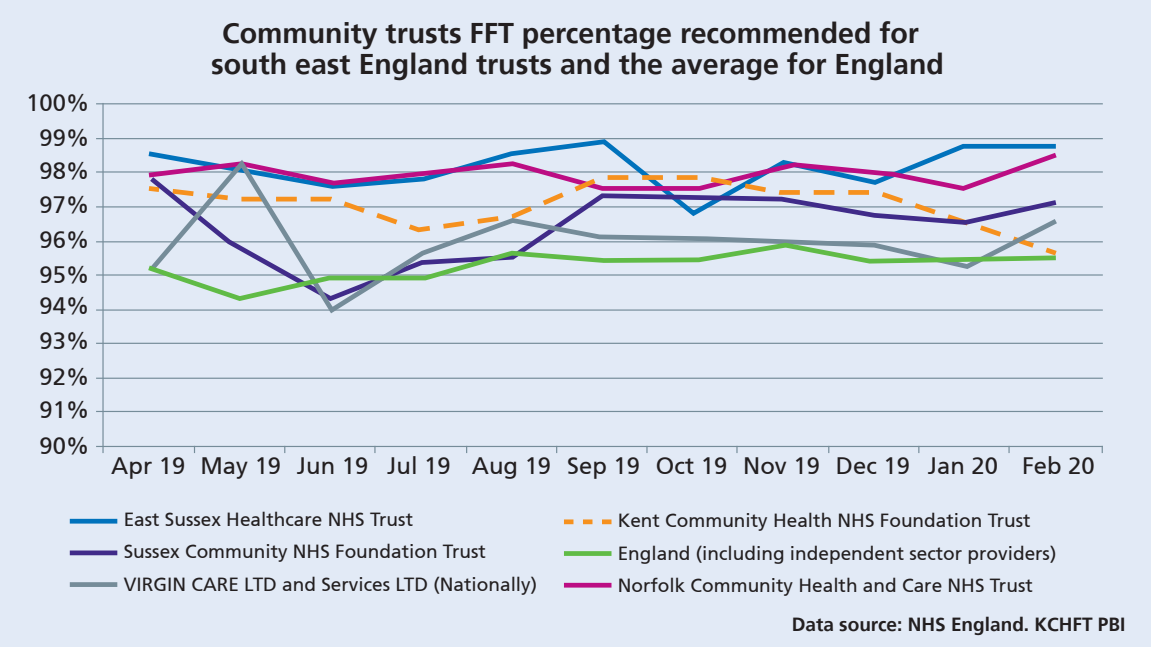
Incidents are subject to a comprehensive review process at multiple levels across the organisation validating the accuracy of the data.

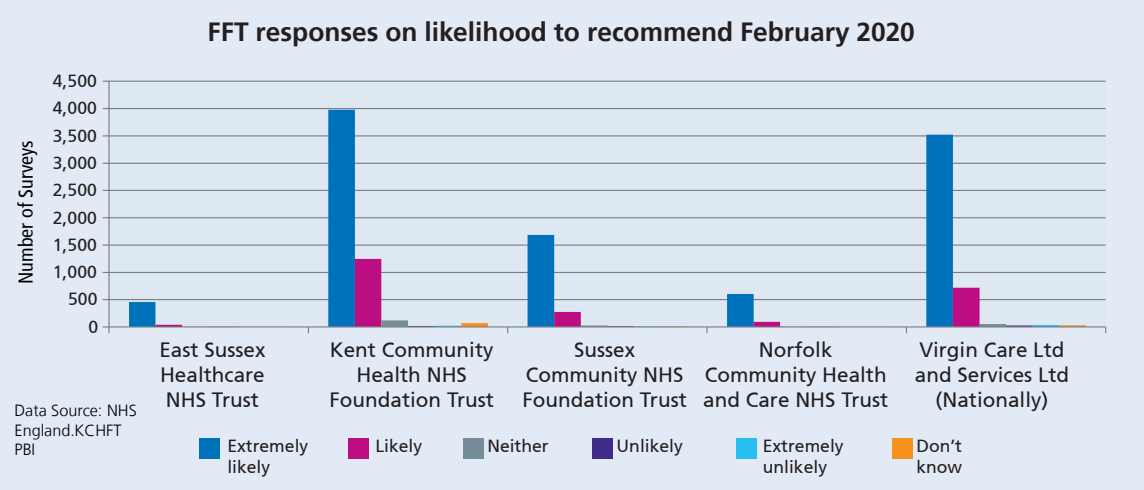
To improve this number and the quality of services, we have:

- developed a comprehensive risk and incident training package, which includes a webinar delivered to new starters
- regularly review the incident reporting system to ensure information captured is relevant and improves patient safety
- enhanced the reports produced to include improvements. This has encouraged a positive patient safety culture where staff are able to see the benefits of reporting incidents.
- shared learning from incidents at the trust's quality improvement network, supporting a positive safety learning culture
- triangulated learning from patient feedback, complaints, internal quality reviews, incidents, claims and developed quality improvement programmes.

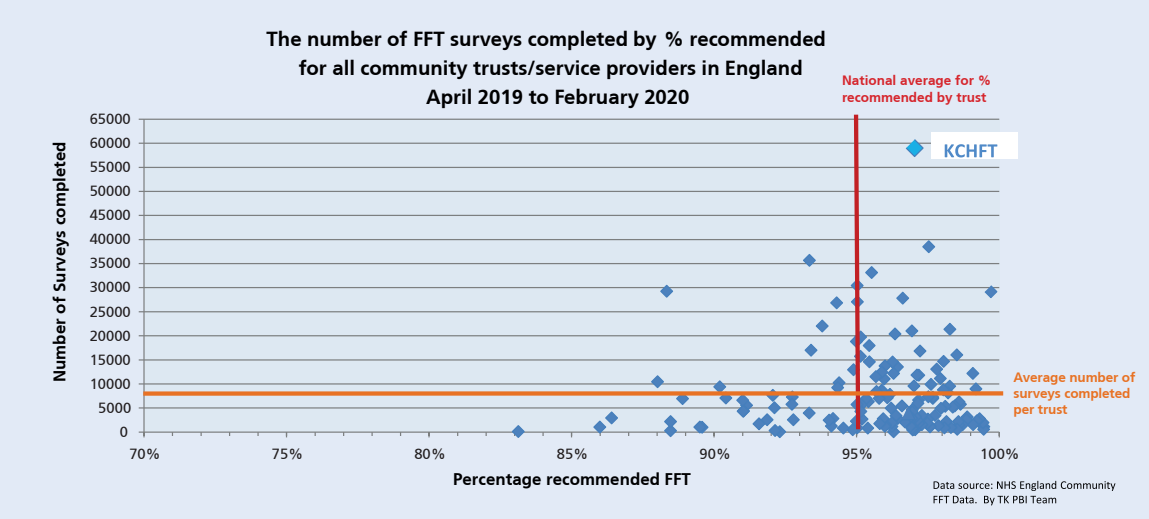
Friends and family test (FFT)

The graphs below show how KCHFT is performing against the patient friends and family test in comparison to other community health trusts and nationally.





As of 22 April 2019, the latest national datasets published run up to February 2020. KCHFT has completed 59,009 responses from April 2019 to February 2020. This is the highest of all the service providers that feature on the national community health datasets. As the below graph shows, KCHFT's percentage (97 per cent) recommend for the FFT is above the national average (95 per cent) for the April to February period and at the top of the upper quartile for surveys completed.



Referral to treatment (RTT) indicator

This section shows our performance against the relevant indicators and performance thresholds set out in the oversight documents issued by NHS Improvement. For our trust, this is only one indicator:

The maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate – patients on an incomplete pathway:

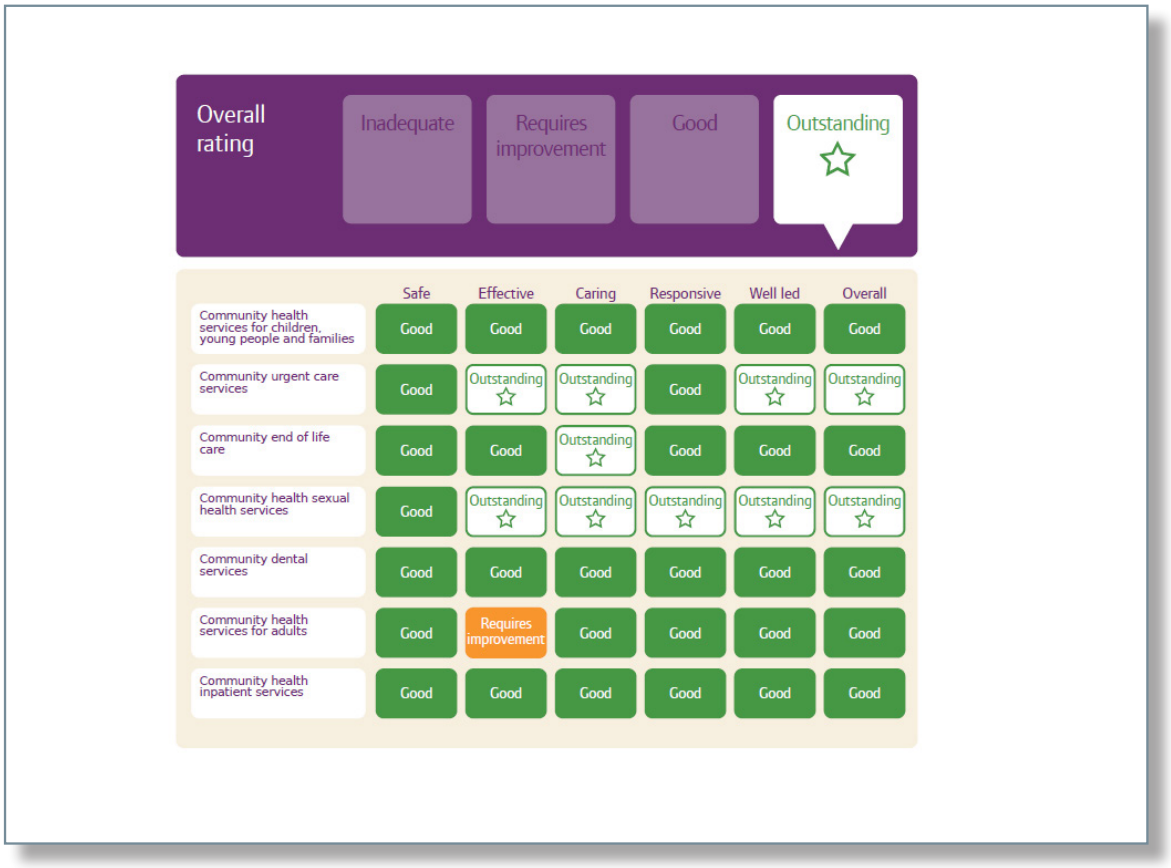
	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
RTT incomplete pathways	95.5 %	95.0 %	89.7 %	88.5 %	85.7 %	87.5 %	89.5 %	91.6 %	93.0 %	95.6 %	97.5 %	97.6 %

Part three:
Overview of quality of care

This section gives an overview of the quality of care offered by KCHFT based on performance against the 2019/20 indicators we agreed and published in our 2018/19 quality account. It explains in more detail what we have achieved during the past year and those areas we need to improve upon.

