

Agenda and Papers

for the

Formal meeting of the

Kent Community Health NHS Foundation
Trust Board

In Public

to be held at 9.30 am

on Thursday 5 November 2020

Virtual meeting via MS Teams

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

MS Teams Live Event

**Meeting of the Kent Community Health NHS Foundation Trust Board
 to be held from 9.30am to 12noon
 on Thursday 5 November 2020 in
 Rooms 6 and 7
 Kent Community Health NHS Foundation Trust Offices
 Trinity House, 110 – 120 Upper Pemberton
 Ashford TN25 4AZ
 and virtually by MS Teams Live Event**

This meeting will be held in Public

AGENDA

1. STANDARD ITEMS 9.30 - 10.15

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|-----|---|-----------------------------|--------|
| 1.1 | Introduction by Trust Chair | Trust Chair | |
| 1.2 | Apologies for Absence | Trust Chair | |
| 1.3 | Declarations of Interest | Trust Chair | |
| 1.4 | Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 6 August 2020 | Trust Chair | |
| 1.5 | Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 6 August 2020 | Trust Chair | |
| 1.6 | Patient Story | Chief Nurse | |
| 1.7 | Trust Chair's Report | Trust Chair | Verbal |
| 1.8 | Chief Executive's Report | Chief Executive | |
| 1.9 | Board Assurance Framework | Corporate Services Director | |

2. STRATEGY 10.15 – 10.35

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|-----|--------------------------------------|---|
| 2.1 | Integrated Care System Accreditation | Chief Executive
Accountable Officer,
Kent and Medway
Clinical Commissioning
Group |
|-----|--------------------------------------|---|

3. PRIORITIES FOR THE YEAR 10.35 – 11.15

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| 3.1 | Operating Plan | Chief Executive |
| 3.2 | Integrated Performance Report | Deputy Chief Executive/Director of Finance |

4. CURRENT YEAR PERFORMANCE 11.15 – 11.45

- | | | |
|-----|---|---|
| 4.1 | Audit and Risk Committee Chair's Assurance Report | Chair of the Audit and Risk Committee |
| 4.2 | Finance, Business and Investment Committee Chair's Assurance Report | Chair of the Finance, Business and Investment Committee |
| 4.3 | Quality Committee Chair's Assurance Report | Chair of the Quality Committee |
| 4.4 | Strategic Workforce Committee Chair's Assurance Report | Chair of the Strategic Workforce Committee |

5. GOVERNANCE, RISK MANAGEMENT AND COMPLIANCE 11.45– 11.55

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|-----|---------------------------------------|-------------|
| 5.1 | Board of Directors Governance Refresh | Trust Chair |
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6. ANY OTHER BUSINESS

- | | |
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| Any other items of business previously notified to the Interim Chair | Chair |
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7. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

8. DATE AND VENUE OF NEXT MEETING

11 February 2021 - Rooms 6 and 7
Kent Community Health NHS Foundation Trust Offices
Trinity House, 110 – 120 Upper Pemberton
Ashford TN25 4AZ

UNCONFIRMED Minutes
of the Kent Community Health NHS Foundation Trust (KCHFT) Board Meeting
held 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; also via
MSTeams Live Event

Present: John Goulston, Trust Chair (Chair)
 Sola Afuape, Non-Executive Director
 Pippa Barber, Non-Executive Director
 Paul Bentley, Chief Executive
 Pauline Butterworth, Chief Operating Officer
 Peter Conway, Non-Executive Director
 Prof. Francis Drobniowski, 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: Vincent Badu, Executive Director of Strategy and
 Partnerships/Deputy Chief Executive (K MPT)
 Gina Baines, Committee Secretary (minute-taker)
 Linda Bradley, Matron, Whitstable and Tankerton Hospital
 Paul Butler, Non-Executive Director
 Natalie Davies, Corporate Services Director

06/08/01 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, all c were requested that the meeting was not recorded. The minutes would be made available on the Trust website.

06/08/02 Apologies for Absence

There were no apologies.

The meeting was quorate.

06/08/03 Declarations of Interest

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

06/08/04 Minutes of the Meeting of 21 May 2020

The minutes were read for accuracy.

The Board **AGREED** the Minutes.

06/08/05 Matters Arising from the Meeting of 21 May 2020

The Board **RECEIVED** the Matters Arising.

06/08/06 Service Impact Story

Ms Linda Bradley joined the meeting to present her story to the Board.

The story related to a complaint that the ward had received from a patient's family regarding the quality of the daily feedback they received about their family member's stay in hospital during the COVID-19 pandemic. They commented that the feedback they received was not clear enough and made some suggestions including use of terminology and that scheduling a daily call in the morning with a specific nurse would be helpful. Ms Bradley discussed this with her team and it was agreed that this would be put in place. The members of staff were very supportive and allocated themselves protected time each morning to contact specific families/carers with a meaningful update on the patient's condition. It also provided an opportunity for any messages from the patient to be passed back to the family or carer. It was found that putting this in place was beneficial to the nurses as well as the family. It reminded the team of the importance of good communication especially at this time when families could not visit.

In response to a comment from Mr Sammon regarding sharing this learning with the wards at the Trust's other community hospitals, Ms Bradley suggested that she would share it with the Matrons at their next meeting.

Action – Ms Bradley

Ms Barber commented that the story was a credit to Ms Bradley's leadership and their learning and reflective practice had demonstrated compassion.

In response to a suggestion from Ms Afuape that there might be value in Ms Bradley coming back to the Board in six months' time to update it on whether the practice had been maintained, it was agreed that Dr Spare

would review this.

Action – Dr Spare

The Board **RECEIVED** the Service Impact Story

06/08/07 Trust Chair's Report

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

Mr Goulston highlighted the importance of Board members reconnecting with staff and patients post COVID-19. He and Ms Barber had discussed this with Ms Jane Kendal, Community Services Director who had agreed to draft some suggestions to facilitate this in east Kent.. Board members would soon receive invitations from services to visit.

Action – Board members

In the meantime Dr Spare would arrange for all Board members to receive an update on their infection prevention and control training.

Action – Dr Spare

Three important documents had been published since the last Board meeting which would guide the Trust over the coming months: the NHS People Plan; Five principles for the next phase of the COVID-19 published by National Voices; and a letter from Sir Simon Stevens, Chief Executive NHS and Amanda Pritchard, Chief Operating Officer detailing how the NHS would be expected to respond to phase three of the pandemic.

The NHS People Plan highlighted the importance of fostering a culture of inclusion and belonging within a compassionate and inclusive culture. With regards to the letter from Sir Simon Stevens and Amanda Pritchard, it brought to the fore the importance of the NHS's response to tackling health inequalities in local communities. Within Kent and Medway, there were a number of localities identified as being in the 'most deprived' category. The Trust would need to address how it could effectively help those hard to reach groups.

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

06/08/08 Chief Executive's Report

Mr Bentley presented the report to the Board for information.

The letter from Sir Simon Stevens and Amanda Pritchard had been received after Mr Bentley's report had been published. In summary, the letter set out how the NHS would be expected to manage the next phase of its response to COVID-19. The Trust was standing up its services. This was challenging but going well. It was anticipated that all services would have completed the process for the new normal by the time the Board met again.

Dr Spare commented on the tenacity of the staff who had been outstanding throughout the pandemic. In response to a question from Mr

Goulston as to whether staff were taking their annual leave, Ms Norris responded that all staff were being encouraged to take their leave. Health and well-being packages were also available and Schwartz Rounds had been introduced and were being well-received.

With regards to the pre-consultation business case for the development of acute services in east kent(PCBC), Mr Bentley explained that the revised version was due to be submitted to NHSE/I in mid-August. As the document required the support of the Board prior to the next Board meeting, it was recommended that the Board approve the delegation of authority to certain specified Board members to review the changes which had been included in the new draft. This review and conclusion would be reported to the Board at its next meeting. It was proposed that authority was delegated to the Mr Goulston, Trust Chair; Mr Bentley, Chief Executive; and Mr Flack, Deputy Chief Executive and Mr Conway, Vice Chair. The Board would be updated on progress at its next meeting.

In response to a question from Ms Afuape as to whether an equality impact assessment had been undertaken as part of preparing the business case, it was agreed that this would be clarified with East Kent Hospitals University NHS Foundation Trust (EKHUFT) who had led on preparing the submission.

Action – Mr Bentley

In response to a comment from Ms Skelton regarding the terms of the Board's support for the business case, Mr Bentley commented that he and the nominated colleagues would examine the document thoroughly to ensure that the PCBC was consistent with the need to invest across all of East Kent Healthcare (even if only in principle). Mr Goulston added that they would endeavour to support the business case if it was fit for purpose and the decision would be circulated to Board members.

Action – Mr Bentley

The Board **RECEIVED** the Chief Executive's Report and agreed the recommended approach to the Pre-Consultation Business Case.

06/08/09 Board Governance Refresh Report

Mr Goulston and Mr Bentley presented the report to the Board for approval.

There was an error on page 27 of 183, Point 5. It should read 'Initially there will be a review of Board effectiveness in Spring 2021.'

Mr Turner suggested there should be some guidelines or training for board report writers to improve the standard of the reports that were submitted to the committees and Board. Mr Sammon commented that the Patient Story should continue to be included on the Board meeting agenda.

It was agreed that a short task and finish group would be convened and would consist of Mr Goulston, Mr Bentley, the chairs of the committees, Mr

Flack and Ms Davies. They would look at the actions identified in the paper and report back to the Board. It was agreed that Ms Davies would lead on arranging this.

Action – Ms Davies

The Board **APPROVED** the Board Governance Refresh Report

06/08/10 Board Assurance Framework (BAF) including the NHS England/Improvement Board Assurance Framework for COVID-19 (KCHFT)

Ms Davies presented the report to the Board for assurance.

In response to a comment from Ms Skelton, it was agreed that the BAF would be reviewed to ensure that the ownership of risks was aligned correctly. Ms Skelton also challenged that Risk 103 (system architecture) should be considered further to ensure that the risk reflected the current system leadership challenges.

Action – Ms Davies

Mr Conway confirmed that the Audit and Risk Committee would be meeting in late August and would be reviewing the BAF. He had some suggestions as to how the document might be improved which he would share with Ms Davies.

Action – Mr Conway

With regards to the NHSE/I BAF for COVID-19, Dr Spare presented the report to the Board for assurance.

She confirmed that it had been submitted to NHSE/I who had fed back that it was assured that the Trust was managing its risk in relation to infection prevention and control during the pandemic. With regards to accessing adequate laboratory support for routine testing, the Trust was working with others across the system to rectify the limited capacity which had been identified.

In response to a question from Ms Afuape as to whether the second report published by Public Health England regarding the impact of COVID-19 on the Black, Asian and Minority Ethnic (BAME) communities and vulnerable categories, had been reviewed against the recommendations in the report, Dr Spare confirmed that all risk groups had been considered. The report did link to the risk assessments that had been carried out on the BAME staff groups and those staff who had been shielding and were now returning to work. Ms Norris added that all BAME staff had had risk assessments carried out and actions had been identified. In addition, staff who had underlying health conditions and those who were working from home had also had risk assessments.

It was agreed that Ms Afuape would share the Public Health England report with the Board. Dr Spare would review the BAF for COVID-19 against this and would update it if any omissions were identified.

Actions – Ms Afuape/ Dr Spare

Dr Spare confirmed that she would be speaking with the Care Quality Commission (CQC) the following week to discuss the report and she would inform the Board of the outcome of the meeting

Action – Dr Spare

The Board **RECEIVED** the Board Assurance Framework including the NHS England/Improvement Board Assurance Framework for COVID-19 (KCHFT).

06/08/11 Charitable Funds Committee Chair's Assurance Report

Prof. Drobniewski presented the report to the Board for assurance.

In response to a question from Prof. Drobniewski as to whether the allocated public donations to the Trust had been distributed to staff, Ms Norris agreed that to investigate this.

Action – Ms Norris

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

06/08/12 Quality Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.

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

06/08/13 Strategic Workforce Committee Chair's Assurance Report

Ms Skelton presented the report to the Board for assurance.

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

Mr Vincent Badu joined the meeting.

06/08/14 Joint paper from Kent Community Health NHS Foundation Trust (KCHFT) and Kent and Medway NHS and Social Care Partnership Trust (KMPT)

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

The joint paper would be received by the Board of Kent and Medway NHS and Social Care Partnership Trust in September 2020.

In response to a question from Ms Barber as to whether the two medical directors had discussed how a joint collaboration could be clinically driven, Dr Phillips confirmed that they had and the areas they had identified initially were learning disabilities, autism, and dementia. As collaboration would allow for a more efficient use of resources, this would be good for

patients and the staff. There would be a need to prioritise where improvements could be made. The two medical directors were keen to see physical and mental health care provision coming together and moving away from the previous system of silo working. In addition, the introduction of the Kent and Medway Care Record would enable the two organisations to work differently. With regards to multidisciplinary team (MDT) working, there was an opportunity to see how teams could be enhanced with a variety of skills as proposed in the new Seacole model that was being implemented in response to COVID-19.

Mr Flack commented that the two organisations shared the same patient information system, Rio. This would provide opportunities for developing it further for the benefit of patients and staff. He was also working with KMPT's Executive Director of Finance on data management.

Mr Sammon indicated that the new arrangement would allow the two organisations to provide greater system leadership as many elements of their strategies overlapped or were aligned. It would also benefit the delivery of social care by Kent County Council (KCC).

Mr Goulston confirmed that there would be a working group to take the collaboration forward. He also confirmed that Mr Conway had been appointed as a non-executive director of KMPT. Additional experience on the KCHFT Board included Ms Afuape who was a non-executive director of South West London and St George's Mental Health NHS Trust and Ms Barber, the Independent Nurse for South West London Clinical Commissioning Group as well as the experience of the executives, several of whom had previously worked for Mental Health Trusts.

Once the proposal had been endorsed by the Board of KMPT, Mr Badu would inform Mr Bentley as to when the Board would receive updates on progress.

Action – Mr Bentley

The Board **ENDORSED** the joint paper from Kent Community Health NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership Trust.

06/08/15 **2020/21 Trust Strategy**

Mr Sammon presented the 2020/21 Trust Strategy to the Board for approval.

The Trust Strategy on a Page was brought for formal approval, following its presentation at the July Part Two Board meeting.

The Board **APPROVED** the 2020/21 Trust Strategy and **APPROVED** the Trust's Revised Strategy on a Page.

06/08/16 **Integrated Performance Report**

Mr Flack presented the report to the Board for assurance. Further work needed to be undertaken to align the report with the new governance arrangements that have been agreed that day. In the meantime, the report had been adapted to highlight those key performance indicators (KPIs) that had been adversely affected by COVID-19.

In response to a question from Prof. Drobniowski regarding introducing a realistic target for telephone and video consultations and how that might support the Trust's strategy, Ms Butterworth commented that this was being considered by the Executive Team. There was variation across the services. Some could deliver high levels of this type of consultation while others services would find it more challenging to implement. Each service was being asked to consider what it could deliver virtually. However, it was clear that some aspects of care delivery would need to continue to be delivered face to face. There was a task and finish group working on the digitisation of services and those services who were most impacted were being given support. Dr Phillips, commenting on the digitisation of services, highlighted the importance of building flexibility into the service models and allowing the clinicians to lead in identifying what was safe to deliver digitally and the best resources to support this.

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

06/08/17 2019/20 Quality Account

Dr Spare presented the report to the Board for approval.

The 2019/20 Quality Account had been scrutinised by the Quality Committee. Following approval by the Board, it would be presented to the Council of Governors in November and published on the Trust's public website. It would also be submitted to NHSE/I and the CQC.

The Board **APPROVED** the 2019/20 Quality Account.

06/08/18 Learning From Deaths Report

Dr Phillips presented the report to the Board for assurance.

Ms Barber confirmed that the Quality Committee had received the report. The Committee had received assurance about the mortality review process and agreed with the conclusions of the report. More work was needed with regards to end of life care and documentation especially in relation to personalised care plans and Do Not Attempt Cardio-pulmonary Resuscitation (DNACPR). Dr Phillips emphasised that the process was robust. The purpose of the reviews was to identify areas for improvement and the exercise was always a great source of learning. The national policy was not about performance but had been developed to engender a culture of open learning in order to improve.

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

06/08/19 Freedom To Speak Up (FTSU) Report

Ms Davies presented the report for assurance.

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

06/08/20 Minutes of the Charitable Funds Committee meeting of 17 January 2020

The Board considered the minutes of the meeting.

The Board **RECEIVED** the Minutes of the meeting of 17 January 2020.

06/08/21 Any Other Business

There was no other business to report.

06/08/22 Questions From Members of the Public Relating to the Agenda

Ms Jan Allen, Staff Governor, requested an update on the patient story that had been given at the February Public Board meeting.

Dr Spare confirmed that following the Board meeting, action updates had been received by the Quality Committee regularly. A formal paper had been received in May and another was to follow in September. Ms Theresa Addison and Ms Ann Eldridge who had brought the complaint would be contacted again in September to update them further on progress. In the meantime, they have been kept updated on developments.

Ms Barber confirmed that the Quality Committee had received good assurance. The Trust was working with the family and she was pleased to hear that they were engaged in a wider piece of work that the Trust was undertaking. She would include an update to the Board in her next report. Ms Butterworth confirmed that she had taken the story to the East Kent Chief Operating Officer's weekly call where it had been discussed. As the system reset itself, she and her colleagues were mindful of the issues that the sisters had raised in their complaint.

Ms Carol Coleman, Public Governor for Dover and Deal confirmed that she would be visiting Deal Hospital on 25 August and would welcome any of the Board members to join her.

With regards to the joint paper from KCHFT and KMPT being received by the Council of Governors, Mr Goulston was hopeful that the signed document would be presented to the Council at its next meeting in November.

In response to a question regarding whether the Board was sighted on the number of unexpected deaths in the community, Dr Phillips cautioned that the term expected and unexpected death was a clinical judgement and not always one that was easy to make. This was a grey area and was discussed with the Trust's community geriatricians. The terms helped the

Mortality Review Group to identify which deaths it would scrutinise. In addition, there were nationally aggregated statistics in relation to COVID-19. These statistics were compiled by the Office for National Statistics and not by the Trust.

In response to a suggestion from Mr Goulston that this could be discussed at a Council Development Session, Ms Barber commented that this had been undertaken previously. The Council had received a report on learning from deaths and end of life care. Governors had been taken through the review process at the time but she would be happy to appraise any new governors.

The meeting ended at 12.05pm.

06/08/23 Date and Venue of the Next Meeting

Thursday 5 November 2020; Rooms 6 and 7, Kent Community Health NHS Foundation Trust Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford Kent TN25 4AZ and MS Teams Live Event

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

Minute number	Agenda Item	Action	Action Owner	Status
06/08/06	Service Impact Story	To share the learning from the service impact story with the Matrons of the other community hospitals.	Ms Bradley	Action open.
06/08/06	Service Impact Story	To invite Ms Bradley to the February 2021 Public Board meeting to update the Board.	Dr Spare	This has been added to the forward plan.
06/08/07	Trust Chair's Report	To begin to reconnect with services and accept invitations to visit services where this was safe to do so.	Board members	Action complete.
06/08/07	Trust Chair's Report	To circulate an update on infection prevention and control training to the Board.	Dr Spare	This has been circulated to all Board members and Governors. Risk assessments will also be carried out. Action complete.

Minute number	Agenda Item	Action	Action Owner	Status
06/08/08	Chief Executive's Report and Pre-Consultation Business Case (PCBC)	To clarify with East Kent Hospitals University NHS Foundation Trust (EKHUT) as to whether an equality impact assessment had been undertaken as part of preparing the business case.	Mr Bentley	Action completed.
06/08/08	Chief Executive's Report and Pre-Consultation Business Case	To ensure that the PCBC was consistent with the need to invest across all of East Kent Healthcare (even if only in principle)	Mr Bentley	Action completed.
06/08/09	Board Governance Refresh Report	To arrange for a task and finish group to convene to look at the actions identified in the paper and report back to the Board.	Ms Davies	Action complete.
06/08/10	Board Assurance Framework	To ensure that the ownership of risks was aligned correctly. To review Risk 103 (system architecture) to ensure that the risk reflected the current system leadership challenges.	Ms Davies	Action complete.
06/08/10	Board Assurance Framework	To share suggestions on how the BAF might be improved with Ms Davies.	Mr Conway	Action complete.

Minute number	Agenda Item	Action	Action Owner	Status
06/08/10	NHS England/Improvement Board Assurance Framework for COVID-19 (KCHFT)	For Ms Afuape to share the Public Health England (PHE) report with the Board and for Dr Spare to review the BAF for COVID-19 against it and update the document if there were any omissions identified.	Ms Afuape Dr Spare	The PHE report has been circulated.
06/08/10	NHS England/Improvement Board Assurance Framework for COVID-19 (KCHFT)	To inform the Board of the outcome of the meeting with the Care Quality Commission.	Dr Spare	The Quality Committee was informed of the outcome at its meeting in September 2020.
06/08/11	Charitable Funds Committee Chair's Assurance Report	To investigate whether the allocated public donations to the Trust had been distributed to staff.	Ms Norris	Completed. Tokens are being distributed to colleagues in October.
06/08/14	Kent Community Health NHS Foundation Trust and Kent and Medway NHS and Social Care Partnership	For Mr Badu to inform Mr Bentley as to when the KCHFT Board would receive updates on progress.	Mr Bentley	The Board of KMPT met on 29 October 2020, the CEO of KCHFT was invited to attend. After a very helpful debate the board of KMPT agreed to authorise the CEO of KMPT to proceed to define the joint MOU in conjunction with KCHFT. We will meet to do so as soon as is practicable, and I will report progress to the Board. Propose action closed.

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	1.8
Agenda Item Title:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive

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

Summary of key points
Not applicable

Equality impact assessment (EIA)
Not applicable
Proposal and/or Recommendation to the Board or Committee
Not applicable

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

CHIEF EXECUTIVE'S REPORT

November 2020

Since the last time the board met in public (August 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. The last three months have seen the number of Covid positive patients who the Trust cares reduce, both in our hospitals and in our community services, however the impact of the pandemic continues to be felt amongst patients who may be receiving their healthcare in a different way, for example digitally rather than in person and for our team members who continue to operate using higher standards of PPE (personal protective equipment) in line with the national guidance. I would like the board to note and formally thank all our team members who continue to practice in the conditions presented by a once in a generation pandemic reports.

I do wish to highlight to the board a number of issues which have arisen since the last time we met, grouped as previously into the following categories patients, our people, and partnerships.

Patients

1. Winter plan

KCHFT has developed a winter plan to ensure the organisation is prepared for managing the complex competing priorities which will need to be managed in the coming months. The plan acts as a guide for our teams enabling rapid decision making and transparency. The plan has been developed with the following considerations.

- The expected COVID-19 scenarios
- EU Transition
- Flu
- Workforce
- Severe Weather

In addition to our own planning we have actively participated in the plans for the systems in both East and West Kent. The system plans are broadly built around the same considerations with an emphasis on collective demand and capacity modelling to support patient flow and the delivery of safe services, including the requirement to protect elective activity. The CQC have taken the step to review all acute trust winter plans. They have not replicated this with community trusts as their emphasis is on the safe delivery of services in Type 1 Emergency Departments.

Our People

1. Schwartz Rounds

Since June 2020, Schwartz Rounds have been delivered each month in KCHFT. The Schwartz round concept is one which has operated internationally for many years, allowing a group of healthcare professionals to come together and explore an issue in a confidential and mutually supportive environment. Each Round has been attended by an average of 60 members of staff. The rounds have been delivered virtually and as a result have been more accessible for staff. The Schwartz Rounds were implemented at a particularly significant time during the height of the first surge of Covid-19. Therefore it is not unsurprising that some themes have arisen which demonstrate the impact on the health and wellbeing of staff. These themes have been in relation to the impact of the pandemic on leadership; psychological safety and staff vulnerability. Organisational learning is being reported to the Strategic Workforce Committee and Reset and Reimagine Groups.

We have also been responsive to live themes and requests for support from staff in the organisation. An additional session was facilitated in September for staff who were either redeployed or involved in redeployment, and a further session focused on providing End of Life Care during COVID is planned for November.

The Rounds have received overwhelmingly positive feedback from staff. The assigned Mentor from the Point of Care Foundation attended the October Round to assess and appraise the efficacy of the round in relation to the licence. His feedback was exceptionally positive and this will be shared with the Point of Care Foundation. Furthermore, the Trust has been approached by neighbouring NHS acute Trusts to see how they can learn from our successful digital delivery.

2. Rio and KMCR project update

The Trust went live on its electronic patient record (EPR) in adult community services on 19th October, this was the final and largest cohort of 1900 staff involving migrating 0.5 million records to use our new record joining our children's and specialist services who went live earlier in the year. This final move marked the culmination of a tremendous effort from the project team and services who have worked diligently over months to get to this point. We now look forward to reaping the benefits from this modern redesigned system.

The Kent and Medway care record project continues to progress with 89% of GP practices information now flowing into the new system with work progressing on the remainder. The Trust expects its records to be incorporated by April 2020. A dashboard to assist the system manage the COVID-19 pandemic is being tested and the Trust is actively involved in clinical pilots on an advanced 'lite' version of the record as a fast track COVID-19 response ahead of the main record being available next year.

3. Staff flu vaccination programme

We are now entering week 6 of the flu vaccination programme and momentum remains high with 2168 (41.5%) of our workforce vaccinated to date. Of these 1701 (43.3%) are patient facing and 467 (36.3%) are non-patient facing.

All vaccine received to date has been allocated to clinical teams and there is a small amount of stock held in MIUs for opportune staff access. We expect the final 1200 vaccines to be delivered in the next few days which will form the final push for patient facing team-member vaccination and support those non-patient facing staff working from home who are unable to

get their vaccine at the local pharmacy or GP. We have seen a number of staff (336) able to access vaccination locally via their GP and Pharmacy.

There are a further 500 vaccines on order with the supplier however these are unlikely to be released until early December as there is a directive from NHSE that the first phase of excess vaccine manufacture should be distributed to primary care.

Current focus is to ensure all vaccines distributed are administered at the earliest opportunity. The flu team are working with services to maintain a clear uptake position and the return of consent forms so this can be reported in a timely way.

4. Big Listen 2 update

During the summer, we held Big Listen 2: where 1,200 of staff took part. This was a further stage of the program to listen to our workforce and use their feedback to be the best employer we can be, below is a little more detail about what we have done and are doing in response to the feedback.

Health and wellbeing

We have put many support tools in place to help people maintain good mental and physical health and wellbeing, including physical and virtual wobble rooms, Time to Talk sessions and sessions with our occupational health provider. There is now an extensive list of support available on flo too.

Redeployment

Powerful feedback around your experiences of redeployment, the experiences were varied, some were great and others not quite so positive.

As a result, we also held a special Schwartz round enabling colleagues to share their thoughts in a safe environment with others who had been redeployed too. Louise Norris also wrote to colleagues who had been redeployed to offer any support they may need as they returned to their own services.

Travel and commuting

While some expressed concern at social isolation and potential effects on their mental health and wellbeing, the vast majority of people said they valued not needing to travel or commute as much. We have developed a home working guide for managers to ensure that colleagues working from home still feel part of the KCHFT family.

Working digitally

Thanks to the tremendous hard work by our IT colleagues, lots had found our IT systems worked really well during the first wave of the pandemic and that you valued the support were given by IT to be able to do your job well, including MS Teams. The trust has committed to keeping MS teams.

Personal development

We have moved lots of training online to make it simpler for colleague to participate. We recognise that some face-to-face training is necessary but that is done Covid-secure surroundings.

Partnerships

1. Governors

Governor elections are due to commence on 11 January 2021. There will be 5 public governor posts and 4 staff governor posts due for election. The public constituencies are Tunbridge Wells, Shepway, Dartford, Ashford and Sevenoaks. The successful candidates will be announced on 8 March, and it is hoped that the new governors will attend the Governor Development Day on 17 March as part of their induction. We want to build on our already excellent and engaged Council of Governors by encouraging a diverse range of members to stand for election, and a communications and engagement plan has been developed to support the elections process, commencing in November.

2. Property repatriation

The Trust was very pleased to receive Department of Health approval for the Business Cases for the transfer of four properties to trust ownership from the current ownership of NHS Property Services. These properties are Tonbridge Cottage Hospital; Victoria Hospital, Deal; College Road in Thanet and Dover Health Centre. As a result of this approval the Trust has now entered the due diligence phase of the transfer where the Trust is able to review the properties in detail including physical surveys and understanding of the finance which will inform the final decision of whether to transfer. Once the trust has completed this and if we wish to proceed, all four transfers will need to be completed by the middle of March 2021.

This transfer is important as it will allow the Trust to own the assets from which it operates, enabling greater synergy between all parts of the service operating from a building.

Once these transfers are progressed further the Trust will identify the next phase of possible transfers.

3. Edenbridge project

Kent Community Health NHS Foundation Trust are working in partnership with Edenbridge Medical Practice and Kent and Medway CCG to develop a new shared facility designed to provide the latest in healthcare innovation. Following approval by the CCG in October 2020, a procurement process will start in the coming weeks to identify a developer. The new facility is scheduled to open in 2022 and host a wide range of services from both KCHFT and The Edenbridge Medical Practice, in part replacing the outdated GP practice and the hospital, on behalf of the Trust I do wish to take the opportunity to thank Tom Tugendhat MP for his support with this project.

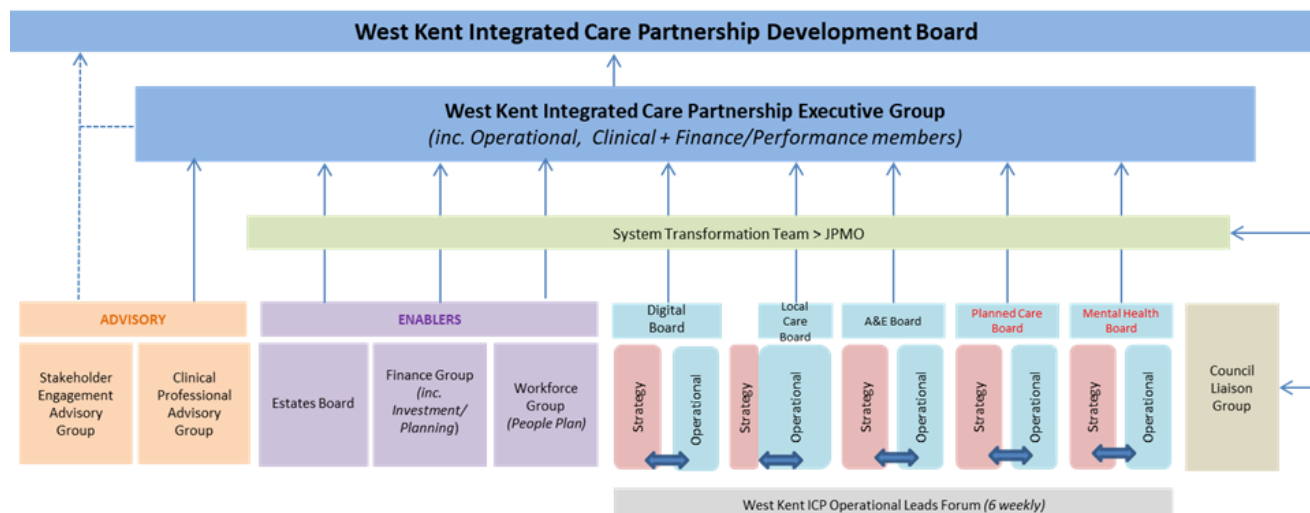
4. Investment in Urgent Treatment Centres (UTC)

I am delighted to be able to report to the board the investment of £1.5m capital, allocated from NHSE to modernise the UTC's in Sevenoaks, Deal and Folkestone. The work has been commissioned and will be in place this year. The investment coincides with the change at Sevenoaks from the Minor Injury Unit to the UTC model which is being delivered in conjunction with our partners Maidstone and Tunbridge Wells NHS Trust. The change in service will enable patients to see nursing team members and a general practitioner.

