Kent Community Health
NHS Foundation Trust

Agenda and Papers

for the

Formal meeting of the

Kent Community Health NHS Foundation Trust Board

In Public

to be held at 10am

on Thursday 20 May 2021

Kent Event Centre, Kent Showground, Detling Maidstone ME14 3JF
and
MS Teams Live Event

Kent Community Health NHS Foundation Trust

Meeting of the Kent Community Health NHS Foundation Trust Board to be held from 10am – 12 noon on Thursday 20 May at Kent Event Centre, Kent Showground, Detling Maidstone ME14 3JF

MS Teams Live Event

This meeting will be held in Public

AGENDA

1.	**STANDARD ITEMS**		
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 11 February 2021	Trust Chair	
1.5	Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 11 February 2021	Trust Chair	
1.6	Service Impact Story – Urgent Treatment Centres	Chief Nurse	
1.7	Trust Chair's Report	Trust Chair	Verbal
1.8	Chief Executive's Report	Chief Executive	
1.9	Board Assurance Framework	Director of Corporate Services	
2.	**STRATEGY**		
2.1	Board submission to Kent and Medway Integrated Care System	Director of Strategy and Partnerships	
3.	**PRIORITIES FOR 2021/22**		
3.1	2021/22 Strategic Priorities	Director of Strategy and Partnerships	

3.2	2021/22 Operating plan (for approval) • including 2021/22 Annual Budget	Deputy Chief Executive/ Director of Finance
3.3	2021/22 Cost Improvement Programme	Chief Operating Officer Deputy Chief Executive/Director of Finance
4.	**PERFORMANCE 2020/21**	
4.1	Integrated Performance Report	Deputy Chief Executive/Director of Finance Executive Directors
4.2	Staff Survey Report	Director of Workforce, Organisational Development and Communications
4.3	Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee
4.4	Finance, Business and Investment Committee Chair's Assurance Report	Chair of Finance, Business and Investment Committee
4.5	Quality Committee Chair's Assurance Report	Chair of Quality Committee
4.6	Strategic Workforce Committee Chair's Assurance Report	Chair of Strategic Workforce Committee
5.	**GOVERNANCE, RISK MANAGEMENT AAND COMPLIANCE**	
5.1	2020/21 Annual Report and Accounts	Chief Executive
5.2	Standing Financial Instructions, Standing Orders and Schemes of Delegation	Deputy Chief Executive/Director of Finance
5.3	Ratification of Terms of Reference of Committees	Trust Chair
5.4	Emergency Preparedness, Response and Resilience Annual Assurance Statement	Corporate Services Director

5.5	Learning From Deaths Report	Medical Director

6. ANY OTHER BUSINESS

6.1	Any other items of business previously notified to the Chair	Trust Chair

7. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

8. DATE AND VENUE OF NEXT MEETING

9 September 2021
Venue to be confirmed. This event will be available to view by MS Teams Live Event

8. DATE AND VENUE OF NEXT MEETING

9 September 2021 -
Venue to be confirmred and MS Teams Live Event

NHS
Kent Community Health
NHS Foundation Trust

UNCONFIRMED Minutes
of the Kent Community Health NHS Foundation Trust (KCHFT) Board Meeting held on Thursday 11 February 2021

virtually on MS Teams

Present:	John Goulston, Trust Chair (Chair) Sola Afuape, Non-Executive Director Pippa Barber, Non-Executive Director Paul Bentley, Chief Executive Paul Butler, Non-Executive Director Pauline Butterworth, Chief Operating Officer Peter Conway, Non-Executive Director 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:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Director of Corporate Services Louise Harley, District Nurse Caseload Manager (agenda item 1.6) Claire Venes, Local Clinical Resource Manager, Canterbury Long Term Services (agenda item 1.6)

11/02/01 Introduction by Chair

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

11/02/02 Apologies for Absence

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

The meeting was quorate.

11/02/03 Declarations of Interest

Ms Barber declared her voluntary role to support the Trust's mass vaccination programme in a clinical capacity.

Ms Afuape confirmed that she was undertaking a piece of work with the Nursing and Midwifery Council and Cafcass on aspects of their equality, diversity and inclusion strategies.

11/02/04 Minutes of the meeting of 5 November 2020

The minutes were read for accuracy.

The following amendment was suggested:

05/11/02 Patient Story – to add after paragraph 4: Prof. Drobniewski offered his sympathies and asked if Mr Dawes felt it would be helpful if families were offered clearer training in how to administer a safe emergency dose of, for example, painkilling medication particular of individuals like him who had experience working in the care sector. Mr Dawes agreed that it would.

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

11/02/05 Matters arising from the meeting of 5 November 2020

06/08/10 NHS England/Improvement (NHSE/I) Board Assurance Framework (BAF) for Covid-19 (KCHFT) – Dr Spare confirmed that this action had been completed and had been reflected in the infection prevention and control (IPC) board assurance framework.
05/11/9 Chief Executive's Report – Service Story; The One You Service story has been deferred to September 2020 following the decision to invite the Canterbury Long Term Service district nurses to present their story at the February Public Board meeting.

The Board **RECEIVED** the Matters Arising.

11/02/06 Service Impact Story – Community Nursing

Dr Spare welcomed Ms Claire Venes and Ms Louise Harley to present their story to the Board.

Claire Venes explained that through the pandemic the community nursing teams had experienced a significant increase in the demand for end-of-life care in addition to the other aspects of care they delivered. Care included syringe driver monitoring and verification of death, as well as support to families, relatives and carers. Because of the relentless workload, staff were unable to return to the office and decompress. This was affecting their well-being and mental health. Louise Hartley realised this and escalated her concerns. With the help of Clare Fuller, Lead Practitioner Palliative and End of Life Care, it was recognised that the staff needed a safe space where they could talk together about their experiences. A pilot was set up and there were two sessions in October, November and December. These listening sessions were well received by those who attended and it was agreed that the sessions would be rolled out across the Trust.

Louise Harley added that her service felt overwhelmed at the time. Patients were scared to go to the usual places of care and all teams were seeing more palliative and end-of-life patients. Nurses were constantly being called to patients in care home to give STAT dose medication. When the care homes became affected by COVID, nurses had to attend in full personal protective equipment (PPE). It felt like they were going to war. For example, she was called to a care home where two patients required medication for comfort and anxiety. When she arrived she was presented with seven patients, each at a different stage of end-of-life. Each patient required specific care and a nurse needed to be mentally and emotionally prepared to provide that care. PPE had to be donned and doffed for each patient. The relentlessness of the care meant that staff had no time or space to reflect on their experience. Patients were presenting with more complex needs; they were vulnerable and scared. Some did not want services coming into their homes in case they brought in the COVID infection which led to them refusing care. This in turn led to crisis management which was very difficult to manage. The team would have its daily handover but this was not always the place to reflect on experiences nor did staff want to take their experiences home to their families. The end-of-life sessions gave staff the chance to open up which staff welcomed.

Dr Spare confirmed that these sessions had been rolled out across the organisation to the other community teams and was being coordinated by the End of Life Care Team.

In response to a question from Mr Turner as to how the community nurses coped with the unpredictable situation in East Kent with the new COVID variant, Louise Harley explained how the teams had learned various coping strategies in the first wave and that they had received support through the redeployment of staff into their teams. Staff found an inner strength to support each other and this prepared them for the second wave. It was not easy but they were as ready as they could be. Anxiety among staff had been high and some felt vulnerable. There was a fantastic team supported by great leadership. The high level of demand was continuing.

In response to a question from Ms Afuape regarding the responsiveness of the Trust in supporting teams with the increased levels of sickness and absence, Claire Venes confirmed that there had been increased sickness. This had been managed internally through regular meetings with clinical leads to discuss staffing and move staff internally. There was also support from the professional lead nurse for east Kent who held meetings regularly to redeploy staff. Staff had gone above and beyond to cover sickness and maintain the service.

In response to a question from Ms Afuape as to how the Trust would sustain the long-term requirement for mental and emotional support to staff, Dr Spare reflected that although the overall number of COVID patients was declining, this was not the case for the community nurses where the number of COVID patients remained high. It was important to continue to listen and ensure that the support staff needed remained in

place. Staff were worried about the culmative effect of the pandemic. The Trust would continue to ensure that various resources were available to them to support their mental and emotional well-being.

In response to a question from Pippa Barber regarding the community nursing teams' experience of support from the members of the wider multidisciplinary teams (MDT), Claire Venes indicated that there had been some issues at the beginning around hospice support but this had been rectified. Louise Harley added that ways of working had changed as some other services were not going into patient homes. The teams had felt supported by the wider MDT.

On behalf of the Board, Mr Goulston thanked the community nursing teams for the work that they had done and reflected that the listening events would play an important part in supporting the health and well-being of staff.

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

Ms Claire Venes and Ms Louise Harley left the meeting.

11/02/07 Trust Chair's Report

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

Mr Goulston, on behalf of the Board and the Council of Governors, thanked all the staff of the Trust for their extraordinary efforts in responding to the pandemic during the last few months.

He and Mr Bentley had been meeting informally with the Governors and he had been meeting weekly with the non-executive directors to keep them abreast of developments. At the Kent and Medway Care Partnership Board meeting that week, the group had discussed the lessons that had been learnt from the challenges of the current wave and how the healthcare system had adapted. The chair of Maidstone and Tunbridge Wells NHS Trust had thanked the community services for the discharge work they had done which in turn had enabled the acute trusts to increase their admissions. The number of medically fit patients still in hospital was at very low levels.

The Department of Health and Social Care had published a white paper that day which set out legislative proposals for a Health and Social Care Bill. This paper looked at the future of integrated care systems and would be discussed by the Board in due course. The Council of Governors would also discuss it at their development day in March. Mr Wilf Williams, Accountable Officer of Kent and Medway Clinical Commissioning Group (CCG), Mr Bentley and Mr Sammon would be at that meeting to discuss the impact of the proposals and what it meant for the Trust.

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

11/02/08 Chief Executive's Report

Mr Bentley presented the report to the Board for information.

COVID had been hard for so many people that the Trust served and Mr Bentley's thoughts continued to be with them and their families. He thanked all the staff for their outstanding continued efforts.

In response to a question from Mr Goulston as to how the vaccination programme was progressing with non-patient facing staff at the Trust and whether it would meet the deadline of mid-February, Mr Bentley responded that the take-up of the vaccination amongst patient facing staff was 72 per cent as of earlier that week. This was comparable to other trusts in Kent but he would like to see a faster take-up in the Trust. There was both a local and national concern that some groups specifically the black, Asian and minority ethnic (BAME) communities were slower to come forward to have their vaccination and work was being undertaken in the workforce and in the wider community to explain the benefits and importance of receiving the vaccination and to improve the take-up.

In response to a question from Ms Skelton regarding the mass vaccination centres, Mr Bentley commented that the centres had been stood up at pace and staff had been learning to improve the flow through of people to ensure that their experience was smooth and quick. With regards to how the Trust was minimising the nervousness of people coming forward for the vaccination, the Trust was using internal and external media to communicate with them and working with MPs, local councils and the voluntary sector to raise awareness and encourage people to come forward.

Ms Afuape commented that she was part of a Seacole group who were a group of BAME non-executive directors working with NHSE/I on this matter. They had identified that those organisations which were struggling least had existing relationships with their local communities. She also highlighted that the reluctance of some to come forward for the vaccine was based on hesitancy. It was important to understand this wider context to minimise reinforcing their anxiety.

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

11/02/09 Board Assurance Framework (BAF)

Ms Davies presented the report to the Board for assurance.

The board assurance framework continued to be reviewed regularly by the executive and at the Board committees.

Mr Conway confirmed that the Audit and Risk Committee had scrutinised the board assurance framework the previous day and that it was in good shape, dynamic and reflective of the current risks. The Board could rely on it as a useful document even though the situation was changing rapidly.

The management co-ordinating organisation (MCO) risk was included but had not been deemed severe enough to be red rated.

Mr Goulston made a point of accuracy. The report indicated that since the BAF had last been presented to the Board there had been no new risks identified. This was correct in relation to the part two board meetings. However since the part one meeting in November 2020, Risk 113 (vaccination programme) had been added. Ms Davies noted the correction.

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

11/02/10 People Strategy

Ms Skelton and Ms Norris presented the report to the Board for approval.

Ms Skelton thanked Ms Norris's team for the work they had done in developing the strategy. Ms Norris confirmed that the strategy had been reviewed and agreed by the Executive. The Strategic Workforce Committee had received the strategy and commended it to the Board for approval.

In response to a question from Mr Butler regarding bank staff and the strategy, Ms Norris responded that bank staff were part of the Trust family; she saw no distinction between them and substantive employees and hoped that some of the bank staff would decide to stay to support services in the future.

Ms Barber praised the layout and presentation style of the strategy and it was agreed that the framework should be applied to the other strategies of the Trust.

Ms Afuape highlighted that the staff networks had a role to play in implementing the strategy and she asked how they could be made more prominent. Ms Norris concurred that their role would be critical in delivering the strategy. The networks were productive and engaged and the Trust's new Workforce Equality, Diversity and Inclusion Lead would be working closely with them to draw their work together. The Trust was progressing with a number of areas including signing up to the Stonewall Diversity Champions Programme and implanting a reciprocal mentoring scheme across all the staff networks. These would provide an opportunity to move forward on the Trust's equality and diversity agenda.

The Strategic Workforce Committee would monitor the delivery of the strategy and provide progress reports to the Board.

The Board **APPROVED** the People Strategy.

11/02/12 Infection Prevention and Control Board Assurance Framework

Dr Spare presented the report to the Board for assurance.

In response to a question from Mr Conway regarding the response from landlords to support improving estates compliance, Dr Spare commented that the Trust had taken time to invest in building good relations with NHS Property Services and other landlords. All were supportive of the Trust's efforts to improve compliance to some degree although the age and condition of some buildings did present challenges. Contracts were in place and within those there were key performance indicators for IPC. The main stumbling block would be if the Trust decided to carry out major work on ventilation which would require moving patients out while the work was completed.

Mr Sammon added that Dr Spare was working directly with the matrons in the community hospitals and it was their leadership and attention to IPC in the wards which was key. Dr Spare confirmed that she met with the matrons weekly and discussed with them any issues they might have and the impact of any changes they had made. These meetings were alongside the regular Trust wide outbreak meetings.

In response to a suggestion from Ms Afuape that section five could be more explicit about what the Trust had put in place for prompt identification of those individuals deemed more vulnerable to COVID, Dr Spare agreed to review that section.
Action – Dr Spare

Ms Barber confirmed that the Quality Committee was monitoring the IPC BAF. In response to her question regarding what the overall impact of the work had been on the number of outbreaks, Dr Spare responded that there had been a small number of outbreaks following the second peak with the new variant. These had greatly reduced and currently there were only two small outbreaks.

The Board thanked the Infection Prevention And Control Team for their work.

The Board **RECEIVED** the Infection Prevention and Control Board Assurance Framework.

11/02/13 Annual Planning Process 2021/22 – Budget; Quality Priorities and Accounts

Ms Davies presented the report to the Board for information.

Mr Conway confirmed that the Audit and Risk Committee had considered the timetable the previous day. The Committee was confident that the timetable was achievable although it would be challenging. Some mitigation had been put in place. Grant Thornton, the auditors would not audit the Quality Account and a two-week extension had been granted by NHSE/I. This would be used if needed.

The Board **RECEIVED** the Annual Planning Process 2021/22 – Budget; Quality Priorities and Accounts.

11/02/14 Integrated Performance Report

Mr Flack presented the report to the Board for assurance.

Ms Barber suggested that the Quality Committee should undertake a deep dive into the referral to treatment waiting times in other services that were visiting the prisons. Ms Butterworth agreed that she would arrange a report to be presented at a future meeting.
Action – Ms Butterworth

In response to a question from Ms Barber as to why the East Kent Rapid Transfer Service daily commissioned discharge performance continued to be marginally under the target, Ms Butterworth explained that she and her team were working collectively with Kent County Council, the Trust's acute partners and the CCG to identify the resources that were required to help the service to support the restoration of non-COVID activity. With regards to the performance issue, the target had been set prior to the pandemic and the commissioning arrangements had not changed since. This was being looked at as part of the reset.

Ms Norris highlighted that the sickness rate had increased in December and she expected that it would remain at a similar level in January with numbers falling back after that.

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

11/02/15 Audit and Risk Committee Chair's Assurance Report

Mr Conway presented the report to the Board for assurance.

The Audit and Risk Committee had met the previous day. It had received positive assurance on cyber security. With regards to the internal audit plan, the Committee encouraged the executive to be Covid congruent, reflecting the current challenges that services now faced and clearly articulating what was needed from the audits. Further work was required on the plan and it would come back to the Committee for approval.

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

11/02/16 Charitable Funds Committee Chair's Assurance Report

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

The Board **RECEIVED** the minutes from the meetings of 8 July and 24 November 2020.

The Board **RECEIVED** the Charitable Funds Annual Report and Accounts 2019/20.

11/02/17 Finance, Business and Investment Committee Chair's Assurance Report

Mr Butler presented the report to the Board for assurance.

The meeting of the Committee that had been due to take place on 27 January had been deferred to the 5 March due to the pressures of COVID. This would be followed by the scheduled meeting on 22 March. The key agenda item at both meetings would be the 2021/22 budget which the Committee expected to commend to the Board at the 22 March meeting. The budget would then come to the April Board meeting for approval.

The Board **RECEIVED** the Finance, Business and Investment Committee Chair's Assurance Report.

11/02/18 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.

11/02/19 Strategic Workforce Committee Chair's Assurance Report

Ms Skelton presented the report to the Board for assurance.

Ms Skelton had been appointed as the Trust's Health and Well-being Guardian. In this capacity, she had attended a launch event on behalf the Board with NHSE/I and a non-executive director diversity and inclusion national event.

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

11/02/20 Any Other Business

There was no other business to report.

11/02/21 Questions from members of the public relating to the agenda

Ms Ruth Davies, Public Governor Tonbridge and Malling asked how the uptake of the COVID vaccination compared to the uptake of the flu vaccination both in staff and in the public and whether the rates were similar to previous years. Mr Bentley confirmed that the uptake of the flu vaccination amongst staff had been 70 per cent which was the best performance the Trust had achieved. The Trust was on course to exceed that with the COVID vaccination. With regards to the uptake of the flu vaccination amongst the public, he was not sighted on the specific numbers as this vaccination was delivered through primary care and the community pharmacists. The Trust was only responsible for delivering the flu vaccination to staff, children and young people.

Ms Ruth Davies also asked for further information regarding the proposal that the Queen Victoria Hospital NHS Foundation Trust in East Grinstead was to be merged into a super-Trust with Western Sussex Hospitals NHS Foundation Trust and Brighton and Sussex University Hospitals NHS Trust with the result that specialist services might only be available to the local population. She queried what the likely impact this might have for Trust patients, particular with regard to dermatology referrals and how this was being addressed. Mr Bentley confirmed that he was aware of the proposal but that it would be around changing organisational form rather than a debate about service configuration. If there were to be any service changes, there would have to be a public consultation process. Ms Butterworth agreed that she was not aware of any potential service changes.

The meeting ended at 11.20am.

11/02/22 Date and Venue of the Next Meeting

Thursday 20 May 2021; Kent Event Centre, Kent Showground, Detling, Maidstone, Kent. The meeting will also be broadcast to the public as an MS Teams Live Event.

Kent Community Health
NHS Foundation Trust

MATTERS ARISING FROM THE BOARD MEETING OF 11 FEBRUARY 2021 (PART ONE)

Minute number	Agenda Item	Action	Action Owner	Status
11/02/12	Infection Prevention and Control Board Assurance Framework (IPC BAF)	To review section five in relation to being more explicit about what the Trust had put in place for prompt identification of those individuals deemed more vulnerable to COVID-19.	Dr Spare	This has been updated in the new version of the IPC BAF published by NHSE/I in February 2021.
11/02/14	Integrated Performance Report	To present a deep dive report to the Quality Committee on the referral to treatment waiting times in other services that were visiting the prisons.	Ms Butterworth	Action complete.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	1.8
Agenda Item Title:	Chief Executive's Report
Presenting Officer:	Paul Bentley, Chief Executive Officer
Action – this paper is for:	☐ Decision ☒ Information ☐ Assurance

Report Summary

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

Proposal and/or recommendation

Not applicable.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis (EA) for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo*	☐ Yes *(please attach)*
If not describe any equality and diversity issues that may be relevant. *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☒ No *(please provide a summary of the protected characteristic highlights in your paper)*

Highlights relating to protected characteristics in paper

Name:	Paul Bentley	Job title:	Chief Executive
Telephone number:	01622 211902	Email	p.bentley@nhs.net

Kent Community Health NHS Foundation Trust

CHIEF EXECUTIVE'S REPORT
May 2021

Since the last time the board met in public (February 2021) consistent with the rest of the country KCHFT has continued to manage the consequence of the global COVID-19 pandemic whilst simultaneously providing the non-pandemic services which we provide. I do wish to highlight to the board a number of issues which have arisen since the last time we met, grouped as in previous reports into the following categories patients and service users, our people, and partnerships

Patients and service users

1. Operational activity

Operational activity has continued to return to pre-pandemic levels, and whilst the detail of this is contained within the performance report I would highlight that:

- Patient occupancy rates in our community hospitals have returned to 92% following very high occupancy during the second wave of Covid
- All bed-based escalation is closed and the hospital bed base has returned to its original footprint
- The recovery working group has now ceased with the majority of patient and service user backlogs recovered. We are working with colleagues in EKHUFT to secure theatre capacity to address the dental general anaesthetics backlog which is on schedule to be complete by the end of June 2021.
- Our referral to treatment time is delivering against the access standards, achieving 99% of patients waiting will wait less than 18 weeks.

2. COVID-19 activity

The impact of the nationwide vaccination programme and the other national and local measures to address the pandemic is now being seen in our services with COVID-19 patient numbers reducing, more specifically

- The incidence of COVID-19 infection in our community hospital beds has fallen significantly; currently there are zero patients with active infection and only 5 patients who have been transferred to us who remain in their step-down period.
- The community prevalence across K&M continues to fall and is below the England rate (England 21.5 : Kent 13.7 ; Medway 11.5) - data: 29 April - 6 May)
- Staff continue to follow national guidance on wearing Personal Protective Equipment and maintaining social distancing. This continues to be reviewed in light of the government roadmap to unlocking public services. The Trust continues as it has

throughout the pandemic to have suitable quantity and quality of PPE for all team members who are required to use or wear it.

- Vaccination of team members continues with 90% of patient facing staff in all services having received a first vaccination and 99% of all staff in the vaccination centres having done the same. Lateral flow tests are provided for team members with over 11,000 test kits delivered. Nationally work has been launched to look at the efficacy of current vaccines against variant strains.
- Planning for the 2021 influenza programme has commenced and our provisional vaccine order has been placed. We will remain flexible to our approach as we learn more in relation to any potential impact of COVID-19 boosters for our workforce.

3. COVID-19 Vaccination Programme

Since KCHFT assumed the role of the management co-ordinating organisation for Kent and Medway the Trust has delivered 230,000 first vaccination doses and 48,000 second vaccination doses, operating out of 7 different centres to create geographical reach. As a Kent and Medway system we are now vaccinating priority groups 10-12. Across Kent and Medway, we have seen high percentages of priority groups 1-9 vaccinated, with all bar one priority group delivering in excess of the 85% ambition.

As we move into the largest groups we revised the arrangements for the COVID-19 vaccination programme, incorporating the programme into business as usual and as such Gordon Flack has stepped back from the programme and Pauline Butterworth takes over the executive lead with Ruth Brown, Chief Pharmacist, being the operational lead. The programme has and continues to be the largest vaccination programme ever delivered in the history of the NHS and I am very grateful to all those involved but the change in leadership is a suitable opportunity to thank Gordon, Clive Tracey and Ruth Brown who have been instrumental in establishing the programme.

Our People

1. Equality and diversity

This year Equality, Diversity & Inclusion has strengthened. Two new Equality Leads joined the Trust to support our ambitions of being a representative, well led workforce that collectively works together to reduce health inequalities for the people we serve.

In May we celebrated Deaf Awareness week introducing on-demand video sign-language interpreting for Deaf patients at all of our mass vaccination centres. Feedback from our Deaf patients highlighted how fantastic it was that we had ensured delivery of the COVID vaccine was accessible to all people.

Vaccine outreach work continues to support those who may experience difficulties attending vaccine sites; this included people with learning disabilities; areas where uptake of the vaccine is lower than average and translated material for Roma Traveller communities. A dedicated telephone interpreting service for those that do use English as their primary language and volunteers from local communities continue to support communication barriers when accessing the vaccine.

This month also saw Equality, Diversity & Human Rights week; with webinars and information being shared across the Trust, to raise awareness and promote inclusivity as we move out of the pandemic into restoring services inclusively.

I do not doubt that there is much work to do to make our workforce and our services as effective and as accessible as they should be but I would like to thank Ali Carruth and Louise Norris for their contribution in raising the profile of this key issue in the events and approaches described above.

2. Kent and Medway Care Record

Progress on mobilising the KMCR is significant. KCHFT staff as well as all staff working for EKHUFT are now able to access a core set of shared data via their own clinical systems, with no additional logins or passwords required. By the end of June all NHS partners are scheduled to have access to this core information including ambulance services, GP out of hours and our hospice partners. Information flows into the KMCR will continue to build over the next 6 months including social care information. KCHFT is playing an important role in the project by hosting the contract and key technical support teams and providing clinical leadership from Dr Sarah Phillips (Chair of clinical and professional group) and Dr George Noble (Clinical Safety Officer).

Partnerships

1. Kent and Medway Integrated Care System (ICS) development

On 1 April Kent and Medway became an Integrated care system which is a key step to the path towards more integrated working across health and social care. Having been approved to become an ICS the ICS sought views of what its end state should look like and the Trust formally responded. I welcome the creation of the ICS and the opportunity to influence what the ICS, of which KCHFT will be a key part, will be and how it will operate. I will share with the Board the response once received.

2. Collaboration with Kent and Medway Partnership Trust (KMPT)

As reported to the board in the summer of 2020 the collaboration between KMPT and KCHFT is strong, and since we met last has been formalized in a Memorandum of Understanding between the two Trust, a work programme is in place ensuring that the work brings benefit for service users and patients. And later in the year we will have a Board to Board meeting with our colleagues in KMPT to reflect on progress and further build the fruitful partnership.

In conclusion the pandemic has profoundly affected so many lives, in May we held a personal event for all team members who wished to participate, facilitated by our end of life care team, this was one of the ways we can honour those who have lost their lives and support our team members as we come to terms with the 'new normal'. Our teams have been remarkable caring for COVID-19 positive patients, vaccinating the residents who we serve and providing high quality healthcare. I take this opportunity to thank them all.

Paul Bentley
Chief Executive
May 2021

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	1.9
Agenda Item Title:	Board Assurance Framework
Presenting Officer:	Natalie Davies, Director of Corporate Services
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Executive team?

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.

Summary of key points

BAF ID 111 – "Risk that the organisation's services may be overwhelmed as result of the impact of winter pressures in combination with Covid". **This risk has now been closed and removed from the BAF.**

BAF ID 113 – Actions complete:-

9. One additional large site to be added to programme for Medway to be set up mid-March
10. Two mobile vaccination units to be setup mid- March

BAF ID 115 – Action added:-

5. Refresh Community Hospital strategy and develop associated workforce plan

BAF ID 116 – New Risk added

Proposal and/or recommendation

It is proposed the Board notes the changes made to the BAF and any further recommendations offered.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis (EA) for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Shane Webber	Job title:	Assistant Director Corporate Operations
Telephone number:	01233667700	Email	shanewebber@nhs.net

Kent Community Health NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK

1. Introduction

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

1.2 The BAF is therefore comprised of high risks. Refer to section 3 below for a definition of high risk.

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

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

1.5 The full BAF as of 13 May 2021 is shown in Appendix 1.

2. Amendments to the BAF

2.1 Since the BAF was last presented there has been one new risk identified against the Trusts strategic objectives.

BAF ID 116 – “Risk that KCC funding is not sufficient to support the necessary development of integrated care and pathway improvement”.

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

BAF ID 111 – “Risk that the organisation’s services may be overwhelmed as result of the impact of winter pressures in combination with Covid”.

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.

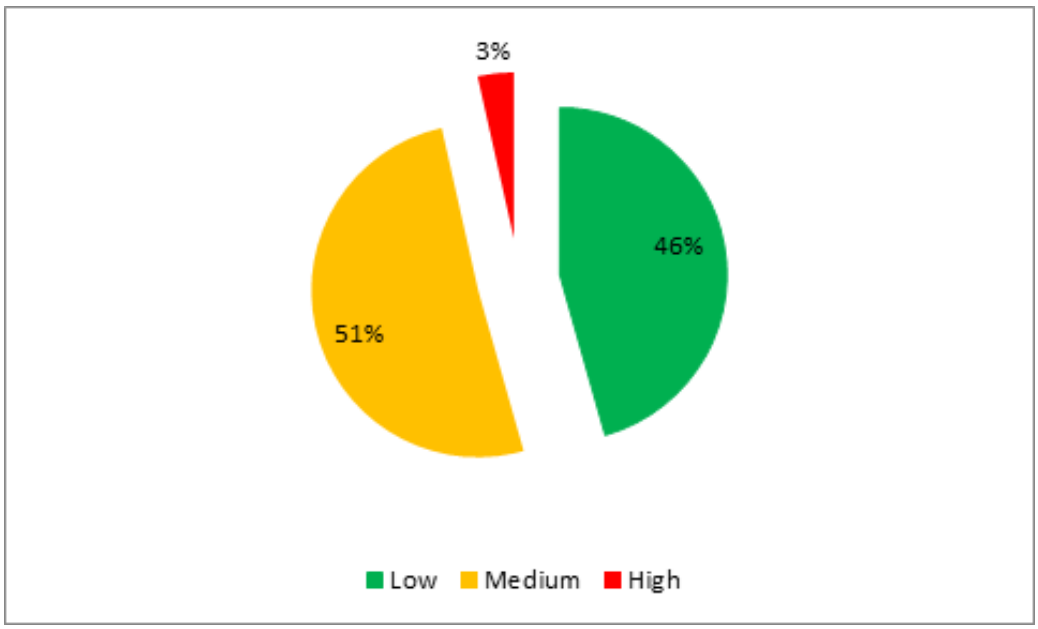
		← *Impact / Severity* →				
		Insignificant	Minor	Moderate	Major	Catastrophic
↓Likelihood ↓		**1**	**2**	**3**	**4**	**5**
Rare	1	1	2	3	4	5
Unlikely	2	2	4	6	8	10
Possible	3	3	6	9	12	15
Likely	4	4	8	12	16	20
Almost Certain	5	5	10	15	20	25

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 1: Organisational High Risk Profile



5. Risk Overview

5.1 The total number of open risks within the Trust stands at 171 this is comprised of 78 low risks, 87 medium risks and 6 high risks. There are currently 7 risks past their review date and 2 risk past target completion date. Low risks are initially reviewed by Heads of Service with further reviews by the responsible officer at least bi monthly. Medium risks would initially be reviewed by Heads of Service and then onward to the Community Service Director/Assistant Director for approval, these would normally be reviewed on a monthly basis. All risks are extracted by the Risk Team on a weekly basis and the officer responsible for those risks that have passed their review date or target completion date are contacted by the team to prompt a review

6. Recommendation

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

Shane Webber
Assistant Director Corporate Operations
13 May 2021

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

Kent Community Health
NHS Foundation Trust

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

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

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

Action status key:

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

				Initial rating				Current rating					Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Top Five Assurances	C	L	Rating	Planned Actions and Milestones	Confidence Assessment	C	L	Rating	Target Date (end)
Prevent ill health																	
	Mar 20		Risk Opened	25 Nov 20	BAF timeline feature initiated	26 Nov 20	Actions completed & removed:- 1. Continuation of IMM, update calls and representation at region. 2. Escalation of supply shortages as required.	04 Jan 21	New actions added: 4.Continuation of IMM update calls 5.. Review stand down of non essential services 6. Continued review of trust governance	22 Jan 21	Action completed: 6. Continued review of trust governance Action added: 7. Further review of trust governance against current context						
107	Mar 2020	Gordon Flack	Risk that the significant impact on the system and the organisation due to the Covid19 pandemic may result in the inability to delivery services to an acceptable standard either in coverage or quality. 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	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 3. Evaluation of additional workforce to support extension of IPC and PPE teams — Mercia Spare — May 21 — G 4.Continuation of IMM update calls — Pauline Butterworth — June 21 — G 5. Review stand down of non essential services — All — May 21 — G 7. Further review of trust governance against current context — Natalie Davies — June 21 — A	Medium	3	3	9	June 2021
	Mar 20		Risk Opened	25 Nov 20	BAF timeline feature initiated	27 Nov 20	Actions completed & removed:- 1. Staff welfare package: continued co-ordination and expanded 2. Executive blog / message 3. 3. All executive Director Operation and Answer 4. 4. BigListen 2 - Results analysed and action planned.	11 Dec 20	New actions added: 5. Annual staff survey results being analysed - corresponding actions to be developed. 6. Regular online 'drop-in's' to be hosted by execs. 7. Roll out of lateral flow testing 8. Continually review wellbeing offer	04 Jan 21	New action added: 7. Continued implementation of lateral flow testing	18 Jan 21	Action completed:5. Annual staff survey results being analysed - corresponding actions to be developed.	18 Jan 21	New action added: 9. Investigate effects of long Covid on staff				
108	Mar 2020	Louise Norris	Risk that the extended and on-going response to Covid will impact on staff stress and morale to an extent that the delivery of services to patients is compromised. 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	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 6. Regular online 'drop-in's' to be hosted by execs — Louise Norris — May 21 — G 7. Continued implementation of lateral flow testing — Louise Norris — April 21 — G 8. Continually review & implement wellbeing offer — Louise Norris — June 21 — G 9. Develop & implement strategy to support colleagues with long Covid. — Louise Norris — May 21 — A	Medium	3	3	9	June 2021
	Aug 20		Risk Opened	25 Nov 20	BAF timeline feature initiated	18 Dec 20	Score reduced from 15 (C5xL3) to 12H (C4xL3).	22 Jan 21	Action completed: 1. Data reset dashboard to be finalised								
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 CQC IPC BAF	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	4	3	12H	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 2. Data reset to be reviewed weekly — Pauline Butterworth — May 21 — G	Medium	3	2	6	June 2021
	Jul 20		Risk Opened	23 Nov 20	BAF timeline feature initiated	26 Nov 20	Actions completed & removed:- 1. ICS/CCG Governance structure proposal 4. Continuation of influence and negotiation at system meetings		Actions completed & removed:- 2. Discharge Planning work progress made, further work required re funding for East. 3. ICP boards some progress but further work completion date moved to Sept								
110	Jul 2020	Pauline Butterworth	System and partner plans to reset and restart could be insufficient or insufficiently coordinated to meet the demand resulting in the system being overwhelmed and patients not receiving the services they require. 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	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 6. Collective work with KCC and CCG to agree social care pathways in east Kent and associated funding — Pauline Butterworth — October 21 — A 3. Development of ICP boards and their impact — Paul Bentley — Sept 21 — A 5. Continue to improve West Kent frailty model options. — Sarah Philips — June 21 — A	Low	3	4	12	June 2021
	Feb 21		Risk Opened				**Action completed and closed:** 1. review of bank rates at other hospitals (staff telling KCHFT they are cancelling shifts with us										

				Initial rating					Current rating					Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Top Five Assurances	C	L	Rating	Planned Actions and Milestones	Confidence Assessment	C	L	Rating	Target Date (end)
115	Feb 2021	Pauline Butterworth	Risk that the on-going pressure and staff shortages specifically in community hospitals and rapid response services, as a result of growing vacancies, high acuity of patients and staff absence may result in unacceptable demands on staff and impact on safer staffing levels, a poorer service to patients and/or the need to shut services with the resultant impact on the system. Board Committee Lead on Assurance: **Strategic Workforce Committee**	5	3	15	• Active recruitment campaign • Weekly staff rota review and escalation paths • Clinical care and Quality meeting • IMM meeting - redeployed staff • Bank system in place	• Daily Sit rep • IMM report to executive • Growing vacancy rate • Continual and long standing pressure in some areas.	5	3	15	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 2. On-going recruitment of staff — Pauline Butterworth — May 21 — G 3. Upskilling programme for staff — Mercia Spare — May 21 — A	Low	2	3	6	June 2021
113	Nov 2020	Pauline Butterworth	Risk that the organisation may encounter collaborative challenges with health partners and demands of an unprecedented logistical scale could result in the trust not being able to cope with the system wide delivery of the Covid19 vaccination programme. Board Committee Lead on Assurance: **Board**	4	3	12H	• Governance structure including programme board and work streams • SRO appointed – Chief Executive • Governance structure matching the regional and national governance • Project plan supported by sit rep • Membership of local, regional and national fora • Implement staff & patient Covid vaccination Programme • Understanding of Covid demand profiles • Establish weekly sit rep to manage system vaccine delivery.	• Daily Sit rep • National oversight and performance monitoring • Staff Covid vaccination programme for KCHFT staff. • Link to winter Pressure Plans. • Collaboration with Covid partners.	4	3	12H	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 3. Develop the system strategy in partnership with CCG and other providers - new focus on GP and trust provision — Paul Bentley — May 21 — A 4. Develop recruitment plan to support mass vaccination programme — Louise Norris — April 21 — G 7. Develop targeted engagement plan aimed at those staff who have not been vaccinated — Louise Norris — May 21 — G 9. One additional large site to be added to programme for Medway to be set up mid-March — Gordon Flack — April 21 — G 10. Two mobile vaccination units to be setup mid- March — Gordon Flack — April 21 — G 11. Recruitment to the BAU vaccination team to be completed — Pauline Butterworth — Jun-21 — A 12. Models for the delivery of mixed vaccine sites to be agreed and implemented — Pauline Butterworth — Jun-21 — A	Medium	2	3	6	June 2021
Develop Sustainable Services (Strategic Enablers)																	
114	Dec 2020	Pauline Butterworth	Potential for the unavailability of GA theatre space to undertake GA dental work could cause patient harm through unaddressed pain, negative impact on child development and represent a reputational risk to the trust. Board Committee Lead on Assurance: **Quality Committee**	4	3	12H	• To review each patient using FSSA surgical prioritisation standard • Offer patients 3 monthly review F2F or via telephone to ensure any changes to dental status is pick up by team • Carry out as many treatment as possible under sedation if patient can tolerate some treatment in the chair	• Internal sit-reporting to Dental SLT on GA patient numbers and wait time twice a week • Internal weekly sit-reporting to exec on GA patient numbers and wait time • Active engagement with EKHFT on securing additional elective sessions • Working in collaboration with Medway and Kent CCGs	4	3	12H	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 1. All Dental GA patients have regular 3 monthly contact with dental team – offered oral health consultation and support via video or telephone call — Pauline Butterworth — April 21 — G 2. Offer treatment under sedation (some patient may be able to tolerate part of the treatment under sedation) — Pauline Butterworth — April 21 — G 3. Complete the implementation of the recovery plan — Pauline Butterworth — Sep-21 — A	Medium	3	2	6	Sept 21
Deliver High Quality Care at Home and in the Community																	
103	Jan 2019	Gerard Sammon	The pace of ICS 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	• Sustainability and Transformation Plan (STP) Programme •Board TORs and membership • TORs for: ICP forums, Local Care Boards; Frailty Group; Chief Executives Forum • KCHFT Chief Executive as SIRO for East ICP • KCHFT Chair is Chair for West Kent ICP and Interim Chair of Kent and Medway STP/ICS • System transformation governance structure • Involvement and promote mature development of ICS • Continue to deliver outstanding healthcare • NED presence and role in the system to be pursued and enhanced. • Active in ICPs	• Local Care Investment received for both east and west Kent - Hospital at Home and Rapid Transfer of Care scheme. • Community Care Funding increase in financial settlement • Chief Exec report to the board • Regular Strategic development update to the board • Membership of the STP board. • Director of strategy report to the Leadership forum	4	3	12H	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** 7. Contribute to the development of the Kent and Medway Recovery and Improvement Plan — Pauline Butterworth — May 21 — G 8. Ensure alignment of work-packages under single system oversight — Gerard Sammon — May 21 — G 9. Regular review of recovery and improvement plan — Gerard Sammon — May 21 — A 10. Influence shape of ICS governance structure — Paul Bentley — May 21 — G 11. Implementation of STP/ICS executive group membership and drive — Paul Bentley — May 21 — A 12. Implementation of the ICS design group membership and drive — Gerard Sammon — May 21 — G 13. Ensure consistent and co ordinated response to Kent and Medway ICS end state proposals — Gerard Sammon — Sept 21 — A 14. Influence ICS operational content that will contain governance arrangements to support delivery of the 2021/22 priorities — Natalie Davies — June 21 — A 15. Implement ICS level financial arrangements for 2021/22 — Gordon Flack — Jul-21 — A	Low	3	3	9	May 2021

				Initial rating				Current rating								Target rating			
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Top Five Assurances	C	L	Rating	Planned Actions and Milestones				Confidence Assessment	C	L	Rating	Target Date (end)
116	May 2021	Pauline Butterworth	Risk that KCC funding is not sufficient to support the necessary development of integrated care and pathway improvement. Board Committee Lead on Assurance: Finance Business and Investment Committee	4	3	12H	LD collaborative agreement Job description of the Public Health Leadership Team Discharge Planning Meetings objectives and governance Funding agreed for 6/12.	Continual delivery against PH and discharge IPR targets Contract agreed	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Amber	4	2	6	**October 21**
												Collective work with KCC and CCG to agree social care pathways in east Kent and associated funding	Pauline Butterworth	October 21	A					
												Review of funding plan arrangements	Gordon Flack	July 21	A					

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	2.1
Agenda Item Title:	Board submission to Kent and Medway Integrated Care System
Presenting Officer:	Gerard Sammon, Director of Strategy and Partnerships

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

Report history and purpose

This paper contains the Trust's response to the consultation about the proposed end state of the Kent and Medway Integrated Care System (ICS).

Summary of key points

A number of themes and key principles emerged as part of a recent Trust seminar debate and were incorporated into the Trust's response to the consultation.

The consultation period has now closed and the Trust will in due course receive feedback to determine the next steps in supporting the development of the ICS.

Equality impact assessment (EIA)

An EIA would be undertaken by the ICS on the agreed end state proposal.

Proposal and/or Recommendation to the Board or Committee

The Board is asked to:

- note the Trust's response letter to the consultation about the ICS end state.

Gerard Sammon	Tel: 01622 211902
Director of Strategy and Partnerships	Email:Gerard.sammon@nhs.net

NHS
Kent Community Health
NHS Foundation Trust

Chair and Chief Executive's Office
The Oast
Unit D, Hermitage Court
Hermitage Lane
Barming, Maidstone
ME16 9NT

Phone: 01622 211903
Email: p.bentley@nhs.net
Web: www.kentcht.nhs.uk

Private and confidential
Wilf Williams
Accountable Officer
Kent and Medway CCG

4 May 2021

Our Ref: PB/CMC18-21

Dear Wilf

Re: Development of the Kent and Medway Integrated Care System

Thank you for the opportunity to feedback thoughts and observations about the *Kent and Medway Health and Care System – Integrated Care System (ICS) end state – Consideration of key topic areas*. The Trust continues to be greatly energised by the prospect of being an equal partner in the Kent and Medway ICS and therefore very much welcomes the opportunity to shape its future form and function. The subject was a workshop agenda item at our April Trust Board Seminar and was subsequently discussed at length. A number of themes and key principles emerged as part of our debate which we would wish to share with you and subsequently see included in determining and developing the future state of the ICS.

Theme one - Clear role definition and accountability for Clinical Leadership.

A prominent theme that emerged throughout the Board's discussion was how crucial it was to get the right clinical leadership embedded and operating successfully in the ICS. This is in the context of there being relatively little national guidance provided to date. It will therefore be important to set out a locally determined Kent and Medway definition of clinical leadership and our expectation of it at all levels of the system. Be it in the ICS, place or neighbourhood. It should be made clear how clinical leadership is accountable, has a voice and is able to influence decision making at all these levels and across pathways of care for our service users, patients and populations.

Theme two - ICS is not a replica of a CCG but instead strategic, a system enabler and adopts 'doing it once' as a discipline.

It was considered that the ICS should learn from the past to inform the future and ensure that it does not end up replicating the way of working of a CCG. We would suggest it can do this by ensuring it occupies a more strategic role in its approach to health and care in Kent and Medway and seeing itself as an enabler to what partners agree it can do better at a system level, be it in common policies or approaches that does away with duplication. We therefore support an approach which would mean the system agreeing what each layer (ICS, ICP, PCN or provider collaborative) is accountable for delivering so that we do not duplicate decision making,

governance or processes. The focus should be about setting out a high degree of ambition, facilitating the development of relationships and formalising collaborations that offer solutions to defined, agreed and recognised system problems.

In short, we shouldn't get caught up in organisational form and governance discussions, but define what do we want to do and then design the governance to facilitate and to do the doing. Otherwise, there is a danger of defaulting to the creation of a complex set of governance and structures in the system which will naturally lead to the stifling of innovation and prompt decision making. We should capitalise on our ambitions and some experience of positive partnership working and nimble responses which was evident in Kent and Medway's response to Covid19.

Theme three - System Leadership engagement detailing how feedback is captured, embraced and acted on.

The transition to the ICS undoubtedly requires a change in 'hearts and minds' and a cultural shift in our way of working as a system and as a leadership team. As such, it would be helpful to set out an approach to system leadership engagement which will enable a managed way of feedback and subsequent progression and course correction during the development of the ICS end state and beyond.

Principle one - Subsidiarity, devolving decisions, working at place and provider collaboration level where possible.

We agree with the stated ICS principle of subsidiarity. There continues to be an opportunity to harness the Integrated Care Partnerships which are maturing as an established part of the new system architecture. In addition, we need to up the pace on provider collaboration. These two layers should be used more to translate 'what' the system wants to achieve into the 'how' it is delivered. For this opportunity to be optimised there needs to be clarity and a definition about who is accountable for the delivery of which priorities. Naturally, some delivery responsibility will remain the duty of the ICS (specialised services including specialist community services) and individual providers e.g. speciality level waiting lists. But having this defined more crisply and with an overlay of the functions to deliver on defined priority areas will secure system alignment and therefore reduce inefficiency and duplication.