Regulation: Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.



Our inspection reports can be viewed here: **https://www.cqc.org.uk/provider/RYY/reports**

Rating

For 2019/20, KCHFT was subject to a trust wide risk based CQC inspection in April and May 2019. The community urgent care, sexual health, end of life and dental services were reviewed as well as a trust-wide well-led inspection. The CQC overall rating of KCHFT at this inspection was outstanding.

"The trust determination to develop a patient-centred culture has improved services. This has ensured that the overall rating has moved to outstanding." **Dr Nigel Acheson**, CQC's Deputy Chief Inspector of Hospitals.

"All the staff are completely deserving of this and it has been a real privilege for me to be associate with aspects of the trust." **Pat Conneely**, patient representative.

We care visit programme

The We care reviews are a supportive programme that drives continual improvement locally, encourages shared learning and stimulates quality improvements.

The programme involves all levels and disciplines of staff within the trust, together with our governors, patient representatives and CCG colleagues. Those participating in a visit receive guidance, tools and training before the visit and are provided with a pre-visit pack summarising the data we hold about the team or service, which includes complaints, incidents, risks and patient feedback.

During the visit, participants talk to staff, visit clinical areas and attend home visits with clinicians, thereby giving a full picture of the standard of care being provided. A collaboration meeting at the end of the visit enables all participants to share their observations from the visit and contribute to the visit report.

The We care programme uses the Care Quality Commission key lines of enquiry (KLOE) and fundamental standards to make sure the teams visited are reviewed within a consistent framework.

Since the inception of the We care reviews in 2018, there have been two full schedules of visits; and following the completion of the 2018 programme a comprehensive evaluation was carried out. In light of this evaluation, the vision for the 2019 We care reviews was to engage teams with continuous improvement cycles and further support our people with the idea of quality improvement.

In 2019, 30 services participated in a We care visit, which included six services that had not previously been reviewed. This approach supported the continuous improvement cycles in the 24 teams previously reviewed, while positively increasing the scope of services participating in We care reviews.

The vision to enable We care reviews as a vehicle to simultaneously engage teams and people with quality improvement can be seen as 25 per cent of overall We care visit ratings increased from the first reviews in 2018. Of the 30 services that participated in a We care visit in 2019, 80 per cent (24) were rated good overall, 11 per cent (five) were rated outstanding and three per cent (one) rated requires improvement.

To support quality improvement, services develop an improvement plan based on the recommendations identified in the We care review report. The operational heads of quality, governance and professional standards are involved in this process to offer teams support, guidance and expertise and the improvement plans are monitored through local governance processes, patient safety and clinical risk group and Quality Committee.

Feedback received from the 2019 reviews include:

"The preparation for the We care visits was extensive and a very positive experience for all the teams involved."

"It was a worthwhile process the teams greatly benefitted from. It really helped to make them appreciate the massive effort that they go to on behalf of their patients."

"It was a really positive experience, we felt valued and given time to celebrate areas of good practice and help the team understand any gaps in provision."

Freedom to speak up guardian

KCHFT has a freedom to speak up (FTSU) guardian who is responsible for supporting colleagues in raising concerns in the trust. The FTSU guardian provides confidential advice to colleagues and agency workers employed by KCHFT or volunteers, about concerns they have and/or the way their concern is handled.

FTSU guardians don't get involved in investigations or complaints, but help the process. They have a key role in making sure colleagues do not experience discrimination or are victimised because they raise a concern in good faith, particularly those who may be more likely to be discriminated against due to race, disability or sexual orientation.

They will make sure:

- colleagues' concerns are treated confidentially unless otherwise agreed
- colleagues receive timely support to progress their concern
- escalate to the Board indications if anyone is being subjected to detriment for raising their concern
- remind the organisation of the need to give colleagues timely feedback on how their concern is being dealt with
- colleagues have access to personal support since raising their concern may be stressful.

In August 2017, KCHFT started to develop a freedom to speak up ambassadors' programme and there are now 10 ambassadors across the trust. Their role includes encouraging colleagues to speak up, by providing informal advice, sign-posting and promoting positive examples of changes that have occurred as a result of speaking up. A campaign to promote the benefits of speaking up ran throughout the year and included a range of promotional materials. It included ways to get in touch, such as the dedicated email and phone line for colleagues to report their concerns and how the FTSU guardian can help. All new colleagues receive FTSU guidance at induction.

Between 1 April 2019 and 31 March 2020, the FTSU guardian logged and was involved in eight new cases. Themes of the cases were discussed with the chief executive officer. A six-monthly report is presented to the Board.

Personalised plans of care

	Goal	2019/0	2019/20 target	Outcome
Patient safety	15 per cent increase of all relevant patients to have a personalised plan of care	68 per cent	69 per cent	Partially achieved
Patient experience	90 per cent of relevant patients report their personal goals were accounted for	Metric introduced 2019/20	90 per cent	Partially achieved
Staff experience	90 per cent of staff state: The personalised plans of care developed meet the needs of the people they care for	Metric introduced 2019/20	90 per cent	Not achieved

Why this is important

A growing body of literature shows that patients benefit from being involved in making decisions about their care and in how that care is delivered to meet their needs and wishes. The impacts include:

- improved knowledge of their condition and treatment options
- increased confidence to self-manage aspects of their own care
- increasing the likelihood of keeping to a chosen course of treatment and participating in monitoring and prevention programmes
- improved satisfaction with their care and chosen treatment
- more accurate risk perceptions
- reduced length of hospital stay and readmission rates.

What we did

Due to challenges in usability and interrogation of our electronic patient record (EPR), a new electronic patient record system was procured and started in 2019/20. Compliance with the quality priorities was difficult to measure due to the known challenges within the original EPR. To make sure the PCPs were in place, a parallel notes audit was carried out monthly. It is anticipated that the introduction of the new system will greatly improve the recording and monitoring of personalised plans of care. The Rio EPR was procured and started in 2019/20 quarter four and children's services were the first to migrate to the new system.

Due to the implementation of the new EPR, data was taken from the monthly notes audit to support the quality goal: *15 per cent increase of all relevant patients to have a personalised plan of care*.

Personalised plans of care

The progress of the following quality priorities will be measured through distinct staff and patient experience surveys once each service has been migrated to the new EPR system.

- 90 per cent of relevant patients report their personal goals were accounted for.
- 90 per cent of staff state: The personalised plans of care developed meet the needs of the people they care for.

What we achieved

While the personalised plans of care quality priorities cannot be reported on directly via the new EPR, the following data provides assurance of progress and improved quality of personalised care plans at KCHFT.

Data source	Question	2019/20
Notes audit	Is the PCP clear for an unregistered member of staff/professional who has not met the patient before to follow all their care needs?	96 per cent
Notes audit	Does the care delivery represent the care that was planned throughout and modified accordingly, three monthly or at change need?	90 per cent
Patient experience feedback (inpatient survey)	Do you feel you have been supported and involved during your stay to build your confidence to undertake your usual activities?	98 per cent
Patient experience feedback (community nursing survey)	Did our visit have a positive impact on your care and wellbeing?	99 per cent

What this means for you as a patient

PCPs aim to make sure you are an equal partner in your health care and will reflect your needs, wishes, goals and choices. They will also help you manage your condition and tell you what support you will receive. If you are unable to make decisions, your care plan will be written in your best interests in consultation with your family and carers, where possible.

Personalised plans of care

	Goal	Outcome
Outcome	Participate in the Sweeney programme collaborative to improve the experience of patients at the end of life and their families	On-track

Why this is important

The Sweeney programme further enables staff to step into the patients' shoes and consciously see care through their eyes. Seeing care through their eyes and gaining feedback from patients receiving end of life care is essential to make sure we deliver the best possible care. The training provided by the Sweeney programme supports a change of mind set, enabling us to learn from our patients and continue to adapt and improve both service planning and delivery.

What we did

In collaboration with the System Transformation Partnership and KCHFT operational services, a multi-disciplinary clinical team, which currently provides end of life care, were identified to take part in the Sweeney programme. The aims and objectives of the programme were discussed to clarify how the training would support the very best outcomes in both service planning and delivery.

The Sweeney programme training is based on quality improvement methodologies such as evidence-based co-design and patient and family centered care. The two day training masterclasss for the Sweeney programme is provided by the Point of Care Foundation and is due to be delivered in 2020/21 quarter one.

What this means for you as a patient

Our multi-disciplinary clinical team will be trained to work collaboratively with our patients, drawing on their experience to deliver a service that is co-designed and meets the needs of patients and their families.

What we achieved

The programme has been scoped and planned with training and delivery scheduled to start in 2020, quarter one.

Human factors

	Goal	Benchmark	2019/20 target	Outcome
Patient Safety	Increase by 20 per cent the number of investigators supported to recognise human factors as a contributing factor	26	31	Achieved

Why this is important

Human factors encompass factors that can influence people and their behaviours.