5. West Kent Alliance

The West Kent ICP Executive has now formally refreshed the governance arrangements which are outlined below. It is chaired by the Chief Operating Officer of KCHFT and reports

into the West Kent ICP Development Board of which the Chief Operating Officer of KCHFT is a member. The membership of the West Kent Alliance Executive includes Maidstone Tunbridge Wells Trust, West Kent Primary Care CIC, Kent & Medway Partnership Trust, the CCG and KCHFT.



The agreed priorities for the WK ICP are:

- COVID-19 virtual ward
- Diagnostics
- Video Consultation Appointments
- Integrated Urgent Care
- Integrated Therapies
- Dementia
- Frailty
- Workforce Forum
- Care Homes
- Health Needs for Rough Sleepers
- Adult Mental Health

6. Kent and Medway Partnership Trust (KMPT)

Following the agreement of our Board in July, I am delighted to be able to report that the board of the KMPT approved the proposed collaboration between our Trust's and authorised the two chief executives to draft the memorandum of understanding referred to in the meetings of the respective boards. Once we have drafted we will share with both boards and progress the work to identify shared opportunities. I will also take the opportunity in conjunction with the Chair the two board members who will develop the work with our colleagues in KMPT.

Paul Bentley
Chief Executive
November 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	1.9
Agenda Item Title:	Board Assurance Framework
Presenting Officer:	Natalie Davies, Corporate Services Director

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

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 BAF is discussed and updated by the Executive Team regularly.

Individual risks have been allocated to relevant committees for scrutiny and are discussed at each meeting and the comments fed back to the Board via the committee chairs' assurance reports.

The full BAF as at 29 October 2020 is shown in Appendix 1.

Summary of key points

Equality impact assessment (EIA)

Equality impact assessments are completed on the risks that feed into the BAF.

Proposal to the Board

The Board is asked to note this report.

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

BOARD ASSURANCE FRAMEWORK

October 2020

1. Introduction

- 1.1 The Board Assurance Framework (BAF) is comprised of strategic risks identified against the strategic goals defined within the Integrated Business Plan (IBP) in addition to risks identified against the achievement of business and operational objectives with a high gross (inherent) risk rating.
- 1.2 The BAF is therefore comprised of high risks. Refer to section 3 below for a definition of high risk.
- 1.3 Risks may be identified by Services or Directorates and escalated upwards to the Executive Team, or may be identified at the Board or any of its sub Committees.
- 1.4 The Executive Team review newly identified high risks to ensure that those with significant potential to impact on the achievement of strategic goals are recorded on the BAF and reported to the Board. This allows the Board to monitor mitigating actions. As actions are implemented, controls improve and this can enable the exposure to risk to reduce.
- 1.5 The full BAF as at 29 October 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 111 - Risk that the organisation's services may suffer significant challenges as result of the impact of winter pressures in combination with COVID.

BAF ID 112 - Uncertainty regarding the details of the UKs exit from the European Union could result in potential significant disruption for the organisation following the deadline date of 31 December 2020.

- 2.2 No risks have been removed since the BAF was last presented to the Board.

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.

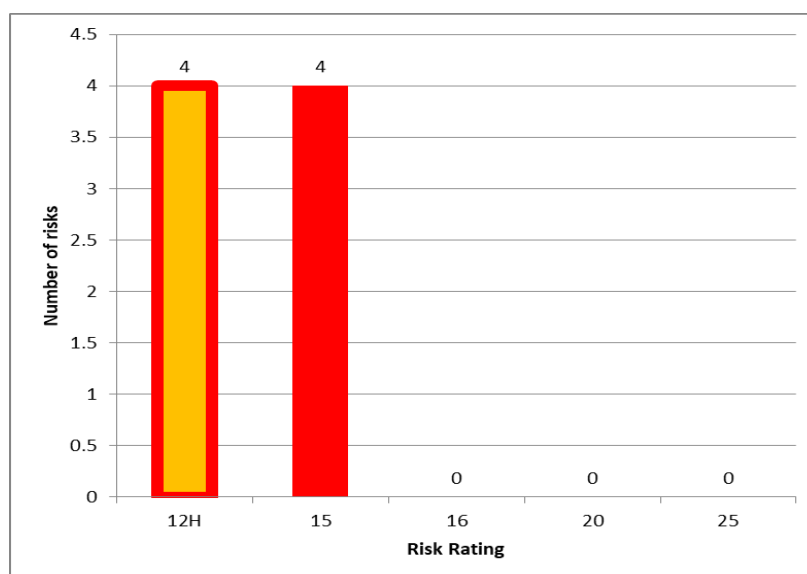
		← Impact / Severity →				
		Insignificant	Minor	Moderate	Major	Catastrophic
↓Likelihood ↓		1	2	3	4	5
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

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

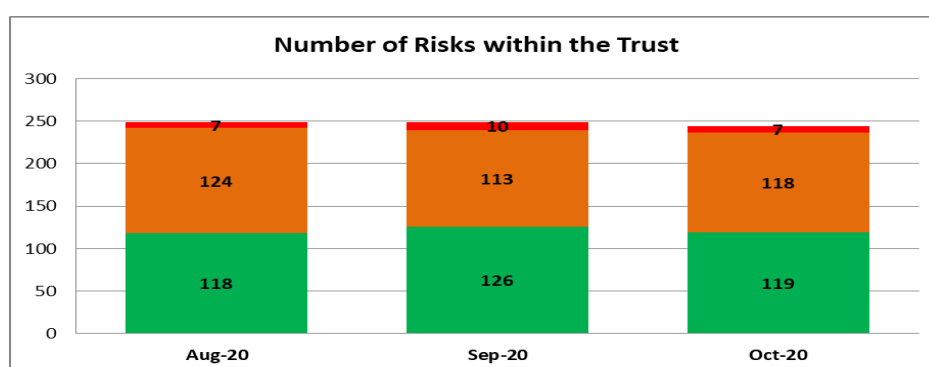
4.1 Figure 2: BAF Risk Profile



5. Risk Overview

5.1 The total number of open risks within the Trust stands at 244 this is comprised of 119 low risks, 118 medium risks and 7 high risks. Figure 3 (below) provides a visual representation. There are currently 26 out of date risks and 11 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 & Risk
23 October 2020

Updated 29th October 2020

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



Definitions:
Initial Rating = The risk rating at the time of identification
Current Rating = Risk remaining with current controls in place. This is reviewed monthly and should decrease as actions take effect.
Target Date = Month end by which all actions should be completed

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating			Controls Description	Top Five Assurances	Current rating			Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating			Target Date (end)																								
				C	L	Rating			C	L	Rating				C	L	Rating																									
Prevent ill health																																										
107	Mar 2020	Paul Bentley	Risk that the organisation's services may suffer significant challenges and become compromised as a result of the impact of the COVID19 pandemic Board Committee Lead on Assurance: The Board	5	4	20	Organisational priorities reviewed and established Covid 19 Response Plan Operational Response SRO appointed On-call structure reviewed and amended to support current COVID activity 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	<table><tr><th>Actions to reduce risk</th><th>Owner</th><th>Target Completion (end)</th><th>Status</th></tr><tr><td>Continuation of IMM, update calls and representation at region twice weekly</td><td>All</td><td>October 20</td><td>G</td></tr><tr><td>Escalation of supply shortages as required</td><td>Mercia Spare</td><td>December 20</td><td>G</td></tr><tr><td>Extension of IPC and PPE teams</td><td>Mercia Spare</td><td>November 20</td><td>A</td></tr></table>	Actions to reduce risk	Owner	Target Completion (end)	Status	Continuation of IMM, update calls and representation at region twice weekly	All	October 20	G	Escalation of supply shortages as required	Mercia Spare	December 20	G	Extension of IPC and PPE teams	Mercia Spare	November 20	A	Paul Bentley	Medium	3	4	12	November 2020								
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Extension of IPC and PPE teams	Mercia Spare	November 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 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	<table><tr><th>Actions to reduce risk</th><th>Owner</th><th>Target Completion (end)</th><th>Status</th></tr><tr><td>Staff welfare package: continued co-ordination and expanded</td><td>Louise Norris</td><td>October 20</td><td>G</td></tr><tr><td>Executive blog / message</td><td>Paul Bentley</td><td>October 20</td><td>G</td></tr><tr><td>All executive Director Question and Answer</td><td>All Execs</td><td>October 20</td><td>G</td></tr><tr><td>Big Listen 2 - Results analysed and action planned</td><td>All Execs</td><td>Oct-20</td><td>G</td></tr></table>	Actions to reduce risk	Owner	Target Completion (end)	Status	Staff welfare package: continued co-ordination and expanded	Louise Norris	October 20	G	Executive blog / message	Paul Bentley	October 20	G	All executive Director Question and Answer	All Execs	October 20	G	Big Listen 2 - Results analysed and action planned	All Execs	Oct-20	G	Paul Bentley	Medium	3	4	12	November 2020				
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Big Listen 2 - Results analysed and action planned	All Execs	Oct-20	G																																							
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 Operational Response SRO appointed 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 Contingency Planning - Local BIAS	5	3	15	<table><tr><th>Actions to reduce risk</th><th>Owner</th><th>Target Completion (end)</th><th>Status</th></tr><tr><td>Data reset dashboard to be finalised</td><td>Pauline Butterworth</td><td>November 20</td><td>A</td></tr><tr><td>Data reset to be reviewed weekly</td><td>Pauline Butterworth</td><td>December 20</td><td>A</td></tr></table>	Actions to reduce risk	Owner	Target Completion (end)	Status	Data reset dashboard to be finalised	Pauline Butterworth	November 20	A	Data reset to be reviewed weekly	Pauline Butterworth	December 20	A	Paul Bentley	Medium	3	2	6	November 2020												
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Data reset dashboard to be finalised	Pauline Butterworth	November 20	A																																							
Data reset to be reviewed weekly	Pauline Butterworth	December 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 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	5	3	15	<table><tr><th>Actions to reduce risk</th><th>Owner</th><th>Target Completion (end)</th><th>Status</th></tr><tr><td>ICS/CCG Governance structure proposal</td><td>Paul Bentley</td><td>October 20</td><td>G</td></tr><tr><td>Development of the East and West Kent discharge model with KCC</td><td>Pauline Butterworth</td><td>November 20</td><td>A</td></tr><tr><td>Development of ICP boards and its impact</td><td>Paul Bentley</td><td>March 21</td><td>A</td></tr><tr><td>Continuation of influence and negotiation at system meetings</td><td>All Execs</td><td>March 21</td><td>G</td></tr><tr><td>West Kent frailty model options paper agreed</td><td>Sarah Philips</td><td>November 20</td><td>A</td></tr></table>	Actions to reduce risk	Owner	Target Completion (end)	Status	ICS/CCG Governance structure proposal	Paul Bentley	October 20	G	Development of the East and West Kent discharge model with KCC	Pauline Butterworth	November 20	A	Development of ICP boards and its impact	Paul Bentley	March 21	A	Continuation of influence and negotiation at system meetings	All Execs	March 21	G	West Kent frailty model options paper agreed	Sarah Philips	November 20	A	Pauline Butterworth	Low	3	4	12	March 2021
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West Kent frailty model options paper agreed	Sarah Philips	November 20	A																																							
111	Aug 2020	Pauline Butterworth	Risk that the organisation's services may suffer significant challenges as result of the impact of winter pressures in combination with COVID. Board Committee Lead on Assurance: Quality Committee	4	3	12H	Vismo Operational and monitored •Implement staff & patient Flu vaccination Programme •An established regional Emergency Pressures Panel has been established to identify levels of system risk and recommend responses • Extra bed capacity by reducing delayed transfers of care • Understanding of COVID/non COVID demand profiles Established daily sit rep to manage response	• Previous emergency plans successful during testing • Staff flu vaccination programme for KCHFT staff. • Winter Pressure Plans. • Actions have been identified in order to reduce the gap in controls relating to this risk. • Collaboration with COVID partners	4	3	12H	<table><tr><th>Actions to reduce risk</th><th>Owner</th><th>Target Completion (end)</th><th>Status</th></tr><tr><td>Monitor Winter Pressure Plans through Governance structures</td><td>Pauline Butterworth</td><td>December 20</td><td>A</td></tr><tr><td>Robust staff Flu Vaccination Programme Delivery plan</td><td>Mercia Spare</td><td>October 20</td><td>G</td></tr><tr><td>Implementation of flu Vaccination Programme</td><td>Mercia Spare</td><td>March 21</td><td>G</td></tr></table>	Actions to reduce risk	Owner	Target Completion (end)	Status	Monitor Winter Pressure Plans through Governance structures	Pauline Butterworth	December 20	A	Robust staff Flu Vaccination Programme Delivery plan	Mercia Spare	October 20	G	Implementation of flu Vaccination Programme	Mercia Spare	March 21	G	Pauline Butterworth	Medium	2	3	6	March 2021								
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				C	L	Rating			C	L	Rating				C	L	Rating					
												Ensure local vaccines secured before 31st Oct	Mercia Spare	October 20	G							
Develop Sustainable Services (Strategic Enablers)																						
112	Jul 2020	Natalie Davies	Uncertainty regarding the details of the UKs exit from the European Union could result in potential significant disruption for the organisation following the deadline date of 31 December 2020. Board Committee Lead on Assurance: Audit and Risk Committee	4	3	12H	<ul style="list-style-type: none">Local Health Resilience Partnership (LHRP) terms of referenceExecutive lead appointedEU Transition plan developedEU exit risk register establishedGovernance structure and escalation structure in place	<ul style="list-style-type: none">Regular discussion and review at Exec/Management Committee and Board.NHS England (NHS E) reporting requirements met.LHRP meetings attendance.Further develop plan in response to new information.Monthly Trust EU exit meetings to resume.Working in collaboration with Clinical Commissioning Groups (CCGs)Staff working from home and virtual clinics for patients mitigate requirement to travel in some cases.	4	3	12H	Actions to reduce risk		Owner	Target Completion (end)	Status	Natalie Davies	Medium	4	3	12L	December 2020
												Coordination with the STP and region		Paul Bentley	December 2020	A						
												Communication Plan refresh approved		Louise Norris	November 2020	A						
												PPE Plan, including buffer store, Transport and Sites		Natalie Davies	November 2020	A						
												Resume monthly reviews - with escalation plan for development		Natalie Davies	December 2020	G						
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. Board Committee Lead on Assurance: Finance, Business and Investment Committee	4	3	12H	<ul style="list-style-type: none">Governance structure & project plan in placeEngagement with the project team delivering the Kent Care RecordPhase implementation plan and resourcing appropriatelyCommunication plans developed with stakeholders Inc. commissioners.Operational risk and mitigations log	<ul style="list-style-type: none">Regular Board reports linked to other projectsProject Group report to Management Committee, Exec Team and Board	4	3	12H	Implementation cohorts - 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	Gordon Flack	High	2	4	December 2020		
												Resource assessment on-going as part of the project governance structure.	Sarah Phillips	October 20	G							
103	Jan 2019	Paul Bentley	The pace of transition is resulting in an inconsistent narrative which could impact our ability to progress the strategic aims of the organisation. Board Committee Lead on Assurance: Board	4	3	12H	<ul style="list-style-type: none">Sustainability and Transformation Plan (STP) ProgrammeBoard TORs and membershipTORs for: ICP forums, Local Care Boards; Frailty Group; Chief Executives ForumKCHFT Chief Executive as SIRO for East ICPKCHFT Chair is Chair for West Kent ICP and Interim Chair of Kent and Medway STP/ICSSystem transformation governance structureInvolvement and promote mature development of ICSContinue to deliver outstanding healthcareNED presence and role in the system to be pursued and enhanced.Active in ICPs	<ul style="list-style-type: none">Local Care Investment received for both east and west Kent - Hospital at Home and Rapid Transfer of Care scheme.Community Care Funding increase in financial settlementChief Exec report to the boardRegular Strategic development update to the boardMembership of the STP board.Director of strategy report to the Leadership forum	4	3	12H	Actions to reduce risk		Owner	Target Completion (end)	Status	Paul Bentley	Low	3	9	March 2021	
												Develop strategy for the involvement of the people of Kent & Medway i.e carers, councils etc.		Gerard Sammon	March 21	G						
												Continue to influence at STP level and influence development of ICS		Paul Bentley	March 21	A						
												Pursue relationship with KMPT and KCC		Paul Bentley	March 21	A						
												Revised Operating Plan developed for remainder 2020/21. Implementation roll out from November		Gerard Sammon	November 2020	A						
												Programme to manage the transition of PCNs into the new system architecture		Gerard Sammon	March 21	A						

ID	Opened	Board Level	Risk Owner	Initial rating			Controls Description	Top Five Assurances	Current rating			Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating			Target Date (end)
				C	L	Rating			C	L	Rating				C	L	Rating	

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	2.1
Agenda Item Title:	Kent and Medway Integrated Care System (ICS) Accreditation Submission
Presenting Officer:	Paul Bentley, Chief Executive and Wilf Williams, Accountable Officer Kent and Medway Clinical Commissioning Group

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

Context

- The 'Kent & Medway ICS accreditation submission' has been prepared for NHS England and NHS Improvement (NHSE/I). Currently, the Kent and Medway system is a Sustainability and Transformation Partnership (STP). ICSs are more advanced forms of STPs, with greater responsibilities for working as a system and for holding regionally delegated authorities/autonomies (as agreed with NHSE/I) that further facilitate the integration of care.
- The NHS Long Term Plan, published in January 2019, set out the intention that all systems across England would become Integrated Care Systems by April 2021. The onset of the COVID-19 pandemic delayed the submission of K&M's application to be accredited as an ICS, and it was jointly agreed between the STP Partnership Board and NHSE/I that a submission would be made in the autumn of 2020.
- As this document has been prepared for NHSE/I it is technical in nature. At the point of being accredited as an Integrated Care System, we will publish an accessible and meaningful summary of what being an ICS will mean in K&M and the benefits for our population.
- This document has been developed to demonstrate evidence of our readiness for accreditation against the NHSE/I minimum operating requirements and ICS Maturity Matrix. It is therefore necessarily comprehensive.
- The document also provides helpful context about the system's achievements to date, direction of travel as a system, and on-going development activities. The document was endorsed by the STP/ICS Partnership Board at the meeting on 18th September.
- In evidencing our readiness to be accredited as an integrated care system, the main submission contains the building blocks of a strategy and plan. However, it is important to note that this submission is not our refreshed strategy or full plan. In our response to the Long Term Plan in autumn 2019, we committed to a strategy refresh process planned to commence in spring 2020. Due to the COVID-19 pandemic, the timeframe

has been amended to Q3/Q4 of this year.

How our ICS accreditation has been developed

- The submission is a reflection and summation of the work to date of the Kent and Medway STP. In setting out our readiness to be accredited as an Integrated Care System, we have needed to describe the achievements and progress to date of the STP. Much of this was set out in our draft Strategy Delivery Plan 2019/20 to 2023/24 – our local response to the national NHS Long Term Plan. There is therefore clear alignment between the ICS accreditation submission and our Strategy Delivery Plan
- Following its development by a large range of stakeholders, our Strategy Delivery Plan was submitted to NHSE/I in the autumn of 2019. Publication and discussion of the plan at our Health & Wellbeing Boards was impacted by both the 2019 election (purdah) and the COVID-19 pandemic, with systems being advised by NHSE/I to delay publication. As outlined above, locally we will be producing a refreshed ICS strategy in Q3/Q4 of this year and we will liaise with NHSE/I to understand the national process for future publication and discussion.
- The ICS accreditation was discussed at a dedicated workshop of the K&M STP/ICS System Development Group on 8th September. The System Development Group is comprised of membership from each of our four ICPs, the Kent and Medway CCG, Kent County Council, Medway Council and the Local Medical Committee. Included within the ICS accreditation is a vision, purpose and set of principles to guide our system development, which was developed by the System Development Group in dedicated workshops in July and August.

Summary of key points

Key messages from the ICS accreditation submission

“We have a clear vision for system working across the system, Integrated Care Partnerships and Primary Care Networks. A key enabler is to agree the delegation of authority and responsibility to the system from NHSE/I that will allow system leaders to align incentives, sanctions and decision making. This is essential in order to secure progress towards our vision. The system has developed considerably in recent years and now meets the ‘maturing level’ of the NHSE/I ICS maturity matrix.

“We will work together to make health and wellbeing better than any partner can do alone”

Structure and features of our Integrated Care System

- **Primary Care Networks (PCNs) are the foundational building blocks of the ICS** – Primary care needs to be resilient and built on a strong foundation. However, PCNs are about more than integrated primary and community care – we will develop networks around neighbourhoods working closely with local

government and the third sector. The delivery of Local Care (our K&M banner name for care closer to home) is also heavily dependent on a strong community services infrastructure at both the neighbourhood level and at higher levels of scale/critical mass where this is necessary to provide effective and high quality care.

- **Integrated Care Partnerships (ICPs) are the engine room for change** – increasingly we will see decisions made at place level to re-align available resources to enhance integration and improve outcomes with clinical input at the heart of these decisions. ICPs are focusing on redesigning pathways so that patients get the best care from the most appropriate services, delivered in the right place. Out of hospital care will be the default, to the benefit of both patients and the system. This will drive improvements in the health and wellbeing of local populations through prioritising keeping people safely at home, independent and self-managing; with the need to visit a hospital kept to circumstances when emergency or specialist care is required.
- **The ICS/STP Partnership Board will become the decision making forum of the ICS** (*within applicable statutory boundaries*), providing oversight of whether the ICS is achieving its vision, purpose and priorities. It will be supported by a System Delivery Group (initially focused on COVID-19 recovery of services) and a System Development Group. The separation of these groups is to ensure sufficient focus on these two important agendas. The 'end state' governance for the ICS is currently being developed and will involve looking at the interactions between CCG committees and future committees of the ICS, to ensure the governance is streamlined.
- **We will apply the principle of subsidiarity, by which we mean that tasks and decisions should only be undertaken at system level when these cannot effectively or meaningfully be performed at local level.** Examples of areas needing a system approach are where we are likely to need a critical mass of scale or expertise beyond the place level; where all places are experiencing similar challenges (potentially to different degrees) which may benefit from collective problem solving; where we believe that working together will create greater power / influence / impact than working alone. Underpinning all of these circumstances, is the underlying driver that by working together as a system we will deliver better outcomes for our population.
- **The Health and Wellbeing Board and oversight and scrutiny committees** will remain a critical part of our infrastructure for strategy setting, decision making and oversight. Local authorities and the NHS, through the CCG, will continue to have a duty to prepare a joint strategic needs assessment and health and well-being strategies for the population, overseen by the Joint Health and Well-Being Board. Scrutiny Committees will continue to examine the provision of health and care services, act as a critical-friend and where required hold organisations to account in ensuring the care needs, quality and experiences of local people are fully considered.
- **The CCG will act as a servant and enabler of system working** – beyond its statutory responsibilities the CCG now has a central role in supporting and resourcing development of the system; this will be through a clear focus on 'central' resources supporting wider system development and the increasing alignment of staff to work as part of ICPs. The system developer role will become a core purpose for the new CCG. Key areas for focus are supporting

PCN development; supporting the service transformation agenda both at place level and for a small number of issues at ICS level; reducing formal financial contracting activity to a minimum.

Key ways of working

An increased focus on addressing variation

The best systems focus on standardisation and directly address unwarranted variation – this needs to cover differences in outcomes/quality, differences in access and differences in productivity and cost base. We will achieve this through:

- *A data driven and data supported approach to improvement* – this is a fundamental building block which will be supported through sharing of data through a common platform having a single source of truth
- *A common approach and system wide framework for Quality Improvement* – all partners agree that a Quality Improvement approach is essential and most organisations have or are considering adopting a single methodology (with many organisations adopting the NHSE/I Act Academy's Quality, Service Improvement and Redesign approach - QSIR). Clinical and patient-engagement will be a central thread, along with understanding root causes.
- *A new approach to commissioning* – Commissioning will be about transformation and not transaction. It will be light touch, focused on service improvement and increasingly shifting to a population health management approach that sets outcomes as the target for services. Resources are being aligned progressively with ICPs and this has already commenced following the creation of ICP facing resources as part of the merger of the eight legacy CCGs.

Living by a ICS values and behaviours

We have started work on our ICS values and behaviours, including a dedicated leadership event on this in September 2020. We have been working with NSHE/I and the NHS Leadership Academy on a programme of work for system wide organisational development which has been approved.

Greater integration leads to better quality of care and better outcomes for our population – Our overriding focus will be integrated service delivery for defined populations, with an agnostic view on how integration is achieved in organisational terms, identifying opportunities for shared budgets and aligned workforce approaches across employers where possible but with the main focus being on integrated care delivery. Integration is being pursued across organisations and sectors, with integration of physical and mental health and with health and social care. Together, the system can be more than the sum of the parts and we will achieve more for the health and wellbeing of our population by maximising the integration of services.

Clinical and service professional engagement must be at the heart of what we do – Strategic initiatives should be led / supported by clinical and professional leaders across health and social care; we will develop and nurture clinical alliances and networks as a means of driving change with a focus on shared learning and improvement founded in a desire to eliminate unwarranted

variation, ensure safety and maximise quality. We are building on the work to date of the STP Clinical and Professional Board and recent appointment of system wide clinical leads for services/programmes.

Engaging with and meaningfully supporting the third sector – The voluntary sector plays an important role in care delivery and integration and is a vital link to local communities. As Primary Care Networks further develop we will place the involvement of the voluntary sector very much at its heart. This will include the need to consider the impact that COVID-19 has had on the viability of some voluntary and third sector partners and how we can best support them.

Meaningful and realistic engagement with local government – Local government are critical members of the Integrated Care System and our councils are longstanding members of our STP/ICS Partnership Board and groups throughout our governance structure. We have many examples of great integration initiatives in both commissioning and delivery of services, but we recognise that there is more we can do, both strategically and operationally to drive greater integration. Initial discussions with both KCC and Medway Council suggest that we can further align around Health and Wellbeing strategies as the focus for agreeing our areas of strategic common focus for Kent and Medway as a whole.

Previous committees where the Kent and Medway accreditation has been discussed in detail

- K&M STP/ICS System Development Group – 8 September
- STP/ICS Partnership Board – 18 September – where the submission was endorsed.

Next steps

- This document was submitted to NHSE/I on 1^h October. The next step is a regional assessment discussion on 1^h November; further assessment processes will be determined following the discussion on 4 November. The outcome of our bid to be accredited will likely be communicated in December (TBC by NHSE/I).

Equality impact assessment (EIA)

Proposal to the Board

The Board is asked to **NOTE** Kent and Medway's submission to be accredited as an Integrated Care System. The submission is being shared with Boards for **INFORMATION** only.

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

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	3.1
Agenda Item Title:	Operating Plan
Presenting Officer:	Paul Bentley, Chief Executive

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

The Board received and approved the organisational and system financial priorities at the previous meeting. This paper presents the culminated Trust priorities and operating plan intentions for the next 6 months. The forecast financial position is unchanged and the contractual regime is suspended so the board is not being asked to approve this plan, the executive has done so but it is important that the board is provided with assurance that the approach is the correct one and that it will be delivered.

Summary of key points

The delivery of health services in the current environment is both highly complex and volatile.

In response to this context, and in recognition of the uncertainty in the coming months, the Trust plans are multifaceted, requiring a high level of nuance and an adaptive and resilience approach.

This plan synthesises the current and future plans in a high level summary which provides a strategic overview of the organisational approach, the clear alignment of the plans with Board approved strategic goals and the assurance of a resilient and adaptive response both in current operation and as a forward plan.

Equality impact assessment (EIA)

The paper summarises a number of different documents coordinating across different plans all of which have undergone an EIA where required.

Proposal and/or Recommendation to the Board

The Board is asked to receive the report and confirm that the assurance provided is both adequate and comprehensive.

The board is asked to note and confirm the mechanisms for escalation and assurance described in the document.

Paul Bentley	Tel: 01622 211902
Chief Executive	Email: p.bentley@nhs.net

1. Introduction

- 1.1 This document describes what the Trust will do and how it will do it from October 2020 until 30 March 2021. It revises the plan which the Trust adopted for 2020/21 because of the implications of the Covid 19 pandemic. This is an internal document for use within the Trust but given the importance of collaboration and system working it can be shared with other partners.
- 1.2 Whilst the emphasis is on recovering where necessary while simultaneously maintaining the position on quality, activity, workforce and the financial position post the first wave of the pandemic, the overall ambition is to act as a guide for the Trust of what is to be achieved throughout the next six months. This will mean responding to the normal winter pressures which the NHS experiences as the increase in demand for some services presents during the colder months, the need to protect our patients, service users and team members by providing protection against 'flu using the vaccination program and maintaining the broader well-being of our team members as they come off the back of the once in a generation demands of responding to a pandemic both at work and at home.
- 1.3 This conflagration of issues is demanding but the plan is mindful of the need to maintain forward progress in the delivery of the strategy of the Trust, including playing a full part in the development of the Kent and Medway Health and social care system and being a full system partner.
- 1.4 The document sets out the approach to be adopted and also explains the actions which the Trust is playing in the development of the system.

2. The Winter plan

- 2.1 Each year NHS organisations produce a plan to manage their way through the time of the year when historically the NHS comes under most pressure, the increase in demand for services arises from increases in some disease types e.g. increase in respiratory decease, and the overall implications of the population of colder weather, poorer travelling conditions and higher mortality during winter months.
- 2.2 This year, the winter plan has been developed with the following considerations:
 - COVID-19 scenarios
 - EU Transition
 - Flu
 - Workforce
 - Severe Weather
- 2.3 In addition to this, KCHFT has met with the CCG and acute trust COOs to agree areas where targeted KCHFT community support could deliver the most impact to support the safe management of surge in demand from November 2020 through to the end of March 2021 across the system.
- 2.4 The following schemes are in development and where appropriate, funding will be requested through the additional national funding, available to support up to 6 weeks of health or social

care as part of the discharge pathway to support the whole system. Further details will be made available once schemes are finalised.

- 2.5 Initiatives that support the winter response include:
- East Kent: respiratory admission avoidance
 - East Kent: implement a community fractured NOF pathway
 - Kent-wide: frailty and support to care homes
 - Kent-wide: stroke pathways – identify and implement key activities to sustain reduction in acute hospitals stroke LOS
 - Achieve and sustain a reduction in long length of stay for super-stranded patients in acute hospital sites (Max. of 60 in EKHUFT and 40 in MTW).
 - Identify and implement opportunities for wrap-around dementia care to prevent avoidable admissions and facilitate timely discharge to the most appropriate pathway.
- 2.6 This plan will be continuously reviewed against performance and flexed in response to emerging circumstances. The Winter Plan is shown in Appendix A.

3 The Response to the Covid 19 Pandemic

- 3.1 The response to the pandemic was initially managed nationally by the NHS as a level 4 (the most severe) incident, with that status 'stood back' to a level 3 incident in the late summer, at the time of writing the incident remains at level 3. During the incident the NHS took a series of steps to maintain inpatient and other capacity, suspending the financial and contracting regime, provided wide-spread tools to support our workforce and facilitated national public health campaigns to raise awareness in the public of what steps could be taken to manage the implications of the pandemic.
- 3.2 Phase 3 of the NHS response to COVID-19 began on 1st August 2020. The three priorities for this phase are:
- A. Accelerating the return to near-normal levels of non-COVID-19 health services, making full use of the capacity available in the 'window of opportunity' between now and winter
 - B. Preparation for winter demand pressures, alongside continuing vigilance in the light of further probable COVID-19 spikes locally and possibly nationally.
 - C. Doing the above in a way that takes account of lessons learned during the first COVID-19 peak; locks in beneficial changes; and explicitly tackles fundamental challenges including: support for our staff, and action on inequalities and prevention.