Principle two - Adopt Quality Service improvement as a common methodology.

The Board would also wish to ensure that the use of Quality service improvement and redesign (QSIR) as a key function is developed at scale and adopted as part of a common methodology in the system by every provider at every level. This would again serve to ensure performance improvement is 'baked' into the ICS end state.

Principle three - Use data to underpin quality improvement, promote population health management and align the direction of PCNs.

Another key principle of the ICS should have centre stage is being much more data driven. This would work hand in hand with a system QSIR approach to eliminate unwarranted variation at every level. Opportunities should also be taken at the same time to strengthen the system's

approach to public health and prevention, again learning from the system's experience of Covid19, and by promoting even more rapidly the NHS population health management programme. This should particularly enable the system to corral and align the direction of Kent and Medway's PCN's. Using a common methodology in population health management coupled with QSIR being used in a consistent manner would enable ICP's and PCN's to be better able for making improvements, share learning and drive better outcomes for their population's health.

Principle four - Develop by doing - make progress with priority programmes of work for our local population, patients and service users as well as building on proven initiatives.

During the transition we consider it important to ensure that we continue as a system to build on what has gone well and adopt the principle of 'developing by doing'. The programmes of work that are progressing well should be maintained, best practice developed and the promotion of good practice shared. For example, supporting the good partnership working established through KMCR and Vaccination activities, individual provider initiatives for health and wellbeing for staff could be designed into a system wide offer and leverage from learning that has been taken from the use of apprentice levies and Educational Academies rolled out are to name just one or two successful organisational initiatives that are scalable. Achieving success at ICS level with a few key priorities will win trust, engage Partners and ensure early progress.

Finally, it would be helpful through this engagement work to hear about any potential areas of common ground or themes that emerge from each provider board, primary care and other system partners. This would allow our Trust board to understand feedback from other organisations and on the strength of this shared understanding enable the system in part to be better able to support the decisions about the end state that will follow.

I hope that you find this feedback helpful and the Trust would welcome your response about how our suggested key themes and principles would be adopted and included into the ICS's end state and any future developments. We would also wish to hear back from you about the leadership engagement programme, which my board supported but felt should be expanded which seems like a good way of inputting and ensuring progression of the ICS development in the coming year.

If it is helpful to discuss any of these matters further I am also more than happy to discuss them with you directly.

Yours sincerely

Paul Bentley
Chief Executive

Cc: Mike Gilbert, Director of Corporate Affairs, Kent and Medway CCG

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	3.1
Agenda Item Title:	2021/22 Strategic Priorities
Presenting Officer:	Gerard Sammon, Director of Strategy and Partnerships

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

Report history and purpose
This paper summarises the outcome of the engagement work undertaken and makes recommendations about the Trust priorities for 2021/22.

Summary of key points
The Leaders' Conference, Governor Development Session and recent Board seminars focussed on workforce, quality and system leadership agreeing these areas were the three priorities for 2021/22. They also identified key themes and important aspects to concentrate one.

Equality impact assessment (EIA)
An EIA was completed during July 2020 as part of the strategy refresh that contains the priority areas for 2021/22.

Proposal and/or Recommendation to the Board or Committee
The Board is asked to: • agree the priorities for 2020/21 as workforce, quality and system leadership

Gerard Sammon	Tel: 01622 211902
Director of Strategy and Partnerships	Email:Gerard.sammon@nhs.net

Kent Community Health
NHS Foundation Trust

2021/22 STRATEGIC PRIORITIES

1. Introduction

1.1. The Trust's strategy identifies eight goals and enablers. It was proposed following extensive engagement work and agreed by the Board in May 2020.

1.2. The delivery plan is in progress with the board sub-committees focused on specific goals and enablers.

1.3. As we enter the next phase of recovery from the COVID-19 pandemic the Board has had the opportunity to discuss whether emphasis should be placed on particular goals or enablers.

1.4. This paper will summarise the engagement work undertaken in relation to the focus areas and makes recommendations about the priorities.

2. Priorities

2.1. For 2021/22 it was proposed that the Trust focus on workforce, quality and system leadership as three priority areas from the established strategy.

2.2. The Leaders' Conference, Governor Development Session and recent Board seminars all concentrated on these areas, agreeing that they were priorities and identifying key themes and important aspects for each of these groups.

2.3. The Leaders' Conference discussed health and wellbeing as a priority within the workforce enabler. Themes around prioritising health and wellbeing and feeling leaders had permission, both personally and organisationally, to focus on theirs and their colleagues' health and wellbeing were strong. The impact of working from home was also recognised and a number of actions were identified to promote uptake of the existing array of health and wellbeing offers. The feedback from the governors on workforce was more varied but included new ways of targeting recruitment as well as health and wellbeing and the issue of permission to access these offers.

2.4. The quality discussions at the Leaders' Conference highlighted the positive impacts of virtual working on quality, as well as areas to remain cognisant of such as access, patient feedback and mixed models as we progress through recovery phases. There was a strong feeling that services had led the development of new models and this should continue, supported by the quality improvement methodology in use across the organisation. The governors focused on the importance of communication in driving the quality of services, both with service users and staff, and the need to be data driven but not through onerous data collection processes.

2.5. Finally the Leaders' Conference discussed system leadership or partnership working. The leaders are keen to recognise where they can add value and

acknowledged the benefits of virtual working in bringing partners together, assuming the platforms used are accessible for all. The governors recognised the range of partnerships in development across the organisation.

2.6. The three focus areas of workforce, quality and system leadership and in particular the topics highlighted within these at the recent discussions align well with the newly published NHS 2021/22 priorities and operational planning guidance. The guidance recognises the necessary support for the health and wellbeing of the workforce and the action required on recruitment and retention as well as the need for collaborative system working to deliver the priorities. In addition the Trust is actively engaged in work to deliver some of the other priorities identified in this guidance such as the vaccination programme, adopting learning and restoring services through the reset and reimagine programme and supporting acute partners through admission avoidance and discharge programmes.

3. Recommendations

3.1. The Board is asked to:

- agree the priorities for 2021/22 as workforce, quality and system leadership

Gerard Sammon
Director of Strategy and Partnerships
May 2021

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	3.2
Agenda Item Title:	2021/22 Annual Operating Plan
Presenting Officer:	Gordon Flack, Director of Finance and Deputy Chief Executive
Action – this paper is for:	☒ Decision ☐ Information ☐ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
The paper is the final operating plan for approval having been drafted by the executive and reviewed by the Finance, Business and Investment Committee.

Summary of key points

The plan set outs the Trust's ambitions for 2021/22 and how these relate to the national priorities.
It encompasses the high-level budget triangulated with workforce and activity plans together with commentary on the quality priorities and enablers of digital, estates and membership.
The focus is on three broad priorities: quality, workforce and system leadership.
This will be delivered within a balanced financial plan whilst recovering our activity levels whilst embracing new ways of working developed during the pandemic.

Proposal and/or recommendation to the Committee or Board

To approve the operating plan.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected*

and maternity, race, religion or belief, sex and sexual orientation.	*characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Gordon Flack	Job title:	Director of Finance and Deputy Chief Executive
Telephone number:	01622 211934	Email	Gordon.Flack@nhs.net

NHS
Kent Community Health
NHS Foundation Trust

Kent Community Health NHS Trust operating plan 2021/2

we care

Introduction

This plan is the document which describes what KCHFT will do this year 2021-22. This plan is positioned within the cortex of the strategy which the Trust refreshed last year.

This is consciously a high-level plan, and further detail of many of the elements can be found in other strategic documents approved by the Trust or within the financial budget approved by the Trust in April 2021.

The plan has two purposes, it is the document which draws together all of the ambitions of the Trust in a single place and secondly it is a reference document against which the performance of the Trust should be judged and evaluated as the year 21-22 progresses.

Strategy

Following extensive engagement with our stakeholders we refreshed our organisational strategy in September 2020 to include four goals and four enablers:

NHS
Kent Community Health
NHS Foundation Trust

Our strategy

Our vision

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

Our mission

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

Our goals

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

Our enablers

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

Our values

Compassionate · Aspirational · Responsive · Excellent

In everything we do, **we care**

www.kentcht.nhs.uk

As part of the planning process for 2021/22 and following consultation across the organisation the Board agreed three very high priority areas for 2021/22 from the established strategy. These are a focus on quality, workforce and system leadership.

The detailed delivery plan for our strategy and priority areas strongly align with the six priorities set out in the operational planning guidance for the year ahead. The following table highlights where the national priorities align with our existing work programmes:

	Operational Planning Guidance Priority	Aligned Trust Strategy and Work Programme
1	Supporting the health and wellbeing of staff, and taking action on recruitment and retention	Strategic enabler and Priority area – Workforce Detailed work programme included in People Strategy
2	Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with COVID-19	Covid vaccination programme Lead Provider for Kent and Medway Strategic goal – quality
3	Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services	Strategic goals – quality, integrate services
4	Expanding primary care capacity to improve access, local health outcomes and address health inequalities	Strategic goal – prevent ill health, integrate services
5	Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay	Strategic goal – quality, integrate services
6	Working collaboratively across systems to deliver on these priorities	Strategic enabler – system leadership

Further information on our supporting strategies is included later in this document.

Link to the emerging Integrated Care System (ICS)

The link between our organisational strategy and the emerging Kent and Medway Integrated Care System is clear and builds on existing work first started during the development of the Sustainability and Transformation Partnership. The opportunity to shape the future form and function of the ICS as an equal partner is an area of focus and energy for the Board.

In 2021/22 we will:

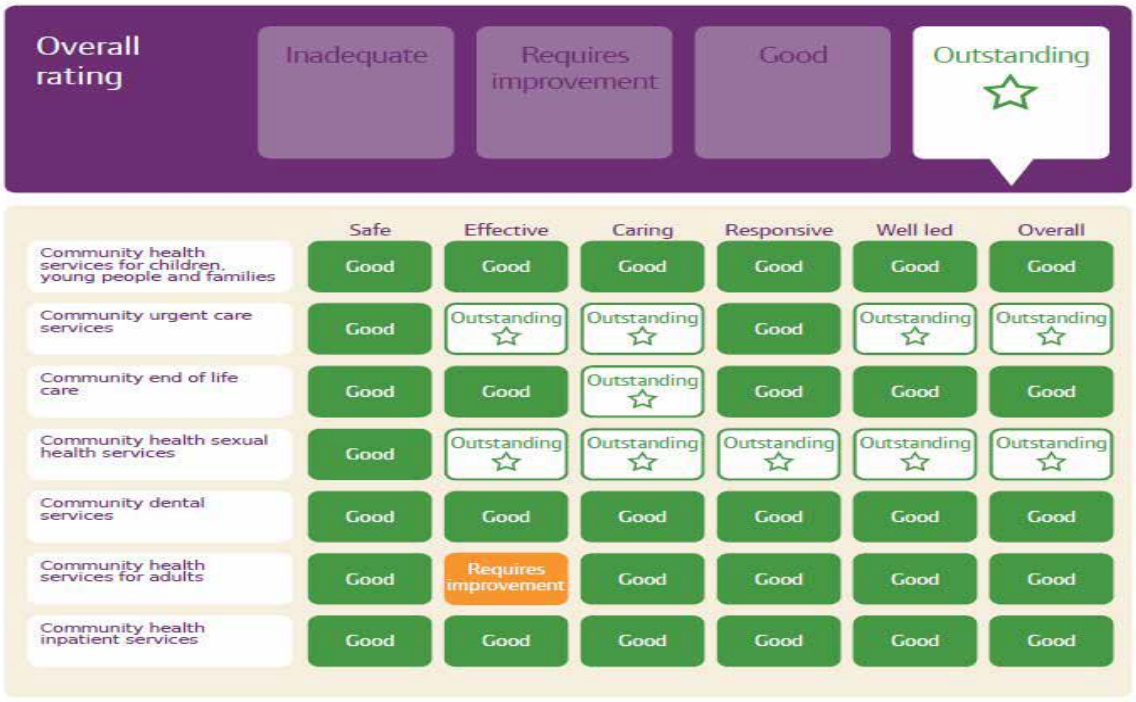
- continue to provide leadership and support across the ICS key functions;
- progress co-creation and implementation of existing and new transformation schemes;
- influence the future shape of the system architecture and creation of an integrated care system.
- actively engage in all four Integrated care partnerships in Kent and Medway

KCHFT also recognises that is provides clinical services in two ICS's outside of kent and medway and as ICS's move into statutory form will work in 2021-22 to meaningfully engage in those geographies.

Approach to quality planning

Quality governance

KCHFT has a comprehensive quality governance framework that supports delivery and continual improvement against regulatory requirements and national standards including Schedule 4 quality requirements as outlined in the NHS Standard Contract 2021/22. Assurance is provided by our Quality Committee, committee sub-groups to the Board who have focused on continuous improvement and reducing bureaucracy in order to promote positive staff experience and ensure continual improvements in patient care. The success of this approach is reflected in the rating of Outstanding following our CQC inspection of April/May 2019 when community urgent care, sexual health, end of life and dental services were reviewed as part of a trust-wide well-led inspection.



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

The CQC inspection report noted a 'significant cultural shift to dissolve bureaucracy, improve accountability, value and empower all staff.'

Quality Account

One of the tools we continue to employ to measure our success in empowering staff and improving staff satisfaction is the quality priority metrics contained within the Quality Account. It is not a requirement to publish a Quality Account this year. However, the Quality Priority metrics relate to patient safety, patient outcomes and patient involvement and demonstrate our commitment to working in partnership with our patients to co-design services. We will, therefore, continue to publish a Quality Account document this year as the visibility of our performance

against 2020/21 patient and staff centred quality priorities and a continued commitment to delivering quality priorities focussed across these areas for 2021/22 is important.

Quality Priorities 2021/22

Improving the safety of the people we care for	Improving clinical effectiveness	Improve the experience of the people we care for	Improving the experience of our people
All patients that experienced a delay to treatment due to the national directives during the COVID-19 pandemic will receive a harms risk assessment. 100% of people relevant people will have had a harms risk assessment completed. Measured through audit.	**Increase recognition of patients in the last year of their life empowering them to make decisions about their care.** 80% of relevant patients will have had a last days of life care plan completed. 40% of relevant patients will have had the "surprise" question completed in line with the gold standards framework. Measured through EPR care plan audit.	**Patients and service users will be involved in co-designing services.** In year one: 3 QI projects initiated by patient/service user feedback with patient/service user representation on the project group. In year two: 7 QI projects initiated by patient/service user feedback with patient/service user representation on the project group. Measured through Life QI.	**Improve the experience of staff providing end of life care by enabling conversations about death and dying.** 12 listening and debrief sessions will be held to provide staff with a safe space to discuss stories and experiences of end of life care.
Fully implement the After Action Review process to apply early learning from incidents. 100% of reviews are completed within two weeks. Measured through audit.	**Identify the areas of health research most important for community nursing.** Co-produce a national list of the top 10 community nursing research priorities with patients, carers and community nurses. Led by the James Lind Alliance.	**The Patient and Carer Council to support 100% of services to have an identified patient/carer voice in the delivery of care.** In year two 100% of services will have an identified patient/carer voice.	**Increase support and guidance to staff to improve knowledge and engagement with information governance standards.** IG training compliance will reach 90% in year one and 92% in year two. Measured through training compliance data.
Identify the determinants of missed/deferred visits in community services. In year one: collect robust data on the numbers and drivers and begin QI projects to reduce missed/deferred visits. In year two: undertake monthly audit to determine reduction in missed visits and increased quality of care.	**Support people to live longer, healthier lives.** Increase the number of health checks completed by 5% in the areas of greatest deprivation in Kent. Achieve an acceptance rate into the Smoke Free service for pregnant women of 45%. Measured through quarterly reporting.	**Support mothers to continue breastfeeding with their child for as long as they both wish.** 1% increase in the number of breastfeeding women when seen 6-8 weeks post-delivery in line with UNICEF National Infant Feeding and PH Outcomes Framework. Measured through audit.	**KCHFT will be a living wage employer by March 2022.** KCHFT will become an accredited Living Wage employer by March 2022.

Quality Strategy 2021-2024

We introduced an organisational Quality Strategy in 2017 in order to ensure that KCHFT was explicitly focused on the quadruple aim of quality which consists of:

- Enhancing patient experience
- Improving population health
- Improving staff experience at work
- Reducing costs and increasing value for money and efficiency

During the last 3 years we have made significant strides in delivering our quality strategy ambitions for KCHFT with key achievements being the introduction of a systematic evidence-based approach to quality improvement (QI) to empower staff to take ownership of the quality agenda. This has resulted in over 400 staff trained in QI Fundamentals and 150 staff receiving more in-depth training known as Quality Service Improvement and Redesign Practitioner. We have also engaged with partners in the health system to provide this training to colleagues in the Integrated care system Clinical Commissioning Group and other trusts.

The quadruple aim remains a cornerstone of our Quality Strategy for 2021-24 and will be delivered through the following 8 objectives:

1. **Focus on continual improvement** enabling staff to feel empowered to take ownership of the quality agenda. 2021/22 strategy deliverables focus on the introduction of alternative approaches to QI training including QI Lite for virtual learning and Bitesize videos.

2. **Ensure that information drives continual quality improvement** – so that we understand the health needs of our service users, patients and the populations we serve enabling targeted quality and effectiveness activities. For 2021/21 our focus is on the development of our analytics resource to support improvement. We are also re-launching our face to face QI training to support staff with measurement for improvement.

3. **Promote positive staff experience** – focusing on what matters to staff using the IHI Joy in Work Framework. For 2021/22 this will include continuing to embed Schwartz Rounds to provide opportunities to reflect on the emotional aspects of work as recommended by the Point of Care Foundation. We will also be implementing After Action Reviews to help to build staff psychological safety.

4. **Improving patient and carer experience** – by working in partnership with the people to whom we deliver services. Considerable work has already been undertaken by the Director of Participation, Experience and Patient Engagement in terms of delivery against a patient participation work-plan and this will be further embedded in 2021. In addition, there will be continued roll-out of end of life care training to deliver proactive personalised care for everyone identified as being in the last year of life.

5. **Reduce health inequalities** – by working as part of the ICP to take community centred and place-based approaches to address the wider determinants of health inequalities. Work in 2021/22 will focus on building relationships with external stakeholders and increasing participation from seldom heard voices.

6. **Effective use of resources** - to use digital technology in a better way to support patient care and staff experience. A Task and Finish Group is already in place helping to develop

the digital vision for the organisation as part of the Digital Strategy which will go live in 2021/22.

7. **Prioritise patient safety** – in line with the NHS Patient Safety Strategy 2019 deliver and clear and compelling patient safety vision and culture which is meaningfully understood by both patients and staff. This should result in staff feeling psychologically safe, the tackling of blame, the valuing and respecting of diversity and support for learning. Strategic objectives 2021/22, include developing a toolkit using QI methodology to support managers to work with teams involved in an incident; ensuring all governance committees include 2 Patient Safety partners trained by April 2022 and development of an implementation plan for Patient Safety Incident Response Framework.

8. **Promote clinical professional leadership** – to ensure clinical services are clinically led and managerially enabled to ensure improved system performance, better patient outcomes and improved staff satisfaction. The focus for 2021/22 will be to continue to support clinicians to engage in peer networks, action learning sets, coaching, mentoring and Schwartz Rounds and in medically led services there will be a focus on clinical directors co-leading with operational managers and lead nurse/AHP.

Quality Improvement is central to the delivery of this Quality Strategy as is the alignment with Digital, Commercial and Our People Strategy as these are key enablers for success.

Summary of quality impact assessment process and oversight of implementation

We measure the quality impact of cost improvement plans (CIPs) on patient safety, clinical effectiveness, patient experience and staff experience.

CIPs are developed as part of business planning in each service and quality impact assessments are completed. The schemes are scrutinised by the Medical Director and Chief Nurse and if supported approved by the Board.

Quality Committee non-executive directors undertake heightened scrutiny (deep dives) into identified schemes, where the risk is noted to be higher and the CIP delivered in full or part. This provides additional scrutiny and assurance for the Board on the process and governance of CIPs.

Triangulation

The Trust uses a statistical process chart driven integrated performance report that presents performance against key performance indicators from quality, activity (including productivity), workforce and finance for each service.

Locally, where performance indicators and soft intelligence suggest concerns, deep dives and support from corporate quality teams are initiated. We care reviews also provide further understanding of the issues in a particular service.

Approach to our workforce.

Our people strategy outlines the aims and intentions about how we will recruit, retain and engage staff as partners to unlock their potential. Our aim is to be the best employer and create an organisation where staff feel empowered to act in line with the trust values and the contribution we make to health and wellbeing.

Our ambition is to create and maintain a happy, engaged and productive workforce, who provide outstanding services and care.

We firmly believe our Trust belongs to our people – both the people we care for and the people who work here. Our people are our most valued asset and the best resource we have to deliver all that is required of us. They shoulder enormous responsibility for the lives of patients and their working life must reflect this; they should be trusted, have compassionate leadership and be duly recognised for their contribution.

Our pledge is simple – to be the best place to work and the cornerstone of our People Strategy for 2021-24 and will be delivered through the following 7 objectives:

Engage our people

- introduce pulse surveys
- all staff to have a what matters to me conversation
- flo app embedded
- launch resolution and accountability framework
- freedom to speak up promotion campaign

Empower our people

- have 54 reimagine teams in place
- staffing levels in adult teams are set to meet population need
- all colleagues will have a buddy
- we will standardise what makes sense
- decision making framework in place

Looking after our people

- well-being conversation for all colleagues
- identify and implement post that can home working and hybrid
- promote flexible working
- psychological PPE in place for all colleagues
- expand the number of people trained to support schwartz rounds
- all staff risk assessed on a regular basis
- Well-being guardian appointed

Developing our people

- Everyone will have a career conversation which will inform our learning and development offering
- Career clinics are offered to all staff
- Capacity of learning and development for all staff will be increased to deliver to larger audiences, utilising technology
- TNA’s will inform central Learning and Development offering
- Clear development pathway and Talent Management Programme for employees wishing to move into a people management role for the first time.
- eLearning and virtual learning will be expanded to ensure staff receive the training they need, as soon as they need it
- Improvements to usability of TAPs, functions to include:
- menu navigation homepages catalogue course “recommendations “linking courses improvements to course detail page

Treating all our people fairly

- equality, diversity and inclusion strategy in place
- gender pay gap actions implemented
- Reverse mentoring implemented
- Cultural awareness training for all staff
- Resolution and accountability framework in place
- Work with the Princes Trust and Kickstart schemes

Compassionate, inclusive and effective leaders for our people

- Leadership career pathways developed and mapped against KCHFT Leaders and Managers Behaviours/Competencies and supporting development opportunities if not meeting competency or wish to develop further
- Leadership Academy Talent Development Programmes running for current KCHFT leaders and managers and those of the future.
- All leaders attended coaching workshops
- All leaders attending ALS
- All managers role model & challenge behaviours when this is not in line with Trust values
- implement assessments for all leadership roles above 8a

Our people of the future

- each directorate develops an integrated workforce plan
- retention plans developed focused on highest rate of turnover and vacancies
- introduce new e rostering module
- develop a programme of secondment opportunities
- improve our internal transfer process
- continue e recruitment and speed up recruitment processes
- promoting careers in schools
- Annual programme of events to attract our workforce of the future and promotion of KCHFT as a place to work
- Continue to expand Bank to cover growth in demand
- Maximising the functionality of Healthroster analytics
- Roll out of e-job planning for all clinical staff

We will know when we have this right when:

- Our turnover in all teams is below 10%
- Our vacancy rates in all teams is below 5%
- Staff sickness levels are below 3%
- 20% of our colleagues work from home
- Our time to hire is below 5 weeks
- Our bank fill rate is 80%
- Our staff survey scores are in top 20% in the country
- An increase in our people nominating their colleagues for awards
- Increased number of contacts made to Freedom to Speak up Guardian
- Year on year increase in colleagues working flexibly
- All staff have a bi yearly risk assessment
- Achieved platinum rating for the Kent and Medway Workplace standard

- All colleagues have a well-being conversation
- All posts advertised as flexible working
- 90% of our academy students remain employed with the trust following qualifying
- All colleagues with a protected characteristic have a coach or mentor
- BAME staff are proportionately represented at all levels of the trust
- Gender pay gap reduced
- Concerns raised by colleagues are resolved informally without recourse to formal investigation

The first national priority for 2021/22 is supporting the health and wellbeing of staff, and acting on recruitment and retention. The Trust's response will build on the good work which has seen the Trust with the best overall staff survey in the South East Region (and scoring the third highest in the health and well-being theme), further work includes the following:

Wellbeing conversations and risk assessments are now built into our local inductions processes. There has been very positive feedback about our end of year reviews taking this format so we will be considering how we can maintain this next year as we revert to business as usual.

At KCHFT we will ensure that we advertise our roles on job boards and through media that ensures that we are reaching a diverse pool of candidates exploring options such as Diversity.com or WorkplaceDiversity.com. We will introduce Values based recruitment into our recruitment process and will aspire to include a BAME representative on recruitment panels or on an assessment centre where the role being appointed to is a Band 6 or above. BAME colleagues will be offered the opportunity to enter a BAME mentoring programme or apply to join the Reciprocal Mentoring programme that the Trust will be launching in 2021.

Workforce Numbers

The budget for the Trust incorporates the workforce plans which will see a modest increase in WTEs by 141 or 3.1%. This is before any additional developments are agreed with the system supporting community transformation.

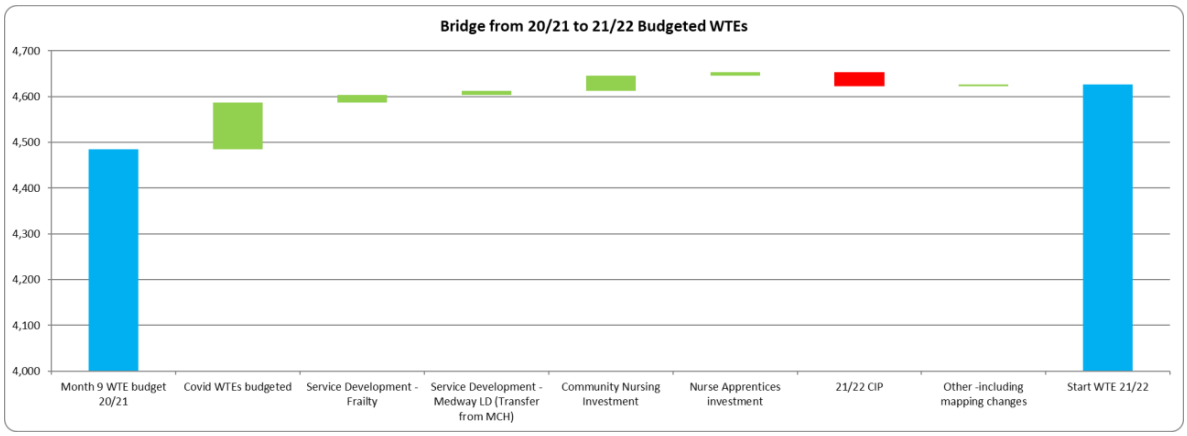
Directorate	Closing WTE 2020/21	Start WTE 2021/22
Operations	3,851	3,865
Childrens Specialist Services	661	665
Dental	205	206
East Kent	982	989
Operations Management	25	23
Public Health	769	769
Specialist & Elective Services	545	538
West Kent	663	676
Clinical, Care and Quality Directorate	57	57
Corporate Services	55	61
Medical Director	66	67
IT	116	120
Estates	203	204
Finance Directorate	95	96
HR, OD & Communications	148	147
Depreciation	0	0
Reserves	-104	8
Central Income	0	0
Grand Total	**4,485**	**4,626**

The reserves budgeted WTEs includes covid 19 (57.6 WTEs) and the hospital discharge programme (45.2 WTEs) as well as negative staff turnover WTEs (-100 WTEs).

Establishment changes by staff group show the increases for service developments (+67 WTEs), expected impact for covid (+102WTEs) and savings from cost improvement schemes (-31 WTEs).

	Month 9 WTE budget 20/21	Covid WTEs budgeted	Service Development - Frailty	Service Development - Medway LD	Community Nursing Investment	Nurse Apprentices investment	21/22 CIP	Other - including mapping changes	Start WTE 21/22
Allied Health Professionals	628	4	-	4	-		-	- 14	**622**
Chairman & Non-Executive Directors	2	-	-	-	-		-		**2**
CIP Holding Account - Pay	-	-	-	-	-		2	-	**2**
CIP Savings - Pay	- 3	-	-	-	-		- 8	1	**- 10**
Consultants	20	-	1	-	-		-	- 2	**19**
Contract Savings - Pay	- 9	-	-	-	-		-	4	**- 5**
Heath Care Scientist	15	-	-	-	-		-	1	**16**
Medical Career/Staff Grades	63	-	3	-	-		-	7	**73**
Medical Trainee Grades	2	-	-	-	-		-		**2**
NHS Infrastructure Support	1,328	27	6	1	-		- 19	25	**1,368**
Other Scientific, Therapeutic and Technical Staff	145	-	-	-	-		- 1	21	**165**
Registered Nursing, Midwifery and Health Visiting Staff	1,276	24	1	3	34		- 2	- 12	**1,324**
Support to Allied Health Professionals	201	-	-	1	-		- 2	- 9	**191**
Support to Nursing Staff	799	47	5	-	-	8	- 1	- 18	**840**
Support to Other Clinical Staff	18	-	-	-	-		-		**18**
Grand Total	**4,485**	**102**	**16**	**9**	**34**	**8**	**- 31**	**4**	**4,626**

We will build on or academy schemes and increase our occupational therapy and physiotherapy training with 9 more places over the coming year and will seek to continue this growth year on year.



Approach to financial planning

Financial forecasts and modelling

We have had a strong financial position since our formation in 2011/12, when we achieved a surplus of £1.5million. A surplus of £2.2million was achieved in 2012/13 and £2.5million in 2013/14. In 2014/15 we delivered a further £2.8million surplus, £3.5million surplus in 2015/16 and £4.6million in 2016/17, including £3.2million sustainability funds and incentives.

In 2017/18, we achieved a surplus of 6.4million, including £4.3million sustainability funds and incentives and £8.9million in 2018/19 (with £3.9m further incentives), in 2019/20 we delivered a surplus of £2.5million, cumulatively £34.9million.

2020/21 was the year the pandemic impacted the UK and the NHS financial system was suspended to concentrate on delivering healthcare for covid patients. The financial system in place was initially a reimbursement model to deliver breakeven in the first part of the year then a system control total to deliver breakeven in the reminder of the year. The Trust's draft position is an underlying surplus of £0.1million after adjusting for an impairment of £373k following property revaluations as this is not part of operational performance.

Our plan for 2021/22 delivers a breakeven position.

The current financial framework will continue into the first half year of 2021/2022 (H1). The Trust has set budgets, building on 2020/21 budgets, using the methodology described in the budget setting framework which was agreed by the FBI Committee in November. Reserves have then been adjusted so that the budgets align with the block funding included in the H1 system funding assumptions. There is further work to be undertaken across the system, which will be completed by 3rd June 2021 to agree the CCG and NHSE allocations for H1 and final system plans. This will impact the funding that Kent Community Trust receives and there is, therefore, still some uncertainty about H1 funding levels. There is, however, agreed financial principles across the Kent and Medway system, that all organisations should break even.

The 2021/22 budget has been built up from the rollover 2020/21 budget, adjusted to align with the H1 block funding assumptions, and in line with the following:

- The budget delivers a break even income and expenditure position.
- The capital plan is affordable without external borrowing.

- The Trust is not reliant on non-recurrent CIP or other savings in order to meet its targets.
- Budgets are sufficient to deliver safe and effective services.

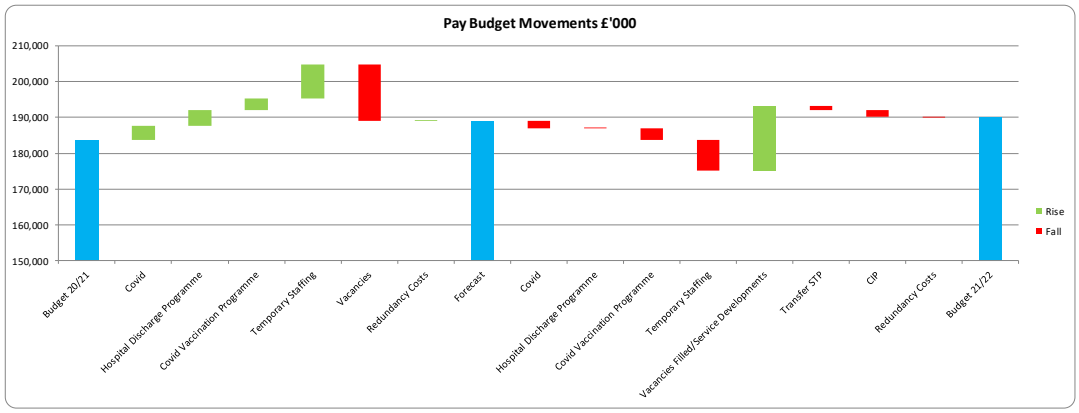
Summary Income and Expenditure Budgets for 2020/21 and 2021/22

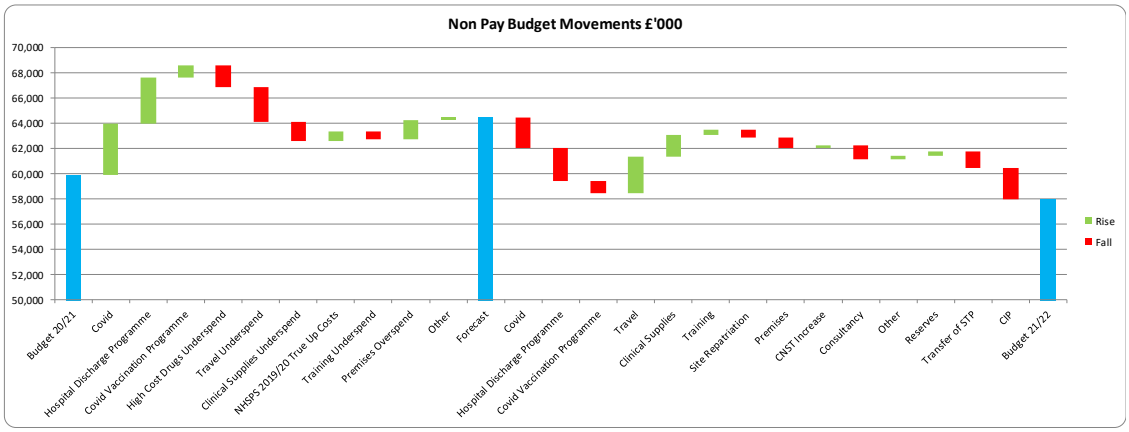
£000s	2020/21 Closing Budget	2021/22 Start Budget
Income	248,011	253,756
Pay	-183,780	-190,094
Non Pay	-59,891	-57,966
Depreciation & Interest	-4,189	-5,696
Total	**150**	**0**

The main changes are:

- In 21/22 £3.6m of covid costs are budgeted (in 20/21 no covid costs were budgeted; forecast covid costs for 20/21 are £8.0m).
- In 21/22 £5.3m of additional supporting hospital discharge costs (above levels included within the current contracts) are budgeted (in 20/21 no additional supporting hospital discharge costs were budgeted; forecast additional supporting hospital discharge costs for 20/21 are £8.0m).
- The Trust no longer hosts the STP, reducing the income (non-patient care services to other bodies) and cost budgets by £2.3m.
- The high costs drugs expenditure budget has been reduced by £1.65m income recognising the expected level of activity, and matching the associated income budget.

The waterfall charts below show - for pay and non-pay costs - the budget in 20/21 through to the forecast costs in 20/21 through to the budget in 21/22.





Significant service developments incorporated into budgets include:

- £1,222k East Kent Frailty investment
- £825k West Kent AQP Physio
- £501k transfer of Medway Learning Disabilities Service
- £487k for prison Dental Services
- £267k West Kent Children's Community Nursing Service
- £227k for Parkinson's nurse, MDT and Orthotics in West Kent
- £175k Learning Disabilities LeDer Service

The reserves includes a negative staff turnover budget of £3.7m, recognising that the levels of staff turnover levels mean that there are always vacancies, and a very small contingency of £309k to fund cost pressures. This is a lower level of contingency than the Trust would normally hold due to the overall budgets being restricted in line with Q3 expenditure levels. It is, however, anticipated that additional growth funding will be allocated to the Trust when the system allocations are distributed during quarter one of the year.

Efficiency savings for 2021/22

We have a robust business planning process. Monitoring takes place with assurance reports to the Finance, Business and Investment Committee, triangulated at the quality and workforce committees, as referred to above in the context of the quality impact assessments

We use benchmarks from national reference costs, benchmarking clubs and the Model Community Services, as well as internal comparisons to understand and investigate variation.

The CIP requirement for 021-22 is £4,415k. At the time of this report plans total £4,434k. This is a planned over achievement of £20k.

A total of fourteen plans have been completed for the Business Planning, CIP for 2021-22. This is made up of seven operational plans and seven non-operational plans. A total of 164 CIP schemes have been identified at the time of this report from the plans.

	Summary				Plans by Risk of Delivery				Plans by QIA Status		
Area	2021-22 Target (£)	Plans Identified (£)	Difference (£)	WTE removal (TWE)	Complete (£)	Low (£)	Medium (£)	High (£)	Approved (£)	To be approved (£)	To be completed (£)
CYPS	526,343	526,343	0	6.25	526,343				526,343		
Dental	208,809	208,809	0	4.06	208,809				208,809		
East Kent	792,267	811,713	19,446		26,693	510,020	275,000		26,693		785,020
Ops Mgt	19,093	19,093	0	0.08	19,093						19,093
Public Health	506,758	506,758	0	14.76	321,084	171,674	14,000		456,619	50,139	
SES	468,696	468,813	117	5.62		455,143	13,670		468,813		
West Kent	527,511	527,511	0	0.53	22,133	75,000	280,378	150,000		42,133	485,378
CCQ	105,098	105,098	0	0.62		92,866		12,232			105,098
Corporate	82,132	82,132	0		7,132	20,000		55,000		42,132	40,000
Estates	620,181	620,181	0			152,000	115,000	353,181		75,000	545,181
Finance	134,517	134,517	0	0.8	134,517				14,075	120,442	
IT	196,188	196,188	0	0.68	116,925		79,263		193,428	2,760	
Medical	99,846	99,846	0	0.44		16,000	83,846		38,172		61,674
PCPT	17,889	17,889	0	0.4	17,889					17,889	
Workforce OD Comms	109,398	109,398	0		23,352	86,046			109,398		
Total	4,414,726	4,434,289	19,563	34.24	1,423,970	1,578,749	861,157	570,413	2,042,350	350,495	2,041,444
Total (%)		100%			32%	36%	19%	13%	46%	8%	46%

This plan exceeds the national target which is currently 1.1% per year but no delivery is expected in Q1 of 2021/22 due to the pandemic. The additional delivery enables the creation of a risk contingency reserve and contributes to the full year effects of service developments.

Contingency
Our plan includes a contingency of £0.3million, representing 0.1 per cent of income, to allow for some unforeseen expenditure.

Sensitivity analysis
The main risk for 2021/22 is the current gap across the system worst case of £66milllion however there is more work to do before this is fully validated and a realistic plan for the system is likely to improve. From a Trust perspective the uncertainty in pay inflation and possible pension on the public health grant services of £2.5million is an additional risk. Nationally agenda for change funding is expected to be fully funded within the NHS.

Agency rules

Planned agency costs and locum costs of £5.9million are within the cap level of £5.9million. This represents a reduction of £0.9million, 13% in locum and agency costs from 2020/21 levels supported by the national application of agency rules and reduction in covid 19 costs.

We use e-rostering (Allocate), including a bank and agency module, to manage use of temporary staff. Specific supply actions to minimize agency use are expansion of the staff bank and planned recruitment. We are also working with ICS partners in adhering to the agency rules, which is collectively monitored.

Capital planning

Our capital plan for 2021/22 is £12.7million, comprising, £1.3million for estates' developments and maintenance, £6.0million for IT rolling replacement and developments including year two costs for Kent and Medway Care Record (KMCR) £2.8million and £0.4million for dental developments and minor schemes. The Trust will hold the Kent and Medway capital contingency £4.9million for system priorities.

No external borrowing is required to fund the programme with £5.2million depreciation and amortisation and £2.6million cash reserves funding the £7.8million programme (excluding

system contingency). System priorities will be cash funded by the organisation given the system approval later in the year.

Capital programme

We are continuing the implementation of the KMCR as noted above and is the single largest capital scheme for the Trust.

Plan Area	Plan Reference	2021-22 Full Year Plan £000s
Estates	Backlog Maintenance incl. Health, Safety & Security Compliance Measures	487
Estates	Capitalisable Responsive Maintenance incl. Leasehold Improvements	137
Estates	Energy Efficiency	260
Estates	Estates Developments - CIP Enabling	360
Estates	Estates Developments	100
	Estates - Total	**1,344**
IT	K&M Digital Priority Scheme - Kent & Medway Care Record	2,841
IT	IT Developments - Clinical Systems	337
IT	IT Developments - Innovation and Strategy	347
IT	IT Rolling Replacement - Hardware	997
IT	IT Infrastructure and Networks	708
IT	IT Developments - EPMA System	800
	IT - Total	**6,030**
Dental	Dental Services	150
	Dental Services - Total	**150**
Other	Other Minor Schemes & Equipment Purchases	250
Other	K&M Capital - Ring-fenced for K&M System Priorities	4,924
	Other Minor Schemes & Equipment Purchases - Total	**5,174**
	Total 2021-22 Capital Expenditure	**12,698**

We are continuing to refresh our Information Technology (IT) estate and replacing hardware at end of life (£997k). Building on our electronic patient record which we replaced in 2020/21, our plan includes building an integration engine working with other partners using Rio particularly KMPT (£208k).

We are replacing our current method of remote access / control which enables the IT Team to provide remote support to end users and a more secure system (£130k).

Estates investment is modest as NHS Property Services is our landlord in the vast majority of the estate. However, we have repatriated three properties to date and will be investing in improving these buildings. We are tackling backlog maintenance and enabling cost improvements and providing 14%of the trust's CIPs.

Financial sustainability risk rating
We have a planned rating of one out of four where one is the strongest, comprising a capital service cover rating of one, a liquidity rating of one and Income & Expenditure margin of one, a variance from control total rating of one and an agency rating of one.

Our approach to activity planning

Our activity planning is supported by detailed information including historical trend analysis, system knowledge, service developments and local intelligence. It is expected that population growth will increase our activity over the next year and beyond in addition to increases in activity derived from delivery of transforming community services under the long-term plan strategy. This information, together with system partner's current and future plans, has been used to model expected activity for 2021/22.

Note that this plan is subject to iteration with several programmes of work planned for delivery in the coming year in addition to other areas of possible development, details of which provided after the activity table.

Detailed planning has been undertaken by directorates and is aligned with budgets and workforce plans.

The following tables summarise the high-level activity that we expect to deliver in 2021/22 and assumptions:

Service Area	Actuals		Plan	Change (from 19/20)
	2019/20	2020/21	2021/22	
Children's Specialist and LD Services	243,405	182,779	213,839	-12.1%
Public Health Services	340,769	232,835	324,005	-4.9%
Adult Specialist and Elective Services	331,070	241,755	304,247	-8.1%
Adult Long Term and Urgent Care Services	1,009,831	997,951	1,052,448	4.2%
Urgent Treatment Centres	125,922	89,635	117,797	-6.5%
KCHFT Total	2,050,997	1,744,955	2,012,336	-1.9%

Service Area	Q1	Q2	Q3	Q4
Children's Specialist and LD Services	47,613	48,879	57,812	59,535
Public Health Services	85,677	76,316	85,029	76,984
Adult Specialist and Elective Services	61,598	69,587	84,398	88,664
Adult Long Term and Urgent Care Services	250,483	264,796	273,216	263,954
Urgent Treatment Centres	22,409	36,820	30,333	28,235
KCHFT Total	467,779	496,398	530,788	517,371

Assumptions
Some growth areas in 20/21 have been forecast forward into 21/22.
Predicted growth for 20/21 assumed and continued into 21/22
Re-designed delivery methods impacting high activity services (Podiatry, MSK). Growth areas in 20/21 continued into 21/22
Growth areas in 20/21 continued into 21/22. Covid-19 affected areas back to previous levels
Impact of National Measures affecting attendances levels in 2021/22 Q1

Programmes of work planned for delivery in 21/22 include:

- Continuation of selected winter initiatives into business as usual, for example, Stroke Early Supported Discharge and Fracture Neck of Femur Community Hospital Pathways
- Community bed strategy
- System Discharge Pathways Programme
- Implementation of a community long-covid rehabilitation pathway
- Continuation of virtual ward arrangements including additional specialist respiratory input
- Acceleration of two-hour crisis response, building on existing teams
- Development of an integrated out of hospital response including ambulatory pathways, domiciliary and community hospitals with the aim of supporting capacity in the system.
- Possible widening of the cohort of eligible ages for flu vaccination for children
- Seven day working
- Supporting Primary Care Networks (PCNs) to deliver Directed Enhanced Services (DESs) and Additional Roles Reimbursement Scheme (ARRS)

Other areas of possible development to support achievement of the operational plan include:

- Elective recovery with rehabilitation services in the community
- Elective activity booking hubs using existing models to ensure right care, right place, right time
- Achieving top quartile performance for cardiology and MSK pathways
- Colleagues in primary care to achieve annual health checks for people with a learning disability
- Delivery of addressing health inequalities and local health outcomes with services from health improvement including smoking cessation, digital weight management and diabetes and cardiovascular disease

National performance targets

Our plan has a level of activity which is expected to deliver:

- 92% referral to treatment position and waiting list size
- Achievement of the 6-week waiting time diagnostic standard (audiology service)
- Urgent community crisis response within 2-hours
- Locally agreed measures to support integrated health and care delivery
- Bed based services to run at an occupancy rate of 92%
- Reduction in number of patients no longer fit to reside in a community hospital bed.