There is rich literature explaining the role of human error and its role in patient safety incidents. It is important to have trained investigators who can recognise and understand human factors as part of the investigation process to identify lessons to be learned and support the changes in process required to mitigate factors and reduce risk.

What we did

In 2019/20 quarter one, three staff attended investigator training provided by Kent Surrey Sussex Patient Safety Collaborative.

To make sure continuous provision for investigator training that included human factors, the KCHFT Patient Safety Team designed, implemented and delivered incident training that started in 2019/20, quarter three.

The training is validated and available to all KCHFT staff to book via the online training platform TAPs.

The Patient Safety Team has created human factors resources to support training and investigations to all colleagues and are available on the KCHFT staff intranet, flo.

The 2019 KCHFT Quality Improvement Conference included two sessions on human factors to raise awareness of human factors in safety incidents, which was attended by more than 200 colleagues.

What this means for you as a patient

Recognition of the systems and processes, which lead to patient safety incidents, including human factors is imperative so that improvements can be made to prevent recurrence and future harm to patients.

What we achieved

We now have an effective training programme to support staff investigator training.

The KCHFT in-house incident training programme has seen 18 new investigators trained and in total, there has been 22 investigators trained in 2019/20.

Human factors

	Goal	2018/19	2019/20	Outcome
Clinical effectiveness	Continue our quality improvement journey with a total of 100 people completing the QSIR practitioner course and 300 people completing the quality improvement fundamentals course	QSIR 66	82	Achieved
		Quality improvement fundamentals 56	324	Achieved

Why this is important

To foster innovation and empower staff to carry out quality improvement initiatives, the trust required a significant training programme to make sure consistency of methodology and increased adoption of quality improvement principles. It is recognised that locally owned quality improvement projects can lead to benefits for both patients and staff.

What we did

KCHFT introduced two levels of quality Improvement training in 2018 as part of a five-year training programme:

- Quality, service improvement and redesign (QSIR) practitioner training detailing a comprehensive quality improvement methodology.
- Quality improvement fundamentals is a one-day course for colleague, volunteers, patients and others using our services.

Eight KCHFT staff have become accredited QSIR associate faculty members enabling training to be delivered internally.

During 2019/20 four QSIR practitioner cohorts were completed and 12 one-day quality improvement fundamentals courses were held.

What this means for you as a patient

The adoption of quality improvement methods and principles throughout the organisation means that colleagues are empowered to work to improve their services, in a consistent way which also produces evidence demonstrating those improvements.

What we achieved

We have established a large scale face-to-face quality improvement training programme.

A total of 150 people completed the QSIR practitioner course and 409 attended the one day Quality improvement fundamentals. Both targets for training attendance were substantially exceeded.

Human factors

	Goal	Benchmark	2019/20	Outcome
Patient experience	15 patient and service users to complete the quality improvement fundamentals training	1	5	Not achieved

Why this is important

Quality Improvement Fundamentals is a one-day course for colleagues, volunteers, patients and others using our services.

Patient/service user involvement in quality improvement projects is a key factor in their success and sustainability. Giving service users the opportunity to participate in training would enable them to participate in project groups with sound quality improvement knowledge and skills to maximise their impact.

What we did

We opened the one-day quality improvement fundamentals training course to all patients and service users.

The training dates were communicated to patients and service users via:

- the KCHFT quality improvement website
- stand at the 2019 quality improvement training conference
- Patient Experience Team and network
- produced a flyer detailing 2019/20 training dates, which was distributed by the Patient Engagement Team.

What this means for you as a patient

Attending quality improvement fundamentals training enables patients and service users to fully understand and participate in quality improvement projects and initiatives which can provide opportunities to become involved in co-design principles to improve the experience of our services.

What we achieved

Five patients and service users attended the training. This was a third of numbers anticipated but those who did attend found the training useful and informative. There are more people booked on future training but the approach has been adjusted to focus more on service user inclusion in project groups because anecdotal evidence has suggested this option would be more attractive and relevant.

Human factors

	Goal	Outcome
Staff experience	Work with our staff to increase the accessibility and usability of our policies, procedures and guidelines using a quality improvement approach	Partially achieved

Why this is important

Polices and other procedural documents provide a framework to guide decision making; they enable staff to carry out their work efficiently, flexibly and safely.

Feedback from our people highlighted the need for KCHFT policies and procedural documents to be streamlined, the essential information they contain to be clear and the documentation should be located and accessed easily. This promotes the best interest of patients and staff by standardising practice.

What we did

Formal documentation is owned and approved by the relevant KCHFT governance group.

Strategy, policy, guideline, protocol and standard operating procedure have been defined, leading to a reduction in the number of documents that qualify as policy by 40. A further 27 polices will be reviewed to confirm their status by November 2020.

An HR handbook has been developed to replace a significant number of policies and provide general practical information where this doesn't already exist in our national terms and conditions of employment.

A health and safety policies handbook and e-book has been agreed.

KCHFT promotes the policy on a page principle to reduce the volume of individual documentation but maintain the critical information points. The policy on a page template is available on the staff intranet, flo.

The digital platform on the KCHFT staff intranet has been developed to enable staff to locate these documents within a few clicks. Best bits have been introduced which highlight the key words within each procedural document without having to open it.

What this means for you as a patient

Staff are able to easily access policies or procedural documentation to effectively support their decision making in providing safe care that is of a high quality.

What we achieved

Our staff have better access to the essential information they need to carry out their jobs efficiently and safely. This work is on track to become business as usual by November 2020.

Improving outcomes

	Goal	Outcome
Patient safety	To implement and embed NEWS2 across our community hospitals	Achieved

Why this is important

We are committed to deliver high-quality care, to improve quality outcomes and patient satisfaction by having standards in place for managing the risk associated with the deteriorating patient. NEWS2 is an established tool to recognise and respond to deterioration in adults; therefore, it is important to implement and embed the use of NEWS2 in all of our community hospitals. This will support standardised working and communication in line with our other NHS and community partners across the care pathway.

What we did

A deteriorating patient working group was established consisting of operational and support service colleagues reporting to the Patient Safety and Clinical Risk Group and directed the implementation of the following:

- NEWS2 charts were developed which included clinical escalation and appropriate response within the community hospital setting
- NEWS2 score included on handover sheets
- review of the sepsis pathway
- the deteriorating patient policy was updated
- training was developed and provided to all community hospital staff
- engagement and pilot sessions were held with colleagues to capture feedback and introduce iterative changes to improve the delivery of NEWS2
- deteriorating patient audit undertaken in 2019/20, quarter three.

What this means for you as a patient

NEWS 2 supports early detection, timeliness, consistent communication and appropriate escalation, all of which improve the quality of care to make sure people receive the best health and wellbeing outcomes.

What we achieved

All community hospitals are using NEWS2 charts; these are being used by staff to respond to clinical signs of deterioration in conjunction with clinical judgement when reviewing presenting soft signs. 94 per cent of patients were escalated appropriately which is a key element of patient safety and improving patient outcomes.

Improving outcomes

	Goal	Outcome
Clinical effectiveness	10 projects with associated reports and poster abstracts will be carried out as part of the Research Champions Programme to develop the research capabilities of our clinical staff	Achieved

Why this is important

Research is significantly important to improve the current and future health and care of the population. It is essential to upskill clinical staff with research and evidence seeking skills, to support them to become research active in their clinical roles. This will contribute to research being embedded across the organisation and enable best practice.

What we did

The Research Champions Programme was opened to a second cohort and all 10 places were recruited to and filled with clinical staff, such as nurses and allied health professionals.

The output alongside personal development is a literature review, or report of investigation into a topic for improvement within the individual's service.

What this means for you as a patient

It has been shown that patients receive improved clinical outcomes in research active organisations and the KCHFT research champions are increasing their evidence seeking skills and supporting their teams to learn from this too. This equips staff to confirm that they are delivering care in line with the best evidence available. At the end of the programme their work will be presented to colleagues and made into a poster for their clinical area, for patients, the public and other members of staff to see.

What we achieved

An additional 10 clinical members of staff engaging with the Research Team and in their own clinical research investigations. Spreading research confidence across the organisation, making improvements to clinical care and encouraging colleagues to do the same.

Improving outcomes

	Goal		2019/20	Outcome
Patient safety	Where able to, 75 per cent of patients report they were confident, empowered and supported to carry out their usual activities	Inpatient survey	98 per cent	Achieved
		Community nursing survey	99 per cent	Achieved

Why this is important

It is a vital part of rehabilitation to make sure our staff do all they can to enable patients to feel confident, empowered and supported to carry out their usual activities once they are discharged from hospital back into the community. Similarly, it is imperative that community nurses support patient goals for positive health and wellbeing outcomes.

What we did

Queen Victoria Memorial Hospital, Herne Bay provided group exercises and staff encouraged patients to attend to support rehabilitation, a sense of community and wellbeing outcomes.

Faversham Cottage Hospital worked with family and carers to make them aware that the discharge processes starts to be planned on admission which enables the multidisciplinary team and family to start considering and putting into place what may be needed on discharge.

Feedback from some patients was that their medication has not been explained to them before leaving hospital. The hospital sister attends MedSavvy meetings and support is being sought from the pharmacist on the days they are present on the ward.

What this means for you as a patient

Our staff will provide the care and support to enable patients to feel confident and able to continue to live independently. This is important for their health and wellbeing

What we achieved

For the inpatient survey question provided to patients on discharge, the ambition was achieved with 615 surveys completed and an overall satisfaction score of 98 per cent.

For the community nursing question provided to patients on discharge, the ambition was achieved with 1,830 surveys completed and an overall satisfaction score of 99 per cent.

The inpatient mid-stay survey question was reworded on 1 March 2020 to make it easier for the patient to understand. This will enable staff to assess whether or not patients feel confident and empowered to carry out their usual activities prior to discharge and amend care plans to meet their needs.