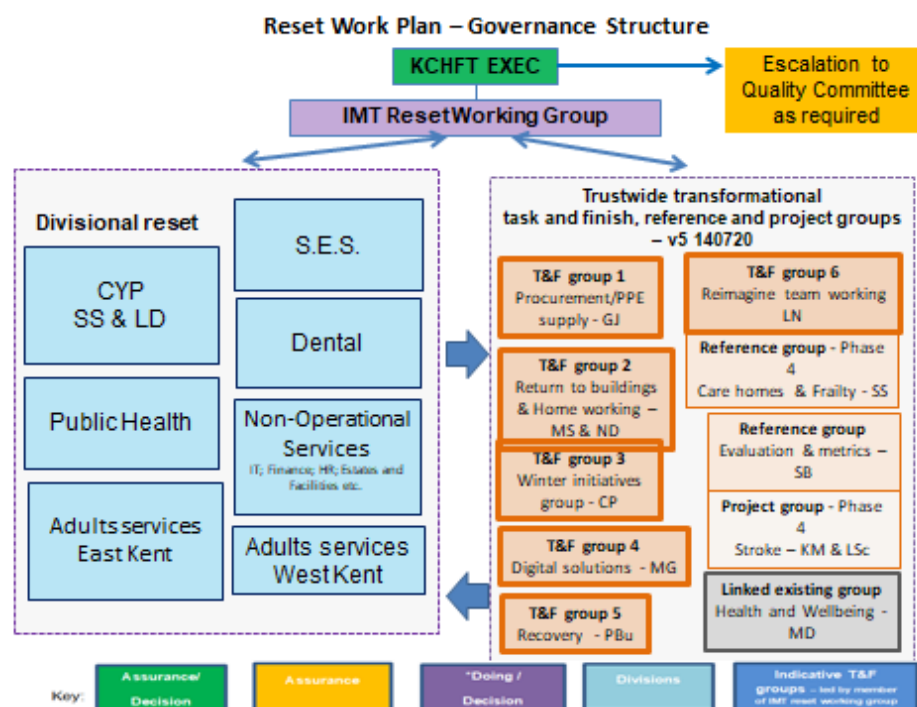
This letter is shown in Appendix B.

- 3.3 From April 2020 the Trust had been paid on a block income basis with a top up to ensure a monthly break even position. This was subject to scrutiny, particularly of COVID-19 related costs. Phase 3 of the response includes a change of regime from October 2020, with block contract values updated, an allocation made for top up, COVID-19 costs and growth, and funding envelopes then issued to systems. The expectation is CCGs and Providers achieve financial balance within these envelopes in line with a return to usual financial disciplines.
- 3.4 This paper describes how the Trust has responded to these priorities and financial arrangement changes and sets out the operating plan for the remainder of 2020-21, recognising that since Phase 3 was initially announced a second wave of COVID-19 has begun. This plan should be

read in conjunction with the appendices and the Board approved Trust Strategy Delivery Plan shown in Appendix C.

4 Operating Model for Reset

- 4.1 Our operating model for the re-set of services incorporated the scrutiny of different aspects of the service stand up.



- 4.2 The Recovery Group, chaired by the Chief Operating Officer, will continue to oversee the restoration of activity levels to pre-COVID-19 levels and monitors achievement of recovery trajectories for any COVID-19 related backlogs.

5. Assessment

Activity

- 5.1. Throughout the COVID-19 response, activity levels within tier 1 or core services were maintained. However, due to a range of factors some tier 2 and 3 services have experienced lower levels of activity compared to the same period in 2019.
- 5.2. As a result of the Reset and Reimagine programme, through the Reset Working Group, the vast majority of services that were stepped down (tier 2 and 3 services) have now enabled full access and enquiries to patients and service users. There are a very small number of outstanding service resets which are either due to be approved imminently or have an agreed longer suspension period with commissioners.
- 5.3. Many services continue to offer a modified service due to social distancing constraints; however anyone who accessed a service for assessment and support pre-Phase 1 of the COVID-19 response can now do so again. Those services that have had to continue the suspension of specific intervention modalities, such as drop-in clinics, group work or hydrotherapy, are offering alternative therapy modalities. As these or other services

identify a need or opportunity to modify or enhance a service offer it is tracked through the Reset Working Group.

5.4. As mentioned above the Recovery Working Group is overseeing restoration of activity to pre-COVID-19 levels and monitors achievement of recovery trajectories for any COVID-19 related backlogs.

5.5. Across the Trust contracted cumulative activity of 78% was achieved up until month five. For the period of August 2020, the main variances in activity compared to August 2019 were within Children's Specialist & LD Services, Adult Specialist and Elective Services, and Public Health Services. The variances are summarised below:

	Aug-19	Aug-20	Variance
Children's Specialist & LD	15,062	10,297	-31.6%
Adult Specialist and Elective	25,710	17,214	-33.0%
Public Health Services	26,552	17,270	-35.0%

5.6. A more detailed summary of those services with lower activity variances and activity forecasts is shown in the table below. The factors affecting service activity levels include, but are not limited to:

- Staff redeployment during the phase 1 response
- Reduced referral demand
- Increased level of DNAs
- Inability to hold group sessions due to social distancing
- Reduced clinical capacity per day due to social distancing and infection prevention and control measures
- Reduced clinical capacity due to shift from clinic to domiciliary contacts
- Services with limited options for virtual consultations e.g. podiatry

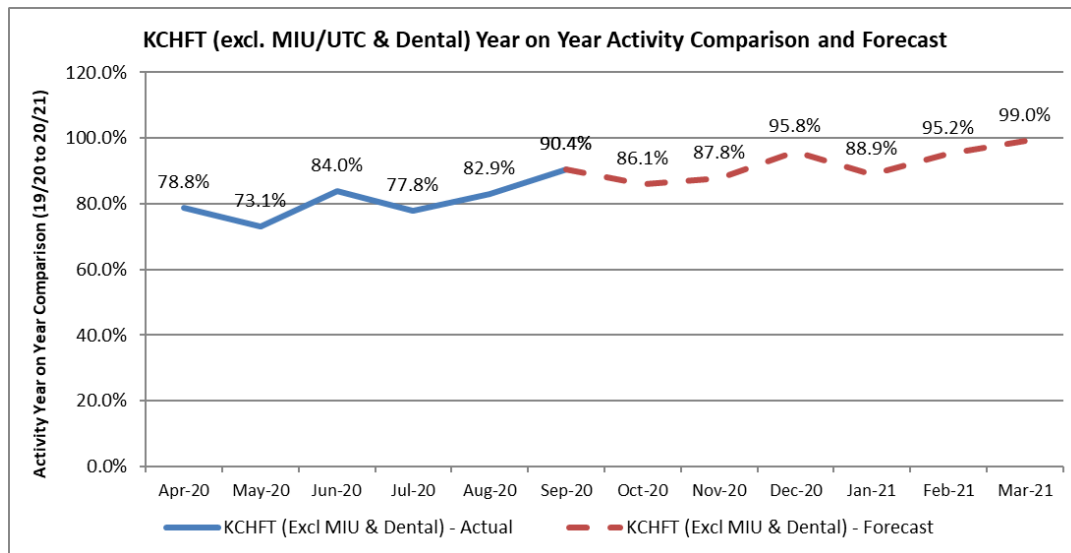
SERVICE	ACTIVITY LEVELS	ACTIVITY DRIVERS	IMPACT	ACTIVITY FORECAST
E Sussex School Public Health	August 2020 -73.1% compared to August 2019	Loss of School based activity Transition to RIO – data capture Redeployment		60% by November 2020 and 90% by January 2021
East Sussex School Health	August 2020 activity -29.4% compared to August 2019	Loss of school based activity No NCMP activity Group activity suspended		80% of pre-COVID-19 activity levels by October 2020 and 90% in December 2020.
Adult Learning Disabilities	August 2020 activity -50.9% compared to August 2019	Lack of Group and Hydrotherapy activity Transition to RIO – data capture		80% of pre-COVID-19 activity levels by October 2020 and 90% in December 2020.
Podiatry	August 2020 activity -29.4% compared to August 2019	Increase in Domiciliary visits - less productive than clinics Increase focus on complex wound care Clinic capacity reduced from 13 to 10 patients /day due to IPC		84% of pre-COVID-19 activity levels by Sept 2020 Oct / Nov – similar level whilst IPC restrictions in place.
Community Orthopaedics	August 2020 activity -14.9% compared to August 2019	Lower referral rates during COVID-19 Improved waiting times		-16% of pre-COVID-19 activity by September 2020 and -8% in October 2020 100% activity dependent return to pre-COVID-19

			referral levels
Community Chronic Pain	August 2020 activity -9.1% compared to August 2019	Decrease in referrals during COVID-19 RIO transition has resulted in non-recorded activity to be corrected Artificial spike of 36.5% activity increase on Aug 2019	Sept – 44.5 % (but should be -18% once activity corrected). Increase into Oct/Nov dependent on referral rates increasing to pre-COVID-19 levels.
Adult MSK Physiotherapy	August 2020 activity -72.9% compared to August 2019	Decrease in Referrals during COVID-19 Change in service model – increase in virtual assessments of longer duration (<i>less contacts</i>) Higher DNAs	Sept - 63% Oct/Nov 55/60% Further improvement will depend on referral rates increasing If virtual consultation model sustained – long term reduction on activity predicted.
Cardiac Rehab	August 2020 activity -34.9% compared to August 2019	Decrease in referrals Increase in DNAs Loss of group activity Increases in activity in 2019 : Aug/Sept 34.5% Sept/Oct 16.4%	Sept/Oct performance expected at -40% The net loss of group activity equates to comparative 35.3% of activity in Sept 2019 and 30.4% in Oct 2019
Pulmonary Rehab	August 2020 activity -7.5% compared to August 2019	Decrease in referrals DNAs increased Loss of group activity	100% activity in Sept Predicted 100% activity in November 2020
Health Visiting	August 2020 activity -30.3% compared to August 2019	Staff redeployment Suspension of Group sessions and drop in clinics Temp suspension of universal reviews	Catch up programme for suspended developmental reviews will drive a temporary surge in activity. Long term return to pre COVID-19 activity will not be possible without resumption of Drop in and Group activity when COVID-19 Restrictions allow.
School Public Health	August 2020 activity -87.9% compared to August 2019	Staff redeployment Schools closed Vision and Hearing screening programme suspended	Referrals increasing but without mass screening activity – activity levels will remain lower than pre-COVID-19
Dental GA services	From w/c 9.11.2020 5 GA sessions will be available / week. Normal level is 9 Sessions per week	Acute Trusts not making theatre space available due to COVID-19 Pressures	If no increase in theatre capacity – Recovery will take 9-13 months

5.7. It should be noted that for some services a return to pre-COVID-19 activity levels may not be imminently achievable; for example those services with previously high levels of group or drop in activity as part of their service model.

5.8. Changes made to services and pathways in response to COVID-19 are assessed through the work of the Evaluation and Metrics task and finish group to ensure sustainability. The Recovery Working Group will make recommendations regarding re-negotiating contracted activity volumes for any sustainable longer term changes that arise.

5.9. A projected overall year end position of Trust activity is shown over:



5.10. The consultant led 18 week Referral to Treatment position is strong and the AHP target will be met during this month. Waiting times are monitored through both the Recovery Working Group and the Executive Performance Reviews.

5.11. Specific factors in dental and MIUs/UTCs have adversely impacted activity. These are being reviewed with targeted recovery plans being developed to address the gaps. These plans will be presented to Quality Committee for assurance shortly.

Quality & Safety

5.12. The Trust remains committed to continuous improvement in quality and safety. Our quality priorities set out for 2020/21 address key area for development and these remain unchanged. A refresh of the quality strategy for 2021/26 is almost complete.

5.13. The implementation of the harm reviews process will continue this includes the Leder assessments of harm. This process analyses and addresses backlog management in support of the recovery of services and is being embedded consistently across the Trust in partnership with commissioners and regulators.

5.14. The Trust assessment and management of backlog is coordinated operationally through the IMM by a recovery group chaired by the COO.

5.15. The use of quality improvement tools has been elevated further during wave one and continues to be embedded into our way of working to further advance quality standards and promote local empowerment.

5.16. A new post leading on Equality, Diversity and Inclusion of our patients has been recruited to. This will enable us to continue to ensure our services are designed and delivered in a way which meets the needs of all of the community we serve. We will also build our working relationships with the voluntary organisations in Kent who work in the field of inclusion.

Workforce

5.17. There has been strong performance across key workforce metrics to August, as the table below demonstrates, and there has been an increase of 119 WTE in the workforce from months one to six.

Indicator	Performance	Target
Turnover	13.27%	14.5%
Stability	88.22%	85%
Absence	3.82%	4.2%
Stress	1.15%	1.2%
Vacancies	4.10%	9.7%

5.18 While the organisation wide figures are very good, we are aware that there are pockets of staff and specific geographies which need additional support and attention. This is being drawn together through a combination of listening events, survey responses and development of plans together with the relevant staff. This analysis continued to be enhanced through the consideration of the early warning trigger tool metrics. Plans to address include a review of redeployment required, reduction of temporary staff. We will continue with this targeted approach for the duration of the plans and hotspot areas will be highlighted through a series of tailored interventions to address the issues identified.

5.19. The table below shows the actual and forecast WTEs split by staffing group, with the largest increases in staffing expected in registered nurses, allied health professionals, support to nursing staff and NHS infrastructure support.

Staff Group	M1 Contracted WTE	M2 Contracted WTE	M3 Contracted WTE	M4 Contracted WTE	M5 Contracted WTE	M6 Contracted WTE	M7 Forecast WTE	M8 Forecast WTE	M9 Forecast WTE	M10 Forecast WTE	M11 Forecast WTE	M12 Forecast WTE	Change from M6 to M12
01. Registered nursing, midwifery and health visiting staff (Substantive)	1,103	1,115	1,130	1,140	1,134	1,144	1,164	1,173	1,178	1,179	1,184	1,183	39
02. Allied health professionals (Substantive)	569	569	578	584	580	592	591	605	608	612	614	615	22
03. Other scientific, therapeutic and technical staff (Substantive)	169	165	167	172	175	164	173	177	178	180	180	180	16
04. Health care scientists (Substantive)						11	9	9	9	9	9	9	-1
05. Support to nursing staff (Substantive)	792	808	832	846	838	828	841	843	843	839	839	839	11
06. Support to allied health professionals (Substantive)	161	165	170	169	173	176	180	181	183	184	184	184	7
07. Support to other clinical staff (Substantive)	18	18	19	18	17	17	18	18	18	18	18	18	1
08. Consultants (Substantive)	17	17	17	17	16	17	17	17	17	17	17	18	1
09. Career/Staff grades (Substantive)	57	59	58	58	58	58	62	65	65	67	68	68	10
10. Trainee grades (Substantive)	1	1	1	1	1	2	2	2	2	2	2	2	0
11. NHS infrastructure support (Substantive)	1,287	1,283	1,287	1,293	1,298	1,290	1,327	1,324	1,330	1,331	1,323	1,322	32
Non-executive directors	1	1	1	1	1	1	1	1	1	1	1	1	0
Staff Turnover Budgets													0
Contract Savings Targets													0
Grand Total	4,174	4,201	4,260	4,300	4,293	4,302	4,384	4,415	4,432	4,437	4,438	4,438	136

5.20. This table factors in the recruitment of public health staff (in Health Visiting and the Immunisation Service); investment in the frailty service and the new cohort of apprentices in February.

Finance

5.21. As noted above the financial regime has moved from a guaranteed breakeven and retrospective reimbursement to one based on a system wide allocation. In addition there will be a continued claim basis for additional discharge costs but limited to the first 6 weeks, and an elective incentive scheme to pay for more acute elective activity at a marginal rate.

- 5.22. The Trust has forecast a financial position including additional reset costs including recruiting to substantive posts, as noted in the workforce section above with some additional non-pay costs to meet new requirements and increased activity levels noted in the activity section above offset by lower covid-19 related costs.
- 5.23. The Trust will cease hosting the STP expenditure as it is more appropriate that the CCG perform this role going forwards this reduces the costs and income during the second half of the year by £2.5m.
- 5.24. The income and expenditure plan for the second half of the year and actuals for the first half of the year are shown below:

Income & Expenditure	2020-21		
	H1	H2	Total
	£000	£000	£000
Income from patient care activities			
CCGs patient care block	80,697	78,989	159,686
System top up/Covid	4,871	3,563	8,434
Other direct commissioning inc LAs	33,679	34,765	68,444
Income from NHS Trusts & FTs	4,319	3,324	7,643
Injury cost recovery scheme	151	151	302
Private patient income	7	14	21
Non NHS: other	820	813	1,633
Total income from patient care activities	124,544	121,619	246,163
Other operating income			
Education and training	761	1,134	1,895
Other operating income	1,887	1,699	3,586
Total other operating income	2,648	2,833	5,481
Total operating income	127,192	124,452	251,644
Provider operating expenditure			
Staff cost: Substantive	-83,352	-84,898	-168,250
Staff cost: Bank	-4,453	-4,769	-9,222
Staff cost: Agency /contract	-3,559	-2,465	-6,024
Staff cost: other	-436	-351	-787
Drugs Costs	-2,030	-2,395	-4,425
Supplies and services	-14,283	-11,711	-25,994
Other operating costs	-19,079	-17,863	-36,942
Total operating expenditure	-127,192	-124,452	-251,644
Financial performance	0	0	0

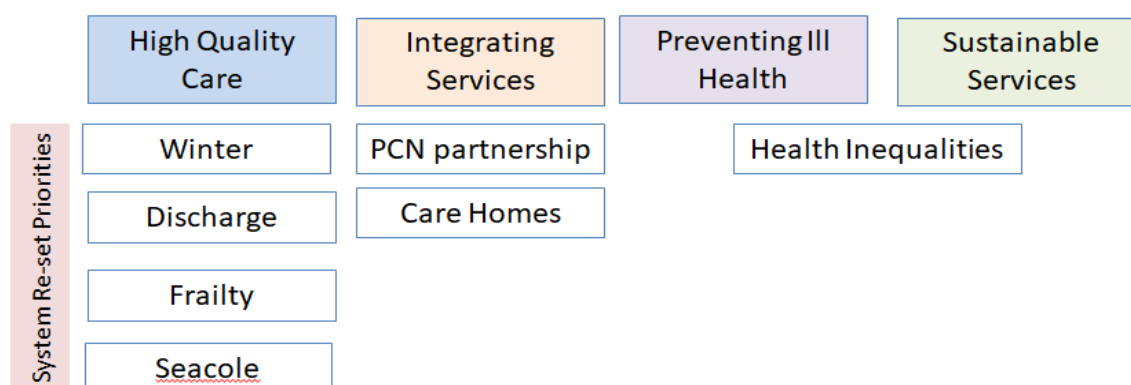
- 5.25. The Trust has worked with system partners to develop financial principles to distribute the funding available and these include:
- 5.25.1. No planned organisational surpluses until all at breakeven
 - 5.25.2. Plans are collectively reviewed for consistency
 - 5.25.3. Any contingencies held at CCG level.
- 5.26. The Trust does not hold any contingencies in accordance with these principles and risks will be managed at a system level.
- 5.27. The resultant plan is one where the Trust and all providers can breakeven and a deficit of £22.5m will be held by the CCG. Discussion is taking place with the Region to access a share of an agreed funding allocation related to lost income such as car parking income that is not fully recoverable to pre-COVID-19 levels. This in total represents £17.6m of the

gap meaning an underlying £4.9m deficit for the system on a £1.7bn allocation for the second half of the year.

- 5.28. The Trust has discussed its financial forecast and risks at the Finance, Business and Investment Committee and the Board approved a plan of breakeven or if necessary to support a system approach a small planned deficit.

6. System working

- 6.1 The Trust is working across the Kent and Medway system to support partners and to draw upon the experience of partners enabling a whole system response to pressures and opportunities. The approach of the Trust is consistent with the NHSE/I stated ambition of 'system by default', which emphasises the need to work as a system adopting a collaborative not a competitive approach. Furthermore it is consistent with the mandate the Trust received from our regulators, the Care Quality Commission and NHSI. The areas identified in this section are not a comprehensive list of all the initiatives which the Trust is involved in but rather the key areas.
- 6.2 The "Kent and Medway System Response to Phase 3 Covid Recovery" Plan (the K&M Recovery Plan) published by Kent and Medway CCG brought together the organisational plans of different partners and to providing an overview of re-set efforts across the county. KCHFT system re-set plans featured heavily in the document. The re-set plans developed by the Trust are routed in the organisational goals and enablers approved by the Board in 2020. The diagram below shows the clear alignment of the items identified in the K&M Recovery Plan to the KCHFT organisational objectives. The full K&M Recovery Plan is shown at Appendix D.



- 6.3 Following the Board approved Strategy; KCHFT developed its Strategic Delivery Plan which describes the key actions to deliver each of our Goals and Enablers. This document, (shown at Appendix C and referenced earlier) has been updated to clearly demonstrate the organisational achievement of the Recovery Priorities and the close alignment of our Trust plans with the system plans.
- 6.4 Key elements of the Trust Re-set and Reimagine plans, together with their link to the K&M Recovery Plan are detailed below.

Seacole

- 6.5 The Trust undertook a significant amount of work to assess the benefit of, and how to implement, a Seacole service in the area. A paper was produced by the Trust and welcomed

as part of system planning. Critical areas of the plans were supported including our frailty model; other aspects of the plan will continue to be considered as part of the longer term system response.

Covid-19 Vaccination

- 6.6 The debate in the Kent and Medway system continues in readiness for a mass vaccination programme. KCHFT continues to be an active partner in the discussions recognising the need for a response at scale.

Timely and Safe Discharge of Patients from Hospital

- 6.7 Following winter 19/20 it became clear that modifying our approach to discharge pathways in Kent was a key piece of work to improve patient outcomes and experience. Kent County Council commissioned a review and building on the outcomes of this a multi- agency programme of work was agreed.
- 6.8 Five work streams have been agreed with a rapid improvement cycle approach being used to drive pace and deliver the changes identified as being most urgent across Kent. The leadership of the steering group for discharge across the county is fulfilled by KCHFT Chief Executive in conjunction with the Accountable Officer of the CCG and KCC Director of Adult Social Care.
- 6.9 The **main** objectives for this project are as follows:
- Improve outcomes and experience for local people
 - Implement a simplified and consistent hospital discharge pathway across Kent including a dementia pathway
 - Ensure the best use of our shared workforce to support the discharge pathway
 - Increase the focus on getting people home following a hospital stay
 - Reduce costs of the hospital discharge process through efficiencies and commissioning arrangements
 - Utilise one version of the truth across health and social care systems
 - Build a culture of trust through assessments and decision making
 - Quicker response time and decision making for discharges
 - Increase capacity in the community to support increased discharges

Priority Work Streams

Workstream	Maximising Innovation to Support Home First	Working Effectively Together		Trusted Assessor	Dementia Pathway
		Single Point of Access and Triage	Effective Integrated MDT		
SRO/Lead	SRO – Chris McKenzie, KCC Project Lead – Clare Maynard, KCC	SRO – Pauline Butterworth, KCHFT Project Lead – Natalie Parkinson, KCHFT	SRO – Pauline Butterworth, KCHFT Project Lead – Natalie Parkinson, KCHFT	SRO – Oena Windibank, Kent and Medway CCG Project Lead – Kim Lee, Kent & Medway CCG	SRO – Oena Windibank, Kent & Medway CCG/ Project Lead – Oena Windibank, Kent & Medway CCG
Overview	Explore and implement innovative approaches to maximising the use of home first as the default position following a hospital stay	Implement a single point of access and triage to ensure better decision making and reduce duplication or hand-offs	Bring teams closer together through integrated multi-disciplinary teams to make better use of the resource available and improve outcomes for users	Reduce the number of assessments a person receives by implementing a trusted assessor model	Design and implement a pathway for people with dementia

- 6.10 The work, led by KCHFT, has been replicated across the South East. From the point of the new discharge arrangements being introduced in March, the average length of stay across all specialities has reduced by 2 days, this coupled with the data showing that Medically Fit for Discharge figures in Kent are among the lowest nationally has resulted in our model being highlighted by national colleagues as good practice.

Digital

- 6.11 The Kent and Medway Care Record is a fundamental tool for the system to integrate care and fulfil its vision on Local Care. The project is well advanced with 89% of GP practices information now flowing into the new system. The Trust expects its records to be incorporated by April following the go live of the new Electronic Patient Record. A dashboard to assist the system manage the Covid-19 pandemic is being tested and the Trust is actively involved in clinical pilots on an advanced 'lite' version of the record as a fast track Covid-19 response ahead of the main record being available next year. The Trust is capital funding the overall project and providing clinical and technical leadership as its contribution to this important system priority.

STP

- 6.12 KCHFT is highly visible in the STP governance structures providing leadership to an array of workstreams and working groups. Almost all the members of the executive are members and in many cases Chairs of Kent and Medway wide groups.

East Kent

- 6.13 In east Kent the Trust is an active partner in the development of the Integrated Care Partnership. The Chief Executive of the Trust is the SRO, the Director of strategy is the co-lead Director and the Trust provides workstream leadership support roles; the Medical Director of the Trust is the Chair of the Improvement Board. The Integrated Care Partnership has identified a number of clinical priorities, agreed with the Kent and Medway CCG which it is delivering through the clinical cabinet.
- 6.14 The Director of Finance/Deputy Chief Executive chairs the Finance Group which commenced operation in east Kent but now encompasses West Kent and has led on the approach to make sure the finances align across the system.
- 6.15 The Trust has led, initially at financial and workforce risk, the implementation of the frailty strategy, which in its delivery has facilitated people staying at home, and avoiding the need for a hospital admission, this in part was because the Trust jointly appointed a Clinical Director for Frailty in the East.
- 6.16 During the first wave of Covid the Trust led on the End of Life Care pilot to improve the quality of patients at the end of their life, working in collaboration with primary care and creating an environment of successful admission avoidance.
- 6.17 The Trust in collaboration with colleagues in primary care changed the use and clinical model of two previous MIU's to UTC's, subsequently securing investment and improved patient care.
- 6.18 The work of the ICP is guided by a clinical cabinet which is chaired by a clinician, and participation is from the senior clinical leaders in east Kent. The group identified the following:

Immediate Priorities

- Care for people with diabetes
- Care for people with mental health needs
- Improving communication
- Being the best employer

- 6.19 These are supported by strong support from the district authorities in the wider public health approach, with the leader of Thanet Council who chaired the health improvement board being a member of the partnership board.
- 6.20 It is recognised that the history of collaborative working across agencies is less matured than in other parts of the county, and as such in some areas we are creating the infrastructure rather than enhancing it.

Primary Care and Primary Care Networks

- 6.21 The pandemic response drove forward a new level of integration with primary care.
- 6.22 The Primary Care Networks and the Trust enjoy bilateral relationship's and multilateral relationships, for example as part of the emergent ICP's .The Trust has employed team members to work as inherent parts of PCN's, for example the employment of pharmacists, podiatrists and first contact practitioners in West Kent. The trust is in discussion with several East Kent PCNs regarding extending these successful schemes into those areas.
- 6.23 For the delivery of Urgent Care, four Urgent Treatment Centres in Deal, Folkestone, Edenbridge and Sevenoaks have been established and launched in conjunction with primary care. Extensive building developments to support these units are on-going led by the Trust. Other estates schemes being developed to enable the delivery of integrated care between primary and community services are at various stages of development in Edenbridge, Canterbury, Dover and Deal for example.
- 6.24 Integration for patient benefit has been developed through the Trust directly employing GPs as part of Frailty Model and in the Acute Response Team in Thanet. These models are having significant impact, for example 93% of people seen by the Frailty team have avoided an acute hospital admission and early figures show that 2900 bed days have been saved through the operation of the Frailty pathway in East Kent.
- 6.25 The collaboration with PCNs is re-enforced by the work of the STP, which has a local and primary care board of which the Trust is an active participant, as are PCN's.
- 6.26 The work in east Kent of the ICP, described above is enabled through active engagement with PCNs and their clinical Directors who form the mainstay of the ICP board and the clinical cabinet.

West Kent

- 6.27 The West Kent ICP Executive is chaired by the KCHFT Chief Operating Officer and. The governance has been refreshed, agreed and supported with delegated authorities approved reporting into the West Kent ICP Development Board chaired by KCHFT Chair. The PCNs are now established and also coordinating through a single entity which has allowed a more focused partnership approach and acted as a catalyst for development.

- 6.28 The ICP Executive has agreed a number of system priorities some which are currently active others which will come online in the coming months.

Active Priorities

- COVID-19 virtual ward
- Diagnostics
- Video Consultation Appointments
- Integrated Urgent Care Integrated Therapies – a series of actions designed to make best use of finite resources across the system with redesigned pathways for rehabilitation.

Additional Agreed Priorities

- Dementia
- Frailty
- Workforce Forum
- Care Homes
- Adult Mental Health

7. Conclusion

This plan is designed to act as a guide for the Trust to enable the successful navigation until 30 March 2021, the plan had to be adopted and adapted to respond to the implications of the Covid-19 pandemic, which has a profound impact on all aspects of how the Trust operates.

There is flexibility within the plan to enable ‘course correction’ where necessary but the plan remains even where the adaption has to be made.

The Trust, like all parts of the health services faces a triple challenge, to provide the correct response to a second wave of Covid; to provide the correct level of services throughout the winter (the historic time of greatest demand) and to recover the activity lost during the first wave of the pandemic. All these three elements are to be delivered to the highest possible quality consistent with the way an outstanding Trust would.

The plan provides a set of commitments against which the Trust will measure its progress, it is ambitious in all domains as it should be but is deliverable and I commend it to the Trust.

Paul Bentley
October 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	3.2
Agenda Item Title:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance

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

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.

Summary of key points

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 7 KPIs moving favourable in month and 5 moving unfavourably whilst 25 are in normal variation.

There are 2 KPIs consistently failing target (target outside of control limits) which are:

- KPI 2.7 Contractual Activity which is currently -22% year to date due to the effect of Covid-19 on service delivery
- KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%. Currently at 11.6% against 0% target

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

Quality

- Six lapses in care were identified within the trust acquired incidents reported during August and September 2020. These related to a patient that developed a category two pressure damage resulting in low harm. Key themes identified were a lack of regular monitoring and documentation was not updated. The remaining five were three category three pressure ulcers and two ungradable pressure ulcers under review to determine whether they meet the serious incident criteria.
- During August and September 2020, 160 falls were reported across the trust. This is a decrease compared with 179 falls reported in June and July

2020. Of the 160 falls, 5 were considered lapses in care, of which four resulted in low harm to the patient and one resulted in no harm to the patient.

- At the time of writing this report, a total of 287 COVID-19 related incidents had been reported. Of the 287 incidents reported, 30 happened in our care and were considered a lapse in care following investigation. Of the 30 incidents 26 were deemed no harm incidents; one low harm incident; one moderate harm incident; one severe harm incident and one unexpected death.

Workforce

- Turnover in September 2020 is on a downward trajectory to 13.27%, a 0.35% decrease from August 2020 (13.62%). With this performance, turnover rates remain below average and below the new target of 14.47%.
- In month sickness absence is in a stable position following an expected increase earlier in the year due to Covid-19. Current performance is below the mean and below target. September in month absence was 3.51%, a marginal increase of 0.26% from August 2020 (3.25%) but remains stable around this level.
- The Vacancy Rate continues to perform below average and target. Currently the vacancy rate is 4.10% which is a small increase of 0.73% since August 2020 which is driven by the phased increase in establishment for Public Health to support winter vaccination campaigns.

Finance

- The Trust is in a breakeven position to the end of September which is £75k behind plan. Cumulatively pay and depreciation/interest have underspent by £344k and £339k respectively and income has over-recovered by £2,415k, partially offset by an overspend on non-pay costs of £3,173k. The Trust has spent £5,845k on the Covid-19 response and received top up income of £4,871k YTD. Additional costs associated with the hospital discharge programme of £3,281k have been incurred, offset by funding from Kent and Medway CCG.
- £2,118k of CIP savings has been achieved to the end of September meeting the YTD target in full. The cumulative position includes £628k of travel savings which have been recognised non-recurrently while the Trust works through reset plans.
- Capital Spend to September was £3,339k, against a YTD plan of £5,070k (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 £10,352k and the Trust expects to utilise this in full. The full year forecast is in line with the Trust's resubmitted capital plan (submitted on 27 July) and includes a further £198k Capital Covid-19 claim, which has again received regional approval and awaits national approval. In addition, the forecast now includes £1,500k capital expenditure on the Trust's Urgent Treatment Centres. This expenditure will be fully funded by PDC (Urgent and Emergency Care Programme) following the approval of the submitted MoU by DHSC in early September.

Operations

- Health Checks had dropped to 0 for Months 1-3 due to the service being paused as a result of the Covid-19 pandemic and is only back up to 1.3% at month 6. 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.
- COVID hit referrals to the Stop Smoking service which reduced significantly, However, these are starting to increase. The major challenge is that 60% of clients are usually seen via community pharmacy and general practice.
- New birth visits - Continued strong performance above target.
- Activity levels at month 5 are around 30% below plan in Adult and Children's Specialist services. However, trajectories have been worked up for recovery to March 2021. Excluding MIU and Dental, the estimate for September is that we will be at 90.4% of activity compared to September 2019. While this is expected to dip slightly in October/November, we are forecasting to increase back up to 95.8% in December. January 2021 is predicted to be a little lower, but with levels increasing back up to 99% in March 2021.
- 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.
- 6 week diagnostics waits for paediatric audiology is now in normal variation
- 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 5 following higher levels in Months 3 and 4. Plans are in place to work on reducing this further to aid patient flow through winter.
- Looked After Children Initial Health Assessment (IHA) performance has dropped to only 51% of IHAs being completed within 28 days of child becoming looked after in month 5. This is due to impact of 2 weeks' self-isolation for young people at Oakwood reception centre, as well as challenges with KCC infrastructure within the centre not being able to support all the remote UASC IHA appointments.
- Bed Occupancy has traditionally shown a varying trend with no periods of special cause variation, however April-May 2020 had 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 lower to ensure there was capacity when needed. However the levels from June onwards have increased back up to near the target level of 87% (although dipping below in Month 5).

Equality impact assessment (EIA)
High level position described and no decisions required.
Proposal to the Board
The Board is asked to note this report.

Nick Plummer	Tel: 07823 777854
Assistant Director of Performance and Business Intelligence	Email: nick.plummer@nhs.net

Integrated Performance Report 2020/21
November 2020 report
Part One



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Assurance on Strategic Goals
Corporate Scorecard
Quality Report
Workforce Report
Finance Report
Operational Report
Appendix 1 – SPC Charts



Glossary of Terms

SPC – Statistical Process Control

LTC – Long Term Conditions Nursing Service

ICT – Intermediate Care Service

Quality Scorecard – Weighted monthly risk rated quality scorecards

C.Diff – Clostridium Difficile

MRSA – Methicillin Resistant Staphylococcus Aureus

MIU – Minor Injury Unit

RTT – Referral to Treatment

GUM – Genitourinary Medicine

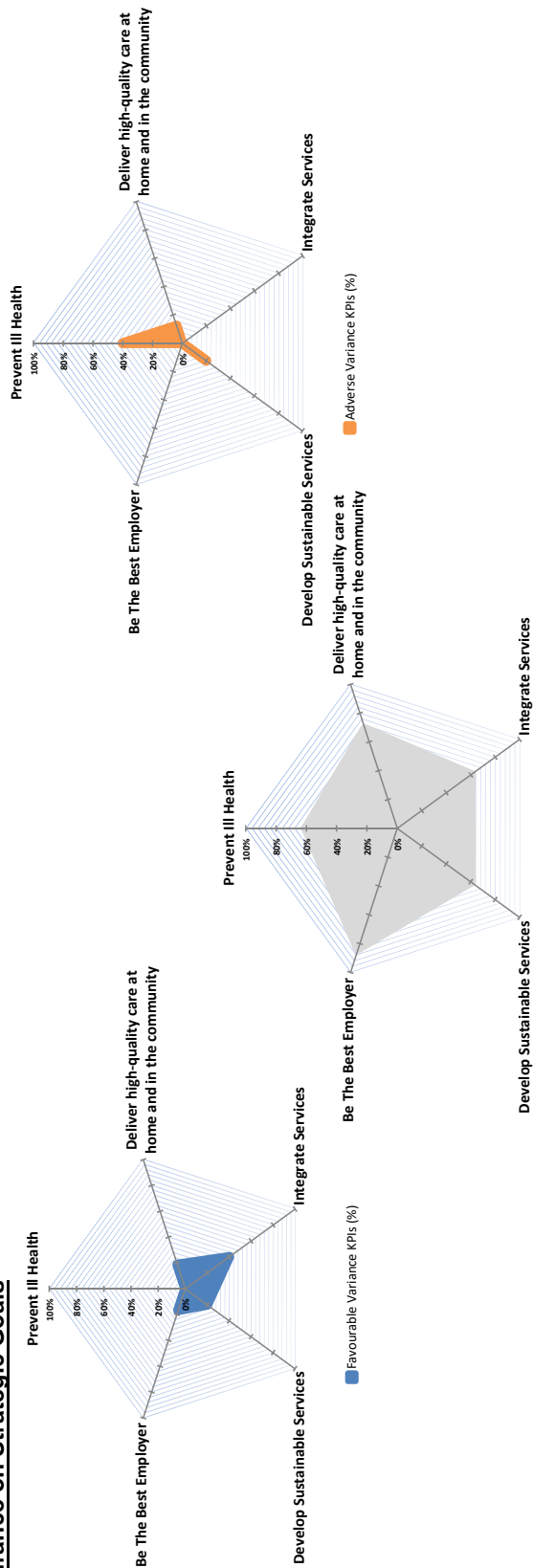
CQUIN – Commissioning for Quality and Innovation

MTW – Maidstone and Tonbridge Wells NHS Trust

WTE – Whole Time Equivalent



1.0 Assurance on Strategic Goals

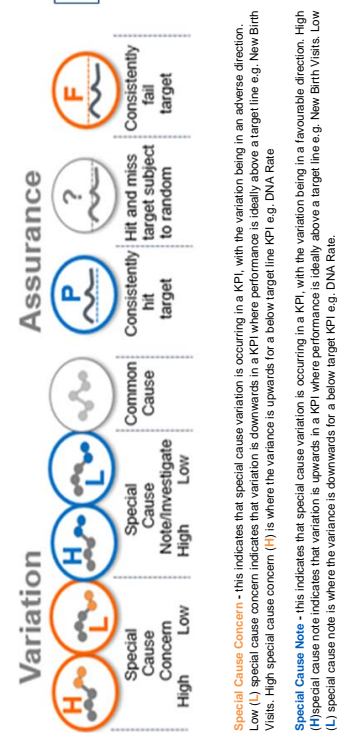


NHSI have confirmed that we will be moved back to segment 1 of NHS Improvement's Single Oversight Framework ("maximum autonomy") should we achieve the RTT 92% standard for 2 consecutive months, which we have done. We are currently waiting for this move to be confirmed

Overall, of the 37 indicators that we are able to plot on a statistical process control (SPC) chart, 18.9% are experiencing favourable in-month variation (7, KPIs 2.12, 2.13, 2.14, 3.3, 3.5, 4.3 and 5.5), 13.5% are showing in-month adverse variance (5, KPIs 1.1, 1.2, 2.7, 2.8, and 4.2) and the remaining 67.6% (25) 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), 5.4% (KPIs 2.7 and 4.5) are consistently failing (i.e. target outside control limits negatively), with the remaining 73% are 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.



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	 August 2020	 45.3%	100%	91%	111%	Reduced levels of referrals due to impact of Covid-19, resulting in the current period of negative special cause variation. However, these are starting to increase.
	KPI 1.2 Health Checks Carried Out	 September 2020	 1.3%	100%	77%	105%	Service paused due to Covid-19. Currently working with GP practices (who do the majority of health check delivery) on timescales for restart.
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	 September 2020	 94.7%	90%	92%	96%	Currently showing normal variation performance above the target. No current concerns of failing to meet the target
	KPI 1.4 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	September 2020	94.6%	90% (year end)			Target achieved for the 19/20 School Year
	KPI 1.5 LTC/ICT - Admissions Avoidance (using agreed criteria)	 August 2020	7147	5257	6630	7926	Metric currently performing with normal variation around the mean and within the control limits.
	KPI 1.6 % LTC/ICT patients that had at least one visit which Avoided a Hospital Admission	 August 2020	17.1%	15.0%	17.8%	20.9%	Metric currently performing with normal variation around the mean and within the control limits.

2. Deliver high-quality care at home and in the community							
Metric	Actual	Target	YTD Actual	YTD Target	Commentary		
KPI 2.1 Number of Teams with an Amber or Red Quality Scorecard Rating	August 2020	0		1	3	6	Target achieved for the month. On target year to date
KPI 2.2 (N) Never Events	September 2020	0		0	0	0	Target achieved for the month. 0 Never Events recorded this year to date
KPI 2.3 (N) Infection Control: C.Diff	September 2020	0		0	0	0	Target achieved for the month. 0 cases recorded this year to date
KPI 2.4 (N) Infection Control: MRSA cases where KCHFT provided care	September 2020	0		0	0	0	Target achieved for the month. 0 cases recorded this year to date





















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

2. Deliver high-quality care at home and in the community						
Metric	Actual	Target	Lower	Mean	Upper	Commentary
KPI 2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days	 September 2020	 0.00	 0.19	0.04	0.18	Decrease back to 0 following higher level of moderate and severe harm falls earlier in the financial year
KPI 2.6 Avoidable Pressure Ulcers - Lapses in Care	 September 2020	 2	 1	2.4	6.1	Normal variation and below the mean, although above target this month.
KPI 2.7 Contractual Activity: YTD as % of YTD Target	 August 2020	 77.7%	 100.0%	94.6%	98.8%	A five month period of performance below the lower control limit as a result of the Covid-19 Pandemic with some services reduced or stopped. This is expected to increase back closer to previous levels in the next 2-3 months. Individual service trajectories being developed to end of March 2021
KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity	 August 2020	 4.9%	 4.0%	3.7%	4.6%	Increased levels of DNAs experienced due to patients willingness to attend appointments, but also increased instances of patients not showing for virtual consultations.
KPI 2.9 LTC/MCT Response Times Met (%) (required time varies by patient)	 August 2020	 96.2%	 95.0%	97.6%	99.4%	Metric currently performing with normal variation around the mean and within the control limits. No current risk to failing target
KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance	 August 2020	 94.0%	 95.0%	97.0%	101.9%	Now normal variation following positive performance trend above the mean, consistently achieving target although marginally below this month
KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	 September 2020	 99.8%	 99.3%	99.7%	100.0%	Metric currently performing with normal variation around the mean and within the control limits. No current risk to failing target
KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways	 September 2020	 100.0%	 90.4%	94.5%	98.6%	Positive special cause variation with the last 9 months above the mean. Target has also been achieved for 9 consecutive months. High performance in all relevant services
KPI 2.13 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Waiting List Size (>18 weeks)	 September 2020	 0	 532	76	610	Positive special cause variation with the last 9 months below the mean. Target has also been achieved for 9 consecutive months
KPI 2.14 AHP (Non-Consultant Led) Referral to Treatment Times (RTT)	 September 2020	 93.2%	 92.0%	92.7%	96.0%	Positive special cause variation with the last 12 months above the mean. Target still within control limits so performance liable to fluctuations and target not always guaranteed to be achieved
KPI 2.15 (N) Access to GUM: within 48 hours	 September 2020	 100.0%	 100.0%	100.0%	100.0%	Metric currently showing normal variation and consistently achieving the target
KPI 2.16 Length of Community Hospital Inpatient Stay (Median Average)	 August 2020	 18.8	 21.0	19.8	25.3	Normal variation within the control limits and near to the mean. Last 5 months have been below the mean
KPI 2.17 Research: Participants recruited to national portfolio studies (20-21 Year to Date)	 September 2020	 1300	 300			Metric currently showing up to end of Quarter 2 20/21











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	 September 2020	 90.2%	82.2%	88.4%	94.7%	Metric currently showing normal variation and consistently achieving the target
	KPI 2.19 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT	 September 2020	 96.7%	92.9%	96.6%	100.2%	Improvement in the last 2 months following a dip below the lower control limit. Has been impacted by reduced survey numbers and effects on patients of changes in service delivery but survey numbers are on the rise as services reset
	KPI 2.20 (N) NICE Technical Appraisals reviewed by required time scales following review	 September 2020	 100.0%	100.0%	100.0%	100.0%	Metric currently showing normal variation and consistently achieving the target
	KPI 2.21 (N) 6 Week Diagnostics	 September 2020	 100.0%	95.3%	98.6%	101.9%	Metric currently showing normal variation and consistently achieving the target
3. Integrate Services	KPI 3.1 Delayed Transfers of Care from a Community Hospital bed as a % of Occupied Bed Days	 August 2020	 10.7%	5.8%	12.9%	20.1%	Slight drop following higher levels seen in months 3 and 4. However, still within control limits and therefore normal variation. While normal variation, this is still mostly above the target level of 9.5%
	KPI 3.2 Home First impact - reduction in average excess bed days (West Kent)	 August 2020	 0.00	-0.14	0.21	0.56	Normal variation currently being seen. Although between the lower control limit and the mean which is positive
	KPI 3.3 Average Daily Medically Fit for Discharge Patients (MFDD) - West Kent	 September 2020	 62	55	82	109	Metric showing positive special cause variation with the current period near the lower control limit, as a result of the Covid-19 Pandemic
	KPI 3.4 Rapid Transfer impact - reduction in average excess bed days (East Kent)	 August 2020	 0.00	-0.19	0.24	0.67	Normal variation currently being seen. Although between the lower control limit and the mean which is positive
	KPI 3.5 Average Daily Medically Fit for Discharge Patients (MFDD) - East Kent	 September 2020	 57	78	117	156	Metric showing positive special cause variation with the current period under the lower control limit, as a result of the Covid-19 Pandemic
	KPI 3.6 East Kent Rapid Transfer Service - Average Commissioned Discharges per day	 September 2020	 28.5	30			Marginally below the target for month 6, as has been the case throughout the Covid-19 pandemic.

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

4. Develop sustainable services									
Metric	Actual	Target	Lower	Mean	Upper	Commentary			
KPI 4.1 Bed Occupancy: Occupied Bed Days as a % of available bed days	 August 2020	 83.8%	92.0%	77.6%	88.1%	98.6%	Reduced bed occupancy due to Covid-19, which had resulted in negative special cause variation, although now moved to normal variation.		
KPI 4.2 Income & Expenditure - Surplus (%)	 September 2020	 0.0%	1.0%	0.72%	1.1%	1.5%	The Trust is in a breakeven position to the end of September which is £75k behind plan.		
KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	 September 2020	 100.0%	100.0%	75.7%	90.4%	105.0%	£2,118k of savings has been achieved to the end of September meeting the YTD target in full. The cumulative position includes £628k of travel savings which have been recognised non-recurrently while the Trust works through reset plans.		
KPI 4.4 External Agency spend against Trajectory (£000s)	 September 2020	 £576,583	£491,250	£225,046	£536,220	£847,394	Currently showing normal variation performance, just above the mean and above target for month 6. Agency costs were £394k for September against a target of £491k, there was an additional £183k spent on agency staff for the covid-19 response.		
KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%	 September 2020	 11.7%	0%	8.3%	16.0%	23.7%	Still performing above target but last 6 months have show a shift towards the lower control limit, suggesting improved performance.		

5. Be The Best Employer							
Metric	Actual	Target	Lower	Mean	Upper	Commentary	
KPI 5.1 Sickness Rate	 September 2020	 3.51%	4.20%	3.31%	4.18%	5.06%	Current month showing strong performance below the mean. Target just above the mean so likely to continue to achieve target some months and fail others.
KPI 5.2 Sickness Rate (Stress and Anxiety)	 September 2020	 1.17%	1.15%	0.89%	1.15%	1.40%	Current month showing strong performance around the mean, although in normal variation. Target at the mean level so likely to continue to achieve target some months and fail others.
KPI 5.3 Turnover (planned and unplanned)	 September 2020	 13.27%	14.47%	12.42%	13.81%	15.20%	Showing normal variation following a resetting of the SPC control from April 2020 in line with the new target.
KPI 5.4 Mandatory Training: Combined Compliance Rate	 September 2020	 96.5%	85.0%	95.3%	96.0%	96.6%	Continuing a normal variation trend between the narrow control limits, suggesting significant month on month change would be unexpected. Failure to achieve 85% is highly unlikely.
KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce)	 September 2020	 4.1%	8.0%	5.8%	7.3%	8.9%	Positive special cause variation below the lower control limit and last 9 months below the mean. Target is within the control limits so performance likely to be variable against target.
KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	 September 2020	 88.2%	87.0%	86.1%	87.4%	88.7%	Showing normal variation following a resetting of the SPC control from April 2020 in line with the new target.

2.0 Quality Report

2.1 Assurance on Safer Staffing

1.1 RN and HCA staffing Community Hospital August 2020	Day Fill Rate %		Night Fill Rate %	
	RN's	HCA's	RN's	HCA's
Faversham	188.7%	143.5%	96.8%	148.4%
Deal	162.1%	146.2%	90.3%	109.7%
QVMH	116.9%	131.7%	98.4%	146.8%
Whit & Tank	143.5%	228.4%	96.8%	151.6%
West View	87.1%	88.3%	95.2%	93.5%
Edenbridge	116.9%	108.1%	98.4%	87.1%
Hawkhurst	116.9%	133.9%	98.4%	116.1%
Sevenoaks	112.9%	90.9%	91.9%	89.2%
Tonbridge	218.2%	176.0%	113.6%	75.0%
Total	134.4%	134.5%	96.5%	113.0%

1.1 RN and HCA staffing Community Hospital September 2020	Day Fill Rate %		Night Fill Rate %	
	RN's	HCA's	RN's	HCA's
Faversham	198.3%	140.0%	96.7%	151.7%
Deal	145.0%	122.8%	100.0%	98.3%
QVMH	120.8%	118.9%	96.7%	121.7%
Whit & Tank	132.5%	152.0%	101.7%	106.7%
West View	102.5%	86.3%	98.3%	72.1%
Edenbridge	114.2%	116.7%	98.3%	98.3%
Hawkhurst	123.3%	141.1%	98.3%	123.3%
Sevenoaks	113.3%	113.9%	98.3%	98.9%
Tonbridge	149.2%	84.8%	113.3%	73.3%
Total	133.2%	115.0%	100.2%	100.6%

The RN night fill rate for most of the community hospitals are now closer to the planned roster template and the number of shifts with only one RN on duty has remained low.

The HCA fill rates for Westview and Tonbridge in September reflects a fill rate of 72% to 90% , however the fill rates once totalled were safe for the acuity of the patients.

Tonbridge Hospital reopened in August following building Repairs

2.2 Covid-19 Incidents

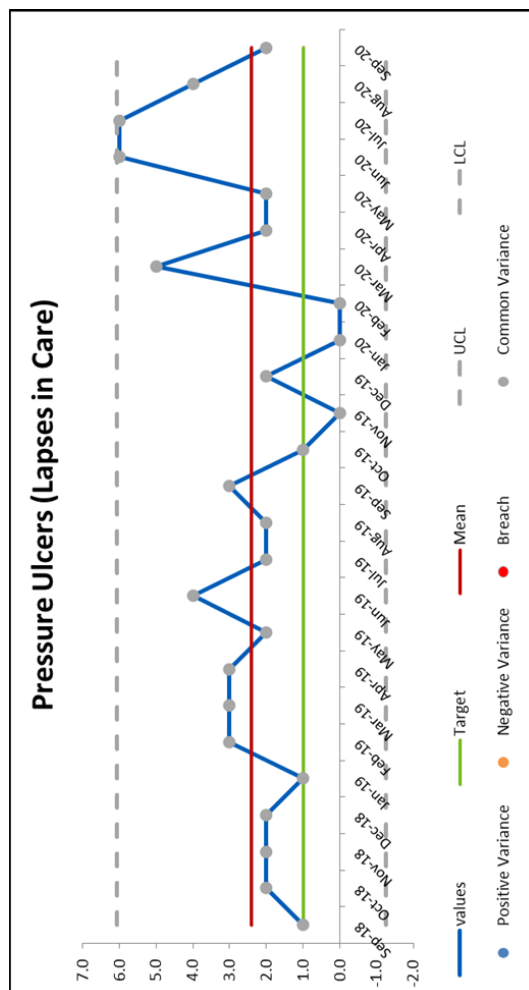
At the time of writing this report, a total of 287 COVID-19 related incidents had been reported. Of the 287 incidents reported, 30 happened in our care and were considered a lapse in care following investigation. Of the 30 incidents 26 were deemed no harm incidents; one low harm incident; one moderate harm incident; one severe harm incident and one unexpected death.

The unexpected death incident occurred in the community hospital; the severe harm incident relates to a patient who had fall and sustained a fracture, both incidents were declared as a serious incident and as such a root cause analysis investigation is underway. The moderate harm incident related to a patient residing in a care home that was unable to get their toe nails cut during this time causing additional pressure to their heels. As a result the patient developed an ungradable pressure ulcer to their left heel. This was also declared as a serious incident.

COVID-19 Related Incidents Reported on Datix	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Total
Incidents Reported	4	11	50	62	27	30	21	23	10	287
Patient Deaths in Community Hospitals	0	0	24	18	6	1	0	0	0	49
Total	4	11	74	80	33	31	21	23	10	287

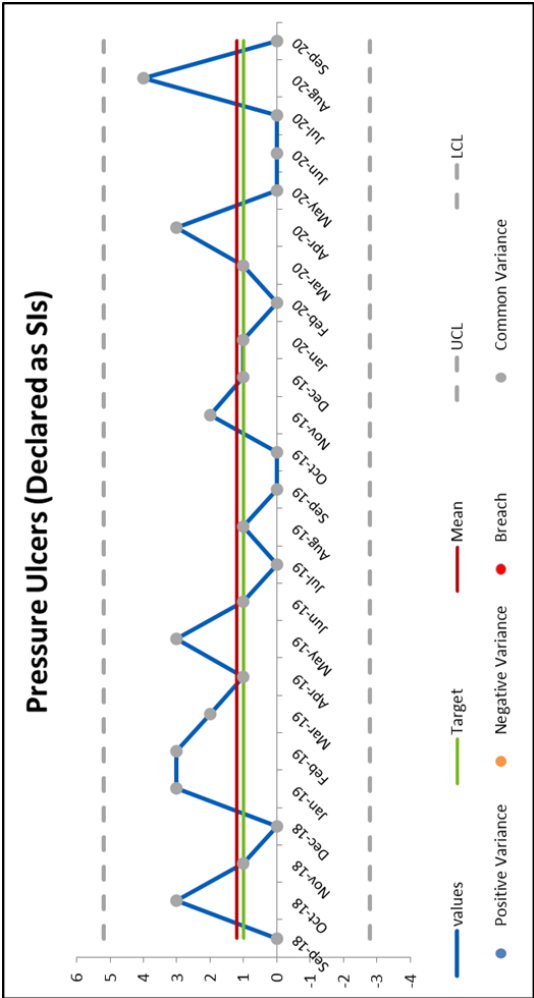
2.3 Assurance on Pressure Ulcers

Four incidents were reported whereby four separate patients developed the following injuries: category three pressure ulcer in the patients home; three deep tissue injuries in a residential care home; three ungradable pressure ulcers in a residential care home and a deep tissue injury in a residential care home. These have been declared as serious incidents and as such full root cause analysis investigations are underway.



Six lapses in care were identified within the trust acquired incidents reported during August and September 2020. These related to a patient that developed a category two pressure damage resulting in low harm. Key themes identified were a lack of regular monitoring

and documentation was not updated. The remaining five were three category three pressure ulcers and two ungradable pressure ulcers under review to determine whether they meet the serious incident criteria.



The TVN service continues to work with clinical services with high pressure ulcer incidences. The support enables reviews of individual patient incidences and targeted lessons learnt and changes required in practice and ongoing patient management. Training and education in the early identification of risks and intervention strategies required for patients to mitigate risks of skin breakdown.

The pressure ulcer App continues to support practice by addressing training needs identified during the covid crisis when access to face to face support has been greatly reduced. Usage has increased from 390 staff in August to 466 in October; who have now downloaded the App and verbal feedback from staff indicates that its very useful in clinical day to day practice, with categorising correct types of pressure damage, risk assessment and equipment usage all themes identified in incident reviews; the app also provides resource information on skin care and associated interventions for patients with moisture associated skin damage, many of which can go onto develop pressure damage.

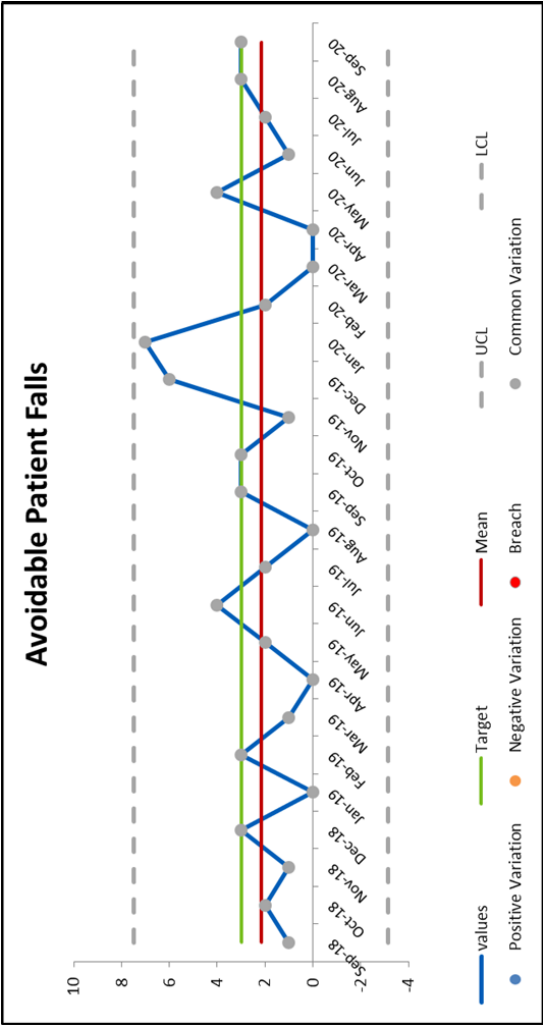
2.4 Assurance on Falls

During August and September 2020, 160 falls were reported across the trust. This is a decrease compared with 179 falls reported in June and July 2020. Of the 160 falls, 5 were considered lapses in care, of which four resulted in low harm to the patient and one resulted in no harm to the patient.

The low harm incidents related to a patient whose boot came off whilst they were walking to the bathroom; a patient that stood up to walk to the bathroom and as they turned fell backwards and hit their head on the bed rail. This was witnessed by a member of staff; a patient

that had an unwitnessed fall as they were trying to stand on their own and sustained a small graze to their spinal prominence and a patient that had an unwitnessed fall in the dayroom that was not being closely monitored as staff were with other patients.

The no harm incident related to a patient who was trying to get up from the chair slid to the floor. The patient was moved to side room for infection control reasons due to potential COVID 19 and does not use the call bell. The patient has a diagnosis of dementia with fluctuating capacity.



2.5 Assurance on Medication incidents

119 medication incidents were considered lapses in care and attributable to KCHFT during August and September 2020 compared to 106 lapses in care incidents reported during June and July 2020. This represents an 11% rise in medication incidents. The community nursing team and community hospital each reported 50(42%) of all the incidents. The remaining lapses in care incidents were by 13 different services.

Avoidable medication incident themes

Omitted medication - (36/119);

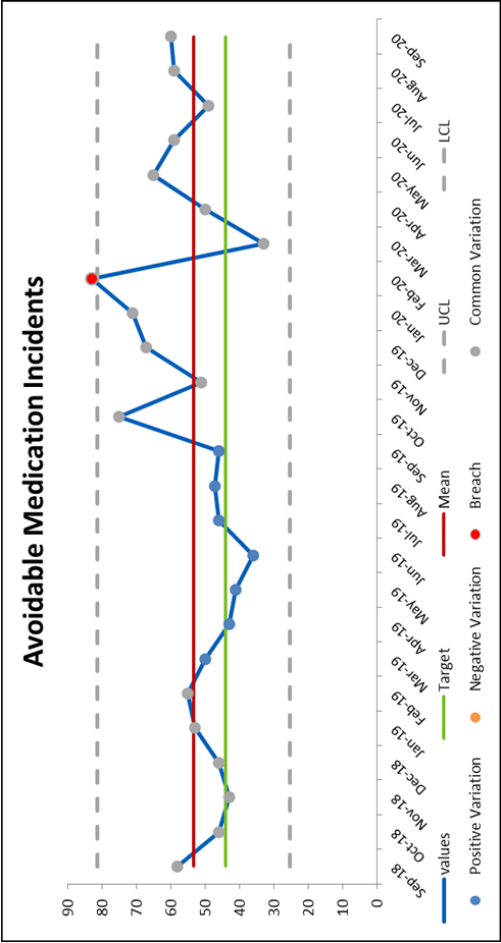
No harm incidents - 31 (30%), Low harm incidents 5 (4.2%).Of the 36 avoidable omitted doses incidents, 14 (39%) were from community nursing.

Wrong/unclear dose or strength - (19/119);

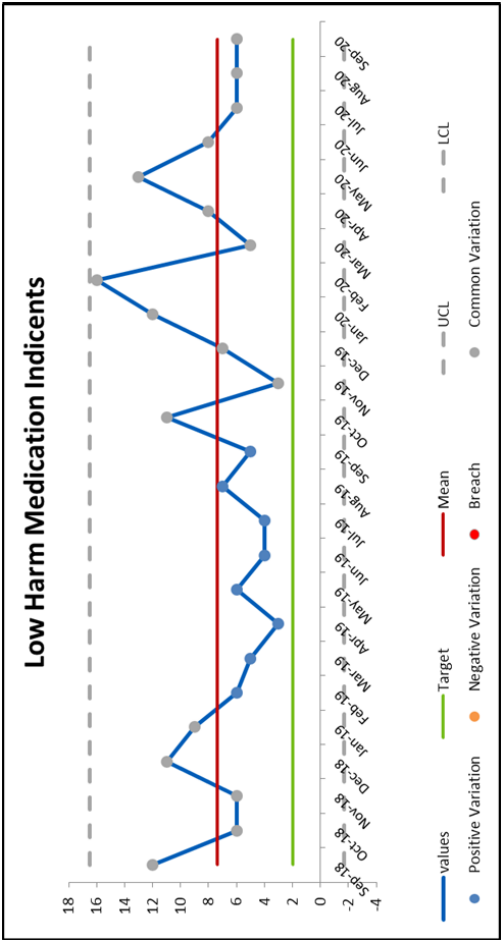
No harm incidents 17 (14%), Low harm incidents 2 (1.7%)

Wrong frequency - (12/119);

No harm incidents 12 (10%)



There were 26 lapses in care controlled drug incidents of which two resulted in low harm and 24 resulted in no harm to the patient. Of the 26, six were wrong quantity; four were wrong/unclear dose or strength; four were mismatching between patient and medicine and four were categorised as 'other'.



2.6 Assurance on Patient Experience

2.6.1 Meridian Patient Experience survey results

3,311 surveys were completed by patients, relatives and carers (this includes 816 remote surveys), with a strong combined satisfaction score of 94.5%. Survey volumes continue to be low due to Covid-19, with an encouraging increase seen in September (1,889).

Overall satisfaction survey percentages trust wide from August to September 2020 are fractionally lower than the previous two months (95.4%).

PALS dealt a total of 804 contacts; 735 telephone calls, 51 on-line forms and 18 queries via text message.

2.6.2 The NHS Friends and Family Test (FFT)

2,060 FFT questions were completed during August and September. The FFT recommend score was 96.9%.

0.9% (19) of our patients rated their overall experience as poor or very poor. The main themes from comments related to appointments and communication, for a variety of services.

3 comments from people who chose a poor or very poor response related to other organisations, 4 were non-qualitative and 1 response was possibly an error as the rest of the survey was positive.

2.7 Assurance on Clinical Audit and Research

2.7.1 Clinical Audit Reporting

Clinical audit was put on hold during from March 2020 until slowly starting again in late June. The improvement in the KPIs from August to September is an indication that the services are beginning to catch up with their actions for improvements from earlier audits and resuming audit activity

KPI Actions	Target %	>75% August	>80% September
Due audit recommendations implemented – KPI 4.6		36%	61%
Actions overdue by more than 3 months – KPI 36 Target <=10%		29%	11%
Actions overdue by more than 6 months – KPI 37 Target <=5%		15%	11%

2.7.2 National Institute for Clinical Excellence (NICE)

714 pieces of NICE Guidance have been issued since 2017. Only 152 are applicable to KCHFT. Of these 12 (8%) remain under initial review and have exceeded our 3 month target to complete the baseline assessment.

2.8 Infection Prevention and Control

2020/21 Infection prevention and control trust objectives	August 2020	Sept 2020	YTD (Apr- March)
No cases of <i>Clostridium difficile</i> infection (CDI) where level 3 lapses in care were identified by KCHFT staff (i.e. the infection deemed avoidable and caused by a failures in care or failure to follow policy/protocol). All cases of CDI will be reviewed and attributed to the following 4 categories: Hospital onset healthcare associated Community onset healthcare associated Community onset indeterminate association Community onset community associated	1 COIA	0	8 6 COHA 1 HOHA 1 COIA
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	podiatric surgery recommenced = 100% screened 90% inpatient units	Podiatric surgery = 100% screened 100% inpatient units	Podiatric Surgery =100% 98% inpatient units
There will be a reduction of acquired urinary tract infections and catheter associated urinary tract infections compared to 2019/20	12 UTI's 3 CAUTI	7 UTI's 3 CAUTI's	43 UTI's 12 CAUTI's
Prevent ongoing transmission COVID within Community Hospitals			Total COVID+ve patients cared for in inpatient wards since March 2020: 285
Total No. COVID +ve patients in inpatient wards at end of month	5	1	
No. of those who tested positive in month, and meet the definition: hospital onset – probable or definitely healthcare acquired (data collection commenced May)	0	0	

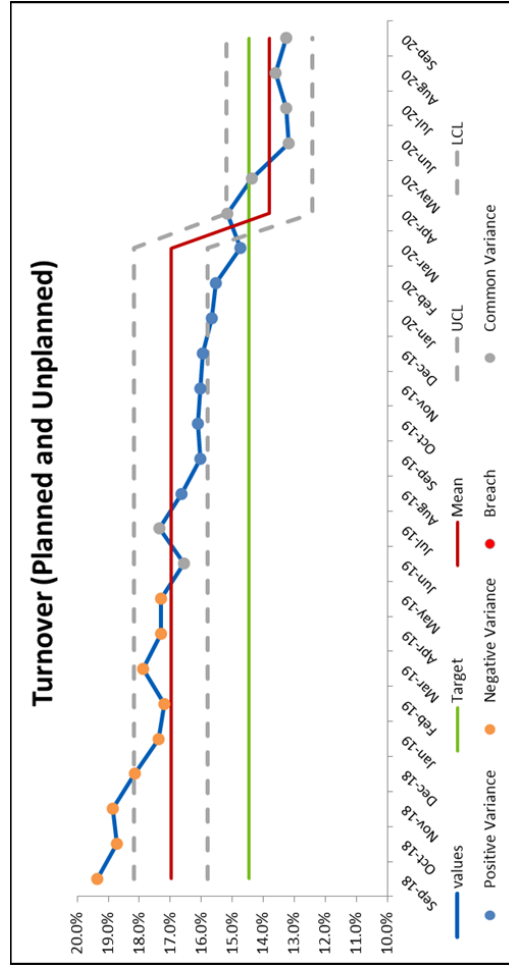
3.0 Workforce Report:

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

3.1 Assurance on Retention

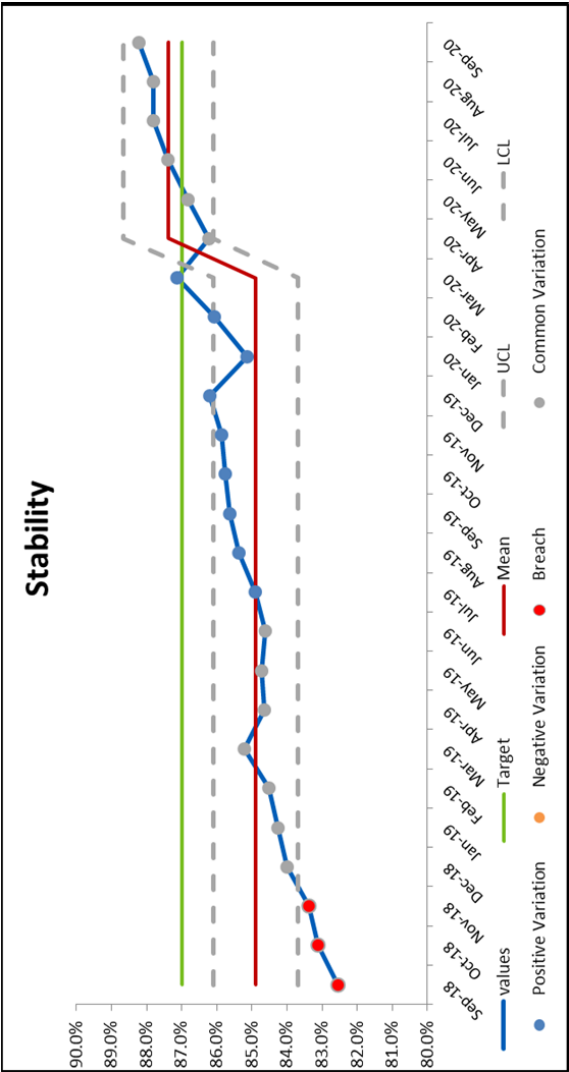
3.1.1 Turnover

Turnover in September 2020 is on a downward trajectory to 13.27%, a 0.35% decrease from August 2020 (13.62%). With this performance, turnover rates remain below average and below the new target of 14.47%.



3.1.2 Stability

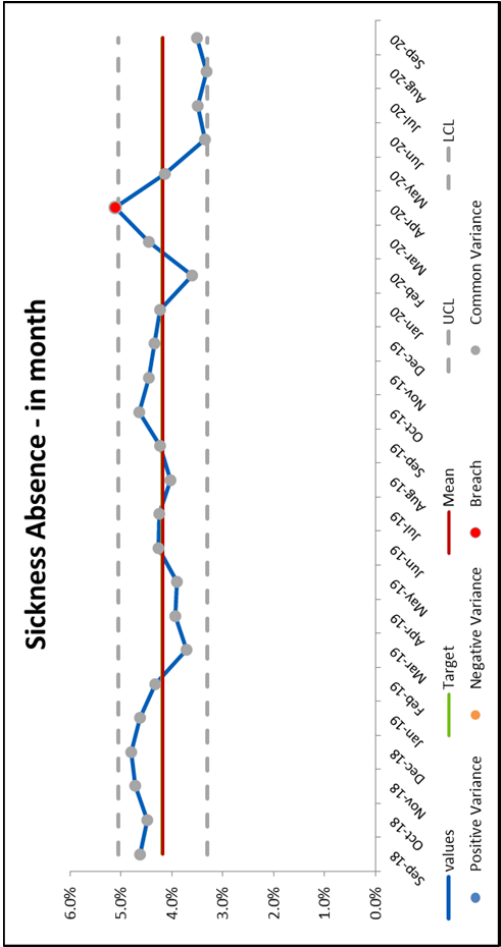
Stability continues to improve and current performance is above the mean and target at 88.22%, an increase of 0.41% from August 2020 (87.81%).



3.2 Assurance on Sickness

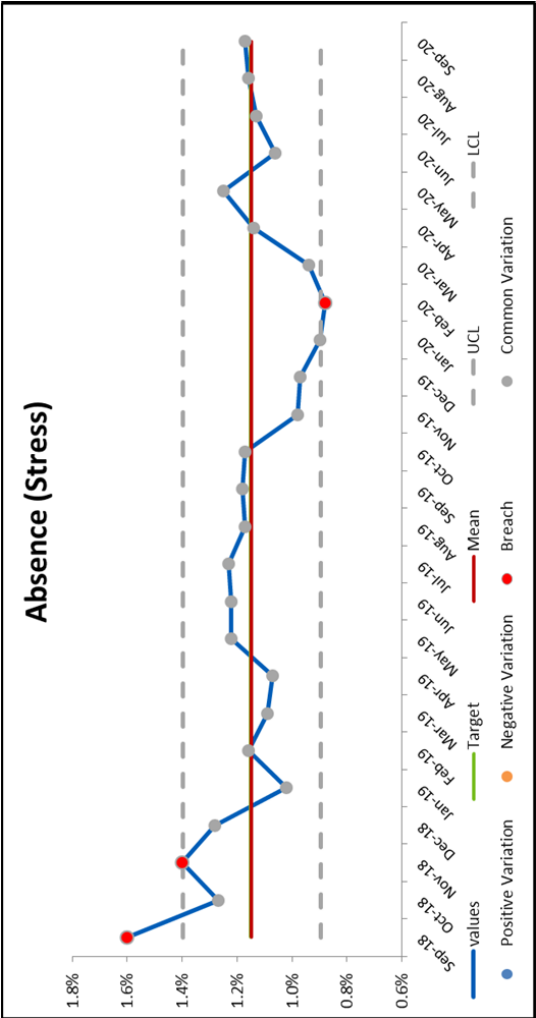
3.2.1 Sickness Absence

In month sickness absence is in a stable position following an expected increase earlier in the year due to Covid-19. Current performance is below the mean and below target. September in month absence was 3.51%, a marginal increase of 0.26% from August 2020 (3.25%) but remains stable around this level.



3.2.2 Stress Absence

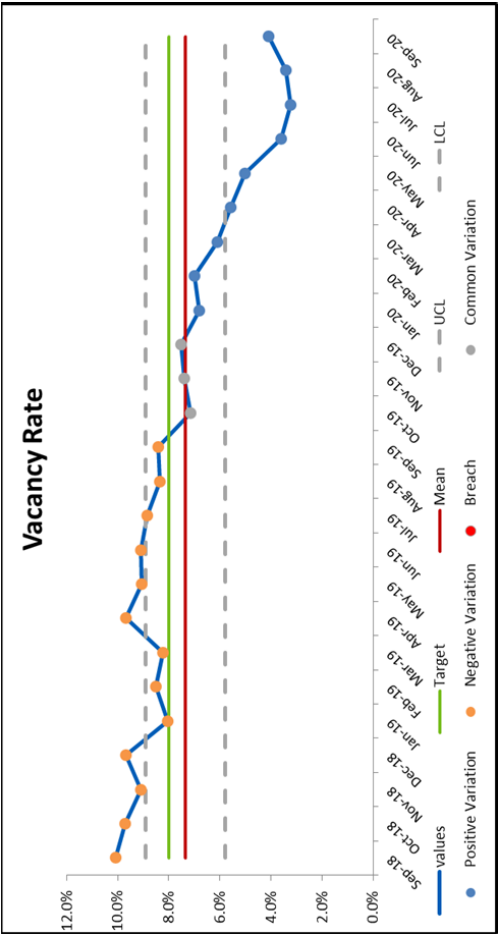
In-month stress absence figures for September 2020 (1.17%) have remained the same as reported in August 2020. The financial year-to-date figure for September 2020 is 1.15% in line with target



3.3 Assurance on Filling Vacancies

3.3.1 Establishment and Vacancies

The Vacancy Rate continues to perform below average and target. Currently the vacancy rate is 4.10% which is a small increase of 0.73% since August 2020 which is driven by the phased increase in establishment for Public Health to support winter vaccination campaigns.

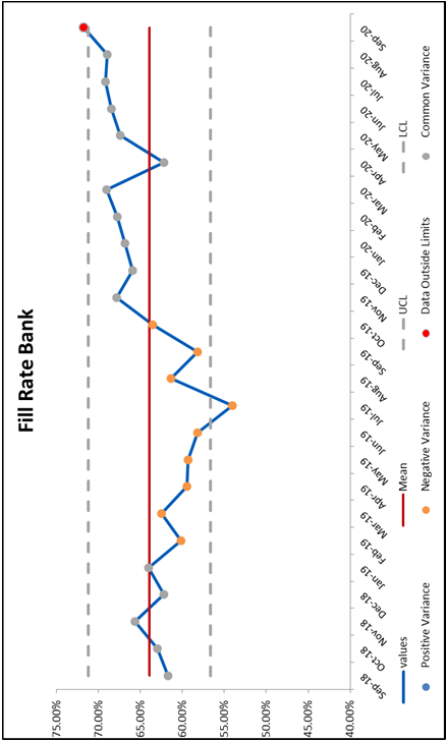
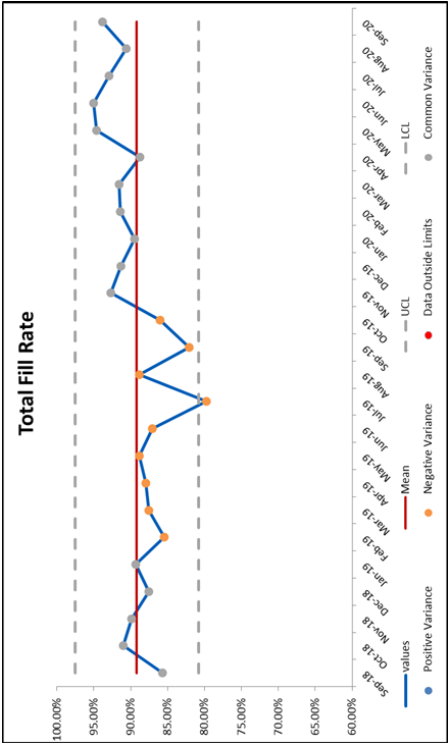


3.3.2 Temporary Staff Usage

The Total fill rate has continued to increase since the last reporting period. Current performance is 93.85% in September 2020, a 2.46% increase since August 2020 (91.39%).

The Bank fill rate also continues to improve with performance reaching 71.80% in September 2020, a huge 4.00% increase since August 2020 (67.80%).

Significant recruitment has been undertaken to increase capacity on the Bank to support the emergency response to the COVID-19 pandemic and this is evident in the above fill rate performance.



4.0 Finance Report:

4.1 Key Messages

Surplus: The Trust is in a breakeven position to the end of September which is £75k behind plan. Cumulatively pay and depreciation/interest have underspent by £344k and £339k respectively and income has over-recovered by £2,415k, partially offset by an overspend on non-pay costs of £3,173k. The Trust has spent £5,845k on the Covid-19 response and received top up income of £4,871k YTD. Additional costs associated with the hospital discharge programme of £3,281k have been incurred, offset by funding from Kent and Medway CCG.

Continuity of Services Risk Rating: EBITDA Margin achieved is 1.4%. The Trust scored overall the maximum 1 against the Use of Resources Rating, the best possible score. 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: £2,118k of savings has been achieved to the end of September meeting the YTD target in full. The cumulative position includes £628k 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 £59,582k, equivalent to 87 days expenditure. The Trust recorded the following YTD public sector payment statistics 98% for volume and 97% for value.

Capital: Spend to September was £3,339k, against a YTD plan of £5,070k (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 £10,352k and the Trust expects to utilise this in full. The full year forecast is in line with the Trust's resubmitted capital plan (submitted on 27 July) and includes a further £198k Capital Covid-19 claim, which has again received regional approval and awaits national approval. In addition, the forecast now includes £1,500k capital expenditure on the Trust's Urgent Treatment Centres. This expenditure will be fully funded by PDC (Urgent and Emergency Care Programme) following the approval of the submitted MoU by DHSC in early September.

Staff: Agency expenditure was £97k below the target for September. Agency costs were £394k for September against a target of £491k, there was an additional £183k spent on agency staff for the covid-19 response. Total agency spend in September was £577k.

4.2 Dashboard

Surplus	Reg rating: Green		Use of Resource Rating		Reg rating: Green		CIP	Reg rating: Green	
	Actual	Plan	Variance		Year to Date Rating	Year End Forecast Rating		Actual	Plan
Year to Date £k	0	75	-75	Capital Service Capacity	1	1	Year to Date £k	2,118	2,118
Year End Forecast £k	0	150	-150	Liquidity	1	1	Year End Forecast £k	4,210	4,210
The Trust is in a breakeven position to the end of September in-line with guidance received from NHSEI, which is £75k behind plan.				I&E margin (%)	2	2	The Trust achieved CIPs of £2,118k to the end of September against a risk rated plan of £2,188k.		
Non-pay has overspent by £3,173k partly offset by underspends on pay and depreciation/interest of £344k and £339k respectively and an over-recovery of income of £2,415k.				Distance from Financial Plan	1	1	84.6% of the total annual CIP target has been removed from budgets at month six.		
The forecast for 2020/21 is to breakeven.				Agency Spend	2	2	The Trust is forecasting to achieve the full plan of £4,210k by the end of the year.		
				Overall Rating	1	1			
Cash and Cash Equivalents	Reg rating: Green		Capital Expenditure		Reg rating: Amber		Agency Targets	Reg rating: Green	
	Actual	Forecast	Variance		Actual/Forecast	Plan		YTD	
Year to Date £k	59,582	59,802	-220	YTD Expenditure £k	3,339	5,070	Actual £k	2,306	2,948
Year End Forecast £k	37,970			Year End Forecast £k	10,352	10,352	Target £k	97	642
Cash and Cash Equivalents as at M6 close stands at £59,582k, equivalent to 87 days operating expenditure.				Spend to September was £3,339k, against a YTD plan of £5,070k (66% achieved). The full year forecast is £10,352k and the Trust expects to utilise this in full. The full year forecast now includes £1,500k capital expenditure on the Trust's Urgent Treatment Centres. This expenditure will be fully funded by PDC (Urgent and Emergency Care Programme) following the approval of the submitted MoU by DHSC in early September.			External Agency Excluding Covid-19 Expenditure £k		
The Trust recorded the following YTD public sector payment statistics 98% for volume and 97% for value.							External Agency Including Covid-19 Expenditure £k		
							External Agency and Locums including Covid-19 expenditure in September was £577k against £491k target. (YTD £3,559k against £2,948k target).		

4.3 Income and Expenditure Position

The position for September was £12k adverse compared to plan, increasing the adverse variance YTD to £75k. The in-month performance comprised an overspend of £1,258k for non-pay partly offset by underspends on pay and depreciation/interest of £406k and £174k respectively and an over-recovery on income of £666k. The summary income and expenditure statement is shown overleaf:

	SEPT ACTUAL £'000	SEPT BUDGET £'000	SEPT VARIANCE £'000	% VARIANCE	YTD ACTUAL £'000	YTD BUDGET £'000	YTD VARIANCE £'000	% VARIANCE
Charitable and Other Contributions to Expenditure	5	4	1	39.9%	18	21	-4	-18.4%
Clinical Commissioning Groups	13,474	13,417	57	0.4%	80,697	80,573	125	0.2%
Department of Health	0	0	0	0.0%	0	0	0	0.0%
Education and Training	199	164	35	21.4%	761	983	-223	-22.7%
Injury Cost Recovery Scheme	-4	32	-36	-112.8%	151	191	-39	-20.6%
Local Authorities	2,572	3,855	-1,282	-33.3%	21,114	23,703	-2,588	-10.9%
NHS England	3,017	1,986	1,031	51.9%	12,565	11,186	1,380	12.3%
NHSEI Top Up Funding	884	0	884	0.0%	4,871	0	4,871	0.0%
NHS England Financial Recovery Funding	0	2	-2	-100.0%	0	12	-12	-100.0%
NHS Foundation Trusts	297	246	51	20.8%	1,352	1,474	-122	-8.3%
NHS Trusts	555	520	36	6.9%	2,967	3,095	-128	-4.1%
Non NHS- Other	161	153	8	5.2%	819	908	-89	-9.9%
Non NHS- Private Patients	2	18	-16	-88.7%	7	107	-100	-99.7%
Non-Patient Care Services to Other Bodies	145	183	-38	-20.5%	882	1,141	-259	-22.7%
Other	104	168	-63	-37.8%	612	1,006	-394	-38.2%
INCOME Total	21,411	20,745	666	3.2%	126,815	124,400	2,415	1.9%
Allied Health Professionals	2,344	2,395	51	2.1%	13,959	14,333	474	3.3%
Apprenticeship Levy	56	64	8	12.4%	346	385	39	10.2%
Consultants	261	283	22	7.8%	1,360	1,494	134	9.0%
Healthcare Scientists	186	0	-186	0.0%	189	0	-189	0.0%
Medical Career/Staff Grades	666	705	39	5.6%	3,362	3,676	313	8.5%
Medical Trainee Grades	18	21	4	16.5%	85	113	27	24.2%
NHS Infrastructure Support	4,144	4,109	35	0.8%	24,175	24,678	503	2.0%
Non-Executive Directors	17	17	0	0.6%	101	103	2	1.7%
Other Scientific, Therapeutic and Technical Staff	446	661	216	34.6%	3,531	3,983	452	11.4%
Registered Nursing, Midwifery and Health Visiting Staff	4,820	5,481	661	12.1%	28,908	29,422	514	1.7%
Support to Allied Health Professionals	396	454	59	12.9%	2,319	2,558	239	9.3%
Support to Nursing Staff	2,261	1,887	374	19.8%	13,368	11,354	2,014	17.7%
Support to Other Clinical Staff	34	39	5	13.4%	207	236	29	12.2%
Redundancy Costs	0	0	0	0.0%	68	0	-68	0.0%
CIP Target Pay	0	-39	39	-100.0%	0	-68	68	100.0%
CIP Holding Account Pay	0	7	7	100.0%	0	144	144	100.0%
Contract Savings	0	-31	31	-100.0%	0	-188	188	100.0%
PAY Total	15,649	16,054	406	2.5%	91,879	92,222	344	0.4%
Audit Fees Payable to the External Auditor	2	3	0	5.9%	33	29	4	-13.6%
Clinical Negligence - Amounts Payable to NHS Resolution	61	61	0	0.0%	365	365	0	0.0%
Consultancy	248	91	157	-173.2%	1,005	557	448	80.2%
Drugs Costs	296	516	220	42.6%	2,030	3,025	995	32.9%
Education and Training - Non-Staff	218	157	62	-39.2%	668	993	325	32.7%
Establishment	692	30	-662	-205.3%	4,280	3,339	941	28.2%
Increase/(Decrease) in Impairment of Receivables	0	0	0	0.0%	0	0	0	0.0%
Operating Lease Expenditure	778	757	21	2.8%	4,614	4,542	72	-1.6%
Operating Lease Expenditure (net)	0	0	0	0.0%	0	0	0	0.0%
Other	226	63	163	-256.7%	661	406	255	62.9%
Premises - Business Rates Payable to Local Authorities	44	57	13	22.9%	312	339	27	8.1%
Premises - Other	513	500	13	-2.7%	3,207	3,023	184	6.1%
Research and Development - Non-Staff	0	0	0	0.0%	0	0	0	0.0%
Supplies and Services - Clinical (excluding drugs costs)	2,099	1,632	467	-28.6%	13,215	10,608	2,607	24.6%
Supplies and Services - General	175	85	90	-105.0%	1,068	511	556	108.8%
Transport	235	336	101	30.1%	1,724	2,182	457	21.0%
CIP Target Non Pay	0	39	39	100.0%	0	68	68	100.0%
CIP Holding Account Non Pay	0	7	7	100.0%	0	43	43	100.0%
Contract Savings	0	-4	4	-100.0%	0	-22	22	100.0%
NONPAY Total	5,587	4,330	1,258	-29.0%	33,181	30,008	3,173	-10.6%
EBITDA	175	361	-186	-51.4%	1,756	2,170	-414	-19.1%
EBITDA %	0.8%	1.7%	0.9%		1.4%	1.7%	-0.1%	
Amortisation	37	21	17	-78.5%	122	125	3	2.6%
Depreciation	293	307	14	4.4%	1,630	1,840	210	11.4%
Finance Income	0	17	-17	-100.0%	0	104	-104	-100.0%
Interest on Late Payment of Commercial Debt	1	0	-1	0.0%	4	0	-4	0.0%
Losses on Disposal of Property, Plant and Equipment	0	0	0	0.0%	0	0	0	0.0%
PDC Dividend Charge	-156	39	195	500.0%	0	234	234	100.0%
SURPLUS/(DEFICIT)	0	12	-12	-100.0%	0	75	-75	-100.0%
SURPLUS %	0.0%	-0.1%	0.1%		0.0%	-0.1%	0.1%	

4.3 Statement of Financial Position and Capital

	At 31 Mar 20 £000s	At 31 Aug 20 £000s	At 30 Sep 20 £000s	Variance Analysis Commentary
NON CURRENT ASSETS:				
Intangible assets	852	1,231	1,240	
Property, Plant & Equipment	19,569	20,385	20,569	
Other debtors	414	385	345	
TOTAL NON CURRENT ASSETS	20,635	22,000	22,154	
CURRENT ASSETS:				
NHS & Non NHS - Invoiced Debtors (net of bad debt provision)	13,137	7,936	11,412	NHS & Non NHS - Invoiced Debtors (net of bad debt provision) The reported in-month increase follows the raising of prior period invoices to K&M CCG, other K&M Providers and KCC which were previously accrued.
NHS Accrued Debtors	1,712	1,325	1,158	
Other debtors	3,088	9,247	8,488	
Total Debtors	17,938	18,508	21,060	Other debtors
Cash at bank in GBS accounts	44,615	58,129	59,569	The reported in-month decrease in the main relates to a reduction/release in non-NHS prepayments and a reduction in the VAT receivable.
Other cash at bank and in hand	51	22	13	
Deposit with the National Loan Fund (Liquid Investment)	0	0	0	
Total Cash and Cash Equivalents	44,666	58,151	59,582	
TOTAL CURRENT ASSETS	62,603	76,658	80,642	
CREDITORS:				
NHS & Non NHS - Invoiced Creditors falling due within 1 year	-3,695	-766	-758	Other creditors The in-month increase in the main relates to deferred revenue adjustments re KCC contract values and top-up funding reimbursements to NHS England.
NHS - accrued creditors falling due within 1 year	-4,719	-4,956	-4,623	
Non NHS - accrued creditors falling due within 1 year	-17,439	-20,685	-21,496	
Other creditors	-9,946	-24,856	-28,594	
Total amounts falling due within one year	-35,799	-51,263	-55,471	
NET CURRENT ASSETS	26,805	25,395	25,171	
TOTAL ASSETS LESS CURRENT LIABILITIES	47,441	47,396	47,325	
Total amounts falling due after more than one year	0	0	0	
PROVISION FOR LIABILITIES AND CHARGES	-1,677	-1,632	-1,561	
TOTAL ASSETS EMPLOYED	45,764	45,764	45,764	
FINANCED BY TAXPAYERS EQUITY:				
Public dividend capital	-2,887	-2,887	-2,887	
Income and expenditure reserve	-41,677	-41,677	-41,677	
Revaluation Reserve	-1,199	-1,199	-1,199	
TOTAL TAXPAYERS EQUITY	-45,764	-45,764	-45,764	

Cash and Cash Equivalents

Cash and Cash equivalents totalled £59,582k as at M6 close, equivalent to 87 days expenditure:

Total Cash and Cash Equivalents as at period end:

	£000's
Cash with the Government Banking Service	59,569
Cash at Commercial Banks and in hand	13
Deposits with the National Loan Fund	0
Total Cash and Cash Equivalents as at period end	59,582

All figures £000's	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	July 21	Aug 21
	Actual	F/cast	F/cast	F/cast	F/cast	F/cast	F/cast	F/cast	F/cast	F/cast	F/cast	F/cast
Opening Balance	58,151	59,582	54,790	55,435	53,493	54,451	54,255	37,970	38,062	37,804	37,413	37,282
SLA	18,038	16,403	18,474	17,557	17,557	17,557	1,927	17,875	17,875	17,875	17,875	17,875
NHS Debtors	1,425	2,489	2,059	2,130	1,856	1,814	1,841	1,832	1,499	1,565	1,521	1,462
Non NHS	1,936	1,617	1,213	1,213	1,213	1,213	1,213	1,213	1,213	1,213	1,213	1,213
P SF	0	0	0	0	0	0	0	0	0	0	0	0
VAT Refund	312	606	190	190	190	190	190	190	190	190	190	190
Interest Receivable	0	0	0	0	0	0	0	0	0	0	0	0
Total receipts	21,721	21,115	21,936	21,090	20,816	20,774	5,171	21,110	20,777	20,843	20,759	20,740
Net Payroll	8,567	8,950	8,950	8,950	8,950	8,950	8,950	8,950	8,950	8,950	8,950	8,950
Pensions	2,460	2,480	2,455	2,455	2,455	2,455	2,455	2,455	2,455	2,455	2,455	2,455
Tax & NI	3,217	3,286	3,280	3,280	3,280	3,280	3,280	3,280	3,280	3,280	3,280	3,280
Payment Runs	5,236	10,735	6,016	7,612	4,462	5,226	6,158	5,823	5,646	6,131	5,812	5,193
PDC Dividends	0	0	0	-346	0	0	0	0	0	0	0	0
Other	46	40	40	40	40	40	40	40	40	40	40	40
Capital	385	416	550	1,041	671	1,019	573	430	654	378	383	746
Total payments	20,300	25,907	21,291	23,032	19,858	20,970	21,456	21,020	21,025	21,234	20,920	20,664
Closing Cash Balance	59,982	54,790	55,435	53,493	54,451	54,255	37,970	38,062	37,804	37,413	37,252	37,368

*The SLA values reported year to date include the Block payments received from K&M CCG and East Sussex CCG, plus the Block payments and Top-up payments received from NHS England. For the period year to date, the Block payments have been received one month in advance i.e. September Block has been received in August. The reduction in the March 2021 SLA value is based on the current assumption that the March block payment will be received in February 2021 but that the April payment will be received in April 2021. As per the most recent guidance, NHSE/I are reviewing the timing of the clawback of the advance payment and the resumption of normal payment terms and further guidance will be issued in due course.

Capital

The table overleaf shows the Trust's total expenditure on capital projects for the year to date 2020-21 and reflects a £1.7m underspend in terms of the revised plan submitted to NHS Improvement on 27 July 2020. The year to date actual spend includes £72k relating to a COVID-19 capital claim which has received regional approval and awaits national approval.

The full year forecast is £10.4m and the Trust expects to utilise this in full, with the £269k reserved for Kent & Medway system priorities being managed separately as part of wider system capital plans. It has been agreed that each Trust within the Kent & Medway system will manage their own capital programme slippage and only keep reserved the additional funding allocated for Kent & Medway system priorities for potential reallocation.

The full year forecast is in line with the Trust's resubmitted capital plan and includes a further £198k COVID-19 capital claim, which has again received regional approval and awaits national approval. The COVID-19 capital claims submitted to date relate to the purchase of laptops and associated equipment to enable remote working for staff. No formal confirmation has yet been made available as to whether national approval for these claims will be received and the Trust continues to assess the risk of not receiving this funding as part of its wider monitoring of the capital plan.

In addition, the full year forecast now includes £1.5m capital expenditure on the Trust's Urgent Treatment Centres. This expenditure will be fully funded by PDC (Urgent and Emergency Care Programme) following the approval of the submitted MoU by DHSC in early September.

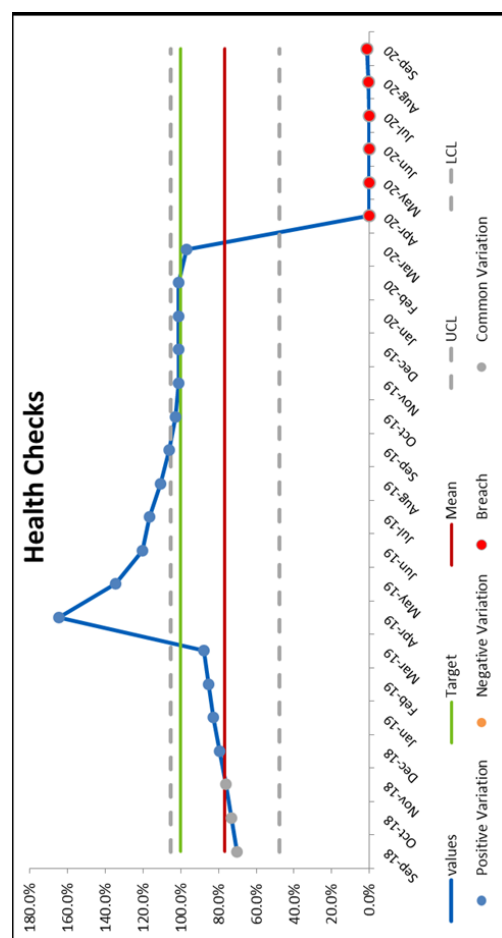
Plan Area	Capital Project	£000s					FY
		YTD	YTD Actual	Variance	YTD Plan	Forecast	
Estates	Replacement Fire Doors Phase 2 Hawkhurst Cottage Hospital - C/fwd 19-20	20	1	19	20	22	-2
Estates	Churchill Centre Improvements - C/fwd 19-20	138	3	135	138	138	0
Estates	Bellingham Way - Installation of Air Conditioning and Internal Reconfiguration - C/fwd 19-20	89	14	75	89	116	-27
Estates	The Oast Toilet Upgrade - C/fwd 19-20	30	40	-10	30	39	-9
Estates	Trinity House Reconfiguration Works - C/fwd 19-20	58	73	-15	58	74	-16
Estates	Westcliff House Improvements - C/fwd 19-20	100	109	-9	100	109	-9
Estates	Hawkhurst Cottage Hospital Reception Reconfiguration - C/fwd 19-20	20	7	13	20	43	-23
Estates	Trinity House - Toilet Refurbishment Works - C/fwd 19-20	181	155	26	181	160	21
Estates	Hawkhurst Cottage Hospital - Mains Electric Transformer Upgrade Works	20	0	20	20	20	0
Estates	Hawkhurst Cottage Hospital - Replacement Nurse Call System	41	2	39	60	69	-9
Estates	Westcliff House - Window Replacement works	1	55	-54	52	54	-2
Estates	Westcliff House - LED Light Installation works	20	0	20	20	8	12
Estates	Solar PV Installations - Various sites	0	0	0	70	140	-70
Estates	Hawkhurst Cottage Hospital - Car Park Extension	0	0	0	100	100	0
Estates	Replacement Cottage Hospital - Reconfiguration works MSK	100	2	98	100	100	0
Estates	Electric Charging Points - Various Sites C/fwd 19-20	25	15	10	25	15	10
Estates	South Park Infirmary - Various Works C/fwd 19-20	101	27	74	101	118	-17
Estates	Exchange House Fire Strategy Works - C/fwd 19-20	1	-1	2	1	-1	2
Estates	Hawkhurst Cottage Hospital - Automated Front Doors	3	1	2	3	5	-2
Estates	The Oast Unit 10 - GCH Relocation - C/fwd 19-20	7	1	6	7	0	7
Estates	Trinity House Air Conditioning Works	50	4	46	50	4	46
Estates	Foster Street - Flat Roof Ballings	15	0	15	15	0	15
Estates	Estates Contingency - Compliance/Life cycle works/ NHS Property Services Repaired Sites/Conkhead Redevelopment	0	0	0	152	82	70
Estates	Bin Store Extension - Trinity House	0	0	0	0	8	-8
Estates	Nurse Call System - Tonbridge Cottage Hospital	0	49	-49	0	49	-49
Estates	Tonbridge Cottage Hospital Security Improvements	0	6	-6	0	13	-13
Estates	Urgent Treatment Centre Works (Severeolaks, Folkestone and Deal) - Urgent and Emergency Care Programme (PDC)	40	7	33	1,500	1,500	0
Estates	K&M SLP Ringfence of Funds - System Priorities	0	0	0	269	269	0
Estates	Whitfield Court Refit - C/fwd 19-20	0	0	0	0	0	0
Estates	Hawkhurst Cottage Hospital Boiler Works - C/fwd 19-20	0	0	0	0	0	0
Estates	Trinity House VOIP - C/fwd 19-20	0	3	-3	0	3	-3
Estates	Conkhead Reconfiguration - C/fwd 19-20	0	0	0	0	0	0
Estates	Discovery Park - Standalone Storage Unit - C/fwd 19-20	0	0	0	0	0	0
Estates	IT/Telephony Works at Regus (Dartford) and Baspoint (Northfleet) - C/fwd 19-20	0	0	0	0	0	0
Estates	Relocation from Beechwood House to Dover District Council offices - C/fwd 19-20	0	0	0	0	0	0
Estates	CIS Replacement - RIO Implementation - C/fwd 19-20	1,135	574	561	3,269	3,143	126
IT	KMCR (Kent & Medway Care Record)	1,115	1,062	53	1,900	1,900	0
IT	KMCR - Provider Digitisation Programme, HSU PDC Funding	1,243	701	542	3,012	2,796	216
IT	Aggresso Upgrade Phase 2 - C/fwd 19-20	112	156	-44	250	250	0
IT	Server Refresh Installation	15	0	15	48	0	48
IT	UPS Refresh	0	0	0	12	0	12
IT	IT Cabinet Reconfiguration	40	0	40	40	40	0
IT	Licensing Upgrades	40	0	40	50	50	0
IT	Microsoft Office 2019	460	750	-290	760	760	0
IT	Citrix Platform Upgrade	217	0	217	217	159	58
IT	Unified Communications as a Service (UCaaS)	0	0	0	0	106	-106
IT	Service Desk System Renewal / Replacement	80	0	80	80	0	80
IT	Secondary Data Centre Move	93	6	87	93	93	0
IT	IT Hardware - Contingency	0	0	0	0	497	-497
IT	VPN Solution	0	0	0	36	36	0
IT	Mobile Device Security	22	0	22	22	22	0
IT	IT Hardware C/fwd 19-20	77	5	72	77	79	-2
IT	VOIP System Edenbridge/Hawkhurst/TCH - IT C/fwd 19-20	0	-2	2	0	-2	2
IT	IT Switch Management Tool	6	6	0	6	6	0
IT	LD Service IT Provision (KCC Sites)	40	29	11	40	40	0
IT	South East Drivability Laptops	0	8	-8	0	8	-8
IT	Laptops & Associated Equipment - Coude 19 Claim	270	32	238	270	270	0
IT	HSN/COIN Refresh 18 19 - C/fwd 19-20	0	-13	13	0	-13	13
IT	Symphony Upgrades - C/fwd 19-20	0	-4	4	0	-4	4
IT	Spina and Accountability Database System - C/fwd 19-20	0	-8	8	0	-8	8
IT	Server Refresh - C/fwd 19-20	0	-40	40	0	-40	40
IT	Single Sign On - C/fwd 19-20	0	-40	40	0	-40	40
IT	Website development for special care and paediatric service	3,830	2,735	1,095	6,953	7,076	-123
Dental	Dental	0	0	0	10	10	0
Dental	OPS X-Ray Equipment - St Leonards	21	0	21	21	22	-1
Dental	IVIZ Ultrasound Scanner - C/fwd 19-20	8	9	0	31	32	-1
Other	Clover Street Refurbishment Works	20	20	0	20	20	0
Other	Public Health Bus	55	0	55	55	55	0
Other	Other Minor Schemes	0	0	0	16	16	0
Other		84	29	55	100	100	0
Other		5,070	3,399	1,771	10,362	10,352	0

5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits

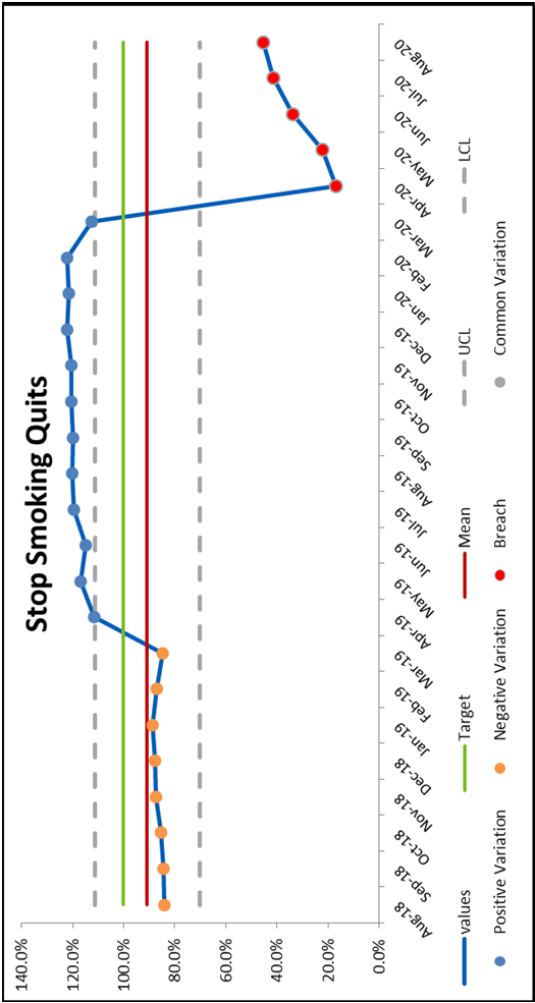
Health Checks



Health Checks had dropped to 0 for Months 1-3 due to the service being paused as a result of the Covid-19 pandemic and is only back up to 1.3% at month 6. 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

Reset for 3rd party providers continues to be challenging - difficult on the grounds of GP priorities, but activity continuing and increasing. We have secured 4 venues to deliver the core provision with others being explored – we now have access to Open space, so are preferring to book rooms in clinical settings due to guarantee of Covid-19 safe spaces. 82 GP practices had confirmed that they would like to reset within this financial year, however it is becoming more apparent that some of this number are no longer in a position to initiate Health Checks at this time. 42 GP practices have completed the assurance checklist. 44 GP practices are still to confirm if and when they are ready to reset – these practices are also being regularly communicated with. 5 practices have stated no intention to re-start Health Checks during this financial year.

Stop Smoking Quits



COVID hit referrals to the service which reduced significantly as can be seen in the graph above. Initially the service saw a huge decline in the number of referrals however, seen a steady increase each week since then.

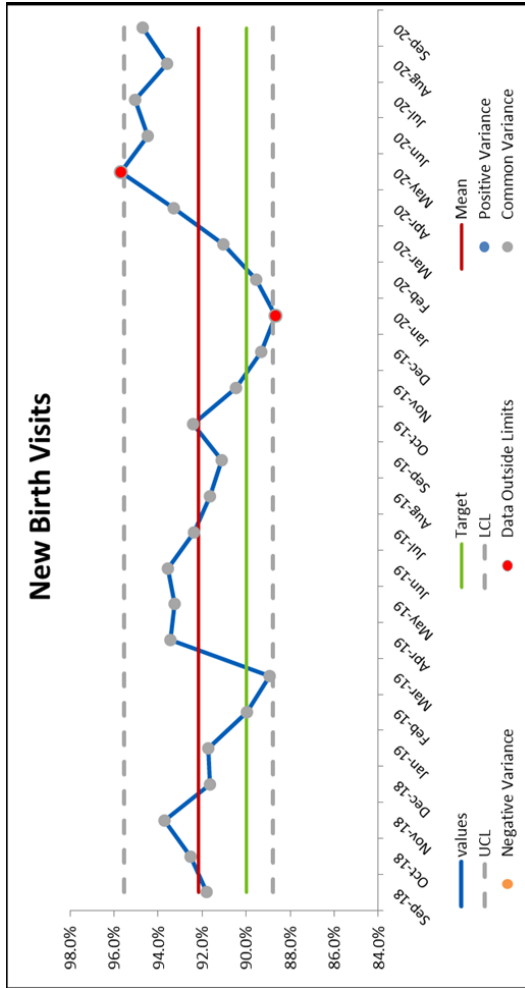
Additional resource through the Lifestyle Service is currently in the training phase and on track to be mobilised from end of October 2020. Suspension of resetting Health Walks so that more staff capacity can be allocated to smoking. Breaking free, My Quit Route app is now available via the ONE You Kent website and is being offered as an alternative way to quit for those on the wait list. The service is also working alongside KCC to develop a light touch intervention with the use of the app and e-cigarettes.

Third party providers (Community Pharmacy and General Practice) has picked up a little, there are currently 29 Pharmacies and 33 GP Practices that have confirmed they are ready to reset either face to face or remotely (telephone support). 26 of the pharmacies have agreed to take 10 clients from the waiting list each and 2 have agreed to take 5 clients.

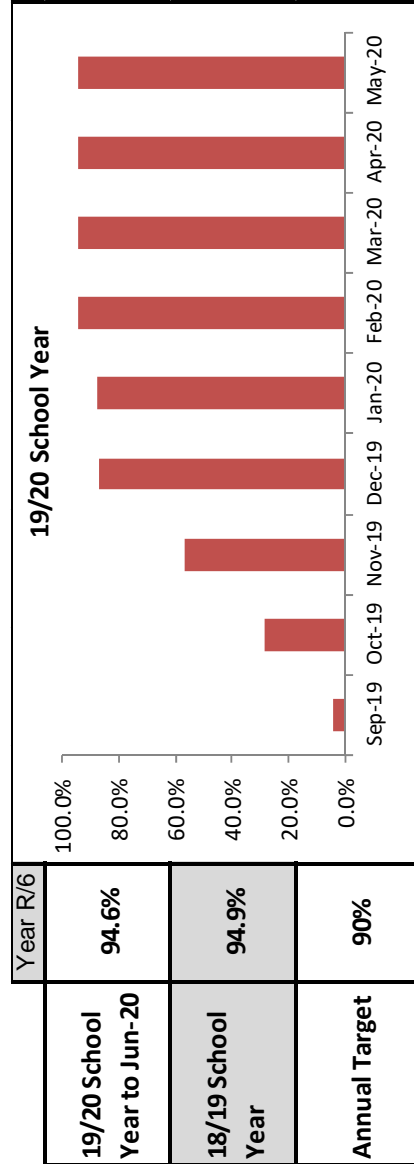
5.1.2 Health Visiting

New Birth Visits

Strong current performance with consistent achievement of the target.

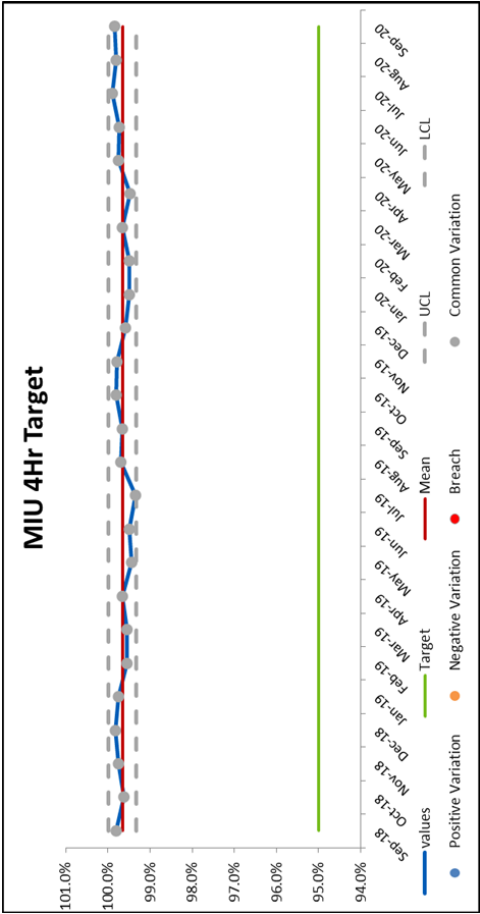


5.1.3 National Child Measurement Programme (NCMP)



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.

5.1.5 GUM 48hr

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

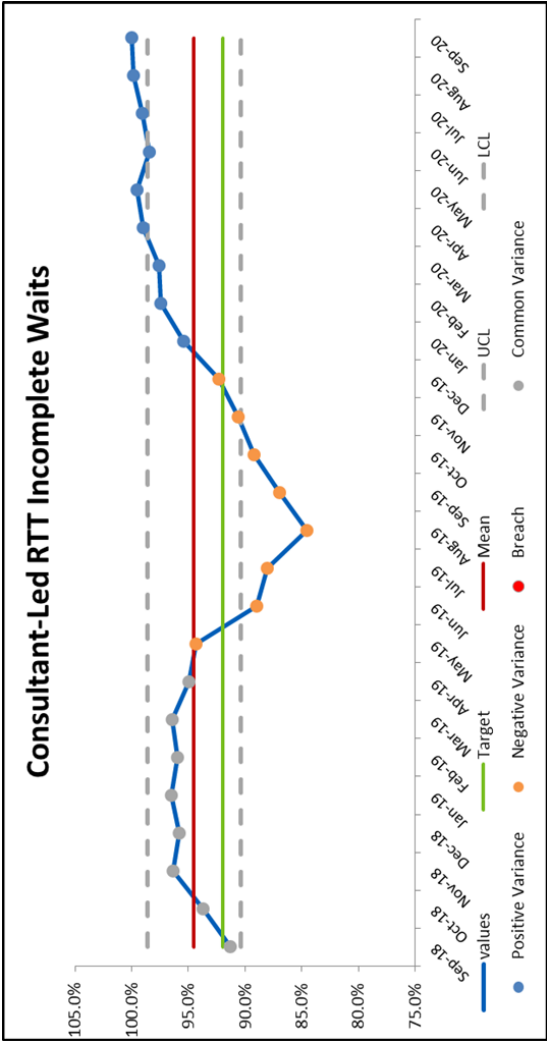
5.1.6 Consultant-Led RTT Incomplete Waits Over 18 weeks

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 3 months) and the Month 6 position being at 100%.

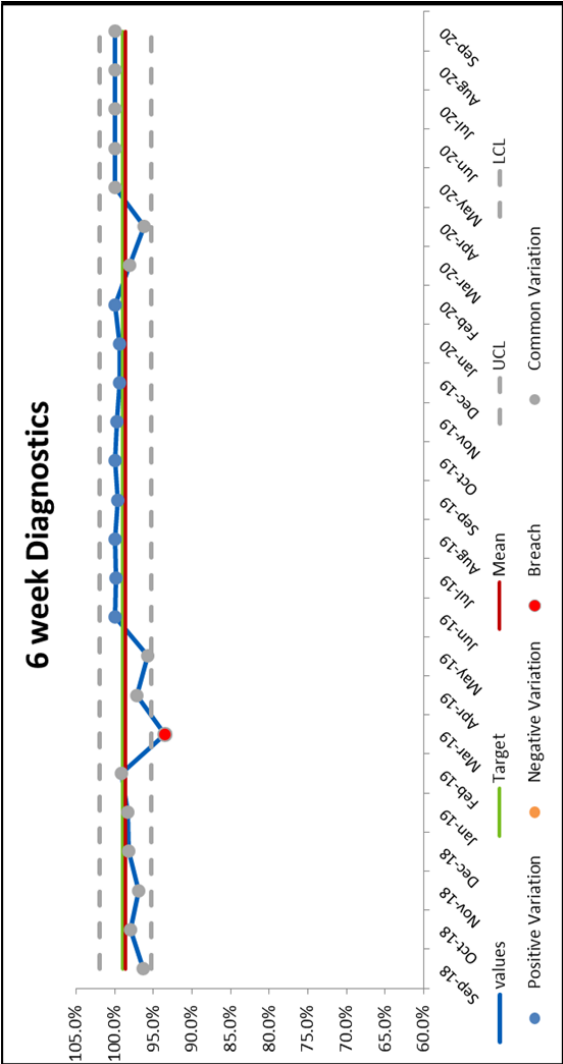
	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	379	92	0	0	0	100.0%
Orthopaedics	1972	31	0	0	0	100.0%
Children's Audiology	191	0	0	0	0	100.0%
Community Paediatrics	417	10	0	0	0	100.0%
KCHFT Total	2959	133	0	0	0	100.0%

The above table shows the current breakdown of the waiting list for all services on a consultant-led pathway. 100% of waits are now below 18 weeks for all service lines. 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)

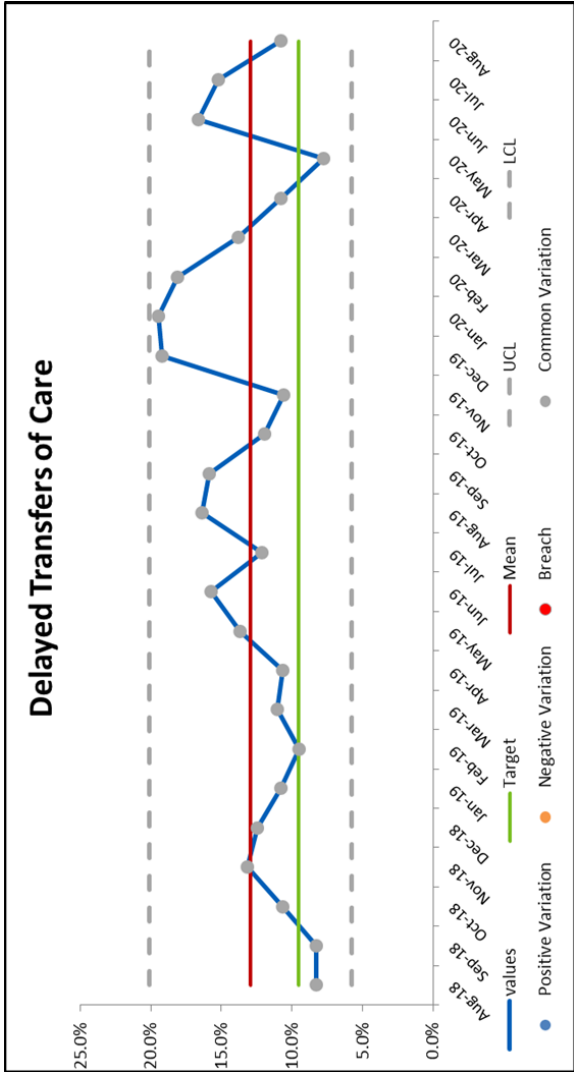


6 week diagnostics waits for paediatric audiology is now in normal variation following a dip in Month 1 to marginally below the mean, achieving 100% in months 2-6

5.1.8 Dental Prisons Waiting Times

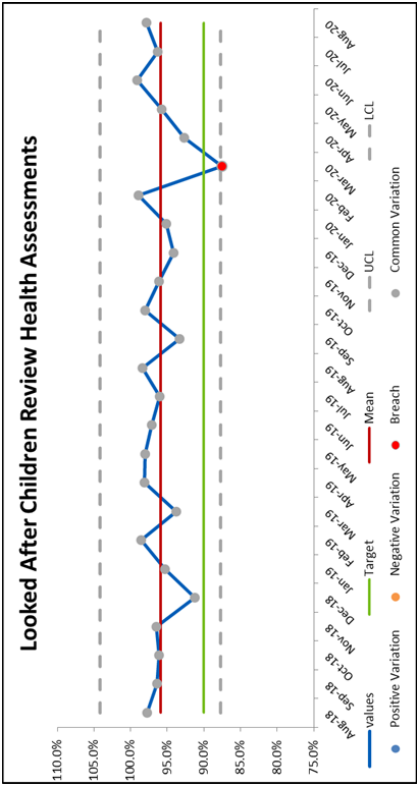
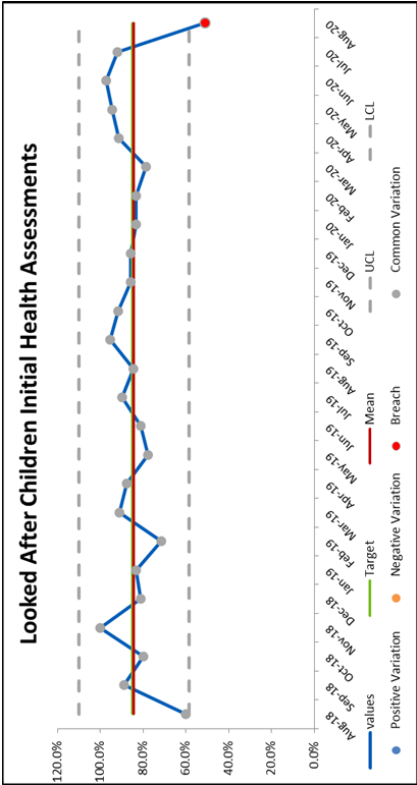
There is currently no wait data for Prisons as sessions are being delivered across the three sites where appropriate and with limited capacity, dependant on the demands and numbers of patients needing to be seen. Standford Hill and Swaleside have not yet fully resumed full access, with only remote phone triage/AAA and attendance for urgent cases.

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 declined in Month 3 although the rate has decreased in months 4 and 5, continuing the fluctuating trend around the mean. The target level continues to be rarely achieved in the current climate (once n last 18 months)

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



Initial Health Assessment (IHA) performance has dropped to only 51% of IHAs being completed within 28 days of child becoming looked after in month 5. This is due to impact of 2 weeks' self-isolation for young people at Oakwood reception centre, as well as challenges with KCC infrastructure within the centre not being able to support all the remote UASC IHA appointments.

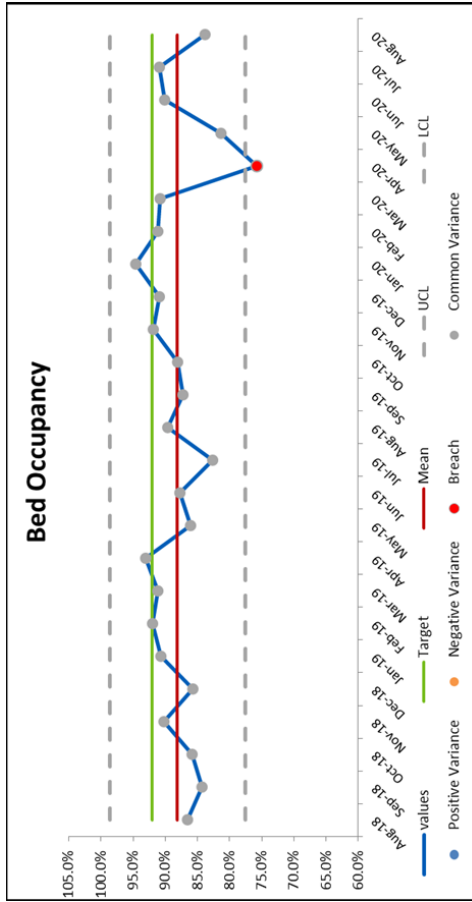
Compliance with the Review Health Assessment target continues to show normal variation following a dip in March 2020. Frequent monitoring through the team weekly calls continues to occur.

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-May 2020 had been affected by the Covid-19 pandemic and the re-reading of wards for the expected demand for Covid-19 patients. As a result the occupancy levels were lower to ensure there was capacity when needed. However the levels from June onwards have increased back up to near the target level of 87% (although dipping below in Month 5)



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

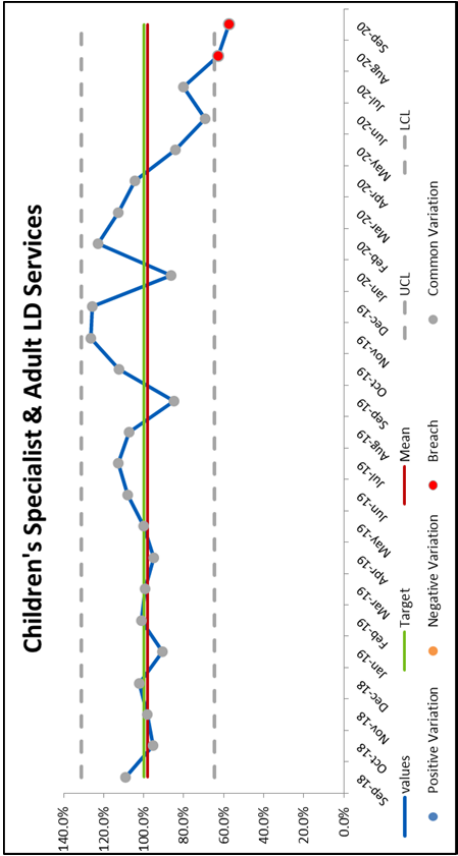
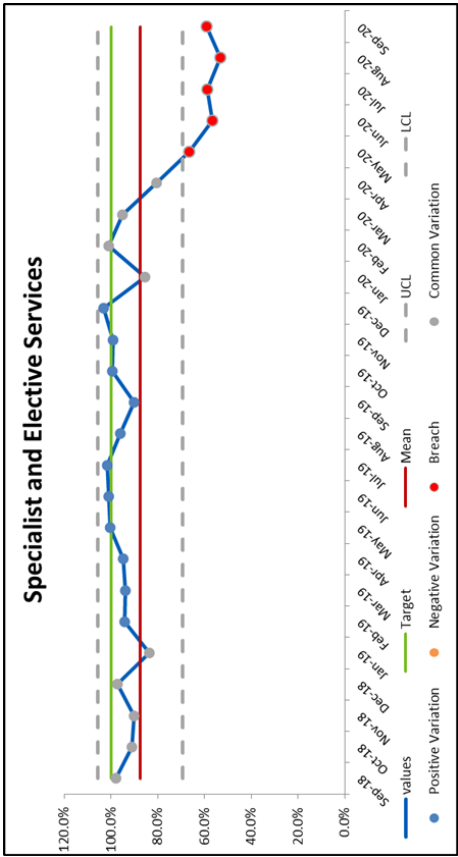
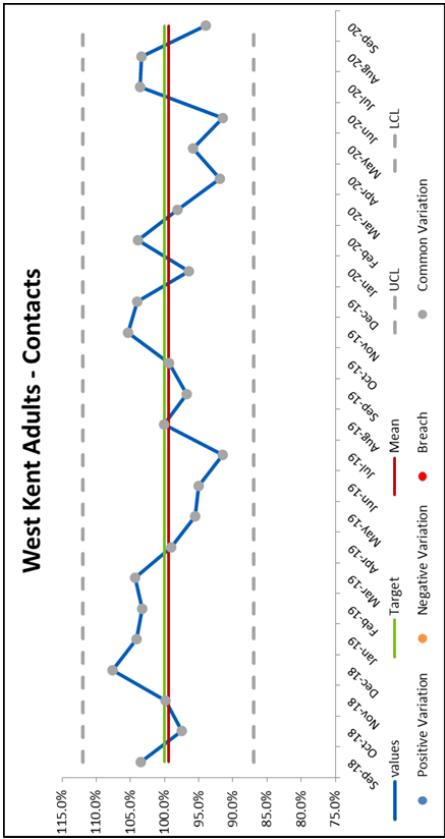
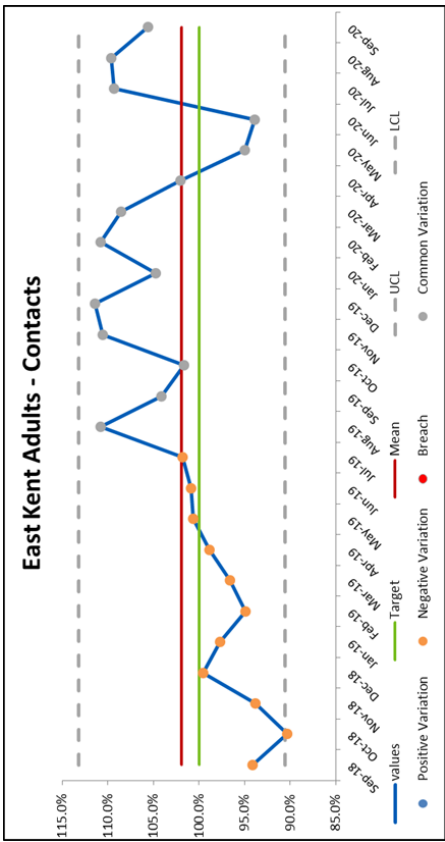
During Month 5 (August 2020) KCHFT carried out 141,103 clinical contacts, of which 10,491 were MIU attendances. For the year to August 2020 KCHFT are 22.3% below plan for all services (some services have contractual targets, some are against an internal plan), predominantly due to the impact of the Covid-19 pandemic. The largest negative variances are within MIUs (-32.7%), Public Health Services (-45.7%) and Adult Specialist Services (-37.7%).

Service Type	M5 Actual	YTD Actual	YTD Plan	YTD Variance	Movement	Internal BRG	Contract BRG
East Kent Adults - Contacts	57,568	276,357	269,172	2.7%	Negative		
East Kent Adults - MIU	3,910	14,791	19,318	-23.4%	Positive		
East Kent Adults - Admissions	97	622	392	58.8%	Negative		
West Kent Adults - Contacts	24,279	124,451	127,454	-2.4%	Negative		
West Kent Adults - MIU	6,581	22,396	35,949	-37.7%	Positive		
West Kent Adults - Bed Days	1,653	8,531	9,338	-8.6%	Positive		
Specialist and Elective Services	17,262	84,244	143,688	-41.4%	Positive		
Children's Specialist & Adult LD Services	10,320	65,667	92,812	-29.2%	Negative		
Public Health Services	17,274	86,351	158,891	-45.7%	Negative		
Dental Service	2,159	4,830	28,438	-83.0%	Negative		
Trust Total Activity against plan	141,103	688,240	885,453	-22.3%	Static		

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

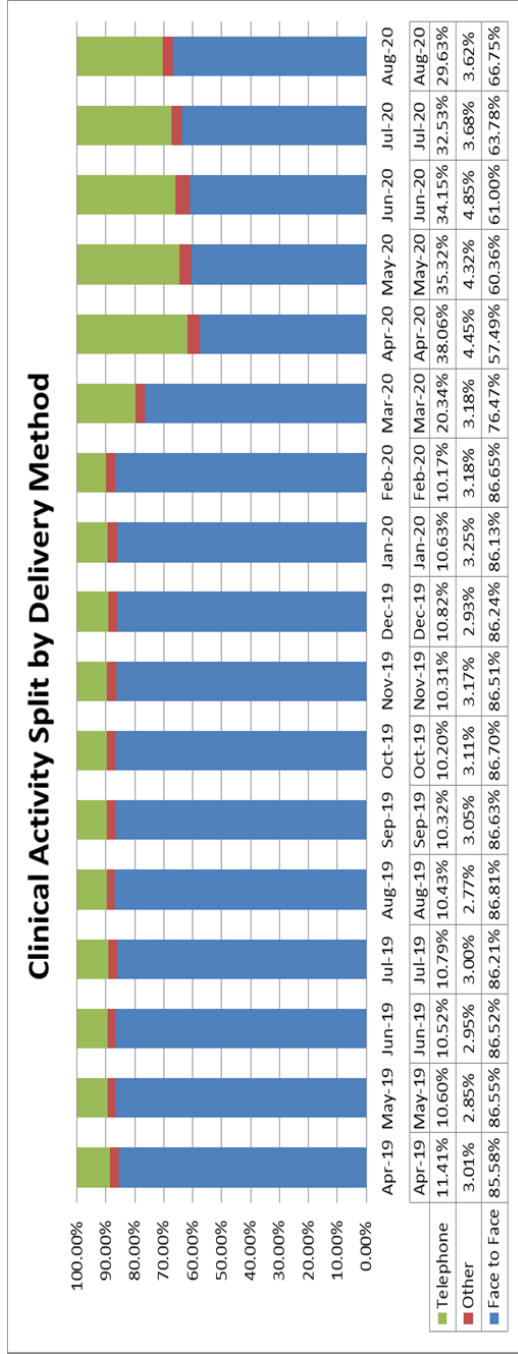
*these figures are not included in the table totals as they don't have a contractual target

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 to August 2020



While activity has decreased as a result of the Covid-19 pandemic, a number of services have re-configured 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 since March 2020 towards telephone and "other" methods of delivery to shift away from face to face to adapt services to the national picture.

With the resetting of some services there has been a small shift back towards face to face clinical activity, although still significantly different top pre-covid levels. Non face to face activity accounted for 33.3% of all activity delivered in August 2020 compared to only 13.2% for August 2020.



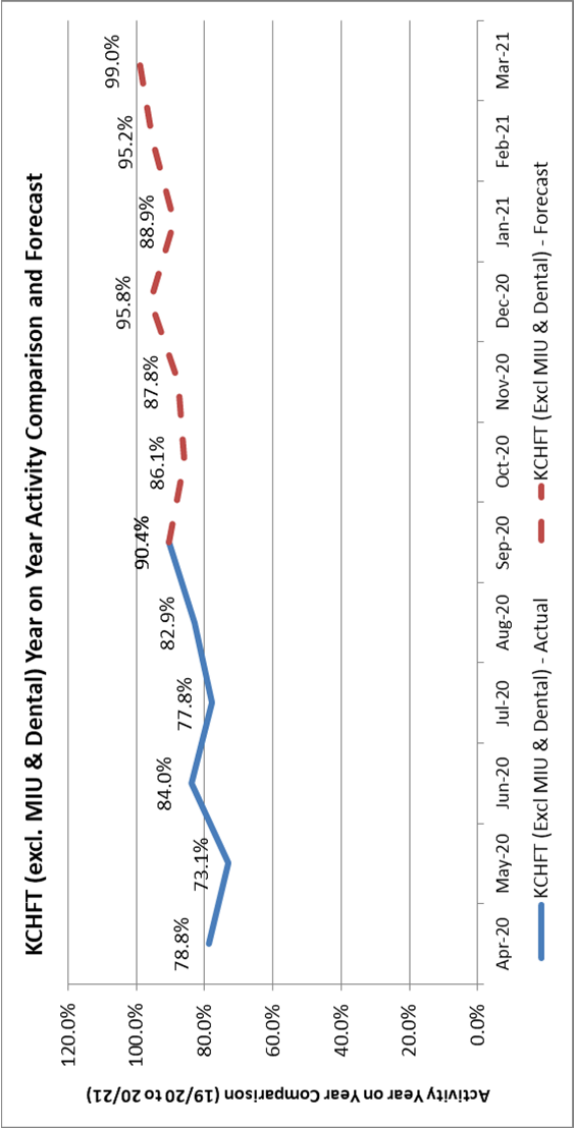
Activity Re-setting

As part of the re-set and re-imagine work, activity levels have been reviewed in comparison to pre-covid levels, predominantly looking at year on year comparisons so the same period of 2019/20.

While, against target, KCHFT is 22.3% behind plan for the year to date, a year on year activity comparison is more helpful in determining the position with regards re-setting of service. The below is an overview of the comparison between August 2019 and August 2020 activity levels across the divisions.

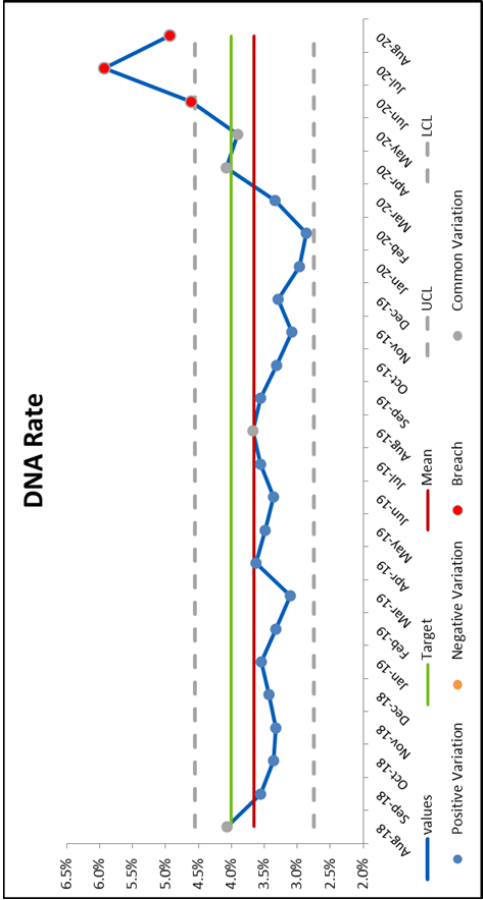
	Aug-19 to Aug-20 Comparison
East Kent Adults (Excluding MIU)	2.7%
West Kent Adults (Excluding MIU)	-5.2%
Adult Specialist and Elective	-32.9%
Children's Specialist & LD	-31.5%
Public Health Services	-34.9%

With a view to increasing activity levels back to pre-covid as soon as is reasonably possible, services have drawn up activity forecasts to the end of the financial year which have been used to draw up the following trajectory.



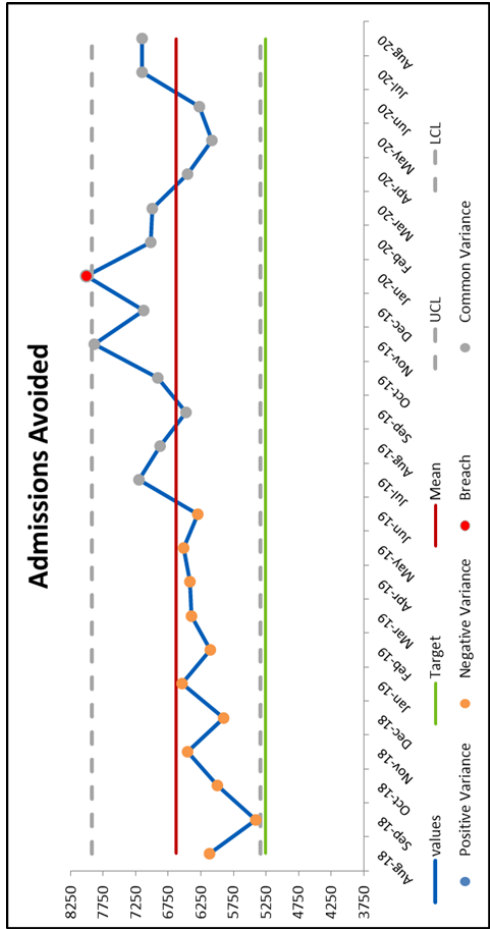
The above chart indicates that, excluding MIU and Dental, the estimate for September is that we will be at 90.4% of activity compared to September 2019. While this is expected to dip slightly in October/November, we are forecasting to increase back up to 95.8% in December. January 2021 is predicted to be a little lower, but with levels increasing back up to 99% in March 2021.

2.2 DNA rates



DNA rates have traditionally fallen below the target of 4%, although there has been an increase in months 3-5 to above the upper control limit as a result of Covid-19 pandemic. This has been caused by more DNAs for virtual appointments, plus an effect of the move to RIO and staff getting to grips with how to record DNAs on the new system. It is expected DNA levels will drop back down and stabilise following further clarification for staff on the use of RIO

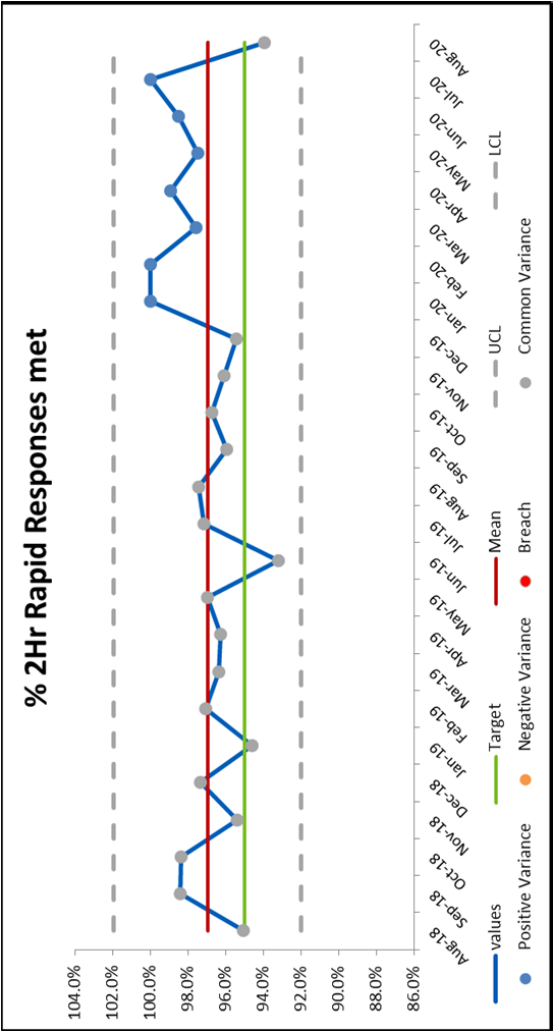
5.2.3 Admissions Avoided



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.

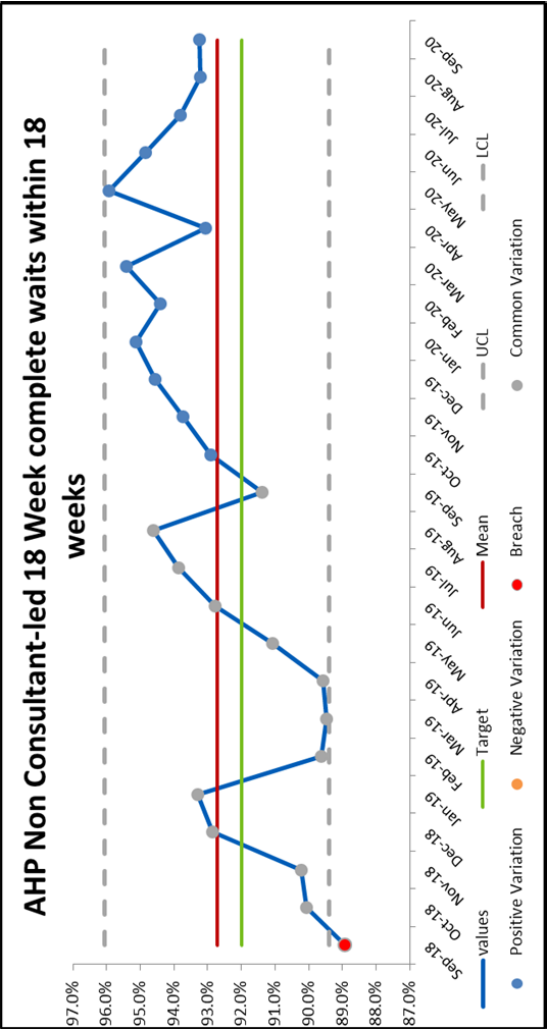
5.2.4 Rapid Response referrals seen within 2 hours

The mean level of performance is sitting above the target level of 95%, with performance in normal variation despite a marginal dip in month 5. 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 there are few initial appointment backlogs and performance is consistently hitting the target



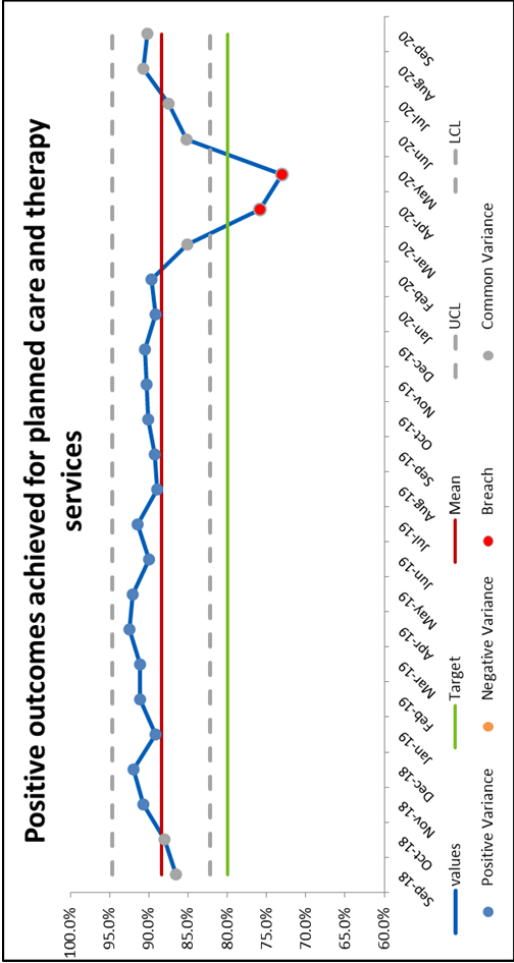
5.4 Covid-19 Related Backlogs

Specialist and Elective services have continued to offer appointments 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, as evidenced by the activity levels in the previous section. 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 has been restricted e.g. podiatric surgery, group work, MSK injection therapy and provision within schools. Trajectories for recovery were developed and are shared with the Trust’s recovery task and finish group and monitored monthly.

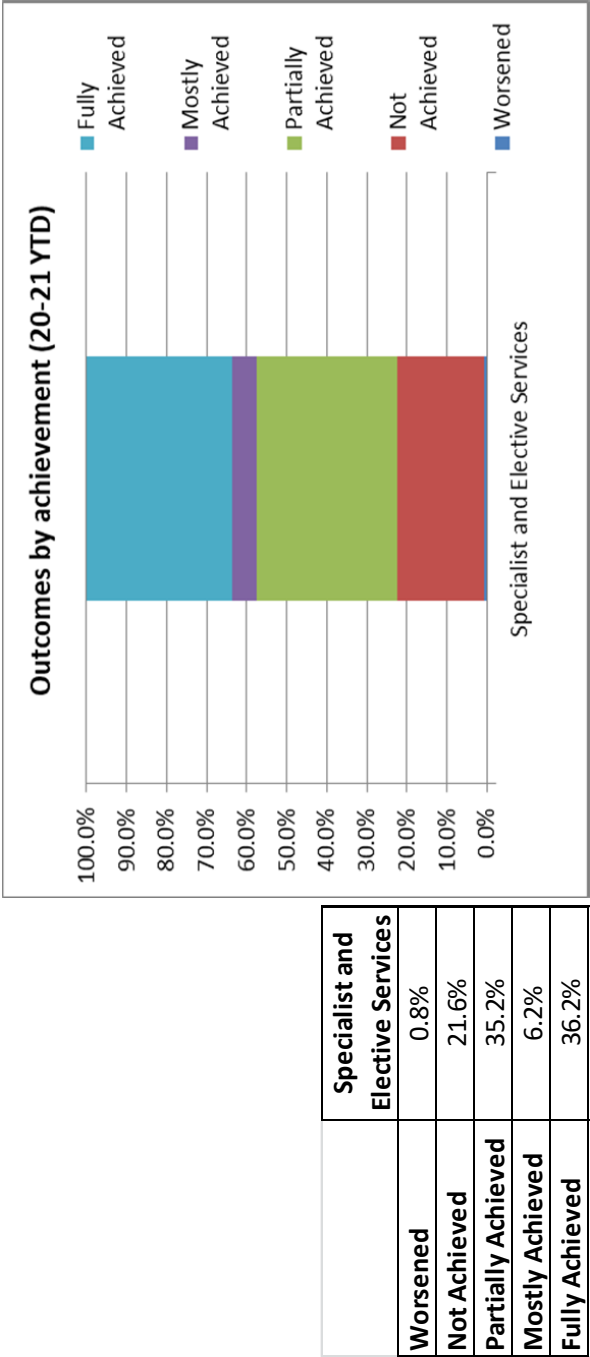
Plans continue to increase face to face clinic access further following approval by the reset working group and all services have recovery plans in place which are reviewed by the SES CSDs, Performance managers and Heads of Service.

5.5 Outcomes

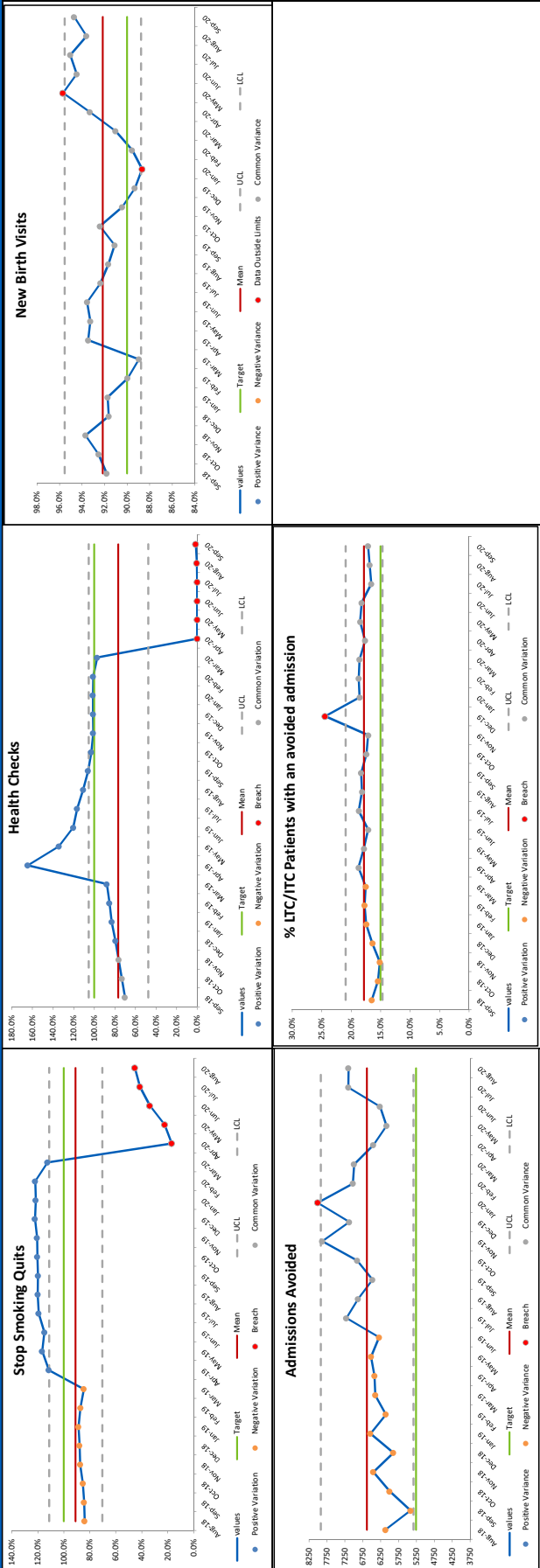
Aggregate outcomes are currently reported for Adult Specialist and Children’s Therapy services, with patients receiving a favourable outcome in the vast majority of cases on a consistent basis. The below shows that negative special cause variation occurred in Months 1 and 2, with the cause as a result 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 month 6. 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.



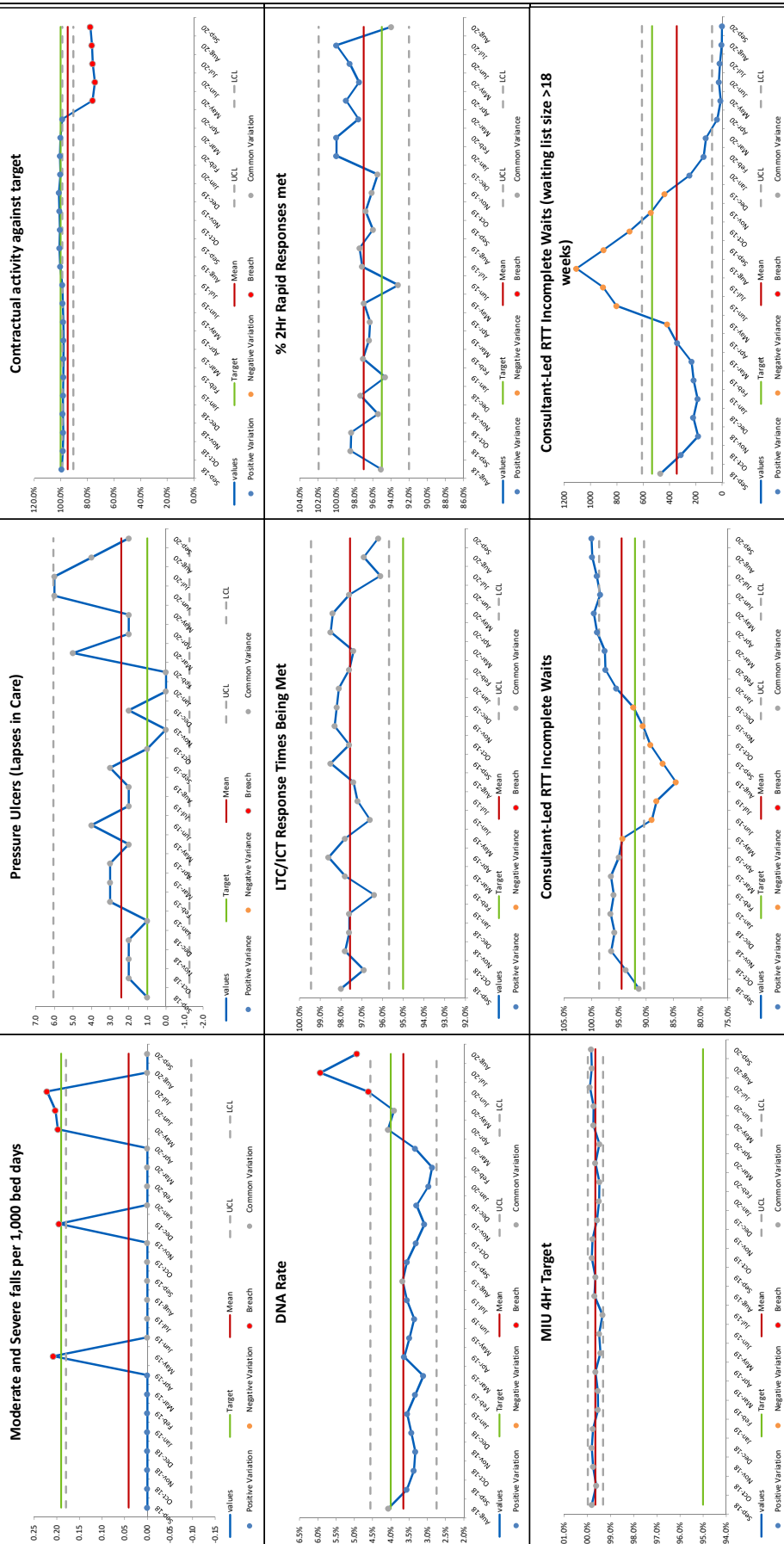
The following table and chart shows the proportion of the grading of each outcome for the year to date. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised. Currently reported as Adults only until reporting is finalised from RIO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



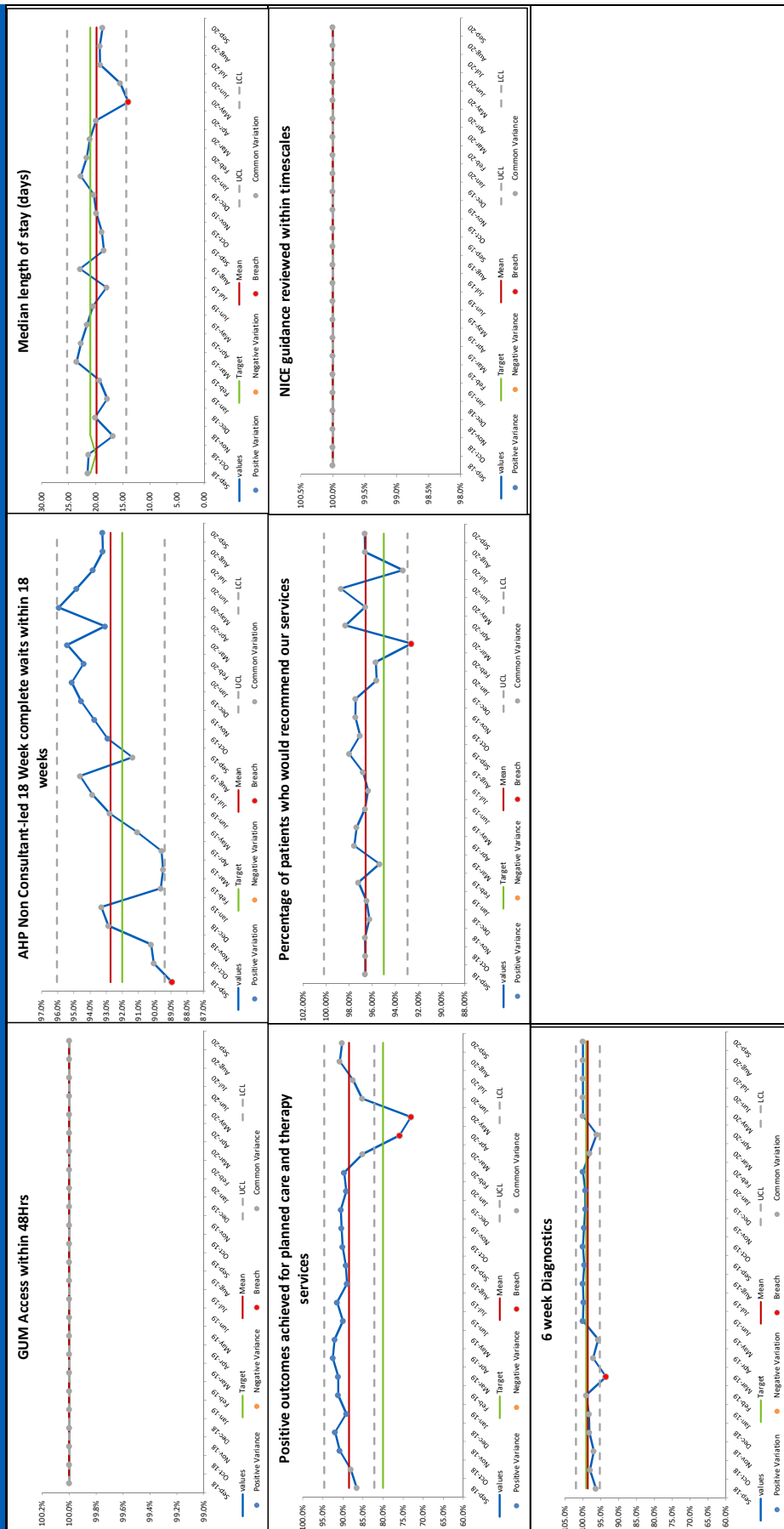
1. Prevent Ill Health



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

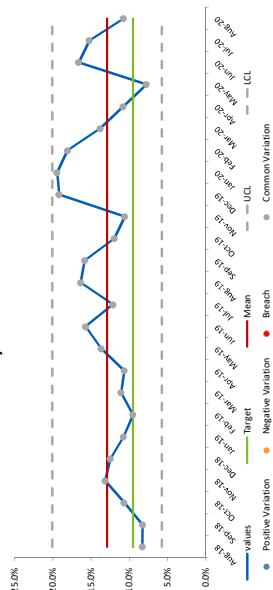


2. Deliver high-quality care at home and in the community

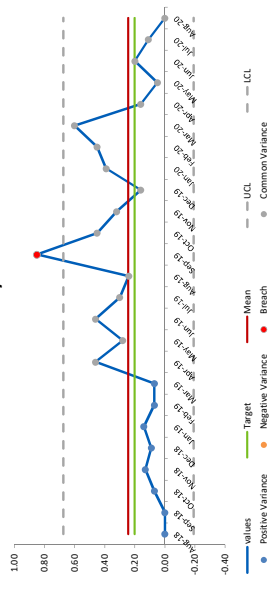


3. Integrate Services

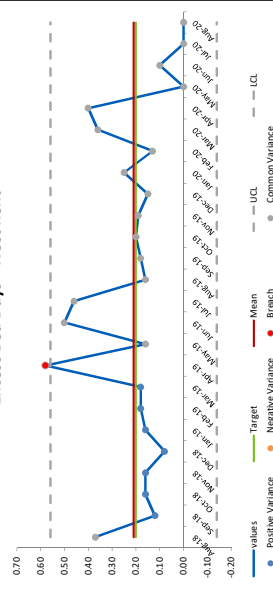
Delayed Transfers of Care



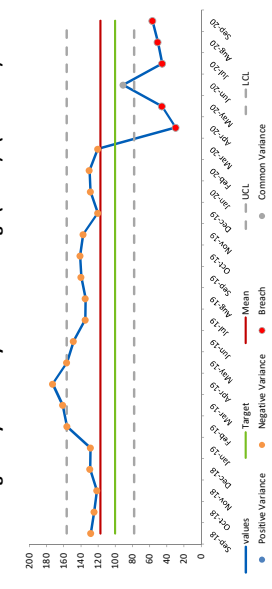
Excess Bed Days - East Kent



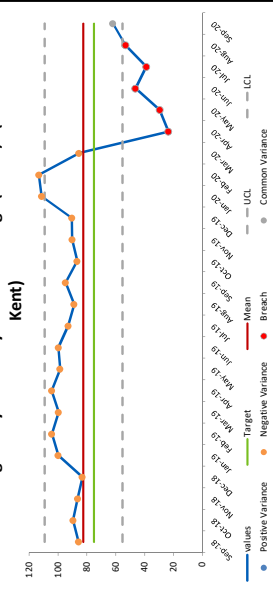
Excess Bed Days - West Kent



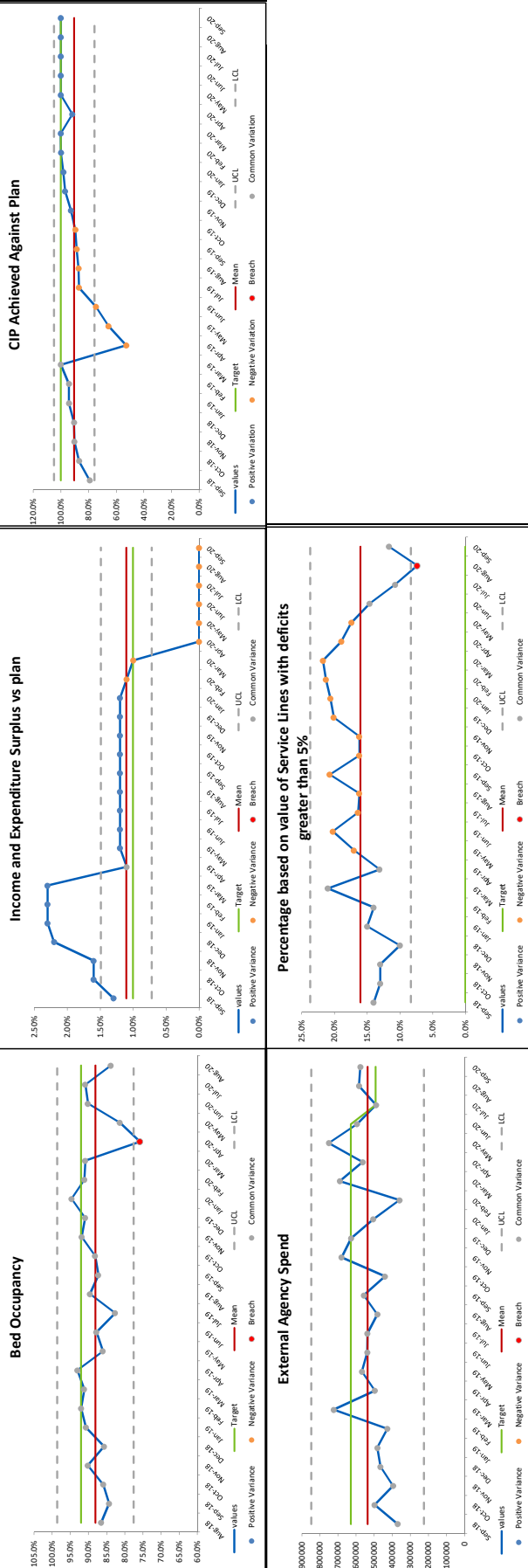
Average Daily Medically Fit For Discharge (MFFD) - (East Kent)