Vaccination Programme

The Trust was appointed to the role of Management Coordination Organisation on behalf of Kent and Medway in 20/21 and has led on the recruitment of bank workers for the programme. This has been hugely successful with over 1750 people joining our workforce in this capacity. This has enabled the Trust to operate two hospital hubs, set up 5 large vaccination centres and a roving model across Kent and Medway.

The Trust has vaccinated over 250,000 people supporting the system vaccinating over 90% of the top cohorts of people at risk.

The Trust will continue to support the programme through the large sites and roving model into the younger age groups to support the delivery of vaccination to all adult who want it by the end of July 2021.

The Trust is working with the system to determine the longer term delivery approach so that it is sustainable.

Our Enabling Strategies

Estates and Sustainability

The Estates Operational plan for 2021/22 closely links to the Operational plan Priorities with a particular focus on the transformation of estate to support new ways of working.

The Trust will be continuing to reset building and services to both respond to the covid impact and to take services forward to lock in advancements which have been made over the last year. This includes supporting the delivery of more care digitally, safe clinics and meeting areas together with the continual focus on the care environment. Linked to this, we will continue to pursue for programme of transferring buildings out of national ownership into trust ownership to support the system coordinated efficient use of buildings. An overall target for the reduction of estates of 20% forms part of the plans, supported by the delivery of digital services, increase in effective operation of space and reducing void. This will assist in the Cost Improvement programme aim of delivering £620K cost reduction this year.

Staff well-being is an organising principle of the estate re-set with more staff based at home, the use and role of our estate is changing and needs to adapt in response. Initiatives developed as part of the pandemic response will be assessed to ensure improvements are kept and built upon including staff break out spaces, green spaces and digital support.

Our environmental sustainability strategy is a priority for this year with the formal launch of the strategy and implementation plan. The Environmental Sustainability Plan has wide aspirations including staff well-being through increasing our green spaces, moving towards green energy and supporting education.

Our capital plan of £1.3 million supports these ambitions with schemes focused on improvement of backlog maintenance of properties returning to local ownership, sustainability schemes such as solar panel and schemes designed to modernise the estate and improve health and well-being.

The Trust has agreed a set of 41 actions as part of the trust's Sustainability Strategy 2021 to 2026. At the core of this strategy is a focus on the health of the communities we serve now and for generations to come. The dedicated sustainability lead position has been created to progress and report against this strategy, consistent with our commitment to the NHS Long Term Plan and Sustainability Agenda. The Trust's strategy targets five broad areas: Journeys, the built environment, supply, wildlife and biodiversity, and our people.
Each of the 41 actions embedded within these focus areas have been designed to improve the related health, environmental and financial outcomes. For example, we are committed to reducing the non-essential journeys connected with our operations. This is beneficial for the environment due to fewer greenhouse gas emissions being released into the atmosphere, beneficial for the trust's finances by reducing mileage claims and beneficial for health through

the reduction of air pollution which is recognised to be strongly correlated with respiratory diseases.

Digital

Our digital strategy outlines the aims about how we will continue to develop digitally-enabled care and exploit technology that is continually creating new possibilities for prevention, care and treatment:

- Clinical and Care – ensuring that our digital solutions support our clinical teams to deliver high quality services to our patients
- Digital Inclusion – supporting our patients and staff so that they can access the digital solutions that we implement
- Digital Innovation – developing and implementing new technologies and solutions that can enhance the delivery of services across the Trust
- Interoperability – ensuring that our systems and solutions can integrate within the Trust as well as with our partner health and social care organisations
- Enterprise IT – introducing a service delivery culture and approach for the support of our digital solutions
- Security – ensuring that we continue to maintain robust levels of security and threat assessment analysis for the technology infrastructure that the Trust accesses and maintains
- Technology – developing an approach that will see a shift, where appropriate, from the current local management of digital solutions to cloud-based computing.

Our capital plan of £6.0 million supports these ambitions (see detail of capital plan above) with schemes focused on completing the implementation of the Kent & Medway Care Record and improvements in the Trust infrastructure and ease of use of technology for our staff and supporting their well-being.

We will build on the virtual culture mainstreamed during the pandemic and retain at least 25% of our patient and service user activity delivered using technology. This will support our sustainability both financially and environmentally in reduced travelling.

Having accessible and integrated technology is the cornerstone of our Digital Strategy for 2021-25 and will be delivered through the following 7 objectives:

Clinical and Care

- Trust access to KMCR
- Citizen / Patient Held Record
- RiO evolvement (mobile workforce enhancements; initial steps towards system integration)
- “End user first” priority thinking to drive all projects
- Service guides / documentation for all front facing toolsets
- Improved communication / information flow to front-line staff

Digital Inclusion

- Aligning service design to national guidance for Digital Inclusion
- Continued work and alignment with the Kent Count Council / Medway Council initiatives in this area
- Create focus groups to enhance digital inclusivity for services delivered
- Create a culture of inclusive thinking for service design and delivery

Digital Innovation

- Build a forum for cross-departmental knowledge sharing to enhance end user experience
- Use of data to empower strategic thinking to enable better patient care
- Horizon scanning and staying agile to digital innovations that can support the Trust mission for better patient care
- Adopt intelligent automation tactics, invoke use of AI and “as code” to empower process and create efficient solution design and deployment.

Interoperability

- Data empowerment – shared use of data across teams
- KMCR and RiO integration into wider health and social care economy

Enterprise IT

- Build compliance into our culture
- Create an Enterprise mindset through adoption and integration of proven frameworks and process to enhance service delivery
- Enhanced Technical Governance
- Refinement of existing process and standards

Security

- Updated security processes and meeting all compliance-based requirements

Technology

- Use technology solutions to automate high-cost processes
- Cloud Adoption (“cloud where appropriate”)
- Delivering scalable, consumption-based services

We will know when we have this right when:

- Create a culture of “user first” thinking for any technical deployment
- We have access to a wide array of data that supports clinical decision making
- Simplified architecture and a standardised user experience
- Improved staff productivity by removing unnecessary procedures

- Digital services providing better access to information giving patients more control over their own healthcare
- Forums for innovation discussions to bring new ideas forward
- More collaboration with other NHS and health and social care providers
- Create flexibility to identify and deliver solutions that are scalable, secure and resilient and take advantage of innovation.

Membership and elections

Our Council of Governors forms an integral part of the governance structure and is the 'voice' of local people, setting the direction for the future of our services, based on members' views. Governors can and do attend Board meetings.

Governor development

Governor development sessions were held prior to the formal council meetings. These meetings were held virtually during 2020/21 due to the COVID-19 pandemic. In addition, Governors were invited to a virtual full-day development session.
Governors are invited to join the Chair and Non-Executive Directors on service visits to observe and understand service provision in action, and regular meetings are arranged between the relevant governors and the senior operational managers. Many of these visits and meetings were postponed in 2020 due to the pandemic. Governors are also encouraged to attend NHS Providers' training or conferences.

Membership and population engagement

We want our members to have real involvement with us, so they can influence the way our services are provided. As a key link to the community we serve, our governors and members provide some checks and balances to make sure we deliver safe, effective and high-quality healthcare.
We engage our members in all sorts of activity, from asking for their involvement in patient participation groups to encouraging their feedback on information the trust may wish to share with a wider audience.
Governors have the opportunity to engage with members and the wider public including attending community events in their constituencies taking part in visits and attending trust and stakeholder events and the annual members' meeting. In 2020, much of this engagement was virtual because of the COVID-19 pandemic and this remains the case at the time of writing. This does not appear to have impacted engagement and in the case of the annual meeting, it increased engagement through using a pre-recorded film shared on multiple platforms and our number of contacts with public members increased from 14,161 in quarter three to 36,194 in quarter four.
There is a Communications and Engagement Committee, established as a sub-group of the council, which provides direction on key topics for the Council of Governors and feeds back on campaigns and information shared by KCHFT.

Conclusion

As the country, the national health service and the Trust recover from the harshest pandemic in a generation this document sets out what the Trust intends to deliver in 21-22 and signals

the level of ambition for subsequent years. This represents an ambitious plan to continue to deliver high quality healthcare, be the best employer we can be and recognise that the Trust is a part of a health and social care system and a high performing system is needed if we are to deliver the care which the people we serve deserve.

As identified above the Trust plans are detailed in a number of separate strategies and documents but this plan presents a cohesive approach for the Trust in 2021-2022.

Executive team

May 2021

Glossary

Agenda for Change is the national pay system for all NHS staff, with the exception of doctors, dentists and most senior managers.

Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012. They are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local populations

CIP stands for cost improvement programme and is the identification of schemes to increase efficiency and/or reduce expenditure. CIPs can include both recurrent (year on year) and non-recurrent (one-off) savings. A CIP is not simply a scheme that saves money as there must not be a detrimental impact on patients.

CQC stands for Care Quality Commission and is the independent regulator of health and social care in England.

CQUIN stands for Commissioning for Quality and Innovation. This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care

Datix is a patient safety web-based incident reporting and risk management software for healthcare and social care organisations.

Getting It Right First Time (GIRFT) a programme designed to improve clinical quality and efficiency within the NHS by reducing unwarranted variations.

IC24 is Integrated Care 24 a Social Enterprise providing integrated urgent care.

ICP stands for Integrated Care Partnership is a model of healthcare provision where a provider, or group of providers, takes responsibility for the healthcare provision of an entire population.

KCHFT stands for Kent Community Health NHS Foundation Trust.

NEWS2 is the latest version of the National Early Warning Score, which advocates a system to standardise the assessment and response to acute illness.

NHS Improvement (NHSI) is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care. It supports providers to give patients consistently safe, high quality, compassionate care within local health systems that are financially sustainable

QI Quality Improvement a set of methods to solve problems in improving processes and systems

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	3.3
Agenda Item Title:	2021/22 Cost Improvement Programme (CIP)
Presenting Officer:	Pauline Butterworth, Chief Operating Officer Gordon Flack, Director of Finance/Deputy Chief Executive Officer
Action – this paper is for:	

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

To provide an overview of the 2021/22 programme.

Summary of key points

The CIP target for 2021/22 is £4,415k. A total of fourteen plans have been completed for the Business Planning, CIP for 2021/22. This is made up of seven operational plans and seven non-operational plans. A total of 159 CIP schemes have been identified at the time of this report. Figures in this report are subject to change as plans continue to be developed further.

Proposal and/or recommendation to the Committee or Board

To approve the 2021/22 Cost Improvement Programme.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.**	☐ Yes *(please attach)* ☐ No

Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.	*(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Pauline Butterworth Gordon Flack	Job title:	Chief Operating Officer Director of Finance/Deputy Chief Executive Officer
Telephone number:		Email	

2021/22 COST IMPROVEMENT PROGRAMM

Kent Community Health NHS Foundation Trust

1. Situation

1.1 The CIP target for 2021/22 is £4,415k. A total of fourteen plans have been completed for the Business Planning, CIP for 2021-

/22. This is made up of seven operational plans and seven non-operational plans. A total of 159 CIP schemes have been identified at the time of this report. Figures in this report are subject to change as plans continue to be developed further.

2. Background

2.1 The 2021/22 CIP target paper was approved by the Executive in Aug-20. Business plans include the 2021/22 business objectives, CIPs and Quality Impact Assessments (QIAs) for the CIPs. The 2021/22 CIP target was agreed as £4,415k.

2.2 A full report on the 2021/22 programme was submitted to the Finance, Business and Investment Committee.

2.3 CIP reviews for areas have been held with the Chief Operating Officer and Director of Finance/Deputy Chief Executive Officer as required. These will continue for areas that have not yet identified their planned savings. Plans have also been reviewed at the Executive Performance Reviews.

2.4 CIP QIA reviews have taken place with the Chief Nurse and Medical Director since Nov-20. CIP QIAs were submitted to the Extraordinary Quality Committee in Feb-21 and continue to be monitored as QIAs are approved.

2.5 A trust wide Business Planning and CIP workshop was held in Nov-20. All operational and non-operational services presented an overview of their CIP plans and business objectives for 2021-22 to ensure there was trust wide alignment and to highlight any lessons learnt.

2.6 CIP progress for some areas has been impacted by the COVID-19 priorities and the development of plans will continue in line with these priorities.

3. Assessment

3.1 There is a planned saving achievement of £4,434k against the 2021/22 CIP target of £4,415k, with an overview shown below:

3.2 Planned savings relate to £2,029k (46%) of pay savings with a whole time equivalent (WTE) of 36.75 WTE and £2,406k (54%) relate to non pay savings.

3.3 Complete schemes total £1,510k (34%), low risk of delivery schemes total £1,435k (32%), medium risk of delivery schemes total £783k (18%) and high risk of delivery schemes total £706k (16%).

3.4 QIAs approved schemes total £2,296k (52%), QIAs to be approved schemes total £185k (4%) and QIAs to be completed schemes total £1,954k (44%).

4. Recommendation

4.1 To approve the 2021/22 programme.

Pauline Butterworth, Chief Operating Officer
Gordon Flack, Director of Finance/Deputy Chief Executive Officer
13 May 2021

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	4.1
Agenda Item Title:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
The Integrated Performance Report is produced to give an overview of performance against a number of national, contractual and internal key performance indicators. This 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

There are 11 KPIs moving favourable in month and 8 moving unfavourably whilst 18 are in normal variation.

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

- KPI 1.2 Health Checks impacted by COVID-19 and working on a restart. Trajectory in place for 21/22
- KPI 2.7 Contractual Activity against plan which is currently -18.2% year to date due to the effect of COVID-19 on service delivery.
- KPI 4.2 Income & Expenditure - Surplus (%). Small surplus for the year against 1% target
- KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%. Currently at 22.9% against 0% target

Of the 7 indicators not measured by SPC charts, 7 (100%) are achieving target

Quality

- Twelve lapses in care were identified during February and March 2021 that happened in our care, this is an increase when compared to December 2020 and January 2021 where six incidents were reported.
- 2 pressure ulcers were declared as SIs in the last 2 months

- No moderate or severe harm falls, avoidable falls in normal variation.
- Slight decrease in medication incidents compared to the previous period. Larger decrease in low harm medication incidents.

Workforce

- Staff Survey - The Trust staff survey results benched marked extremely well, when compared to other Community Trust in England and was ranked as 2nd. When compared with all Trust in the South East Region the trust was ranked as 1st. To achieve such fantastic results in a year that has put everyone across the NHS under such pressure is a great achievement.
- Turnover in March 2021 continues to be reported below the target, at 13.50%. The organisation saw a steady increase up to December 2020; the highest rate was reported at 13.97% in December 2020. However, this has continued to reduce and continues to remain below average and below the new target of 14.47%
- At 3.5% the in-month sickness absence rate for March 2021 is a significant decrease from the sickness absence levels experienced in December 2020 and January 2021, and brings the absence rate below the mean and the target.
- The Vacancy Rate had been on a continual downward trajectory until July 2020. Since this point the Vacancy rate has increased and is reported at 4.3% in March 2021, 1.07% higher than the lowest rate in July 2020. The Vacancy rate continues to remain significantly below the target of 8%.

Finance

- The Trust has made a surplus of £102k when adjusted for an impairment of £373k. Pay and non-pay have overspent by £3,344k and £5,622k respectively offset by an underspend on depreciation/interest of £420k and an over-recovery on income of £8,498k
- The Trust achieved CIPs of £4,210k for the year against a risk rated plan of £4,210k and so CIP has been achieved in full
- Spend to March was £10,098k, against a YTD plan of £10,485k (96% achieved). The plan figures referenced include the effect of the PDC funded schemes approved after the revised plan submitted to NHSE/I on 27 July 2020. The full year outturn includes £3,699k capital expenditure funded by PDC (£1,356k on the Trust's Urgent Treatment Centres, £113k on enhanced cyber security, £2,139k on the Kent & Medway Care Record and £91k relating to the Covid-19 response). The underspend in the main relates to the final spend incurred on the Urgent Treatment Centres being less than the originating PDC funding request (£144k) and £198k underspend relating to a second PDC Covid-19 capital claim (for IT equipment) not approved
- There were £291k of Covid costs in March increasing the total spent on the Covid response to £7,891k for 2020/21. In addition there were £710k of costs in March for the hospital discharge programme, increasing the total to expenditure to £7,941k for 2020/21, all of which has been invoiced directly to Kent and Medway CCG.
- Covid-19 vaccination costs: there were £1,835k in March increasing the total

spend for 2020/21 to £3,440k.

- Of the temporary staffing costs in March, £503k related to the covid response and hospital discharge programme (16% of the trust total expenditure on temporary staffing for the month) and the 2020/21 costs were £5,797k or 30% of the total temporary staffing spend for the year.
- Temporary staffing costs for the covid vaccination programme were £1,429k in March (45% of the trust total expenditure on temporary staffing for the month) and £2,360k for 2020/21 or 12% of the total temporary staffing spend for the year.

Operations

Health Checks has been impacted by the Covid-19 pandemic and has only achieved 8.4% of the annual target. commissioners have set a realistic target on a consistent 20% increase on a quarterly basis. The starting baseline for Q1 is 1056 – this has been worked out using Quarter 4 average monthly amount. Commissioners are pleased with the progress made in Kent with resetting NHS Health Checks in comparison to other areas where no activity or reset has happened.

- COVID-19 affected referrals to the Stop Smoking service which reduced significantly. Initially the service saw a huge decline in the number of referrals however, seen a steady increase each week since then but not yet back to pre-COVID levels. A projection of the demand has been worked up until end of Quarter 2 (21/22) and the additional staff required will have an impact on the ONE You Service. Discussions have taken place with commissioners and HR and plans have been agreed and mobilised.
- New birth visits - Continued strong performance above target.
- While, against target, KCHFT is 18.2% behind plan for the full year, a year on year activity comparison continues to be more helpful in determining the position with regards position of services. Excluding MIU and Dental, 109.8% of activity was achieved compared to March 2020.
- 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. 99.9% for M12.
- 6 week diagnostics waits for paediatric audiology is now in normal variation and consistently meeting target. However, an issue has been identified whereby some patient clocks were stopped prematurely as an in depth plan of care was made and a diagnostic decision was made. It was confirmed on the 23rd March 2021 that this this did not comply with the DM01 guidance and NHSE were notified and consulted, with corrective action going forward agreed. As a result, the performance for M1-3 of 2021/22 will likely see a negative impact

- KCHFT's target for the proportion of patients who are no longer fit to reside 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 has been consistently above the mean, (bar a decrease in month 9). The target level continues to be rarely achieved in the current climate (twice in the last 18 months).
- Bed Occupancy continues to show a varying trend with no periods of special cause variation, other than when affected by the Covid-19 pandemic and meeting demands for Covid-19 patients. Levels continue to be between 80-85% and as a result escalation beds have been closed as we moved out of winter pressures.
- Specialty backlogs were managed over the course of the year through the Recovery group, chaired by the Chief Operating Officer. With the exception of Dental GA, Podiatry, Southeast Driveability, Health Checks and the remaining Prison waits, Covid-19 related backlogs have been cleared. These remaining backlogs will now be managed through the monthly Executive Performance Reviews.

Proposal and/or recommendation to the Committee or Board
The Board is asked to note this report.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	
High level position described and no decisions required	

Name:	Nick Plummer	Job title:	Assistant Director of Performance and Business Intelligence
Telephone number:	07823 777 854	Email	nick.plummer@nhs.net

Kent Community Health
NHS Foundation Trust

Integrated Performance Report 2020/21

May 2021 report

Part One

we care

Kent Community Health
NHS Foundation Trust

Contents

we care

Kent Community Health
NHS Foundation Trust

Glossary of Terms

SPC – Statistical Process Control

LTC – Long Term Conditions Nursing Service

ICT – Intermediate Care Service

Quality Scorecard – Weighted monthly risk rated quality scorecards

CDI – Clostridium Difficile Infection

MRSA – Meticillin Resistant Staphylococcus Aureus Bloodstream Disorder

MIU – Minor Injury Unit

RTT – Referral to Treatment

GUM – Genitourinary Medicine

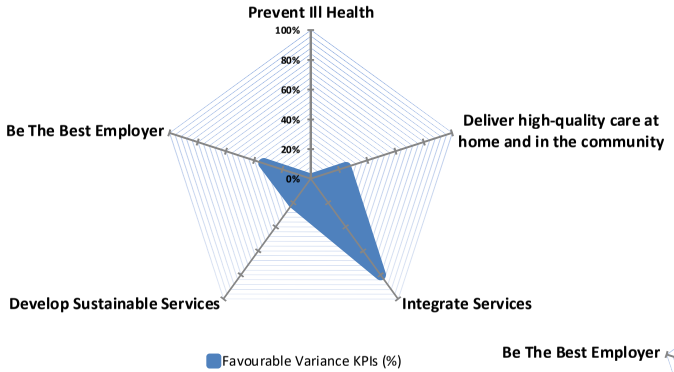
CQUIN – Commissioning for Quality and Innovation

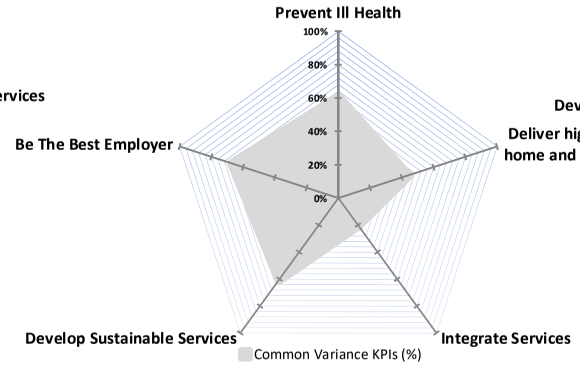
MTW – Maidstone and Tonbridge Wells NHS Trust

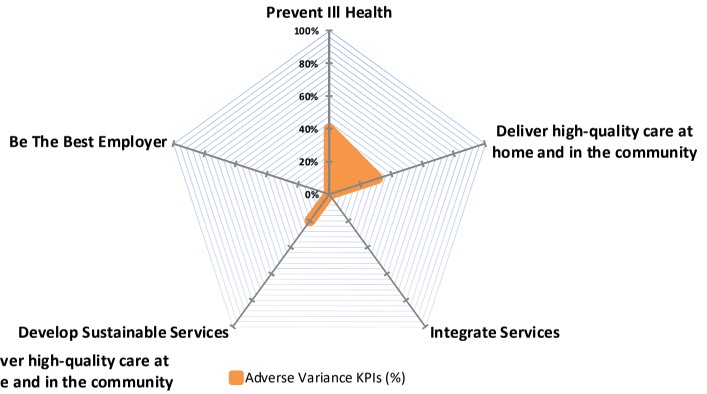
WTE – Whole Time Equivalent

we care

1.0 Assurance on Strategic Goals



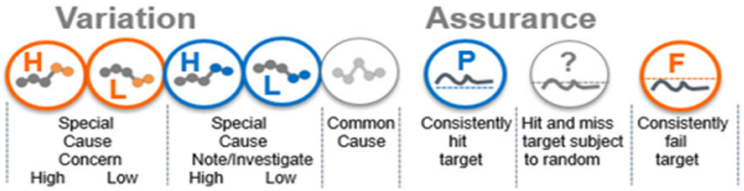




Overall, of the 37 indicators that we are able to plot on a statistical process control (SPC) chart, **29.7% are experiencing favourable in-month variation (11, KPIs 2.5, 2.12, 2.13, 2.21, 3.2, 3.3, 3.4, 3.5, 4.3, 5.5 and 5.6), 21.6% are showing in-month adverse variance (8, KPIs 1.1, 1.2, 2.6, 2.7, 2.8, 2.9, 2.10 and 4.2)** and the remaining **48.6% (18) are showing normal variation.**

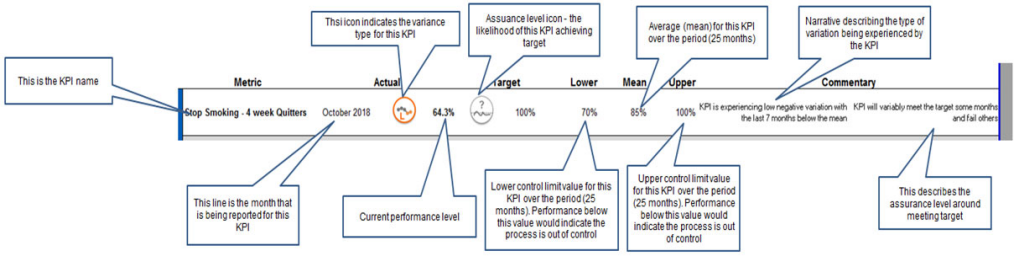
27.0% of the KPIs are consistently achieving target **(KPIs 1.5, 2.5, 2.11, 2.12, 2.13, 2.15, 2.18, 2.20, 5.4 and 5.5),**
10.8% (KPIs 1.2, 2.7, 4.2 and 4.5) are consistently **failing (i.e. target outside control limits negatively),**
with the remaining **62.2% are variably achieving target** with no trend of consistent achievement/failure.

Of the 7 indicators where an SPC chart is not currently appropriate, **100% (7) have achieved the in-month target.**



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

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



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

Kent Community Health NHS Foundation Trust - Corporate Scorecard

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

	Metric	Actual		Target	Lower	Mean	Upper	Commentary
1. Prevent Ill Health	KPI 1.1 Stop Smoking - 4 week Quitters	March 2021	85.0%	100%	64%	87%	111%	Reduced levels of referrals due to Covid-19, resulting in negative special cause variation. However, they are on the increase and now only just below the mean
	KPI 1.2 Health Checks Carried Out	March 2021	8.4%	100%	32%	59%	87%	Service was paused due to Covid-19. Currently working with GP practices (who do the majority of health check delivery) on timescales for restart but challenging with the national picture
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	March 2021	92.1%	90%	89%	93%	97%	Now showing normal variation with stong table performance. 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	March 2021	94.6%	90% (year end)				Target achieved for the 19/20 School Year. 20/21 programme delayed due to school closures
	KPI 1.5 LTC/ICT - Admissions Avoidance (using agreed criteria)	November 2020	6787	5257	5509	6732	7954	Data collection for this metric has been revised due to move to RIO. New data due from 1st April 2021
	KPI 1.6 % LTC/ICT patients that had at least one visit which Avoided a Hospital Admission	November 2020	17.0%	15.0%	14.7%	17.9%	21.0%	Data collection for this metric has been revised due to move to RIO. New data due from 1st April 2021

	Metric	Actual		Target	20/21 YTD Actual	20/21 YTD Target	Commentary
2. Deliver high-quality care at home and in the community	KPI 2.1 Number of Teams with an Amber or Red Quality Scorecard Rating	March 2021	1	1	19	12	Below target for the month but exceeding target for the year to date
	KPI 2.2 (N) Never Events	March 2021	0	0	0	0	Target achieved for the month. 0 Never Events recorded this year to date
	KPI 2.3 (N) Infection Control: CDI	March 2021	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	March 2021	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

	Metric	Actual		Target		Lower	Mean	Upper	Commentary
2. Deliver high-quality care at home and in the community	KPI 2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days	March 2021	0.00	P	0.19	-0.10	0.04	0.18	Decrease back to 0 following higher level of moderate and severe harm falls earlier in the financial year. Upper limit below target so high assurance levels
	KPI 2.6 Pressure Ulcers - Lapses in Care	March 2021	8	?	1	-1.5	2.8	7.2	Twelve lapses in care were identified during February and March 2021 that happened in our care, this is an increase when compared to December 2020 and January 2021 where six incidents were reported
	KPI 2.7 Contractual Activity: YTD as % of YTD Target	March 2021	81.8%	F	100.0%	85.3%	89.7%	94.2%	An full year of performance below the lower control limit as a result of the Covid-19 Pandemic with some services reduced or stopped. Stronger performance in M12. Activity plans have been drawn up for 21/22
	KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity	March 2021	4.7%	?	4.0%	3.1%	4.1%	5.2%	Increased levels of DNAs experienced due to patients willingness to attend appointments and increased instances of patients not showing for virtual consultations. Levels impacted further by wave 2 lockdowns but now on the decline
	KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)	March 2021	85.3%	?	95.0%	90.3%	94.7%	99.1%	Metric currently showing negative variation with period below the mean as a result of revised data capture following the move to RIO. Exepected to return to previous levels in early 21/22 following staff education
	KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance	March 2021	72.0%	?	95.0%	82.2%	93.2%	104.1%	Metric currently showing negative variation with period below the mean as a result of revised data capture following the move to RIO. Exepected to return to previous levels in early 21/22 following staff education
	KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	March 2021	99.6%	P	95.0%	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	March 2021	99.9%	P	92.0%	92.4%	95.7%	99.0%	Positive special cause variation with the last 15 months above the mean. Target has also been achieved for 15 consecutive months. High performance in all applicable services
	KPI 2.13 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Waiting List Size (>18 weeks)	March 2021	5	P	532	57	280	503	Positive special cause variation with the last 15 months below the mean. Target not at risk of being missed
	KPI 2.14 AHP (Non-Consultant Led) Referral to Treatment Times (RTT)	March 2021	95.2%	?	92.0%	89.5%	94.0%	98.5%	Positive variation in Months 9-11 although impacted by fewer appointments in the month. Target still within control limits so performance liable to fluctations and target not always guaranteed to be achieved
	KPI 2.15 (N) Access to GUM: within 48 hours	March 2021	100.0%	P	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)	March 2021	17.6	?	21.0	14.6	19.5	24.4	Normal variation within the control limits but positive in-month performance below the mean.
	KPI 2.17 Research: Participants recruited to national portfolio studies (20-21 Year to Date)	March 2021	1971	●	300				Despite Redeployment of most of the team and a pause on all but one study in Q1, recruitment has siginificantly over-achieved against the annual 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
2. Deliver high-quality care at home and in the community	KPI 2.18 Percentage of patient goals achieved upon discharge for planned and therapy services	March 2021		94.6%	P	80.0%	81.2%	88.2%	95.1%	Metric currently showing normal variation and much improved following negative change as a result of the the move to RIO and data being captured differently.
	KPI 2.19 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT	March 2021		97.2%	?	95.0%	92.9%	96.7%	100.4%	Improvement in the second half of 20/21 following a dip below the lower control limit. Currently meeting target and performing aboive the mean
	KPI 2.20 (N) NICE Technical Appraisals reviewed by required time scales following review	March 2021		100.0%	P	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	March 2021	H	100.0%	?	99.0%	97.0%	99.1%	101.3%	Metric currently showing positive variation (12 months above the mean) and consistently achieving the target. Liable to see decrease in months 1-3 as a result of an issue with incorrectly stopped clocks. Action plan is in place to address

	Metric	Actual			Target		Lower	Mean	Upper	Commentary
3. Integrate Services	KPI 3.1 No Longer Fit to Reside in a Community Hospital bed as a % of Occupied Bed Days	March 2021		12.5%	?	9.5%	4.8%	14.4%	24.0%	Still within control limits and therefore normal variation, but above target in-month. While normal variation, performance is generally above the target level of 9.5%
	KPI 3.2 Home First impact - reduction in average excess bed days (West Kent)	March 2021	L	0.00	?	0.20	-0.16	0.17	0.50	Positive special cause variation currently being seen with a shift below the mean
	KPI 3.3 Average Daily Medically Fit for Discharge Patients (MFFD) - West Kent (Complex and Non complex)	March 2021	L	49	?	75	42	72	101	Metric showing positive special cause variation with the current period towards 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)	March 2021	L	0.00	?	0.20	-0.21	0.24	0.69	Positive special cause variation currently being seen with a shift below the mean
	KPI 3.5 Average Daily Medically Fit for Discharge Patients (MFFD) - East Kent (Complex Only)	March 2021	L	67	?	100	64	101	138	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	March 2021		31.4		30				Above the target for month 12, following a drop as a result of the Covid-19 pandemic and the effect it has had on acute bed usage and flow.

* Note

Kent Community Health NHS Foundation Trust - Corporate Scorecard

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

	Metric	Actual			Target		Lower	Mean	Upper	Commentary
4. Develop sustainable services	KPI 4.1 Bed Occupancy: Occupied Bed Days as a % of available bed days	March 2021		82.4%		92.0%	74.9%	85.9%	96.9%	Following reduced bed occupancy due to Covid-19, which had resulted in negative special cause variation, position has moved to normal variation and near the mean level
	KPI 4.2 Income & Expenditure - Surplus (%)	March 2021		0.0%		1.0%	0.37%	0.7%	0.9%	The Trust has made a surplus of £102k when adjusted for an impairment of £373k. Pay and non-pay have overspent by £3,344k and £5,622k respectively offset by an underspend on depreciation/interest of £420k and an over-recovery on income of £8,498k
	KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	March 2021		100.0%		100.0%	80.1%	92.9%	105.7%	The Trust achieved CIPs of £4,210k for the year against a risk rated plan of £4,210k and so CIP has been achieved in full.
	KPI 4.4 External Agency spend against Trajectory (£000s)	March 2021		£646,837		£491,250	£272,011	£560,991	£849,972	Currently showing normal variation performance below the mean, although above the target for month 12. Agency costs were £646k for March against a target of £491k, of which £131k related to locums
	KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%	March 2021		22.9%		0%	8.6%	17.7%	26.8%	Performing above target and the mean. Sustained performance above the mean and target still outside control limits so unlikely to be achieved

	Metric	Actual			Target		Lower	Mean	Upper	Commentary
5. Be The Best Employer	KPI 5.1 Sickness Rate	March 2021		3.50%		4.20%	2.93%	4.16%	5.39%	Back within target and below the mean following increase in M9-10 due to Covid-19 sickness. Normal variation as performance continues to fluctuate within the control limits
	KPI 5.2 Sickness Rate (Stress and Anxiety)	March 2021		1.13%		1.15%	0.93%	1.13%	1.32%	Slight drop this month to the mean level, although in normal variation. Target around the mean level so likely to continue to achieve target some months and fail others.
	KPI 5.3 Turnover (planned and unplanned)	March 2021		13.47%		14.47%	12.80%	13.76%	14.72%	Showing normal variation with performance just below the mean
	KPI 5.4 Mandatory Training: Combined Compliance Rate	March 2021		96.0%		85.0%	95.5%	96.1%	96.7%	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)	March 2021		4.3%		8.0%	4.9%	6.1%	7.4%	Positive special cause variation below the lower control limit and last 15 months below the mean. Target is now below the lower control limit so consistent acheivement is assured
	KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	March 2021		88.8%		87.0%	86.9%	87.8%	88.8%	Showing positive variation and currently achieving target

2.0 Quality Report

2.1 Assurance on Safer Staffing

RN and HCA staffing Community Hospital February 2021	Day Fill Rate %		Night Fill Rate %	
	RN's	HCA's	RN's	HCA's
Faversham	94.64%	82.08%	95.24%	98.86%
Deal	90.54%	90.12%	91.46%	98.21%
QVMH	96.39%	96.17%	91.07%	100.00%
Whit &Tank	97.42%	92.67%	100.00%	99.83%
West View	78.84%	91.06%	93.10%	98.21%
Westbrook House	100.00%	100.00%	100.00%	100.00%
Edenbridge	84.88%	57.22%	84.10%	85.98%
Hawkhurst	95.50%	89.67%	94.75%	91.55%
Sevenoaks	92.55%	95.88%	90.53%	99.23%
Tonbridge	88.09%	72.37%	90.00%	95.88%
Total	93.90%	80.54%	92.16%	96.79%

1.1 RN and HCA staffing Community Hospital March 2021	Day Fill Rate %		Night Fill Rate %	
	RN's	HCA's	RN's	HCA's
Faversham	79.38%	82.94%	98.30%	98.88%
Deal	75.00%	96.35%	92.77%	96.88%
QVMH	89.33%	94.45%	98.39%	94.79%
Whit &Tank	98.86%	99.81%	100.00%	97.96%
West View	76.70%	96.07%	86.15%	79.33%
Westbrook House	100.00%	100.00%	100.00%	100.00%
Edenbridge	81.76%	55.10%	93.55%	99.21%
Hawkhurst	82.96%	89.34%	96.92%	89.19%
Sevenoaks	84.93%	91.85%	93.60%	91.17%
Tonbridge	79.08%	73.95%	91.49%	93.41%
Total	82.89%	85.37%	94.33%	93.78%

The staffing fill rates at Community Hospitals have improved from the December and January reporting period where 5 out of 10 community hospitals had a fill rate of less than 90% due to the second wave of the COVID-19 pandemic. In February, 8 of 10 community hospitals had a fill rate of over 90%, however this decreased in March to only 6.

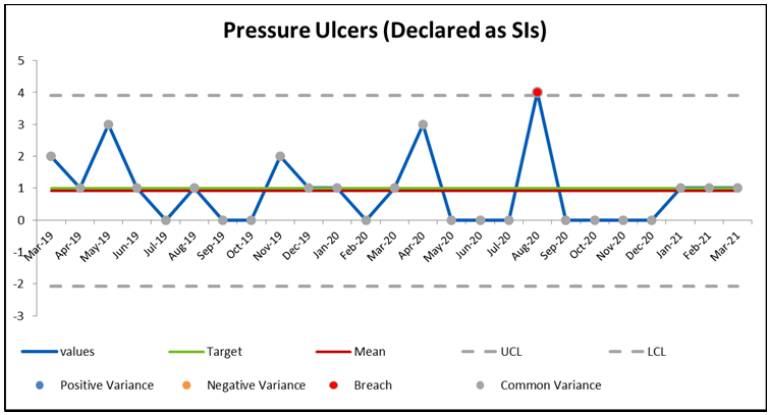
The HCA fill rate at Edenbridge Hospital in February and March was below 65% and the registered nurse day fill rate was 81.76% in March. This is because substantive Edenbridge Hospital staff were previously loaned to support Sevenoaks and Tonbridge hospitals, and now that the pressures relating to COVID-19 have relieved, staff have been able to take some annual leave.

2.2 Assurance on Pressure Ulcers

Twelve lapses in care were identified during February and March 2021 that happened in our care, this is an increase when compared to December 2020 and January 2021 where six incidents were reported.

Five incidents were recorded as low harm to the patient and seven incidents were recorded as moderate harm. Of the seven moderate incidents two were declared as a serious incident (same patient), which is currently under investigation. The learning for one incident was captured through an After Action Review.

The remaining incidents have been investigated and were deemed not an SI following a review from the TVN service.



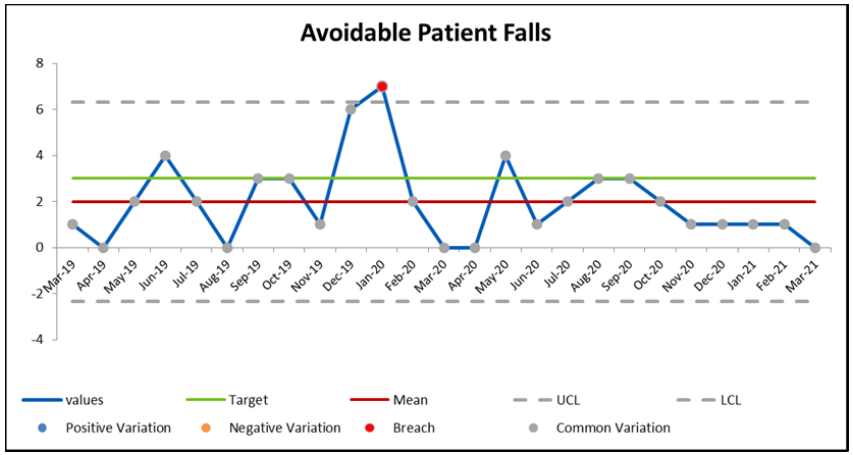
The TVN service continues to review all moderate harm incidents identifying key themes. Main themes: Delay in risk assessments, Timely interventions and the actions required to support patient outcomes which led to skin damage. Bespoke training sessions have been arranged with areas recognised as having increased incidents and requiring support.

To date 50 clinical staff have completed the bespoke training sessions including the learning around the pressure ulcer prevention App and how staff can complete the knowledge checker within the APP supporting improved patient outcomes. A new Trust Wide Pressure Ulcer work plan has been written in consultation with operational services based on the themes noted and staff training requirements. This plan incorporates short and long term targets focusing on clinical outcomes.

The improvement plan will be presented at the next Patient Safety and Clinical Review Group meeting in May and will be added to the agenda regularly to provide ongoing assurance and governance.

2.3 Assurance on Falls

During February and March 2021, 189 falls were reported across the trust with an increase of 2.71% (5) compared to the last period December 2020 and January 2021 which could be due to the acuity of patients and staffing through the second wave of the pandemic. Of the 189, there was one avoidable incident, which resulted in no harm to the patient.



The one avoidable incident relates to:

A patient on a ward was heard calling out for help and when the staff attended the patient was found leaning on his knees and holding onto the bed. This was an unwitnessed fall, after investigation, the learning was shared with the ward staff.

Lessons identified: The earlier bed rail assessment indicated that it was safe to be used however, this should have been re-reviewed once unsafe behaviours by the patient were identified. The use of bed rails should have been discontinued and the appropriate falls prevention measures incorporated in his care plan.

2.4 Assurance on Medication incidents

106 reported medication incidents were considered avoidable and attributable to KCHFT during February and March 2021 compared to 109 incidents in December 2020 and January 2021,this represents a 3% decrease.

The number of avoidable low harm incidents for February was 10 and March was 6 incidents (total 16). This is a 38% decrease (10 incidents) compared to the previous two month period. There was 1 moderate harm incident involving COVID-19 vaccine administration.

Themes during this period:

<u>Omitted medication</u>

33% (35/106) of all medication administration incidents were omitted doses. Community nursing team (16/35) and community hospital ward (18/35).

Low harm – 14% (5/35)

<u>Wrong quantity</u>

13% (14/106) of medication incidents were wrong quantity/dose administered.

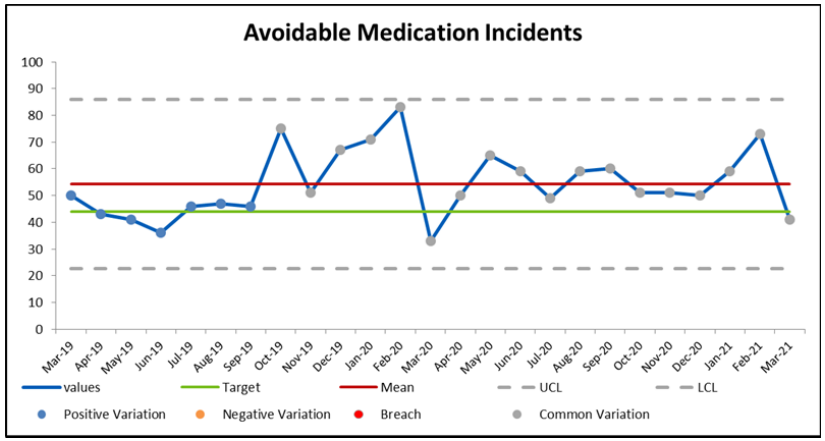
Low harm – 36% (5/14)

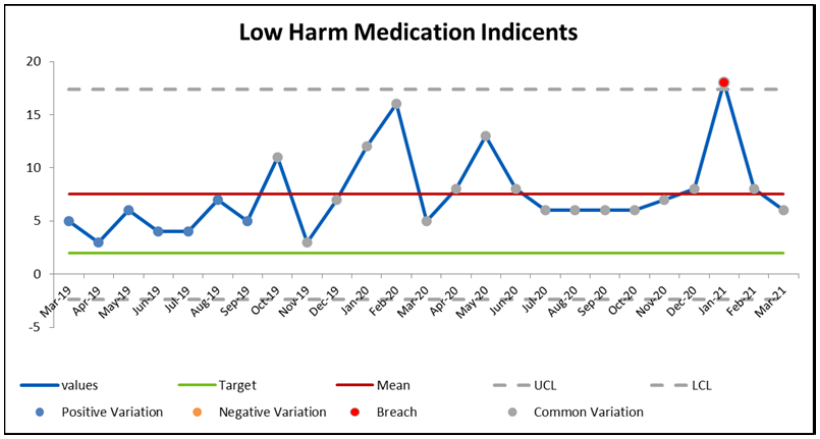
Wrong frequency

8% (8/106) of incidents were wrong frequency – all no harm.

Controlled drug incidents

6.6% (7/106) medication incidents were controlled drugs related, all no harm incidents. However common themes identified includes wrong storage and balance discrepancy which were all accounted for.





2.5 Assurance on Patient Experience

2.5.1 Meridian Patient Experience survey results

6,298 surveys were completed by patients, relatives and carers (this includes 1,103 COVID-19 vaccination surveys), with a strong combined satisfaction score of 95%. This is a vast increase in survey volumes (3,518) and a consistent score when compared with the previous two months (95.5%).

Following the sudden decline in returns at the out-set of Covid-19, the number of completed surveys continues to increase.

2.5.2 The NHS Friends and Family Test (FFT)

5,828 FFT questions were completed during February and March 2021, with 97.4% rating their overall experience as either good or very good.

1% (59) of patients rated their overall experience as poor or very poor, 21 of which were for the vaccination centres, where people were unhappy with the long queues and waiting time. Communication is the main theme seen from the remaining poor or very poor responses.

Services were able to discuss and resolve issues for 4 people who had chosen to leave their details.

2.6 Assurance on Clinical Audit and Research

2.6.1 Clinical Audit Reporting

<u>2020/21 Audit Programme</u>

There were 64 original audits on the programme.

4 did not start, 16 were deferred until 2021/22, 44 were completed.

<u>2021/22 Audit Programme</u>

There are 59 original audits on the 2021/22

5 new topics, 1 new re-audit, 36 carried over 11 deferred from 2020/21, 6 annual re-audits.