Improving outcomes

	Goal	Outcome
Staff experience	A 35 per cent positive response in the NHS staff survey for: Does your organisation take positive action on health and wellbeing? in the NHS staff survey	Achieved

Why this is important

We need to make sure colleagues are provided with an environment and opportunities that encourage and enable them to lead healthy lives and make choices that support their wellbeing. It is more important than ever that NHS workplaces become environments that support staff to do this. There is evidence that good staff health, wellbeing and engagement can lead to improvements in patient experience of care, productivity and reduced used of agency staff.

What we did

The Time to Change programme was further promoted and the number of champions increased from 116 at the start of 2019/20 to 175 at the end of quarter four. Two large health and wellbeing events were organised to share good practice and ideas to support wellbeing in the workplace.

A KCHFT football and netball team were developed in addition to the choir which sang at the trust's annual staff awards.

The KCHFT Menopause Network was created, which included a get together event for our staff with expert advice on hand.

We have developed a health and wellbeing magazine published in January 2020, collating the health and wellbeing resource and support available for KCHFT colleagues. The topics included:

- MSK physio
- counselling
- walking challenge flo fit
- sports (netball, football)
- One You health checks
- discounts (such as at gyms, hair salons)
- Time to Change – examples of what people have been doing
- Importance of a lunch break – using an example of a clinical team
- wellness passport
- cycling to work scheme
- bring your whole self to work initiative
- men's health.

What we achieved

The 2019 staff survey showed a 43.5 per cent positive response for: Does your organisation take positive action on health and wellbeing? compared to a 33.1 per cent positive response rate in comparator trusts.

The 2019 staff survey showed a 43.5 per cent positive response for: Does your organisation take positive action on health and wellbeing? compared to a 33.1 per cent positive response rate in comparator trusts.

2019/20 quality priorities – what happens next?

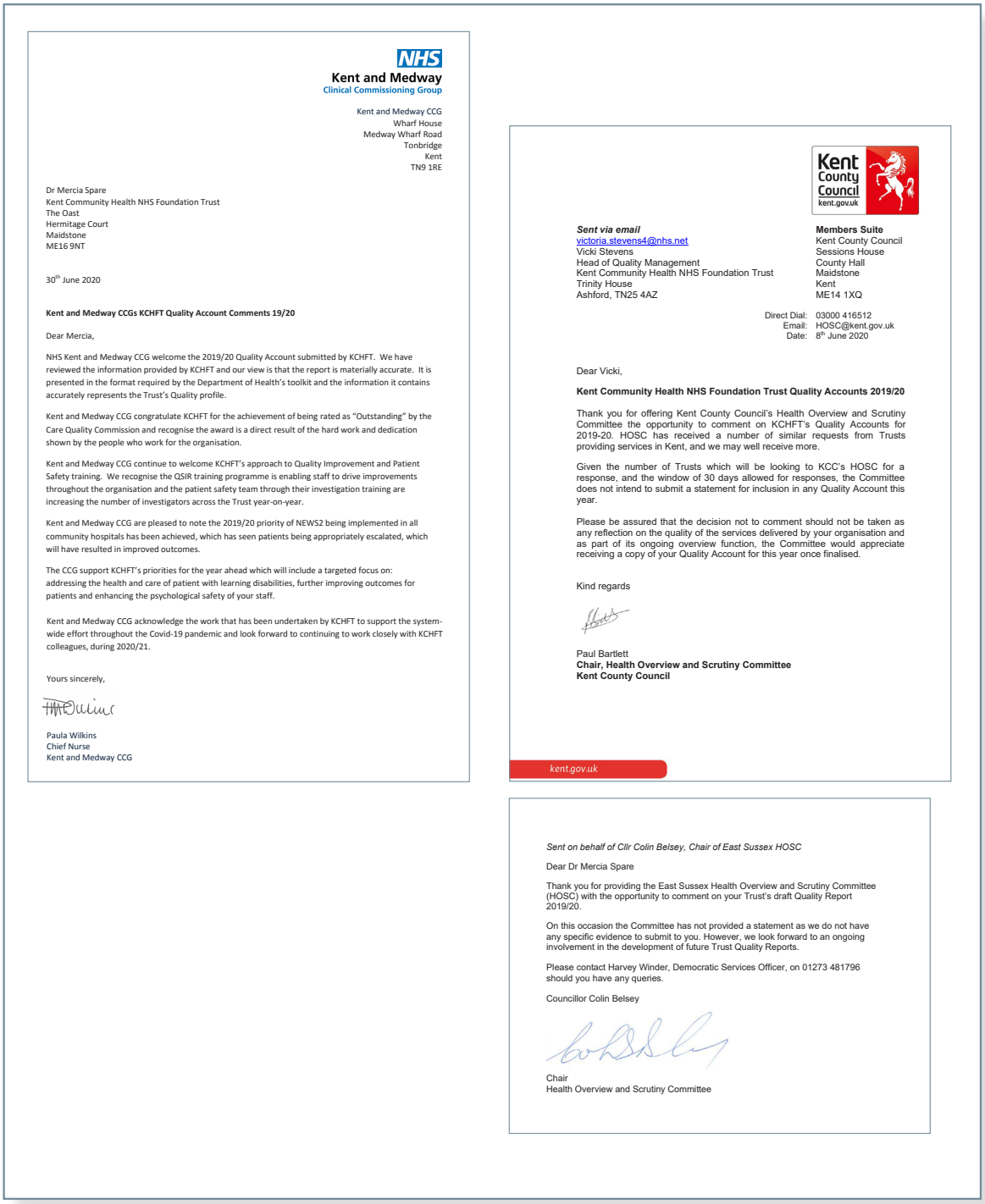
The work carried out to improve the quality of our services through the ambitions of the 2019-20 quality priorities will continue. The quality priorities that have been achieved are embedded in practice and the projects that have not been achieved or partially achieved will continue as business as usual, monitored through trust governance processes, to make sure full benefits will be realised for patients.

Abbreviations

BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
CARE values	Compassionate, aspirational, responsive, excellent
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CQUINs	Commissioning for Quality and Innovation
EPR	Electronic patient record
DNACPR	Do Not Attempt cardiopulmonary resuscitation
DSPA	Data security and protection assessment
FFT	Friends and family test
FTSU	Freedom to speak up
HIV	Human Immunodeficiency Virus
HMP	Her Majesty's Prison
ICS	Integrated Care System
IV	Intravenous
KCHFT	Kent Community Health NHS Foundation Trust
KLOE	Key lines of enquiry
Medsavvy	Project to improve administration of medicines
NACEL	National audit of care at the end of life
NAIF	National audit of inpatient falls
NCEPOD	National confidential enquiries into patient outcome and death
NDFA	National diabetes footcare audit
NEWS2	National Early Warning Scores (updated)
NHS	National Health Service
NHSI	NHS Improvement
PCP	Personalised care plans
PEWS	Paediatric early warning signs
QSIR	Quality, service improvement and redesign
RAG status	Red, amber, green
RCP	Royal College of Physicians
RTT	Referral to treatment
SOEL	Software of excellence
SSNAP	Sentinel stroke national audit programme
TIAA	The trust's auditors

Annex 1

Statements from commissioners, local Healthwatch organisations and oversight and scrutiny committee



NHS
Kent and Medway
Clinical Commissioning Group

Kent and Medway CCG
Wharf House
Medway Wharf Road
Tonbridge
Kent
TN9 1RE

Dr Mercia Spare
Kent Community Health NHS Foundation Trust
The Oast
Hermitage Court
Maidstone
ME16 9NT

30th June 2020

Kent and Medway CCGs KCHFT Quality Account Comments 19/20

Dear Mercia,

NHS Kent and Medway CCG welcome the 2019/20 Quality Account submitted by KCHFT. We have reviewed the information provided by KCHFT and our view is that the report is materially accurate. It is presented in the format required by the Department of Health's toolkit and the information it contains accurately represents the Trust's Quality profile.

Kent and Medway CCG congratulate KCHFT for the achievement of being rated as "Outstanding" by the Care Quality Commission and recognise the award is a direct result of the hard work and dedication shown by the people who work for the organisation.

Kent and Medway CCG continue to welcome KCHFT's approach to Quality Improvement and Patient Safety training. We recognise the QSIR training programme is enabling staff to drive improvements throughout the organisation and the patient safety team through their investigation training are increasing the number of investigators across the Trust year-on-year.

Kent and Medway CCG are pleased to note the 2019/20 priority of NEWS2 being implemented in all community hospitals has been achieved, which has seen patients being appropriately escalated, which will have resulted in improved outcomes.

The CCG support KCHFT's priorities for the year ahead which will include a targeted focus on: addressing the health and care of patient with learning disabilities, further improving outcomes for patients and enhancing the psychological safety of your staff.

Kent and Medway CCG acknowledge the work that has been undertaken by KCHFT to support the system-wide effort throughout the Covid-19 pandemic and look forward to continuing to work closely with KCHFT colleagues, during 2020/21.

Yours sincerely,

Paula Wilkins
Chief Nurse
Kent and Medway CCG

Kent County Council
kent.gov.uk

Sent via email
victoria.stevens4@nhs.net
Vicki Stevens
Head of Quality Management
Kent Community Health NHS Foundation Trust
Trinity House
Ashford, TN25 4AZ

Members Suite
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Sessions House
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Maidstone
Kent
ME14 1XQ

Direct Dial: 03000 416512
Email: HOSC@kent.gov.uk
Date: 8th June 2020

Dear Vicki,

Kent Community Health NHS Foundation Trust Quality Accounts 2019/20

Thank you for offering Kent County Council's Health Overview and Scrutiny Committee the opportunity to comment on KCHFT's Quality Accounts for 2019-20. HOSC has received a number of similar requests from Trusts providing services in Kent, and we may well receive more.

Given the number of Trusts which will be looking to KCC's HOSC for a response, and the window of 30 days allowed for responses, the Committee does not intend to submit a statement for inclusion in any Quality Account this year.

Please be assured that the decision not to comment should not be taken as any reflection on the quality of the services delivered by your organisation and as part of its ongoing overview function, the Committee would appreciate receiving a copy of your Quality Account for this year once finalised.