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

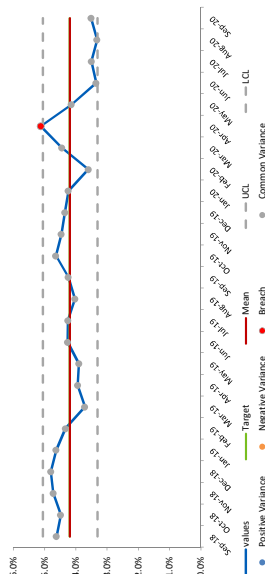


4. Develop sustainable services

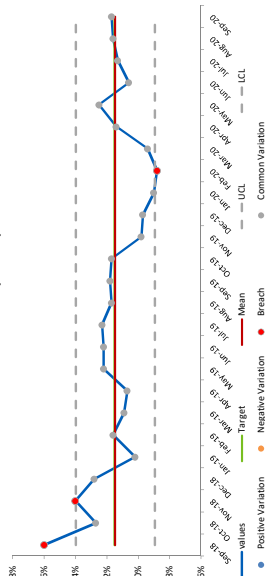


5. Be The Best Employer

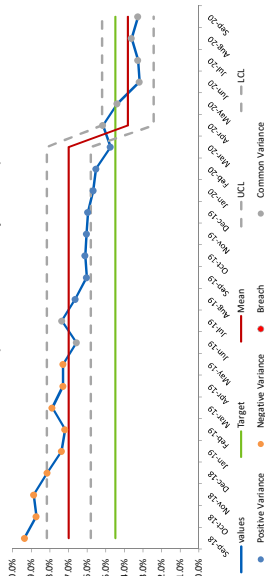
Sickness Absence - in month



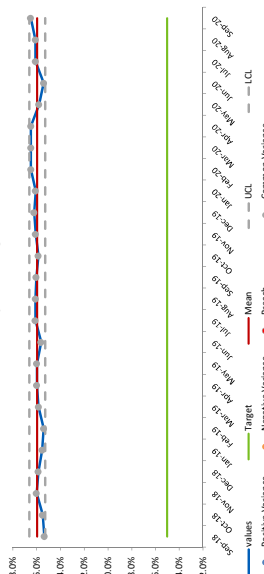
Absence (Stress)



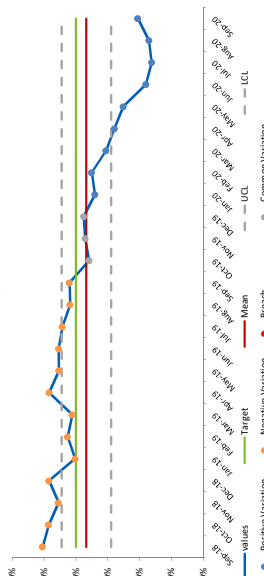
Turnover (Planned and Unplanned)



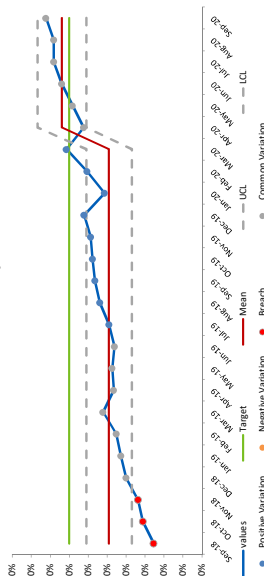
Mandatory Training Rate



Vacancy Rate



Stability



Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	4.1
Agenda Item Title:	Audit and Risk Committee Chair's Assurance Report
Presenting Officer:	Peter Conway, Chair of Audit and Risk Committee

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report history and purpose
The report summarises the Audit and Risk Committee meeting held on 26 August 2020 and provides assurance to the Board.

Summary of key points

Equality impact assessment (EIA)
An equality impact assessment has not been completed as this is an assurance report and no decisions are required. Papers received at the meeting had undertaken an equality impact assessment.
Proposal to the Board
The Board is asked to receive the Audit and Risk Committee Chair's Assurance Report.

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

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

This report is founded on the Audit and Risk Committee meeting held on 26 August 2020.

Area	Assurance	Items for Board's consideration and/or next steps
Risk Management	<p>1) <u>Board Assurance Framework (BAF)</u>: the more dynamic register is working well. Timeliness and relevance of some actions remain work-in-progress.</p> <p>2) <u>Risk Management during COVID and appetite</u>: preliminary discussions covering higher risks during and post COVID, new and good working practices such as virtual risk clinics, more dynamic risk management and risk appetite/tolerances.</p>	<p>1) Further improvements planned for the BAF including streamlining, the better connection of actions with gaps and the inclusion of a "target risk appetite" column.</p> <p>2) Common principles and thoughts agreed (particularly the focus on outputs being practical) and to be worked up for (1) Exec consideration, (2) review by ARAC in November and then (3) full Board endorsement.</p>
Assurance (Third party)	<p>1) <u>Internal Audit</u>: Five audits completed all reasonable with one substantial. No high priority recommendations. 11 actions on director's risk registers past review or incomplete. Annual Plan reviewed and revised in the light of COVID.</p>	<p>1) Future audits to include a quick look back at COVID experience to provide assurance that processes remained effective during the "governance lite" period. Recruitment audit to be replaced by Reset Plans Audit and Implementation of Self-Managed Teams put back into next year. Overdue actions to be reviewed to support hypothesis that it is a process issue rather a systemic weakness.</p>

Area	Assurance	Items for Board's consideration and/or next steps
	<p>2) <u>Counter Fraud</u>: usage of electronic devices and mobiles in particular emerging as COVID related weak spots. Annual Plan agreed comparable with previous years and based on Trust's latest risk profile.</p> <p>3) <u>External Audit</u>: Final Annual Audit Letter noted.</p>	<p>2) Whole area of electronic devices and cyber to be tightened up with target completion of March 2021. One supplier fraud reported which requires further consideration of the wider implications</p> <p>3) Value for Money Audit arrangements changing for next year - detail awaited.</p>
Assurance (Internal)	<p>1) <u>Standards of Business Conduct Annual Review</u>: positive assurance.</p> <p>2) <u>Use of Trust Seal Annual Review</u>: positive assurance.</p> <p>3) <u>Annual NHS Provider Licence Self-Assessment Review</u>: positive assurance.</p> <p>4) <u>Corporate Assurance and Risk Management (CARM)</u> activity: some slippage because of COVID - eg. fire safety training levels (82%), fire compliance for community hospital wards (85% level to be restored by end August), Rio related patient information incidents (majority of total 2820 incidents reported on Datix in the last quarter) and 64 risks open for more than one year.</p> <p>5) <u>Cyber Security</u>: positive assurance. Good response to COVID challenges including appropriate higher risk tolerances to facilitate better outcomes for patients</p>	<p>1) Some slippage because of COVID which will be caught up. Counter-fraud to review declarations of gifts by clinical staff.</p> <p>3) Assurance process to be re-imagined for next year making it more risk based and lighter touch.</p> <p>4) All items to be investigated and remediated soonest.</p> <p>5) Next review by ARAC in February 2021.</p>

Area	Assurance	Items for Board's consideration and/or next steps
	and staff. 6) <u>Physical Security (including loan working, building security, fire safety and Health and Safety):</u> positive annual review.	
Financial Reporting and Controls	1) <u>Single Tender Waivers and Retrospective Requisitions:</u> positive assurance. 2) <u>Payments and Debt Write-offs:</u> positive assurance.	
Other	Audit and Risk Committee (ARAC) reimagine aspirations explored.	Continued focus on risk based assessments, greater insights arising from data and less paper.

Peter Conway
Chair, Audit and Risk Committee
August 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	4.2
Agenda Item Title:	Finance, Business and Investment Committee Chair's Assurance Report
Presenting Officer:	Paul Butler, Chair of Finance, Business and Investment Committee

Action - this paper is for:	Decision <input type="checkbox"/>	Information <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>
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Report history and purpose
The paper summarises the Finance, Business and Investment Committee meeting held on 29 September 2020 and provides assurance to the Board.

Summary of key points

Equality impact assessment (EIA)
An equality impact assessment has not been completed as this is an assurance report and no decisions are required. Papers received at the meeting had undertaken an equality impact assessment.
Proposal to the Board
The Board is asked to receive the Finance, Business and Investment Committee Chair's Assurance Report.

Paul Butler	Tel: 01622 211906
Non-Executive Director	Email:

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on Tuesday 29 September 2020.

Issue	Committee review and assurance	Matters for Board awareness and/or action
System and Trust Forecast	Paper presented on scenarios of financial outcome for 2020/21 financial year, given best available information on how the second half of financial year could "pan out"	The forecast suggests worst case scenario of £4.0m deficit but this comes with many caveats.
Finance Report for ytd August 2020	Additional COVID costs of £5.3m ytd (excluding costs incurred for hospital discharge programme) highlighted in Finance Report with an assumption of recoverability assumed.	This will need to be monitored further by the Committee when we next meet in November. The Director of Finance has been specifically asked to assess implication on KCHFT of shortfall position in 2020/21 at STP level as more information becomes available.
2021/22 Cost Improvement Plan (CIP) Approach	Paper setting out approach to oversee establishment if 2021/22 CIP programme presented. The target is £4.4m cost reduction which represents 1.85% of total opex - this compares with an NHS target figure of 1.1%.	

Issue	Committee review and assurance	Matters for Board awareness and/or action
Environmental Sustainability Strategy (ESS) 2021-26	Paper presented on ESS 2021-26 which had previously been signed off by the Executive on 15 September 2020.	The Committee ratified ESS as presented.
Business Development Report	<p>Report discussed, and it is clear, that there is ongoing significant business development activity.</p> <p>Agreed that report should be expanded to cover strategic intent with potential future pipeline highlighted to reflect envisaged regional delivery changes and opportunities.</p>	<p>As part of the Board/Committee reset it is important that the Board concludes on how/where business development activity will be discussed / assured. This needs to be clarified not only in terms of potential value and risk assessments associated with “take -on” of new business but also in terms of remits throughout period from inception discussions to signed contract.</p>
Electronic Patient Record Risk Register	Presentation on status of project was received.	Project is in good position and it was agreed that further “deep dive” papers would not be required – with risk issues being picked up as part of the Board Assurance Framework (BAF) review.
Kent and Medway Care Record	Short demonstration of system front end given.	As part of BAF review at the November Committee meeting, assessment will be made of the need for a follow up

Issue	Committee review and assurance	Matters for Board awareness and/or action
		presentation in January by the project director.
Investment and Cash Review	Paper setting out projected cashflow/balance position through balance of FY2020/21 was presented. The paper confirmed that based on forecast there was adequate headroom against any potential public dividend liability.	It was agreed that the cash balance would stay with government rather than seek any third party commercial deposits.
National Cost Collection Review	Paper setting out methodology to be used for collation of reference costs for 2019/20 which needs to be submitted by 29 October was reviewed and noted by the Committee.	

Paul Butler
Chair of Finance, Business and Investment Committee
30 September 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	4.3
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Pippa Barber, Chair of Quality Committee

Action - this paper is for:	Decision	<input type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input checked="" type="checkbox"/>
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Report history and purpose
The report summarises the Quality Committee meeting held on 22 September 2020 and provides assurance to the Board.

Summary of key points

Equality impact assessment (EIA)
An equality impact assessment has not been completed as this is an assurance report and no decisions are required. Papers received at the meeting had undertaken an equality impact assessment.
Proposal to the Board
The Board is asked to receive the Quality Committee Chair's Assurance Report.

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

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report follows the Quality Committee Part One meeting held on 22 September 2020.

Agenda item	Assurance and Key points to note	Further actions and follow up
Matters arising: Learning from Patient story to the Board	Assurance was received on the actions and learning in place and that the family are very helpfully now part of the East Kent patient group to ensure wider learning continues to take place. The Trust has now formally responded to the family following the initial complaints setting out the learning that has taken place.	
Learning from COVID-19 and its impact on black, Asian and minority ethnic (BAME) groups and hard to reach groups	Discussion took place on the work that is going to take place with Diversity House to support people with a BAME background when the new post holder is appointed.	A further update will be provided in November on how patients on caseloads from the specialist respiratory, cardiac and diabetes teams and BAME are being considered and specifically hard to reach groups.

Agenda item	Assurance and Key points to note	Further actions and follow up
Terms of reference (ToR) and strategic oversight of Trust Strategy	The Committee agreed to continue to revise and update the ToR with the aim to sign off in November. The agenda for the September meeting was beginning to be shaped by the governance refresh and the need for the Committee to oversee elements of the Trust's strategic plan.	<p>The Executive Team will give further consideration to setting out the specific requirement of each of the strategic objectives to enable each committee to be clear on its oversight objective.</p> <p>A more detailed update will be provided for each of the strategic objectives for our November meeting and actions being taken and risks identified. A specific inclusion will be KCHFT support of the care home sector.</p> <p>The process for undertaking harm reviews will be shared with the Committee before the next meeting by the Chief Nurse.</p>
Quality Report	Assurance received on a number of quality areas. Medication incidents will be followed up in our November meeting. Assurance was received on staffing in the inpatients areas (Westbrook will now remain open as a ward and will be added to the report) with further assurance received in the meeting on the safer staffing model that will enable sight of acuity, number of patients and skill mix to enable support to be identified for community teams under pressure.	

Agenda item	Assurance and Key points to note	Further actions and follow up
Rio Care Planning	<p>Feedback from the non-executive director (NED) visits indicated some concerns regarding planned implementation of Rio into the Adults services. Assurance was received on how this will be undertaken with support in place across the service to identify staff/clinical issues and to respond to concerns when it is rolled out to this service.</p> <p>The Committee received a brief demonstration on the new functionality of the Rio care plan. Previous SIs have indicated how important a risk mitigation tool the care plans are.</p>	<p>A number of We Care visits are currently being undertaken to Adults services. A themed report will come back to the Committee following completion of this phase of the We Care programme.</p> <p>The Chief Nurse will follow up the audit of care plans to ensure the personalised nature of the plans is effective.</p>
Pressure ulcer action plan deep dive	<p>The pressure ulcer action plan was considered as a deep dive as this remains an area of ongoing quality focus for the Trust. Lapses in care indicate the ongoing need for a further review of the action plan across the Trust. Consideration will be given to a Trust wide Quality Improvement (QI) approach to pressure ulcer care providing support to particular teams.</p>	<p>It was agreed this is a priority area and an updated plan will be brought back to the Committee in November.</p>
Board Assurance Framework (BAF)	<p>Written assurance was received that the Care Quality Commission (CQC) was content with the Infection Prevention and Control (IPC) BAF report and the</p>	

Agenda item	Assurance and Key points to note	Further actions and follow up
	<p>subsequent assurance call with Chief Nurse. The Trust has effective IPC systems in place. CQC specific assurance received included; a thorough assessment of IPC across all services had been carried out. Specific SOPs were in place, with clear lines of accountability. Appropriate systems for identifying people who have, or are at risk are in place. Appropriate cohorting and isolation and staff training are in place. Finally and importantly the Trust continues to provide information for patients/carers and the wider public on their website and wider media. Assurance was received verbally that the accessibility of testing had improved since the IPC BAF had been undertaken.</p>	
<p>KCHFT Participation, engagement and experience, work plan progress report</p>	<p>The Committee received an update on the plan to date. Good progress has been made with the plan. However with the priorities of the last six months there will be some reset work with completion plans revised. The ambition to set up a Peoples Network is work in progress. Some progress has been made. However, the target date has realistically been slipped to March 2021.</p> <p>The need for volunteers of all ages and the impact they can have on co-production of the service offer was discussed with recognition of the challenges of this in the</p>	<p>An update on progress with the whole work programme will come back to the Committee in January.</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
	current climate.	
End of life care (EOLC) deep dive report	<p>The Committee received a report into EOLC work across the Trust and a review of the period June to August. Significant collaborative responsive work was completed across the Trust during the peak of COVID-19. Audits are in place to monitor effectiveness. Work is ongoing on this, led by our newly appointed Consultant Nurse. Areas of work include: a review of competencies and skills training, a review of the EOL Champion role, and the need to ensure we are embedding learning with an after action review methodology following audits including Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Finally ensuring our EOLC strategy is reviewed and co-produced with stakeholder engagement.</p> <p>Any rapid learning is being picked up as part of the We Care visits so a targeted approach and support for teams can be considered.</p>	The EOLC steering group will oversee the refreshed work programme for this work.
Learning From Deaths Annual Report	The annual report (September 2019-August 2020) was considered by the Committee. No deaths had been judged more likely than not due to problems in healthcare in line with NHS England (NHSE) guidance. The number of deaths in scope for this review process increased during	

Agenda item	Assurance and Key points to note	Further actions and follow up
	<p>April and May compared to previous years due to the COVID-19 pandemic. Areas of good practice and learning are being identified and methods for sharing across the Trust .The mortality surveillance group continued to meet over the period (virtually over the last few months) to ensure reviews were being undertaken in a timely way. The work links to the EOLC steering group.</p>	
Flu vaccinations to vulnerable groups	<p>The need to ensure the Trust's staff flu vaccination uptake rate continues to improve is being overseen by the Strategic Workforce Committee (SWC). The Quality Committee has requested a further update on the work being undertaken by the Trust to provide flu vaccinations to appropriate vulnerable patients with the increased clinical risk this year due to COVID-19.</p>	<p>An update report will be provided on patient flu vaccinations in November.</p>
Quality Improvement (QI) update	<p>This report was requested by the Committee last time to ensure ongoing focus on this critical enabler as part of our reset and reimagine plans. Assurance was received that the QI digital offer is being strengthened, divisional forums have restarted from this month and the QI methodology has been incorporated into the reset evaluation framework.</p>	<p>Ongoing focus on the QI sponsor role is taking place as a key element of phase two of the QI strategy and training will restart in January. The Committee will receive updates via the Clinical Effectiveness Group and in addition twice yearly via a QI Strategic and Performance update. Evidence of sharing best practice QI</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
		projects and Trust wide initiatives will be highlighted.
Ratification of policies	The Committee ratified the following two policies: MM013 Controlled Drugs Policy MO16 Injectable Medicines Policy	

Pippa Barber
Chair, Quality Committee
September 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	4.4
Agenda Item Title:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Chair of Strategic Workforce Committee

Action - this paper is for:	Decision <input type="checkbox"/>	Information <input type="checkbox"/>	Assurance <input checked="" type="checkbox"/>
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Report history and purpose
The report summarises the Strategic Workforce Committee meeting held on 23 September 2020 and provides assurance to the Board.

Summary of key points

Equality impact assessment (EIA)
An equality impact assessment has not been completed as this is an assurance report and no decisions are required. Papers received at the meeting had undertaken an equality impact assessment.
Proposal to the Board
The Board is asked to receive the Strategic Workforce Committee Chair's Assurance Report.

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

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on 23 September 2020.

Agenda item	Assurance and Key points to note	Further actions and follow up
Workforce report Board Assurance Framework (BAF) risk 73	Positive assurance in relation to the workforce dashboard. Noted increase in stress levels resulting from number temporarily redeployed, now with enhanced support. Lowest sickness numbers in Kent and Medway achieved by proactive personal protective equipment (PPE) education and supply. Recruitment hotspots including Faversham and Deal have heightened attention. Expected increase of 226 WTE in east Kent, children's specialist services, West Kent, and Specialist and Elective Services. Risk assessment of all black, Asian and minority ethnic (BAME) complete with some further home working assessments outstanding. Strategic Workforce Committee effort to support the achievement of Kent and Medway recovery plan underway.	Strategic workforce initiatives and focus to support the Kent wide system integrated care partnership (ICP). Integrated care system (ICS) and sustainability and transformation partnership (STP) will be reported through the bi-monthly workforce report.
Operational Workforce Report	The Incident Management Team now defined as the Integrated Management meeting is now preparing for the second wave using lessons learnt. The redeployment exercise has enabled a 'ready to go pool'. Critical work is being done with Kent County Council (Further consideration to the 'integrate services' outcomes and their key metrics will be covered in the Operational Workforce

Agenda item	Assurance and Key points to note	Further actions and follow up
	KCC) to integrate patient pathways, giving patients a single point of contact, effective triage and benefits to effective workforce utilisation.	report picking up issues working with partners including Kent County Council (KCC) and primary care networks (PCNs), reducing regulator intervention and reviewing our care home offering.
Significant Employee Relations Report Employee Relations Lessons Learnt	<p>Only one member of staff is currently suspended. Since the beginning of 2019, the Trust has successfully defended all four of the tribunal claims made against it.</p> <p>A huge amount of work has taken place to learn lessons to improve service delivery, including lessons about quality, resource levels and the complexity of cases requiring regular case reviews. Greater collaborative working and support to managers on 1,254 occasions as well as absorbing staff side activity has resulted in a well-earned recognition in terms of external validation - Merits awarded for CIPD level 7 employment law and becoming a finalist in the Disability Confident category in the Recruitment Industry Disability Initiative RIDI awards. A full learning and sharing calendar is set out for 2020 /2021.</p>	The Committee will review the external legal spend on cases.

Agenda item	Assurance and Key points to note	Further actions and follow up
Recruitment and Retention	<p>Achievements include vacancy rate of 3.2% reduction of 5.6% over last year. Turnover rate is 13.6% reduction of 3% compared to last year. Bank shift rate was 69.17% in July compared to 54.7% in July 2019 a 15.1% improvement. 100% increase in recruitment activity during COVID April - June 2020. 276 substantive staff and 145 bank staff started in post in the last 3 months. All changes to processes that occurred as a result of COVID have remained in place due to their success. Further enhancements are being introduced for internal transfers and supporting services in the best way possible when issues arise. Many retention schemes have been introduced across the whole Trust but also localised to address specific issues. Both the future recruitment plans and many of the retention initiatives will form part of the 2021 – 5 People Strategy.</p>	
Pay, Recognition and Benefits	<p>Most of the staff terms and conditions are set nationally. At the centre they are concluding a three year pay deal. Expectations need to be managed due the challenging last six months and the absence of a large pot.</p> <p>Badges and letter have been received by all staff thanking them for an exemplary contribution. Vouchers from the Charitable Trust will be distributed week commencing 28 September, from the NHS charities award.</p>	<p>Draft 'management of expectations' communication for staff to express appreciation and manage hopes over level of increase likely.</p>

Agenda item	Assurance and Key points to note	Further actions and follow up
Staff Engagement – Big Listen 2	22.5% participated plus 15 MS Team focus groups. Benchmark with original Big Listen – 21% said they would consider leaving if offered another job compared to 41% in 2018. 39% said they would stay compared to 20% in 2018. People's experiences of COVID were polarised, but valuable lessons were learnt. Useful information was extracted to inform the draft People Strategy.	
Medical Validation	The Committee received the annual report to obtain assurance that all licensed doctors are up to date and fit to practice. Appraisal and revalidation were complete. Development as well as ongoing appraisal and validation stalled by NHS England April – September then to December being encouraged to pick it up now with an emphasis on wellbeing and development.	
Safer Staffing Report	2018 Developing Workforce Safeguards document set out the requirement for a safer staffing review in community nursing. A comprehensive review shows a significant opportunity for optimisation of the electronic rostering system. Currently not being used to its full potential with 20 – 40% changes to the e-roster and does not track the work of advanced clinical practitioners (ACPs). Further work will help better utilise unused hours. This will be achieved partly with the introduction of a 'safer care module', due for implementation in January. The parameters that are in use enable provision of assurance around the quality of care but a nuance	

Agenda item	Assurance and Key points to note	Further actions and follow up
	around acuity and patients' occupancy will enhance the value of this work.	
Staff Flu Vaccination	Using learning to inform programme with 60% being the best take up to-date. Looking to achieve 100% but recognition that 15% refuse and it is not mandatory, despite critical to maintain wellbeing through winter. High numbers of up-take will also minimise staff to staff infection and staff to patient infection: reducing significant increase in mortality of COVID and flu at the same time, etc. Challenges have been considered including working from home, no large gatherings taking place, a tired and vulnerable workforce and social distancing requirements. Peer vaccinations, mobile units and GP pharmacy access should help as well as electronic consent and 3 x more peers available to administer vaccinations.	An equality impact on the flu vaccination programme is imminent.
People Refresh Strategy	A one-page draft People Strategy setting out themes, ambitions and focus areas was well received, to be finalised at the November Committee meeting.	Assessment on the extent of work required against each focus area to be included in the next phase of work. The 'Inclusivity' ambition to be articulated in such a way it reflects the importance of equity.

Bridget Skelton
Chair, Strategic Workforce Committee
23 September 2020

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	05 November 2020
Agenda Number:	5.1
Agenda Item Title:	Board of Directors Governance Refresh Report
Presenting Officer:	John Goulston, Trust Chair

Action - this paper is for:	Decision	<input checked="" type="checkbox"/>	Information	<input type="checkbox"/>	Assurance	<input type="checkbox"/>
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Report history and purpose
<p>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. The Board Governance paper was approved at the Board meeting on 23 March 2020.</p> <p>The proposals in this paper build on both existing governance arrangements and those put in place to meet the challenges of COVID-19.</p> <p>The paper has been informed by the discussions at the part two Board meeting in July and reflects the output of the task and finish group established after the meeting to finalise the document.</p>

Summary of key points
<p>The paper outlines the principles underpinning the governance refresh; the expectation of the Board of Directors meeting agenda and meeting arrangements, Board meeting practices, Board reports, the work of the Board committees, Board committee effectiveness and learning from others.</p>

Equality impact assessment (EIA)
<p>This is a high level report which addresses Board governance arrangements and as such does not extend to requiring an equality impact assessment.</p>
Proposal to the Board
<p>The Board is asked to approve the proposed governance refresh as detailed in the paper with a review in early 2021.</p>

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

BOARD OF DIRECTORS GOVERNANCE REFRESH

Revised draft post task and finish group meeting on 10 September 2020 and final review by the Chair of the Audit and Risk Committee (ARAC) and Chief Executive (CEO)

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 2020). The proposals in the paper build on;

- both existing governance arrangements and those put in place to meet the challenges of COVID 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.
- the paper has been informed by the discussions at the part two Board meeting in July and reflects the output of the task and finish group established after the meeting to finalise the document. The task and finish group consists of the Chair, Chairs of Quality, Strategic Workforce (SWC) and Finance, Business and Investment (FBI) Committees together with the Deputy Chief Executive and the Corporate Services Director.

Given the proposed focus of the Board as detailed in section three of this paper, each committee chair and the lead executive 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 replication 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 1 and part 2 Board meetings should focus through six headings:

1) Standard items - e.g. minutes and action log. This section will include the patient's / staff story. The patient story will be taken as the first item in the part one Board.

2) Board Assurance Framework

3) Strategy

3.1 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).

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

3.3 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.

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

5) Current Year Performance

- a. 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.
- b. Triangulating evidence with patient and staff experience.

6) Governance, Risk Management and Compliance

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 1 meetings - quarterly (up to 2 hours split broadly 1.0 hours on first 3 items and 1.0 hours on remaining 3 items) including approving strategy and plans followed by Part 2 - (maximum of 90 mins) Part 1 meetings times to include IPR for the quarter (e.g. July or Sep Q1, Nov for Q2, Feb for Q3, May Q4,).
- Part 2 only Board meetings - three per year (up to 3 hours) – including refining and delivering strategy and plans; 6 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 2 (1 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 for use both for Board and committee reports(see attached) -
 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. This includes stating whether the paper is for a decision, assurance or information.
- 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 1 unless items comply with the legislation for Part 2 items.

4. Board Committees

Given the proposed focus of the Board as detailed in section 3 of this paper, we will review what work is 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 as assurance committees. In this way, there will not be duplication between the work of the committees and the work of the Board. Board committees will review their ToRs and make recommendations to the Board for amendment if appropriate.

Our review has confirmed that best practice is that Governors will not attend the Committees as members or observers. Governors can attend a committee meeting as a one off visit as part of the induction process.

- 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 2 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	Finance, Business and Investment
	Gerard Sammon	
Sustainable services	Gordon Flack	Finance, Business and investment
	Louise Norris	
People	Louise Norris	Strategic Workforce
	Pauline Butterworth	
Digital	Sarah Phillips	Finance, Business and Investment
	Gordon Flack	
System leadership	Executive Team	Trust Board
Environmental sustainability	Natalie Davies	Strategic Workforce
	Ali Carruth	

- Although there is a proposed committee lead for each goal and enabler, certain deliverables and actions to achieve the goals and progress the enablers will fall under the remit of another committee (e.g. integrate services and sustainable services have workforce, quality and financial elements). The executive leads should work with committee chairs on a matrix which assigns each deliverable / action for each goal and enabler to the relevant Board committee for oversight and assurance. The Deputy Chief Executive has drafted the matrix for review at the Trust Executive meeting on 6 October.
- The implementation of the strategy should be reviewed at a part 2 Board meeting (2 times per year) with escalation reports from the three Board committees and in particular, time spent on the system leadership enabler (Board responsibility) and on areas that straddle more than one committee.
- Consider ways that FBI, ARAC and Charitable Funds Committees could be better aligned and brought closer together. It is recognised that the Charitable Funds Committee is different in role, membership and purpose as it is a decision making committee in contrast to both the ARAC and FBI Committee. The latter two are assurance committees discharging a critical role in strategic challenge and assurance rather than decision making.

- After agreement between the committee chair and the lead executive, all Board committee terms of reference are being reviewed for post COVID-19 relevancy
 - What can be stopped, and
 - What is the specific ask by the Board - is it clear and transparent?
 - Are amendments required to the delegated authority of executives to free up the FBI Committee to discharge the assurance role?
- The revised approach agreed above will be reported to and endorsed by the Board on 10 December 2020.

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

Initially there will be a review of Board effectiveness in early 2021. 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.

Board committees are responsible for fulfilling their terms of reference. We will 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 Trust 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 given the pace of change of post COVID phase 1 and the evolving health and care system in Kent and Medway. The specific actions required by the part 2 Board meeting on 10 December 2020 are:

- 7.1 Revised terms of reference of Board committees reported to the Board
- 7.2 Reporting back on the learning from exemplars
- 7.3 Recommended changes from the aligning of the FBI/ARAC and Charitable Funds Committees.

John Goulston, Chair and Paul Bentley, Chief Executive
September 2020