KPI Actions Target %	>95%
Due audit recommendations implemented – KPI	**85%**
Actions overdue by more than 3 months – KPI Target <=10%	**1%**
Actions overdue by more than 6 months – KPI7 Target <=5%	**1%**

2.7 Infection Prevention and Control

2020/21 Infection prevention and control trust objectives	February 2021	March 2021	YTD Apr- Mar
No cases of *Clostridium difficile* infection (CDI) where level 3 lapses in care are 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	11 8 COHA 1 HOHA 2 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 surgery100% in-patient units 100%	Podiatric surgery100% in-patient units 100%	Podiatric Surgery =100% 97 % inpatient units
There will be a reduction of acquired urinary tract infections and catheter associated urinary tract infections compared to 2019/20	5 UTI's 1 CAUTI	4 UTI's 2 CAUTI	92 UTI's 24 CAUTI's
Prevent ongoing transmission COVID within Community Hospitals Total No. COVID +ve patients in wards at end of month (including stepdown) Total number Currently infectious patients in wards at end of month No. of those who tested positive in month, and meet the definition: hospital onset – probable / definitely healthcare acquired (data collection commenced May 2020)	58 12 12	26 2 3	Total COVID+ve patients cared for in wards since March 2020: **656** Total nosocomial (probable and definite) 100 % nosocomial 15.5%

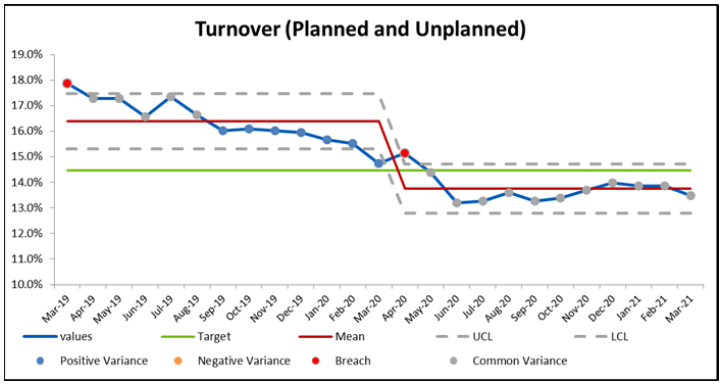
3.0 Workforce Report:

Staff Survey - The Trust staff survey results benched marked extremely well, when compared to other Community Trust in England and was ranked as 2nd. When compared with all Trust in the South East Region the trust was ranked as 1st. To achieve such fantastic results in a year that has put everyone across the NHS under such pressure is a great achievement.

3.1 Assurance on Retention

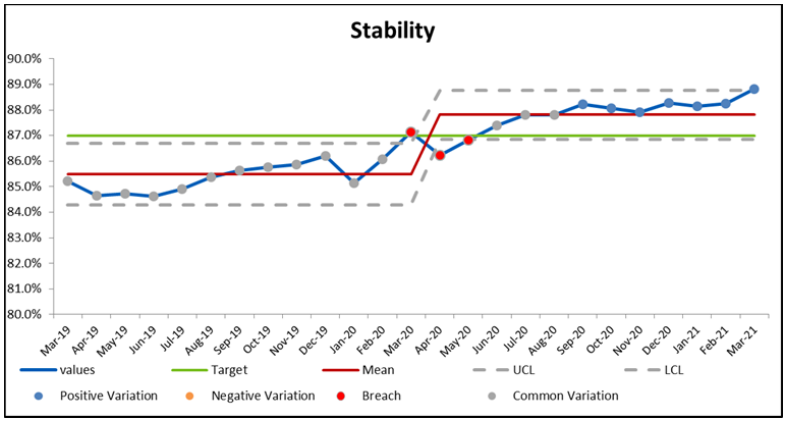
3.1.1 Turnover

Turnover in March 2021 continues to be reported below the target, at 13.50%. The organisation saw a steady increase up to December 2020; the highest rate was reported at 13.97% in December 2020. However, this has continued to reduce and continues to remain below average and below the new target of 14.47%.



3.1.2 Stability

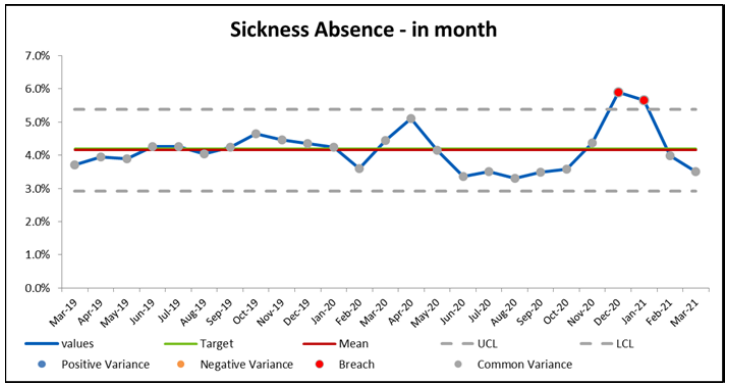
Stability continues to perform above the mean and target. As of March 2021 stability was at 88.81%, 1.81% above the new target rate of 87% and is once again the highest rate of stability across the reporting period.



3.2 Assurance on Sickness

3.2.1 Sickness Absence

At 3.5% the in-month sickness absence rate for March 2021 is a significant decrease from the sickness absence levels experienced in December 2020 and January 2021, and brings the absence rate below the mean and the target.

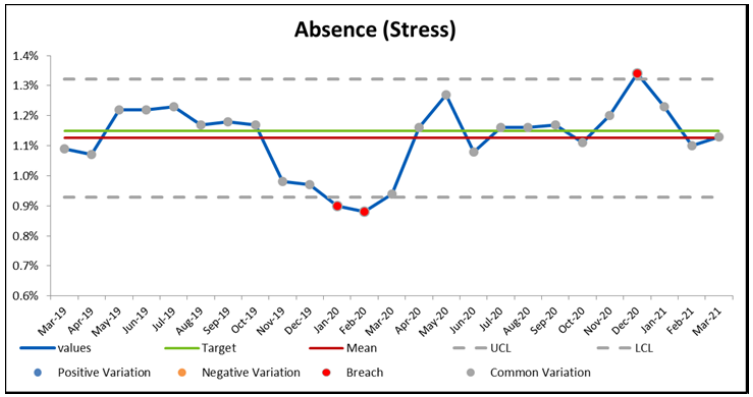


Covid-19 Related absence

44 employees were recorded as sick in March due to exhibiting COVID-19 symptoms, this account for 6.92% of the total number of staff (636) off sick in the month. This is a significant decrease since the last reporting period in February 2021.

3.2.2 Stress Absence

In-month stress absence figures for March 2021 have shown a slight increase from February to March to 1.13%. This level of absence is 0.02% below the target. Since December 2020 there has been a steady decrease in stress related absence.



In correlation with the first wave of the Covid-19 Pandemic this metric increased significantly over December and January as a result of the emergency response to the COVID-19 pandemic. We have implemented multiple measures to mitigate this expected increase and maintained the health and wellbeing of our people especially as we enter the second peak. It is also recognised that the impact of Covid-19 may have a delayed presentation for our colleagues so this is also being monitored and managed appropriately across the Trust.

3.3 Assurance on Filling Vacancies

3.3.1 Establishment and Vacancies

The Vacancy Rate had been on a continual downward trajectory until July 2020. Since this point the Vacancy rate has increased and is reported at 4.3% in March 2021, 1.07% higher than the lowest rate in July 2020. The Vacancy rate continues to remain significantly below the target of 8%.

There are hot spots which exceed the Trust vacancy rates. These are in the community hospital and long terms services community teams. Agreed actions to address this are:

1. Improve Roster Management

- Operational services have funded a small rostering team to work on improving budgets across operational services with the aim of improving roster management.

- Safecare and eCommunity additional Allocate Healthroster modules are being investigated to see if these would support better roster management and oversight.

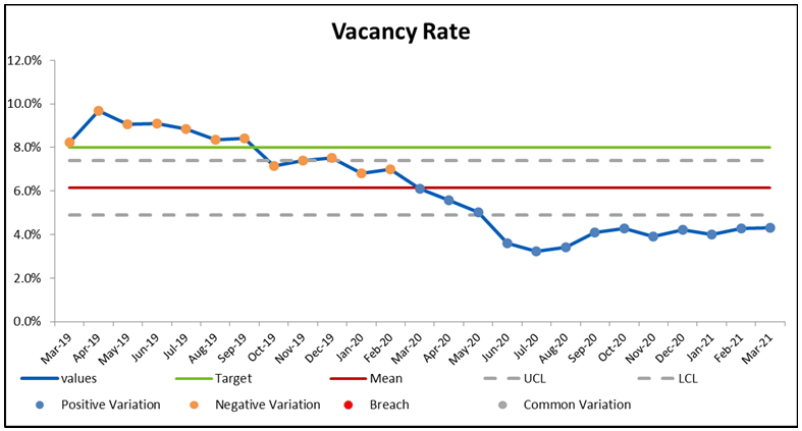
2. Develop a Community Hospital Strategy

- It was agreed that the time is right to re-vision the function and value of community hospitals; review admission criteria and the profiling of sites to meet population need. This will include the learning from wave 1 and 2 of COVID-19 during which many previously acute pathways have been moved to community.

- This would then enable a focused review of site specific establishments required to support each community hospital with appropriate consideration of specialist nurse roles, therapists, nurse associates and ACPs

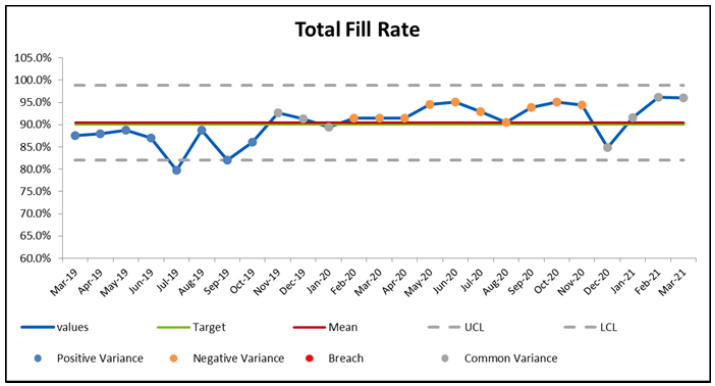
3. Recruitment Review

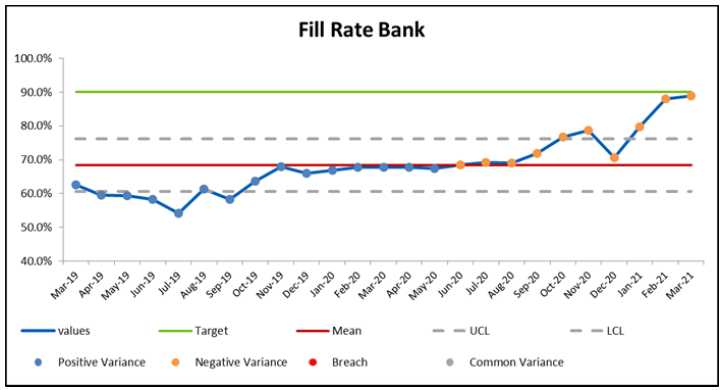
- A recruitment process review is underway with the view to simplify the process for managers and candidates, reduce paperwork and make this easier for candidates to navigate and return, as well as maximising the utilising of automation.



3.3.2 Temporary Staff Usage

The Total fill rate has decreased by 0.03% since the last reporting period in February 2021. In March 2021 the total fill rate sits at 96.08%, this is above the Mean. The Bank fill rate also reports above the mean at 88.84%. This is also the highest bank fill rate over the reporting period of 24 months.





The Covid-19 Vaccination sites were operating throughout March, 11,718 shifts were worked over March across all sites, the fill rates are listed below:

Folkestone	81.55%
Woodville Gravesend	80.28%
SAGA Thanet	90.50%
Angel Centre Tonbridge	74.44%
Pentagon Medway	71.63%

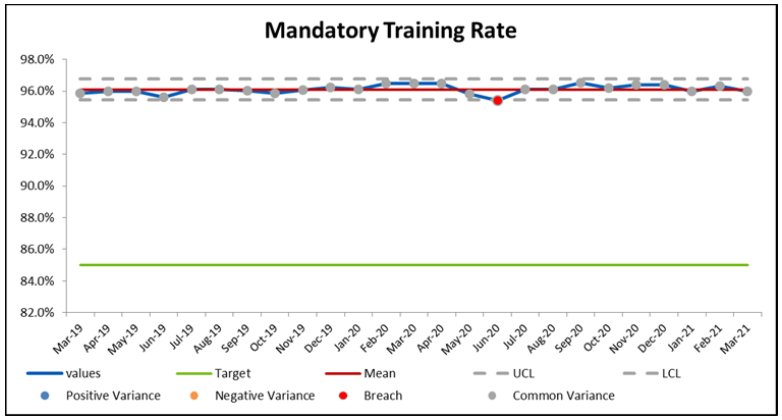
3.4 Mandatory Training

Whilst Mandatory Training figures are currently in a state of natural variation around the mean, and are consistently above the target there are some areas which continue to receive close attention:

Fire safety training in community hospitals- 78.1% which is a drop of 5.3% on the previous month. This is a small target audience and whilst these swings are natural fluctuation, this topic remains consistently below target. The health and safety, fire and security team had a plan to change their delivery method to this group by delivering it on the wards and running evacuation practices. This was placed on hold, during our response to the pandemic, in order to reduce the footfall in clinical services but is being reset starting next week. This change will be monitored to assess the impact. If not then it is likely that it will need to be the subject of a QI project to assess whether there needs to be a significant shift in how the target is achieved.

Moving and Handling Level 4 (74.7%) and BLS (80%) have been highlighted in previous reports and have been the subject of significant discussion at Executive Performance Reviews and the Integrated Management Meeting. The most recent concern was to map the backlog of people now out of date to the availability of places and the significant wastage of seats over previous months had now created a concertina effect. For moving and Handling we have been able to move resources from some of the more proactive work and direct that time to training and, on the basis that colleagues attend, this topic should achieve compliance by July 2021 at the latest but for some areas this could be sooner. For BLS there is now a capacity gap in order to meet the backlog however there are still free training places in the current programme. This was escalated to IMM and agreed that until existing places were being fully booked no further capacity would be added. This is under close review.

Immediate life support- 75% and Paediatric immediate life support- 71.5%. These topics were the subject of a QI project where it was determined that rather than a centralised programme, as these topics cover a very small target audience with very specific services, the model worked better if training was arranged directly with services and they directed their staff to those sessions. Where services have engaged this is working but we are in the process of a deep dive to escalate those services where further engagement and attention is necessary.



4.0 Finance Report:

4.1 Key Messages

Surplus: The Trust has made a surplus of £102k when adjusted for an impairment of £373k. Pay and non-pay have overspent by £3,344k and £5,622k respectively offset by an underspend on depreciation/interest of £420k and an over-recovery on income of £8,498k.

Continuity of Services Risk Rating: EBITDA Margin achieved is 1.5%. 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: The Trust achieved CIPs of £4,210k for the year against a risk rated plan of £4,210k and so CIP has been achieved in full.

Cash and Cash Equivalents: The cash and cash equivalents balance was £42,859k, equivalent to 62 days expenditure. The Trust recorded the following YTD public sector payment statistics 98% for volume and 97% for value.

Capital: Spend to March was £10,098k, against a YTD plan of £10,485k (96% achieved). The plan figures referenced include the effect of the PDC funded schemes approved after the revised plan submitted to NHSE/I on 27 July 2020. The full year outturn includes £3,699k capital expenditure funded by PDC (£1,356k on the Trust's Urgent Treatment Centres, £113k on enhanced cyber security, £2,139k on the Kent & Medway Care Record and £91k relating to the Covid-19 response). The underspend in the main relates to the final spend incurred on the Urgent Treatment Centres being less than the originating PDC funding request (£144k) and £198k underspend relating to a second PDC Covid-19 capital claim (for IT equipment) not approved.

Staff: Temporary staff costs for March were £3,150k, representing 17.5% of the pay bill. Of the temporary staffing usage in March, £515k related to external agency and £131k for locums, representing 3.59% of the pay bill. Contracted WTE decreased by 2 to 4,330 in post in March which includes 16 posts funded by capital projects. Vacancies remained at 194 in March which was 4.3% of the budgeted establishment.

4.2 Covid-19 Costs

There were £291k of costs in March increasing the total spent on the Covid response to £7,891k for 2020/21. In addition there were £710k of costs in March for the hospital discharge programme, increasing the total to expenditure to £7,941k for 2020/21, all of which has been invoiced directly to Kent and Medway CCG.

Covid-19 vaccination costs: there were £1,835k in March increasing the total spend for 2020/21 to £3,440k.

Of the temporary staffing costs in March, £503k related to the covid response and hospital discharge programme (16% of the trust total expenditure on temporary staffing for the month) and the 2020/21 costs were £5,797k or 30% of the total temporary staffing spend for the year.

Temporary staffing costs for the covid vaccination programme were £1,429k in March (45% of the trust total expenditure on temporary staffing for the month) and £2,360k for 2020/21 or 12% of the total temporary staffing spend for the year.

4.3 Dashboard

Surplus — Rag rating: Green

	Actual	Budget	Variance
Full Year £k	102	150	-48

The Trust has made a surplus of £102k when adjusted for an impairment of £373k.

Pay and non-pay have overspent by £3,344k and £5,622k respectively offset by an underspend on depreciation/interest of £420k and an over-recovery on income of £8,498k.

Use of Resource Rating — Rag rating: Green

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

The Trust has scored overall the maximum 1 rating against the Use of Resource rating metrics for M11 2020-21. The YTD I&E margin % has returned a rating of 2 as a result of the current break-even regime and the YTD Agency spend rating is 2 following an increase in actual agency costs due to Covid-19.

CIP — Rag rating: Green

	Actual	Plan	Variance
Full Year £k	4,210	4,210	0

The Trust achieved CIPs of £4,210k for the year against a risk rated plan of £4,210k and so CIP has been achieved in full.

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	42,859	43,379	-520

Cash and Cash Equivalents as at M12 close stands at £42,859k, equivalent to 62 days operating expenditure.
The Trust recorded the following YTD public sector payment statistics 98% for volume and 97% for value.

Capital Expenditure — Rag rating: Amber

	Actual	Plan	Variance
YTD Expenditure £k	10,098	10,485	387

Spend to March was £10,098k, against a YTD plan of £10,485k (96% achieved). The plan figures referenced include the effect of the PDC funded schemes approved after the revised plan submitted to NHSE/I on 27 July 2020.
The full year outturn includes £3,699k capital expenditure funded by PDC (£1,356k on the Trust's Urgent Treatment Centres, £113k on enhanced cyber security, £2,139k on the Kent & Medway Care Record and £91k relating to the Covid-19 response).
The underspend in the main relates to the final spend incurred on the Urgent Treatment Centres being less than the originating PDC funding request (£144k) and £198k underspend relating to a second PDC Covid-19 claim (for IT equipment) not approved.

Agency Targets — Rag rating: Green

	M12			YTD		
	Actual £k	Target £k	Variance £k	Actual £k	Target £k	Variance £k
External Agency Excluding Covid-19 Expenditure £k	461	491	31	4,242	5,895	1,653
External Agency Including Covid-19 Expenditure £k	647	491	-156	6,817	5,895	-922

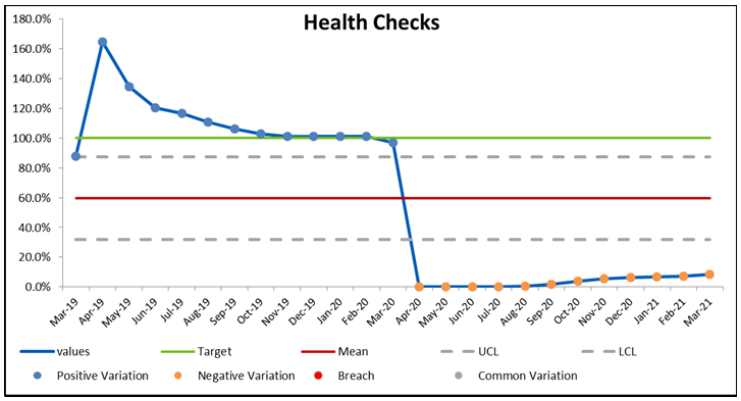
External Agency and Locums excluding Covid-19 expenditure was £461k against £491k target in March. (Full year costs of £4,242k against £5,895k target).
External Agency and Locums including Covid-19 expenditure in March was £647k against £491k target. (Full year costs of £6,817k against £5,895k target).

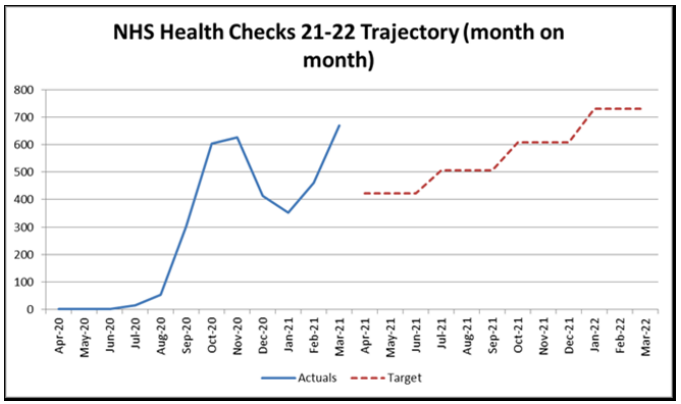
5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and SS Quits

Health Checks



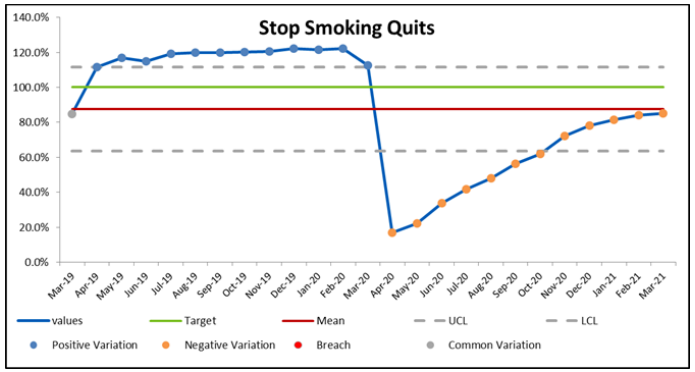


As of 1st April only 56 GP practices are currently inviting and delivering Health Checks (155 pre-Covid). 12 additional GP's have indicated that they are likely to come back on stream in Quarter 1.

The second chart above has been developed showing activity in 2020/21 but also commissioners have set a realistic target on a consistent 20% increase on a quarterly basis. The starting baseline for Q1 is 1056 – this has been worked out using Quarter 4 average monthly amount.

Commissioners are pleased with the progress made in Kent with resetting NHS Health Checks in comparison to other areas where no activity or reset has happened.

Stop Smoking Quits



COVID affected referrals to the service which reduced significantly as can be seen in the graph above. The service has seen a steady increase each week since then but not yet back to pre-Covid levels.

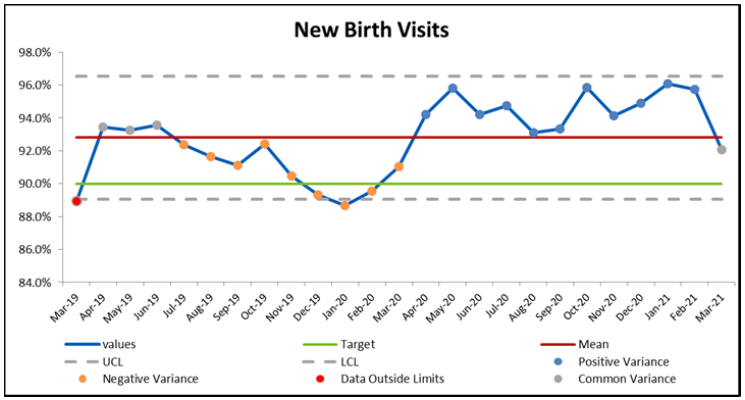
Quit Date set to date is 4096 and number of quits achieved is 2396 which is 80% or target, with final year end position expected to be 85%. This is an incredible achievement considering that this is for the most part the work of the core team only this year.

Options paper in development to work through service provision in the future given the success of the core team to deliver a virtual offer and to work through role of community pharmacy in the future. E.g. dispensing / prescribing only

5.1.2 Health Visiting

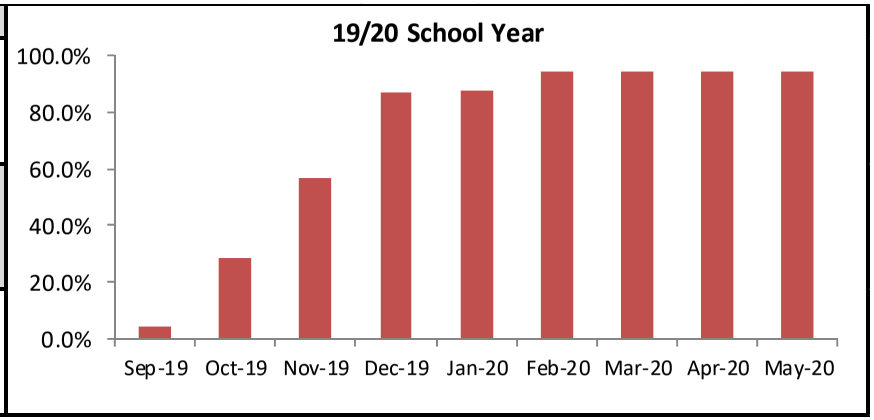
New Birth Visits

Strong current performance with consistent achievement of the target, despite a small dip below the mean in M12.



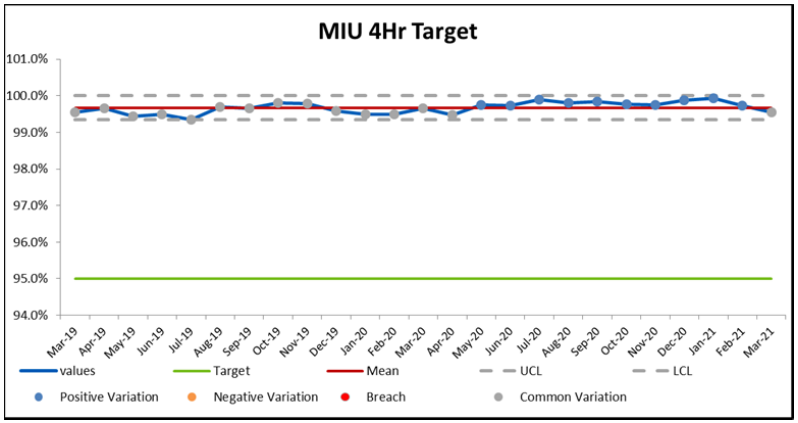
5.1.3 National Child Measurement Programme (NCMP)

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



The measurement programme for Year R and 6 pupils met the trajectory for the 19/20 school year, with both programmes achieving the 90% target for the school year. 2020/21 Programme has been deferred to commence from April 2021 due to school closures.

5.1.4 Urgent Treatment Centres (UTCs)/Minor Injury Units (MIUs) 4 Hour Wait Target



KCHFT's achievement of the 4 hour wait target for UTCs and MIUs has consistently been high, with very little variation from the mean. These units have formed an integral part in managing non-elective demand through Wave 2 Covid-19 and continue to do so, with activity now on the increase

5.1.5 GUM 48hr

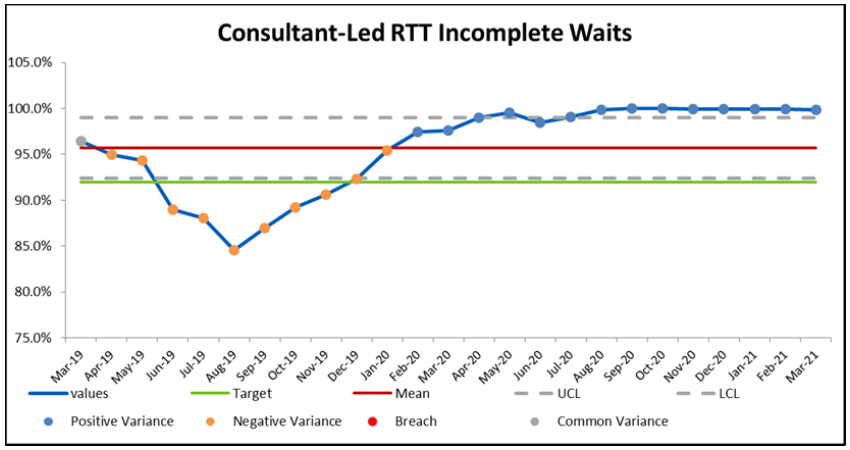
Access to GUM clinics within 48hrs has been consistently 100%, with no reported breaches

5.1.6 Consultant-Led RTT Incomplete Waits Over 18 weeks

We continue to achieve the consultant-led Referral to Treatment (RTT) pathway target of 92% with the Month 12 position being at 99.9%, with only 5 patients out of 3,716 waiting longer than 18 weeks

	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	314	16	1	0	0	99.7%
Orthopaedics	2158	42	3	0	0	99.9%
Children's Audiology	166	0	0	0	0	100.0%
Community Paediatrics	884	131	1	0	0	99.9%
KCHFT Total	3522	189	5	0	0	99.9%

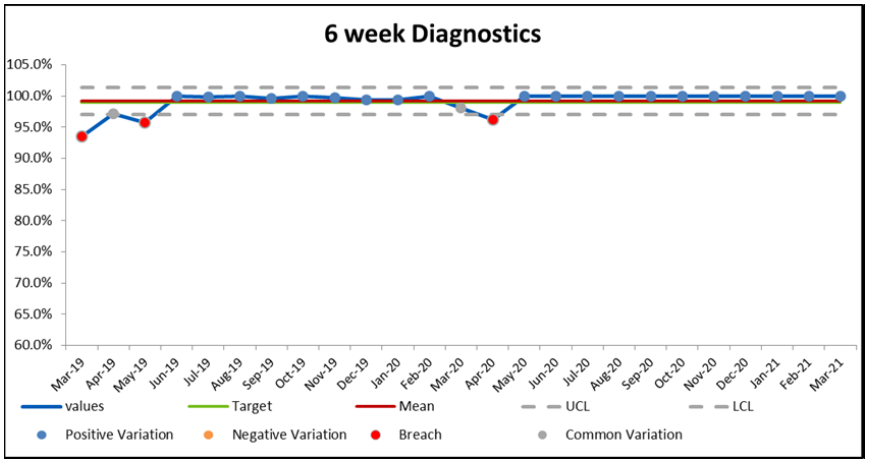
The above table shows the current breakdown of the waiting list for all services on a consultant-led pathway. All consultant-led services are currently meeting target.



5.1.7 6 Week Diagnostics (Audiology)

6 week diagnostics waits for paediatric audiology has consistently achieved 100% throughout 2020/21. However, an issue has been identified whereby some patient clocks were stopped prematurely as an in depth plan of care was made and a diagnostic decision was made. It was confirmed on the 23rd March 2021 that this this did not comply with the DM01 guidance and NHSE were notified and consulted, with corrective action going forward agreed. As a result, the performance for M1-3 of 2021/22 will likely see a negative impact.

The service is making good progress with booking appointments and is ahead of trajectory in April with 122 appointments booked, leaving 456 appointments to be booked. As of 12th April, 150 of the ring fenced back log children have been seen.

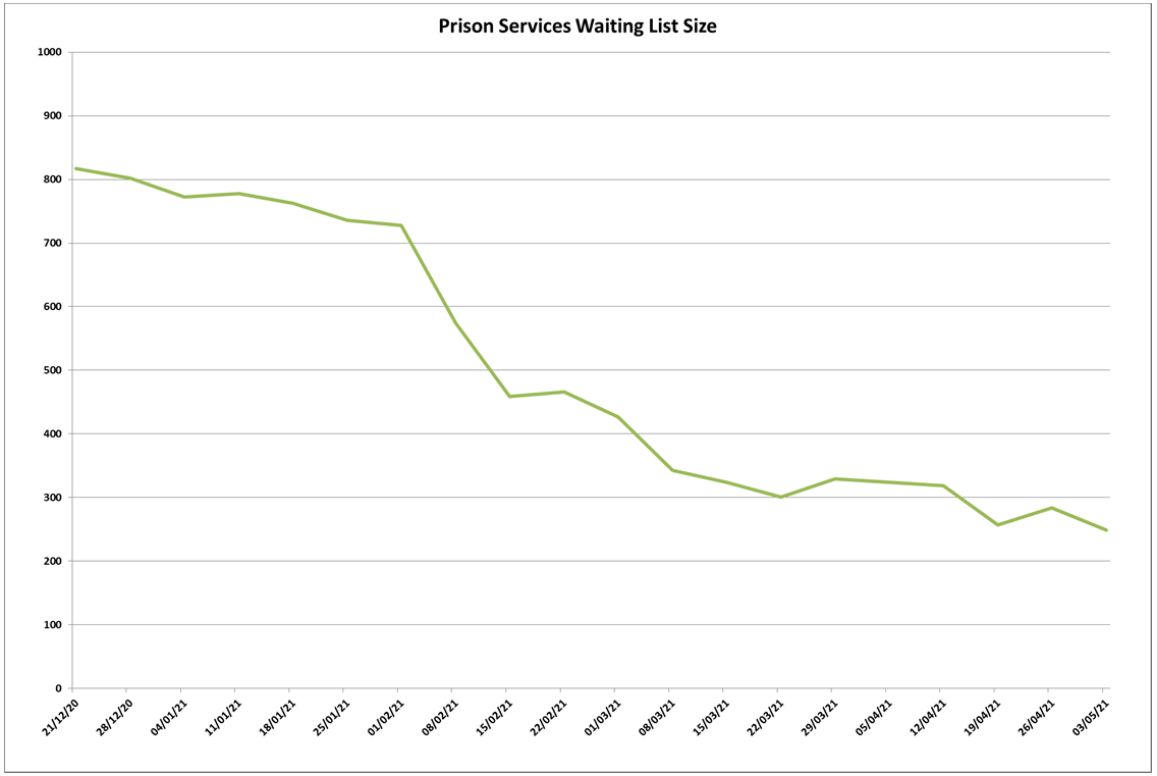


5.1.8 KCHFT Prison health services Waiting Times

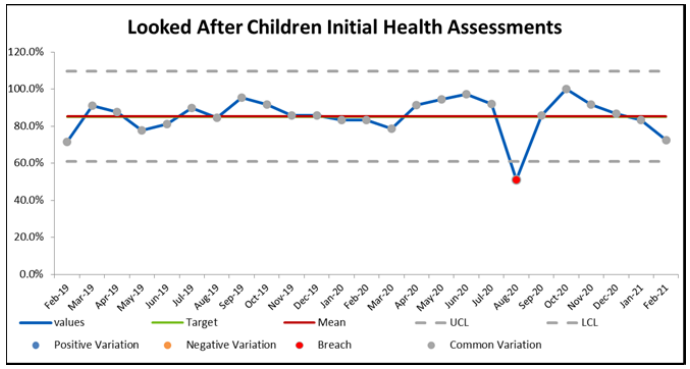
A separate report is reviewed at the monthly divisional performance reviews to understand the challenges KCHFT services are experiencing within prisons. Prison services include Chronic Pain, Dental, Orthopaedics, Podiatry and Sexual Health. The main issues remain:-

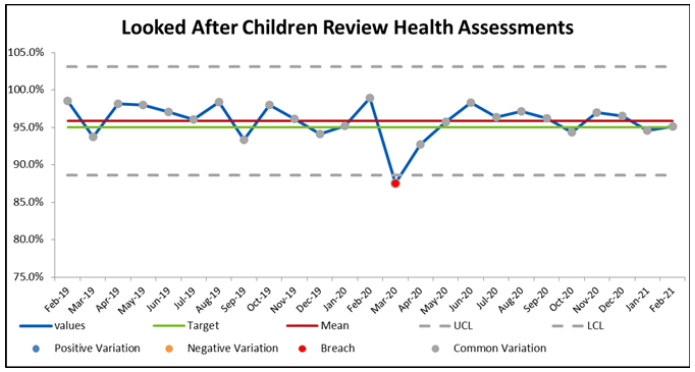
- Access – inconsistent access to prison sites.
- Access to patients – due to waiting room restrictions and prisoner escort delays, the numbers of patients seen per session is reduced.

However, the waiting list has reduced to 249 as at 3rd May (as high as 728 on 1st February)



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



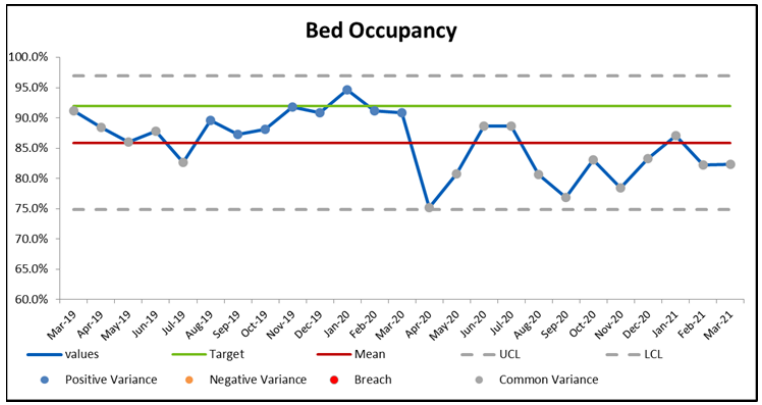


Initial Health Assessment (IHA) performance had dropped to 72% of IHAs being completed within 28 days of child becoming looked after in month 11. There were 8 breaches in the month of which 5 were late requests from KCC and 3 were DNAs. None of the breaches were attributable to the service. Discussion with KCC regarding the late requests has identified that this was due to the KCC Liberi system being unavailable.

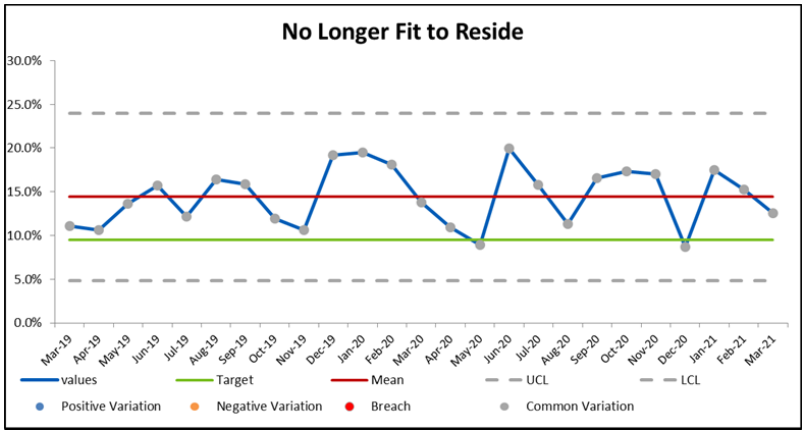
Compliance with the Review Health Assessment target continues to show normal variation around the mean but above target. Frequent monitoring through the team weekly calls continues to occur.

5.1.11 Bed Occupancy

Bed Occupancy continues to show a varying trend with no periods of special cause variation, other than when affected by the Covid-19 pandemic and meeting demands for Covid-19 patients. Levels continue to be between 80-85% and as a result escalation beds have been closed as we moved out of winter pressures.



5.1.12 No Longer Fit to Reside



KCHFT's target for the proportion of patient who are no longer fit to reside 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 has been consistently above the mean, (bar a decrease in month 9). The target level continues to be rarely achieved in the current climate (twice in the last 18 months).

A dedicated piece of work continues with Kent County Council to review patient flow out of Community Hospital.

5.1.10 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.

5.1.13 CQUIN

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

5.2 Assurance on activity and productivity

5.2.1 Activity

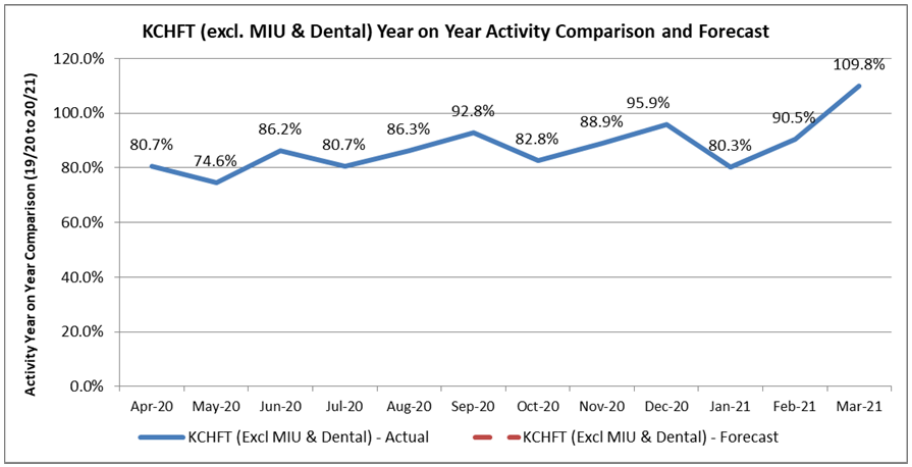
Activity Re-setting

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 18.2% 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 March 2020 and March 2021 activity levels across the divisions.

	Mar-20	Mar-21	Variance
East Kent Adults (Exc MIU)	55,120	66,088	19.9%
West kent Adults (Exc MIU)	26,289	28,358	7.9%
Adult Specialist and Elective	23,998	23,793	-0.9%
Children's Specialist & LD	21,622	17,460	-19.2%
Public Health Services	18,783	21,927	16.7%

The following chart indicates that, excluding MIU and Dental, a large increase was seen in March 2021 to 109.8% compared to March 2020, which was better than forecast. For additional comparison, activity levels in M12 were 20.9% higher than M11 and the highest since January 2020. As part of the Operational Plan, activity trajectories have been drawn up for 2021/22 in line with the current status of services and these will be measured against going forward into 2021/22.



Covid-19 Activity Impact

During Month 12 (March 2021) KCHFT carried out 172,764 clinical contacts, of which 9,044 were MIU attendances. For the year to March 2021 KCHFT are 18.2% below the pre-Covid 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 (-32.2%), Public Health Services (-41.9%), Adult Specialist Services (-31%) and Dental Services (-73%).

Public health service activity has been particularly impacted by school closures affecting Immunisations and School-based Public health screening programmes. Dental activity has been impacted by the new interim national Standard operating procedure for triage and AAA. This telephone based activity is not captured in the national dental activity returns. Dental face to face activity and capacity has also been significantly affected by the restrictions associated with fallow time in dental surgeries in-between Aerosol Generating Procedures (AGPs)

Service Type	M12 Actual	YTD Actual	YTD Plan	YTD Variance	Movement	Internal BRAG	Contract BRG
East Kent Adults - Contacts	66,884	692,492	643,901	7.5%	Positive		
East Kent Adults - MIU	4,107	36,686	46,211	-20.6%	Positive		
East Kent Adults - Admissions	90	1,366	937	45.8%	Negative		
West Kent Adults - Contacts	26,291	295,579	304,891	-3.1%	Positive		
West Kent Adults - MIU	4,937	52,949	85,996	-38.4%	Positive		
West Kent Adults - Bed Days	2,067	21,820	22,338	-2.3%	Positive		
Specialist and Elective Services	23,790	241,828	350,521	-31.0%	Positive		
Children's Specialist & Adult LD Services	18,806	182,866	224,058	-18.4%	Positive		
Public Health Services	21,927	232,762	400,769	-41.9%	Positive		
Dental Service	3,865	28,124	104,109	-73.0%	Positive		
Trust Total Activity against plan	**172,764**	**1,786,472**	**2,183,731**	**-18.2%**	Static		

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

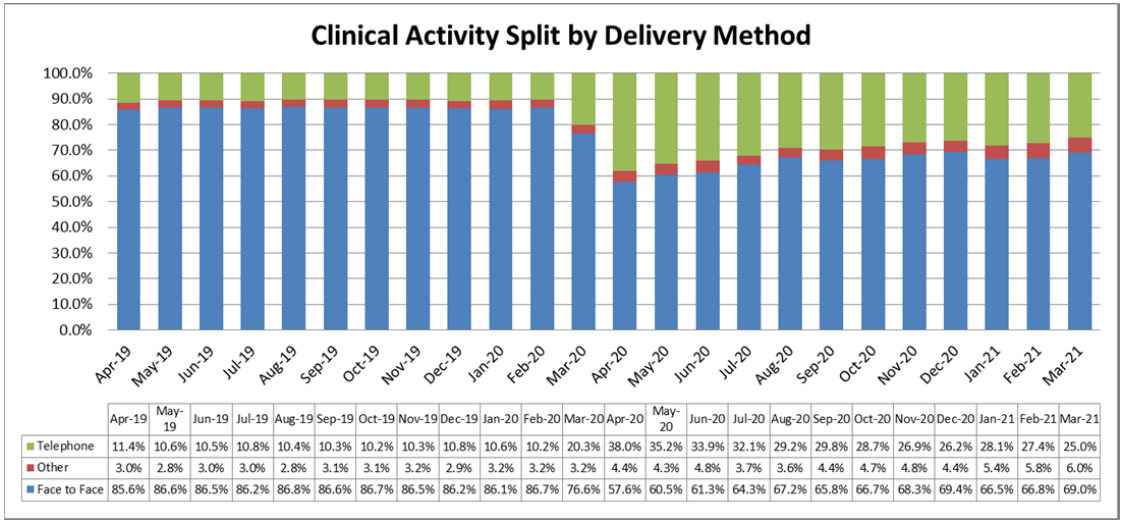
*these figures are not included in the table totals as they don't have a contractual target

Activity Delivery Method

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 to pre-Covid levels. Non face to face activity accounted for 31% of all activity delivered in March 2021 compared to only 13.6% on average pre-Covid.

As detailed in the Operational Plan for 2021/22, the intention is to embed and maintain a level (>25%) of virtual consultations. As such, a metric will be included in this report going forward to measure and track this delivery.



	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Telephone	11.4%	10.6%	10.5%	10.8%	10.4%	10.3%	10.2%	10.3%	10.8%	10.6%	10.2%	20.3%	38.0%	35.2%	33.9%	32.1%	29.2%	29.8%	28.7%	26.9%	26.2%	28.1%	27.4%	25.0%
Other	3.0%	2.8%	3.0%	3.0%	2.8%	3.1%	3.1%	3.2%	2.9%	3.2%	3.2%	3.2%	4.4%	4.3%	4.8%	3.7%	3.6%	4.4%	4.7%	4.8%	4.4%	5.4%	5.8%	6.0%
Face to Face	85.6%	86.6%	86.5%	86.2%	86.8%	86.6%	86.7%	86.5%	86.2%	86.1%	86.7%	76.6%	57.6%	60.5%	61.3%	64.3%	67.2%	65.8%	66.7%	68.3%	69.4%	66.5%	66.8%	69.0%

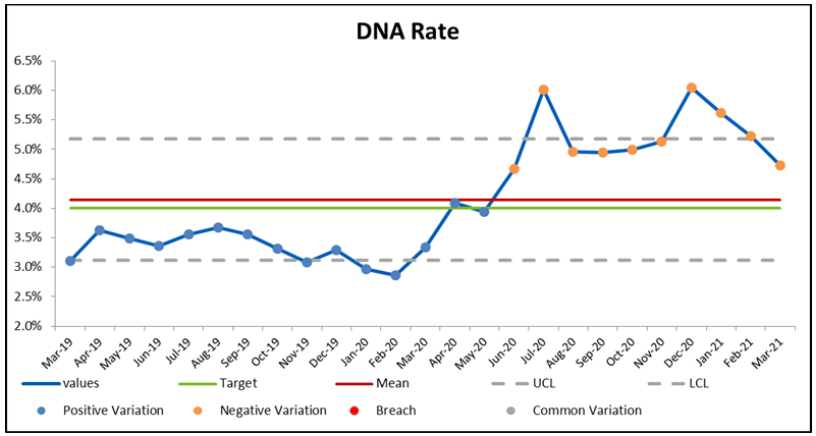
5.2.2 Covid-19 Related Backlogs

Specialty backlogs were managed over the course of the year through the Recovery group, chaired by the Chief Operating Officer.

With the exception of Dental GA, Podiatry, Southeast Driveability, Health Checks and the remaining Prison waits, Covid-19 related backlogs have been cleared.

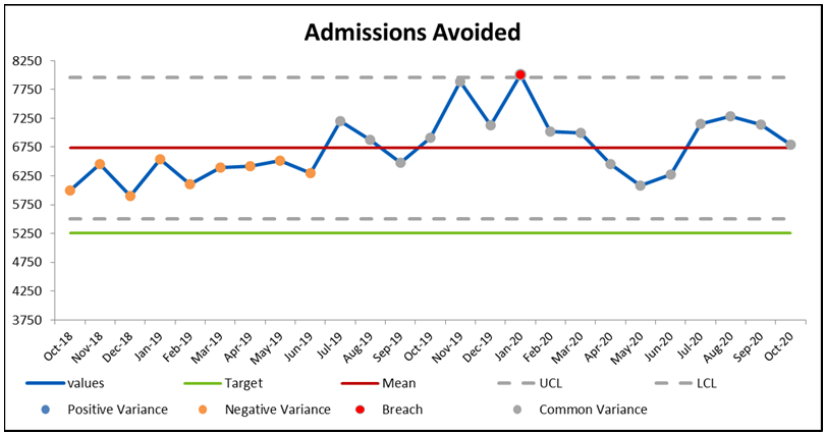
These remaining backlogs will now be managed through the monthly Executive Performance Reviews.

5.2.3 DNA rates



DNA rates pre-Covid-19 traditionally fell below the target of 4%, although there has been a marked increase from month 3 onwards to above the upper control limit as a result of Covid-19 pandemic. It continues to be impacted 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. However, the increased focus has started to drive levels back down, with M12 at the lowest level since M3 and 3 consecutive monthly decreases

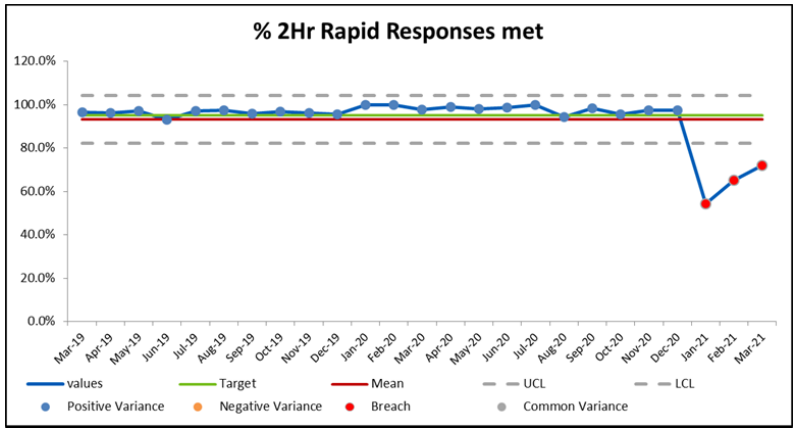
5.2.4 Admissions Avoided



The above chart is currently only updated to October 2020. There have been challenges collecting this data on RIO which have now been resolved and data is returning to previous levels. Revised data will reported from 2021/22 Month 1

5.2.5 Rapid Response referrals seen within 2 hours

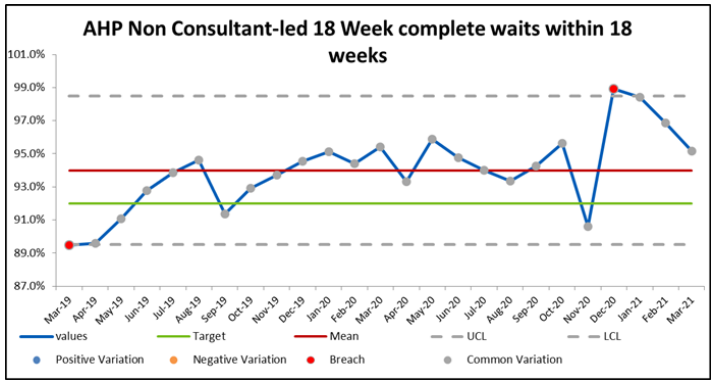
The level of performance has been negatively impacted by the move to RIO and the revised way in which data has been captured for this metric. The Rapid Response teams are aware of the impacts of this change and the importance of recording the correct data points, in a timely manner, to enable to accurate measurement of the response time. Pre-RIO reporting was based on the clinician assessment of the response time being met, whereas this is now an automated calculation of time between referral and response. Improvements back to target level are being seen, with West kent now meeting target. Further work to improve reporting in East kent is continuing.



5.3 Assurance on Local Wait Times

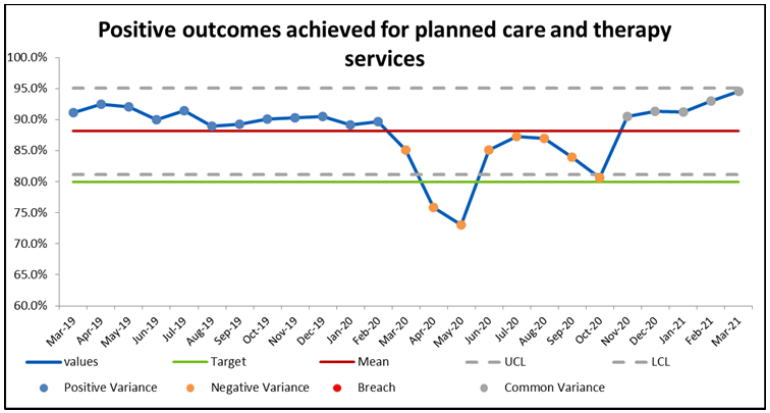
Completed wait times across non-consultant-led AHP services are now showing normal variation with a trend above the mean as there are minimal initial appointment backlogs and performance is consistently hitting the target.

However, we are currently experiencing significant wait times above 18 weeks in MSK Physiotherapy services. A deep dive has been initiated to understand the underlying issues and address identified concerns.



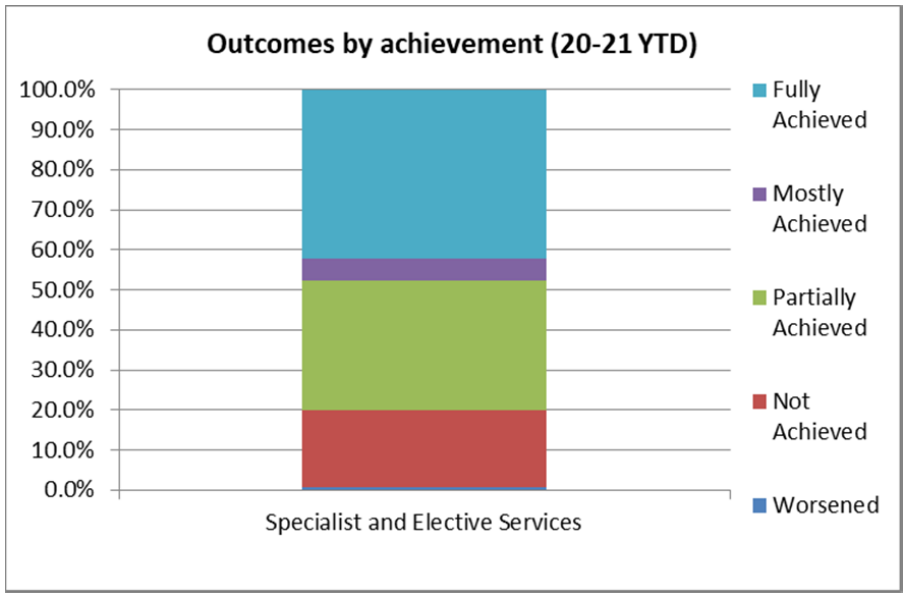
5.4 Outcomes

Aggregate outcomes are currently reported for Adult Specialist and Children's Therapy services, with patients receiving a favourable outcome in the vast majority of cases on a consistent basis. The below shows that negative special cause variation occurred in Months 1,2 and 7, 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 since month 8. 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 normally fall low enough to breach target.



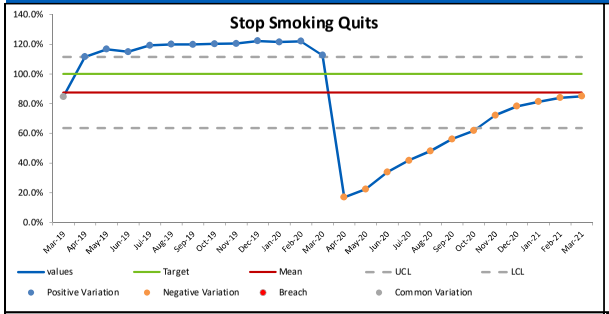
The following table and chart shows the proportion of the grading of each outcome for the year to date. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised. Currently reported as Adults only until reporting is further developed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

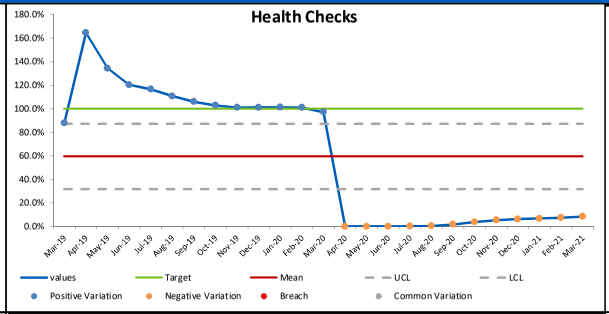
	Specialist and Elective Services
Worsened	0.7%
Not Achieved	19.4%
Partially Achieved	32.1%
Mostly Achieved	5.6%
Fully Achieved	42.2%

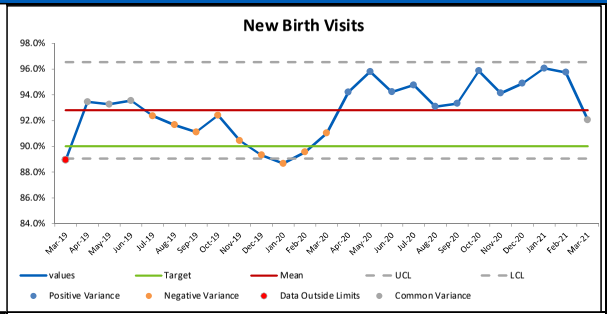


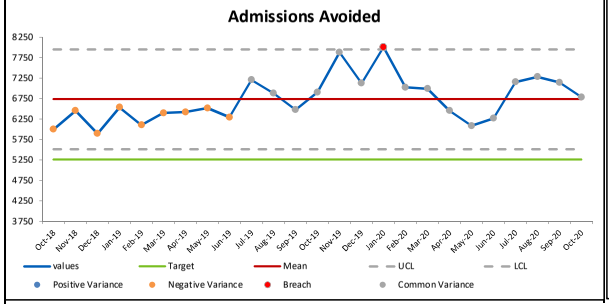
Appendix - Scorecard SPC Charts

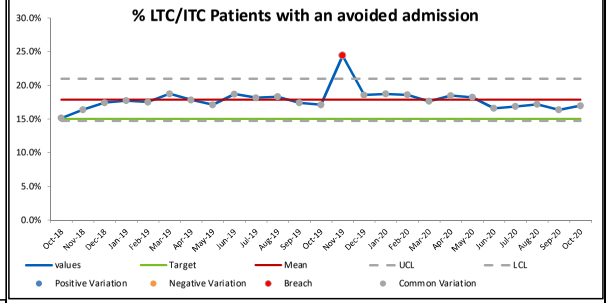
1. Prevent Ill Health





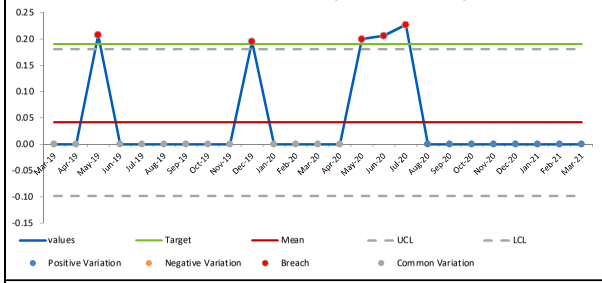




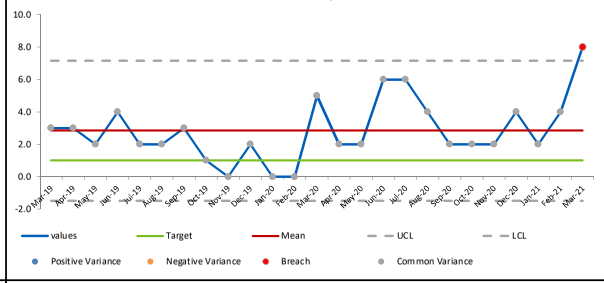


2. Deliver high-quality care at home and in the community

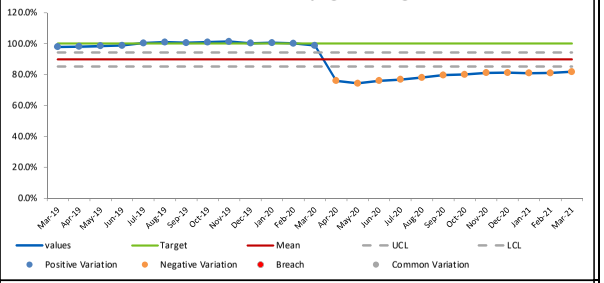
Moderate and Severe falls per 1,000 bed days



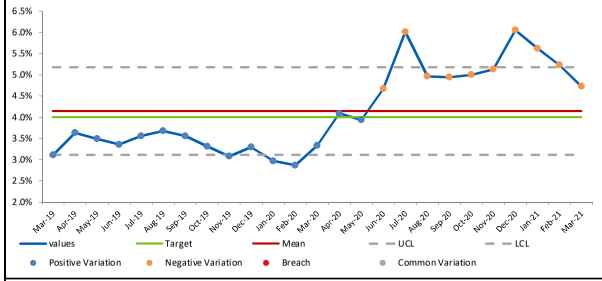
Pressure Ulcers (Lapses in Care)



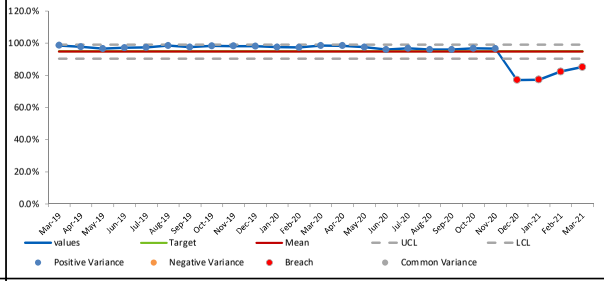
Contractual activity against target



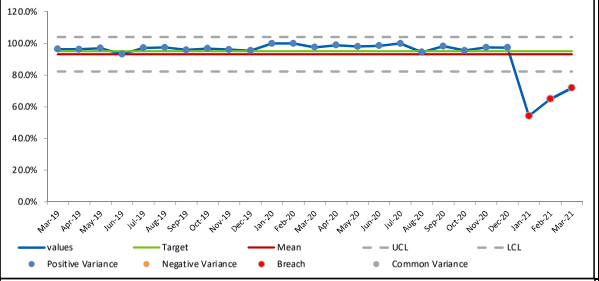
DNA Rate



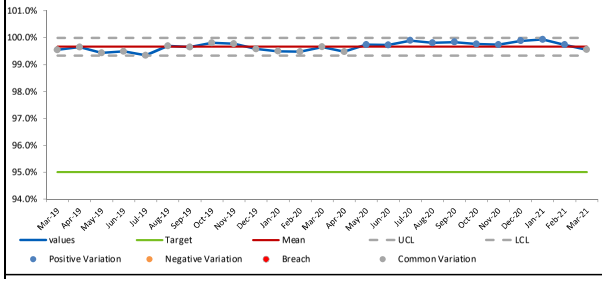
LTC/ICT Response Times Being Met



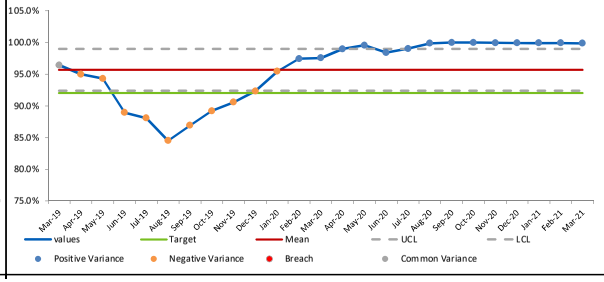
% 2Hr Rapid Responses met



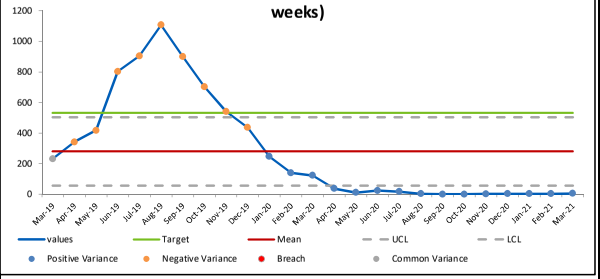
MIU 4Hr Target



Consultant-Led RTT Incomplete Waits

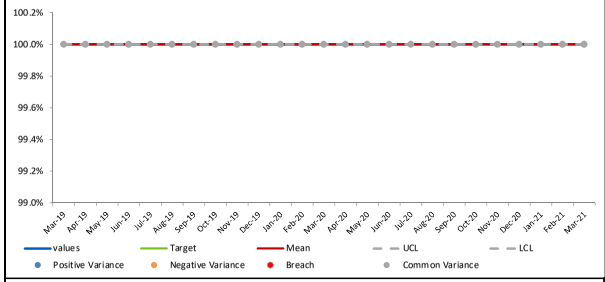


Consultant-Led RTT Incomplete Waits (waiting list size >18 weeks)

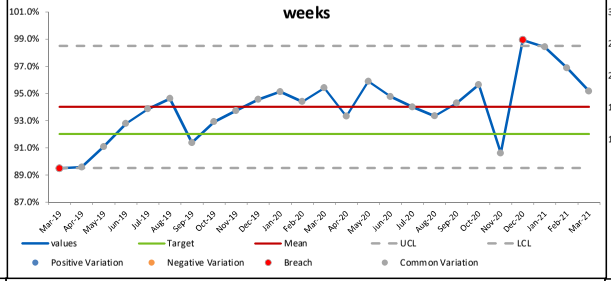


2. Deliver high-quality care at home and in the community

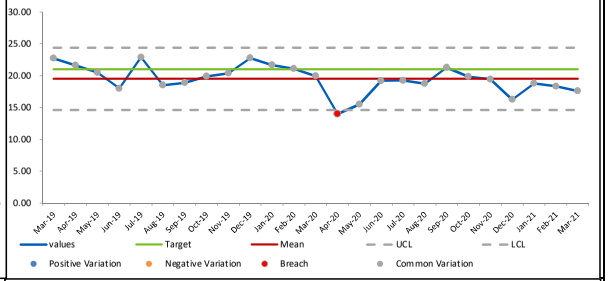
GUM Access within 48Hrs



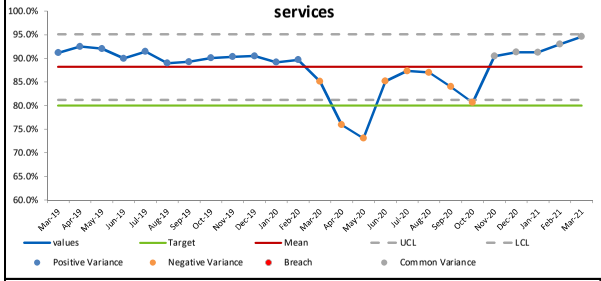
AHP Non Consultant-led 18 Week complete waits within 18 weeks



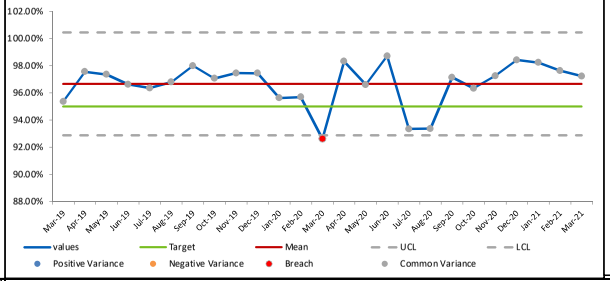
Median length of stay (days)



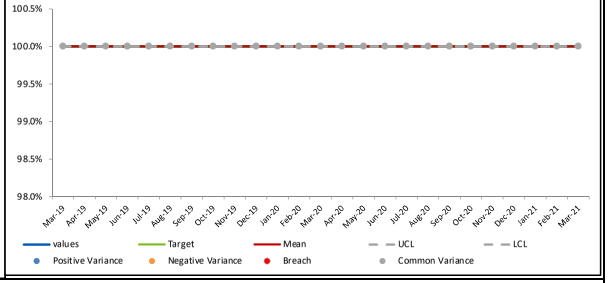
Positive outcomes achieved for planned care and therapy services



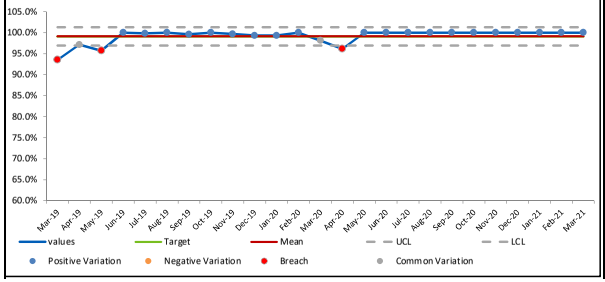
Percentage of patients who would recommend our services



NICE guidance reviewed within timescales

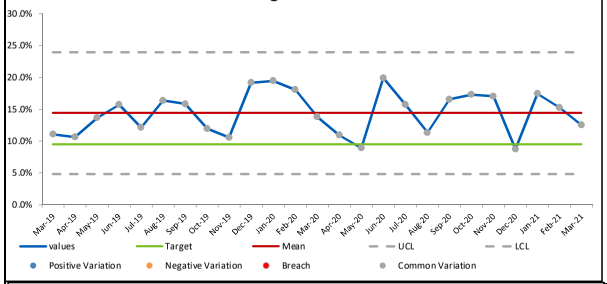


6 week Diagnostics

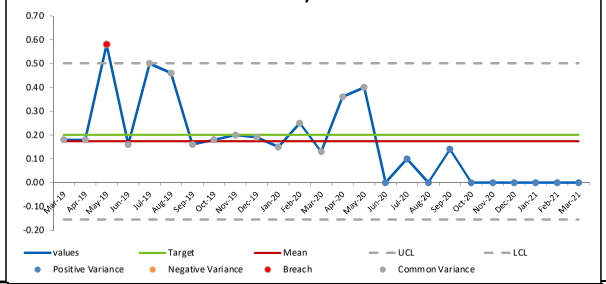


3. Integrate Services

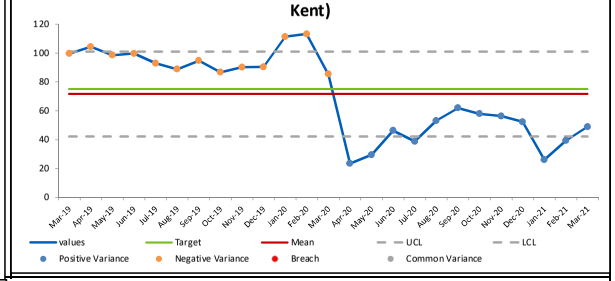
No Longer Fit to Reside



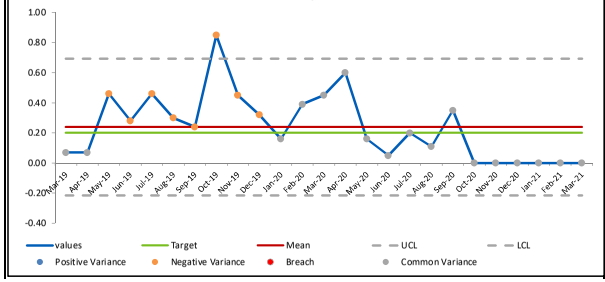
Excess Bed Days - West Kent



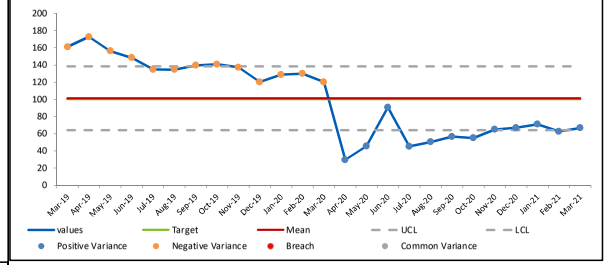
Average Daily Medically Fit For Discharge (MFFD) - (West Kent)



Excess Bed Days - East Kent

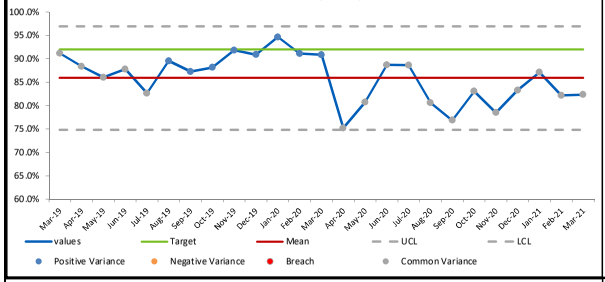


Average Daily Medically Fit For Discharge (MFFD) - (East Kent)

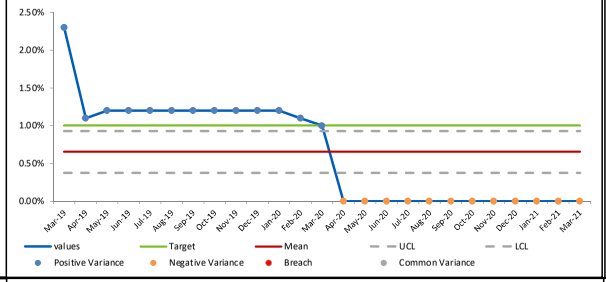


4. Develop sustainable services

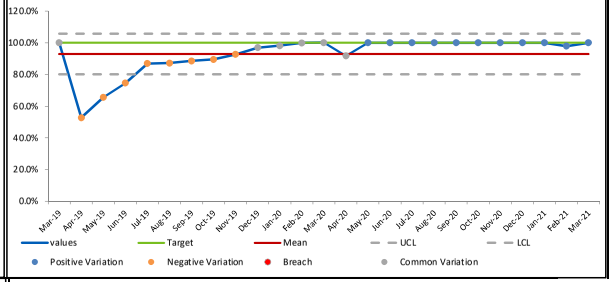
Bed Occupancy



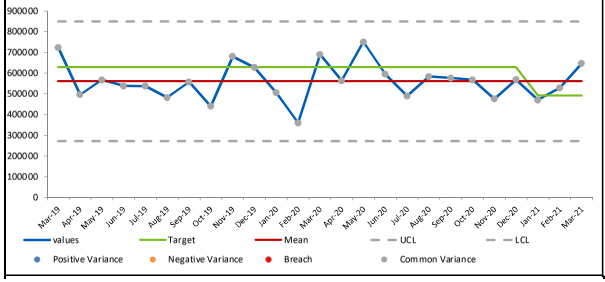
Income and Expenditure Surplus vs plan



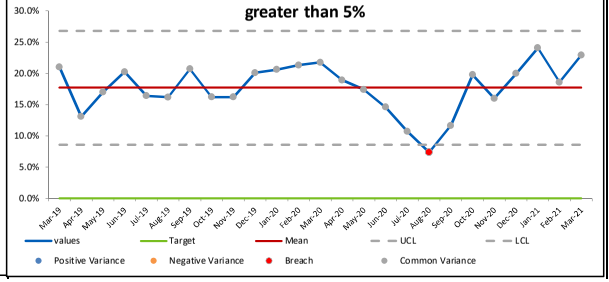
CIP Achieved Against Plan



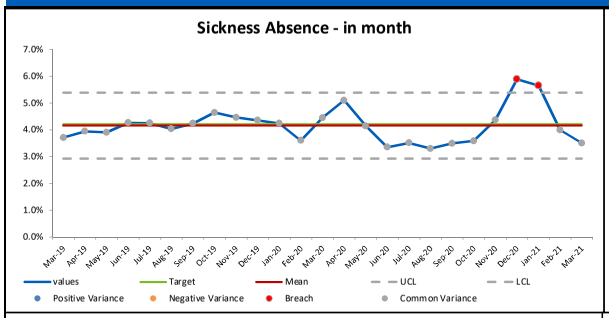
External Agency Spend

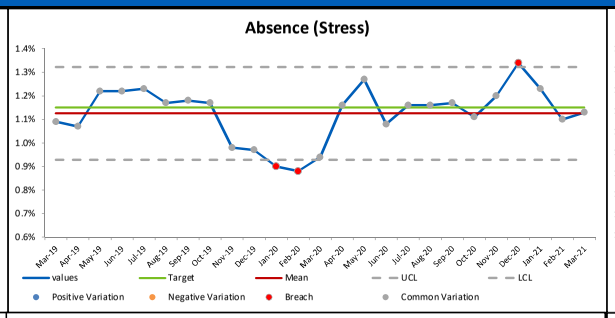


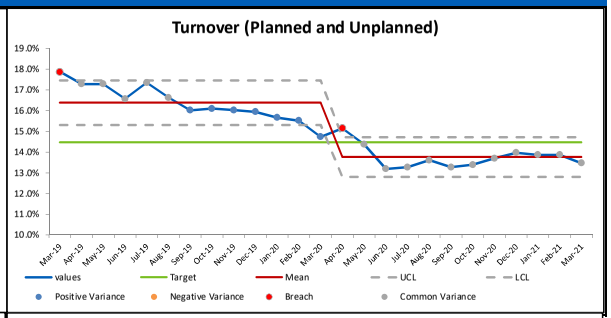
Percentage based on value of Service Lines with deficits greater than 5%

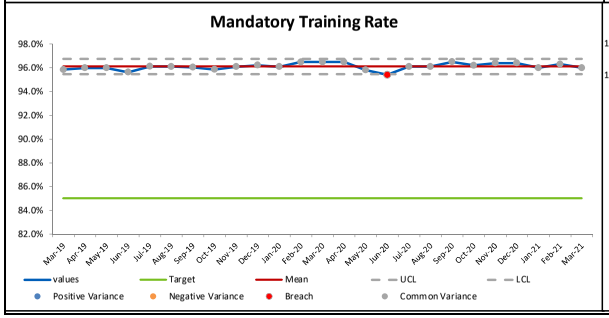


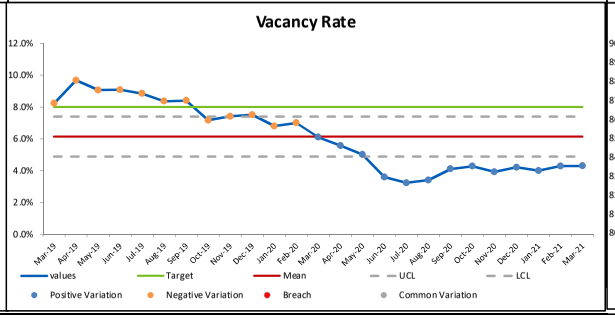
5. Be The Best Employer

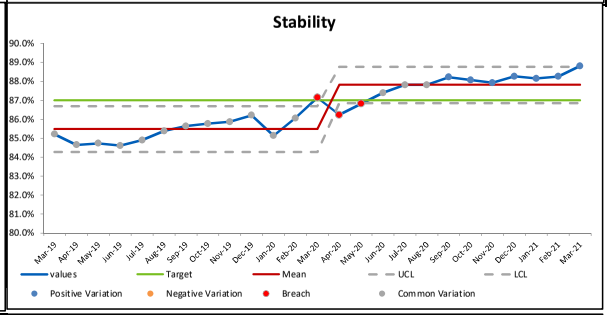












Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting – Part One (Public)
Date of Meeting:	20 May 2021
Agenda Item:	4.2
Subject:	Staff Survey Results
Presenting Officer:	Louise Norris, Director of Workforce, Organisational Development and Communications

Action - this paper is for:	Decision	☐	Assurance	x

Report Summary (including purpose and context):

The Trust has been benchmarked against 14 other Community Trusts.

	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Care	Safe Environment	Violence	Safety Culture	Staff Engagement	Team Working
Birmingham CHFT	8.8	6	7	6.1	7.5	8.2	9.6	6.8	6.9	6.6
Bridgewater CHFT	9.5	6.2	7	6.4	7.5	8.7	9.9	7.1	7.2	6.9
Cambridgeshire Community Services	9.5	6.6	7.6	6.7	7.5	8.9	9.9	7.5	7.5	7.5
Central London CHFT	9	6.3	7.3	6.3	7.8	8.3	9.8	7.1	7.3	7
Derbyshire CHFT	9.5	6.6	7.2	6.7	7.7	8.7	9.7	7.2	7.4	6.8
Hounslow and Richmond CHFT	9.1	6.4	7.2	6.4	7.9	8.4	9.8	7.3	7.4	7.1
Independent Health Group	9.9	8.5	7.8	6.9	8.7	9.4	10	7.7	7.7	7.9
Kent Community Health FT	9.5	6.7	7.6	6.7	7.6	8.8	9.8	7.5	7.4	7.4
Norfolk Health & Care NHS Trust	9.4	6.2	7.2	6.5	7.5	8.4	9.7	7.1	7.3	6.9
Sirona Care & Health	9.4	6.1	7.3	6.2	7.2	8.6	9.8	6.9	7.1	6.8
Wirral CHFT	9.4	6.1	7.2	6.3	7.3	8.7	9.9	7.0	7.1	6.6

The response rate was 62.4%, above the median (57.5%) and an increase of 3.6% from 2019.

All the questions are grouped into 10 themes and in eight; we scored significantly higher than trusts we were benchmarked against. In five of them, we had the top score. These were:

- equality, diversity and inclusion
- health and wellbeing
- immediate managers
- morale
- safety culture..

While it's great to be able to compare to other community health trusts, what we really want to see is improvement at KCHFT each year and in four of the 10 themes we have significantly improved since 2019. These were:

- health and wellbeing
- safe environment – bullying and harassment
- safe environment – violence
- safety culture.

When comparing the Trusts results across the Kent & Medway System our results were the highest across all 10 themes

	Equality, Diversity & Inclusion	Health & Wellbeing	Immediate Managers	Morale	Quality of Care	Safe Environment	Violence	Safety Culture	Staff Engageme
MTW	9	6.2	6.8	6.4	7.6	8	9.5	6.9	7.2
EKUHFT	8.8	5.5	6.5	5.7	7.2	7.3	9.4	6.2	6.5
DGS	8.9	6.2	6.7	6.2	7.5	8		6.6	7
CCG	8.9	5.7	7.1	5.6	6.4	8.4	10	6.5	6.3
Medway	8.7	5.6	6.3	5.8	7.3	7	9.5	6.3	6.6
KCHFT	9.5	6.7	7.6	6.7	7.6	8.8	9.8	7.5	7.4

When benchmarked across all Trusts in the SE Region the Trust is ranked 1st.

	Teamwork	Safety Culture	Safe Environment - Violence	Safe Environment - Bullying and Harassment	Quality of Care	Morale	Immediate Managers	Health and Well-being	Equality, Diversity and Inclusion	Engagemen
Kent Community Health NHS Foundation Trust	1	1	1	1	8	2	4	3	1	3
Solent NHS Trust	4	2	4	2	14	1	3	2	2	5
Berkshire Healthcare NHS Foundation Trust	2	3	7	6	9	3	5	4	9	1
Surrey and Borders Partnership NHS Foundation Trust	3	6	16	4	4	4	1	1	7	4
Sussex Community NHS Foundation Trust	8	5	3	3	21	6	9	13	3	10
Queen Victoria Hospital NHS Foundation Trust	21	11	2	5	1	11	12	7	6	7
Surrey and Sussex Healthcare NHS Trust	7	4	22	11	2	7	10	5	20	2
Southern Health NHS Foundation Trust	6	10	6	8	22	8	7	6	4	17
Oxford Health NHS Foundation Trust	10	9	10	7	24	9	8	11	5	14
Royal Surrey County Hospital NHS Foundation Trust	11	7	9	12	7	18	11	14	17	8
Royal Berkshire NHS Foundation Trust	12	8	26	21	3	12	16	10	19	6
University Hospital Southampton NHS Foundation Trust	17	12	24	10	15	13	17	12	12	11
Sussex Partnership NHS Foundation Trust	9	16	25	20	27	5	6	15	11	18
Buckinghamshire Healthcare NHS Trust	19	20	5	9	13	23	22	9	16	21
Kent and Medway NHS and Social Care Partnership Trust	5	13	27	19	20	16	2	8	25	20
East Sussex Healthcare NHS Trust	13	21	11	16	12	15	13	23	10	24
Oxford University Hospitals NHS Foundation Trust	18	17	13	17	11	19	15	17	15	16
Ashford and St Peter's Hospitals NHS Foundation Trust	15	19	15	22	5	17	18	19	21	9
Western Sussex Hospitals NHS Foundation Trust	14	22	17	18	18	10	19	24	8	12
Frimley Health NHS Foundation Trust	16	15	23	13	6	22	20	16	23	15
Maidstone and Tunbridge Wells NHS Trust	24	18	14	24	10	14	23	18	18	13
Portsmouth Hospitals University NHS Trust	20	14	20	15	17	20	14	22	13	22
Hampshire Hospitals NHS Foundation Trust	23	23	18	14	16	21	24	21	16	19
Dartford and Gravesham NHS Trust	22	24	8	23	19	24	25	20	22	23
Brighton and Sussex University Hospitals NHS Trust	25	25	19	25	25	25	21	25	24	25
Medway NHS Foundation Trust	26	26	12	26	23	26	27	26	27	26
East Kent Hospitals University NHS Foundation Trust	27	27	21	27	26	27	26	27	26	27

Highest ranked 1 — Lowest ranked 27

Data caveats -
Isle of Wight removed as split into sectors unlike other trusts making comparisons difficult
Ambulance trusts removed

This year staff were also asked four classification questions relating to their experience during COVID19.

a. Have you worked on a Covid-19 specific ward or area at any time? Yes No
b .Have you been redeployed due to the Covid-19 pandemic at any time? Yes No
c. Have you been required to work remotely/from home due to the Covid-19 pandemic? Yes No
d. Have you been shielding? Yes, for myself Yes, for a member of my household

No

These results show that broken down in this way the results were not as favourable as the cumulative scores, although all scored above average.

Compared to last year's results the areas the responses had significantly improved in 4 of the 10 themes

- Health & Wellbeing
- Safe Environment – Bullying & Harassment
- Safe Environment – Violence
- Safety culture

The report demonstrates that the Trust People Strategy is having an impact.

The Executive recommended to the Strategic Workforce Committee that the areas of focus for 2021 should be:

- Reducing discrimination felt by colleagues via the equality and diversity strategy and action plan
- Further developments on health and well-being including MSK
- Re energising QI
- Quality of care
- Reimagine Team working
- Staff engagement as this underpins all themes

The recommendations were unanimously agreed by the Strategic Workforce Committee

Proposals and /or Recommendations:

The Board is asked to note this report and the areas of focus for 2021.

Relevant Legislation and Source Documents:

No

Equality / Diversity Issues

As with previous years, the questions compared the experience of Black, Asian and Minority Ethnic (BAME) colleagues to white colleagues. It also compared the experience of colleagues with a long-term health condition (LTC) or other illness to colleagues without a LTC or other illness.
There was improvement in most experience areas; however, there is still more work to do to close the gap in experience of our BAME colleagues and those with a LTC or other illness.

BAME colleagues and colleague with long term conditions report experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months and experiencing harassment, bullying or abuse from staff in last 12 months However both are below the national average.

BAME colleagues report 14% less than white colleagues in believing that the Trust provides equal opportunities for career progression or promotion. Colleagues with long term conditions also report a lower percentage than colleagues without a long term condition by 3%.

Significantly more BAME colleagues report they experienced discrimination at work from manager / team leader or other colleagues in last 12 months than white colleagues

Colleagues with long term conditions report significantly more pressure from their manager to come to work, despite not feeling well enough to perform their duties, than colleagues without a long term condition. In addition they report less satisfaction with the extent to which the organisation values their work

Colleagues with long term conditions report above average that the Trust made adequate adjustments to enable them to carry out their work.

Name:	Louise Norris	Job title:	Director of Workforce, Organisational Development and Communications
Telephone number:	07789 440007	Email	louisenorris@nhs.net

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	4.3
Agenda Item Title:	Audit and Risk Committee Chair's Assurance Report
Presenting Officer:	Peter Conway, Chair of Audit and Risk Committee
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

The report summarises the Audit and Risk Committee meeting held on12 May 2021 and provides assurance to the Board.

Summary of key points
The meeting covered a range of topics including the 2021/22 Annual Report and Accounts including the Annual Governance Statement; the external audit report and opinion; internal audit opinion; the local counter fraud workplan for 2021/22;

Proposal and/or recommendation to the Committee or Board
The Board is asked to receive the Audit and Risk Committee Chair's Assurance Report.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected characteristic highlights in your*

	paper)
Highlights relating to protected characteristics in paper	
The Board has asked authors to consider their papers through the equality and diversity lens and highlight any issues in their papers.	

Name:	Peter Conway	Job title:	Non-Executive Director
Telephone number:	01622 211906	Email	

Kent Community Health
NHS Foundation Trust

AUDIT AND RISK COMMITTEE CHAIR'S ASSURANCE REPORT

Audit & Risk Committee (ARAC) meeting on 12 May 2021

Area	Assurance	Items for Board's Consideration and/or Next Steps
Annual Report & Accounts 2020/21 (AR&A)	1)ARAC: considered the draft Accounts in detail on 10.5.21. Various issues discussed and clarified. All satisfactory pending completion of External Audit work. Positive support for the unaudited Annual Report subject to further accuracy checks and some drafting suggestions 2)External Audit: ''subject to the completion of the outstanding work, our anticipated audit report opinion will be unmodified''. 3)Internal Audit: subject to their final 2 pieces of work, ''TIAA is satisfied KCHFT has reasonable and effective risk management, control and governance processes in place''	-ARAC to reconvene in the first week of June to receive final versions and opinions after which a recommendation will be provided to the Accounting Officer and Board. -AR&A Board sign off scheduled for 17 June which is well within DoH timetable -Value for Money Audit scheduled for end June (ie. after AR&A)
Risk Management	1)BAF: No assurance possible as out of date report submitted.	1)Latest BAF to go to the Board for 20.5 meeting. Refresh of BAF review processes to be undertaken given mitigating actions and related timings tend to lag

Area	Assurance	Items for Board's Consideration and/or Next Steps
	2)Corporate Assurance & Risk Management Committee: Increase in number of legal claims, SARs and RIDORs. Critical security updates delay identified. Clinical record documentation becoming an issue again in claims investigations	2)QC to follow up clinical documentation. ARAC to monitor the wider adverse trends. CARM to review lessons learned and slips/trips guidance to staff plus arrangements with landlords
Assurance (3rd party)	1)Internal Audit: 4 reports all reasonable assurance (User Access Management, Reset Processes, Data quality of KPIs, Critical Financial Assurance - Financial Accounting, Non-Pay Spend and Payroll). 8 recommendations under previous Asset Management Lifecycle Audit overdue because of Covid reprioritisation 2)Anti-Crime Specialists (formerly local counter fraud): positive assurance	1)IA to consider how 3rd party assurance is gained (eg. when outsourcing, with counterparty NHS Trusts or by pan-ICS audits). 2)ACS to calibrate achievability of new national standards after the first assessment and base-lining in May
Financial Reporting and Controls	1)Single Tender Waivers and Requisitions: positive assurance albeit adverse trends because of Covid 2)Losses and Special Payments: noted	1)Reinforcement of pre-Covid processes, behaviours and standards underway 2)Salary overpayments improved but merit further consideration of potential for additional system based controls
Risk/Governance:	AOB:	1)Obtaining sub-contractor and counterparty risk assurance to be considered by ARAC 2)ICS Board Assurance Framework to be considered when available in August/at next ARAC

Peter Conway
Chair, Audit and Risk Committee
13 May 2021

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	4.4
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 ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

The papers summarise the Finance, Business and Investment Committee meetings held on 5 March, 1 April and 11 May 2021 and provides assurance to the Board.

Summary of key points

The meetings covered a range of topics including the 2021/22 budget; the 2021/22 cost improvement programme; the Trust's operational plan; the Adult Neurodevelopment (Autism and ADHD) Service Development Proposal 2022/23; property transfers from NHS Property Services to Kent Community Health NHS Foundation Trust; and the Edenbridge Report; .

Proposal and/or recommendation to the Committee or Board

The Board is asked to receive the Finance, Business and Investment Committee Chair's Assurance Report.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the*

reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.	*protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	
The Committee has asked authors to consider their papers through the equality and diversity lens and highlight any issues in their papers.	

Name:	Paul Butler	Job title:	Non-Executive Director
Telephone number:	01622 211906	Email	

Kent Community Health
NHS Foundation Trust

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S REVIEW AND ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on Friday 5 March 2021

Issue	Committee review and assurance	Matters for Board awareness and/or action
Finance report 10/12	Finance Report for January 2021 presented Performance ytd is breakeven compared with full year surplus of £150k COVID related costs are £7.3m ytd CAPEX is £6.5m ytd compared against ytd plan figure of £9.2m. Discussion and assurance given by Executive on CAPEX for the full year being in line with budget	
NHS Property Services Transfer of Assets Report	Presentation of final position regarding due diligence undertaken by Executive in advance of transfer of Dover Health Centre and Victoria Hospital Deal from NHSPS to KCHFT	

Issue	Committee review and assurance	Matters for Board awareness and/or action
	Transfer approved by FBI	
2021/22 Draft Budget and CIP Proposal	Process for preparation of 2021/22 budget presented. This will be difficult process with uncertainties in assumptions to be made in budget. FBI noted the approach and emphasised need to highlight key assumptions and associated risks Paper also set out approach being adopted to include CIP target of £4.4m -2% across all areas	

Paul Butler
Chair. Finance Business and Investment Committee

11 May 2021

Kent Community Health
NHS Foundation Trust

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S REVIEW AND ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on Thursday 1 April 2021

Issue	Committee review and assurance	Matters for Board awareness and/or action
Business Development and Service Improvement Report	Committee reviewed the report and supported the proposed tender with Oxleas for prison healthcare contracts for Sheppey cluster, Rochester, Maidstone and East Sutton Park; KCHFT is sub-contractor with 5 year contract from Dec 2021- total value to KCHFT of c£5.9m Agreed that format and content of report to be reviewed out with meetings and revised presentation to be be included in future reports It was agreed that revised commercial strategy needed to be presented to FBI in due course -appropriate timetable in coordination with Board presentation to be set	Revised commercial strategy to be presented to Board – timetable to be set by Executive

Issue	Committee review and assurance	Matters for Board awareness and/or action
Provider Selection Regime – KCHFT draft response	Draft response by Executive presented to FBI and noted. Any further detailed comments from Committee members to be sent to Director of Strategy and Partnership	
2021/22 Draft Budget Proposal incorporating financial assumptions, risks, and capital expenditure	Committee received presentation of draft budget for 2021/22. Following detailed discussion FBI approved draft budget as presented for submission to Board meeting for final approval.	FBI asked that financial risk associated with budget was summarised clearly in budget document presented to Board
Reference costs and approach	Committee reviewed and noted approach to be adopted for preparation of reference cost data for 2020 NHS report on 2019 on cost data not yet published but needs to be presented to FBI once available	
Estates 2020/21 CIP Deep Dive	Estates 2020/21 Estates CIP programme presented to FBI. Executive asked to give updates during the year as to progress against targets as it was felt that under the circumstances delivery of programme looked challenging There was a discussion on presentation of Estates strategy update. Executive are scheduling this for the Autumn	Estates strategy update to be presented to FBI and the Board in the Autumn

Issue	Committee review and assurance	Matters for Board awareness and/or action
Edenbridge Report	A further report regarding development at Edenbridge site was presented to FBI. Committee supported the intended tendering process but required the options resulting to be represented to FBI and then subsequently to Board for approval	FBI supported tendering process but require possible solutions to be presented to FBI and the Board for approval
Committee terms of reference	Revised terms of reference for the FBI presented by FBI Chair. Revised TOR better reflect activity of Committee as undertaken during the last year combined with more appropriate approval levels for the Executive, FBI and Board in relation to capex and opex project spend and commercial contract values	

Paul Butler
Chair, Finance Business and Investment Committee

11 May 2021

Kent Community Health
NHS Foundation Trust

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S REVIEW AND ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on Tuesday 11th May 2021

Issue	Committee review and assurance	Matters for Board awareness and/or action
Finance report 12/12 including cost improvement programme report	Final management accounts for year presented which were in line with previous expectations Explanation of subsequent adjustments made for draft statutory accounts given FBI noted final year end position	
Autism and ADHD Service Development Proposal 2022/3	Proposal presented to FBI and supported by Committee There is an outstanding issue regarding acceptability of not tendering. Executive to send further paper setting out final position and risks with agreed appraoch	It is important that tendering risks are understood so that appropriate decision can be made
Going concern and working capital report	Year-end going concern position reviewed including support from DHSC FBI supported position as set out	
Draft Operating Plan 2021/2	Draft operating plan for 2021/2 was presented to FBI	

Issue	Committee review and assurance	Matters for Board awareness and/or action
	Discussion on both internal, system and NHI approach discussed. Paper to be presented at forthcoming Board meeting for approval. FBI members asked to feed any comments to Executive ASAP	
Phase Two Property Transfers	Presentation of initial business case for potential transfer of four properties – Sevenoaks Hospital, Queen Victoria Memorial Hospital, Herne Bay, Molehill Copse Clinic, Maidstone and Vicarage Lane Clinic, Ashford -from NHSPS to KCHFT. Executive supported by Avison Young, transfer value of properties is estimated at £16.1m. FBI supported business case for transfer	
Kent and Medway Care Record Risk Register Report	Presentation of project status given by Project Director and FBI were assured that good progress is being made Presentation of initial work on benefits analysis. FBI concluded that although goo work had been done, there was a need to reduce current schedule of benefit areas to a more manageable schedule of key benefits linked to those identified at project development FBI asked for future iterations of benefits assessment to be presented as appropriate	

Paul Butler
Chair, Finance Business and Investment Committee

11 May 2021

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	4.5
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Pippa Barber, Chair of Quality Committee
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

The reports summarise the Extraordinary Quality Committee meeting held on 16 February 2021 and the Quality Committee meetings held on 23 March and 12 May 2021 which provide assurance to the Board.

Summary of key points

The meetings covered a range of topics including the review of the quality impact assessments of the 2021/22 cost improvement programme schemes; an update on the patient story presented to the Board in November 2020; risk 110 on the Board Assurance Framework; quality priorities 2021/22; progress with health checks; health inequalities; and the Hygiene Code.

Proposal and/or recommendation to the Committee or Board

The Board is asked to receive the Quality Committee Chair's Assurance Report.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.**	☐ Yes *(please attach)* ☒ No *(please provide a*

Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.	*summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	
The Committee has asked authors to consider their papers through the equality and diversity lens and highlight any issues in their papers.	

Name:	Pippa Barber	Job title:	Non-Executive Director
Telephone number:	01622 211906	Email	

Kent Community Health
NHS Foundation Trust

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report follows the Extraordinary Quality Committee meeting held in February to consider the quality impact assessments (QIAs) of the cost improvement plans (CIPs) and the Committee meeting in March 2021 (Part one).

Agenda item	Assurance and Key points to note	Further actions and follow up
Extraordinary Quality Committee February 2021 and March Quality Committee meeting follow up	All the Board non-executive directors (NEDs) and the Chair attended to review the QIAs and progress with CIPs with executive members of the Quality Committee. Good progress was being made on the identification of schemes and the sign off of the QIAs by the Medical Director and Chief Nurse. Themes arising from the schemes and individual schemes were discussed and reviewed as needed with two schemes being identified as medium risk. The programme of deep dives by NEDs was agreed.	Further updates on progress with schemes will come back to the Quality Committee as they are agreed. The Finance Business and Investment (FBI) Committee will continue to oversee delivery of the financial elements of the CIP programme including the impact of Rio (the electronic patient record) and the inclusion of the run rate to the plan. FBI Committee oversight, specifically of the estates plans, will also take place. The Quality Committee at its March meeting received further information on the process for ensuring equality considerations of the CIPs are part of the quality impact review.

Agenda item	Assurance and Key points to note	Further actions and follow up
		The need for a possible wider workforce discussion on supporting staff to continue to have conversations/develop capability to consider equality impacts to be discussed at the Strategic Workforce Committee.
Board Patient Story update	An update on progress was received by the Committee on the patient story presented at the November Board meeting. Improvements have been made based on feedback received. These include communication with families at night, the administration of medication by families, and the triaging of patients to identify increased need. Staffing capacity was discussed with a risk identified in the west Kent service currently and assurances provided on cover arrangements whilst recruitment takes place. Assurance were also received on the work that has taken place between the night service and GPs, specifically electronic drug charts enabling improvements to be made to administration and prescribing of medication out of hours .	Further discussion will take place to agree the most appropriate way of obtaining assurance on actions by a NED visit/Teams call with the night service/updates to Quality Committee.
Terms of Reference (ToR)	The annual review of the ToR of the Quality Committee was considered and agreed subject to the following additional areas: • Oversight of system quality issues that are provided by KCHFT	System Quality issues, where needed, will need to be included in the Quality Report.

Agenda item	Assurance and Key points to note	Further actions and follow up
	• Ensuring equality considerations and analysis are integral to quality impact assessments, performance and risk reporting. The TOR of the Patient Safety and Clinical Risk Group subcommittee was also agreed.	Equality impacts will need to be considered for all papers brought to the Committee
Board Assurance Framework	Discussion took place on Risk 110. This risk is being reviewed by the Chief Operating Officer (COO). The recent funding announcement and working arrangements with partner organisations are reducing the risk.	
External regulation and inspection	The Committee received a verbal update on KCHFTs contribution to a Care Quality Commission (CQC) provider collaborative system review being undertaken on the Learning Disabilities (LD) services. The review also included other system partners and the report will be produced later in the year. Verbal feedback during the visit to the Chief Nurse on KCHFT services was positive. Written positive assurance has now been received from Public Health England (PHE) following its visit to the New Born Hearing Service.	
Quality Priorities 2021/22	The Committee supported the approach for the identification of priorities from April onwards. The long list is currently out for consultation with a range of groups and staff.	Assurance was received that the three priorities chosen under each heading will not preclude further work being undertaken in other quality areas as needed.

Agenda item	Assurance and Key points to note	Further actions and follow up
Preventing Ill Health		
Operational deep dive - Progress with Health checks	The delivery of this programme remains below target with a significant part of it delivered in primary care. A meeting is to take place with Kent County Council (KCC) Director of Public Health to agree how these checks can be re-started as a system going forward.	A further update and output from the meeting will be provided at the next Quality Committee.
Health inequalities	Following discussion it was agreed a report on how KCHFT is supporting the system work on reducing health inequalities will be added to the Quality Committee forward plan.	
High Quality Care		
Patient safety and clinical risk	Progress is being made on the access to Dental general anaesthetic services. It is expected that lists may become available next week and the team will work quickly to reduce the number of patient waiting with a trajectory put in place. Further positive assurance was received that all patients waiting on lists had been contacted and a high quality review has taken place.	
Quality Report	Discussion took place on staffing levels in some community hospitals. Assurance that the Strategic Workforce Committee is sighted on the work for both Faversham and Deal. Further updates on the deep dive work will come back in a May safer staffing report.	The timing of the review of the strategic work on community hospitals to be considered and further updates will come to the Quality Committee in either May or July.

Agenda item	Assurance and Key points to note	Further actions and follow up
	Avoidable medication incidents, specifically controlled drugs, were reviewed and discussed. Further data on themes and if inpatient or community to be included next time with targeted actions to reduce recurrence. Nosocomial infection numbers and actions in place were reviewed and considered with an additional slide now included in the Quality Report. This remains a risk across all inpatient areas. The numbers of positive patients with COVID-19 is reducing. At the time of the meeting one outbreak was open. The Trust has reviewed its screening processes and the Infection Prevention and Control (IPC) Team is supporting outbreaks in line with national guidance. The age and lay out of some the estate remains a challenge.	Assurance on the BAF action plan will take place at Public Board meetings. NED attendance at the IPC meeting in April will take place and fed back to the Quality Committee.
Clinical Effectiveness Group Chair's Assurance Report	A summary of the work being undertaken by the group was provided. The overriding theme from all of the work streams including NICE, audit, research, end of life care (EOLC) , wound care and Quality Improvement (QI) was positive innovation and adaptations by services during these difficult times. Examples of taking part in regional networks and using digital innovations to improve efficiency and patient outcomes.	The Committee has asked how we are supporting all services to level up to the best and reduce variation in our offer across the Trust with examples of where we are sharing and spreading innovative and best practice.

Agenda item	Assurance and Key points to note	Further actions and follow up
We Care Programme Annual Report	The Committee received the excellent annual report which was able to demonstrate the maintenance of Quality during the last year on the services visited. The Head of Quality Management was thanked for the support and leadership to the programme and all staff who have supported these valuable visits. The themes identified in the report for ongoing support are all areas being or have been considered by the Quality Committee or its sub groups or the Strategic Workforce Committee.	
Operational deep dives	Did not Attends (DNAs): A report was provided giving detail on services with an increase in DNAs during COVID-19 and the mitigations in place. Thought has being given in a targeted way service by services on what is driving this and how it can be mitigated. The actions are now beginning to have an impact and this will be further monitored through the integrated performance report (IPR). The Committee received a report on waiting lists in KCHFT services in prisons - the waiting list position and the mitigations in place for each service and each prison. Access has improved more recently where COVID-19 outbreak cases have reduced. Virtual triage is in place for all referrals and the total waiting list number overall is gradually reducing. Referrals are being monitored.	Further work on understanding the equality demographics of the data is being considered with more work to do. The output from that work and how the data benchmarks (where available) with others to more fully understand our relative positon will be brought back to the Quality Committee. Continue to monitor progress through the integrated performance report.

Agenda item	Assurance and Key points to note	Further actions and follow up
Policies for ratification	The following policies were ratified by the Committee: • Standard Operating Procedure for protecting patients who walk with purpose/wander in the community hospitals • Enhanced Observations Standard Operating Procedure • Clinical Record Keeping guidelines following Adoption • Transition from children and young People Service to adult Services Protocol • Admission to Community Hospitals Standard Operating Procedure	
Infection Prevention and Control Declaration	The declaration was considered by the Committee who were content to recommend to the Board the Trust is compliant with the Hygiene Code.	

Pippa Barber
Chair, Quality Committee
March 2021

Kent Community Health
NHS Foundation Trust

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report follows the Quality Committee meeting held on 12 May 2021.

Agenda item	Assurance and Key points to note	Further actions and follow up
Relevant feedback from other committees	The Finance, Business and Investment Committee has considered the ADHD proposal. ARAC have raised the issue of the learning identified in legal claims in relation to documentation.	This will be considered from a quality perspective at our July Committee. A report will come to the July committee on issues identified, learning and actions.
Annual Quality Priorities 2021/22	The Committee reviewed and considered the priority areas that will form the Quality Account for 21/22.These will not be the only areas of quality improvement considered by the Trust this year. The final report now includes areas agreed following consultation with internal and external stakeholders. The priority themed areas cover; • Patient safety, learning and improvement, • The needs of people, families, carers and staff to improve the experience of end of life care. • Prevention • The voice of our patients and service users	The priorities will be monitored by the Quality Committee quarterly.

Agenda item	Assurance and Key points to note	Further actions and follow up
	Using these themes three quality priorities have been assigned to the four pillars of Patient safety, clinical effectiveness, and patient and staff experience. Quality improvement programmes with identified outcomes measures will be used to deliver and drive improvement. Following discussion and a minor amendment the Committee Approved the 12 indicator Qualities Priorities.	
	Preventing ill health	
Health Inequalities Update Report	A good summary update was provided on the significant work that is in progress across the Trust. Recommendations and actions are in place to ensure decision making considers protected groups, addresses health inequalities and has due regard for the three aims of the public sector equality duty. The Committee were assured on the breadth and depth of the range of activities being undertaken. The action plan is RAG rated and being overseen by EMT. Updates included progress on supporting and working with the Roma community to support vaccine uptake, an update on a train the trainer programme to deliver cultural safety training to staff. The development of equality data sets, support to staff on completion of EIAs and the support of EDS2 actions .A Red Quadrant racism	Further discussion to be considered by the whole Board to ensure oversight and knowledge of the whole work programme supporting both patients and staff . Quality issues identified as part of the Red quadrant review and the output from the

Agenda item	Assurance and Key points to note	Further actions and follow up
	review is underway and work is being undertaken to review the impact of DNAs and RTT breaches.	DNA RTT review will be considered at a future QC.
	High Quality Care	
Quality Strategy	The final Quality Strategy was presented to the Committee for approval. The Strategy has been considered and shaped by a number of different groups and committees. Quality improvement is central to the delivery of the strategy as is the alignment to the forthcoming digital and commercial strategies and the approved Our People Strategy. The strategy will enable delivery of the national quality quadruple aim. The strategy focusses on eight core objectives; Continuous improvement, the use of information to drive continuous QI, the promotion of positive staff and patient and carer experiences and the reduction of health inequalities. Using resources effectively, prioritising patient safety and finally promoting clinical leadership. Each Strategic ambition has key enabler/co dependencies supporting its delivery. The Strategy is set out in the same format as the People strategy. The Committee approved the strategy with consideration of the KMCR being considered as an enabler.	The strategy following final comments made at QC will be reviewed by Coms for formatting and come to a future full board meeting and Council of Governors.

Agenda item	Assurance and Key points to note	Further actions and follow up
Quality Report	It has been agreed to prevent duplication the 6 monthly safer staffing report will now only be considered by the SWC. It was reported that avoidable medication errors had seen a significant drop in quarter one. Work continues with the pharmacy and quality teams supporting the community hospitals to improve the recording of controlled drugs. A verbal update was provided on nosocomial infection , with none reported in community hospital beds. The action plan remains in place. Two NEDS had attended the Trust IPC committee and gained good assurances on the range of measures in place across IPC with the Trust.	
Learning from Deaths Quarterly Report	The data for quarter 4 was considered by the Committee. The Committee were reminded of the adaptations to the review process that have been put in place during the pandemic with continued assurance that the process of reviews is compliant with the National guidance Areas for improvement emerging from reviews include advance care planning and missed opportunities to identify end of life, medicines issues, and general documentation and team communication. The age,	

Agenda item	Assurance and Key points to note	Further actions and follow up
	gender and ethnicity of all patients dying with COVID-19 are now being collected. Areas of improvement and learning continue to be taken the Matrons forum for sharing and with oversight of themes being by the EOLC group. In line with National guidance any deaths considered to be an SI are included in the review process. A Route cause analysis is being undertaken on the one identified in this quarter. The Committee received and considered the Kent and Medway annual report of learning disabilities mortality (LeDer) programme. The significant work undertaken by the Trust team on behalf of the wider system was noted with thanks to all of the staff involved. Assurance was given that the themes and learning identified in the annual report are being overseen by the CCG quality group. There were no deaths in current scope of the policy judged more likely than not due to problems in care in line with National guidance. In addition to the above all Trust HCAI Covid-19 inpatient deaths will now in addition be reviewed in line with new national guidance with a focus on generating insights to underpin effective and sustainable care. This will be undertaken retrospectively and will be considered as part of the SI process with duty of candour applied .	An update will be provided in the Part 2 SI report to the July Quality Committee on the outcome of the RCA and learning identified The July Quality committee will receive a report as part of their part 2 Si report, outlining the process of the review ,the number of cases in scope and the outcome of the review.

Agenda item	Assurance and Key points to note	Further actions and follow up
Patient Safety and Clinical Risk	Some increased risk identified in risk registers and SIs in staffing (some during the peak of second wave Sis) .The COO gave assurance the staffing risk was reducing but remains a focus in some specific areas .The need to continue to ensure best practice is shared and we can demonstrate spread where appropriate is a theme for continued focus in patient safety and clinical effectiveness. Work is going on to reduce the risk for some community teams in accessing patient records whilst working in the community. The number of outstanding actions from Sis is reducing but the need to focus on the learning from pressure ulcer investigations was highlighted Assurance was given that the Trust wide improvement plan for pressure ulcer care has now completed its consultation with staff and there was considerable ownership of the actions needed.	A further update on progress and mitigation of this risk will be brought to QC in July. A further update on the progress and outcomes of the pressure ulcer action plan will come to a future QC.
Operational Deep Dives	Paediatric audiology .An update was provided on the number of children identified who are waiting to complete their diagnostic pathway following an incorrect application of the 6 week RTT stop the clock criteria .It has been identified an incorrect reporting of compliance of achievement of this standard has been reported. In March 578 children were identified as still needing to complete the diagnostic procedure .The recovery plan	Progress to be overseen via the IPR and with a further update at the July QC.

Agenda item	Assurance and Key points to note	Further actions and follow up
	trajectory indicates this will reduce to 378 in May and with none outstanding by October. All children had been screened via a virtual assessment and clinical prioritisation has been inplace through out, however the actual diagnostic test was not undertaken. 7, 52 week breaches have been identified and harm reviews completed with no harm identified. The committee were concerned to note that the new born hearing service had to undertake another recovery plan. Assurance was received that the regulator was aware of the work that was being undertaken and was supportive of the plans in place. Assurance was sought following discussion on if there was a risk other service pathways were not complying with the guidance An external peer review is being undertaken of relevant services. A further update was received on progress with undertaking GAs for dental patients .There has been a slowly reducing number of patients waiting as acute Trust theatre capacity slowly becomes available .Providing all sessions are able to be completed it is hoped all paediatrics waiting will have been seen by the end of May and adults by early June .	An update on the peer review ill come to the next meeting
Policies for Ratification	The following policy was ratified by the Committee;	

Agenda item	Assurance and Key points to note	Further actions and follow up
	• Comments Concerns and Complaints Policy	

Pippa Barber
Chair, Quality Committee
14 May 2021

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	4.6
Agenda Item Title:	Strategic Workforce Committee Chair's Assurance Report
Presenting Officer:	Bridget Skelton, Chair of Strategic Workforce Committee
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
The report summarises the Strategic Workforce Committee meeting held on 22 March 2021 and provides assurance to the Board. A verbal report will be provided on the meeting of 18 May.

Summary of key points

A range of topics was covered at the meeting including Risk 73 on the Board Assurance Framework, the Staff Survey and the Trust's Sustainability Strategy.

Proposal and/or recommendation to the Committee or Board

The Board is asked to receive the Strategic Workforce Committee Chair's Assurance Report.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected*

maternity, race, religion or belief, sex and sexual orientation.	*characteristic highlights in your paper)*
Highlights relating to protected characteristics in the paper	
The Committee received the Workforce Race Equality Standard and the Workforce Disability Equality Standard action plans.	

Name:	Bridget Skelton	Job title:	Non-Executive Director
Telephone number:	01622 211900	Email	

Kent Community Health
NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Strategic Workforce Committee meeting held on 22 March 22 2021.

Agenda item	Assurance and Key points to note	Further actions and follow up
Workforce report BAF risk 73	The Committee received positive assurance from the workforce data. 11 metrics are in a stable or positive position. Two are in a negative position, compliance with agency price cap and average time to hire, both directly attributable to the emergency response to COVID-19 and supporting the additional recruitment for the large vaccination centres. Sickness levels have significantly reduced, as well as stress related absence. Hardcopy booklets are being sent to home addresses to ensure all staff know what wellbeing support is available should they not have seen it on Flo. The review to look for any signs of institutional racism existing has been commissioned and should be concluded in three months. The next Nursing Academy cohort started in February with 19 offers, taken up by 16. The EDI Lead started and is picking up immediately the data in the staff survey and the outcomes in the Workforce Strategy to frame early interventions. Work to define the Community Hospital strategy should be in draft form by the end of April and is involving partners in defining a system solution, with new robust admissions criteria being set out. A task and	

Agenda item	Assurance and Key points to note	Further actions and follow up
	finish group is looking at data to inform what can be done to support staff with symptoms of long Covid which will include fast track assessment, management guidance and support for self-help.	
Operational Workforce Report	Hotpots of challenge are community hospitals and the West Kent Home Treatment Team. Actions to address both are in place including focused recruitment, better roster management and greater use of the 'safe care' module. Mitigation for challenge of significant number of shifts being covered by agency is supported by data mapping and weekly meetings. 125 people were redeployed to help in east Kent, 54 remain but will be returned by the end of March to help reinstate services. Recruitment is in pipeline but with eight weeks' gap these significant issues are receiving close attention.	
Significant Employee Relations Report	There has been one new suspension since the last report; an alternative was offered but refused. The case load remains high. The Trust successfully defended four cases at tribunal, eight ongoing tribunal cases but could take up to two years with current backlog. Issues of 'investigation' competence is being addressed through supervision and training, but availability has been challenging. Being clear on the outcome desired would help resolve cases earlier and using a facilitated conversation approach which are the approaches now being used more often through the introduction of the resolution/accountability framework. A complexity matrix has also helped ensure the distribution of case load is fair.	.
DBS Board Assurance	The Committee received assurance that KCHFT is fully compliant with DBS checks for non-executive directors.	

Agenda item	Assurance and Key points to note	Further actions and follow up
Effectiveness of HR/OD Function	The Committee received a report on how technology is supporting the effectiveness of the HR/OD function. It has been positively impacted by the use of bots with ten automated systems and another 14 under review, recruitment and induction successfully conducted digitally, work placements for the Clinical Academy successfully achieved virtually enabling the continuation of study with work placements made possible. All training has been qualitatively evaluated as well as having qualitative impressive results. Training offered 18,000 spaces compared to 2000 and with a decrease in cost from £167 to £30 per session of training.	
Staff Engagement – including Staff Survey	An astonishing set of survey results is a credit to all management at KCHFT to achieve the consistent and sustained improvement of scores across the entire set of themes. There are some astonishing shifts like safety culture in 2016 was 6.9 to 7.5 in 2020, as well as recommend as a place to work in 2016 was 58.5% to 75.3% in 2020. The improvement in the management scores and wellbeing scores are also excellent. The response rate was 62.4% above the median of 57.5% and an increase of 3.6% in 2019. In five of the themes KCHFT scored highest when benchmarked against 14 other Community Trusts: equality, diversity and inclusion; health and wellbeing; immediate managers; morale and safety culture. Four of the ten themes where we significantly improved from 2019 are health and wellbeing; safe environment – bullying and harassment;	

Agenda item	Assurance and Key points to note	Further actions and follow up
	safe environment – violence and safety culture. Areas for focus for 2021will be: • Reducing discrimination felt by colleagues via the equality and diversity strategy and action plan • Further developments on health and well-being including MSK • Re energising Quality Improvement (QI) • Quality of care • Reimagine team working • Staff engagement as this underpins all themes	
Sustainable Environment	The Committee received assurance that all workforce related actions in the Sustainability Strategy are progressing to schedule including the living wage initiative and the renewable energy education and application. The KCHFT Sustainability Strategy 2021 – 26 is in draft and is about to be launched through internal channels and the public facing website. Animation and tabulation will aid staff to visit areas of specific interest.	Request for one page version to be available to staff. Clarification on protection of cover secured for direct loan scheme and offers on competitive renewable tariffs to be provided to the Committee (with legal view sought) before initiatives become available.
Transformation of Workforce (Quality improvement)	Capacity for QI work was reduced through COVID-19 but bitesize videos were launched and Q1 lite was available to support those with the fundamentals. A data analyst and two advisors are still available to support work. Measurement is captured via three questions What are youy trying to improve? How will you know it has improved? And	

Agenda item	Assurance and Key points to note	Further actions and follow up
	What will you have to do to bring improvement about? New ways of working will be supported by further engagement to include training, management of projects providing models for improvement and promotion of QI through communication, marketing and events. Data sourcing is critical to ensure we have a base line to measure the improvement of a project. Embedding QI is also high on the agenda.	
Terms of Reference	These were reviewed and agreed by the Committee	

Bridget Skelton
Chair, Strategic Workforce Committee
22 March 22 2021

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	5.1
Agenda Item Title:	2020/21 Annual Report and Accounts
Presenting Officer:	Paul Bentley, Chief Executive
Action – this paper is for:	☐ Decision ☒ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

To confirm to the Board the annual reporting timetable with regards to the 2020/21 Annual Report and Accounts.

Summary of key points

The following timetable to receive and approve the 2020/21 Annual Report and Accounts was agreed by the Board at its meeting in March.

The Audit and Risk Committee received the draft annual accounts at its meeting on 12 May. The Board will receive the final accounts at its meeting on 17 June for approval.

The finalised Annual Report including the Accounts will be received by the Audit and Risk Committee at its meeting on 2 September, followed by approval by the Board at its meeting on 9 September.

Proposal and/or recommendation to the Committee or Board

To note the timetable to receive and approve the annual report and accounts.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper?	☐ Yes *(please attach)*

National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process. *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☐ No *(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Gina Baines	Job title:	Assistant Trust Secretary
Telephone number:		Email	Gina.baines@nhs.net

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	5.2
Agenda Item Title:	Standing Financial Instructions, Standing Orders and Schemes of Delegation
Presenting Officer:	Gordon Flack, Deputy Chief Executive/Director of Finance
Action – this paper is for:	☒ Decision ☐ Information ☐ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
The Standing Financial Instructions (SFIs) set out the regulation of the conduct of its Directors and Officers in relation to all financial matters with which they are concerned. The SFIs are updated annually and the Board is asked to approve this update.

Summary of key points

The Standing Financial Instructions have been updated to reflect:

- The Scheme of Delegation which has been reviewed by the Integrated Management Team and Executive Team and provides a detailed list of the authorisation levels for officers of the Trust.
- The role of the Integrated Management Team, replacing the former Management Committee.
- The change in title of the Local Counter Fraud Specialist (LCFS) to Counter Fraud Specialist (CFS).
- Private finance section updated to change the requirement to market test for PFI and replace with requirement to follow latest Treasury and Department of Health and Social Care guidance in relation to testing for PFI.

Proposal and/or recommendation to the Committee or Board

To approve the Standing Financial Instructions

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.*	☐ Yes *(please attach)*

You can find out more about EAs here on flo **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☒ No *(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	
No impact and no decisions being made.	

Name:	Gordon Flack	Job title:	Deputy Chief Executive/ Director of Finance
Telephone number:	01622 211934	Email	Gordon.flack@nhs.net

Kent Community Health
NHS Foundation Trust

Standing Financial Instructions

1 Introduction

1.1 General

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

1.1.2 These SFIs detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with Laws and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Scheme of Delegation shown at Appendix 1.

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

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

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

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

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

1.2 Responsibilities and delegation

The Board of Directors

1.2.1 The Board exercises financial supervision and control by:

1.2.1.1 formulating the financial strategy;

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

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

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

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

The Chief Executive and Director of Finance

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

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

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

The Director of Finance

1.2.6 The Director of Finance is responsible for:

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

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

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

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

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

1.2.6.4.1 the provision of financial advice to Directors and Officers;

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

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

1.2.7 **Directors and Officers**

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

1.2.7.1 the security of the property of the Trust;

1.2.7.2 avoiding loss;

1.2.7.3 exercising economy and efficiency in the use of resources;

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

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

Contractors and their employees

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

2 Audit

Audit and Risk Committee

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

2.1.2 overseeing internal and external audit services;

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

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

2.1.5 monitoring compliance with SOs and SFIs;

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

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

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

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

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

2.4 Director of Finance

The Director of Finance is responsible for:

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

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

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

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

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

2.4.4.2 major internal financial control weaknesses discovered;

2.4.4.3 progress on the implementation of internal audit recommendations;

2.4.4.4 progress against plan over the previous year;

2.4.4.5 strategic audit plan covering the coming 3 years; and

2.4.4.6 a detailed plan for the coming year.

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

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

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

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

2.5.4 explanations concerning any matter under investigation.

2.6 Role of internal audit

Internal audit will review, appraise and report upon:

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

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

2.6.3 the suitability of financial and other related management data;

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

2.6.4.1 fraud and other offences;

2.6.4.2 waste, extravagance, inefficient administration;

2.6.4.3 poor value for money or other causes.

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

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

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

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

2.10 External audit

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

Fraud and corruption

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

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

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

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

Security management

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

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

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

Finance, Business and Investment Committee (FBI)

2.18 The FBI committee has responsibility for the following ;

2.18.1 Scrutinise current financial performance and future financial plans (including Annual Plan and Budget and longer term financial plans);

2.18.2 Monitor performance against Cost Improvement Plans;

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

2.18.4 Approve treasury management policy and scrutinise implementation.

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

Preparation and approval of plans and Budgets

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

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

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

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

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

3.2.2 accord with workload and manpower plans;

3.2.3 be produced following discussion with appropriate Budget Holders;

3.2.4 be prepared within the limits of available funds; and

3.2.5 identify potential risks.

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

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

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

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

3.7 Budgetary delegation

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

3.7.1.1 the amount of the Budget;

3.7.1.2 the purpose(s) of each Budget heading;

3.7.1.3 individual and group responsibilities;

3.7.1.4 authority to exercise virement;

3.7.1.5 achievement of planned levels of service; and

3.7.1.6 the provision of regular reports.

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

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

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

3.11 Budgetary control and reporting

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

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

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

3.11.1.2 movements in working capital;

3.11.1.3 movements in cash and capital;

3.11.1.4 capital project spend and projected outturn against plan;

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

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

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

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

3.11.4 monitoring of management action to correct variances; and

3.11.5 arrangements for the authorisation of Budget transfers.

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

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

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

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

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

3.12 Capital expenditure

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

3.13 Monitoring returns

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

4 Annual accounts and reports

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

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

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

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

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

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

5 Bank and Government Banking Service (GBS) accounts

5.1 General

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

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

5.2 Bank and GBS accounts

The Director of Finance is responsible for:

5.2.1 bank accounts and GBS accounts;

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

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

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

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

Banking procedures

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

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

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

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

Tendering and review

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

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

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

Income systems

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

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

Fees and charges

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

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

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

Debt recovery

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

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

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

Security of cash, cheques and other negotiable instruments

6.9 The Director of Finance is responsible for:

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

6.9.2 ordering and securely controlling any such stationery;

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

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

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

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

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

7 Tendering and contracting procedure

7.1 Duty to comply with SOs and SFIs

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

7.2 EU Directives governing public procurement

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

7.3 Reverse eAuctions

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

7.4 Other Department of Health and Social Care guidance

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

Formal competitive tendering

7.5 General applicability

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

7.5.1.1 the supply of goods, materials and manufactured articles;

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

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

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

7.6 Health care services

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

Exceptions and instances where formal tendering need not be applied

7.7 Formal tendering procedures need not be applied where:

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

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

7.7.3 regarding disposals as set out in SFI 7.25 below;

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

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

7.8.2 where the requirement is covered by an existing contract;

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

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

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

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

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

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

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

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

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

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

7.11 Fair and open procurement process

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

7.12 Building and engineering construction works

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

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

7.13 Items which subsequently breach thresholds after original approval

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

7.14 Contracting/tendering procedure

Invitation to tender

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

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

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

Receipt and safe custody of tenders

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

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

Opening tenders and register of tenders

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

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

7.15 Admissibility

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

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

7.16 Late tenders

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

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

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

7.17 Acceptance of formal tenders

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

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

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

7.17.3.1 experience and qualifications of team members;

7.17.3.2 understanding of client's needs;

7.17.3.3 feasibility and credibility of proposed approach;

7.17.3.4 ability to complete the project on time.

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

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

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

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

7.17.6.2 that best value for money was achieved.

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

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

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

7.18 Quotations: competitive and non-competitive

7.18.1 **General position on quotations**

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

7.18.2 **Competitive quotations**

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

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

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

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

7.18.3 **Non-competitive quotations**

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

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

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

7.18.3.3 miscellaneous services, supplies and disposals;

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

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

Competitive quotation need not be applied where:

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

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

7.18.5 **Quotations to be within financial limits**

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

7.18.6 **Authorisation of tenders and competitive quotations**

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the Officers in line with the Scheme of Delegation.

7.18.6.1 The levels of authorisation may be varied or changed by the Board at its sole discretion. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors, this shall be recorded in its minutes.

7.19 Preferred procurement route

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

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

7.20 Private finance for capital procurement

The Trust should have due regard to current HM Treasury and Department of Health and Social Care guidance in relation to the requirement to test for Private Finance Initiative/PPP funding when considering capital procurement.. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

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

7.20.2 where the sum exceeds delegated limits, a business case must be completed for approval via the Department of Health and Social Care.

7.20.3 the proposal must be specifically agreed by the Board.

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

7.21 Compliance requirements for all contracts

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

7.21.1 the Trust's SOs and SFIs;

7.21.2 EU Directives and other statutory provisions;

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

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

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

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

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

7.22 Personnel and agency or temporary staff contracts

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

7.23 Health care services agreements

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

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

7.24 Disposals

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

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

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

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

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

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

7.25 In-house services

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

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

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

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

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

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

7.25.4 The evaluation team shall make recommendations to the Board.

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

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

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

8 NHS service agreements for provision of services

8.1 Service Contracts

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

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

8.1.2.1 the standards of service quality expected;

8.1.2.2 the relevant national service framework (if any);

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

8.1.2.4 the NHS Oversight Framework; and

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

8.2 Reports to Board of Directors on Service Contracts

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

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

9.1 Remuneration and terms of service

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

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

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

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

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

9.1.2.1.3 arrangements for termination of employment and other contractual terms;

9.1.2.2 making such recommendations to the Board on the remuneration and terms of service of Directors and senior Officers to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

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

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

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

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

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

9.2 Funded establishment

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

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

9.3 Staff appointments

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

9.3.1.1 authorised to do so by the Chief Executive; and

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

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

9.4 Processing payroll

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

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

9.4.1.2 the final determination of pay and allowances;

9.4.1.3 making payment on agreed dates; and

9.4.1.4 agreeing method of payment.

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

9.4.2.1 verification and documentation of data;

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

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

9.4.2.4 security and confidentiality of payroll information;

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

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

9.4.2.7 methods of payment available to various categories of Officers;

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

9.4.2.9 procedures for the recall of cheques and bank credits;

9.4.2.10 pay advances and their recovery;

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

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

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

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

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

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

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

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

9.5 Contracts of employment

The Board shall delegate responsibility to an Executive Director for:

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

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

10 Non-pay expenditure

10.1 Delegation of authority

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

10.1.2 The Chief Executive will set out:

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

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

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

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

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

10.3 System of payment and payment verification

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

10.4 The Director of Finance will:

10.4.1 advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the SOs and SFIs and/or Scheme of Delegation (as appropriate) and regularly reviewed;

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

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

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

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

10.4.4.2 certification that:

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

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

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

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

10.4.4.2.5 the account is arithmetically correct;

10.4.4.2.6 the account is in order for payment;

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

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

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

10.5 Prepayments

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

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

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

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

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

10.6 Purchase orders

Purchase orders for goods and/or services must:

10.6.1 be consecutively numbered;

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

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

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

10.7 Duties of Officers

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

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

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

10.7.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care and NHS England and NHS Improvement;

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

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

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

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

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

10.7.5.3 the Code of Conduct for NHS Managers 2002; and

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

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

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

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

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

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

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

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

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

10.7.6 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and

engineering contracts and property transactions comply with the SFIs 7.15.3. The technical audit of these contracts shall be the responsibility of the relevant Director.

11 External borrowing

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

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

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

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

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

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

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

12 Investments

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

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

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

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

13.1 Capital investment

The Chief Executive:

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

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

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

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

13.2.1 that a business case is produced setting out:

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

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

13.2.1.3 appropriate project management and control arrangements;

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

13.2.3 that for capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Department of Health and Social Care.

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

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

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

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

13.6.1 specific authority to commit expenditure;

13.6.2 authority to proceed to tender;

13.6.3 approval to accept a successful tender.

13.7 The scheme of delegation for capital investment is included in Appendix 1.

13.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account any current delegated limits for capital schemes.

13.9 Asset registers

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

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

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

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

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

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

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

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

13.9.6 Where a full valuation of assets has not been undertaken, the value of each material asset shall be indexed to current values in accordance with the most up-to date BCIS Index (Building Cost Information Service of RICS). The BCIS Index fulfils the requirement of being current and is approved by the Royal Institution of Chartered Surveyors. Where the BCIS Index is not appropriate for a class of asset i.e. Land, an assessment of current valuation will be provided by an approved External Chartered Surveyor. Non-Property assets, those assets which have short useful lives or low values (or both) are not re-valued.

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

.

13.10 Security of assets

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

13.10.2 Asset control procedures (including non-current assets, cash, cheques and negotiable instruments, and also including donated

assets) must be approved by the Director of Finance. This procedure shall make provision for:

13.10.2.1 recording managerial responsibility for each asset;

13.10.2.2 identification of additions and disposals;

13.10.2.3 identification of all repairs and maintenance expenses;

13.10.2.4 physical security of assets;

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

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

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

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

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

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

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

14 Stores and receipt of goods

14.1 General position

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

14.1.1 kept to a minimum;

14.1.2 subjected to proper control and recording; and

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

Control of stores, stocktaking, condemnations and disposal

14.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to

departmental Officers and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of any pharmaceutical inventories shall be the responsibility of a designated Officer for pharmaceutical matters; and the control of any fuel oil and coal shall be the responsibility of a designated Officer for estates matters.

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

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

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

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

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

14.8 Goods supplied by NHS Supply Chain

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

15 Disposals and condemnations, losses and special payments

Disposals and condemnations

15.1 Procedures

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

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

15.1.3 All unserviceable articles shall be:

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

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

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

Losses and special payments

15.2 Procedures

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

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

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

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

15.2.4.1 the Board of Directors; and

15.2.4.2 the external auditor.

15.2.5 Within delegated limits, the Integrated Management Team and the Executive Team shall approve the writing-off of losses.

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

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

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

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

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

16 Information technology

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

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

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

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

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

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

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

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

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

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

16.4.1 details of the outline design of the system; and

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

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

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

16.6 Risk assessment

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

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

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

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

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

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

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

17 Patients' property

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

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

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

17.2.2 hospital admission documentation and property records; and

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

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

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

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

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

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

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

18 Funds held on trust

18.1 Corporate trustee

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

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

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

18.2 Accountability to Charity Commission and Secretary of State

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

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

18.3 Applicability of SFIs to funds held on trust

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

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

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

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

20 Retention of records

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

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

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

21 Risk management and insurance

Programme of Risk Management

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

21.2 The programme of risk management shall include:

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

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

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

21.2.4 contingency plans to offset the impact of adverse events;

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

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

21.2.7 arrangements to review the risk management programme.

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

21.4 Insurance: risk pooling schemes administered by NHS Resolution

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

21.5 Insurance arrangements with commercial insurers

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

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

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

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

21.6.3 All the risk pooling schemes require scheme members to make some contribution to the settlement of claims (the "**Deductible**"). The

Director of Finance should ensure documented procedures also cover the management of claims and payments below the Deductible in each case.


Appendix 1 - Scheme of Delegation 12_05_

Gordon Flack
Director of Finance
May 2021

Kent Community Health
NHS Foundation Trust

Appendix 1 – Scheme of Delegation

Delegated Matter	Lowest Level of Authority
Budgetary Control	
Revenue Spending Approval Limits; - up to £19,999 - from £20,000 to £49,999 - from £50,000 to £99,999 - up to £100,000 up to a total maximum of 20% of Trust contingency budget - from £100,000 to £499,999 - from £500,000 to £999,999 per annum and up to £5,000,000 for a 5 year contract. No limit on income contract renewals. - from £1,000,000 to £2,999,999 per annum and up to £15,000,000 for a 5 year contract. - over £3,000,000per annum and over £15,000,000 for a 5 year contract For property capital equivalent transactions see Capital Scheme Approval Limits	 Budget Holder Assistant/Deputy Director Board Director Integrated Management Team Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors
Management of Budgets; - Individual Budget Level - Service Level Directorate - Trust Level	 Budget Holder Assistant/Deputy Director and Heads of Service will oversee the budgetary position for the services within their remit and take corrective action where necessary, in conjunction with the budget holder.. Director of Service Board of Directors
Budget Virement (transfer of budget from one budget to another): Transfer within cost centre (under 20%) Transfer within cost centre (over 20%) Cost Centre mergers/splits with no change to subjective budgets Between cost centres but within the same directorate	 Budget Holder Budget Holder and Head of Service Budget Holder Budget Holder and Head of Service Clinical Service Director/Assistant Director

Between directorates	from both directorates
Any non-pay to pay transfer	Budget Holder and Head of Financial Management
Any transfer involving income	Budget Holder and Deputy Director of Finance
Significant restructure to budgets	Clinical Service Director/Assistant Director & Director
Capital Investment	
Approval of Annual Capital Programme	Board of Directors
Capital Scheme Approval Limits (on receipt of a business case approved by Head of Service); - Up to £100,000 - up to £999,999 - property capital equivalent transactions up to £5,000,000 e.g. long term leases of 25 years would be limited to £200,000 per annum. - from £1,000,000 to £2,999,999 - property capital equivalent transactions over £5,000,000 and up to £10,000,000 e.g. long term leases of 25 years would be limited to £400,000 per annum. - over £3,000,000 - over £10,000,000 for a property capital equivalent transaction e.g. long term leases over 25 years over £400,000 per annum.	 Integrated Management Team Capital Steering Group Chief Executive Chief Executive and Finance, Business & Investment Committee Chief Executive and Finance, Business & Investment Committee Board of Directors Board of Directors
Capital Expenditure Approval Limits (once capital scheme has been approved as per above); - up to £19,999 - from £20,000 to £49,999 - from £50,000 to £99,999 - from £100,000 to £499,999 - - from £500,000 to £999,999 - from £1,000,000 to £2,999,999 - over £3,000,000	 Designated Capital Project Lead Assistant/Deputy Director Board Director Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors

Selection of architects, quantity surveyors, consultant engineers and other professional advisers.	Director of Estates subject to tender limits
Financial monitoring and reporting on all capital scheme expenditure.	Director of Finance
Entering, extending or termination of leases with an annual rental up to £150,000	Deputy Director of Finance and Director of Estates
Entering, extending or termination of leases with an annual rental in excess of £150,000	Director of Finance
Tendering, Quotations and Contracting	
Overview; - For expenditure below £10,000 competitive quotations are not required, however Budget Holders are responsible for ensuring value for money. - 3 competitive written quotations required for expenditure from £10,000 to £50,000. - Formal tendering procedures are required where the intended expenditure is in excess of £50,000.	
Approval to waive competitive quotation process for expenditure in excess of £10,000 but below £50,000	Assistant/Deputy Director
Approval to waive formal tendering procedures for expenditure in excess of £50,000	Director of Finance
Receipt of Tenders	Chief Executive Nominated Rep
Opening of Tenders	2 x Board Directors (one of which must not be from the originating department)
Formal authorisation and awarding of a contract; - up to £19,999 - from £20,000 to £49,999 - from £50,000 to £99,999 - from £100,000 to £499,999 - from £500,000 to £999,999 - from £1,000,000 to £2,999,999 - over £3,000,000	 Budget Holder Assistant/Deputy Director Board Director Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors
Agreements/Licences	
Letting of premises to outside organisations	Director of Finance
Approval of rent based on professional assessment	Director of Finance
Condemning and Disposal	

Items obsolete, obsolescent, redundant, irreparable or not cost-effective to repair (liaison with the Procurement and Finance team is required to ensure safe and compliant disposal and value for money); - Estimated replacement cost <£5,000 - Estimated replacement cost >£5,000	 Budget Holder In line with Revenue Spending Approval limits
Disposal of Plant and Machinery, Vehicles and Medical equipment in excess of £5,000	In line with Revenue Spending Approval limits
Sale of Property (Land and Buildings)	Board of Directors
Losses and Special Payments	
Losses and Special Payments (within limits delegated by the Department of Health)	Head of Service and Director of Finance (report presented to Audit and Risk Committee)
Petty Cash Disbursements	
Purchases from Petty Cash should not exceed £20	Budget Holder
Personnel and Pay	
Authority to fill funded post on the establishment with permanent staff	Line manager
Authorisation of payment of removal expenses incurred by recruits taking up new appointments (providing consideration was promised at interview);	Budget holder and Deputy Director of HR
Authority to appoint staff to post not on the formal establishment i.e. unfunded	Budget holder
All requests for upgrading / regrading via job evaluation panel	Budget holder
Authority to complete confirmation of appointment forms, identifying appropriate starting salary (in line with Salary on Appointment policy)	Line Manager
Authority to complete change forms effecting pay and variations to terms and conditions within funded establishment	Line Manager
Authority to confirm successful probationary period has been completed	Line Manager
Authority to extend probation or refer to a probationary review hearing	Line Manager
Authority to authorise temporary staffing	Budget holder
Authority to authorise travel and subsistence expenses	Line Manager
Authority to offer and confirm acting up arrangements in funded establishment	Line Manager
Authority to approve staff secondments within funded establishment	Line Manager
Approval of annual leave	Line Manager

Approval of, changes to and finalisation of rosters	Line Manager
Approval of requests to buy additional annual leave	Line Manager
Approval of requests to sell annual leave	Budget holder
Approval of special leave (carers, unexpected events, jury service or compassionate leave)	Line Manager
Approval of leave without pay	Line Manager
Approval of time off in lieu	Line Manager
Approval of maternity leave, adoption, surrogacy, shared parental and maternity support (paternity) leave	Line Manager
Approval of career breaks	Line Manager
Approval of study leave	Line Manager
Authorisation for funding for conferences, courses and further education	Training Panel
Medical staff revalidation	Responsible Officer
Nursing revalidation	Line Manager
Proposing changes that impact on structure, roles, terms and conditions	Line Manager
Requesting equipment for staff including laptops, mobile phones, tablets and furniture	Authorised signatory (request to be shared with the Estates / IT Departments for confirmation of available stock / budget)
Renewal of fixed term contract in funded establishment	Line Manager
Authorisation of retire and return and other flexible retirement applications options	Line Manager
Authorising retirement gifts and contribution to parties	Budget holder
Agreeing flexibility or support requested by staff in relation to the staff work and wellbeing passport	Line Manager
Making referrals to Occupational Health	Line Manager
Making referral to the Trust Fast track physiotherapy services for staff	Member of staff
Implementing reasonable adjustments for staff with disabilities	Line Manager
Authorising additional counselling sessions for members of staff payable by the service	Line Manager
Appraisal ratings that impact on eligibility for incremental progression	Line Manager
Award of Clinical Excellence awards for Consultants	Local Award Committee (in accordance with Trust Clinical Excellence awards procedure)
Informal action in relation to capability, grievance, sickness absence or disciplinary issues	Line Manager
Issue of informal recorded warnings (that	Line Manager

do not impact incremental pay)	
Suspension of staff	Assistant/Deputy Director
Exclusion of medical or dental staff	Medical Director (or an appropriate Deputy or Executive Director in the absence of the Medical Director)
Issue of disciplinary warnings that impact on incremental pay and progression	In accordance with the Trust disciplinary procedure and authority to take action table
Approval of posts for redundancy	Board Directors
Support for Ill Health Retirement applications	Line manager
Termination of employment	In accordance with the Trust disciplinary, capability, managing sickness policies and authority to take action table.
Provision of references	Line Manager
Acknowledging and accepting staff resignation	Line Manager
Completion of leavers forms	Line Manager (including returning leaver's IT / telephony equipment to the IT Department).
Miscellaneous	

NB the line manager may or may not be the budget holder

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	5.3
Agenda Item Title:	Ratification of Terms of Reference of Committees
Presenting Officer:	John Goulston, Trust Chair
Action – this paper is for:	☒ Decision ☐ Information ☐ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

Summary of key points

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

- Audit and Risk Committee
- Charitable Funds Committee
- Finance, Business and Investment Committee
- Quality Committee
- Strategic Workforce Committee

The Terms of Reference for the Remuneration and Terms of Service Committee will be submitted to the next Public Board meeting in September 2021.

Proposal and/or recommendation to the Committee or Board

The Board is asked to ratify the Terms of Reference.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.**	☐ Yes *(please attach)* ☒ No

Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.	*(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Natalie Davies	Job title:	Director of Corporate Services
Telephone number:	01622 211906	Email	Natalie.davies1@nhs.net

NHS
Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

AUDIT AND RISK COMMITTEE

Document Control

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

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

Version	Draft/Final	Date	Author	Summary of changes
				Framework.
2.9	Draft	February 2020	Gina Baines	1.2 Objectives. Amendment of wording: changes from NHS Internal Audit Standards to NHS public sector standards
2.10	Draft	February 2021	Peter Conway	External audit – first bullet to be deleted and a final bullet to be included “Make recommendations to the governors on the appointment/re-appointment of external auditors. Decision-making – reword to “The ARAC is an assurance committee of the Board and holds no decision-making delegated authorities *except as delegated by the Board.* Frequency of meetings – change to “At last four times a year with additional meetings as necessary.

Review

Version	Approved date	Approved by	Next review due
1.0	4 April	KCHT Board	April 2012
1.1	26.01.2012	KCHT Board	April 2012
2.0	Sept 2012	Audit and Risk Committee	Sept 2013
2.0	Sept 2012	KCHT Board	Sept 2013
2.1	Feb 2013	Audit and Risk Committee	Sept 2013
2.2	Sept 2014	Audit and Risk Committee	Sept 2015
2.3	March 2015	KCHFT Board	April 2016
2.4	March 2015	KCHFT Board	April 2016
2.4	February 2016	Audit and Risk Committee	May 2017
2.5	February 2017	Audit and Risk Committee	February 2018
2.5	May 2017	KCHFT Board	May 2018
2.6	February 2018	Audit and Risk Committee	February 2019
2.6	May 2018	KCHFT Board	May 2019
2.8	February 2019	Audit and Risk Committee	February 2020
2.8	May 2019	KCHFT Board	May 2020
2.9	February 2020	Audit and Risk Committee	February 2021
2.9	May 2020	KCHFT Board	May 2021
2.10	February 2021	Audit and Risk Committee	February 2022

1. Role

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

1.1 Purpose:

The purpose of the Audit and Risk Committee is to:

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

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

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

1.2 Objectives:

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

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

In particular, the committee will review the adequacy of:

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

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

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

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

- Cyber security controls

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

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

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

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

Internal Audit

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

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

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

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

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

- Annual review of the effectiveness of Internal Audit

External Audit

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

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

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

- Make recommendations to the Governors on the appointment/re-appointment of external auditors.

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

Counter Fraud

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

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

Trust Governance

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

Financial Reporting

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

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

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

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

2. Accountability

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

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

3. Decision Making

The Audit and Risk Committee is an assurance committee of the Kent Community Health NHS Foundation Trust Board and holds no decision-making delegated authorities *except as delegated by the Board.*

4. Reporting Arrangements:

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

5. Governance

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

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

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

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

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

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

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

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

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

5.6 Frequency of Meetings:
At least four times a year with additional meetings as necessary.

The Chair of the Committee can call extra-ordinary meetings as necessary.

5.7 Notice of Meetings:

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

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

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

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

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

6. Approval and Review of Terms of Reference

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

7. Monitoring Compliance

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

Kent Community Health NHS Foundation Trust

TERMS OF REFERENCE

CHARITABLE FUNDS COMMITTEE

Document Control

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

Version	Draft/Final	Date	Author	Summary of changes
1.5	Draft	30.01.2019	Gina Baines, Assistant Trust Secretary	1. Role – Amended to reflect that the Committee is a sub-committee of the Board and membership is wider than non-executive directors.
1.6	Draft	07.06.2019	Gina Baines, Assistant Trust Secretary	Objectives – Addition of consideration of published external reviews relating to Trust services *and* oversight of specific risks on the Board Assurance Framework as assigned by the Board. 5. Governance – Amendment to appointment of Chair of Committee
1.6	Draft	01.03.2020	Gina Baines Assistant Trust Secretary	5.1 Membership amended to include a second non-executive director and formalise the Deputy Chair arrangements
1.7	Draft	07.01.2021	Francis Drobniewski	2. Accountability – Charity Commission of England and Wales Key relationships – delete Audit and Risk Committee and replace with Finance, Business and Investment Committee Declarations of interest – further explanation

Review

Version	Approved date	Approved by	Next review due
1.0	26.01.2012	KCHT Board	April 2012
1.1	26.03.2015	KCHFT Board	April 2016
1.2	March 2016	Charitable Funds Committee	April 2017
1.3	April 2017	Charitable Funds Committee	April 2018
1.3	May 2017	KCHFT Board	May 2018
1.4	April 2018	Charitable Funds Committee	April 2019
1.4	May 2018	KCHFT Board	May 2019
1.5	January 2019	Charitable Funds Committee	January 2020
1.5	May 2019	KCHFT Board	May 2020
1.6	January 2020	Charitable Funds Committee	January 2021
1.6	May 2020	KCHFT Board	May 2021
1.7	January 2021	Charitable Funds Committee	January 2022

1. ROLE

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

Purpose:

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

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

Objectives:

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

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

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

2. ACCOUNTABILITY

Accountable to:
KCHFT Board

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

The Committee's activities are governed by the Charity Commission of England and Wales as well as Kent Community Health NHS Foundation Trust.

3. DECISION MAKING

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

4. MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

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

5. GOVERNANCE

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

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

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

Members will include:

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

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

Key Relationships:
Finance, Business and Investment Committee
The Executive Committee
The Charity Commission of England and Wales

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

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

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

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

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

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

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

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

7. APPROVAL / REVIEW OF TERMS OF REFERENCE

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

Kent Community Health NHS Foundation Trust

Terms of Reference V.7

Finance, Business and Investment Committee

Document Control

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

				timing.
V6.6	Draft	June 2019	Gordon Flack	1.2 – addition of consideration of published external reviews which relate to the Trust's services *and* oversight of specific risks on the Board Assurance Framework as assigned by the Board.
V6.7	Draft	March 2020	Gordon Flack	Section 2 – Membership. Updated. Four non-executive directors; the Chief Executive is no longer a member; the Director of Strategy and Partnership is a new member.
V7.0	Draft	March 2021	Paul Butler/ Gordon Flack	Streamline purpose and update financial thresholds and addition of appendices of the strategic goal details assigned to the committee for assurance

Review

Version No.	Approved Date	Approved By	Next Review Date
6.1	March 2015	Board	April 2016
6.2	March 2015	Board	April 2016
6.3	April 2016	Finance, Business and Investment Committee	March 2017
6.4	March 2017	Finance, Business and Investment Committee	March 2018
6.4	May 2017	KCHFT Board	May 2018
6.5	March 2018	Finance, Business and Investment Committee	March 2019
6.5	May 2018	KCHFT Board	May 2019
6.6	May 2019	Finance, Business and Investment Committee	May 2020
6.6	July 2019	KCHFT Board	May 2020
6.7	March 2020	Finance, Business and Investment Committee	March 2021
6.7	May 2020	KCHFT Board	May 2021
7.0	April 2021	Finance, Business and Investment Committee	March 2022

FINANCE, BUSINESS AND INVESTMENT COMMITTEE
TERMS OF REFERENCE

1. CONSTITUTION

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

1.2. The overall objectives of the Committee are to:

- Scrutinise current financial performance
- Scrutinise any - financial plans in advance of Board presentation
- Monitor performance against Cost Improvement Plans;
- Scrutinise the development and implementation of Service Line reporting and Service Line Management;
- Monitor decisions to bid for new business opportunities and approve those between £5m and £15m contract turnover in line with Trust Strategy and reviewing and then referring and recommending larger and novel bids to the Trust Board for approval (executive can approve all renewals of income contracts);
- To review business cases for total spend between £1m to £3m of all capex or £1m to £3m per annum for opex multi-year schemes. FBI to approve all spend up to these limits and make recommendation of approval by the Trust Board for cases in excess.
- To review property capital equivalent transactions (i.e. including leases) of between £5m and £10m for FBI approval and make recommendation of approval by the Trust Board for cases in excess.
- To review commercial plans (single or multi-years) in advance of Board presentation
- To review any replacement supplier contracts with contract value (all years) in excess of £5m, approve those with value up to £15m and make appropriate recommendation to the Trust Board for those in excess of £15m.
- Approve treasury management policy and scrutinise implementation;
- To consider any published external reviews which relate to the Trust's services within the scope of the committee;
- The Committee will be allocated 'approved strategic direction themes' by the Board. The Committee will establish appropriate reviews to assess appropriateness of delivery programme and performance against such programmes (see appendices for details).
- The Committee will be allocated appropriate Board Assurance Framework (BAF) risks by the Board to lead on assurance related to financial and business risks. The Committee will seek assurance on the actions being taken and the control system in place for the risks in question.

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

2. MEMBERSHIP

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

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

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

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

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

3. ATTENDANCE AT MEETINGS

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

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

4. FREQUENCY OF MEETINGS

4.1. The Committee will meet - at least four times a year.

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

5. AUTHORITY

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

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

6. DUTIES

The duties of the Committee can be categorised as follows:

6.1. Finance:

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

- To review the annual Trust Cost Improvement Programme and assess whether the Trust has established robust PMO arrangements to ensure delivery and with regular reporting from the Trust CIP group meeting;
- To review business cases for total spend between £1m to £3m of all capex or £1m to £3m per annum for opex multi-year schemes. FBI to approve all spend up to these limits and make recommendation of approval by the Trust Board for cases in excess.
- To review property capital equivalent transactions (ie including leases) of between £5m and £10m for FBI approval and make recommendation of approval by the Trust Board for cases in excess.
- To review any replacement supplier contracts with contract value (all years) in excess of £5m, approve those with value up to £15m and make appropriate recommendation to the Trust Board for those in excess of £15m
- To approve the annual National Costs return on behalf of the Board and to undertake follow-up review of NHS wide reporting of comparative outturn.

6.2. Business

- To scrutinise capex proposals for financial implications and consistency with annual budget and Trust long term plans
- To review the Trust's long term plans
- To review commercial plans (single or multi-years) in advance of Board presentation
- Monitor decisions to bid for new business opportunities and approve those between £5m and £15m contract turnover in line with Trust Strategy and reviewing and then referring and recommending larger and novel bids to the Trust Board for approval (executive can approve all renewals of income contracts);
- The Committee will be allocated 'approved strategic direction themes' by the Board. The Committee will establish appropriate reviews to assess appropriateness of delivery programme and performance against such programmes (see appendices).
- The Committee will be allocated appropriate Board Assurance Framework (BAF) risks by the Board to lead on assurance related to financial and business risks. The Committee will seek assurance on the actions being taken and the control system in place for the risks in question.
- To review, periodically, market analysis undertaken on behalf of, or by, the Trust.

6.3. Investments

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

7. REPORTING

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

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

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

8. ADMINISTRATION

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

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

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

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

9. APPROVAL / REVIEW OF TERMS OF REFERENCE

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

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

Appendices - Strategic Goal/Enabler Assurance

Goal: Sustainable services - Developing affordable services.

This means providing existing and new services that provide value to commissioners and will be measured in cost terms against benchmarks most commonly used the NHS cost index and in quality terms against the local service specification, safety, effectiveness, experience and innovation.

The goal for FBI review will be measured in overall terms against the cost index with the Trust maintaining a below average cost position within the range -5% to -2.5% i.e. cost index of 95% to 97.5% during the 5 years to March 2025 co-terminus with the commercial strategy.

At a detailed level the cost index provides a unit cost (total cost/total activity) benchmark by service and the goal will be to reduce variation and have all services at least at the average benchmark by March 2025.

Outcome: The National cost collection index for 2018-19 showed the Trust at 95.7% ie 4.3% below the average and maintaining this competitive advantage is described above. The outcome is to ensure existing Trust services are not subject to competitive tender but are continued beyond current contracts to March 2024 within the proposed new national procurement framework.

This will be underpinned by the Trust maintaining its delivery of cost improvement targets of at least of 1.1% per annum following approved quality impact assessments (QIA).

Offering new services either by competitive tender or commissioner request that provide best value and are commissioned in 95% of the opportunities.

Eliminate services with deficits greater than 5% by March 2023. Eliminate all service deficits by March 2025.

Key Management Activities: Management action plans developed where divergence and risks identified to outcomes above; Refreshed commercial strategy developed and agreed; Monitoring of directorate performance at monthly executive performance review sessions; Approval of cost improvement targets and monitoring delivery and adherence to QIA processes; Building QI capability and capacity to drive innovation and productivity; Influence commissioners in service model development and procurement route.

IPR metrics: KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%; KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%); KPI 4.2 Income & Expenditure - Surplus (%);

Key FBI assurance: Monitor commercial strategy delivery; Monitor cost improvement plan development and delivery; Monitor management accounts and service line reporting performance. Monitor decisions to bid for business opportunities and success rates related to cost; Monitor the Trust performance in the national cost index and impact of action plans to improve performance at service level.

Specific Agenda Items: Finance report including CIP and Service Line Reporting; Benchmarking reports such as national cost index; Review Commercial Strategy and associated action plan including plans to improve services in deficit; Contract negotiations framework and Budget Setting framework reviews. Review QI activity and its impact on productivity

Enabler: Digital - Having accessible and integrated technology

This means having integrated information systems and devices that support efficient working at home, in the community and at workplaces.

The Kent and Medway Care Record is a transformation project that will deliver a clinical record integrating and curating provider records.

The Rio electronic patient record is a replacement digital clinical information system for the Trust and the principal system used by most services.

The goal for FBI review will be the success of these projects in delivering 100% of the benefits by March 2025 and milestones towards this. At key measure will be the % of clinical time that is patient facing by one hour per nurse per day.

The investment in technologies and devices to provide the tools to staff is described in the digital strategy and evident at project level in the capital programme.

The goal for the FBI will be to oversee the refresh of the digital strategy and its delivery action plan and monitoring of the elements of the capital programme supporting this work to March 2025 aligning with the strategy period.

Outcome: Benefits fully realised for EPR and KMCR. Easy access to real time (24 hours) information including analytics and performance reports; virtual working fully supported and 20% of first clinical appointments virtual.

Key Management Activities: Management action plans developed where divergence and risks identified to outcomes above; Refreshed digital strategy developed and agreed; Monitoring of directorate performance at monthly executive performance review sessions; Approval of cost business cases and monitoring delivery; Drive innovation and productivity eg introduce MS Teams as business as usual

IPR metrics: New - % of all first clinical contacts to be digital; % clinical time patient facing; KPI 1.5 LTC/ICT – Admissions Avoidance (KMCR); KPI 2.16 Length of Community Hospital Inpatient Stay (EPR); overall timeliness of data within 24 hours.

Key FBI assurance: Monitoring digital strategy delivery; monitor benefits realisation plans; monitor capital programme and business cases that meet financial thresholds for approval.

Specific Agenda Items: Digital Strategy and associated action plan. EPR benefits realisation plan monitoring; KMCR project directors report and benefits realisation plan; Capital Programme monitoring – IT; CIP schemes enabled by digital strategy.

Goal: Integrate services – connecting the care patients receive

This means connecting services provided by KCHFT with those provided by other NHS trusts, social care or voluntary or community organisations so patient experiences of care pathways are less fragmented. It will be measured through a range of partnership programmes, such as the partnerships with Kent County Council and KMPT, work with primary care networks (PCNs) and the introduction of the Kent & Medway Care Record, and key performance indicators that reflect integration with acute trusts. As such there are strong links with the system leadership and digital enablers and high quality care goal.

Outcome: The join up of our healthcare service with social care and mental health will be improved through partnership working with KCC and KMPT and the delivery of the programmes of work detailed in those partnerships.
We will embed and increase the number of partnerships established with PCNs.
As noted above there are strong links with other goals and enablers. In particular the care home offer that is linked to the system leadership enabler, the delivery of the KMCR through the digital enabler and more effective use of the voluntary sector detailed in the high quality care goal.

Key Management Activities: Mental health partnership with KMPT developed, MoU signed and work programme agreed. Partnership with KCC developed and extended to a provider to provider relationship. Role in children's services is defined. PCN Steering Group established (complete) and work programme set for the year.

IPR metrics: KPI 3.1 Delayed Transfers of Care from a Community Hospital bed as a % of Occupied Bed Days; KPI 3.2 Home First impact - reduction in average excess bed days (West Kent); KPI 3.4 Rapid Transfer impact -reduction in average excess bed days (East Kent); KPI 3.6 East Kent Rapid Transfer Service - Average Commissioned Discharges per day; KPI 3.3 Average Daily Medically Fit for Discharge Patients (MFFD) - West Kent; KPI 3.5 Average Daily Medically Fit for Discharge Patients (MFFD) - East Kent

Key FBI assurance: Monitor the Trust's Annual and Strategic Business Plans, Monitor partnership programme delivery, Monitor risks associated with the integration of services, particularly in relation to the management of external relationships given the complexity and scale of these.

Specific Agenda Items: Review of MoU with KMPT and subsequent action plans; Kent County Council partnership update – review proposed changes; Receive recommendation on trust role in children's services; Review PCN Steering Group work programme and prioritisation of this work in relation to other partnership programmes

Kent Community Health
NHS Foundation Trust

TERMS OF REFERENCE

QUALITY COMMITTEE

Document Control

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

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

Version	Draft/ Final	Date	Author	Summary of changes
				5.0 Governance Membership – Amended to reflect changes to Board and committee governance arrangements 7.0 – Frequency – change to quarterly
2.4	Draft	27.10.2020	Pippa Barber, Chair of the Committee and Committee members	Changes made to objectives; clinical audit; reporting arrangements; standard agenda; membership; key relationships to reflect the refresh of the governance arrangements agreed by the Board July 2020.
2.5	Draft	15.03.2021	Pippa Barber, Chair of the Committee and Committee members	Addition of two objectives relating to equality considerations and system quality issues

Review

Version	Approved date	Approved by	Next review due
0.2	26.01.2012	KCHT Board	April 2012
0.5	27.09. 2012	Quality Committee	September 2013
0.9	03.06.2014	Quality Committee	June 2015
1.0	26.03.2015	KCHFT Board	April 2016
1.0	08.03.2016	Quality Committee	March 2017
1.1	07.03.2017	Quality Committee	March 2018
1.1	25.05.2017	KCHFT Board	March 2018
2.0	12.09.2017	Quality Committee	March 2018
2.0	28.09.2017	KCHFT Board	May 2018
2.1	17.04.2018	Quality Committee	March 2019
2.1	24.05.2018	KCHFT Board	May 2019
2.2	19.03.2019	Quality Committee	March 2020
2.2	14.05.2019	Quality Committee	March 2020
2.2	25.07.2019	KCHFT Board	May 2020
2.3	17.03.2020	Quality Committee	March 2021
2.3	21.05.2020	KCHFT Board	May 2021
2.4	17.11.2020	Quality Committee	March 2021
2.5	23.03.2021	Quality Committee	March 2022

1.0 ROLE

Purpose:

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

Objectives:

Specific responsibilities of the Quality Committee include:

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

Providing assurance to the Board by:

- Providing oversight of performance and risk of the Trust strategic objectives/enablers assigned to the committee by the Board
  1. Prevent ill health
  2. High quality care

- Ensuring that the strategic priorities for quality assurance are focused on those which best support delivery of the Trust's quality priorities in relation to patient experience (including equitable accessibility to services), safety of patients and service users and effective outcomes for patients and service users.
- Ensuring equality considerations and analysis are an integral feature of quality impact assessments, performance and risk reporting
- Reviewing compliance with regulatory standards and statutory requirements, for example those of the Duty of Candour, the CQC, NHSLA and the NHS Performance Framework.
- Reviewing quality and performance risks which have been assigned to the Quality Committee and satisfying itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances.
- Reviewing the Annual Quality Report ahead of its submission to the Board for approval.
- Overseeing Deep Dive Reviews of identified risks to quality and performance identified by the Board or the Committee, particularly Serious Incidents and how well any recommended actions have been implemented. This will include cost improvement programme quality impact assessment deep dives.
- Considering and seeking assurance on any published external reviews which relate to the Trust's services within the scope of the Committee.
- Having oversight of specific risks on the Board Assurance Framework as assigned by the Board.
- Having committee oversight of the Trust Quality Strategy.
- Providing assurance on system quality issues as they relate to Kent Community Health NHS Foundation Trust

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

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

Clinical Audit

The Committee shall ensure there is an effective clinical audit function established by the executive team.

This will be achieved by:

- Consideration of the Clinical Audit Strategy and Annual Plan via the Clinical Effectiveness Group Chair's report to determine the scope, scale and focus of the plan meets Trust identified risk priorities.

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

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

2.0 ASSURANCE

Assurance to:
KCHFT Board

Groups:
Patient Safety and Clinical Risk Group
Clinical Effectiveness Group
Patient Carer Council

3.0 DECISION MAKING

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

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

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

4.0 MONITORING AND REPORTING

Monitoring Arrangements:
See in objectives above.

Reporting Arrangements:
A report setting out the points that need to be considered by the full Board will be provided to the next part one Public Board meeting. The minutes of each meeting will be included on the next part two Board meeting agenda.

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

5.0 GOVERNANCE

Chair:
One Non-Executive Director will be appointed as Chair of the committee by the Trust Board and one non-executive director will be appointed Deputy Chair.

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

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

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

- Apologies for absence
- Declarations of interest
- Minutes of last meeting
- Action log
- Progress and risks identified with Trust strategic goals
- Progress against Quality Priorities
- Summary assurance report from Clinical Effectiveness Group
- Summary assurance report from Patient Safety and Clinical Risk Group
- Summary assurance report from Patient Carer Council
- Committee reports for assurance including but not exclusively Quality Report and items from We Care visits
- Areas of concern highlighted in the Integrated Performance Report
- Published external reviews relating to the Trust's services within the scope of the committee
- Non-executive director led deep dives
- Updates from service visits including We Care visits if relevant to agenda items
- Feedback from other committees including the Board Assurance Framework
- Ratification of policies
- Any other business
- Date of next meeting

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

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

Key Relationships:
Audit and Risk Committee
Finance, Business and Investment Committee
Strategic Workforce Committee
Executive Team
Trust Board

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

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

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

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

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

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

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

6.0 APPROVAL / REVIEW OF TERMS OF REFERENCE

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

7.0 MONITORING COMPLIANCE WITH THESE TERMS OF REFERENCE

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

Kent Community Health NHS Foundation Trust

TERMS OF REFERENCE

STRATEGIC WORKFORCE COMMITTEE

Document Control

Version	Draft/Final	Date	Author	Summary of changes
1.0	Draft	29.09.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	
1.1	Draft	03.10.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	Reformatted into Trust template
1.1	Final	22.11.2017	Louise Norris, Director of Workforce, Organisational Development and Communications	Language in purpose revised and inclusion of Ratification of Policies and membership to include Finance added.
1.2	Final	30.01.2019	Louise Norris, Director of Workforce, Organisational Development and Communications	3. Decision Making - Addition for Committee to oversee the approval of workforce policies
1.3	Draft	11.06.2020	Louise Norris, Director of Workforce, Organisational Development and Communications	Objectives updated to include overseeing Equality, Diversity and Inclusion Strategy
1.4	Draft	04.11.2020	Louise Norris, Director of Workforce, Organisational Development and Communications	Objectives updated to include FTSU Guardian report submission for assurance.
1.5	Draft	16.11.2020	Louise Norris, Director of Workforce, Organisational Development and Communications	Objectives updated to include oversight of Environmental Sustainability Strategy

Review

Version	Approved date	Approved by	Next review due
1.1	14.11.2017	Strategic Workforce Committee	March 2018
1.1	30.11. 2017	Board	March 2018
1.2	30.01.2019	Strategic Workforce Committee	March 2020
1.2	25.07.2019	Board	May 2020
1.2	18.03.2020	Strategic Workforce Committee	March 2021
1.3	04.12.2020	Strategic Workforce Committee	December 2021
1.4	04.12.2020	Strategic Workforce Committee	December 2021
1.5	04.12.2020	Strategic Workforce Committee	December 2021
1.5	22.03.2021	Strategic Workforce Committee	March 2022

1. ROLE

The Strategic Workforce Committee is a committee of the Board with delegated decision-making powers specified in these Terms of Reference.

1.1 Purpose:

- The Strategic Workforce Committee (The Committee) is an assurance Committee. It will provide assurance to the Board on the organisational priority of creating and maintaining Kent Community NHS Foundation Trust as an organisation operating at the highest levels of workforce engagement, performance and efficiency delivery high quality care to our patients.

- To keep abreast of the strategic context, the National Strategic direction and the 'System' in which the Trust is operating in, understanding the consequences and implications on the workforce and ensure our Culture and Values remain at the core of everything we do.

1.2 Objectives:

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

- Oversee the development and implementation of the Trust's people strategy and ensure that the Trust has robust plans in place to support the on-going development of the workforce.

- Ensure the Trust defines its culture and values clearly, to underpin the way of working, supporting the valuing and engagement of staff.

- Oversee the development and role modelling of a comprehensive workforce Equality, Diversity and Inclusion strategy.

- Review the Trust's plans to identify and develop leadership capacity and capability within the Trust, including talent management.

- Ensure that there is an effective workforce plan in place, to ensure that the Trust has sufficient staff, with the necessary skills and competencies to meet the needs of the Trust's patients and services users.

- Ensure that the Trust continually reviews its workforce models, to reflect new roles and new ways of working to support delivery of the Trust's contractual obligations.

- Receive and provide assurance that the Trust has an appropriate pay and reward system that is linked to delivery of the Trust's strategic objectives, outcomes and desired behaviours.

- Ensure that the training and education provided and commissioned by the Trust is fully aligned to the Trust's strategy.

- Ensure that there are mechanisms in place to support the mental and physical health and well-being of the Trust's staff.

- Ensure that the trust is compliant with relevant legislation, strategic themes and regulations relating to workforce matters.

- Ensure that the Trust has appropriate workforce policies in place.

- Receive and provide assurance that the Trust has a robust Freedom to Speak Up Guardian process.

- High level oversight of the delivery of the Environmental Sustainability Strategy

2. ACCOUNTABILITY

Accountable to:
KCHFT Board.

Accountable for:
The Strategic Workforce Committee has an Operational Workforce sub group that reports to it.

Works with other Trust Committees for comprehensive assurance of triangulation of Trust issues.

3. DECISION MAKING

The Strategic Workforce Committee is an Assurance Committee that has delegated authority from the Kent Community Health NHS Foundation Trust Board to provide assurance and hold the Executive to account for strategic workforce issues.

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

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

The Strategic Workforce Committee is further authorised to oversee the approval of workforce policies as required.

4. MONITORING AND REPORTING

4.1 Monitoring Arrangements:

To ensure the Strategic Workforce Committee complies with its Terms of Reference, compliance will be monitored through the following methods:

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of Trust workforce strategy	Annual Board report	Board	Annually
Frequency of attendance	Attendance register of each meeting	Committee Secretary will report to the Committee Chair	Annually

4.2 Reporting Arrangements:

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

5. GOVERNANCE

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

5.2 Secretariat:
All administrative matters and the minutes will be undertaken by the Committee secretary.

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

Members will include:

Chair	Non Executive Director
Other Members	Non Executive Director Director of Workforce, Organisational Development and Communications Chief Operating Officer Chief Nurse Medical Director Deputy Director of HR (EWD) Deputy Director of HR (Operations) Deputy Director of Finance

Other officers will attend as required.

In the absence of the Chair, another Non-Executive Committee member will perform this role.

5.4 Key Relationships:
Audit and Risk Committee
The Executive Committees
Quality Committee

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

5.6 Frequency of Meetings:
Meetings will be held bi-monthly.
The Chair of the Committee can call extra-ordinary meetings as necessary.

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

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

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

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

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

6. APPROVAL / REVIEW OF TERMS OF REFERENCE

The Committee will review these Terms of Reference at least once each year to reflect changes in NHS requirements or best governance practice. These Terms of Reference will be approved by the Trust Board.

Kent Community Health NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	5.4
Agenda Item Title:	Emergency Preparedness, Response and Resilience Annual Assurance Statement
Presenting Officer:	Natalie Davies, Director of Corporate Services
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
This report is to provide assurance to the Board that plans and systems are in place to meet the Trust's obligations with respect Emergency Preparedness, Resilience and Response and relevant statutory obligations under the Civil Contingencies Act 2004. The report sets out the Trusts state of readiness to respond to major incidents and disruptive events that impact on the delivery of services and performance.

Summary of key points

Proposal and/or recommendation to the Committee or Board
The Board receives assurance of KCHFT state of preparedness.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected*

maternity, race, religion or belief, sex and sexual orientation.	*characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Natalie Davies	Job title:	Director of Corporate Service
Telephone number:	01622 211900	Email	Natalie.Davies1@nhs.net

Kent Community Health NHS Foundation Trust

EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

ANNUAL REPORT APRIL 2020 – MARCH 2021

1. Introduction

This report describes the work undertaken in 2020/21 on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (CCA) 2004 and the NHS England Emergency Preparedness Framework 2015

The Trust has a mature suite of plans to deal with Major Incidents and Business Continuity issues. These conform to the CCA (2004) and current NHS guidance. All plans have been developed in consultation with partner organisations to ensure cohesion with their plans.

The report covers the following;

- The training and exercising programme delivered
- The continuing development of the emergency planning arrangements
- A summary of incidents the Trust has responded to

2. Risk Assessment

The CCA (2004) places a legal duty on responders to undertake risk assessments and publish risks in a Community Risk Register. The purpose of the Community Risk Register is to reassure the community that the risk of potential hazards has been assessed, that preparations are undertaken and that response plans exist. Those standing risks currently identified on the Kent Community Risk Register include;

- Influenza-type disease (pandemic)
- Flooding
- Severe Weather
- EU Exit

As a result of risk assessments with internal services there has been progress made across services in pursuing the necessary actions to control and mitigate the risks. The Head of EPRR and the EPRR manager have developed a close working relationship with services and assisted in the development of service level business continuity plans including detailed information on the Recovery Time Objectives and the Maximum Tolerable Period of Disruption for Information Technology across services.

Within this reporting period the Trust has met four times at the combined On Call/EPRR meeting. Attendance by relevant managers/staff at these meetings has continued throughout 2020/21, senior management support is in place to ensure appropriate attendance at these meetings.

3. Compliance

EPRR remains a key priority for the NHS and forms part of the NHS Commissioning Board Framework (Everyone Counts; Planning for Patients), the NHS Standard Contract and the NHS Commissioning Board Emergency Planning Framework (2015).

A set of core standards for EPRR have been in place since April 2013. All organisations who receive NHS funding are asked to carry out a self- assessment against the NHS Standards for EPRR. KCHFT completed this exercise in August and NHS England agreed with KCHFT's assessment that it was successful in meeting all of the requirements for 'full' compliance.

4. Partnership working

The Trust works in collaboration with a range of partner agencies through formal standing meetings and ad hoc arrangements. Formal committees of which the Trust is a member include the Kent and Medway Local Health Resilience Partnership (LHRP). The purpose of this group is to ensure that effective and coordinated arrangements are in place for NHS emergency preparedness and response in accordance with national policy and direction from NHS England – South, South East.

The LHRP work plan is delivered by the Trust as required. An area of responsibility agreed at the LHRP for the Emergency Preparedness leads across the county is accountability to the local authorities for the medical risk assessment of community events taking place; the Head of EPRR is responsible for the Dover authority.

4.1 Student Placement

The EPRR team in partnership with Maidstone and Tunbridge Wells NHS Trust facilitated an EPRR student placement from August 2019 for a period of one year. The student experienced an extensive insight into the role of EPRR within the acute and community settings.

5. Planning

5.1 Major Incident Plan

The Major Incident Plan was reviewed in February 2021 to ensure it continues to accurately reflect the role of the Trust in a major incident and how this role fits with the plans of other NHS organisations and the emergency services. The Major Incident Plan was ratified by the Corporate Assurance Risk Management Committee on behalf of the Executive Management Team

5.2 Emergency Resilience and Business Continuity Policy and Business Continuity Plans (BCP)

The Emergency Resilience and Business Continuity Policy outline's how the Trust will continue to discharge core functions in the event of disruption to business operations.
Following discussion at the Incident Management meetings the following was agreed;
Each service to have its own Business Impact Analysis and associated action cards. A BCP is required for Tier One services however this plan may be written to incorporate more than one service.
The Associate Director or the Community Services Director will agree if a BCP is required for Tiers two and three services. Due to the second wave of the pandemic the IMM have agreed that the deadline for completion of these documents will be extended.

5.3 Heatwave Plan

The Heatwave Plan for the Trust was updated as required for 2020. The Trust received health watch alerts for the period 1 June - 15 September 2020. The plan allows for escalation of operational services, and specific actions would be implemented to safeguard patients and staff as necessary.

5.4 Lockdown Policy

The Trust is required to have lockdown plans for appropriate sites, such as the Community Hospitals. The Head of EPRR developed a Lockdown policy and worked collaboratively with the Head of Health, Safety, Security and Fire to embed this in to the Trust. The Trusts several Minor Injuries Units/ Urgent Treatment Centres are located on National Health Service Property Services (NHSPS) sites, the aim of each of these is to develop and embed multi occupancy Lockdown Plans, this has proved challenging with lack of engagement from NHSPS.

5.5 EU Exit Planning

The potential impact of the UK leaving the EU with or without a deal was a significant threat to the business continuity of the trust. In preparation for an exit from the European Union (EU) the Trust instigated and embedded far reaching and detailed plans in accordance with the EU Exit Operational Readiness Guidance, and local plans which recognised the unique position of the Kent in the potential exit. The national guidance summarised the Government's contingency planning and covered all actions that health and adult social care organisations had to prepare for but these required local adaption for the potential extremely high impact on Kent roads. In accordance with the guidance and in partnership with multiagency partners the Trust prepared extensively for an EU Exit, this included a significant focus on the following;

- supply of medicines and vaccines;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables, goods and services;
- workforce;
- reciprocal healthcare;
- research and clinical trials; and
- data sharing, processing and access.

The Trust was represented at a large number of exercises and meetings set up in anticipation of the UK's exit from the European Union. Lessons identified and planning required was discussed at the Trust EU Exit exercise facilitated by the Head of Emergency Preparedness Resilience and Response. These exercises allowed the discussions to assist in the formulation of the Trust operational EU Exit plan
Strategic meetings took place by weekly, nine work streams reported directly into the strategic meeting.

As part of workforce planning Vismo was implemented, this software allows the strategic managers a visual representation of the location of staff's home addresses, and identification of skillset of individual staff member's who may be required to support the delivery of care of Tier One services. Much of the work for the preparation of EU exit was utilised as part of the Trust response to Covid-19

The EU and UK reached a post-Brexit trade deal, ending months of disagreements over fishing rights and future business rules. The UK exited the EU trading rules 31 December 2020 a year after officially leaving the 27 nation bloc.

It will mean big changes for business, with the UK and EU forming two separate markets, and the end of free movement. The impact specifically associated to the M20 road network is unknown and continues to be monitored.

5.6 COVID-19

The UK government declared a level 4 incident in response to the COVID-19 global pandemic on 3 March 2020.The declared Level 4 incident immediately activated Command, Control and Coordination at local and national levels. At each stage, in advance of national directive, the Trust activated its plans in response to COVID-19. Governance structures were set up, including strategic and tactical levels of command and staff were asked to activate working from home. The trust has played a full part in the regional and national cells and actions.

Trust response to the pandemic included the preparation of and then implementation of, the seven day Incident Management Team (IMT) co located at the Incident Coordination Centre Trinity House, Ashford. As part of planning the Trust conducted a review of Strategic On Call arrangements and many staff from Tiers 2 and 3 temporally transferred to Tier 1 services.

Trust response to the second wave of the pandemic continues. The United Kingdom moved to the higher alert level 5 in January 2021 which then reverted to level 4 in March 2021. At the time of writing the report Incident Management meetings (IMM) take place three times each week.

The Salvation Army provided support and food to teams across the Trust throughout the reporting period. Members of the Kent Voluntary Sector Emergency Group. (KVSEG) supported the Trust through delivery of Lateral Flow testing kits. The delivery of these was Trust wide and completed over two day period 12/13 December.

Mass vaccination

Five mass Covid Vaccination sites across Kent and Medway are operational. These are located at Folkestone, Tonbridge, Thanet, Gravesend and Medway. Extensive preparedness commenced in November 2020. A core team including the Head of Emergency Preparedness, Resilience and Response (EPRR) which was led by the Corporate Services Director enthusiastically worked together to ensure a seamless implementation of the mass vaccination sites, this work continues at a reduced pace however support from the core team is vital to the effective operational response of the mass vaccine sites.

Prior to the implementation date of the vaccination sites, two live exercises were planned and facilitated by the Head of EPRR and the EPRR manager. The live exercises were supported by members of the Kent Voluntary Sector Emergency Group. The lessons identified at the exercise have been used to support the modelling for the live vaccination sites.

A large number of volunteers affiliated to KVSEG continue to support the day to day operation of the vaccine sites.

6. Training and Exercising

In order to comply with our obligations, the Trust must undertake a number of emergency preparedness activities or be able to offer assurance that through a live incident the following requirements have been met;

These are:

- a communication test every six months

- a desktop exercise once a year
- a major live exercise every three years
- Command Post exercise every three years

Through the reporting period the Trust is compliant with the required elements;

6.1 Training

The EPRR team continue to present at Trust Induction through eLearning. Education and Workforce (EWD) have reported a figure (March 2021) of 99.6% compliance for the mandatory element of EPRR training for staff that joined the Trust since March 2020.

6.2 Exercises

Throughout the Covid 19 pandemic the EPRR team in consultation with the IMM agreed to suspend the exercise programme, a review has taken place and exercises are currently being planned.

7. Incidents

Throughout the year there have been a number of incidents across the Trust which has involved implementation of Service Level Business Continuity arrangements.

Examples of incidents are documented below;

Tonbridge Cottage Hospital (TCH)

At 19:15 19 May 2020 a loud bang was heard above the nursing station in Goldsmith Ward at TCH followed by a staff member noticing a small trickle of water from the light fitting near the nurses' station. The ceiling collapsed with a vast amount of water emanating from the hole in the ceiling. The Head of EPRR was contacted and attended site leading on the coordination of the incident. The patients were evacuated to alternative Trust community hospitals. Extensive works took place before staff and patents were able to return to TCH. No harm was reported to either staff or patients.

Westcliffe House, Folkestone

On 2 September 2020 Westcliffe House Folkestone was broken into overnight. This was initially discovered by Hotel Service staff and then nursing staff reported items missing. The incident was reported to the Head of EPRR who coordinated the response, post incident meetings and debrief. The EPRR manager assisted in this process.

Thieves entered the premises through the access doors via the garage. It appeared a lever bar was used on two doors to gain access into the main office area. It is believed they entered all rooms and searched pedestal drawer units, various items were stolen.

A second break in occurred at Westcliffe House, Folkestone on 10th/11th October 2020. This was initially discovered by nursing staff. Kent Police were again informed;

Sheppey Hospital Chemical incident 6 October 2020

A Chemical incident at Sheppey Hospital was reported to the Head of EPRR, the incident affected the Minor Injuries Unit (MIU). Lock down of the site was immediate.

Two patients presented at the hospital affected with exposure to Chlorine gas from their work area, they had been wearing Personal Protective Equipment however the chemical had penetrated through.

Chief Hazmat officer from Kent Fire and Rescue advised staff. The Head of EPRR attended site and facilitated a hot debrief.

Operation Stack

On Sunday 20 December 2020, the French authorities announced a travel ban on all vehicles and passengers from the UK for 48 hours due to the spread of a new variant of the COVID-19 virus.

In response to the potential for significant traffic disruption during one of the busiest times of the year for the Short Straits, Kent Police with support of its partner agencies declared a Critical Incident and implemented Operation Stack. The M20 coastbound carriageway was closed from junctions 8 to 11 to allow the queuing of EU-bound HGVs attempting to enter Kent before the travel ban was lifted. Subsequently, and in consultation with partner agencies and the Government, approval was given for Operation Brock to be implemented and work to do so began at 8pm on Monday 21 December. Operation Brock involves the introduction of a contraflow system on the London-bound carriageway and cross-Channel freight is filtered and queued on the empty coast-bound carriageway. The use of the Manston airfield to queue HGVs was also approved. These traffic contingencies were put in place to help manage the anticipated flow of cross-Channel freight once it could travel back to France.

This challenging incident was discussed daily at the Trust IMM, BC arrangements were implemented, staff were adaptable to the fast moving situation. Communication continued at a local level, additionally regular Trust communications were coordinated by the communications team.

Summary

The Trust continued to develop its resilience arrangements throughout 2020/21 which was a year of significant challenge in the field of emergency planning. During 2021/22 this work will continue, ensuring the Trust maintains the ability to respond to emergencies and business continuity incidents. Lessons learned and good practice have been identified and shared amongst staff. On-going embedding of the EPRR arrangements remains a key priority.

The focus for the continued development of the service in 2021/22 will be;

- To continue to effectively respond to incidents
- To maintain compliance with the EPRR requirements
- To continue the planned works in respect of Lockdown
- To facilitate exercises for clinical and non-clinical services

The Board is asked to note the progress of the service in 2020/21 and endorse the continued development of the service for 2021/22.

Jan Allen
Head of Emergency Preparedness, Resilience and Response
1 April 2021

Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	20 May 2021
Agenda Number:	5.5
Agenda Item Title:	Learning From Deaths Quarterly Report
Presenting Officer:	Dr Sarah Phillips, Medical Director
Action – this paper is for:	☐ Decision ☒ Information ☐ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?

In line with national guidance on learning from deaths, since September 2018, KCHFT has collected and published mortality data quarterly via a paper to Quality Committee and Public Board, which must include mortality data and learning points. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths that the Trust has subjected to case record review. Of those deaths reviewed, the Trust must report how many deaths were judged more likely than not to have been due to problems in care. The Committee is asked to note Quarter 4's data and learning points described in this report, for assurance. Following submission to the Committee, the report is published on the Trust's public website.

Summary of key points

Mortality review processes have adapted over the last year in response to increasing numbers of deaths due to the COVID-19 pandemic, while still meeting the national remit.

This report reminds the Committee of the evolution of these processes and presents learning and actions from mortality reviews carried out in Quarter 4. Areas for improvement emerging from reviews include advance care planning and missed opportunities to identify end of life, medicines issues, and general documentation and team communication. The age, gender and ethnicity of all patients dying with COVID-19 are now collected and this quarter's data is included in the report although this data set is not of sufficient size or breadth to be statistically significant on its own. All our mortality and ethnicity data feeds into larger national and regional data sets.

All Trust HCAI Covid-19 inpatient deaths will be reviewed in line with national guidance with a focus on generating insights to underpin effective and sustainable

improvements in care to reduce future risks to patients and engagement of duty of candour. There have been 20 nosocomial cases resulting in death since May 2020 to date.

Proposal and/or recommendation to the Committee or Board
For information.

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	

Name:	Dr Sarah Phillips	Job title:	Medical Director
Telephone number:	07391 861077	Email	sarahphillips4@nhs.net

Kent Community Health
NHS Foundation Trust

LEARNING FROM DEATHS REPORT QUARTER 4
JANUARY – MARCH 2021

1. Introduction

1.1 In line with national guidance on learning from deaths, Kent Community Health NHS Foundation Trust (KCHFT) collects and publishes mortality data quarterly via a paper to Quality Committee and Public Board, which must include mortality data and learning points. Guidance states this data should include the total number of the Trust's inpatient deaths and those deaths the Trust has subjected to case record review. Of those deaths reviewed, the Trust must report how many deaths were judged more likely than not to have been due to problems in care.

2. COVID-19

2.1 The mortality review process was adapted in April 2020 in response to COVID-19 and these changes were approved at an Extraordinary Quality Committee shortly after the beginning of the pandemic. This allowed for reviews to be completed virtually, first by a doctor using physical notes, and then circulated to at least two other clinicians for independent review of electronic notes, to offer further comment and a safe degree of peer review. A minimum of three clinicians including the lead medical reviewer were required.

2.2 Following a spike in the number of deaths in April due to the first COVID-19 wave, numbers returned to normal levels from June onwards. However, December saw another rise due to the second wave. In response to the rise in deaths, a backlog of reviews requiring completion, and lack of capacity for clinicians to conduct reviews, an adapted process was approved at an Extraordinary Quality Committee on 11 December 2020.

2.3 Under the adapted system, all inpatient deaths continue to undergo initial Datix investigation in accordance with existing Trust policy. Any concerns regarding potential Serious Incidents arising from Datix investigation follow the Serious Incident review process. In accordance with current national statutory guidance, for all other inpatient deaths, mortality reviews using the structured judgement review (SJR) process are conducted for any cases where a concern has been raised about the quality of care provision, all unexpected community inpatient deaths, deaths of people with severe mental illness and deaths where learning will inform our existing or planned improvement work. Five deaths per month receive a full SJR, including a random sample of other deaths in addition to the above criteria to provide an overview of where learning and improvement is needed most.

2.4 These reviews are conducted by a senior clinician; due to pressure on frailty/HTS services, the Deputy Medical Director or Medical Director have been supporting this function. It is expected that now pandemic pressures are reducing, senior doctors from the East and West Kent Frailty Teams will resume their role in regularly completing reviews. Cases are then discussed at a virtual multidisciplinary review meeting for closure.

2.5 Reviews of deaths in the community ceased during COVID pressures. These cases do not require review under current national mortality review recommendations but have previously been part of our review scope within the Learning from Deaths policy.

However any issues regarding individual deaths in the community are entered on Datix and will therefore continue to follow the Datix investigation process as outlined above during this process in the context of the pandemic.

2.6 Mortality reviews of deaths of people with a learning disability are unaffected by these changes and continue to be managed by the learning disability team.

2.7 In light of the HCAI Covid-19 response advice relating to nosocomial COVID-19 deaths, all such Trust inpatient deaths will be reviewed with a focus on generating insights to underpin effective and sustainable improvements in care to reduce future risks to patients and engagement of duty of candour. There have been 20 nosocomial cases resulting in death since May 2020 to date.

3. March Dashboard

3.1 The dashboard below is based on national suggested format. Deaths in scope include all community hospital inpatient deaths and any deaths in the community where a Datix, complaint or potential SI has been raised.

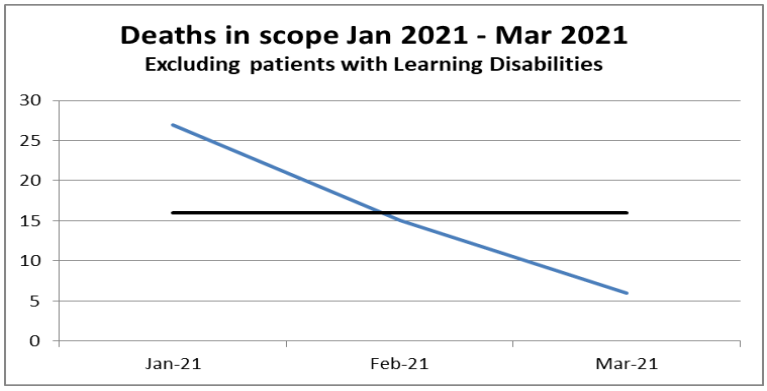
Total Number of Deaths in Scope			Total Deaths Reviewed			Number of deaths judged to be more likely than not due to problems in healthcare	
This Month		**Last Month**	**This Month**		**Last Month**	**This Month**	**Last Month**
6		15	10*		14	0	0
This Quarter (QTD)		**Last Quarter**	**This Quarter (QTD)**		**Last Quarter**	**This Quarter (QTD)**	**Last Quarter**
48		44	62		43	0	0
This Year (YTD)		**Last Year**	**This Year (YTD)**		**Last Year**	**This Year (YTD)**	**Last Year**
48		179	62		178	0	0

**Of which 7 were full SJRs and 3 were case reviews*

3.2 This quarter, one community death is being reviewed as a Serious Incident, relating to a patient who died with an ungradable pressure ulcer while under the care of the Maidstone Community Nursing team. When the RCA is complete, themes and learning will be recorded and disseminated through the usual processes.

One community hospital inpatient death at Westview in May 2020 was reviewed as a potential SI but was subsequently downgraded by the CCG.

3.3 The graph below shows the number of deaths in scope by month over the last quarter, along with the average.



3.4 Deaths are cross-checked with Performance and Infection Prevention and Control to ensure records are accurate. The total number of COVID deaths to date is 122; this figure includes 4 deaths which took place in the acute very shortly after transfer from Westview therefore they were investigated in the same way as deaths occurring within our community hospitals. In Quarter 4, there were 42 COVID deaths.

3.5 The ages of patients dying with COVID-19 this quarter ranged from 68 to 101. The gender split was 48% male, 52% female. Of the patients dying with COVID this quarter, 53% had their ethnicity listed as White British, 2% were listed as Any Other White Background, and the ethnicity for the remaining 45% was not recorded.

3.6 Of the 42 patients dying with COVID-19 in Quarter 3:

- 25 were COVID positive on admission or within the first 2 days of admission i.e. community onset
- 8 were hospital onset indeterminate (positive swab on day 3 – 7)
- 4 was probable hospital onset (positive swab on day 8 – 14)
- 5 were definite hospital onset (positive swab on day 15+)

4. Learning from Mortality Reviews

4.1 Many examples of good practice continue to be identified, including involvement and support of relatives, staff taking the time to get to know patients' individual preferences, and good cross-team working with appropriate referrals to other teams.

4.2 All areas of good practice and areas for learning are reported at monthly matrons'/clinical leads meetings in East and West Kent and wider dissemination to staff is encouraged. A summary report is also reviewed at the bi-monthly End of Life Steering Group, and themes are discussed at the bi-monthly Mortality Surveillance Group (MSG).

4.3 Recurring areas for learning and improvement identified during the last quarter include issues with advance care planning and late recognition of end of life, medicines, and team communication. Graphs can be seen in Appendix 1 showing the frequency of each problem type, in line with Royal College of Physicians reporting categories.

Themes for Learning	Comments/Actions
Advance Care Planning and Late	

Recognition of End of Life There could be improvement in areas such as: • Ensuring the last days of life assessment and care plan on Rio are consistently used • Anticipating the need for Fast Track earlier • Stopping observations when the dying phase is recognised • Looking for soft signs and early indicators that patients are approaching end of life, to make the most of opportunities to discuss what is important to the patient and document their wishes. This would better support staff in the event of sudden deterioration and avoid unnecessary interventions in the final hours or days of life	The Consultant Nurse for End of Life Care and the Lead Practitioner for Palliative and End of Life Care are continuing to roll out education across the Trust around recognition and communication at end of life. One particular recent case will be taken to the Mortality Surveillance Group and End of Life Steering Group as an example to support discussion around triggers for operational teams to aid in earlier recognition of signs of end of life, including cues from patients themselves.
Medicines Issues • Considering holistic assessment for any other underlying causes of agitation before administering midazolam, and ensure rationale is clearly documented • Ensuring buprenorphine patch records are daily checks are completed • Considering adaptations where necessary, for example explore the possibility of IV antibiotics if a patient has difficulty swallowing	There is attendance and input from Medicines Management at each Mortality Review meeting. Staff have been reminded that advice can be sought from the on call pharmacist, and that it should be clearly documented that alternative options have been considered if appropriate.
General Documentation Issues • Ensuring paperwork is consistent throughout community hospitals in the East and West so that out of date forms are no longer in circulation.	Head of Quality, Governance and Professional Standards to raise this with hospitals across West Kent to ensure consistency.

5. Medical Examiners Process

5.1 The rollout of the Medical Examiners process in East Kent was originally planned for January 2021 but was postponed due to pandemic pressures. Systems are now in place from early April 2021 but as there have been no community hospital deaths in the first half of the month, there has not yet been an opportunity to test the process. Updates on progress and effectiveness should be available for the next quarterly report.

Dr Lisa Scobbie - Deputy Medical Director
Melissa Ganendran - Mortality Review Project Lead

On behalf of
Dr Sarah Phillips - Medical Director
April 2020

6 Learning Disability (LD) Mortality Reviews Report

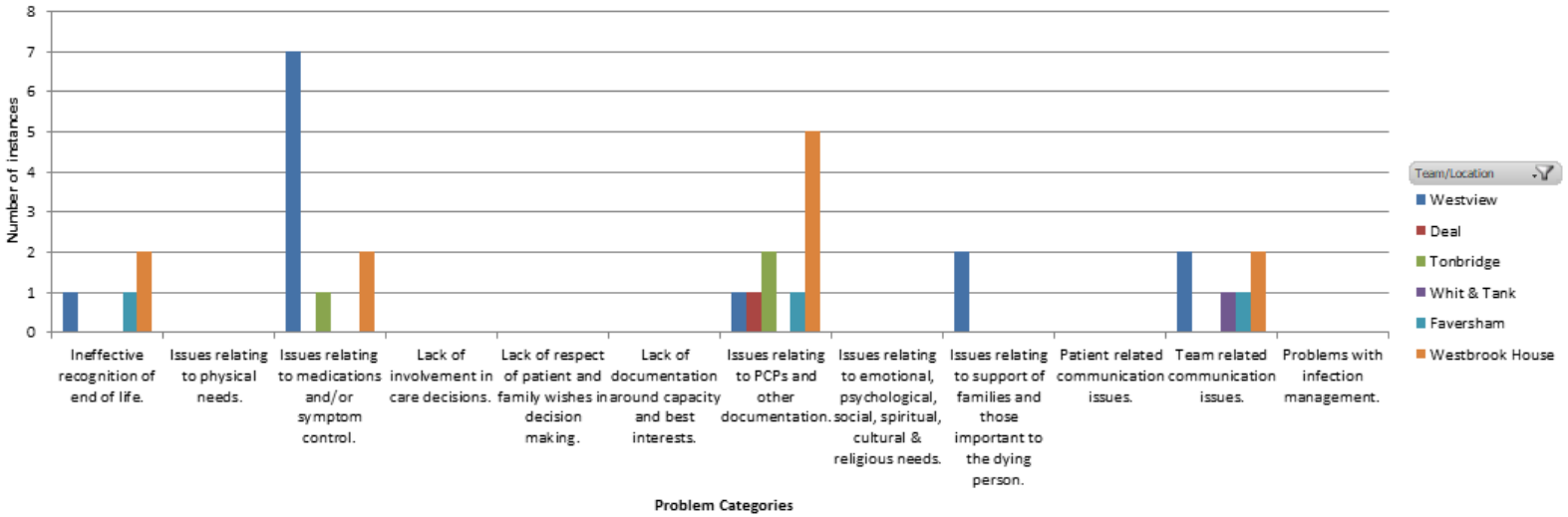
6.1 The embedded report covers learning from LeDeR reviews for deaths between 1 April 2020 and 31 March 2021.

LD Annual Report.pptx

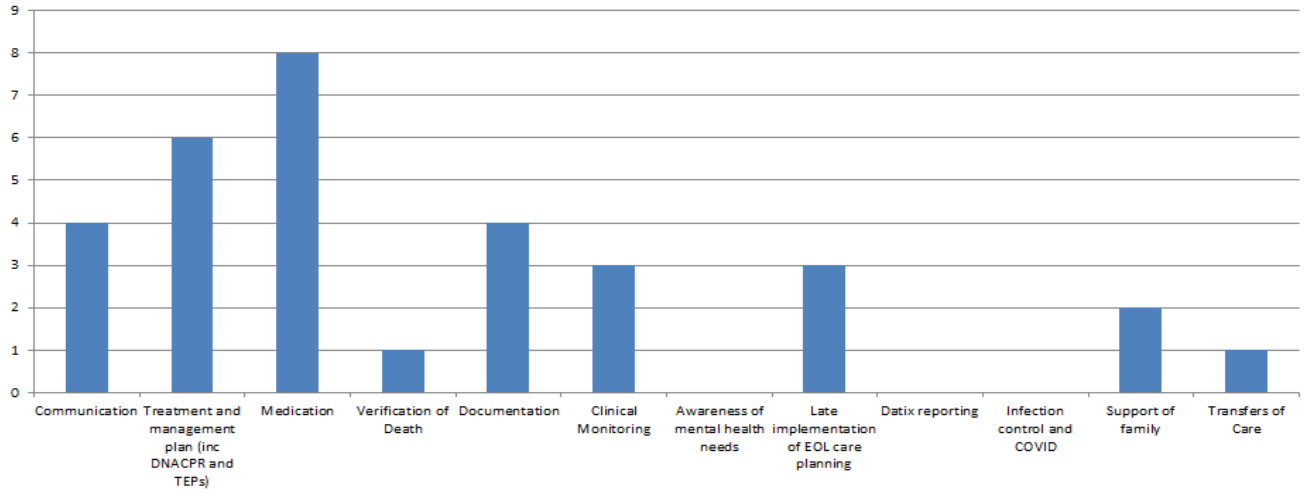
Mandy Setterfield - Specialist Practitioner
Chantelle Lloyd - Business Support Officer
April 2021

Appendix 1

Number of instances of each problem (mapped to Royal College of Physicians categories) in KCHFT community hospitals for 2021 deaths



Problem categories in 2021 mapped to the areas feeding into Patient Safety Summit



LeDeR Annual Report
Kent Community Health NHS Foundation Trust
Kent and Medway CCG

For the period 1st April 2020 – 31st March 2021

NHS England and NHS Improvement

Content

Executive Summary

The Kent and Medway annual report of the Learning Disabilities Mortality Review (LeDeR) programme presents information about the individuals with a learning disability as well as the care and treatment provided to them for all deaths between 1st April 2020 to 31st March 2021.

The annual report will evaluate and summarise the key themes and trends from the LeDeR reviews undertaken during this period and will focus on factors including:

- Age of death
- Month of death
- Gender
- Ethnicity
- Place of death
- Cause of death
- Quality of care

Themes and trends linked to best practice, learning and recommendations have also been summarised. Some of the themes from the local data have been compared to the national 2019 – 2020 LeDeR annual report data for comparison. This report is available to read at https://www.bristol.ac.uk/sps/leder/resources/annual-reports/

Introduction

The national Learning Disabilities Mortality Review (LeDeR) programme was established in 2016 following the Confidential Enquiry into the premature Deaths of people with Learning Disabilities (CIPOLD). It was commissioned by the Healthcare Quality Improvement Partnership (HQIP), on behalf of NHS England, from the University of Bristol. It involves reviewing the deaths of all people with a learning disability to identify potentially avoidable contributory factors. LeDeR focuses on the learning that can be gained from reviewing the circumstances in which a person with learning disabilities dies, and their care and treatment through their life.

From March 2020, the CCG commissioned Kent Community Health NHS Foundation Trust to clear the backlog of LeDeR reviews from 2017 – 31 – June 2020. On successful completion of this workstreams, the CCG have granted funding to Kent Community Health NHS Foundation Trust from 1st April 2021 for a dedicated LeDeR team to undertake Kent and Medway reviews. This team consists of two full time band 6 reviewers, a lead nurse and administrative support.

Key Findings

Some of the report's key findings include:

- Within the Kent and Medway district, 151 deaths were notified to the programme between 1st April 2020 – 31st March 2021.
- Of these cases, over half of the deaths were male at 57%, comparable to the national data at 58%.
- Where the person's ethnicity was recorded, 98% were White British, this was higher than the national data at 90%.
- Corresponding to the national picture (60%), 57% of Kent and Medway deaths took place in hospital.
- The most common cause of death was Pneumonia closely followed by Covid19.
- The average age of death for a Male was 3 years older than for a Female.
- The most common severity of Learning disability seen was moderate at 32% reflecting the national data at 33%.
- 45% of completed reviews concluded that the individuals received care that met or exceeded good practice (Grade 1 or 2). This is lower than the national data of 56% meeting or exceed good practice.

Equality Impact

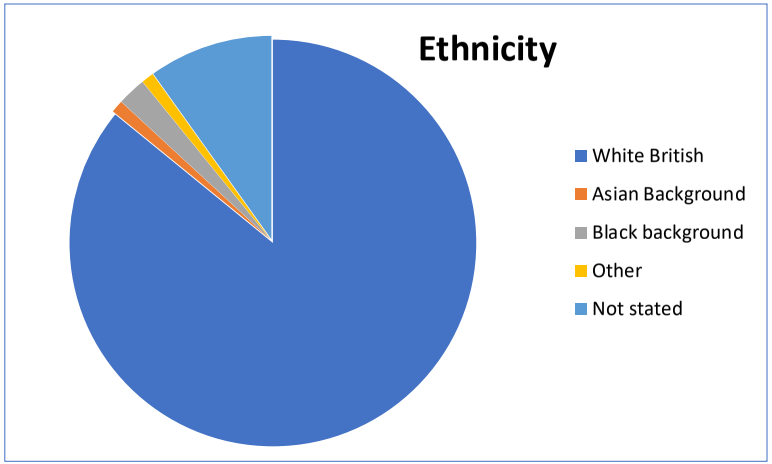
Ethnicity

The table shows the ethnicity breakdown of the people whose lives and deaths we reviewed between April 2020 – March 2021.

The person's ethnicity was reported for 89% of deaths.
Out of all deaths were ethnicity was recorded:

- 87% of adults with a learning disability were White British.
- 1% were from an Asian background
- 2.3% were from a Black background
- 1% were recorded as 'Other'
- 10% were not stated.

Compared to our local population information, this shows a slight under reporting of deaths from BAME communities in our population.



Ethnicity	White				Mixed/Multiple ethnicity groups				Asian or Asian British				Black or Black British			Other Ethnic Groups		
	British	Irish	Traveller or Gypsy	Any other White background	White & Black Caribbean	White & Black African	White & Asian	Any other mixed background	Indian	Pakistani	Bangladeshi	Any other Asian background	Caribbean	African	Any other Black background	Chinese	Any other ethnic group	Not stated
No. of reported deaths	131	0	0	0	0	0	0	0	0	0	0	1	0	1	2	0	1	15
% of all reported deaths	87%	-	-	-	-	-	-	-	-	-	-	1%		1%	1.3%	-	1%	10%

Case studies:

Case study by LeDeR Reviewer and Speech and Language Therapist

I found that being a LeDeR reviewer has a significant impact on my clinical practice. There was particular resonance with my role within the multi-disciplinary Acute Liaison team where I could see scenarios being played out that mirrored experiences I had reviewed. On one occasion there was a gentleman whose condition was deteriorating and hospital staff were having difficulty supporting him to understand his treatment options. As a reviewer I had read examples where there was lack of evidence of accessible information being used to support someone, and where hospital staff did not know how to communicate with a person. We were able to find this gentleman's communication passport and share it with the LD Liaison Nurse who printed it and took it to the ward. This supported the ward staff with how to present information in the best way for this person. They were able to use this information to talk with him about wearing an oxygen mask, and about having an NG tube.

Throughout my LeDeR reviews I have seen that sometimes decisions are made with an assumption that a person won't be able to understand something or won't be able to tolerate a particular intervention. This may end up being the case but by improving our practise presenting information in an accessible way and by being aspirational in our care, we can ensure that we are doing our best to support people to access the care and support they need.

Case study by LeDeR Reviewer and Speech and Language Therapist

I completed a review into the care and support for A at the end of her life. It is an important part of the work to involve the person's family so I phoned her Mum. Over the course of the call, she told me the brief story of A's life from the day of her birth to her death and all that that entailed for her as a mother. She was able to tell me about who her daughter was, what her life had been like and what she felt about her care, particularly when she was very unwell and dying.

Towards the end of the conversation, it transpired that she had not known why her daughter had died. For whatever reason, whether stress at the time or poor communication, the very late diagnosis of bowel cancer just two days before A's death had not been understood by her Mum. She had been worrying that something had gone terribly wrong and as her daughter's lifelong advocate, perhaps it could have been her fault. When people asked her why A had died, she told me she wasn't able to say and couldn't speak or even cry about it with anyone. She told me that she had thought about it every single day.

As her LeDeR reviewer, I had been piecing together the story of A's illness, her missed and misinterpreted symptoms and the story of how the medical professionals worked out in the end what was wrong. I knew what was on the death certificate and I had sifted through the medical jargon in her notes from multiple people trying to treat her. My role was to check what sort of care she had had, whether it was the best it could be and to make recommendations for best practice in the future.

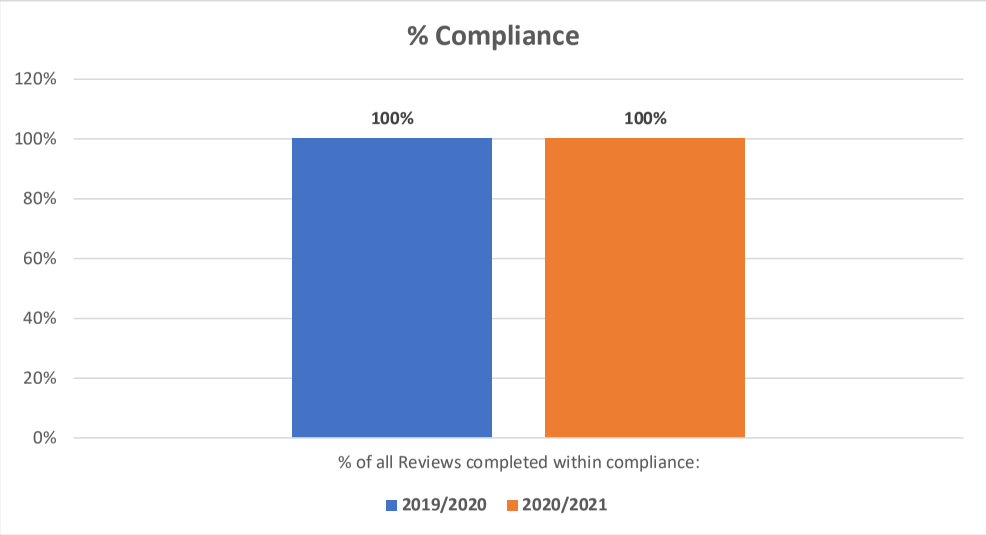
Being part of the LeDeR review allowed this grieving mother to speak about her beloved daughter for the first time in many months, to have someone listen to her story, to carefully explain to her why her daughter had died and what from, to reassure her that it was not her fault, to know that someone was checking how things went at that terrible time, that someone was speaking up for A and getting her voice heard even though in life she never spoke.

At the end of the review, I felt very grateful to this mother for her brave words and her honesty but she was even more grateful to me. In thanking me she told me that she felt "as if something has been lifted off me; a weight". It was a humbling thing to hear and has made me so proud to be part of the LeDeR team."

Data Set: Performance

	Notifications No. & %		Completions No. & %		Multi Agency Reviews	% of all Reviews completed within compliance:
2019/2020	89	100%	166	187%	2	100%
2020/2021	152	100/%	97	64%	0	100%

During 2019/2020, 89 notifications were received however, Kent Community Health NHS Foundation Trust were commissioned to complete the backlog of reviews from 2017 – 2020. resulting in 166 reviews being completed. All reviews were completed within the timeframe set by NHS England of 31st December 2020 therefore, the team achieved 100% compliance.



Local Reviewer Arrangements

Kent and Medway formed a small dedicated LeDeR team in order to achieve review completion compliance and clear the backlog of reviews from 2017 – June 2020. As from 1st April, funding has been granted to form a permanent LeDeR Team. This team consists of two whole time equivalents one part time senior reviewer and administrative support. The team's background consists of registered nurses specialising in learning disabilities and speech and language therapists from community settings and mental health.

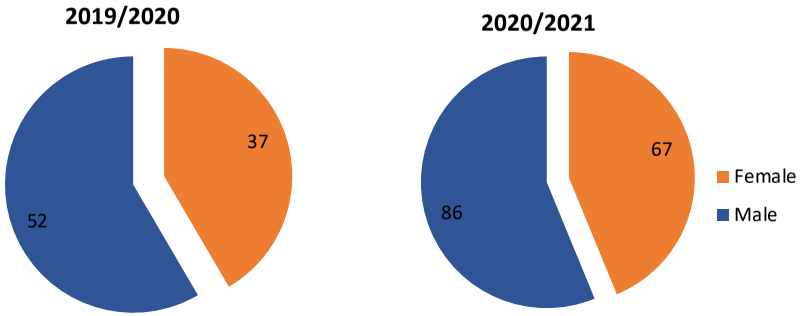
Data Set: Demographics

- **Gender**

The person's gender was reported for all 151 deaths that were notified between 1st April 2020 – 31st March 2021. Of these cases, the majority (56%) were male and 44% were female.

	2019/20	
	Male	Female
No.	52	37
%	58%	42%

	2020/21	
	Male	Female
No.	86	67
%	57%	44%



- **Level of Learning Disability**

For every review carried out the level of learning disability for that person is confirmed and recorded as either mild, moderate, severe or profound/multiple. The information below shows the breakdown of this information for all of the people reviews have been completed for in the last year.

Serverity of Learning Disability		
Level	N= 99	%
Mild	29	29%
Moderate	32	32%
Servere	27	27%
Profound/ Multiple	2	2%
Not known	9	9%
Awaiting confirmation	52	

The most common severity of learning disability seen was Moderate (32%) closely followed by Mild (29%). 9% of reviews were unable to confirm the severity of the persons learning disability.

52 death notifications are still under review and the level of severity is therefore still waiting to be confirmed.

Data Set: Demographics, Age

All Adults with learning disabilities who died from April 2020- March 2021:

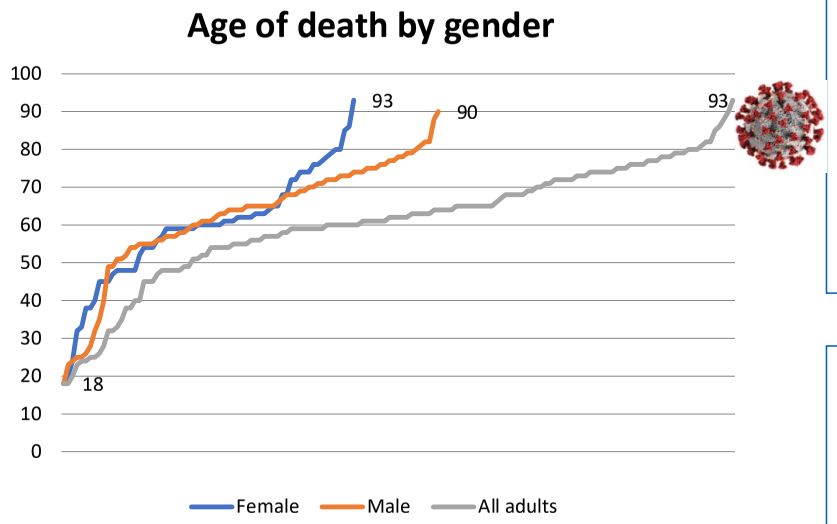
- There was a total of 151 deaths
- The range of age at death was 18 - 93
- The mean average age of death was 60
- The median average age was 62

Women with learning disabilities who died from April 2020- March 2021:

- There was a total of 66 deaths
- The range of age at death was 18 - 93
- The mean average age of death was 59
- The median average age was 60
- Female life expectancy in the general population of Kent and Medway is 83.4

Men with learning disabilities who died from April 2020- March 2021:

- There was a total of 85 deaths
- The range of age at death was 18 – 90
- The mean average age of death was 62
- The median average age was 65
- Male life expectancy in the general population of Kent and Medway is 79.9



All Adults with learning disabilities who died from confirmed or suspected COVID-19 in 2020-2021:

- There was a total of 54 deaths, this could increase following the completion of the pending 52 reviews.
- The range of age at death was 38 – 86
- The mean average age of death was 64.7
- The median average age was 64
- No. of women who died 21
- No. of men who died 33

Children with learning disabilities who died in 2020-2021:

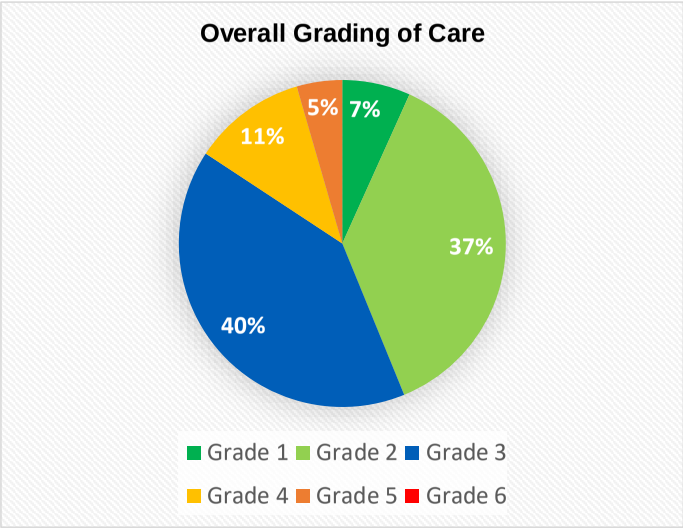
- There was a total of 6 deaths
- The range of age at death was 4 – 17.
- The mean average age of death was 11.67 years.
- The median average age was 13/14 years.

Data Set: Cause of Death and Quality of Care

- **Quality of Care**

The table below shows the number and percentage of completed reviews graded at each level of the overall quality of care received by the person.

Grade	Grading of Care
1	This was excellent care (it exceeded expected good practice).
2	This was good care (it met expected good practice).
3	This was satisfactory care (it fell short of expected good practice in some areas but this did not significantly impact on the person's well-being).
4	Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death.
5	Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death.
6	Care fell far short of expected good practice and this contributed to the cause of death.



45% of individuals received care that met or exceeded good practice whereas 57% of deaths fell short of good practice.

5% of reviews significantly impacted the person's wellbeing, there were no reviews where practice contributed to the cause of death.

Two multi agency reviews were completed. This resulted in the GP acknowledging that the annual health check and screening opportunities were missed and was therefore going to speak to the practice regarding following up when people do not attend for health checks and to be aware that referrals to the community learning disability team are made sooner.

Data Set: Cause of Death and Quality of Care

- **Cause of Death**

Out of 102 deaths, the most common cause of death this year was Pneumonia. The number of deaths from this was 36 which is 35% of all deaths this year.
The table below shows the top 5 primary and secondary cause of death

No	Primary Cause of Death	No	Secondary Cause of Death
1	Pneumonia/Respiratory	1	Covid-19 related
2	Covid-19 related	2	Dementia
3	Dementia	3	Epilepsy/Seizures
4	Brain Tumour/Hypoxic brain injury	4	Respiratory Condition
5	Cancer	5	Diabetes

This last year saw an increase in death from Covid19. The Kent variant increased deaths in the months December 2020 and January 2021 to over double the previous year.

12% of deaths inappropriately had a cause of death as Down syndrome and 3 % of deaths inappropriately had a cause of death as Learning Disability.

- **DNACPR – Do not attempt cardio-pulmonary resuscitation**

A DNACPR decision is designed to protect people from unnecessary suffering by receiving CPR that they don't want, that won't work or where the harm to them outweighs the benefits

The DNACPR decision-making process should always take account of the benefits, risks and burdens of CPR and consider the individual person's wishes and preferences, the views of the healthcare team and, when appropriate, those close to the person.
Hospital trusts and other providers are legally obliged to have a clear DNACPR policy for staff to follow. It must be accessible so that patients and/or their families are able to understand the decision-making process.

During the first wave of the Covid-19 pandemic, concerns were raised about the potential for "blanket" decisions being made around resuscitation, particularly for more vulnerable populations. As a result, the Care Quality Commission undertook a review of practice across a number of systems, taking into account the understanding and application of the Mental Capacity Act both when it comes to clinical decision making and taking into account the views of individuals.

Kent Community Health NHS Foundation Trust (KCHFT) upskilled health and social care professionals internally through each service and externally through GP surgeries, acute trusts and fire and rescue to become Learning Disability champions. During Covid19, the LeDeR team used this platform to share immediate learning through a newsletter. This newsletter included information around DNACPR highlighting that the terms learning disability and down's syndrome should never be a reason for issuing a DNACPR order.

The Clinical Lead GP for Kent and Medway for Autism, ADHD and Learning Disabilities Learning Disability wrote to all GP practices highlighting the message shared by the National medical director regarding DNACPRs for people with a learning disability.

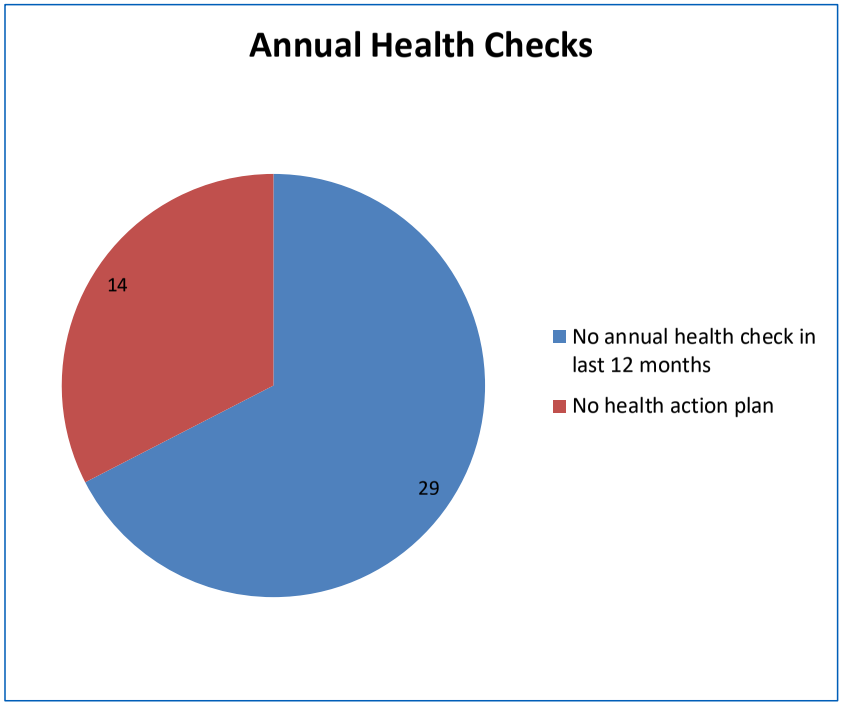
Data Set: Cause of Death and Quality of Care

- **Annual Health Checks**

From January 2020 – 31st March 2021, 55 people who's death was reported through LeDeR were identified as experiencing a gap in care in relation to Annual Health Checks.

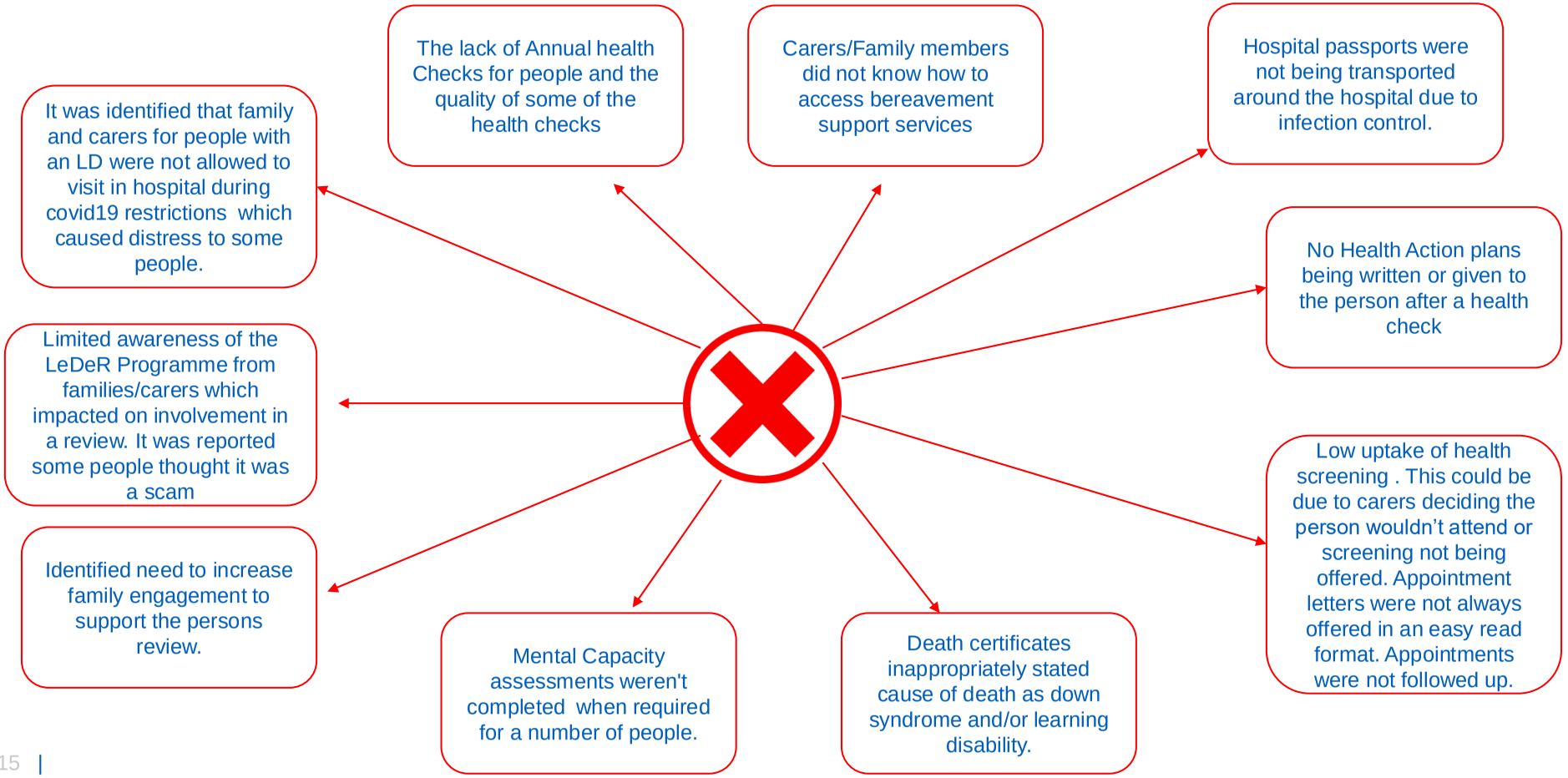
78% of these issues were experienced between April 2020 – 31st March 2021, affecting 43 people with a learning disability.

The issues recorded included the person not receiving an annual health check within the last 12 months or a health action plan not being formulated following an annual health check.

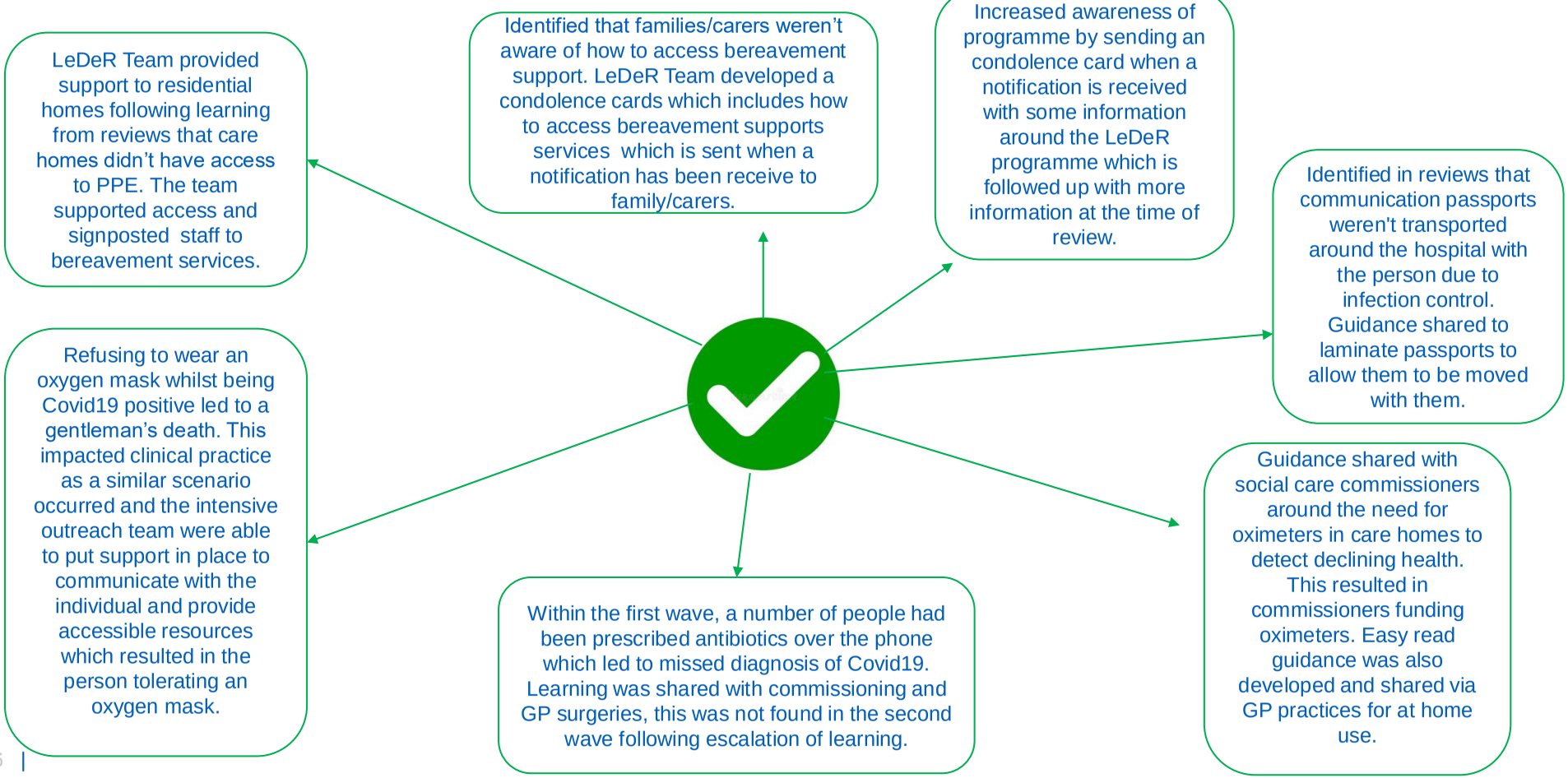


Action from Learning:
What best practise and positive outcomes have been learned from the reviews

Action from Learning: What areas for improvement were identified in recommendations from reviews



Action from Learning:
What best practise and positive outcomes have been learned from the reviews of Covid-19 deaths



Action from Learning: Local Priorities for delivery in 2021/2022 based on the learning from reviews locally and nationally