Kind regards

Paul Bartlett
Chair, Health Overview and Scrutiny Committee
Kent County Council

kent.gov.uk

Sent on behalf of Cllr Colin Belsey, Chair of East Sussex HOSC

Dear Dr Mercia Spare

Thank you for providing the East Sussex Health Overview and Scrutiny Committee (HOSC) with the opportunity to comment on your Trust's draft Quality Report 2019/20.

On this occasion the Committee has not provided a statement as we do not have any specific evidence to submit to you. However, we look forward to an ongoing involvement in the development of future Trust Quality Reports.

Please contact Harvey Winder, Democratic Services Officer, on 01273 481796 should you have any queries.

Councillor Colin Belsey

Chair
Health Overview and Scrutiny Committee

Annex 2
Statement of directors' responsibilities for the quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare quality accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports, which incorporates the above legal requirements and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation
- trust annual reporting manual 2017-18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2019 to March 2020
    - papers relating to quality reported to the board over the period April 2019 to March 2020
    - feedback from commissioners dated 30/06/2020
    - feedback from local Healthwatch organisations 07/07/2020
    - feedback from Overview and Scrutiny Committee dated 08/06/2020
    - feedback from the trust's Governors dated July 2020
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 01/06/2020
    - the 2019 National Staff Survey
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 23/04/2020
    - CQC inspection report dated July 2019
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Repor**t.**

The directors confirm to the best of their knowledge and belief they have complied with above requirements in preparing the Quality Report.

By order of the Board.

.....Date .....Chairman

.....Date ..... Chief Executive

Do you have feedback about our health services?

Phone: 0300 123 1807, 8am to 5pm, Monday to Friday
Text: 07899 903499
Email: kentchft.PALS@nhs.net
Web: www.kentcht.nhs.uk/PALS

Patient Advice and Liaison Service (PALS)
Kent Community Health NHS Foundation Trust
Unit J, Concept Court
Shearway Business Park
Folkestone
Kent CT19 4RG

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we care

Our values
Compassionate Aspirational Responsive Excellent

I20068969 Produced by the Communications and Marketing Team

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	2.8
Agenda Item Title:	2020/21Trust Strategy
Presenting Officer:	Gerard Sammon, Director of Strategy and Partnerships

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

Report Summary
This paper sets out the refreshed Trust strategy and provides an outline of how the strategy will be delivered.

Proposals and /or Recommendations
The Board is asked to note the Trust strategy and how the strategy will be delivered.

Relevant Legislation and Source Documents
Has an Equality Analysis (EA) been completed?
Yes ☒ High level position described. The strategy is accessible to all people with no targeted promotion or reasonable adjustments needed.

Gerard Sammon, Director of Strategy and Partnerships / Rachel Jennings, Deputy Director of Strategy	Tel: 01622 211938
	Email: Gerard.sammon@nhs.net r.jennings@nhs.net

Kent Community Health
NHS Foundation Trust

TRUST STRATEGY

1. Introduction

1.1. The Board stated its intent to refresh the organisational strategic ambitions as part of a new three year cycle.

1.2. A timetable was set out for the refresh connected with the Board development programme and included extensive internal and external engagement work.

1.3. This paper sets out the refreshed trust strategy. It also starts to provide an outline of how the strategy will be delivered, summarising what has been progressed (taking into account or despite the impact of covid-19) and how the work plan and communications plan is progressing.

2. Background

2.1. The strategy refresh was the focus of a number of board development sessions and direct feedback was received from surveys of staff, patients and the public, at the leaders' conference, from NHS partner organisations, from the staff partnership forum and at governors' meetings.

3. Assessment

3.1. Based on the feedback received the Trust's vision and mission and strategic goals remain unchanged. The goals are supported by four longer term enablers that provide new focus and delivery mechanisms.

3.2. The refreshed strategy on a page is attached as appendix one.

3.3. As part of our strong, positive response to covid-19 we have remained focused on the need to continue, wherever possible, key pieces of work that support our strategic ambitions.

3.4. This has been demonstrated through the continued successful roll out of our electronic patient record, the ongoing development of the Kent Medical Care Record, a continued focus on relationships with Kent County Council, development of our strategic intent towards equality and diversity and the completion of a sustainability strategy which is due shortly to be approved.

Developing the work plan

3.5. Recent strategy focused sessions with the executive team have considered the relative scale of each of the goals and enablers and scoped high level

work plans, from which definitions, outcomes and underpinning requirements have been produced. The requirements for delivery include quick wins and note where engagement with the wider system is necessary.

3.6. Enabling strategies, such as the people strategy, digital strategy and sustainability strategy will detail how they will support the delivery of each strategic goal.

3.7. Assurance of delivery has been considered for each goal and enabler and proposed executive director leads and board sub-committee for reporting purposes have been proposed.

3.8. The Trust's quality improvement approach and methodology will remain and continue to be embedded as our way of doing things. It will be used to support delivery of all parts of our strategy.

Communication plan

3.9. The communications team have updated the strategy on a page and accompanying descriptive booklet and a detailed plan to support the refresh is being produced.

4. Next stages

4.1. The Board is asked to;

i) note the refreshed strategy and approach in delivering the strategy
ii) receive an update regarding progress at its next meeting

Rachel Hewett
Deputy Director of Strategy

Gerard Sammon
Director of Strategy and Partnerships

August 2020

NHS
Kent Community Health
NHS Foundation Trust

Our strategy

Our vision

A community that **supports each other** to **live well**.

Our mission

To **empower adults and children** to live well, to be the **best employer** and **work with our partners** as one.

Our goals

- **Prevent** ill health
- Deliver high-quality care **at home** and **in the community**
- **Integrate** services
- Develop **sustainable** services

Our enablers

- **Digital** – having accessible and integrated technology.
- **People** – engaging, developing and valuing our people.
- **Environmental sustainability** – improving our environmental impact.
- **System leadership** – improving population health and wellbeing.

Our values

Compassionate

Aspirational

Responsive

Excellent

In everything we do, **we care**

www.kentcht.nhs.uk

00746 Produced by the KCHFT Communications and Marketing team 01622 211940

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	6 August 2020
Agenda Item:	2.9
Subject:	Kent Community Health NHS Foundation Trust (KCHFT) and Kent and Medway Partnership Trust (KMPT)
Presenting Officer:	Paul Bentley, Chief Executive KCHFT and Vincent Badu, Director of Partnerships and Deputy Chief Executive, KMPT

Action - this paper is for:	Decision	☒	Assurance	☐

Report Summary

The report summarises the close and productive working relationship between the two organisations and seeks to build on this foundation to make a step change in the quality of care we offer through working in partnership.

Proposals and /or Recommendations:

The paper recommends the Board endorses the direction of travel, supports the signing of a Memorandum of Understanding and establishes a small group of four directors to take it forward.

Relevant Legislation and Source Documents:

Not applicable

Has an Equality Analysis been completed?

No. High level position described.

Paul Bentley, Chief Executive	Tel: 01622 211900

Kent Community Health
NHS Foundation Trust

JOINT REPORT FROM KENT COMMUNITY HEALTH NHS FOUNDATION TRUST AND KENT AND MEDWAY NHS AND SOCIAL CARE PARTNERSHIP TRUST

Background and Introduction

Kent Community Health Foundation Trust (KCHFT) and Kent and Medway Partnership Trust (KMPT) have many things in common and over recent years especially, have established strong and positive working relationships. We also hold dear in our respective trusts, the same belief and commitment; that anything we do, should be in the best interests of our patients or service users and their loved ones.

This brief paper has been jointly written by the Chief Executive of each Trust, and marks a moment in time when we believe even greater benefit for those we serve could be derived from formally recognising through a Memorandum of Understanding, our joint working and in particular, explore opportunities for innovation and collaboration that facilitate:

a) Improved outcomes for our service users and patients in common
b) Greater efficiencies in sharing resources
c) Improved flow of patients to enhance performance and reach of services

With the advent of a global pandemic, came the imperative for the system as a whole to work differently. It has been clear that better joint working, more proactive collaboration and the removal of non-value adding activity creates capacity to think and act differently.

KMPT and KCHFT have previously considered areas for potential joint working, and to that end a Non Executive and Executive pair from each trust met to discuss this in 2018. The sense was that there were areas of overlap and potential joint working but at that time, it felt reasonable to continue as we were. The pandemic and our learning from it has made us think again.

In many instances staff from our respective organisations already collaborate in the interests of patient care, and we have of course, many patients in common.

At a recent Chair and Chief Executive 2:2 meeting, the idea of areas of synergy and overlap were revisited and the potential benefits to patients explored. It was agreed that in order to maximise the opportunity, the importance of collaboration should be made formal and public. To this end, the possibility of a Memorandum of Understanding was discussed.

Potential Benefits to Patients and Service Users

The thinking about potential benefits is in its earliest stage but it is easy to see that for some of our most vulnerable populations, together, KCHFT and KMPT could make a significant difference.

People who have a dementia, autistic people and those who live with long term mental illness all use the services of both organisations and sadly, their experience is not universally excellent, the Trusts collaborate in the provision to people with learning difficulties

Formally committing to joint working on a particular care pathway could significantly improve the experience of those we serve, and at the same time improve our efficiency and staff satisfaction. For some it could be as simple as not having to see two health workers and instead just see one. For others, it could be the behind the scenes improvements that together we could make to the entire care pathway; much more difficult to do on our own, so much easier to deliver together.

These are unworked examples that might lend themselves to testing the concept. Our respective Executive Medical Directors have been tasked with thinking about what could make the biggest difference to the greatest number of people. They will report back to us in July.

The estates challenges arising from the pandemic are significant and need creative solutions; both Trusts have been hampered by the relationship of tenant and landlord with NHS Property Co. The acceleration of the digital solutions enabling our teams to work with each other and with the people we serve are profound and significant, offering further potential areas of shared benefit.

Summary and Conclusions

We already have good working relationships at all levels of the two trusts. We have an established interest in improving the quality of care that we offer, through joint working but the pandemic, and our learning from it has created the drive to further strengthen this commitment and to signal to both the wider system and the public that we want to make a step change and set ourselves some ambitious targets to drive up the quality of what we offer.

Next Steps

If the Board endorses the direction of travel, the next steps would be for the two Chief Executives to formally sign a Memorandum of Understanding. Whilst not a legally binding document or contract, the signing of such an agreement between the two trusts, makes a strong statement about working in the interests of our patients and signals that we want to do things in a more joined up way.

In order to support the work, re-establishing a Non Executive and Executive pair from each trust would ensure that the work was sponsored at the highest level with a clear line of sight from both boards to the work as it unfolds.

The starting point for this and any changes that the two trusts make, is always to improve the quality of what we offer those we serve. This simple change, could be the start of some significant improvements, in particular, for our most vulnerable patients.

Paul Bentley
Chief Executive KCHFT

Helen Greatorex
Chief Executive KMPT

August 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 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, 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.

The mortality review process was amended in April 2020 in view of Covid-19 restrictions and was approved at a quality meeting shortly after the beginning of the pandemic. Reviews are now completed virtually, first by a doctor using physical notes, and then circulated to at least two other clinicians for independent review of CIS notes. This allows for further comment and a safe degree of peer review. A minimum of 3 clinicians including the lead medical reviewer are required.

Numbers of deaths in community hospitals increased dramatically as a result of Covid-19, with 41 deaths in KCHFT community hospitals in April. Indications are that April was the peak month for deaths. The volume of deaths in May and June has decreased significantly but remains above average.

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. The Committee is asked to share the learning and themes in this report with the Quality Assurance Team to assist with triangulation of information for We Care visits.

Proposals and /or Recommendations

For assurance.

Relevant Legislation and Source Documents

Has an Equality Analysis (EA) been completed?
Yes ☒ The Equality Analysis found a positive impact for age, disability, pregnancy and maternity as the policy makes specific reference to reviewing deaths of patients under 18, those with severe mental illness and learning disabilities, and that the Trust would assist in reviews of maternity deaths if required.

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

Kent Community Health
NHS Foundation Trust

THEMES FROM MORTALITY REVIEWS APRIL 2020 – JUNE 2020

1. Introduction

1.1 In line with national guidance on learning from deaths, 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. Covid-19

2.1 The mortality review process was adapted in April 2020 as part of the response to Covid-19 pandemic and these changes were approved at a quality meeting shortly after the beginning of the pandemic. Reviews are now completed virtually, first by a doctor using physical notes, and then circulated to at least two other clinicians for independent review of CIS notes. This allows for further comment and a safe degree of peer review. A minimum of 3 clinicians including the lead medical reviewer are required.

2.2 Numbers of deaths in community hospitals increased dramatically as a result of Covid-19, with 41 deaths in KCHFT community hospitals in April. Indications are that April was the peak month for deaths. The volume of deaths in May and June has decreased significantly but remains above average.

2.3 Deaths are cross-checked against a list from the Performance Team each month, including their submission of Covid-19 deaths, to ensure records are accurate. The total number of Covid-19 deaths this quarter was 48.

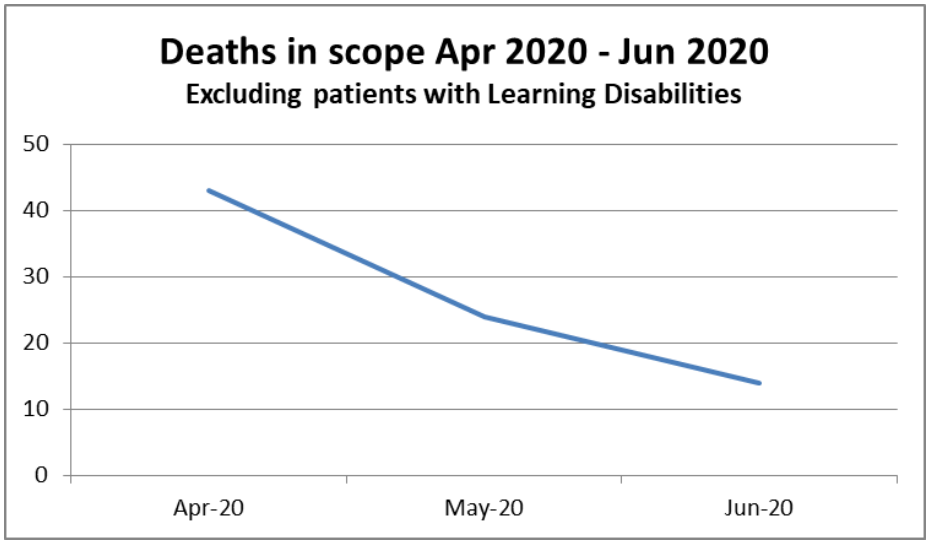
3. June Dashboard

3.1 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.

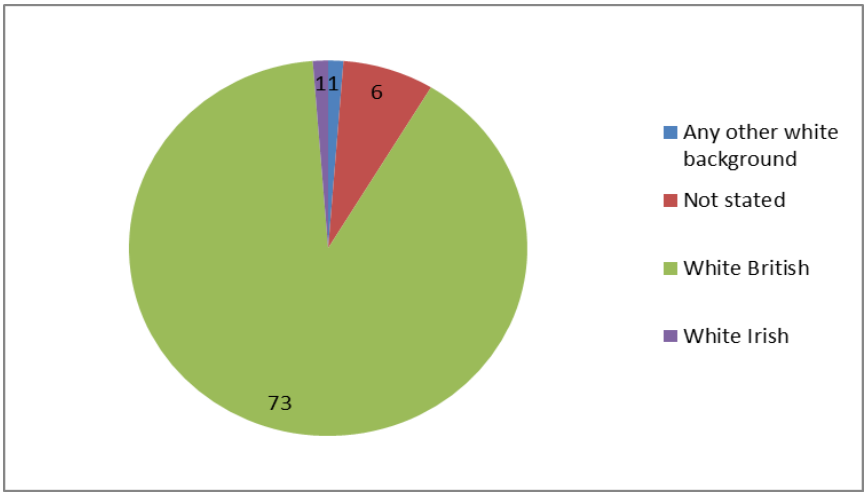
Total Number of Deaths in Scope			Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month		Last Month	This Month		Last Month	This Month	Last Month
14		24	28		13	0	0
This Quarter (QTD)		Last Quarter	This Quarter (QTD)		Last Quarter	This Quarter (QTD)	Last Quarter
81		22	45		15	0	0
This Year (YTD)		Last Year	This Year (YTD)		Last Year	This Year (YTD)	Last Year
103		68	60		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.*

3.2 The graph below shows the number of deaths in scope this quarter, by month.



3.3 The chart below shows the breakdown of ethnicities for the 81 deaths in scope this quarter.



3.4 The ages of patients dying with Covid-19 between April and June ranged from 61 to 100. The gender split was 60% male, 40% female

3.5 According to Infection Prevention and Control data, of the 20 patients who tested COVID-19 positive while in the community hospital and subsequently died (as opposed to testing positive prior to admission):

- 6 were deemed to be community onset
- 6 were hospital-onset (definite)
- 3 were hospital-onset (probable)
- 5 were hospital-onset (indeterminate)

4. Learning from Mortality Reviews

4.1 The table below outlines key areas of good practice identified in reviews completed this quarter.

4.2 All areas of good practice and areas for learning are reported at monthly matrons' meetings in the East and West and wider dissemination to all ward staff is encouraged. A summary report is also reviewed at the bi-monthly End of Life Steering Group. Themes are discussed at the bi-monthly Mortality Surveillance Group (MSG). A summary report to the weekly patient safety summit has been piloted since mid-June to ensure increased awareness of any emerging areas of concern arising from mortality reviews.

Areas of Good Practice aligned to the Five Priorities for Care of the Dying Person	
Recognise Many examples of good clinical practice were documented in mortality reviews including; Early recognition and implementation of end of life care, clear documentation of end of life care plans and appropriate review of medication required at the end of life. In one notable case there was prompt review of a deteriorating patient with appropriate initial trial of active treatment whilst also considering the probability that the patient may continue to deteriorate and require end of life care. There was also good evidence of use of the Treatment Escalation Plans implemented during COVID -19 to support advance care planning	**Involve** Frequent examples of patient involvement in decisions about care were documented during completion of care plans, treatment escalation plans, DNACPR discussions and advance care planning.
Plan & Do Very frequent examples of clear assessment and responsive management plans were documented during reviews. It was noted that on some occasions the intervention of the discharge support team ensured that patients were transferred from the acute	**Communicate** Clear documentation and communication with family were frequently recorded during reviews with good examples of alternative use methods of communication during COVID. There were also good examples of clear communication with other providers to support good patient care. **Support**

	Frequent evidence of support provided to enable visiting during End of life care whilst maintaining COVID-19 IPC precautions were documented. There were also examples of efforts made to ensure contact by phone or virtual link where possible and supportive care provided to patients who did not have visitors.

4.3 Themes for learning and improvement this quarter have been primarily around medicines, transfers of care from the acute and documentation, particularly DNACPRs and TEPs. These are summarised below along with ongoing or planned actions. A chart can be seen in Appendix 1 which shows the frequency of each problem type, in line with RCP reporting categories, across the community hospitals. All feedback is sent to ward matrons for sharing with the team, and is reported monthly for dissemination at Matrons and Clinical Leads meeting. A brief summary of issues is provided weekly for the Patient Safety summit for more rapid action where necessary

Themes for Learning	Comments/Actions
Recognition of End of Life There have been recurring themes of missed opportunities for early recognition of end of life. For example:	
• Possible missed opportunity to reconsider the management goals and reflect the patient's wishes not to return to the acute hospital.	Team to utilise the end of life assessment tool on CIS for capturing decisions in place and for monitoring symptoms.
• Potential missed opportunities for EoLC planning and a lack of review of the initial EoL care assessment which extended the previous months that this patient was known to KCHFT services.	Issues regarding failed discharge and advance care planning shared with Patient Safety summit
• Not clear from CIS that there was recognition of the dying phase. NEWS continued to be scored, blood tests were planned and clexane was being given. In other examples NEWS scores and	Measures in place to support medical staff involved, including training regarding treatment escalation planning. Work is also being scoped to address additional support regarding recognition of the last year of life

baseline observations continued to be recorded during final days of life when actively dying • EOL not clearly identified for the patient in the CIS record and there was not clear evidence of advance care planning • Although patient documented as having end stage COPD on the board round, was no clear documentation of any discussion with patient or family regarding advance care planning and patient's wishes. There was possibly an over focus on equipment provision for home and missed opportunity to recognise that the patient was approaching the end of life	Issues regarding failed discharge and advance care planning shared with Patient Safety summit
Medicines **Examples of medication issues included:** • Delays in availability of medication For example a 4 hour delay in obtaining alternative medication for nausea during out of hours cover. • Omissions in documentation. For example omission of the record of Fentanyl patch application on 3 days. (But no other omissions in controlled drug documentation and the prescription chart for the patch is correct) • Dosage of subcutaneous glycopyrronium was noted to be incorrect on the palliative end of life medication chart which does not enable a 200mcg dose to be prescribed even though the starting dose of 200mcg is recommended in the accompanying prescribing guidance. This is anomaly has been raised with medicines management for correction. • Medicines charts were not completed	All medicines issues are fed back to the Pharmacy team, in addition to the usual feedback channels.

in full, abbreviations used and not as per guidelines found on each chart. • Regular medication recorded as omitted or unable to take without any clear review or reconciliation of medication with the clinical situation • Clearer transparent process of prescribing drug chart out of hours required. Poor completion of drug chart as completion of allergies and signatory not clear • In one case there was no recorded pharmacy reconciliation of medication or reference to the EDN and GP record discrepancy re diabetic medication. There does not appear to have been any consideration of contacting the GP to check the medication history particularly regarding a patient suspected to have delirium.	
Transfer of Care Issues There have been a number of Transfer of Care issues from the acute. Many of those relate to missing or incomplete DNACPR and TEP forms, which will be listed separately under the DNACPR/TEP heading. Transfer of care issues particularly in relation to lack of documentation or advance care planning are noted to be particularly problematic when late transfers occur and have in some instances led to inappropriate escalation of care in patients for whom end of life care would have been appropriate.	Logs are being kept of issues arising from transfers from both MTW and EKHUFT. Lisa Scobbie has met with the Deputy Director of Clinical Governance at MTW to raise some of these issues; a channel of communication has been agreed to share feedback both ways and another meeting will be held in 8 weeks. It is hoped that there will be a future opportunity to do the same with EKHUFT. The transfer of care task and finish group will also restart in July having been stepped down during COVID. The referral handover and admission checklist has now been amended to include questions in relation to MCA, End of Life, Treatment Escalation Plans and DNAR.

DNA CPR forms and TEPs On several occasions, incomplete or poor quality DNACPR forms have been received from the acute. Problems include: • DNACPR undated, unsigned and identity of clinician not clear • DNACPR omits any summary of discussion with the patient or family • KCHFT staff not always aware of when it would be best practice to review and re-write a DNACPR form e.g. capacity has changed, form sent by the acute does not include discussion with family • Treatment Escalation Plan not fully completed; good summary of known conditions but no documentation of frailty or WHO performance status on document and no comment on patients personal preferences	
Documentation • Issues include handwritten notes without clearly identified staff entries and incomplete patient details, lack of documentation around capacity and some lack of consistency between electronic and written notes • Documentation of verification was provided over the phone on one occasion due to the lack of trained staff • In one case there was no apparent documentation of the patient's significant mental health history or of any specific needs. Not documented in the GP SCR record or in any patient handover documentation. Rapid transfer	All current documentation issues are fed back to ward matrons. Implementation of the new electronic patient record system is due in October 2020 Guidance for remote verification of death has been developed since this incident occurred and online training for verification of death is now available to trust staff Case shared with community mental health team

service ready to transfer form also has box ticked to state patient has no mental health history.	

5. Learning Disability (LD) Mortality Review Report
Written by Mandy Setterfield, Specialist Practitioner

5.1 Introduction

In response to the Coronavirus pandemic, Kent and Medway made a decision to pause the LeDer programme to prevent added pressure on GP's, Hospitals and families. During this time, we have introduced the Rapid Covid19 Review which takes place for anyone with a Learning Disability who has died with a suspected or a confirmed case of Coronavirus.

The review template used for all rapid reviews was developed by the London Boroughs and more recently adapted by the LeDer South East Regional Coordinator. The rapid review does not replace the full LeDer review it will be used as supporting documentation.

The rationale for the rapid reviews is to:

- Quickly gain local knowledge regarding deaths from Covid19
- Disseminate the evolving themes to try to avoid further deaths
- Support care homes and providers
- Gain softer intelligence that can inform other areas of Covid19 across health and social care.

5.2 Comparison of deaths in 2019

The graph below shows the number of deaths between October 2019 – April 2020. There was a significant increase in deaths in April 2020 due to Covid19.

October to December 2019	17 deaths in 3 months
January to March 2020	26 deaths in 3 months
April to June 2020	53 deaths in 3 month. 26 cases are covid19 positive Confirmed or suspected.

The KCHFT LeDer team so far have received 26 cases to review. All 26 cases have been completed, 17 cases were male and 9 cases were female. The graph below shows that this mainly affected people between the ages of 50-60 years old. 24 people were of white British ethnicity.

Age at death:

40 Years	4
50 years	6
60 Years	7
70 Years	5
80 Years	4

Testing

Out of the 26 reviews, 16 people tested positive for Coronavirus, 5 people tested negative but were symptomatic, and 5 people were not tested.

Place of death
17 People died in hospital
8 People died in residential homes
I Person died in hospice

Where person originally lived.

6 people lived in Supported Living, 2 people in a family home and 18 people lived in residential home, therefor the majority of people lived in shared accommodation.

Pre existing health needs.
All bar one person had pre-existing health needs, these included:

Pre-existing health need
Diabetes
Reoccurring chest infections
Past Pneumonia
Advanced heart failure
Acute liver failure
Dementia
Autism

Cases open to Community LD Teams.
22 of the cases were open to the Community Learning Disability Team.
3 cases open to Medway teams
1 case had received a referral 3 days before hospital admittance for support with epilepsy.

My Health Navigation
Although the people who died were not on the health navigation spreadsheet, Health navigation was happening eg, in depth support was being given by the crisis virtual team. A decision was made not to put the names on the MyHn list due to the time it takes to complete the paperwork.

5.3 **Evolving Themes**

- 6 people had Diabetes
- 5 people Down Syndrome
- 6 People were prescribed antibiotics for infections in the community a week - 10 days before going into hospital. Evidence of this has come from the person's provider or the hospital.
- Rapid health deterioration within 24hours when symptoms of covid19 appeared.
- Lack of PPE and understanding in care homes re guidance.
- 18 of the case called 999 direct, only 3 went through to 111. Reasons given waited over an hour for call back, told to ring GP the next day.
- Good care in hospital

DNACPR

8 people already had a community DNACPR. 9 DNACPR orders were put in place in hospital due to covid19.
6 people were on end of life before being confirmed with covid19. Checks on CIS and KCC system would indicate that the DNACPR's for end of life were appropriate and reviewed regularly.

Lessons Learnt

- Care homes could have benefited from more support advice around government guidance and PPE in the earlier days of the pandemic.
- Communication and Hospital passports were not always taken to the hospital with the person. Where these were with the person they could not be moved around the hospital with the person e.g. Ward to ward due to infection risk.
- A number of people were prescribed Antibiotics for infections in the community in the week before being admitted to hospital. (Was there a missed opportunity for earlier detection of Covid19).
- People were admitted to hospital alone and died without family or carers with them.

Immediate actions taken

Following rapid reviews, it was recognised there was a need for some immediate changes, these included:

- Supporting care homes with the government guidance and where to get PPE.
- Feeding into the vulnerable adult's spreadsheet.
- Weekly data is fed into KCC commissioning for social care spreadsheet.
- Softer intelligence from reviews highlighted to KCC where people had been living in older persons homes for them to follow up.

Actions going forward.

- Full LeDer review will be completed. NHSE have commissioned a sample review of 7 Kent & Medway cases to have full LeDer reviews immediately.
- De briefing/bereavement support for carers families.
- To have a section in the Learning Disability Champions bulletin around preparedness in case of a second spike of covid19.
- Kent & Medway LeDer steering group are looking at the DNACPR in hospitals, pertaining to covid19

Preparedness.

- Covid19 passports are ready and will be laminated so they can be moved around hospital sites.
- Care home initiative is underway with the frailty team. Train the trainers for PPE users to increase care homes and supported livings understanding of how to use PPE.
- Work with carers to think more clinically and to inform GPs that people with a learning disability may have a lower body temperature than the norm. Look at ways of supporting GP's with silent hypoxia.

- Continue the use of tablets in hospital for staff who knows the person well to be able to identify for nurses/doctors that this is a normal or out of character behaviour. This has been used locally and worked well.

LD report by Mandy Setterfield, Specialist Practitioner

Overall report by
Dr Lisa Scobbie - Deputy Medical Director

and

Melissa Ganendran - Mortality Review Project Lead

on behalf of **Dr Sarah Phillips - Medical Director**
July 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	3.2
Agenda Item Title:	Freedom To Speak Up (FTSU) Index Report
Presenting Officer:	Natalie Davies, Corporate Services Director

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

Report Summary
The purpose of this report is to inform the Board of the recently published Freedom to Speak Up Index Report 2020.

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 and no decisions required.

Joy Fuller, Freedom To Speak Up Guardian	Tel: 01622 211972
	Email: joy.fuller@nhs.net

Kent Community Health NHS Foundation Trust

FREEDOM TO SPEAK UP (FTSU) GUARDIAN REPORT

1. Purpose

The purpose of this paper is to inform the Board of the recently published Freedom to Speak Up) Index Report 2020.

2. Freedom to Speak Up Index Report

Background

In September 2019, the National Guardian's Office published the first '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 survey questions used were:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (Q17a).
- % of staff responded "agreeing" or strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (Q17b).
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (Q18a).
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (Q18b).

On 9 July 2020, the National Guardian's Office published the Freedom to Speak Up Index Report 2020, based on responses to the same four questions in the 2019 annual staff survey.

Assessment

I am pleased to report that there has been a notable improvement in the index score for Kent Community Health NHS Foundation Trust from 2019 to 2020. The summary below provides a comparison between the two reports:

2019 - Index score: 81%
2020 - Index score: 84.2%

2019 - Position in the Country: 32nd
2020 - Position in the Country: 11th

2019 - Number of community trusts with a greater index score: 10
2020 - Number of community trusts with a greater index score: 5

I also wish to highlight that Kent Community Health NHS Foundation Trust has the greatest index score across all NHS Trusts and Foundation Trusts in Kent, Medway and Sussex.

A full copy of the index report can be found here: FTSU Index Report 2020

Next Steps

- Contact the Freedom to Speak Up Guardian's at the five Community Trusts with a greater index score in order to discuss their Freedom to Speak Up arrangements, and to share learning and best practice.
- Continue to promote the role of the FTSU service across the trust, by publicising on the staff intranet site, blogs, attending team meetings and staff network meetings.
- Review feedback from staff who use the FTSU service, using the newly introduced feedback survey form.
- Continue to identify themes and potential barriers to speaking up across the trust.

3. Recommendation

The Board is asked to receive this report.

The next report will be submitted to the formal Board meeting in November. This report will summarise the cases received between April 2020 to September 2020 (quarter one and quarter two).

Joy Fuller
Freedom to Speak Up Guardian
July 2020

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	06 August 2020
Agenda Number:	3.3
Agenda Item Title:	Approved Minutes of the Charitable Funds Committee Meeting
Presenting Officer:	Prof. Francis Drobniewski, Chair of Charitable Funds Committee

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

Report Summary
The paper presents the confirmed Minutes of the Charitable Funds Committee meeting of 17 January 2020.

Proposals and /or Recommendations
The Board is asked receive the confirmed minutes.

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

Prof. Francis Drobniewski, Non-Executive Director	Tel: 01622 211906
	Email:

Kent Community Health NHS Foundation Trust

CONFIRMED Minutes of the Charitable Funds Committee held on Friday 17 January 2020 in the Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone Kent ME16 9NT

Present: Jen Tippin, Non-Executive Director (Chair) (by phone)
Pippa Barber, Non-Executive Director
Pauline Butterworth, Chief Operating Officer
Carol Coleman, Public Governor, Dover and Deal
Gordon Flack, Director of Finance / Deputy Chief Executive

In Attendance: Gina Baines, Committee Secretary/Assistant Trust Secretary (minute-taker)
Jo Bing, Assistant Financial Accountant
Jane Kendal, Community Services Director (agenda item 2.3)
Dawn Levett, Strategic Delivery Manager Urgent Care (agenda item 2.3)
Jo Treharne, Head of Campaigns (agenda item 2.2)
Carl Williams, Head of Financial Accounting (agenda item 2.1)

001/2020 Welcome and apologies for absence

Pippa Barber, Acting Chair welcomed everyone present to the meeting of the Charitable Funds Committee Jen Tippin would chair the meeting when she joined later by phone.

Apologies were received from Victoria Cover, Head of Clinical Services Urgent Care and Hospitals West Kent; Paul Ducker, Acting Convenor Staff Side; Brenda Hollier, Senior Clinical Nurse Specialist; Claire Poole, Community Services Director Public Health/Deputy Chief Operating Officer; and Stephanie Rhodes, Head of Service Long Term Services West Kent

The meeting was quorate.

002/2020 Declarations of Interest

Pippa Barber confirmed that she was a trustee for Demelza Hospice Care for Children.

There were no other declarations of interest given apart from those formally noted on the record.

003/2020 Minutes of the Previous Meeting held on 29 November 2019

The following amendments were suggested:

036/19 Any Other Business page 6 of 7 final paragraph – spelling correction: 'passed' should read as 'pass'.
036/19 Any Other Business page 7 of 7 paragraph 3 – spelling correction: Tunbridge should read as Tonbridge.

The Minutes were **AGREED**, subject to the amendments.

004/2020 Matters Arising of the Meeting of 29 November 2019

The Matters Arising Table Actions Closed was **AGREED**.

Jen Tippin joined the meeting and took the Chair.

The outstanding actions were discussed and updated as follows:

023/19 Forward Plan –. Jo Bing confirmed that she had liaised with Claire Poole, Community Services Director Public Health who was still waiting to hear on bids from the service. Claire Poole had also wanted to establish the outstanding balance on the fund. Action open.
033/19 Fund Manager presentations; East Kent Charitable Funds Update including Heron Ward (Mermikides) Fund, Bow Road Fund – Action open.

All other outstanding actions were closed.

005/2020 Relevant Feedback from Other Committees including Board Assurance Framework

There was nothing to report from the other recent committee meetings.

There were no comments regarding the Board Assurance Framework.

006/2020 Charitable Funds Report and Accounts 2018/2019

Carl Williams presented the report to the Committee for approval.

The accounts now included the independent examination from the auditors. Gordon Flack had advised two minimal changes to the document. The first related to the Board membership on page 3. Richard Field had been the acting trust chair from 25 May to 31 October 2018. The second related to donation envelopes. The committee had decided that donation envelopes would not be used. Reference to this would be

deleted from the report on page 8. These changes had been made to the report and accounts which were now ready to be approved that day.

It was agreed that as Jen Tippin was not physically present at the meeting, her electronic signature would be applied to the accounts.

The Committee **APPROVED** the 2018/2019 Charitable Funds Report and Accounts.

007/2020 Charitable Funds Marketing Report

Jo Treharne presented the verbal report to the Committee for assurance.

The Trust had run a number of initiatives and events since the Committee last met. These included two health and well-being initiatives on the subject of the menopause; the launch of a Trust football team and a Christmas Jumper Day. All these activities had been well received.

With regards to the rebranding of the charity, the Committee had received visual examples of their preferred option shortly before the meeting. Carl Williams requested that Kent Community Health Charitable Funds was included to avoid any misunderstanding. Jo Treharne would make the amendment.
Action – Jo Treharne

Jo Bing commented that she had been searching the home page on the website Just Giving and icare had not been found. It was agreed that Jo Treharne would investigate and request that this was changed on the website.
Action – Jo Treharne

The Committee **NOTED** the Charitable Funds Marketing Report.

008/2020 East Kent Charitable Funds Update - Heron Ward (Mermikides Fund)

Jane Kendal and Dawn Levett presented the report to the Committee for assurance.

Jane Kendal commented that the planned refurbishment of Heron Ward using the Mermikides funds had been in place to begin in April 2019 but it had been delayed due to the change of project manager in the Estates team. She now had a pre-budget estimate and the estates had aligned the funding. NHS Property Services had committed to fund the outstanding improvement works and maintenance on the ward. The League of Friends at the hospital had been unhappy with the state of the building. She was now in a position to identify how much the fund could be spent. The League of Friends had agreed to fund the occupational therapy room and sensory Garden. The project would now go out to

tender.

In response to a question from Carol Coleman as to whether the majority of the fund would be spent, Jane Kendal confirmed that £165k would be spent leaving an underspend of £110k.

In response to a question from Gordon Flack regarding the revised timing of the project, Jane Kendal indicated that she hoped it would go ahead over the summer months. Although she wished to liaise with the League of Friends first, she agreed that the project could start without their input. It was agreed that that the tender would proceed immediately.
Action – Jane Kendal

Gordon Flack commented that the League of Friends element could be funded from the Mermikides Fund. Jane Kendal added that the replacement of the medicine cabinet, the refurbishment of the bathroom and the improvements to the unit to make it more dementia friendly had been carried out, although the Mermikides fund had not been used for these improvements.

In response to a question from Carol Coleman as to whether the outcomes from the Patient-Led Assessment of the Care Environment (PLACE) inspections had informed the works tender proposal, Jane Kendal confirmed that they had.

The Committee **NOTED** the East Kent Charitable Funds Update - Heron Ward (Mermikides Fund**).**

009/2020 Terms of Reference Review

Jen Tippin presented the report to the Committee for approval.

Gordon Flack requested that the membership of the Committee was amended now that Lesley Strong, previously Chief Operating Officer had left the organisation. Gina Baines would amend the Terms of Reference.
Action – Gina Baines

The Committee **APPROVED** the Terms of Reference, subject to the amendment.

010/2020 Committee Effectiveness Review

Jen Tippin presented the report to the Committee for approval.

It was agreed that the review template would be circulated to members of the committee to complete and return.
Action – Gina Baines

The Committee **APPROVED** the Committee Effectiveness Review.

011/2020 Forward Plan

Jen Tippin presented the report to the Committee for approval.

The Committee considered whether the Charitable Funds could support the Trust's environmental sustainability strategy with funding towards the estate's biodiversity plan and development of its grounds. The fund could support the purchase of equipment and plants.

Gordon Flack highlighted that the Committee was required to receive a quarterly statement on the fund and accounts. He would circulate this electronically each quarter and bring it to each meeting.
Action – Gordon Flack

In response to a question from Carol Coleman as to whether there were any restrictions attached to the Tonbridge Community Hospital fund, Jo Bing confirmed that there were none except that all the money should be spent at the community hospital. Victoria Cover, the nominated fund manager had suggested that it should be spent on creating a garden in the grounds.

The forward plan would be updated.
Action – Gina Baines

The Committee **AGREED** the Forward Plan.

012/2020 Any Other Business

Pippa Barber thanked Jen Tippin for chairing the Committee during her term of office and her commitment to keeping its focus. Gordon Flack added his thanks to Jen Tippin for her input to the Finance, Business and Investment (FBI) Committee as well.

It was agreed that there would be a handover to the new chair of the Committee, Prof. Francis Drobniewski. Gina Baines would make the necessary arrangements. It was agreed that the meeting dates for the Committee for the rest of the year would also be reviewed to align them more closely with either the FBI Committee or Board meetings. The non-executive director membership would also be confirmed.
Actions – Gina Baines

The meeting ended at 11am.

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013/2020 Date and time of next meeting

Wednesday 8 July 2020; Virtually via Teams or The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT