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 9am

# on Wednesday 25 May 2022

# The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT

# This meeting will be broadcast to the public on MS Teams Live Event

Kent Community Health
NHS Foundation Trust

**Meeting of the Kent Community Health NHS Foundation Trust Board**
**to be held at 9am**
**on Wednesday 25 May 2022**
**in The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone, Kent ME16 9NT**

**This meeting will be broadcast to the public on MS Teams Live Event**

# AGENDA

| | | | |
|---|---|---|---|
| **1.** | **STANDARD ITEMS 9.00-9.40** | | |
| 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 9 February 2022 | Trust Chair | |
| 1.5 | Matters arising from the Kent Community Health NHS Foundation Trust Board meeting held on 9 February 2022 | Trust Chair | |
| 1.6 | Patient story | Chief Nurse | |
| 1.7 | Trust Chair's report | Trust Chair | Verbal |
| 1.8 | Acting Chief Executive's report | Acting Chief Executive | |
| **2.** | **BOARD ASSURANCE 9.40-10.40** | | |
| 2.1 | Board assurance framework | Director of Corporate Services | |
| 2.2 | Infection prevention and control board assurance framework | Chief Nurse | |
| 2.3 | Audit and Risk Committee chair's assurance report | Deputy Chair, Audit and Risk Committee | |
| 2.4 | Charitable Funds Committee chair's assurance report<br>• Confirmed minutes of the Charitable Funds Committee meeting of 20 January 2022 | Chair, Charitable Funds Committee | |

| | | |
|---|---|---|
| 2.5 | Finance, Business and Investment Committee chair's assurance report | Deputy Chair of Finance, Business and Investment Committee |
| 2.6 | Quality Committee chair's assurance report | Chair of Quality Committee |
| 2.7 | Strategic Workforce Committee chair's assurance report | Chair of Strategic Workforce Committee |
| 2.8 | Learning from deaths report | Medical Director |
| 2.9 | Ockenden Inquiry assurance report | Chief Nurse |
| | **BREAK – 10.40-10.55** | |
| **3.** | **BOARD APPROVAL 10.55-11.10** | |
| 3.1 | Summary annual plan for 2022/23 | Director of Strategy and Partnerships |
| 3.2 | Ratification of the terms of reference of the committees | Trust Chair |
| **4.** | **PERFORMANCE 11.10-11.35** | |
| 4.1 | Integrated performance report | Acting Director of Finance<br>Executive Directors |
| 4.2 | Staff survey | Director of People and Organisational Development |
| **5.** | **GOVERNANCE AND COMPLIANCE 11.35-11.45** | |
| 5.1 | Risk management policy | Director of Corporate Services |
| 5.2 | Emergency preparedness, resilience and response annual assurance statement | Director of Corporate Services |
| **6.** | **REPORTS TO THE BOARD 11.45-11.55** | |
| 6.1 | 2022/23 Annual budgets– revenue and capital | Acting Director of Finance |
| 6.2 | 2022/23 Cost improvement programme | Chief Operating Officer |

| | | |
|---|---|---|
| 6.3 | 2022/23 Quality priorities | Chief Nurse |
| 6.4 | Board of directors – committee membership and designations | Trust Chair |

## 7. ANY OTHER BUSINESS

| | | |
|---|---|---|
| 7.1 | Any other items of business previously notified to the Chair | Trust Chair |

## 8. QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

## DATE AND VENUE OF NEXT MEETING

The next Public Board meeting will take place 7 September 2022 in The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone, Kent ME16 9NT. This meeting will be broadcast to the public on MS Teams.

Kent Community Health NHS Foundation Trust

**UNCONFIRMED Minutes**
**of the Kent Community Health NHS Foundation Trust (KCHFT) Board Meeting held on Wednesday 9 February 2022**
**The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT**

**Meeting held in Public via MS Teams Live Event**

| | |
|---|---|
| **Present:** | John Goulston, Trust Chair (Chair)<br>Pippa Barber, Non-Executive Director<br>Paul Butler, Non-Executive Director<br>Pauline Butterworth, Chief Operating Officer<br>Gordon Flack, Acting Chief Executive<br>Gill Jacobs, Acting Director of Finance<br>Kim Lowe, Non-Executive Director<br>Dr Sarah Phillips, Medical Director<br>Victoria Robinson-Collins, Director of People and Organisational Development<br>Gerard Sammon, Director of Strategy and Partnerships<br>Razia Shariff, Associate Non-Executive Director<br>Bridget Skelton, Non-Executive Director<br>Dr Mercia Spare, Chief Nurse<br>Nigel Turner, Non-Executive Director |
| **In Attendance:** | Gina Baines, Committee Secretary (minute-taker)<br>Annie Caulfield (agenda item 1.6)<br>Natalie Davies, Director of Corporate Services<br>Sue Mitchell, Assistant Director of Patient Participation (agenda item 1.6) |

**09/02/01 Introduction by Trust Chair**

Mr Goulston welcomed everyone and particularly Ms Lowe and Ms Shariff, the new non-executive director and associate non-executive director respectively to the Public Board meeting of Kent Community Health NHS Foundation Trust (the Trust).

He congratulated Mr Paul Bentley, the Trust's former chief executive, in his new role as the Chief Executive Officer Designate at the Kent and Medway Integrated Care Board. He welcomed Mr Flack as the Trust's acting chief executive and Ms Jacobs as the acting Director of Finance.

**09/02/02 Apologies for Absence**

Apologies were received from Peter Conway, Non-Executive Director and Karen Taylor, Non-Executive Director.

The meeting was quorate.

**09/02/03 Declarations of Interest**

The following interests were declared.

Ms Lowe declared her interests as a non-executive director at Kent and Medway NHS and Social Care Partnership Trust (KMPT); a lay member and senior independent governor at the University of Kent; and the Chair of the University of Kent Academies Trust Board.

Ms Shariff declared her interests as the Chief Executive Officer and Company Secretary of the Kent Refugee Action Network; and a member of the South East Main Grants Committee, Children in Need (BBC).

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

**09/02/04 Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 11 November 2021**

The minutes were read for accuracy.

The Board **AGREED** the Minutes.

**09/02/05 Matters arising from the Kent Community Health NHS Foundation Trust Board meeting held on 11 November 2021**

Mr Goulston confirmed that Mr Cedi Frederick, Chair of the Kent and Medway Integrated Care Board and Mr Paul Bentley would be attending the governor development day on 6 April. All members of the board were welcome to attend and invitations would be circulated shortly.

The Board **RECEIVED** the Matters Arising.

**09/02/06 Patient/Service Impact Story - Annie's story and the Expert Patient Programme**

Dr Spare introduced the presentation to the Board for information.

Ms Annie Caulfield joined the meeting and presented her story as a user and facilitator on the expert patient programme.

In response to a question from Mr Sammon about the pros and cons of online facilitation versus meeting face-to-face, Ms Caulfield explained that the advantage to online sessions was that those who were unable to get to

a physical venue could still access the programme. The disadvantage of meeting virtually was that for the facilitator it was more difficult to read the non-verbal cues from participants. Face-to-face learning had more impact as it offered participants the opportunity to interact with each other to help with their learning. The midway break also provided an opportunity for them to share ideas and tips with each other which was lacking when the session was online. However, both approaches still worked well.

In response to a question from Ms Skelton regarding how more people could be encouraged to join the programme, Ms Caulfield responded that making people aware of the programme was a perennial problem. There had been a lot of effort to promote it both locally and nationally and this would continue. With regards to Ms Skelton's suggestion of a hybrid approach to delivering the programme, Ms Caulfield agreed that this could work. It would need to be trialled to see how it compared to the current delivery. Dr Spare confirmed that the programme was now part of the Director of Participation Experience and Patient Engagement's portfolio and there was a plan to increase awareness. Six or seven referrals were being received a month and the coordinating team was looking at targeting the chronic illness teams and GPs to increase this number.

In response to a question from Mr Flack regarding the ambition for the programme, Ms Mitchell described that an online course would be coming shortly. She would take the idea of a hybrid format forward. Information on the website was being rejuvenated. There had been a piece in the Community Health magazine as well as a new promotional film. With regards to raising awareness internally, there would be a presentation to the community matrons and to the diabetes team.

In response to a question from Mr Flack regarding research on what the programme has and could potentially deliver, Ms Mitchell explained that it was a licenced programme but she would be interested to evaluate the online learning and the impact of the programme on referrals. She would explore this with the research team. Dr Spare suggested that she would discuss this further with her and Ms Caulfield.
**Action** - Dr Spare

In response to a question from Ms Lowe, Ms Caulfield indicated that her greatest wish was that more GPs understood the benefits of the programme and how it could work alongside the support they gave to their patients. The aim of the programme was to help people to realise that there were many things they can do themselves and to live independently.

The Board thanks Ms Caulfield for presenting her story.

Ms Caulfield and Ms Mitchell left the meeting.

**09/02/07 Trust Chair's Report**

Mr Goulston presented the report to the Board for information.

Mr Goulston extended his thanks to Ms Afuape and Prof. Drobniewski who had finished their terms of service in January. Ms Barber had taken over the Freedom to Speak Up non-executive director lead post. Ms Skelton would be finishing her term of office on 31 March and today would be her final public board meeting. He thanked her, on behalf of the Board and the Trust for the considerable role she had played as the senior independent director, chair of the Strategic Workforce Committee and member of the Audit and Risk Committee and the Finance, Business and Investment Committee. She had contributed tirelessly to many service visits and worked closely with the Council of Governors.
Mr Goulston confirmed he would present a paper at the next public board meeting and the Council of Governors meeting which would confirm the changes to the Board and the new roles of the Board members.

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

**09/02/08 Acting Chief Executive's Report**

Mr Flack presented the report to the Board for information.

In response to a question from Mr Goulston regarding the rules for community hospital visitors, Dr Spare explained that the Trust was following the latest guidance which advised that there should be one person only at the bedside. For those patients who were end of life, had learning disabilities or a mental health condition, visitors were welcome but where possible the number was kept to a minimum. The hospitals were abiding by the Health and Safety Executive (HSE) rules regarding social distancing. Visiting was by appointment and visitors were supported with personal protective equipment (PPE) and asked to undertake a lateral flow test with a negative result before they visited. However, the wards had a level of discretion to manage visiting for the benefit of patients without overcrowding.

Mr Goulston updated the Board on progress with the recruitment of the new chief executive. There was a long list of nine candidates. Shortlisting would take place in two weeks and Mr Conway, Ms Barber and Ms Anne Eden, Regional Director South East NHS England/Improvement would be involved in the process. A stakeholder event would be taking place on 11 March and invitations had been extended to participants across Kent and Medway. The final interview panel would take place on 16 March. As the Trust was a foundation trust, the appointment of the chief executive would be approved by the governors at an extraordinary governors' meeting where they would receive the recommendation of the interview panel.
In response to a question from Dr Spare as to whether a patient partner was being considered for the interview panel, Mr Goulston supported the close involvement of the public in the appointment and reflected this was an important role for governors as public and patient representatives. It was agreed that Dr Spare would link in with Ms Robinson- Collins to discuss.
**Action** – Dr Spare.

In response to a question from Ms Barber as to whether compliance with the staff flu vaccination programme had been benchmarked against other trusts, Dr Spare provided an update on the Trust's current position. Flu vaccination uptake among patient facing staff was currently 60 per cent. The Trust had been four weeks late in beginning its programme due to a delay in receiving the vaccine. This meant that in terms of benchmarking, it was four weeks behind its Kent and Medway peers. Based on that, the Trust was seven or eight per cent behind. Staff continued to receive the vaccination but the programme would end on 20 February. Dr Spare reflected that the Trust would not meet the 85 per cent target nor was she convinced that the Trust would perform as well as the previous year. The driver for this was the competition between flu and Covid vaccinations and the acceleration of the Covid vaccination programme nationally. This had led to fewer peer vaccinators being available and staff had felt under pressure to receive multiple vaccines.

In response to a question from Ms Barber as to whether it was anticipated that offering both flu and Covid jabs together to staff this autumn would improve the flu uptake, Ms Butterworth responded that preparation for the autumn vaccination programme was underway. The Trust was part of the Kent and Medway flu and Covid vaccination programme board and would be working with system partners to ensure that there was a coherent way of delivering the two vaccinations across Kent and Medway. Dr Spare confirmed that the Trust had ordered its flu vaccines for 2022/23.

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

**09/02/09 Board Assurance Framework (BAF)**

Ms Davies presented the report to the Board for assurance.

Ms Skelton agreed that there was a dynamic risk environment at present. She confirmed that the Strategic Workforce Committee was aware of all the risks relating to workforce and also the tone in which engagement with staff around mandatory vaccination was critical. The Committee had noted that Covid was less of a risk now and that other work pressures were having an impact on retention.

In response to a question from Ms Lowe as to whether there was an escalation route for the Trust to highlight the risks it faced from delivering the mandated staff Covid vaccination policy, Ms Davies commented that the executive had discussed the impact of the policy on staff. They were aware that the last-minute change in policy had had a significant impact on morale with some staff which managers were working through and providing support to their staff. Ms Robinson-Collins confirmed that there was an escalation route which had been used. There was a positive communication channel in Kent and Medway, the south-east and up to the national team which was reflected back in the communication. The national team had provided answers to a number of FAQs and local systems had been supporting with health and well-being. She added that the impact on

staff could not be underestimated and extended beyond HR to senior and middle managers and Staff Side. She hoped that the pause would have a positive impact in the future engagement with staff.

In response to a question from Mr Turner as to whether the Strategic Workforce Committee would be reviewing the risk relating to turnover, Ms Skelton confirmed that the Committee would review all the risks relevant to the workforce. Ms Robinson-Collins would be including further information in her workforce report and she had agreed that the wording of the workforce risk would be updated to reflect the fast-moving environment and the issues facing the workforce.

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

**09/02/10 Infection Prevention and Control Board Assurance Framework**

Dr Spare presented the report to the Board for assurance.

It was noted that the Trust was fully compliant with the Health and Social Care Act 2008 Code of Practice for the Control and Prevention of Infection guidance.

In response to a question from Mr Goulston as to whether the Patient Led Assessment of the Care Environment (PLACE) reviews would be restarted in the community hospitals, Ms Davies confirmed that they would. However, they would be a scaled down version but still within the guidance. The visits would be started as soon as possible. These visits were invaluable in giving insight to the patient experience of the care environment and she would be inviting governors to attend as well.

Ms Barber added that the Quality Committee had received assurance on the framework at its recent meeting and the detail was included in her assurance report to the Board. The Committee had asked for follow-ups for West View Integrated Care Centre and Westbrook House. Dr Spare explained that the Committee had sought assurance that the two sites were included in the normal governance reporting and oversight which she could confirm they were.

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

**09/02/11 Audit and Risk Committee Chair's Assurance Report**

Ms Skelton presented the report to the Board for assurance.

The Audit and Risk Committee had met earlier that week and a verbal update was provided. Substantial assurance had been received on the BAF. The two risks which required redefinition related to staff vaccinations and potential Kent County Council (KCC) funding shortfall. The completion dates on some actions would also be updated. The risk strategy and an update on the Trust's risk appetite would be received later in the year. Fire

safety training in community hospitals had fallen to 81 per cent which was not acceptable and this was being addressed urgently. With regards to lone working arrangements, a new app had been introduced which had received good feedback. However, assurance was sought on the robustness of the network coverage to ensure that all staff were safe. The 2022/23 plans from internal audit and counter fraud had been reviewed and further clarification on the scope of the audits would be discussed at the next meeting. Substantial assurance had been received regarding cyber security and it had been confirmed that the Board would be receiving training on this shortly. A report on estates compliance had been presented and the Committee had received substantial assurance on all aspects of the questions which had been raised to the Trust. The internal auditors would undertake an audit in quarter one on the key performance indicators and data quality. The Committee had received a report on how the sustainability performance would be set out in the annual report and the accounting policies and timetable for the annual report and accounts have been received.

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

**09/02/12 Charitable Funds Committee Chair's Assurance Report**

Ms Barber presented the report to the Board for assurance.

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

**09/02/13 Finance, Business and Investment Committee Chair's Assurance Report**

Mr Butler presented the report to the Board for assurance.

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

**09/02/14 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.

**09/02/15 Strategic Workforce Committee Chair's Assurance Report**

Ms Skelton presented the report to the Board for assurance.

In response to a question from Ms Shariff as to whether there were any synergies between the Strategic Workforce Committee and the Charitable Funds Committee as she noted that the latter was struggling to use its funds, Ms Skelton responded that the Strategic Workforce Committee had discussed the use of food banks and extra initiatives to support staff.

In response to a suggestion from Ms Lowe that it would be helpful to have some benchmarking statistics on sickness turnover to understand how the Trust was performing in this area, Ms Robinson-Collins confirmed that this information would be in her next workforce report to the Committee.

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

**09/02/16 Learning from Deaths Report**

Dr Phillips presented the report to the Board for approval.

The report had been received by the Quality Committee. Mr Goulston highlighted an error on page141 and it was agreed that it should read Queen Victoria Memorial Hospital (Herne Bay).

In response to a question from Mr Goulston as to whether there were any specific areas of learning that Dr Phillips was concerned about, she responded that although the process was working well, there were those grey areas in the process which needed continuous improvement such as recognising end of life in more ambiguous situations. Clinicians needed to be more confident to start having dual conversations with those patients who they were aiming to send home but because of their frailty and co-morbidities could deteriorate and die before being discharged. The clinicians already had good skills but there was still a need for continuous improvement.

As to seeing the benefits of the Kent and Medway Care Record for end of life care and mitigating some of the risks identified in the report, Dr Phillips confirmed that there was access to better shared information on the system and staff knew where to look. The KMCR also had the facility to record and flag an advanced care plan and that would be rolled out in the next 12 to 24 months through training.

In response to a question from Mr Sammon regarding when the report would include an update on the Kent and Medway Learning Disability and Autism 3-year system development plan, Dr Phillips suggested that this would be included in the next report but she would check with the team for confirmation. Ms Barber added that any learning in the report would be brought out and logged at the Quality Committee.
**Action** – Dr Phillips

Ms Barber commented that on a recent We Care Visit to the Podiatry Service, she had seen first-hand the benefits of the KMCR in action. Dr Spare added that she had observed that the community nurses had been energised by the KMCR as well as it was helping them with being more efficient in their work.

In response to a question from Mr Flack as to whether the updating of the Trust's syringe drivers in the next few weeks would help to mitigate some

of the points raised in the report, Dr Spare confirmed that the Trust would be replacing all syringe drivers that were over seven years old. She emphasised that there had been no patient harms directly attributable to the syringe drivers. The new drivers would be easier for staff to use. Full training would be given and by having one model in use across the Trust, this would take out the risk that came with having a variety of models.

In response to a question from Ms Shariff as to whether there was an information sharing protocol for the KMCR with the voluntary sector, Dr Phillips indicated that there was not. The KMCR was primarily a record for health and social care organisations. The challenge would be how much information to share and how that would be done with other private organisations who were providing health and social care including voluntary organisations where appropriate.

The Board **NOTED** the Learning from Deaths Report.

**09/02/17 Integrated Performance Report**

Ms Jacobs, Ms Butterworth and Dr Spare presented the report to the Board for assurance.

Ms Butterworth stated that the Trust did not have any over 52 week waits at present. [Post-meeting note: Ms Butterworth confirmed that this applied to the planned care services and dental services. With regards to autism spectrum disorder (ASD) services, the wait currently stood above the 52 week threshold.]

In response to a request from Mr Goulston for an update on the Nightingale unit at the William Harvey Hospital, Ms Butterworth confirmed that work on supporting it had paused. The unit had capacity for over 90 beds. East Kent Hospitals University NHS Foundation Trust (EKHUFT) had been partnering with the Trust to scope initially 30 beds and care activity which the Trust would look to support through the rapid response service should the unit come on stream.

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

**09/02/18 Any Other Business**

There was no other business to report.

**09/02/19 Questions from members of the public relating to the agenda**

There were no questions from the public.

The meeting ended at 10.49am.

**Date and Venue of the Next Meeting**

Wednesday 25 May 2022; The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT. This meeting will be broadcast to the public on MS Teams

Kent Community Health
NHS Foundation Trust

## MATTERS ARISING FROM THE BOARD MEETING OF 9 FEBRUARY 2022 (PART ONE)

| Minute number | Agenda Item | Action | Action Owner | Status |
|---|---|---|---|---|
| 09/02/06 | Patient/Service Impact Story - Annie's story and the Expert Patient Programme | To discuss the research on what the programme has and could potentially deliver with Ms Sue Mitchell and Ms Annie Caulfield. | Dr Spare | This is being considered as to the feasibility of attracting funding. |
| 09/02/08 | Acting Chief Executive's Report | To link in with Ms Robinson-Collins regarding identifying a patient partner for the chief executive's interview panel. | Dr Spare | Action complete. After discussion, it was felt that the inclusion of our patient governors on the stakeholder panel sufficed to meet this action. Action to be closed. |
| 09/02/16 | Learning from Deaths Report | To check when the report would include an update on the Kent and Medway Learning Disability and Autism three-year system development plan. | Dr Phillips | Going forward a section will be added to the report on the Kent and Medway Learning Disability and Autism three-year system development plan. The next report and future reports will have an update regarding the plan. |

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 1.8 |
| **Agenda Item Title:** | Acting Chief Executive's Report |
| **Presenting Officer:** | Gordon Flack, Acting Chief Executive Officer |
| **Action – this paper is for:** | ☐ Decision<br>☒ Information<br>☐ 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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br><br>**If not describe any equality and diversity issues that may be relevant.**<br><br>*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)*<br><br>☒ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |
| **Highlights relating to protected characteristics in paper** | |
| | |

Kent Community Health
NHS Foundation Trust

| | | | |
|---|---|---|---|
| Name: | Gordon Flack | Job title: | Acting Chief Executive |
| Telephone number: | 01622 211902 | Email | Gordon.flack@nhs.net |

Kent Community Health
NHS Foundation Trust

# CHIEF EXECUTIVE'S REPORT
# May 2022

Since the last time the board met in public (February 2022) Mairead McCormick has been appointed substantive Chief Executive for the Trust and will commence on 1st July, this is my last chief executive report to the Board as Acting Chief Executive and I have been pleased the Trust has continued to make progress in recovering from COVID and serving the local population.

I 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. Edenbridge

The NHS, local council and development/construction partners joined together with local people and Tonbridge and Malling MP, Tom Tugendhat, for the ground-breaking ceremony on the development site in Four Elms Road, Edenbridge.

Combining services from Kent Community Health NHS Foundation Trust and Edenbridge Medical Practice, the new Edenbridge Memorial Health Centre will include community space and rooms, putting health services at the heart of the community.

Building for the future, the health centre has been designed to be sustainable and fit in with the local environment, including a memorial garden area for conservation and with an emphasis on the health, wellbeing and lifestyle services that will be available under one roof. Services already planned include a GP practice, outpatient services, minor injury unit, x-ray services, therapies and social prescribing.

The development provides a 2,180 square metre of clinical and community space, along with parking and landscaping, with construction due to complete in Autumn 2023.

### 2. Ageing Well

Ageing well investments of £2.5m will support our community frailty service and hospital at home and increasing our urgent community response to support the new 2-hour national target. Recruitment is underway in all areas but there will be a delay in increasing activity in some areas as recruitment did not start until 1st April when funding was confirmed.

Work is ongoing with the commissioners to agree how an additional £1.9 million available funding should be utilised to support home with support. At this stage it is supporting bank and agency usage in KCHFT services but it is anticipated that some of this may be transferred to Kent County Council.

## Our People

### 1. Staff Survey

A detailed paper is on the agenda. When our staff survey results were revealed in March 2022 – with our biggest response rate yet – we were pleased that in five of the seven people promises, KCHFT scored significantly higher when compared to similar organisations. Colleagues told us we are compassionate, inclusive and they feel part of the team. However nationally, results have deteriorated when compared to 2020, including KCHFT and reflected in:

- Pressure remains high on NHS services; colleagues feeling burnt out and exhausted, in line with the national picture
- Number of unpaid and paid additional hours worked has increased
- Levels of emotional exhaustion and frustration with work have increased.

### 2. Staffing pressures

Staff Covid-19 sickness levels has significantly improved - only 17 staff members are off sick or isolating due to Covid-19 as at Monday 16th May. Easing Infection Protection Control protocols in non-clinical areas has removed social distancing.

.

Turnover/ retention levels of improvement are small albeit incremental. April figures show another slight improvement and a three-month positive trend following the peak in January 22; turnover is 17.18% and voluntary turnover is 15.61% whereas March reported turnover at 17.20% and voluntary turnover at 15.85%. This remains a key risk for the Trust.

### 3. International recruitment

The Trust is expecting the first cohort of 13 nurses of the 100 to arrive in June. Pastoral support is in place and we will assist our new recruits to settle in and attain a UK driving licence. Interviews for the next cohort took place beginning of May and 87 provisional offers have been made. Colleagues are investigating an approach to international recruitment for Allied Health Professional roles

### 4. Staff Awards

This year, we want to return to the more traditional evening of glitz and glamour. All shortlisted nominees and the people who nominated them are invited to the evening on 1st July, which includes a three-course meal and entertainment.

There are seven categories, ranging from the popular 'Rising Star' award to 'Employee of the Year', and several more where we can really showcase the incredible work colleagues have done and continue to do.

### 5. Living Wage accreditation

We are now an accredited Real Living Wage Employer. This means that every colleague in the trust will earn at least the Real Living Wage. We are one of only three NHS trusts in the South East and the first in Kent and Medway to get the accreditation.

The Real Living Wage is higher than the government's minimum, or National Living Wage. It is an independently-calculated hourly rate of pay based on the actual cost of living. It's recalculated each year and is announced by the Living Wage Foundation as part of Living Wage Week. At the moment it is £9.90 in the UK, with a higher rate for London, which reflects the higher costs of living in the capital.

KCHFT has committed to pay the Real Living Wage as part of our dedication to supporting our colleagues and the economies of the local communities which we serve and particularly important during a period of pressurised cost of living. While working within the national pay structure, we took our first stride towards full accreditation as a living wage employer in March 2021, increasing the wages of more than 200 of our colleagues. Since then, we have strengthened our commitment, working with third-party service providers and contractors to uplift wages.

## Partnerships

### 1. 2022/23 plan

The Trust budget has been approved and the system plan has been submitted but is not balanced and further work is required to resubmit in June 2022. The Trust has identified cost pressures of around £1.8m related to recent inflationary rises that are well outside of the national planning expectation and risk the breakeven budget agreed in March.

Embedding quality improvement will be a key part of our future; using insight from data and working with our partners to tackle joint challenges. Some key innovations will include expanding our virtual wards, improving urgent care services and taking a leading role in improving mental health and autism services in Kent and Medway. We will also be leading on a digital transformation through the delivery of the Kent and Medway Care Record and continuing to invest in our buildings to improve the environment for our patients.

**Gordon Flack**
**Acting Chief Executive**
**May 2022**

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.1 |
| **Agenda Item Title:** | Board Assurance Framework |
| **Presenting Officer:** | Natalie Davies, Director of Corporate Services |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ Assurance |

**What is the purpose of the paper and the ask of the Committee or Board?**

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**

- New risk – BAF 122 added – Equalities & Diversity
- New risk – BAF 123 added – KCC Social Care

- Risk appetite column added to the BAF
- BAF key updated

**Proposal and/or recommendation to the Committee or Board**

It is proposed the Board reviews any 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?**<br><br>*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.*<br>*You can find out more about EAs here on flo* | ☐ Yes *(please attach)* |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **If not describe any equality and diversity issues that may be relevant.**<br><br>*Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.* | ☒ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |
| **Highlights relating to protected characteristics in paper** | |
| | |

| | | | |
|---|---|---|---|
| Name: | Ben Norton | Job title: | Head of Corporate Services Improvement |
| Telephone number: | 07391861148 | Email | ben.norton@nhs.net |

Updated 5th May 2022

# Appendix 1

NHS
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.

**Confidence Assesment** = This represents the confidence level of the risk being mitigated by the target completion date. High confidence/medium confidence/low confidence

**Appetite score** = This reflects the appetite towards the risk in line with the the trust's position: 1 Minimal/2 Cautious/3 Open/4 Seek/5 Pro-active

**Target Rating** = The risk can be removed from the BAF (and if appropriate onto the directorate risk rgister) once this score is achieved.

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

**Action status key:**

| | |
|---|---|
| Actions completed | G |
| On track but not yet delivered | A |

| ID | Opened | Board Level Risk | Risk Description (Simple Explanation of the Risk) | C | L | Rating | Controls Description | Top Five Assurances | C | L | Rating | Planned Actions and Milestones | | | | Confidence Assess | Appetite | C | L | Target | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Prevent ill health** | | | | | | | | | | | | | | | | | | | | | |
| 108 | March 2020 | Victoria Robinson-Collins | Risk that the extended and on-going response to the pandemic surge & reset will impact on staff stress levels, fatigue and morale to an extent that the delivery of services to patients is compromised.<br><br>Board Committee Lead on Assurance:<br>**Board** | 5 | 4 | 20 | Surge Response Plan<br>Operational Response SRO appointed<br>Incident Team appointed<br>Membership of LHRP<br>Established Battle rhythm reporting and communications plan<br>Wellbeing initiatives for staff Reimagine Team Working and Flex for the Future Projects Wellbeing conversations and inclusion of wellbeing and career conversation in appraisal process | Internal and External Reporting<br>Executive sit-reporting daily<br>Department of Health Response confirmation<br>Operational KPIs<br>LRF area ratings nationwide and local<br>Trust 121 template | 5 | 3 | 15 | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Medium | 5 - Pro-active | 3 | 3 | 9 | **March 2023** |
| | | | | | | | | | | | | Local oversight of the delivery of quality matrix and escalation via PSCRG as indicated | Mercia Spare | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Continue additional staff support and wellbeing mechanisms utilising regional initiatives and funding streams to maximise benefits | Pauline Butterworth<br>Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Regular review of staff turnover, vacancy rates and stability metrics with interventions/ recovery plans tracked through EPR and IPR processes | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Ongoing recruitment campaigns to ensure vacancy rates remain within tolerated thresholds. Utilise all options of potential supply including International Recruitment, Return to Practice and Step into Health | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Promotion and utilisation of flexible working options, opportunities for reasonable adjustments and access to career conversations to enable staff to work for longer whilst balancing carer, health and family commitments whilst increasing engagement | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Regular communications campaigns throughout 2022/23 to support physical and mental health. | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| 110 | July 2020 | Pauline Butterworth | System and partner plans to manage, surge and reset could be insufficiently coordinated to meet the demand resulting in the system being overwhelmed and patients not receiving the services they require. | 5 | 3 | 15 | System led, surge and recovery plans monitoring across the system.<br>Weekly COO collaborative meeting in place to ensure providers are working in a joined-up way..<br>Daily Sitrep reporting - Locally and Nationally.<br>Operational risk and controls logs.<br>Membership of LHRP | System response through LHRP/NHSE<br>Internal and external reporting<br>LRF area ratings | 4 | 3 | 12H | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Medium | 3 - Open | 3 | 4 | 12 | **September 2022** |
| | | | | | | | | | | | | Confirm funding with KCC | Pauline Butterworth | May 2022 | A | | | | | | |
| | | | | | | | | | | | | Work in collaboration with acute provider partners across K&M to manage the risk of the NLFTR caseload (e.g. MADE events) | Pauline Butterworth | September 2022 | A | | | | | | |

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

**Confidence Assesment** = This represents the confidence level of the risk being mitigated by the target completion date. High confidence/medium confidence/low confidence

**Appetite score** = This reflects the appetite towards the risk in line with the the trust's position: 1 Minimal/2 Cautious/3 Open/4 Seek/5 Pro-active

**Target Rating** = The risk can be removed from the BAF (and if appropriate onto the directorate risk rgister) once this score is achieved.

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

| ID | Opened | Board Level Risk | Risk Description (Simple Explanation of the Risk) | C | L | Rating | Controls Description | Top Five Assurances | C | L | Rating | Planned Actions and Milestones | | | | Confidence Assess. | Appetite | C | L | Target | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 115 | February 2021 | Mercia Spare | Risk that the on-going operational pressures combined with staff shortages or skill mix issues as a result of managing high turnover alongside a deterioration in retention, 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 limit services with the resultant impact on the system. Risk that the ongoing nature of the pressure described will impact on staff stress levels, fatigue and morale to an extent that the delivery of services to patients is compromised.<br><br>Board Committee Lead on Assurance: | 5 | 5 | 20 | Active and bespoke recruitment campaigns for key professions i.e. nursing, facilities<br>Weekly staff rota review and escalation paths<br>Patient Safety & Clinical Risk Group<br>IMM meeting - redeployed staff<br>Bank system in place Wellbeing initiatives for staff<br>Reimagine Team Working and Flex for the Future Projects<br>Wellbeing conversations and inclusion of wellbeing and career conversation in appraisal process Retention steering group.<br>KCHFT academy and recruitment to further cohorts with assessment to consider expansion. Regular review of skill mix to ensure full use of MDT i.e. therapists, and over establishment of assistant grades to support registered professionals. | Daily Sit rep<br>IMM report to executive<br>Management of vacancy and turnover rates<br>Oversight of recruitment of workforce metrics by quality committee & board<br>Monthly quality report<br>Twice weekly safer staffing review | 5 | 4 | 20 | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Low | 5 - Pro-active | 2 | 3 | 6 | **March 2023** |
| | | | | | | | | | | | | Safer staffing reviews for community hospitals and hot spot areas weekly | Mercia Spare | May 2022 | A | | | | | | |
| | | | | | | | | | | | | Develop safer staffing model framework for community Nursing | Mercia Spare | May 2022 | A | | | | | | |
| | | | | | | | | | | | | Report safer staffing to execs monthly | Mercia Spare | May 2022 | A | | | | | | |
| | | | | | | | | | | | | Review & streamline the current assessment centre model/process | Victoria Robinson-Collins | Jun 2022 | | | | | | | |
| | | | | | | | | | | | | Financial initiatives to support colleagues who are struggling and considering exiting healthcare as a result | Victoria Robinson-Collins | June 2022 | A | | | | | | |
| | | | | | | | | | | | | On-going recruitment of staff via range of supply streams including international, national and local recruitment. Utilising pipelines including Step into Health, Return to Practice | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Regular review of skill mix to ensure full use of MDT i.e. therapists, and over establishment of assistant grades to support registered professionals. | Pauline Butterworth<br>Victoria Robinson-Collins Mercia Spare | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Local oversight of the delivery of quality matrix and escalation via PSCRG as indicated | Mercia Spare | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Continue additional staff support and wellbeing mechanisms utilising regional initiatives and funding streams to maximise benefits | Pauline Butterworth<br>Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Regular review of staff turnover, vacancy rates and stability metrics with interventions/ recovery plans tracked through EPR and IPR processes | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Ongoing recruitment campaigns to ensure vacancy rates remain within tolerated thresholds. Utilise all options of potential supply including International Recruitment, Return to Practice and Step into Health | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Promotion and utilisation of flexible working options, opportunities for reasonable adjustments and access to career conversations to enable staff to work for longer whilst balancing carer, health and family commitments whilst increasing engagement | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| | | | | | | | | | | | | Regular communications campaigns throughout 2022/23 to support physical and mental health. | Victoria Robinson-Collins | March 2023 | A | | | | | | |
| **Deliver High Quality Care at Home and in the Community** | | | | | | | | | | | | | | | | | | | | | |
| 103 | January 2019 | Gerard Sammon | Within the context of a heightened level of activity and seasonal pressures, the ICS discussions and establishment could impact on the system ability to provide clarity and focus.<br><br>Board Committee Lead on Assurance:<br>**Board** | 4 | 3 | 12H | Programme •Board TORs and membership<br>TORs for: ICP forums, Local Care Boards; Frailty Group; Chief Executives Forum<br>KCHFT Chief Executive as SIRO for East HCB<br>KCHFT Chair is Chair for West Kent ICP<br>System transformation governance structure<br>Involvement and promote mature development of ICS<br>Continue to deliver outstanding healthcare | Local Care Investment received for both east and west Kent - Hospital at Home and Rapid Transfer of Care scheme.<br>Community Care Funding increase in financial settlement<br>Chief Exec report to the board<br>Regular Strategic development update to the board | 4 | 3 | 12H | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Low | 3 - Open | 3 | 3 | 9 | **July 2022** |
| | | | | | | | | | | | | Ensure consistent and co ordinated response to Kent and Medway ICS end state proposals | Gerard Sammon | July 2022 | A | | | | | | |
| | | | | | | | | | | | | Contribute to the production of the ICS system governance that includes composition of the Integrated Care Board (ICB) and its new constitution and BAF | Gordon Flack | July 2022 | A | | | | | | |
| 116 | May 2021 | Gordon Flack | There is significant pressure on social care budgets. KCC's budget for 22/23 includes 7.4% of spending growth and £37.9m of savings/income to balance its budget. There is a risk that KCC won't be able to fund the 22/23 pay award for KCC funded services because of its budget pressures. This is a risk of c. £1.2 million.<br><br>Board Committee Lead on Assurance:<br>**Finance Business and Investment Committee** | 4 | 3 | 12H | KCC have identified budget funding for a 3% average pay award (including NI).<br>There is currently a forecast underspend on services commissioned by KCC, due to vacancies, which will mitigate the risk of the contract not being uplifted by the cost of the pay award. | Contract Agreement LD&A<br>Delivery Partnership, delegated to deliver and micro commission all LDA health and social support agreed.<br>KCC public health partnership agreement and governance structure.<br>Monitoring the financial performance against the budget and the service line reporting position. | 4 | 3 | 12H | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Medium | 3 - Open | 4 | 2 | 6 | **March 2023** |
| | | | | | | | | | | | | Reset the executive partnership relationship KCC/KCHFT | Gordon Flack | May 2022 | A | | | | | | |
| | | | | | | | | | | | | Continue to monitor the financial performance against the budget and service line reporting position. Offsetting any underspend in the services against any income shortfall. | Gill Jacobs | March 2023 | G | | | | | | |
| 121 | Dec 2021 | John Goulston | Transition in the Board at a time of significant system and organisational pressure may impact the boards leadership of the organisation and the ability to respond effectively and in a focused way to the challenges impacting on organisational operation.<br><br>Board Committee Lead on Assurance:<br>**Board** | 4 | 3 | 12H | New CEO successfully appointed<br>Confirmation of Interim CEO<br>Confirmation of interim arrangements to be approved by RemCom | Organisational response e.g.IPR reporting | 4 | 3 | 12H | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Medium | 3 - Open | 4 | 2 | 6 | **May 2022** |
| | | | | | | | | | | | | Swift, detailed and effective Induction process for new NEDs | John Goulston | May 2022 | A | | | | | | |
| | | | | | | | | | | | | Continuation of board and exec development programme in collaboration with our OD partners to uphold positive culture and team working. | Victoria Robinson-Collins | May 2022 | A | | | | | | |

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

**Confidence Assesment** = This represents the confidence level of the risk being mitigated by the target completion date. High confidence/medium confidence/low confidence

**Appetite score** = This reflects the appetite towards the risk in line with the the trust's position: 1 Minimal/2 Cautious/3 Open/4 Seek/5 Pro-active

**Target Rating** = The risk can be removed from the BAF (and if appropriate onto the directorate risk rgister) once this score is achieved.

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

| ID | Opened | Board Level Risk | Risk Description (Simple Explanation of the Risk) | C | L | Rating | Controls Description | Top Five Assurances | C | L | Rating | Planned Actions and Milestones | | | | Confidence Assess. | Appetite | C | L | Target | Target Date (end) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 122 | May 2022 | Victoria Robinson - Collins | Risk that we are not reaching the whole community of our population or our colleagues that do not readily access services or organisational initiatives which may lead to a wider gap in health outcomes, or a marginalisation of voice<br><br>Board Committee Lead on Assurance: | 5 | 3 | 15 | community engagement focussed on health inequalities.<br>Use of data.<br>Increased drive on equality monitoring.<br>Working together groups.<br>Healthy communities steering group focussed on migrant and ethnic minority groups.<br>Health inequalities programme board.<br>Workforce equality steering group.<br>Veteran programme group. | Health inequalities programme board reporting to execs and assurance oversight to Quality Committee and Board.<br>Data from Power BI.<br>EDI strategy with oversight from execs and assurance via Strategic workforce committee and Board.<br>Assurance/advice from independent experts (RedQuadrant).<br>Consideration of staff council. | 4 | 3 | 12H | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Medium | 3 - Open | 2 | 3 | 6 | **May 2023** |
| | | | | | | | | | | | | Establishment of carer champions and triangle of care' | Victoria Robinson-Collins/Ali Carruth | April 22 | G | | | | | | |
| | | | | | | | | | | | | Secure increased resource in health inequalities team. | Victoria Robinson-Collins/Ali Carruth | May 22 | G | | | | | | |
| | | | | | | | | | | | | establishment of health inequalities programme board. | Victoria Robinson-Collins/Ali Carruth | May 22 | A | | | | | | |
| | | | | | | | | | | | | Establishment of veteran network. | Victoria Robinson-Collins/Ali Carruth | June 22 | A | | | | | | |
| | | | | | | | | | | | | Data focussed post/ EDI inequalities | Victoria Robinson-Collins/Ali Carruth | June 22 | | | | | | | |
| | | | | | | | | | | | | Develop reciprocal mentoring programme. | Victoria Robinson-Collins/Ali Carruth | July 22 | A | | | | | | |
| | | | | | | | | | | | | Development of leadership framework and supporting development aligned to EDI charter and pledges. | Victoria Robinson-Collins/Ali Carruth | September 22 | A | | | | | | |
| | | | | | | | | | | | | Recruitment to post of head of health inequalities. | Victoria Robinson-Collins/Ali Carruth | September 22 | A | | | | | | |
| | | | | | | | | | | | | Establishment of inclusion ambassador programme | Victoria Robinson-Collins/Ali Carruth | October 22 | A | | | | | | |
| | | | | | | | | | | | | Delivery of EDI strategy actions, WRES, WDES, Gender pay gap actions and EDS2. | Victoria Robinson-Collins/Ali Carruth | March 23 | A | | | | | | |
| | | | | | | | | | | | | Continued support for established staff networks. | Victoria Robinson-Collins/Ali Carruth | March 23 | A | | | | | | |
| | | | | | | | | | | | | Delivery of equality objectives. | Victoria Robinson-Collins/Ali Carruth | April 23 | A | | | | | | |
| 123 | May 2022 | Pauline Butterworth | There has been a sustained lack of domiciliary care capacity for long term packages of care in the system since July 2021. This is caused by a number of factors including availability of workforce, reduced number of providers in the market place, variation in rates of pay and local authority funding. This issue will get worse when the D2A funding is withdrawn (end Q2). This has a backward chaining impact on system flow and, specifically for KCHFT and will impact the performance of a number of services.<br><br>Board Committee Lead on Assurance:<br>Board | 4 | 5 | 20 | Working with system partners to place additional bed and Hilton capacity in the system to manage demand.<br>Joint work stream with the CCG and KCC to agree a handover of social care delays for pathway 1.<br>Daily sitrep reporting and system level mutual aid.<br>Regular implementation of Opel 4 actions including caseload review, identification of alternative pathways and MADE events. | Internal daily sitrep.<br>System sitrep calls and support from OCC.<br>Shrewd reporting. | 4 | 5 | 20 | **Actions to reduce risk** | **Owner** | **Target Completion** (end) | **Status** | Low | 3 - Open | 3 | 3 | 9 | **April 2023** |
| | | | | | | | | | | | | Escalation of system level risk | Pauline Butterworth | May 22 | A | | | | | | |
| | | | | | | | | | | | | Partnership working with acute providers to maximise the opportunity for pathway 0 discharges and review caseloads | Pauline Butterworth | July 22 | A | | | | | | |
| | | | | | | | | | | | | Regular MADE events | Pauline Butterworth | July 22 | A | | | | | | |
| | | | | | | | | | | | | Partnership working with KCC to agree a trajectory to reduce social care delays in line with end of D2A funding. | Pauline Butterworth | October 22 | A | | | | | | |
| | | | | | | | | | | | | Partnership working with the CCG and other providers to reduce additional beds in the system in line with end of D2A funding | Pauline Butterworth | October 22 | A | | | | | | |

NHS
Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.2 |
| **Agenda Item Title:** | Infection Prevention and Control Board Assurance Framework |
| **Presenting Officer:** | Dr Mercia Spare, Chief Nurse |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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?*

COVID-19 Board Assurance Framework (BAF) is presented to provide assurance to the Board on compliance with Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and other related guidance.

Amendments to the previous submission have been highlighted in purple font.

**Summary of key points**

The Trust remains compliant with the regulatory requirements of the Health and Social Care Act (2008) Code of Practice on the prevention and control of infections and other related guidance.

There continues to be a daily focus on the key actions that will provide the biggest impact on management and prevention of nosocomial infection including

- Hand washing/decontamination
- Patient isolation/cohorting
- Personal protective equipment and social distancing
- Environmental and equipment decontamination
- Ventilation
- Vaccination

Key changes in guidance, actions and mitigation since the last review is highlighted in purple.

**Proposal and/or recommendation to the Committee or Board**

To note the report.

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.**<br><br>*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)*<br><br>☒ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |
| **Highlights relating to protected characteristics in paper** | |
| | |

| | | | |
|---|---|---|---|
| Name: | Dr Mercia Spare | Job title: | Chief Nurse |
| Telephone number: | 07384878317 | Email | mercia.spare@nhs.net |

Classification: Official

Publication approval reference: C1501

# Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Changes to the previous version are shown in Purple text

## Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have further developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with UKHSA Infection prevention and control for seasonal respiratory infections in health and care settings (including SARS-CoV-2) for winter 2021 to 2022and other related infection prevention and control guidance to identify risks associated with COVID-19 and other seasonal respiratory viral infections The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors, and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

**Ruth May**
Chief Nursing Officer for England

## 1. Introduction

As our understanding of COVID-19 has developed, guidance on the required infection prevention and control measures has been published, this has now been updated and refined to reflect the learning from the SARS-CoV-2 and to acknowledge the threat from other respiratory viruses. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users, and staff.

This framework has been developed and updated following updates in the guidance to help providers assess themselves as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors, and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

## 2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self -employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co- operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work. Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of SARs-CoV-2 and other seasonal respiratory viruses, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed, and mitigated effectively.

# Infection prevention and control board assurance framework May 2022

**1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks their environment and other users may pose to them**

| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
|---|---|---|---|
| • Systems and processes are in place to ensure that:<br>• a respiratory season/winter plan is in place:<br>• that includes point of care testing (POCT) methods for seasonal respiratory viruses to support patient triage/placement and safe management according to local needs, prevalence, and care services<br>• to enable appropriate segregation of cases depending on the pathogen.<br>• plan for and manage increasing case numbers where they occur.<br>• a multidisciplinary team approach is adopted with hospital leadership, estates & facilities, IPC Teams and clinical staff to assess and plan for creation of adequate isolation rooms/units as part of the Trusts winter plan.<br>• health and care settings continue to apply COVID-19 secure workplace requirements as far as practicable, and that any workplace risk(s) are mitigated for everyone.<br>• Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are:<br>• based on the measures as prioritised in the hierarchy of controls. including evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new variants of concern in the local area.<br>• applied in order and include elimination; substitution, engineering, administration and PPE/RPE.<br>• communicated to staff.<br>• safe systems of working; including managing the risk associated with<br>• infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems.<br>• if the organisation has adopted practices that differ from those<br>• recommended/stated in the national guidance a risk assessment has been completed and it has been approved through local governance procedures, for example Integrated Care Systems.<br>• risk assessments are carried out in all areas by a competent person with the skills, knowledge, and experience to be able to recognise the hazards associated with respiratory infectious agents.<br>• if an unacceptable risk of transmission remains following the risk assessment, the extended use of Respiratory Protective Equipment (RPE) for patient care in specific situations should be considered.<br>• ensure that patients are not transferred unnecessarily between care areas unless, there is a change in their infectious status, clinical need, or availability of services.<br>• the Trust Chief Executive, the Medical Director or the Chief Nurse has oversight of daily sitrep.in relation to COVID-19, other seasonal respiratory infections, and hospital onset cases<br>• there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas.<br>• resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external contractors).<br>• the application of IPC practices within this guidance is monitored, e.g.:<br>• hand hygiene.<br>• PPE donning and doffing training.<br>• cleaning and decontamination.<br>• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board.<br>• the Trust Board has oversight of ongoing outbreaks and action plans.<br>• the Trust is not reliant on a particular mask type and ensure that a range of predominantly UK Make FFP3 masks are available to users as required. | • A task and finish group has completed a seasonal virus risk assessment (respiratory and enteric). This will now form a management plan for the incidence of multiple virus'.<br>• Lateral flow testing in place; patient facing staff testing twice per week; electronic system in place to monitor, and results uploaded to NHSHSA POCT centre.<br>• Additionally, where outbreaks identified, contact tracing using PCR tests are in place for patients. Staff are using LFTs.<br>• Symptomatic patient testing for COVID remains in place. Testing for influenza A, B and RSV is discussed with Microbiologist in the first instance.<br>• Point of care testing (PoCT) s explored with peer providers however:<br>  ○ PoCT infrastructure requirements are not suitable for disparate community setting.<br>  ○ Patients now have an LFT carried out on Day 3 & Day 6 following admission as per national guidance. RIO Infection Prevention status form has been amended to facilitate recording of this and facilitate performance team to extrapolate that data.<br>• Patients are isolated/cohorted according to results of PCR and LFT results.<br>• MDT approach is in place with estates and facilities. This includes discussions regarding isolation facilities where indicated.<br>• As part of the guidance review of September 2021, the team have reviewed the requirement for the hierarchy of controls against current working practice and are assured that the current risk assessment encompasses the 5 domains of the hierarchy of controls.<br>• Operational capacity to care for patients are considered as part of the admission criteria and the weekly safer staffing reviews, this includes acuity | | |

| | | | |
|---|---|---|---|
| | monitoring.<br>• The DIPC and IPC team receive the daily PHE communicable disease reports for Kent Surrey and Sussex which details variant related outbreak activity. We also participate in system networks<br>• Staff wear a FFP3 mask for delivering care to patients with a confirmed or suspected respiratory virus such as COVID. Ongoing FFP3 fit testing in place as per resilience principles.<br>• When unacceptable risk of transmission is identified further risk assessment is undertaken to consider any alternative/extended RPE equipment required. A trigger and escalation tool is in development in response to recent guidance for the implementation of RPE.<br>• All outpatient departments & MIU/UTC assess prior to attendance (UTC's utilising 111 appointments). Patients assessed again on arrival – flow charts for these processes. Domiciliary – assessed via phone, and in person before entering.<br>• Staff risk assessments in place to support management of staff which was developed as a system.<br>• National guidance has been implemented as published.<br>• Patients only moved if deteriorate and require admission to Acute OR if their infectious status changes<br>• Director level approval of COVID-19 sitreps in place.<br>• The Board and Governors are visible in operational and infrastructure services and are able to challenge as necessary.<br>• There is a monthly audit of performance with IP&C guidance and facilities management.<br>• The IP&C BAF is presented at the quality committee which is reported to each Board meeting.<br>• The Quality Committee receives updates on outbreaks and reports to the board.<br>• Inpatients are screened on admission using PCR, day 3 and day 6 using LFT. Screening also if patients have onset of symptoms and day 3 of symptoms, isolated/cohorted until 2 negative results | | |

| | | | |
|---|---|---|---|
| | received (flow chart updated with latest swabbing guidance on intranet) – and IPC team record all results of the swabs from symptomatic patients.<br>• Where cohorting is required, all IPC measures implemented, and when 'stepped down' terminal cleans undertaken – evidenced on deep clean checklist<br>• Discharge letters include information on patient results and length of isolation requirements if positive or exposed. All patients screened using PCR 48/72 hours prior to discharge if going to care home / vulnerable people at home<br>• IPC team supporting teams, inpatient visits – checklists and monitoring and audits<br>• Reviewed by IPC team on visits – team leads reviewing<br>• Periodic checks by H&S teams through safer space champions.<br>• Mandatory training programme – current compliance 94.5%<br>• Training in place for donning and doffing PPE and COVID information pages on flo<br>• Back to basic focused comms campaign targets hand hygiene, equipment cleaning, spacing and PPE and links to national resources and posters for local print and display<br>• IPC training provided both electronic and face to face where required. Full PPE info on Flo, and posters available. Flow chart put in place with latest PPE guidance.<br>• Fit-testing training programme in place on multiple masks for all staff that perform AGPs or work in areas where AGPs are performed & for staff to whom will be delivering care for patients with suspected or confirmed respiratory virus such as COVID.<br>• All guidance reviewed, discussed at IMM, and changes implemented where required, through internal cascade system, as well as on internal intranet.<br>• Risks highlighted on Datix and discussed through IMM, any high risks, on Trust BAF<br>• All IPC policies remain in date and reviewed within agreed timescales.<br>• Director level approval of COVID-19 sitreps in place. | | |

| | | | |
|---|---|---|---|
| | • Outbreak management team is minuted and common themes reported to DIPC and bimonthly to IPCAS.<br>• Overarching data provided to performance team daily, presented through IPCAS and in daily exec sitrep. Reported to Quality committee and to board.<br>• IP&C audit programme in place. Evidence of compliance assessed twice per month<br>• Chief Nurse hosts weekly calls with Matrons.<br>• Ward huddles and key focus areas include PPE awareness and key risk information.<br>• Comms remains live to changes in guidance for NHS staff and reiteration of expectations for all work-related activity | | |

**2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**

| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
|---|---|---|---|
| • Systems and processes are in place to ensure that:<br>• the Trust has a plan in place for the implementation of the National Standards of Healthcare Cleanliness and this plan is monitored at board level.<br>• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms<br>• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.<br>• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.<br>• Where patients with respiratory infections are cared for: cleaning and decontamination are carried out with neutral detergent or a combined solution followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance.<br>• if an alternative disinfectant is used, the local infection prevention and control team (IPCT) are consulted on this to ensure that this is effective against enveloped viruses.<br>• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.<br>• a minimum of twice daily cleaning of:<br>• patient isolation rooms.<br>• cohort areas.<br>• Donning & doffing areas<br>• 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails.<br>• where there may be higher environmental contamination rates, including:<br>• □ toilets/commodes particularly if patients have diarrhoea.<br>• A terminal/deep clean of inpatient rooms is carried out:<br>• following resolutions of symptoms and removal of precautions.<br>• when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens);<br>• following an AGP if room vacated (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room).<br>• reusable non-invasive care equipment is decontaminated:<br>• between each use.<br>• after blood and/or body fluid contamination<br>• at regular predefined intervals as part of an equipment cleaning protocol<br>• before inspection, servicing, or repair equipment.<br>• Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment.<br>• As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national | • IPC training updated to incorporate COVID-19 information, donning and doffing, viral swabbing, and face to face fit test training including donning and doffing. Facilities staff have received training, and where appropriate have been fit tested.<br>• Non COVID-19 areas cleaned and visited prior to COVID-19 areas.<br>• Patient information available and the offer of masks for patients is risk assessed.<br>• Terminal clean checklists - utilising Chlorine 1000 ppm in place<br>• Implemented – daily cleaning sheets in place and undertaken twice daily if outbreaks are declared.<br>• Chlorclean/titan chlorine-based cleaning solutions are in place for outbreaks/ isolation areas.<br>• National cleaning standards are measured and audited in all areas.<br>• Revised National cleaning standards published in April 2021. Working group in place to identify any required amendments from current processes.<br>• Frequent touch areas cleaned as part of daily schedules and in addition when visibly contaminated.<br>• Ward checklist for daily equipment - evidenced | | |

| | | | |
|---|---|---|---|
| recommendations for minimum air changes refer to country specific guidance.<br>• In patient Care Health Building Note 04-01: Adult in-patient facilities.<br>• the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer.<br>• a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways<br>• where possible air is diluted by natural ventilation by opening windows and doors where appropriate<br>• where a clinical space has very low air changes and it is not possible to increase dilution effectively, alternative technologies are considered with Estates/ventilation group.<br>• when considering screens/partitions in reception/ waiting areas, consult with estates/facilities teams, to ensure that air flow is not affected, and cleaning schedules are in place. | on IPC team checklist<br>• Linen and laundry handled in line with national guidance and checked on all observational audits<br>• Where possible equipment is single use<br>• Equipment cleaning protocols in place – evidenced on checklists by IPC team<br>• Monthly audits by facilities and presented at IPCAS<br>• Mechanical ventilation, air flow and air change compliance has been reviewed and is currently subject to discussions with landlords for any remedial works.<br>• Currently no specialist ventilation is in place across the estate. Window opening regime in place.<br>• Policy and protocols in place for decontamination of all equipment which includes the elements outlines. Checks lists are located on all clinical units and IPC check these as part of their checklist. As part of the safer space programme staff are required to clean all IT equipment and desk spaces before and after use.<br>• New cleaning standards for 2021 being reviewed via a task and finish group to identify any changes required to current audit and reporting regimen. | | |
| 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
| • Systems and process are in place to ensure that:<br>• arrangements for antimicrobial stewardship are maintained previous antimicrobial history is considered<br>• the use of antimicrobials is managed and monitored:<br>○ to reduce inappropriate prescribing.<br>○ to ensure patients with infections are treated promptly with correct antibiotic.<br>• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.<br>• risk assessments and mitigations are in place to avoid unintended consequences from other pathogens. | • IPCAS held bimonthly, antimicrobials Task and Finish group for antimicrobial stewardship in place.<br>• PGD audit programme in place undertaken by pharmacy.<br>• Pharmacy techs on wards weekly support prudent prescribing. | • Currently audit of antimicrobial prescribing in inpatient wards only completed annually. | • Prescribing data presented to IPCAS bimonthly for discussion and action.<br>• Board oversight of antimicrobial stewardship will be through quality committee quarterly updates. |
| 4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion. | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
| Systems and processes are in place to ensure that:<br>• visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported whilst maintaining the safety and wellbeing of patients, staff and visitors<br>• national guidance on visiting patients in a care setting is implemented.<br>• restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment.<br>• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face | • Guidance on Intranet, reflect national guidance. This has been updated on flo in response to recent updated in guidance in April 2022.<br>• All patients in inpatient units cohorted or in side-rooms as per IP&C guidance. In non- | | |

| | | | |
|---|---|---|---|
| covering and physical distancing.<br>• if visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM.<br>• visitors with respiratory symptoms should not be permitted to enter a care<br>• area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (eg, parent/child) a risk assessment may be undertaken, and mitigations put in place to support visiting wherever possible.<br>• visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian.<br>• Implementation of the Supporting excellence in infection prevention and control behaviors Implementation Toolkit has been adopted C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk) | inpatient areas, specific rooms / streaming in place for segregation of potential symptomatic / non-symptomatic patients, and SOP's in local services for this<br>• Available on Internet and Intranet – easy read version in process for most information<br>• Patients and visitors accessing our buildings are currently required to wear face coverings/masks and PPE where indicated.<br>• Discharge and transfer information identifies COVID-19 status and date of swab.<br>• Patient information leaflets for patients able to read, visual posters from PHE for those who are unable to.<br>• There is a programme in place in pre-work considerations against the tool kit has been done planned rollout in 2022. | | |
| 5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
| Systems and processes are in place to ensure that:<br>• signage is displayed prior to and on entry to all health and care settings instructing patients with respiratory symptoms to inform receiving reception staff, immediately on their arrival.<br>• infection status of the patient is communicated to the receiving organisation, department or transferring services, when a possible or confirmed seasonal respiratory infection needs to be transferred.<br>• staff are aware of agreed template for screening questions to ask.<br>• screening for COVID-19 is undertaken prior to attendance wherever possible to enable early recognition and to clinically assess patients prior to any patient attending a healthcare environment.<br>• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19/ other respiratory infection symptoms and segregation of cases to minimise the risk of cross-infection as per national guidance.<br>• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible.<br>• there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved.<br>• patients with suspected or confirmed respiratory infection are provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated.<br>• patients with respiratory symptoms are assessed in a segregated area, ideally a single room, and away from other patients pending their test result.<br>• patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing.<br>• patients at risk of severe outcomes of respiratory infection receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare eg, priority for single room isolation and risk for their<br>• families and carers accompanying them for treatments/procedures must be<br>• considered.<br>• where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes.<br>• face masks/coverings are worn by staff and patients in all health and care facilities.<br>• where infectious respiratory patients are cared for physical distancing remains at 2 metres distance.<br>• patients, visitors, and staff can maintain 1 metre or greater social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, eg, to protect reception staff.<br>• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced | • All services have triage questions and SOPs in place<br>• In wave 1 joint work implemented between primary care and KCHFT to identify vulnerable patients. KCHFT assessments and flow charts identify the appropriate pathways for these patients (e.g. home visit, clinic or virtual assessment).<br>• Triage questions at entrance to hospitals / services / prior to domiciliary visits<br>• Services have own questions – based on national triage form<br>• Initial triage for allocation of waiting room etc. undertaken by receptionist – clinical staff triage in MIU/UTC as appropriate<br>• All staff has an individual COVID risk assessment completed. This is updated when any changes occur for the individual or / and annually.<br>• Staff wear TIIR masks in all Clinical buildings.<br>• Patients are encouraged by staff to wear face masks when mobilising around the ward.<br>• All patients are requested to wear masks when unable to socially distance, and when not detrimental to | Signage is being confirmed across all locations to ensure consistent. | |

| | | | |
|---|---|---|---|
| promptly.<br>• isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative.<br>• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately. | health or care. Posters and leaflets available to encourage this.<br>• Mandatory face coverings, all comms ask patients and visitors to comply.<br>• Patient information leaflet (for those that can read) Poster visual prompts<br>• Inpatients are screened on admission using PCR, & day 3 and 6 using LFT and at onset of symptoms, isolated / cohorted until 2 negative results received (flow chart on intranet) – and IPC team records all symptomatic swab results Wards record all patient swabs on RIO infection prevention status form.<br>• Isolated at assessment as required<br>• Monthly audit of compliance to screening | | |
| 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
| • appropriate infection prevention education is provided for staff, patients,<br>• and visitors.<br>• training in IPC measures is provided to all staff, including: the correct use of PPE including an initial face fit test/and fit check each time when wearing a filtering face piece (FFP3) respirator and the correct technique for putting on and removing (donning/doffing) PPE safely.<br>• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely put it on and remove it;<br>• adherence to national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.<br>• gloves are worn when exposure to blood and/or other body fluids, non-<br>• intact skin or mucous membranes is anticipated or in line with SICP's and<br>• TBP's.<br>• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.<br>• staff maintaining physical and social distancing of 1 metre or greater wherever possible in the workplace<br>• staff understand the requirements for uniform laundering where this is not provided for onsite.<br>• all staff understand the symptoms of COVID-19 and take appropriate action if they or a member of their household display any of the symptoms (even if experiencing mild symptoms) in line with national guidance.<br>• to monitor compliance and reporting for asymptomatic staff testing<br>• there is a rapid and continued response to ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals).<br>• positive cases identified after admission who fit the criteria for investigation should trigger a case investigation. Two or more positive cases linked in time and place trigger an outbreak investigation and are reported. | • Full guidance on Flo, shared through communication channels.<br>• In community services car sharing is not always avoidable due to students or high dependency of some patients etc., therefore clear guidance provided to staff to reduce risk. Staff advised to wear fluid repellent surgical mask.<br>• IPC training continues, Fit-testing continues, records held centrally by EWD and reported biweekly to IPC team<br>• Dedicated fit tester in place who maintains compliance on multiple masks.<br>• PPE not re-used unless re-usable or sessional<br>• Decontamination options available (visors)<br>• COVID-19 Datix reporting in place<br>• IPC team visit wards and complete feedback and checklists twice per month<br>• 6 steps hand hygiene posters, respiratory hygiene posters. PPE poster prompts in place<br>• Floor signage for social distancing in place and being reviewed in light of the recent guidance<br>• Documented cleaning checked in IPC audits / checklists<br>• Clear guidance on intranet, posters and through Trust comms | | |

| | | | |
|---|---|---|---|
| | • Hand Hygiene assessments formally reported monthly through IPC team for inpatient areas, non-inpatient service report locally and report issues and risks to IPCAS twice per year<br>• Hand air-dryers in non-clinical areas (offices) have these, none in clinical settings<br>• Posters / soap dispensers have hand hygiene technique in toilets and bathrooms<br>• Staff guidance on intranet and policy for uniform laundering<br>• Staff testing available through national tier 1, LFTs and symptoms displayed throughout comms and intranet, updated when nationally updated<br>• COVID-19 undergoes daily review of cases internally, daily regional information shared, weekly IPC CCG and NHSI/E IPC team meet. RCA's for single cases >15-day acquisitions, outbreaks for 2 cases.<br>• Outbreak policy in place and updated since COVID – alongside updated protocols, incorporating reporting arrangements | | |
| 7. Provide or secure adequate isolation facilities | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
| Systems and processes are in place to ensure:<br>• that clear advice is provided, and monitoring is carried out of inpatients compliance with wearing face masks (particularly when moving around the ward or healthcare facility) providing it can be tolerated and is not detrimental to their (physical or mental) care needs.<br>• separation in space and/or time is maintained between patients with and without suspected respiratory infection by appointment or clinic scheduling to reduce waiting times in reception areas and avoid mixing of infectious and non-infectious patients.<br>• patients who are known or suspected to be positive with a respiratory pathogen including COVID-19 where their treatment cannot be deferred, their care is provided from services able to operate in a way which minimise the risk of spread of the virus to other patients/individuals.<br>• patients are appropriately placed ie, infectious patients in isolation or cohorts.<br>• ongoing regular assessments of physical distancing and bed spacing, considering potential increases in staff to patient ratios and equipment needs (dependent on clinical care requirements).<br>• standard infection control precautions (SIPC's) are used at point of care for patients who have been screened, triaged, and tested and have a negative result<br>• the principles of SICPs and TBPs continued to be applied when caring for the deceased | • Confirmed COVID-19 bays / rooms on inpatients units identified by isolation posters. MIU's UTC's identified 'Hot' rooms and routes through which patients enter<br>• Cohorts / rooms in inpatient wards, in out-patients areas zoning as appropriate with identified rooms for COVID-19 positive or symptomatic people<br>• Bays have 2 metre bed spacing – curtains drawn (when safe and appropriate to do so) between beds space, and patients asked not to enter other bed spaces (where they are able to comply)<br>• IPC team review placement daily with clinical staff<br>• Policy for caring for the deceased in place and available on flo which includes COVID positive patients. | • Limited single rooms in some settings<br>• Formal compliance with patient use of facemasks being developed. | • Non COVID-19 areas cleaned and visited prior to COVID-19 areas.<br>• Lateral flow testing in place for staff twice weekly.<br>• Zoning, identified hot rooms, SOP's for flow SOP's for cleaning if high risk patients attend. Identified processes for waiting externally (as appropriate) and escorted in buildings<br>• Single rooms prioritised, and cohorting of patients implemented.<br>• IP&C team observational audit when visiting clinical areas. |
| 8. Secure adequate access to laboratory support as appropriate | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |

| | | | |
|---|---|---|---|
| There are systems and processes in place to ensure:<br>• testing is undertaken by competent and trained individuals.<br>• patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance;<br>• staff testing protocols are in place<br>• there is regular monitoring and reporting of the testing turnaround times, with focus on the time taken from the patient to time result is available.<br>• there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data).<br>• screening for other potential infections takes place.<br>• that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission.<br>• that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise.<br>• that all emergency admissions who test negative on admission are retested for COVID-19 on day 3 of admission, and again between 5-7 days post admission.<br>• that sites with high nosocomial rates should consider testing COVID-19 negative patients daily.<br>• that those being discharged to a care home are tested for COVID-19, 48 hours prior to discharge (unless they have tested positive within the previous 90 days), and result is communicated to receiving organisation prior to discharge.<br>• those patients being discharged to a care facility within their 14-day isolation period are discharged to a designated care setting, where they should complete their remaining isolation as per national guidance<br>• there is an assessment of the need for a negative PCR and 3 days self-isolation before certain elective procedures on selected low risk patients who are fully vaccinated, asymptomatic, and not a contact of case suspected/confirmed case of COVID-19 within the last 10 days. Instead, these patients can take a lateral flow test (LFT) on the day of the procedure as per national guidance. | • All patients screened within 24 hours of admission with PCR and processed by external laboratories Turnaround times outside of our control but there are no delays in results.<br>• Day 3 & Day 6 admission swabs are carried out by LFTs. Staff shown and given instructions how to swab<br>• Daily reporting of staff positive cases via IMM and for executive sitrep.<br>• MRSA, CDI and UTI/CAUTI protocols in place.<br>• All screening protocols implemented, and audited outbreak screening discussed at outbreak meetings<br>• Swabs taken, and IPC support wards as required with obtaining results.<br>• Specialist clinical advice is available from both Acute trusts via clinical microbiologists/virologists.<br>• Point of care testing (PoCT) for patients explored with peer providers however:<br>• PoCT infrastructure requirements are not suitable for disparate community setting.<br>• Due to minimal direct referral in to community hospitals, requirement for Lateral flow testing is only used for Day 3 & Day 6 admission swab. All patients are routinely screened on 24 hours of admission using PCR and if indicated, isolated until results known.<br>• Discharge letters include information on patient results and length of isolation requirements if positive or exposed. All patients screened using PCR 48/72 hours prior to discharge if going to care home / vulnerable people at home<br>• Elective Podiatric surgery only Low risk pathway – separate entrances and flow.<br>• Updated guidance for green pathways published on 27/09/2021.Following review all patients now screened prior to surgery using Lateral flow tests as opposed to PCR. | | |
| 9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |

| | | | |
|---|---|---|---|
| Systems and processes are in place to ensure that<br>• the application of IPC practices are monitored and that resources are in place to implement and measure adherence to good IPC practice. This must include all care areas and all staff (permanent, agency and external<br>• contractors).<br>• staff are supported in adhering to all IPC policies, including those for other alert organisms.<br>• safe spaces for staff break areas/changing facilities are provided.<br>• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of an outbreak.<br>• all clinical waste and linen/laundry related to confirmed or suspected COVID- 19 cases is handled, stored and managed in accordance with current national guidance.<br>• PPE stock is appropriately stored and accessible to staff who require it. | • Checklist and audit by IPC team, data reporting for alert organisms<br>• All Guidance reviewed daily, and updated when national changes occur within 24-48 hours. Immediate risks are communicated vis Flo<br>• Dedicated PPE team in place to manage stock and logistics.<br>• Stocks of correct PPE available, information on stock levels reported via Flo for staff. Stored within multiple locations/hubs for ease of access.<br>• Waste audit in place compliant with national guidance.<br>• Linen and laundry handled in line with national guidance and checked on all observational audits | | |
| 10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection | | | |
| Key lines of enquiry | Evidence | Gaps in assurance | Mitigating actions |
| Systems and processes are in place to ensure that:<br>• staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy.<br>• bank, agency, and locum staff follow the same deployment advice as permanent staff.<br>• staff who are fully vaccinated against COVID-19 and are a close contact of a case of COVID-19 are enabled to return to work without the need to self-isolate (see Staff isolation: approach following updated government guidance)<br>• staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE.<br>• a fit testing programme is in place for those who may need to wear respiratory protection.<br>• where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will:<br>• lead on the implementation of systems to monitor for illness and absence.<br>• facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce<br>• lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19<br>• encourage staff vaccine uptake.<br>• staff who have had and recovered from or have received vaccination for a specific respiratory pathogen continue to follow the infection control precautions, including PPE, as outlined in national guidance.<br>• a risk assessment is carried for health and social care staff including pregnant and specific ethnic minority groups who may be at high risk of complications from respiratory infections such as influenza and severe illness from COVID-19.<br>• A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups;<br>• that advice is available to all health and social care staff, including specific advice to those at risk from complications.<br>• Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff .<br>• A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff.<br>• vaccination and testing policies are in place as advised by occupational health/public health.<br>• staff required to wear FFP3 reusable respirators undergo training that is compliant with HSE guidance and a record of this training is maintained and held centrally/ESR records.<br>• staff who carry out fit test training are trained and competent to do so.<br>• all staff required to wear an FFP3 respirator have been fit tested for the model being used and this should be repeated each time a different model is used.<br>• all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks | • Managerial support, OH only for management referrals, not routine OH monitoring, contact tracing for COVID-19 or COVID vaccination.<br>• Individual risk assessments completed for ALL staff, including those in at risk groups<br>• Risk assessments undertaken and completed for ALL BAME and pregnant staff. Updated guidance communicated to managers via Infrastructure divisional meeting.<br>• Fit-testing in place – recorded through EWD<br>• Trained dedicated fit-testers through fit-test programme utilising approved resources and competency assessments.<br>• Portacount training by company rep and Fit – to – FIT company completed and two machines purchased.<br>• Fit-test results reported and recorded locally and centrally.<br>• Since Nov 2020 all staff trained on multiple masks, as per resilience principles, to enable choice and responsiveness to changes in push stock.<br>• HR processes in place ensure risk assessments are acted upon to limit occupational exposure to COVID-19.<br>• Voluntary staff vaccination programme in place for COVID and | | |

| | | | |
|---|---|---|---|
| • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation.<br>• those who fail a fit test, there is a record given to and held by employee and centrally within the organisation of repeated testing on alternative respirators and hoods.<br>• that where fit testing fails, suitable alternative equipment is provided.<br>• Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions.<br>• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm.<br>• a documented record of this discussion should be available for the staff member and held centrally within the organisation, as part of employment record including Occupational health.<br>• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board.<br>• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance.<br>• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace risk(s) are mitigated maximally for everyone.<br>• staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing.<br>• staff who test positive have adequate information and support to aid their recovery and return to work. | Flu with uptake reported to Board and committees.<br>• IPC team report numbers of staff fit-tested in PSCRG report monthly<br>• Guidance information on Flo, shared internally, implemented through SOP's and challenged on IPC team walkabouts, and H&S walkabouts<br>• Face-mask SOP's in place and evidenced<br>• E-roster reporting tool in place. HR policy on Flo for testing through national portal<br>• Lateral flow testing in place for staff twice weekly. | | |

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.3 |
| **Agenda Item Title:** | Audit and Risk Committee Chair's Assurance Report |
| **Presenting Officer:** | Pippa Barber, Deputy Chair of Audit and Risk Committee |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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 meetings held on 16 May 2022 and provides assurance to the Board.

**Summary of key points**

The May meeting covered a range of topics including the annual report and accounts, external audit report and opinion and head of internal audit annual report and audit opinion. The Committee is also discussed the risk management strategy and risk appetite.

**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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.**<br><br>*Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy* | ☐ Yes *(please attach)*<br><br>☒ No<br>*(please provide a summary of the protected characteristic* |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| *and maternity, race, religion or belief, sex and sexual orientation.* | *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 (ARAC) CHAIR'S ASSURANCE REPORT

This report is founded on the Audit and Risk Committee meeting held on 16 May 2022.

| Area | Assurance | Items for Board's consideration and/or next steps |
|---|---|---|
| Annual Report and Accounts 21-22 | *Reasonable Assurance* | On track for Board sign off on 16 June. Board members will receive Annual Report final draft during the first week of June. |
| Auditors' Annual Reports | *Reasonable Assurance* | Internal Audit Annual Assessment likely to be ''reasonable assurance.'' Anti-Crime Service Annual Report confirmed that no frauds are meeting reporting materiality levels, no control weaknesses, counter-fraud well embedded in the Trust and a likely green rating for Fraud National Functional Standards. |
| Auditors Progress Reports | *Limited Assurance* | Limited assurance for 'estates moves and changes' report (lack of strategic oversight and inefficient processes also not being complied with). Both auditors and management provided verbal reassurance based on the remediation activity undertaken since the report's field work was done in Q4 2021. Internal Audit is to do a formal follow up between July and September and ARAC to have a deep-dive on Estates at the Committee's September meeting. |
| Risk Management and Board Assurance Framework (BAF) | *Reasonable Assurance* | The latest BAF update needs to unbundle some of the risks particularly health inequalities and equality, diversity and inclusion (EDI). Further work |

| Area | Assurance | Items for Board's consideration and/or next steps |
|---|---|---|
| | | done on risk appetite which will be shared with Board (themes include practical application, when things go wrong, use in Board papers). |
| Governance | *Reasonable Assurance* | Previous concern of fire risk training in community hospitals remediated: now 93% (+12%). Further analysis of the increasing number of quality risks to be undertaken. |
| Financial Matters | *Reasonable Assurance* | Single Tender Waiver for £4.7m (until 2025) Channel Health Alliance (UTC subcontractors). Recommend the Finance, Business and Investment Committee (FBI) to consider process for subcontractor selection. |
| Other | | The ARAC to meet on 13 June to approve the Accounts, Annual Governance Statement and Remuneration Report and final recommendations for Board on 16 June. |

**Peter Conway**
**Chair, Audit and Risk Committee**
**16 May 2022**

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.4 |
| **Agenda Item Title:** | Charitable Funds Committee Chair's Assurance Report and Minutes |
| **Presenting Officer:** | Nigel Turner, Chair of Charitable Funds Committee |
| **Action – this paper is for:** | ☐ Decision<br>☒ Information<br>☒ 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 summarise the Charitable Funds Committee meeting held on 29 April 2022 and includes the confirmed minutes of the meeting held on 20 January 2022.

**Summary of key points**

**Proposal and/or recommendation to the Committee or Board**

The Board is asked to receive the Charitable Funds Committee Chair's Assurance Report and the approved minutes.

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.**<br><br>*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)*<br><br>☒ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |

Kent Community Health
NHS Foundation Trust

| **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: | Nigel Turner | Job title: | Non-Executive Director |
| Telephone number: | 01622 211906 | Email | |

Kent Community Health NHS Foundation Trust

# CHARITABLE FUNDS COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Charitable Funds Committee meeting held on 29 April 2022

| Agenda item | Assurance and Key points to note | Further actions and follow up |
|---|---|---|
| Board Assurance Framework (BAF) | A discussion around the board assurance framework concluded that a specific board assurance framework risk should be drafted and brought to Committee. | A Charitable Funds Committee board assurance framework risk to be brought to the July Committee meeting. |
| Annual statement 2021/22 | The Committee reviewed the annual statement. A discussion around a recent material legacy concluded that a paper be brought to Committee adding formal detail around the background, any restrictions and accounting treatments. | A paper to be forwarded to Committee detailing the recent legacy. In addition, an action was taken away to explore the extent to which, prior to the July Committee meeting, prompt clearance could be arranged for fund managers to begin processing the legacy and also any appropriate marketing and comms. |

| Agenda item | Assurance and Key points to note | Further actions and follow up |
|---|---|---|
| Quarter four Finance Update | A discussion around the update took place including a summary of spending. A fundraising event at Hever Castle which raised £7,700 was included. | |
| Heron Ward, Queen Victoria Memorial Hospital, Herne Bay refurbishment | A detailed verbal update on the Heron Ward refurbishment included a discussion over the treatment of the Charitable Funds contribution of £215k plus VAT + fees which was proposed would be drawn from the previous Mermikides donation. The Committee received assurance that the funds had been allocated appropriately. | A paper detailing the breakdown of costs and treatments to be circulated to Committee members. |
| Charitable Funds Marketing Report | A presentation "i-care January - March 2022" was shared on screen. Content included: the 'gift of play' appeal, the fun-to-go bike, and also work on the Heron Ward. | The presentation to be shared with Committee members. |
| Bid ideas 2022/23 | Fund managers shared updates and bid ideas going forwards. Key points included:<br>• Support to staff awards and long service had been received and approved. Requests were coming in to improve staff rest areas and were being considered.<br>• With General funds reaching a sizeable sum, a discussion followed around the response to the 2022 cost of living crisis and the role of the Committee.<br>• An enthusiasm to get timely and serious feedback from staff as to charitable needs and priorities was shared. A consensus to acknowledge the recent material legacy to catalyse a 'big-push' in comms and marketing was shared and agreed. | Conduct a 'big push' (comms and marketing) to staff to gain feedback and ideas and discuss as a committee in the context of the cost of living crisis. |
| Any other business | • Overheads were raised and a discussion followed around appropriateness and value for money<br>• A proposal to raise a budget for the CFC Committee | • A paper detailing overheads and relativities to be |

| Agenda item | Assurance and Key points to note | Further actions and follow up |
|---|---|---|
| | • Discussed that the high-level staff survey results show that the Trust benchmarked well, albeit scores had reduced in several areas. Hot spots would be analysed and themes discussed in focus groups. A full report will come to the next Strategic Workforce Committee.<br>• New Committee members asked that a separate Teams call be arranged by way of a Q and A induction discussion. | circulated for further discussion.<br>• Finance to explore the practicalities of raising 2022/23 budget for the Charitable Funds Committee was agreed.<br>• The previous year's accounts to be circulated.<br>• A Q and A induction Teams call to be set up. |

**Nigel Turner**
**Chair, Charitable Funds Committee**
**29 April 2022**

Kent Community Health NHS Foundation Trust

**CONFIRMED Minutes of the Charitable Funds Committee meeting held on Thursday 20 January 2022**

**MS Teams**

**Present:** Prof. Francis Drobniewski, Non-Executive Director (Chair)
Pippa Barber, Non-Executive Director
Dr Mercia Spare, Chief Nurse

**In Attendance:** Gina Baines, Committee Secretary (minute-taker)
Jo Bing, Assistant Financial Accountant
John Goulston, Trust Chair
Jo Treharne, Head of Campaigns
Carl Williams, Head of Financial Accounting (agenda item 2.1)

**001/22 Welcome and apologies for absence**

Francis Drobniewski welcomed everyone present to the meeting of the Charitable Funds Committee.

Apologies were received from Pauline Butterworth, Chief Operating Officer; Victoria Cover, Head of Clinical Services Urgent Care and Hospitals and Claire Poole, Deputy Chief Operating Officer.

The meeting was quorate.

Francis Drobniewski thanked Sola Afuape, non-executive director for her hard work on the Committee during her term of service. He also thanked Carol Coleman, Public Governor Dover and Deal for her input during her time on the Committee.

**002/22 Declarations of interest**

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

**003/22 Minutes of the previous meeting held on 17 November 2021**

The minutes were read for accuracy.

The Minutes were **AGREED**.

**004/22 Matters Arising of the meeting of 17 November 2021**

The Matters Arising Table Actions Closed was agreed.

Jo Bing commented that she had not had contact from Kim Novis, the Equality, Diversity and Inclusion Lead. Mercia Spare explained that she was on sick leave and would be returning to work shortly. It was agreed to keep action 025/21 Any Other Business open and that Jo Bing would be the new action owner.

The outstanding Open actions were discussed and updated as follows:

034/2020 Mermikides Fund Update (digital devices) – Action closed.
034/2020 Mermikides Fund Update (project costs) - Francis Drobniewski suggested that the Committee should meet in April to discuss this item in more detail with Fleur Cromarty, Head of Estates Capital Projects. Carl Williams commented that as the refurbishment of the Heron Ward had been incorporated into the 2022/23 capital plan, this development should be taken into account by the Committee. In response to a question from Pippa Barber, Carl Williams added that the Heron Ward project would be dependent on the hospital site being transferred to the Trust. There were refurbishment plans for the site and £680k had been set aside in the capital plan for this work. Pippa Barber commented that she had raised the issue at the Finance, Business and Investment Committee meeting and she supported Francis Drobniewski in that the refurbishment should take place in 2022/23 at the latest. She also supported the Committee meeting in April but cautioned against spending money from the fund for the sake of it. She would like to see the refurbishment take place and the Mermikides Fund contribute to it in the appropriate way. Mercia Spare confirmed that she was well sighted on the project and had discussed it recently with Carl Williams. She agreed that the fund should be spent on elements that would enhance staff and patient experience. John Goulston commented that the 2022/23 capital plan would be agreed by the Board at its meeting on 31 March 2022, following scrutiny by the Finance Business and Investment Committee. It was agreed that Gina Baines would make the necessary arrangements for the April meeting.
**Action** – Gina Baines

020/21 Charitable Funds Marketing Report (Talking Together peer support group) – Action open.
020/21 Charitable Funds Marketing Report (Update) – Jo Treharne confirmed that the Gift of Play fund raising through the Amazon Wish List had provided for around 30 toys. The Comms Team had put together a short article in the Community Health magazine and

a video explaining how the money had been spent. The programme would continue. The Comms Team was drafting a piece on the Om Mobii Magic Table for the next edition of the magazine. She confirmed that the adapted bicycle at Gravesend had been delivered along with training dummies and equipment and funding for the football team.

034/21 Update on the Covid-19 Health and Well-being fund - Francis Drobniewski had met with Victoria Robinson-Collins, Director of Organisational Development and People to discuss the NHS Together residual funds. They had agreed that a food bank would be difficult to arrange. Jo Bing reiterated that NHS Charities had issued guidance that the funds could not be spent on vouchers. She was still receiving requests for Team Treats funding as well as waiting for the purchase of garden furniture and invoices for hard landscaping at some of the sites. Pippa Barber suggested that Jo Bing confirm what was left in the fund at the April meeting so that the Committee could make a final decision on what the residual amount could be spent on. Action closed.

036/21 Spending Plans – Francis Drobniewski had spoken to Mercia Spare about the Om Mobii Magic Table. She had discussed the purchase of this equipment with the community hospital matrons. Tonbridge Cottage Hospital had one and were using it to good effect. A joint bid was being put together and would come to the Committee in April. Action closed.

036/21 Spending Plans (Sustainability bids) - Jo Bing had received an email from Dan Wright for £4000 to cover ecological surveys at Trust sites. Some further work was required on the bid before it could be approved. Action closed.

All other actions were closed.

**005/22 2020/21 Charity Report and Accounts**

Carl Williams presented the report to the Committee for approval.

The independent examination of the accounts had concluded in December. The auditors had been happy with the accounts and would be signing them off. No changes had been required following their independent examination. With regards to the signing process, Jo Bing would liaise with Francis Drobniewski who would sign the accounts on behalf of the Committee. She would then pass them to the auditors so that the accounts and auditors report could be submitted to the Charities Commission by the 31 January deadline.

John Goulston highlighted that on page three in the list of voting members of the Trust, Ali Carruth had been included in error. Carl Williams would liaise with the auditors to have her name removed.

The Committee noted the imperative to spend the funds and Mercia Spare reflected that she would be working closely with Jo Bing between committee meetings to encourage fund managers to access their funds to support their staff and patients.

The Committee **APPROVED** the 2020/21 Charity Report and Accounts, subject to the amendment.

**006/22** **Any Other Business**

Carl Williams reported that the audit fees were likely to increase for the 2021/22 accounts and the Trust might consider using alternative auditors.

Pippa Barber thanked Francis Drobniewski on behalf of the Committee for his chairmanship during his term of office and his commitment to ensuring that the charities funds were spent.

The meeting ended at 12.37pm.

**Date and time of next meeting**
29 April 2022 at 9am in The Boardroom at The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.5 |
| **Agenda Item Title:** | Finance, Business and Investment Committee Chair's Assurance Report |
| **Presenting Officer:** | Kim Lowe, Deputy Chair of Finance, Business and Investment Committee |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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 3 February and 23 March 2022 and provides assurance to the Board.

**Summary of key points**

The meetings covered a range of topics including the Edenbridge Memorial Health Centre project, the draft 2022/23 capital plan, an update on progress with implementing the digital strategy, the national cost collection framework, going concern review including working capital, the draft budget 2022/23 and the 2022/23 cost improvement programme. The terms of reference were reviewed and approved.

**Proposal and/or recommendation to the Committee or Board**

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

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.** | ☐ Yes *(please attach)*<br><br>☒ No |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| *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** | |
| 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 (FBI) COMMITTEE CHAIR'S ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on Thursday 3 February 2022

| Issue | Committee review and assurance | Matters for Board awareness and/or action |
|---|---|---|
| ICS Edenbridge Memorial Health Centre Procurement Report | Director of Corporate Services and senior project team (including external advisors) presented the latest position regarding the Edenbridge procurement. The Committee noted the status of the procurement and related risks and supported the onward presentation to the full Board.<br><br>It was noted that an agreed position with the integrated care system/clinical commissioning group (ICS/CCG) would hopefully be finalised ahead of the Board meeting | Board will need to ensure satisfactory comfort with ICS/CCG has been achieved. |
| Board Assurance Framework | Latest reported was presented and noted. | |
| Business development and service improvement | The paper included an update on the Trust's current activities with and strategic intent with regard re-care networks (PCNs). | The Committee concluded that the PCN strategy combined with a full Trust plan should be presented and discussed at the forthcoming Board meeting before more detailed scrutiny by the FBI Committee. |

| Issue | Committee review and assurance | Matters for Board awareness and/or action |
|---|---|---|
| Finance report including service line and cost improvement programme (9/12)<br><br>Update on planning for 2022/23 | The latest report was presented and noted by the Committee. Issues regarding deliverability of the cost improvement programme (CIP) and the capital programme for the full year was discussed.<br><br>The Committee advised on the approach to budgeting for 2022/23.<br><br>A similar approach to the previous year, save for the funding allocation approach.<br><br>The Committee noted the paper. | |
| Draft 2022/23 capital plan | A draft capital programme for 2022/23 was presented to and noted by the Committee. | |
| Estates Strategy | The Committee was advised that the next iteration of the Estates Strategy was delayed and would be included for the next meeting of the Committee in March. | |

**Paul Butler**
**Chair, Finance, Business and Investment Committee**
**10 February 2022**

Kent Community Health NHS Foundation Trust

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

This report is based on the Finance, Business and Investment Committee meeting held on Wednesday 23 March 2022

| Issue | Committee review and assurance | Matters for Board awareness and/or action |
|---|---|---|
| Digital strategy update | A presentation of the delivery of the annual programme was made and noted. The update identified that there was an amount of slippage in the second half of the financial year although the risks of non-delivery appear to be being appropriately managed. The Committee noted the need for a good start to next financial year was going to be important. | |
| Board assurance framework | The latest report was presented and noted. | |
| Business development and service improvement | The latest report was presented and noted. | |
| Finance report including service line and cost improvement programme (11/12) | The latest report was presented and noted. | |

| | | |
|---|---|---|
| National cost collection 2021/22 | The cost collection framework for 2021/22 was presented and noted. | |
| Going concern review including working capital | The paper presented supporting the assessment of working capital adequacy and assumptions regarding going concern assessment.<br><br>The Committee approved the assessment as a precursor to preparation of financial statements for year ended 31 March 2022. | |
| Draft Budget 2022/23 | The draft budget for 2022/23 was presented to the Committee with a detailed explanation of key assumptions and related risks.<br><br>After considerable discussion, the budget was supported by the Committee for onward presentation and approval by the Board. The executive asked to ensure that key risks were highlighted to the Board as part of the subsequent presentation. | The Board will need to consider risks included in the budget for 2022/23 and specifically within the CIP programme as part of budget approval. |
| 2022/23 CIP plan | As part of the budget, a cost improvement programme (CIP) was included and presented to the Committee. The difficulty of full quantification and challenges of delivery were highlighted.<br>The Committee commented that the need to look at alternative multiyear programmes of efficiencies was going to be necessary. The Committee agreed the plan | It should be noted that the draft budget as presented has an unidentified CIP of £3m. |

| | | |
|---|---|---|
| | for inclusion as presented, with a need to highlight risks of delivery to the full Board. | |
| Terms of reference review and approval | The latest terms of reference progress report was reviewed and noted.<br>The Committee agreed that the review of strategic outcomes should be presented as a separate report going forward.<br>It was agreed that the current terms of reference to be recirculated to Committee members for review and comment with an intention that a revised document would be presented at next Committee for approval. It was notes that as there had been a significant review last year that it was likely that any change this year would be quite minor. | |

**Paul Butler**
**Chair, Finance Business and Investment Committee**
**29 March 2022**

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.6 |
| **Agenda Item Title:** | Quality Committee Chair's Assurance Report |
| **Presenting Officer:** | Pippa Barber, Chair of Quality Committee |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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 Quality Committee meetings held on 15 February and 15 March 2022. The meeting in February was an extraordinary meeting. The Board will receive a verbal update of the meeting held on 17 May 2022.

**Summary of key points**

The meetings covered a range of topics including reports on the quality impact assessment of the schemes for the 2022/23 cost improvement programme, the infection prevention and control annual declaration, community rehabilitation adults waiting times, long terms services coastal staff challenges, We Care annual report, the Patterson Inquiry and Ockenden Inquiry recommendations, and the Healthy Communities project.

**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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.** | ☐ Yes *(please attach)*<br><br>☒ No<br>*(please provide a summary of the* |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| *Protected characteristics are: age, disability, gender 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: | 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 on 15 February 2022.

| Agenda item | Assurance and Key points to note | Further actions and follow up |
|---|---|---|
| Quality impact assessments (QIAs) of the 2022/23 cost improvement programme (CIPs) schemes | Approved quality impact assessments of the cost improvement programme were considered to the value of £2,228k (33% of CIP) target for 2022/23. Discussion took place specifically on timeframe and delivery of Adults CIPs, specifically the issue between increased demand for many services. Medium risk scores had been identified for four schemes. These were discussed and other schemes where further information was needed. Two schemes were identified for a follow up by non-executive directors later in the year. Impact on equality of access will be considered as part of those deep dives. Two schemes have been withdrawn and reconsidered following review by the executive. | The Finance, Business and Investment Committee will follow up in its March meeting progress with identification of further CIP schemes for next year. Achievement of longer-term pathway redesign is being considered by the executive team. As CIPs are identified and QIAed these will be presented to regular Quality Committees. Equality impact assessment (EqIA) of future schemes are being considered by the executive. |

**Pippa Barber**
**Chair, Quality Committee**
**February 2022**

Kent Community Health NHS Foundation Trust

# QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report follows the Quality Committee meeting held on 15 March 2022.

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| Feedback from other committees/service visits<br>Legislation changes/updates | Feedback was received from a non-executive director deep dive to West Kent night nurses following feedback at a public Board on end of life care 9EoLC) experiences. A good discussion was had with the team, a number of changes have been put in place and recommendations made which have been accepted by the service. | Follow through on actions including appointment of health care assistant (HCA) will be carried out by the operational team. |
| Infection Prevention and control annual declaration | The Committee received the update on the infection prevent and control declaration. Following discussion and review the committee agreed the Trust is compliant and approved the annual declaration. | |
| Monthly quality report January data | Assurance provided that overseas recruitment is now beginning to alleviate some community hospitals pressures. Four covid outbreaks noted in Tonbridge, Faversham and Queen Victoria Memorial Hospital (QVMH). | Significant amount of work is ongoing with teams. The executives to continue as part of the Quality Improvement (QI) work to consider with them areas that can be stopped, redesigned, etc. |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| | Sexual Health teams have been awarded the NHRI prize for research. Work continues to encourage nurses to undertake research in line with CNO research strategy. The Quality Strategy targets remain on track. Assurance sought on the frequency of peer checking as part of medication administration due to its mitigating link with incidents. Safeguarding training is on track however the ambition of achievement of the training will be reviewed. | |
| Operational performance update | Deep dive updates provided on:<br>**Dental elective GA** - 0 cases waiting over 52 weeks, adults and children. Work is ongoing to review all children and adults who are over the 18 weeks waiting time. Work is ongoing with East Kent University Hospitals NHS Foundation Trust (EKHUFT) on theatre capacity with some consistent availability now in place.<br>**Community rehabilitation adults waiting times** - Wait times increasing in some services and areas, driven by a number of factors including sickness in teams. Cover and a range of other mitigations being put in place. Physio access remains a challenge.<br>**Long term service coastal staff challenges** - An update was provided on the staffing vacancies in the community in the East Kent coastal strip. A range of mitigations are in place or being put in place. Currently | Further update to Quality Committee in May on progress.<br><br>The Committee in July to receive an update on impact of QI work in the area on pathways, with triangulated data on impact on patient experience. Hot spots will |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| | no significant risk increase in patient outcomes. Triangulation to take place on patient experience as part of the measures of impact. Quality Improvement (QI) work ongoing. | continue to be considered at the Strategic Workforce Committee. |
| We Care annual report | The annual report setting out the areas of review, outcomes and themes for learning. In 2021, 20 visits took place to the specialist children and young people, public health and specialist and elective services. This schedule also included two visits to community hospitals and two long term services that did not have their scheduled review in 2020 due to COVID-19 and winter pressures. 8 of the reviews were held virtually via Microsoft Teams. Of the 20 services that participated in a We Care review in 2021, 45 per cent of services were rated Outstanding overall and 55 percent were rated good. The 2022 We Care review programme will begin in May, with visits scheduled to the adult community core services that have not been visited in the previous three years. These services will include: acute response, rapid response, home with support, hospital at home, home treatment and the rapid transfer service. Discussion and assurance sought on the learning from the visits and sharing of the learning. Trust wide areas for learning and the groups with oversight for follow through were set out in the | The data provided for the reviews will include available information on health inequalities and the review will begin to capture how services are adapting to improve access experience and outcomes. |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| | report. The team was thanked for its ongoing work in supporting the programme and the teams who have participated in the reviews. | |
| Learning from deaths quarterly report quarter two | Assurance received on quarter two data. The full paper is with the Board. Key areas of learning continue to be picked up by the EoLC steering group. No deaths more likely than not due to problems in care.<br>Learning disabilities reviews did not identify any specific learning for KCHFT this quarter. | Data on learning themes to be reviewed to see if a longer-term trend can be presented. Learning disability section to provide further information on KCHFT specific learning in future reports. |
| Patterson Inquiry recommendations | A Trust benchmarking review has been undertaken against the recommendations. Assurance was received on a range of actions in place, with ongoing work to ensure all electronic patient care systems the Trust uses are able to and are producing the requested patient discharge letters. | Further updates to be provided to the Committee. |
| Terms of reference of sub-committee | The yearly review of the patient safety and clinical risk group's terms of reference were considered and approved by the Committee. | |
| Healthy Communities project presentation | A presentation on the plans and actions in place to support this important programme were set out. Supporting the equality objectives, increasing equality monitoring across all services, with four workstreams. Ethnicity recording, cultural awareness, community relationships and a steering group. Good work so far. | A further update on progress will be provided to the Committee as the project develops. |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| | Assurance sought on the recording of ethnicity data, training to be covered, how we ask questions and how we are working with underrepresented to groups to ask them how they would like questions to be asked. The project is working closely with public health and the actions needed to consider and change our offer to take account of the impact of deprivation. | |

**Pippa Barber**
**Chair, Quality Committee**
**March 2022**

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.7 |
| **Agenda Item Title:** | Strategic Workforce Committee Chair's Assurance Report |
| **Presenting Officer:** | Kim Lowe, Chair of Strategic Workforce Committee |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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 meetings held on 21 February and 22 April 2022 and provides assurance to the Board.

**Summary of key points**

A range of topics was discussed at the meetings including the workforce report, the workforce risks on the board assurance framework, vaccination as a condition of deployment, the significant employee relations report, turnover and retention, academy review, an update on Freedom To Speak Up and the results of the latest staff survey. Mandatory fire training, vacancies, talent and leadership development.

**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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.** | ☐ Yes *(please attach)*<br><br>☒ No |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| *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 the paper** | |
| | |

| | | | |
|---|---|---|---|
| Name: | Kim Lowe | 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 21 February 2022

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| Legislation update - impact | Vaccination as a condition of deployment (VCOD) – no public outcome to consultation yet. Pension penalty's relaxed for returners at present – full consultation to aid returners taking place between March and October. | |
| Workforce Update<br><br>Board assurance framework (BAF)<br><br>Vaccination as a condition of deployment (VCOD) | Highlights from workforce data confirm turnover is going up and stability down, sickness absence is also above target. A further breakdown separating out long term sick from short term absences will help address issues. Stress related sickness is lower than this time last year.<br><br>The financial health and wellbeing offers being considered for staff was supported in principle with strong assurance required to mitigate any reputational damage and challenge to advice /recommendation from financial discounts and offers. We are behind others in the system with our offer. | A full review of key performance indicators (KPIs) is being conducted in April to ensure the targets are right for 2022/23.<br><br>Consider the data available from the Community Benchmark to better understand our position and learn from actions taken elsewhere.<br><br>Talk to others in the system to better understand what they |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| | The four workforce BAF risks have been refreshed to better reflect current risks. In April a complete redrafting of the risks will again take place to combine some, remove some and ensure they truly reflect the workforce issues of the Trust. A challenge to the rating was accepted recognising the risk inducting and upskilling the significant number of new staff.<br><br>Mandatory fire training was an issue raised as well as having been raised at Audit and Risk Committee with an immediate action taken to discuss at the integrated management meeting (IMM) this week. | offer, and the assurance sought and mitigation in place as well as lessons learnt.<br><br>Revisit the rating on the Workforce BAF to either uplift the rating or better explain how the mitigations impact on the likelihood.<br><br>Action to be agreed at IMM to ensure fire training takes place. |
| Operational update Service redesign | Three areas of service redesign were described to the Committee: the issues the redesign was going to address, the challenges with the redesign and the benefits that were being sought. Community Paediatrics, Musculoskeletal Physiotherapy (MSK) and Podiatry. Lessons learnt from change, Quality Improvement (QI) and project management being used as part of this work. | |
| Significant Employee Relations Report | The Committee received the significant employee relations report and was assured by lessons are being learnt on an ongoing basis. Question whether disability was a theme led to confirmation that we were looking at 'disability' across all HR practices to ensure greater inclusion and understanding. | |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| Turnover and retention | Findings from a deep dive by a group of organisational development business partners (ODPBs) was shared, highlighting critical elements necessary to better retain our staff, as well as illustrations of new for purpose initiatives in Dental and Adult services. Encouragement was given to do much more listening and to give the staff a voice. | Turn findings into actions that the line managers can use to engage better with staff, both listening and learning. |
| Academy review | Revisited significant success against ambition and business case back from 2018, as well as lessons learnt. Further disciplines being added as well as consideration of our partner, currently the Open University. Immediate need to articulate what the Trust wanted from the Academy to support its workforce plan and ambitions for services. Further work to embrace other parts of the system to avoid duplication of effort and maximise the opportunity this presents the system. | Define what the Trust wants from the Academy and engage parts of the system to work with us to achieve that. |
| Freedom to Speak-up update | Annual report summarised the number of new cases which aligns with previous years, as well as confirms the main theme of issues being relationship ones.<br>A gap analysis presented against the Blackpool Teaching Hospital case study which gives the Trust substantive assurance on our education/awareness and processes supporting the Freedom to Speak Up programme of work. The results of our staff survey further reinforce this assurance with a significantly improved score in 'staff feeling they are able to speak up'.<br>Further training and awareness work is underway as part of the action plan following the gap analysis. | Add to the Freedom to Speak Up Policy the role of the non-executive director (NED). |
| Any other business<br>Staff Survey | High level staff survey results show that we benchmark well albeit scores have reduced in several areas. Hot spots will be analysed, | |

| Agenda item | Assurance and key points to note | Further actions and follow up |
|---|---|---|
| | and themes discussed in focus groups. A full report will come to the next Committee meeting. | |

**Bridget Skelton**
**Chair, Strategic Workforce Committee**
**21 February 2022**

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 April 2022.

| Agenda items | Notes | Assurance status. Actions and follow up |
|---|---|---|
| • **Workforce Report**<br>• **Operational Workforce Report**<br>• **Employee relations**<br>• **DBS assurance**<br>• **Medical revalidation**<br>• **Effectiveness of People and Organisational Development function**<br>• **Health and wellbeing**<br>• **Talent and leadership**<br>• **Sickness and absence**<br>• **Sustainable environment**<br>• **Workforce transformation** | Significant areas of concern have been bought to the Board's attention through the integrated performance report (IPR) process.<br><br>Board Assurance Framework (BAF) risk II5 has been updated and increased to a significant risk of 20. | This report provides an overview of key areas to bring to the Board's attention.<br><br>Significant assurance was delivered against agenda items except in the areas highlighted below. |
| **Staff Turnover** | Turnover continues to be above target.<br>BAF risk highlighted (risk 115) | Limited assurance that the actions in place will reverse this |

| Agenda items | Notes | Assurance status. Actions and follow up |
|---|---|---|
| | | position quickly enough due to both internal and outside influences. |
| **Mandatory Training - Fire** | Mitigations are in place to ensure we are safe, whilst we continue to roll out training. Currently at 82 per cent and rising. | ACTION - Report progress to the Committee at its next meeting. |
| **Vacancy rates** | Significant vacancy rates and workforce pressures were highlighted in: Musculoskeletal Physiotherapy (MSK), Podiatry, South East Drivability, Special Care Dentistry, Children's Therapy, Health Visiting, Coastal Teams and Community Hospitals. BAF risk highlighted (risk 115) | Limited assurance that the situation will improve. Mitigations and action plans are in place but with limited impact to date. |
| **Effectiveness of People and Organisational Development function** | A welcome additional investment in key roles in this service, particularly health and wellbeing, rostering and equality, diversity and inclusion (EDI) coupled with a prioritised work plan with some areas on hold. | ACTION - HRD to confirm next steps.<br>Limited assurance that we have strengthened our key areas to the right level required e.g. EDI and recruitment and retention. |
| **Talent and leadership development** | Plans are in hand across this area. The Committee requested further information on our succession planning status and to see the plans in train. | ACTION - SP overview to be bough to the next Committee meeting. |

| Agenda items | Notes | Assurance status. Actions and follow up |
|---|---|---|
| **Staff Survey** | Next steps were shared with the Committee. | ACTION - detailed plans to be bought to the June Committee meeting. |
| **Environmental Report** | Comprehensive report, worth sharing an update with the Board at some stage in the future. | ACTION - request a Board update. |

**Kim Lowe**
**Chair Strategic Workforce Committee**
**22 April 2022**

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.8 |
| **Agenda Item Title:** | Learning From Deaths Report |
| **Presenting Officer:** | Dr Sarah Phillips, Medical Director |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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 April 2021, 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 and Board are asked to note Quarter 4's data and learning points described in this report, for assurance. Following submission to the Committee and Board, 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

Kent Community Health NHS Foundation Trust

| |
|---|
| candour. Two nosocomial cases resulting in death were reported one during Quarter 3 and one during Quarter 4. |

| **Proposal and/or recommendation to the Committee or Board** |
|---|
| To note the report. |

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.**<br><br>*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)*<br><br>☒ 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 Annual Report 2021-2022 Including Quarter Q4 (January - March 2022)

## 1. Introduction

Kent Community Care Foundation Trust (KCHFT) uses the structured judgement review method to assess medical records and comment on the specific phases of care in the period before an inpatient death occurred. In line with national guidance on learning from deaths, mortality data is published quarterly and learning points recorded. This data includes the total number of community inpatient deaths and those deaths the Trust has subjected to case record review. Of those deaths reviewed, the Trust report how many deaths were judged more likely than not to have been due to problems in care.

## 2. Community Inpatient Deaths Reported during Quarter 4 2021-2022: Results and Analysis

During Q4 2021-2022, 22 deaths were reported at community inpatient sites. In the previous quarter, Q4 2021-2022, 49 deaths were reported.

| Number of Comminity Hospital Inpatient Deaths Reviewed - Including Deaths Occuring <28 days post Transfer of Care (ToC) in Q4 & 2021-2022 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Inpatient Community Hosptials Deaths | | | | Inpatient Community Hosptials Deaths Reviewed | | | | Number of deaths considered more likely than not due to problems in care | | | |
| March | Feb. | Jan. | | March | Feb. | Jan. | | March | Feb. | Jan. | |
| **10** | **7** | **5** | | **3** | **7** | **8** | | **0** | **0** | **0** | |
| Q4 | Q3 | Q2 | Q1 | Q4 | Q3 | Q2 | Q1 | Q4 | Q3 | Q2 | Q1 |
| **22** | **16** | **8** | **8** | **18** | **8** | **9** | **21** | **0** | **0** | **0** | **0** |
| | | | | | | | | | | | |
| 2021-2022 | | 2020-2021 | | 2021-2022 | | 2020-2021 | | 2021-2022 | | 2020-2021 | |
| **54** | | **178** | | **60** | | **177** | | **0** | | **0** | |

| Number of Community Hospital Deaths | Q4 | Total 2021-2022 |
|---|---|---|
| East - Deal | 3 | 11 |
| East – Faversham Cottage Hospital | 3 | 9 |
| East – Westview<br>Westview (East Ward) | 3<br>1 | 6<br>1 |
| East – Whitstable and Tankerton | 3 | 15 |
| East – Queen Victoria Memorial Hospital | 5 | 8 |
| West - Edenbridge | 0 | 0 |
| West - Hawkhurst | 1 | 2 |
| West - Sevenoaks | 0 | 0 |
| West - Tonbridge | 1 | 2 |
| Total | **22** | **54** |

| Community Hospital Inpatient Mortality Data | | |
|---|---|---|
| | **Q4** | **2021 -2022** |
| 2021-2022 Deaths reviewed (%) | - | 77.78 |
| Deaths reviewed by Structured Judgement Review (SJR) % | 63.64 | 74.08 |
| Deaths reviewed by Case Review (%) | - | 3.7 |
| Gender (%) Female<br>Male | 45<br>55 | 50.5<br>49.5 |
| Age range (years) | 53-94 | 53-98 |
| Mean Age (years) | 85.25 | 86.85 |
| Ethnicity (%) White British<br>Not Stated | 86<br>14 | 76.67<br>23.33 |
| Length of stay range (days) | 2-63 | 2-65 |
| Length of stay mean (days) | 20.91 | 24.48 |
| Number of cases where resuscitation documentation not in place at time of death | 0 | 0 |
| COVID-19 deaths recorded | 6 | 11 |
| Nosocomial deaths Recorded | 1 | 2 |
| Cause of Deaths including Frailty and Advanced Frailty | 14 | 33 |

During Q4 the coroner was consulted for two deaths both with respect to a pathological fracture following a fall prior to admission. Both cases have been concluded and closed.

The Medical Examiner Process was introduced for all community hospitals in East Kent in May 2021. During Q4, the Medical Examiner (ME) did not make a recommendation for further review of any inpatient deaths. All inpatient deaths have been continued to be reviewed by the Structured Judgement Review (SJR) process in accordance with Trust policy. The introduction of the Medical Examiner Process is still awaited but anticipated to commence in Q1 2022-2023.

Primary causes of death included; Myocardial infarction, Frailty, Cerebrovascular Disease, Metastatic Carcinoma, Locally invasive carcinoma, Sepsis, Covid 19, Bronchopneumonia, Urinary Sepsis, Heart Failure and Atrial Fibrillation, Aspiration Pneumonia.

No cases in Q4 were judged to be potentially avoidable due to problems in care and there was no evidence that any patient death was contributed to by unsafe practice arising from mismanagement or misuse of controlled drugs. However, one case in February was identified as a nosocomial COVID 19 case, hospital; onset definite and was judged to be probably avoidable but not very likely. The case is awaiting patient safety review as a possible SI.

Two cases in Q4 were judged as poor for ongoing care due to a lack of evidence of an effective system to ensure planned investigations were completed, results reviewed and actions documented. This case also received a poor score for the quality of the patient record. The second case related to a patient stay of 56 days where earlier recognition that the patient could have been transferred nearer to

home and family was identified as a concern. One case was judged poor for End of Life Care, as use of multidisciplinary team discussion could have supported follow through of agreed treatment escalation plans to avoid inappropriate use of 999 services.

One case from Westview hospital received scores of excellent across all phases of care with five cases judged excellent for end of life care.

| Spread of Scores Awarded for the Phases of Care of The Community Hospital Deaths in Q4 | | | | | |
|---|---|---|---|---|---|
| Phase of care | Grading | | | | |
| | Very Poor | Poor | Adequate | Good | Excellent |
| Admission and Initial Care Phase | 0 | | | 10 | 5 |
| Ongoing Care Phase | 0 | 2 | 3 | 9 | 1 |
| End of Life (EoL) Care Phase | 0 | 1 | 1 | 8 | 5 |
| Overall Care Phase | 0 | | 9 | 3 | 3 |
| Patient record quality | 0 | 1 | 6 | 8 | 0 |

See appendix I for the full annual scoring.

**3. Evidence of Good Practice recognised in Community Hospital reviews**

57 elements of good practice have been recorded from the reviews from deaths in Q4, the majority relating to good and excellent care given during the end of life phase. Feedback included; Good discussion with family and patient about wishes and communication with families, high standards of advanced care planning, good standards of pain and pressure area management, appropriate deprescribing at end of life and provision of anticipatory medicines. The RTS team were involved in the swift utilisation of a community palliative care bed avoiding occupancy of acute beds and ensuring receipt of good end of life care evidenced by comprehensive frailty review, excellent advanced care practitioner documentation of assessment, planning and communication with the patient and family, holistic care and prompt recognition and management of patient needs. Another case gave evidence of care and treatment planning rated as excellent, communication between cardiac nurse, patient, HTS and community nurses prior to admission by cardiac nurse enabling appropriate acute admission avoidance and supporting subsequent management and effective symptom control at end of life. Positive feedback was also received from the Medical examiner following their contact with next of kin sharing who stated that Westview staff were wonderful, very caring with lovely staff.

### 4. Learning from Mortality Reviews for Community Hospital Deaths

| Themes Identified for Learning from Deaths Q4 2021/22 |
|---|
| 1. Problems in assessment, investigation of diagnosis<br>Including assessment of pressure ulcer risk, Ventricular Tachycardia (VT) risk, history of falls |
| • No MCA on record, this would have been appropriate with the patient's diagnosis of Alzheimer's and being pleasantly confused. |
| 2. Problems with medication including administration of oxygen |
| • Lack of JIC meds discussion, with paperwork for JIC meds being held with drug chart on the ward.<br>• Continue to datix drugs/drug charts which are not transferred with patient. The Pharmacy team are collating, tracking and reporting these incidents to the acute trusts<br>• Need for accurate recording on Drug Chart of names, dosage, countersigning and signing and dating discontinuation of medicines.<br>• Opioid patch was removed with no explanation documented in the notes available for review when syringe driver commenced.<br>• If subcutaneous fluids are felt to be indicated then clear rational for appropriate management needs to be documented, explaining benefits to patient. |
| 3. Problems related to treatment and management plan |
| • Earlier identification of patient/their family wishes; their goals and expectations. 2 x 999 calls and no JIC meds available despite TEP in place, with no face to face or virtual review once dying. Better MDT discussion could have supported improved follow through of TEP actions - involvement of patient and family are important and MDT clinical approach is optimal.<br>• Pro-active planning on how to manage symptoms such as breathlessness likely to be encountered due to patient's end stage heart failure could have supported care management but care was noted to be of an extremely high standard.<br>• There was no indication that patient's wishes considered and plan for non-transfer and best interest not to be considered for further surgery agreed with son.<br>• Potential to avoid the 999 call out by giving supplemental oxygen and talking to patient about her wishes before escalating. Although TEP at that time was for escalation, staff support with appropriate updating of TEPs would have been preferable to plan care effectively.<br>• Need for improved documentation – to clearly convey how agitation symptoms were appropriately managed to evidence the patient centred care and that patient's wishes were well catered for. |
| 4. Problems with infection management |
| • IPC improvements needed - cleaning audit score falling below 95% for January 2022<br>• Problems with infection management (cat 4) Probable Harm - Patient contracted Hospital Onset COVID 19 |
| 5. Problems related to invasive procedure |
| No Improvements Identified |
| 6. Problems in clinical monitoring |
| • More frequent re-assessment and planning would have been beneficial in this case. MDT notes were focused on plans for discharge, a 7 – 10day interval check to monitor for clinical changes and detect any signs of deterioration especially when prolonged package of care delays occurred and family contact was decreased could have avoided a failed discharge. |

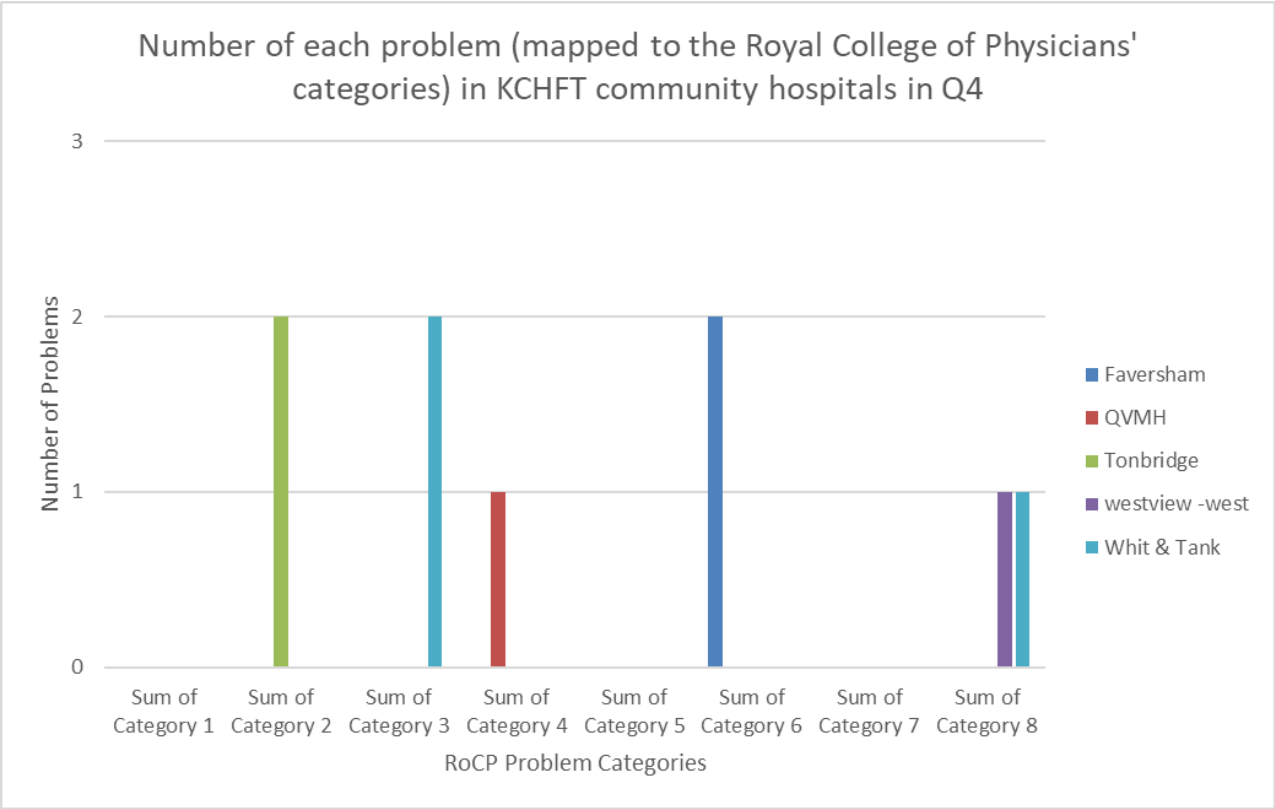
| Themes Identified for Learning from Deaths Q4 2021/22 |
|---|
| 6. Problems in clinical monitoring |
| • Ideally would avoid OOH transfers however this reflects difficulties with timings of transfers/transport from other providers.<br>• Help staff feel empowered to stop clinical observations where these are documented as not supporting care management plans at end of life. |
| 7. Problems in resuscitation following cardiac or respiratory arrest |
| No Improvements Identified |
| 8. Problems of any other type not fitting other categories |
| • Documentation by home treatment services of the rationale behind opting for phone assessment rather than physical review could help to support assessment documentation. i.e. capacity of team, balanced with notes from other teams meant phone assessments was appropriate to minimize work load without compromise to patient care in this case but not evident in documentation. |
| 8. Problems of any other type not fitting other categories |
| • Documentation of conversations with family and board round discussions lacking.<br>• Some RIO entries not completed e.g. Verification of Death and delay in verification of death – Operational planning needs to consider staffing provision and skill sets when commissioning step-up-beds.<br>• Early recognition that the patient could be transferred nearer to home and family. – Ensure unit is fully integrated into operational trust services.<br>• Liaison about infection control with the family may have helped avoid a difficult confrontation.<br>• Ongoing discussions with the family about end of life and the likely prognosis may have helped their expectations at discharge. |

A total of 37 areas of improvement were identified from the 14 community hospital inpatient deaths during Q4 that have been collated and reviews closed. No cases in Q4 were judged to be potentially avoidable due to problems in care and there was no evidence that any patient death was contributed to by unsafe practice arising from mismanagement or misuse of controlled drugs.

| Number of themes identified from mortality reviews of deaths occurring in each month (in line with Royal College of Physicians (RCoP) categories) | | | | |
|---|---|---|---|---|
| **Areas of Improvement Categories** | **Jan-22** | **Feb-22** | **Mar-22** | **Total 2021-2022** |
| **Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls** | | | | **11** |
| Ineffective recognition of end of life | 1 | 0 | 0 | **8** |
| Issues relating to physical needs | 0 | 0 | 0 | **3** |
| **Problems with medication including administration of oxygen** | | | | **32** |
| Issues relating to medications and/or symptom control | 3 | 2 | 3 | **32** |
| **Problems related to treatment and management plan** | | | | **72** |
| Lack of involvement in care decisions | 1 | 2 | 0 | **5** |

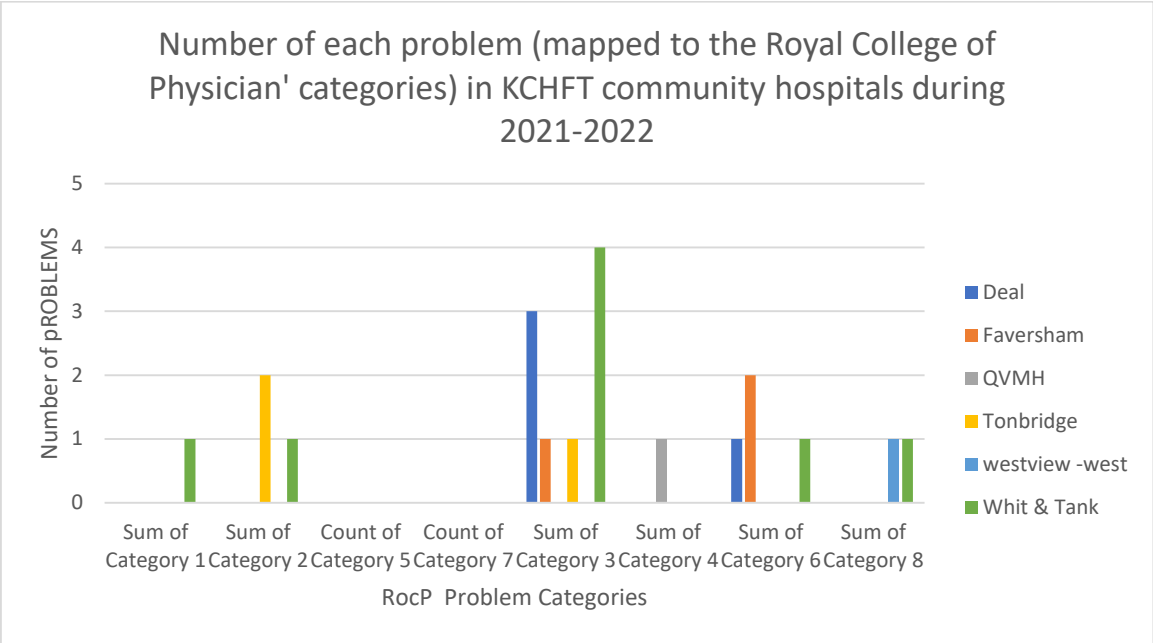
| Number of themes identified from mortality reviews of deaths occurring in each month (in line with Royal College of Physicians (RCoP) categories) | | | | |
|---|---|---|---|---|
| **Areas of Improvement Categories** | **Jan-22** | **Jan-22** | **Jan-22** | **Total 2021-2022** |
| Lack of respect of patient and family wishes in decision making | 1 | 0 | 0 | **2** |
| Lack of documentation around capacity and best interests | 1 | 1 | 0 | **6** |
| Issues relating to Personalised Care Plans and other documentation | 6 | 3 | 2 | **53** |
| Issues relating to Fast Track and palliative care support | 1 | 0 | 0 | **6** |
| **Problems with infection management** | 0 | 2 | 0 | **3** |
| **Problems related to invasive procedures** | 0 | 0 | 0 | **0** |
| **Problems related to clinical monitoring** | | | | **7** |
| Reversible causes of deterioration not considered/excluded and/or documented | 1 | 0 | 0 | **7** |
| Issues relating to nutrition and hydration | 0 | 0 | 0 | **0** |
| **Problems in resuscitation following cardiac or respiratory arrest** | 0 | 0 | 0 | **0** |
| **Problems of any other type not fitting other categories** | | | | **19** |
| Issues relating to emotional, psychological, social, spiritual, cultural and religious needs | 0 | 0 | 0 | **1** |
| Issues relating to support of families and those important to the dying person | 0 | 0 | 2 | **6** |
| Patient related communication issues | 0 | 0 | 0 | **1** |
| Team related communication issues | 1 | 1 | 3 | **11** |
| **No. deaths by month with completed reviews** | 5 | 4 | 5 | **43** |
| **Total number of issues arising by month** | **16** | **11** | **10** | **144** |

Each problem is mapped to Royal College of Physicians (RCoP) problem categories and recorded against each hospital. The problem data for Q4 is displayed in the following chart. When a problem has been identified, the reviewer is also asked to assess if the problem led to harm or an adverse event using the National Reporting and Learning System (NRLS) definitions of harm. The nine problems identified in the following chart where all answered as no harm or adverse event for Q4.




Key;
Cat. 1 - Problems in assessment, investigation of diagnosis inc. assessment of PU risk, VT risk, history of falls
Cat. 2 - Problems with medication including administration of oxygen
Cat. 3 - Problems related to treatment and management plan
Cat. 4 - Problems with infection management
Cat. 5 - Problems related to invasive procedures
Cat. 6 - Problems related to clinical monitoring
Cat. 7 - Problems in resuscitation following cardiac or respiratory arrest
Cat. 8 - Problems of any other type not fitting other categories

The problem data for the year 2021 -2022 is displayed in the following chart. The 20 problems identified in the following chart where all answered as no harm or adverse event for Q4.




## 5. Community Deaths Mortality Data

| Number of Comminity Deaths Reviewed - Including Deaths Occuring in Q4 & 2021-2022 | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Community Deaths Reported | | | | Community Deaths Reviewed throught the SJR process | | | | Number of deaths considered more likely than not due to problems in care | | | |
| Q4 | Q3 | Q2 | Q1 | Q4 | Q3 | Q2 | Q1 | Q4 | Q3 | Q2 | Q1 |
| **25** | **22** | **18** | **13** | **13** | **14** | **3** | **0** | **0** | **0** | **0** | **0** |
| | | | | | | | | | | | |
| 2021-2022 | | 2020-2021 | | 2021-2022 | | 2020-2021 | | 2021-2022 | | 2020-2021 | |
| **78** | | **60** | | **30** | | **27** | | **0** | | **0** | |

| Community Mortality Data | | |
|---|---|---|
| **Number of** | **Q4** | **2021-2022** |
| Community Deaths reported via Datix | 25 | 78 |
| Community Deaths referred for full SJR | 13 | 35 |
| Complaints | 9 | 20 |
| Patient Safety Raised SIs/AAR | 5 | 9 |
| Referred to Coroner | 2 | 11 |
| Safeguarding Involvement | 1 | 5 |
| MEO recommendations for an SJR | 0 | 1 |

In September 2021 the ME process began its phased induction for all community deaths in East Kent. During this quarter, the ME did not make any recommendations for further review of community patient deaths. Two deaths were referred to the coroner both as sudden deaths. Both cases have been concluded and closed

## 6. Feedback and Lessons learned from Community Deaths Completed in Q4.

A total of 47 areas of improvement were identified from the ten community deaths during Q4 that have been collated from reviews closed at the time of report. A total of 214 areas for improvement for the year of 2021-2022. No cases in Q4 were judged to be potentially avoidable due to problems in care and there was no evidence that any patient death was contributed to by unsafe practice arising from mismanagement or misuse of controlled drugs.

| **Number of themes identified from mortality reviews (including Datix investigations, After Action Reviews (AARs) and Coroner Inquests) of deaths occurring in each month in line with RCoP categories** | | | | |
|---|---|---|---|---|
| **Areas of Improvement Categories** | **Jan-22** | **Feb-22** | **Mar-22** | **Total 2021-2022** |
| **Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls** | | | | **22** |
| Ineffective recognition of end of life | 2 | 0 | 0 | **12** |
| Issues relating to physical needs | 0 | 0 | 0 | **10** |
| **Problems with medication including administration of oxygen** | | | | **38** |
| Issues relating to medications and/or symptom control | 2 | 5 | 0 | **38** |
| **Problems related to treatment and management plan** | | | | **84** |
| Lack of involvement in care decisions | 1 | 1 | 0 | **6** |
| Lack of respect of patient and family wishes in decision making | 0 | 1 | 0 | **2** |
| Lack of documentation around capacity and best interests | 0 | 1 | 0 | **6** |
| Issues relating to Personalised Care Plans and other documentation | 9 | 9 | 3 | **69** |
| Issues relating to Fast Track and palliative care support | 1 | 0 | 0 | **1** |
| **Problems with infection management** | 0 | 0 | 0 | **1** |
| **Problems related to invasive procedures** | 0 | 0 | 0 | **1** |
| **Problems related to clinical monitoring** | | | | **7** |
| Reversible causes of deterioration not considered/excluded and/or documented | 1 | 0 | 0 | **7** |
| Issues relating to nutrition and hydration | 0 | 0 | 0 | **0** |
| **Problems in resuscitation following cardiac or respiratory arrest** | 0 | 0 | 0 | **0** |
| **Problems of any other type not fitting other categories** | | | | **61** |
| Issues relating to emotional, psychological, social, spiritual, cultural and religious needs | 0 | 0 | 0 | **0** |
| Issues relating to support of families and those important to the dying person | 1 | 2 | 0 | **14** |
| Patient related communication issues | 0 | 2 | 0 | **10** |
| Team related communication issues | 3 | 0 | 3 | **37** |
| **Number of deaths this month with completed reviews** | 3 | 3 | 3 | **40** |
| **Total number of issues arising** | **20** | **21** | **6** | **214** |

All nine deaths have been reviewed against the RCP problem categories. One problem was identified from the nine deaths that occurred in Q4 but no harm was identified This was categorised as 'Problems in assessment, investigation of diagnosis

## 7. Actions and Developments

Information gained from mortality reviews in the 2021-2022 period highlighted, the need for improved advanced care planning for end of life, treatment escalation plan completion and in particular awareness of and planning for the management of implantable cardioverter-defibrillator devices (ICD). Other themes included effective recognition of end of life particularly at the point of transfer of care and the effective use of clinical monitoring and NEWS scores to support prompt escalation and recognition of active dying.

Actions taken in consequence of what has been learnt during the reporting period included, the updating of electronic record templates to include an alert for ICDs, staff training and patient safety alerts regarding ICDs and development of a wider project regarding a pathway for ICD deactivation at end of life. The modification of transfer of care forms to add specific questions relating to end of life care and provision of fast track training for discharge planning teams was also implemented. NEWS 2 training focused on support for clinical decision making and appropriate escalation of deteriorating patients, increased training resources for learning specifically for management of end stage Heart Failure at end of life. The reinstatement of palliative care multidisciplinary meetings and work by the trust end of life care nurse consultant to support hospital matrons in promoting staff confidence with the process and completion of treatment escalation plans was also instigated.

Further case investigation following the actions relating to ICD deactivation have demonstrated a marked improvement in the proactive planning for appropriate end of life care. All community hospitals also now have a stock of magnets for emergency ICD deactivation when needed. The trust is also part of a Kent and Medway wide project to adopt the use of the resuscitation council Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) to enhance cross boundary recognition of agreed clinical recommendations developed from shared discussion between a person and their clinician.

Work has is underway to reintroduce Community hospital matrons to direct involvement in mortality review work which was previously suspended at the onset of the COVID-19 pandemic. This will ensure that the appropriate clinical insight is available for reviews and in turn help to improve both the learning and positive feedback to share with staff.

We also continue to make progress in regards to setting up a cross organisational learning from deaths forum with a joint presentation with the East Kent Medical examiner service at the East Kent Clinical forum scheduled for May 2022.

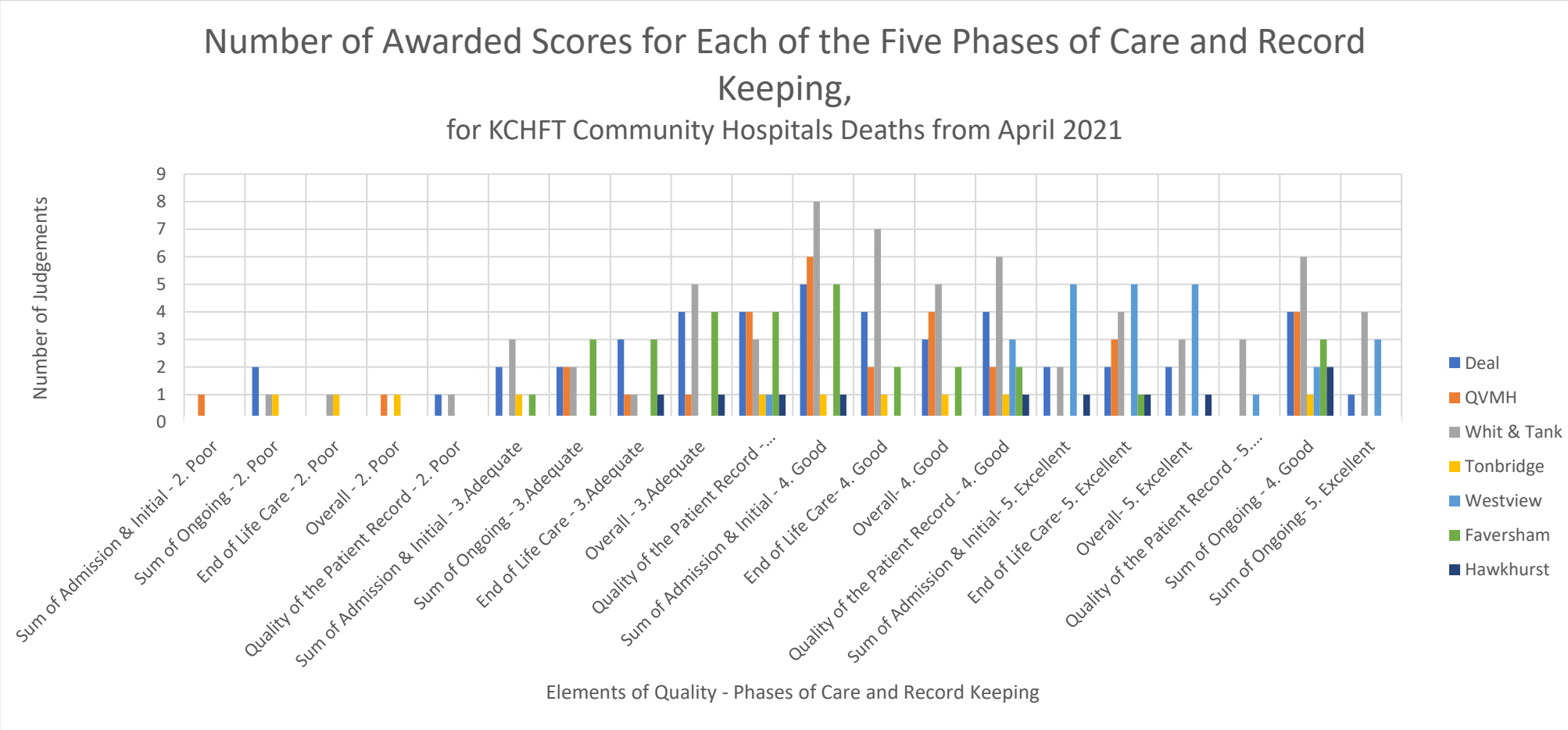
In West Kent, the Medical Examiner Service is continuing with its planned roll out to include scrutiny of deaths within Trust community hospitals and the West Kent Home Treatment Service.

## 8. Learning Disability (LD) Mortality Reviews Report

LeDeR Internal Q4 Report.pdf

**Dr Lisa Scobbie - Deputy Medical Director**
**Tatum Mallard – Mortality Review Project Lead**
**April 2022**

Kent Community Health NHS Foundation Trust



# LeDeR Review Programme
# Quarter 4 Report

## January – March 2022
## (reporting on deaths July-September 2021)

Written By

Mandy Setterfield – Senior Reviewer

Renée Fenton – LeDeR Business Support

## Contents

# 1. Quarterly Update

Since the LeDeR platform was updated and went live on 1st July 2021, the review process has been a success and progressing ever since.

There were some initial system errors which caused delay in submitting some reviews.
There is now a process in place for focused reviews to be heard at a panel; this occurs on average once a month where the panel take SMART actions from the reviews.
This initially caused a small back-log to the reviews as some had to be placed on hold before going to the Focused Review Panel Meetings.
There is currently one review breaching due to awaiting sign off before going to panel.

We have also recently set up bi-monthly Operational Groups to bring forward any objectives/ actions and learning from reviews and bi-monthly Steering Groups to discuss key areas on a more strategic level.

## Completion of Reviews

To date we have completed a total of 144 reviews for the time frame October 2020 – April 2022, 16 of these were in Q4 (deaths recorded in July-September 21) with a staff capacity of 100% and the trajectory being overachieved every month (with the exception of 1 review breaching due to awaiting archive on the LeDeR system, previously awaiting an SJR.).

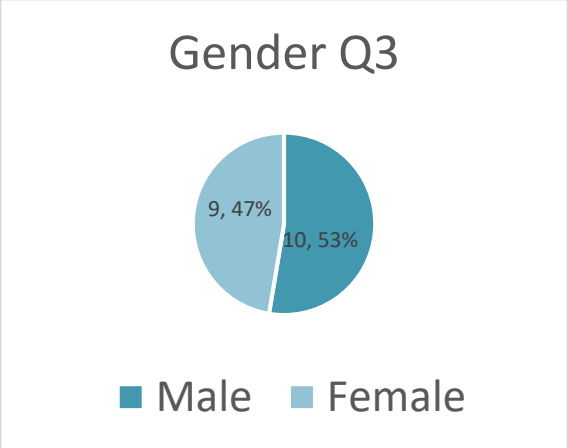
Below, the table shows the number of reviews completed for Quarter 4, deaths recorded Jul-Sept 2021. There was a slight dip in the number of notifications received for August but July and September had the same figures.

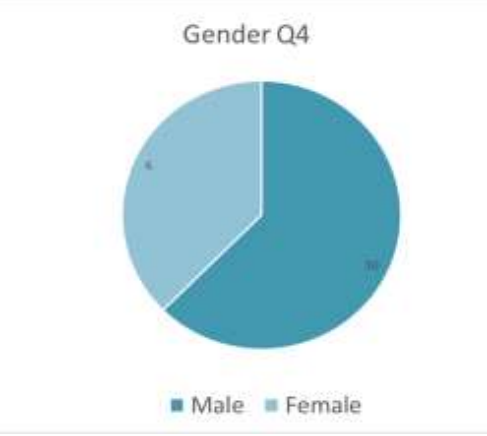
| Jul-21 | Aug-21 | Sep-21 |
|---|---|---|
| **6** | **4** | **6** |
| 5 | 4 | 6 |
| 1 | 0 | 0 |
| 0 | 0 | 0 |
| 0 | 0 | 0 |
| 0 | 0 | 0 |
| 0 | 0 | 0 |
| 0 | 0 | 0 |
| **1** | **0** | **0** |
| **Jan-22** | **Feb-22** | **Mar-22** |

## 2. Personal Demographic Trends

**Gender**

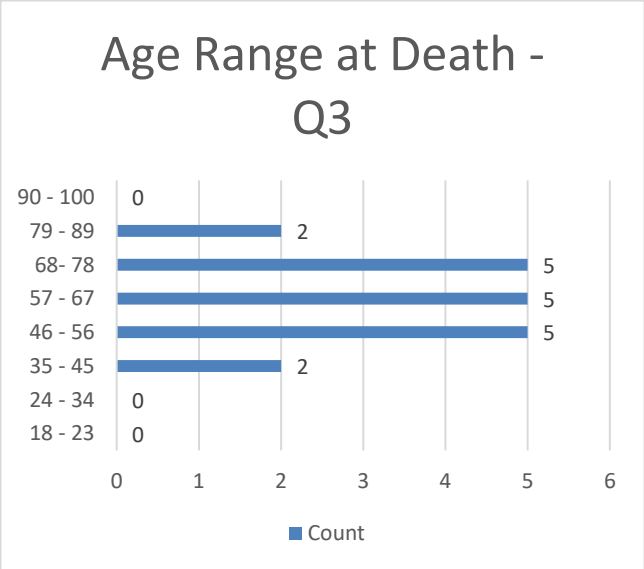
The table below shows that there were more Male to Female deaths in Q4, much like there was in Q3. In Q4, 62% of deaths were male compared to 52% in Q3.

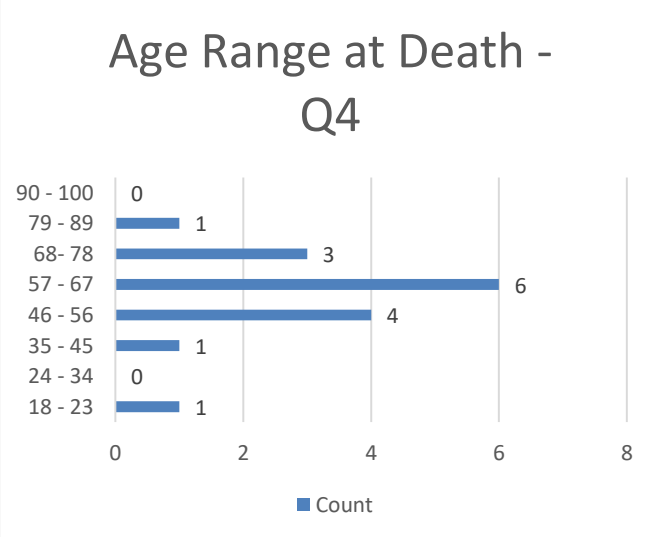



**Age**

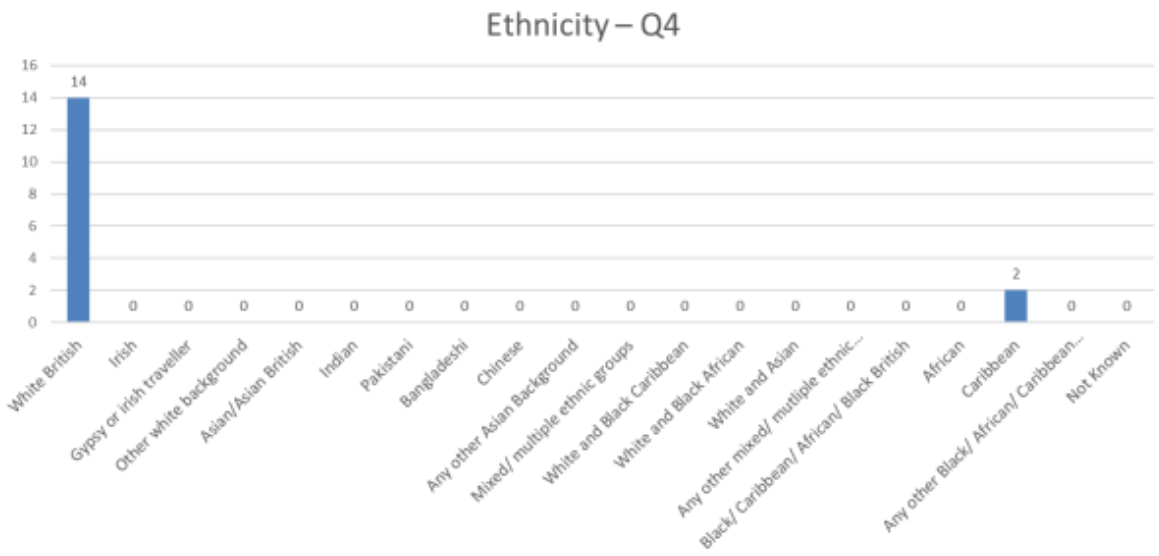
In Q4, the graph below shows that the highest age range at death still remains between 57 – 67 years old; although in Q3 we saw that there were 3 age ranges with the same number of deaths.



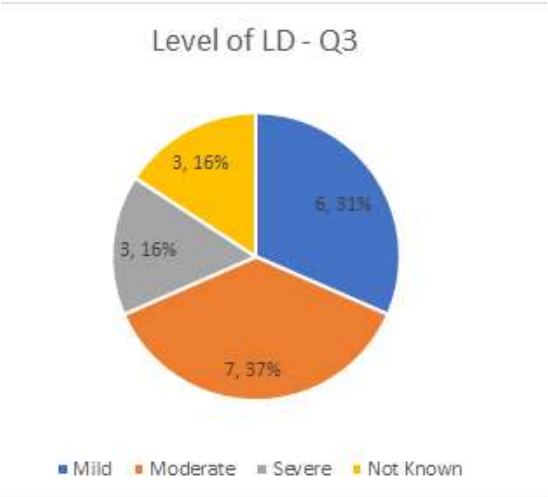
## Ethnicity

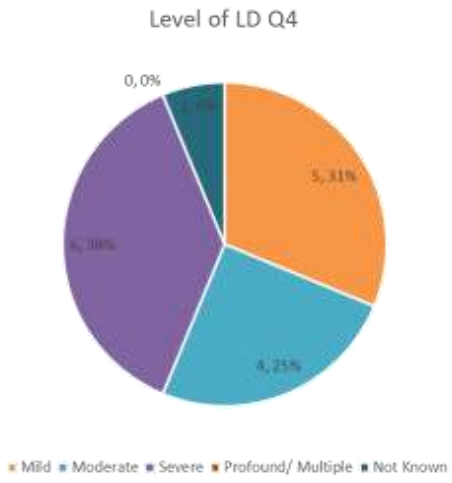
Out of the 16 reviews completed in Q4, there were 14 patients recorded as White British and 2 Caribbean. This recording is very similar to Q3, where 15 out of 19 deaths were recorded as White British, and 3 were from BAME decent.




## Severity of LD

In Q4, the highest level of LD was Severe at 38%, closely followed by Mild at 31%. Unlike Q3 where the highest level of LD was Moderate at 37%, closely followed by Mild at 31%. This shows an influx in the number of deaths recorded as having a severe learning disability.

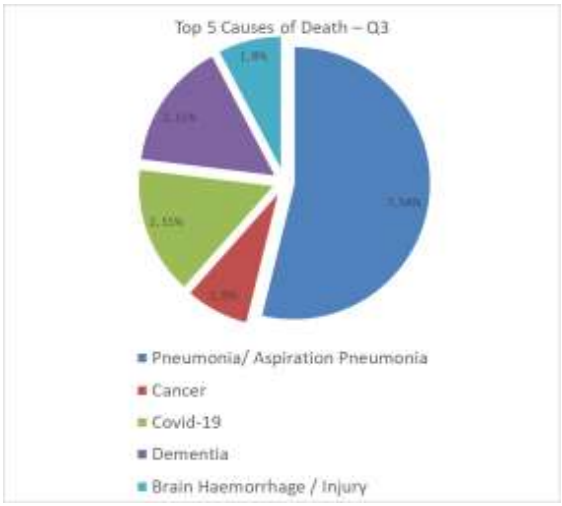


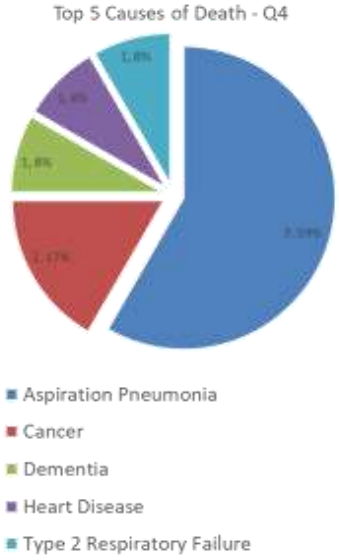



## 3. Causes of Deaths

Pneumonia (including Aspiration and Broncho) still remains the highest cause of death, with 59% in Q4, compared to 54% in Q3.

In Q4 it is the first time we have not seen Covid-19 in our top 5 causes of death due to the decrease in Covid-19 cases and the roll out of the vaccine.

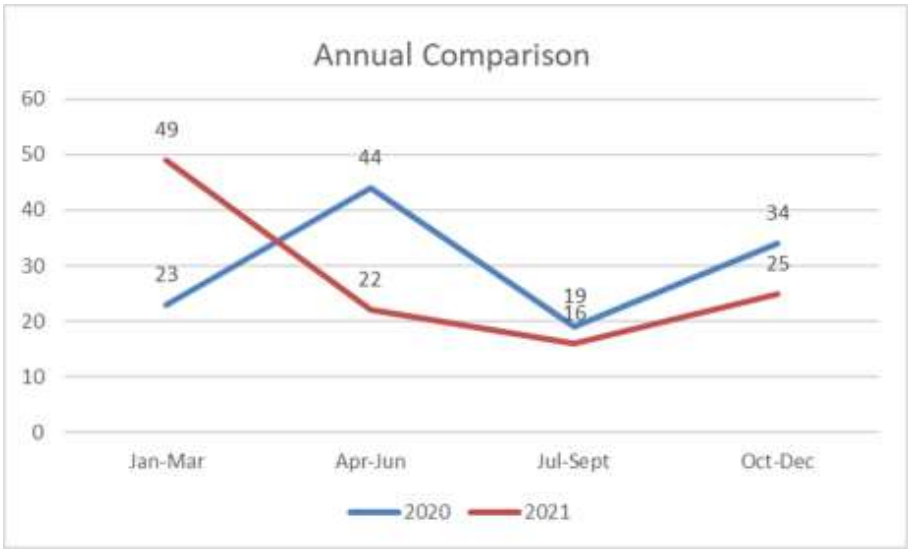



**Number of Deaths - Annual Comparison**

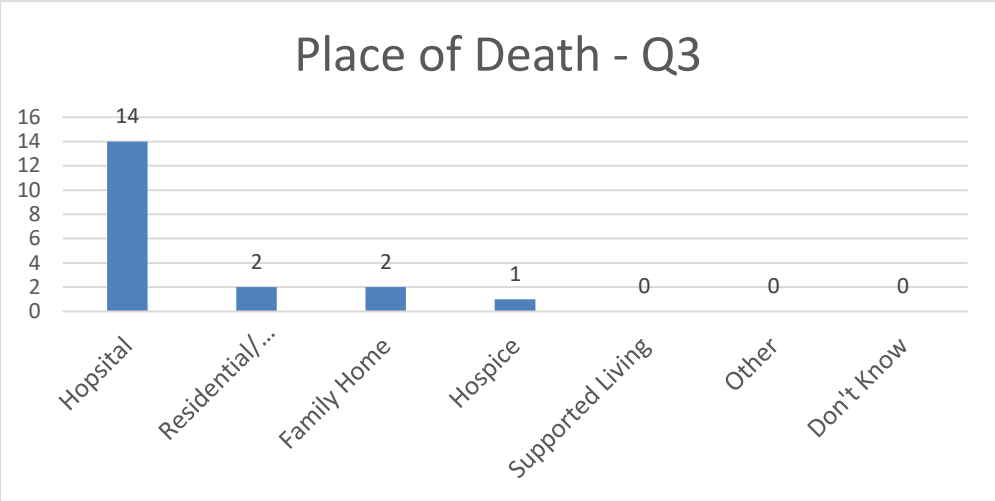
The graph below shows the annual number of deaths across each quarterly period.

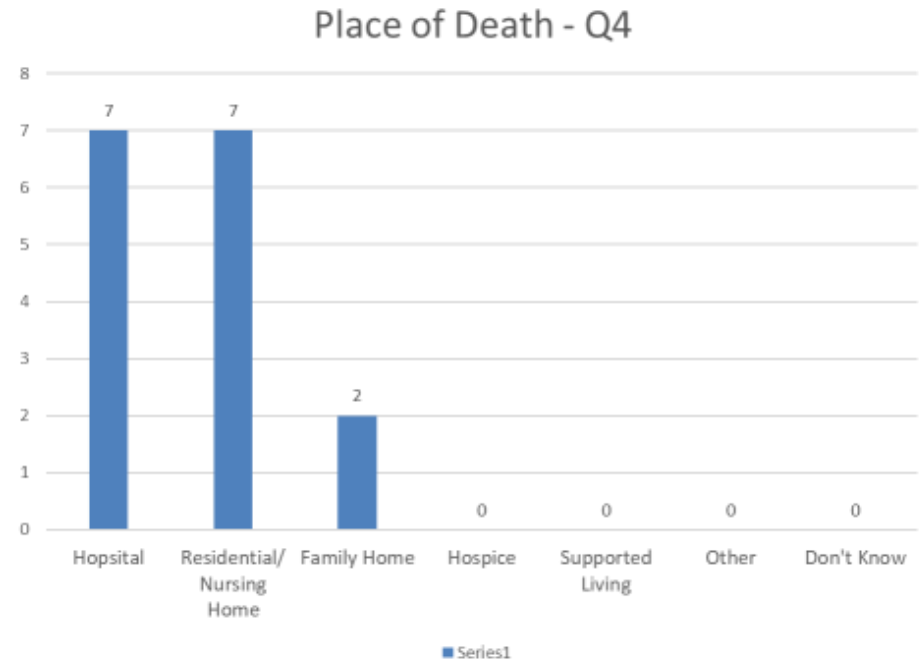
- 2020 displays from Jan 2020 – Dec 2020 deaths
- 2021 displays from Jan 2021 – Dec 2021 deaths



## 4. Place of Death

For the first time in this last year, we have seen a significant change in the number of deaths in Hospitals vs other places of death. In Q4, there was an equal number of Hospital and Residential/ Nursing Home deaths at 7, compared to Q3, where the Hospital deaths were still much higher at 14 out of 19 deaths recorded.



# 5. Best Practice & Learning from Reviews

Alongside the Focused Review Panel Meetings, An Operational Group has been set up to undertake Deep Dive's on the wider themes and trends identified in the initial reviews and to ensure learning is not lost from these reviews. The first Deep Dive will begin in June 2022, theme to be confirmed.

The learning that was identified in quarter 3 remains relevant for quarter 4, all actions are in various stages of progress.

Learning and Actions

- Within the Focused Review Panel Meetings, an issue had been identified that "Did Not Attend (DNA): Was not brought to outpatient appointments" was appearing as a theme and these DNA appointments were not being followed up. - An action has been taken by the acute trust and the Learning Disability (LD) hospital nurse will be notified when there is a DNA and they will follow up with the local LD team.
- Lead GP for LD and LeDeR has taken forward an action to discuss with GP's a flagging system when someone with an LD does not attend an appointment (via Annual Health Check Steering Group). Further to this action, another action has been taken forward by our GP Lead to arrange for letters to be checked by admin and raised if there is a DNA by a patient with an LD.
- Arrangements for all GP practices to have one admin person as a LD Champion.
- Data is being kept around the use of antipsychotic medication against the Cause of Death, this is in the early stages and will be analysed when further data is collected.
- A LeDeR reviewer is attending the Trust' STOMP/STAMP Meetings, End of Life Care Meetings and Annual Health Check Steering Group Meetings to gain wider learning and to pass on themes and trends from reviews.
- Contact is being made with Local Authority (education) to discuss concerns regarding transfer of care from educational settings and possible actions we can take to address these. KCHFT is taking this forward.
- "Identifying Sepsis" guidance to be looked at by Lead GP and panel members re issues being raised in reviews with carers not identifying infection markers.
- GP onward referral letters to include that a person has an LD at the very beginning of the letter so recipient is aware that reasonable adjustments may be needed.

Positive Practice

- The LeDeR team have attended Provider Conferences and held workshops.
- Offered individual providers workshops.
- The Outpatient Action is progressing at different rates in each individual Hospital.
- One of our reviewer's links in with other groups, for example STOMP and STAMP Steering Group, Annual Health Check Steering Group, End of Life Care (EOL) and Respect Group.
- From May, an individual reviewer will be a link person for each CLDT.
- Deep Dives will include members of the CLDT.
- Deep Dives will occur on initial reviews.
- A Task & Finish Group will be held at QEQM regarding DNACPR's.
- Enforcing LD Champions in GP Practices.

- Bulletins now go out to CLDT's GP's and Safeguarding Boards.
- Co-producing documentation with people with lived experience and a local group called Bemix.

**KCHFT Learning Actions and Positive Practice:**

- From the 16 deaths reviewed, 11 people were open to KCHFT Community Learning Disability team; either Nursing, Physio, SLT or Occupational Therapy or a combination of therapies. Other services open to the same people were Community Dietetic and Nutrition teams or Community Nursing Teams.
- 6 Deaths were unexpected and have been progressed to Focused Reviews for further discussion.
- 2 of the deaths were graded as 'care fell short of expected good practice and could have contributed to the persons death'. These 2 people were not open and not known to any services in KCHFT. 1 case has been referred to safeguarding for further enquiry. Both cases have been through the Focused Review panel process.
- No issues have been attributed to services within KCHFT.
- Going forward members of KCHFT services will be invited to sit on the Focused Review panels.
- Each CLDT will have a link reviewer who will take back any learning and actions to the teams.

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 2.9 |
| **Agenda Item Title:** | Ockenden Inquiry KCHFT Assurance paper |
| **Presenting Officer:** | Dr Mercia Spare, Chief Nurse |
| **Action – this paper is for:** | Decision<br>Information<br>☒ Assurance |

**What is the purpose of the paper and the ask of the Committee or Board?**
*(Include reference to any prior Executive Team review) Has the paper been to any other meeting or committee?*
The purpose of this paper is to summarise the findings from the Ockenden public inquiry in to maternal, new born and infant deaths at The Shrewsbury and Telford Hospital NHS Trust (2009-2014).

While Kent Community Health NHS Foundation Trust (KCHFT) do not directly provide maternity services, we do provide Heath Visiting services which enable continuation of care for new born babies and infants. Not all of the findings from the inquiry are directly relevant to KCHFT however, there are a number of wider findings relating to governance and leadership which do translate to our statutory responsibilities. The Board is asked to note the assurance statements for KCHFT in response to the findings.

**Summary of key points**

The Independent Review was established following a number of serious clinical incidents (1592), beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

a. appropriate investigations were conducted; and
b. the assurance processes relating to investigations in the maternity service were adequate.

Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones. The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to

learn lessons from serious events in the past. The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

The review was commissioned by the Secretary of State for Health. The NHS Senior Responsible Officer for the review is the National Medical Director of NHS Improvement and NHS England who periodically updated the Department of Health and Social Care on progress.

The review continued to be led by independent Chair, Donna Ockenden and the final report was presented to the Department of Health and Social Care. The Chair was supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

A number of findings were published relating directly to maternity services but also wider governance-based findings that would apply to all healthcare providers. The paper provides and assurance statement against all of the findings relevant to KCHFT.

| **Proposal and/or recommendation to the Committee or Board** |
|---|
| The Board is asked to receive the assurance statements for KCHFT in response to the findings. |

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis (EA) for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br><br>**If not describe any equality and diversity issues that may be relevant.**<br><br>*Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy* | ☐ Yes *(please attach)*<br><br>☑ No<br>*(please provide a summary of the protected characteristic* |

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

| | | | |
|---|---|---|---|
| Name: | Dr Mercia Spare | Job title: | Chief Nurse |
| Telephone number: | 07384878317 | Email | mercia.spare@nhs.net |

Kent Community Health NHS Foundation Trust

## THE OCKENDEN PUBLIC INQUIRY

### 1. Introduction

It is important to note that KCHFT do not provide maternity services, however due to the nature of some of the wider findings and recommendations which were in relation to leadership, clinical governance, investigations, communication, multiagency care and seamless transfers of care for patients, service users, clients and their significant others, KCHFT systems and processes were assessed against the services KCHFT provide, including Health Visiting.

1.1. The Independent Review was established following a number of serious clinical incidents, beginning with the death of a new born baby in 2009; an incident which was not managed, investigated or acknowledged appropriately by the Trust at the time. From 2009 to 2014 a number of further investigations and reviews (internal and external) were undertaken to confirm whether:

a. appropriate investigations were conducted; and
b. the assurance processes relating to investigations in the maternity service were adequate.

1.2. Serious complications and deaths resulting from maternity care have an everlasting impact on families and loved ones. The families who have contributed to this review want answers to understand the events surrounding their maternity experiences, and their voices to be heard, to prevent recurrence as much as possible. They are concerned by the perception that clinical teams have failed to learn lessons from serious events in the past. The learning of lessons and embedding of meaningful change at The Shrewsbury and Telford Hospital NHS Trust and in maternity care overall is essential both for families involved in this review and those who will access maternity services in the future.

1.3. In the summer of 2017, following a letter from bereaved families, raising concerns where babies and mothers died or potentially suffered significant harm whilst receiving maternity care at The Shrewsbury and Telford Hospital NHS Trust, the former Secretary of State for Health and Social Care, Jeremy Hunt, instructed NHS Improvement to commission a review assessing the quality of investigations relating to new-born, infant and maternal harm at The Shrewsbury and Telford Hospital NHS Trust.

### 2. Governance

2.1 The review was commissioned by the Secretary of State for Health.

2.2 The NHS Senior Responsible Officer for the review was the National Medical Director of NHS Improvement and NHS England who reported progress to the Department of Health and Social Care.
2.3 The review continued to be led by independent Chair, Donna Ockenden and the final report was presented to the Department of Health and Social Care.
2.4 The Chair was supported by the Review Team, a multidisciplinary clinical team of independent external reviewers.

## 3. Recommendations

3.1 The Independent Inquiry made recommendations and these can be found in Appendix A.
3.2 There is no single legislative or regulatory mechanism to ensure safety for all and therefore a review of the recommendations which are relevant to KCHFT with a statement of assurance is also detailed in Appendix A.

**Dr Mercia Spare**
**Chief Nurse**
**May 2022**

Kent Community Health NHS Foundation Trust

**Appendix A**

**KCHFT assurance statements in response to the recommendations from the Ockenden Public Inquiry in to maternity services at Shrewsbury and Telford NHS Trust**

| Recommendations from the Ockenden Inquiry | Government's response to the independent inquiry report | KCHFT Statement of Assurance |
|---|---|---|
| Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight | Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months. | KCHFT do not provide maternity services. However, Health Visiting services provide continuing care for babies and infants. Health Visiting was previously a member of the Safety and Quality local Maternity System (LMS) which was an opportunity for collaborative learning following Serious Incidents. This group has now been disbanded following revisions to the LMS structure as part of the ICB development. Jinny Robinson-Bright (Clinical Services Manager) is leading discussions on to how joint learning can be achieved in the new structure. |
| | External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum foetal death, maternal death, neonatal brain injury and neonatal death. | Community child death notifications are received by the safeguarding team and the Chief Nurse. KCHFT have a Mortality Surveillance group in place that also receives child death reports. The directorate Head of Quality is the representative for the health visiting service at that group, to enable shared learning - this is an internal KCHFT group and process. |
| | LMS must be given greater responsibility | Not relevant to KCHFT as we do not deliver |

| | | |
|---|---|---|
| | and accountability so that they can ensure the maternity services they represent provide safe services for all who access them. | maternity services. |
| | An LMS cannot function as one maternity service only. | Not relevant to KCHFT as we do not deliver maternity services. |
| | The LMS Chair must hold CCG Board level membership so that they can directly represent their local maternity services which will include giving assurances regarding the maternity safety agenda. | Not relevant to KCHFT as we do not deliver maternity services. |
| | All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months. | Not directly relevant to KCHFT as we do not deliver maternity services however, a summary of all SI investigations are reported bimonthly to the quality committee for assurance and this is provided to the Board via the quality committee chair who is a non-executive director. |
| Maternity services must ensure that women and their families are listened to with their voices heard. | Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. | This is not directly relevant to KCHFT however, Karen Whitehouse (Head of Operational Services Health Visiting) is the representative at the Maternity Voice's Partnership Group who links our engagement and workstreams with wider work and feeds back any learning that may be relevant for KCHFT Health Visiting services.<br><br>KCHFT have developed 'The Strong Programme' for patient engagement and co-design which was recently received an |

| | | |
|---|---|---|
| | | award due to their successful work<br><br>The Chief Operating Officer leads on the operational engagement and oversight on delivery of health visiting services. |
| | Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. | Not relevant to KCHFT as we do not deliver maternity services. |
| | CQC inspections must include an assessment of whether women's voices are truly heard by the maternity service through the active and meaningful involvement of the Maternity Voices Partnership | KCHFT have an embedded 'we care' process where internal reviews are arranged of services operated by KCHFT; this includes Health Visiting. The visits are designed to allow teams to showcase their services and the hard work they are continually providing as well as hearing the voice of the patients/people that receive our care. |
| Staff who work together must train together. | Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. | Health visiting teams are aligned to district geographical based teams and training is gained based on the trusts mandatory requirements and the health visiting competency-based statement pack for each individual role in line with the regulatory bodies. This is a health visitor led service therefore multidisciplinary training opportunities are limited. |
| | Multidisciplinary training and working | Not relevant to KCHFT as we do not deliver |

| | | |
|---|---|---|
| | together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward.<br><br>Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only. | maternity services.<br><br>Not relevant to KCHFT as we do not deliver maternity services. |
| There must be robust pathways in place for managing women with complex pregnancies through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. | Women with complex pregnancies must have a named consultant lead.<br><br>Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team.<br><br>The development of maternal medicine specialist centres as a regional hub and spoke model must be an urgent national priority to allow early discussion of complex maternity cases with expert clinicians.<br><br>This must also include regional integration of maternal mental health services | Not relevant to KCHFT as we do not deliver maternity services. |
| Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway | All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.<br><br>Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. | Not relevant to KCHFT as we do not deliver maternity services. |
| All maternity services must appoint a dedicated Lead Midwife and Lead | The Leads must be of sufficient seniority and demonstrated expertise to ensure they | Not relevant to KCHFT as we do not deliver maternity services. |

| | | |
|---|---|---|
| Obstetrician both with demonstrated expertise to focus on and champion best practice in foetal monitoring | are able to effectively lead on: Improving the practice of monitoring foetal wellbeing; Consolidating existing knowledge of monitoring foetal wellbeing; Keeping abreast of developments in the field; Raising the profile of foetal wellbeing monitoring; Ensuring that colleagues engaged in foetal wellbeing monitoring are adequately supported; Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.<br><br>The Leads must plan and run regular departmental foetal heart rate (FHR) monitoring meetings and cascade training. They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice.<br><br>The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines | |
| All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. | All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care<br><br>Women must be enabled to participate | Not relevant to KCHFT as we do not deliver maternity services. |

| | | |
|---|---|---|
| | equally in all decision-making processes and to make informed choices about their care.<br><br>Women's choices following a shared and informed decision-making process must be respected | |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 3.1 |
| **Agenda Item Title:** | Summary Annual Plan for 2022/23 |
| **Presenting Officer:** | Gerard Sammon, Director of Strategy and Partnerships |

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

**Report history and purpose**

Each year the Trust produces an Annual Plan for the coming year. This sets out an overview of the plans for the Trust. An engagement exercise was undertaken to give a range of stakeholders across the organisation the opportunity to shape what the Trust prioritises and moves on further and faster. The Executive Management Team have co-developed the summary Annual Plan for 2022/23 for Trust Board approval.

**Summary of key points**

The Annual Plan is a cumulation of plans from across the organisation that have been developed by our people and stakeholders through our business planning and priority setting process.

Our key focus for 2022/23 will be on improving the quality of care we provide to all our service users and the experience and wellbeing of our staff. To do this we will focus on the four priorities of:

- Improving staffing levels
- Equity, diversity and inclusion and reigniting the passion
- Continual quality improvement
- Digital

This summary plan also highlights the agreed activities from key supporting strategies notably the Trust's People and Quality Strategy. Operational, activity and financial plans are also summarised in the plan which expect to deliver all national performance targets and a breakeven position. Our plans align and support the delivery of the national operating plan guidance and system plans.

Progress against components of the plan is overseen by the Board and its committees and is monitored by Executive Performance Reviews. The Trust Annual Report will outline the achievements we have made against this plan.

**Equality impact assessment (EIA)**

An EIA process has been conducted when required for the component parts of the annual plan.

| **Proposal and/or Recommendation to the Board or Committee** | |
|---|---|
| The Trust Board is asked to<br>• approve the summary Annual Plan for 2022/23 | |
| Gerard Sammon | Tel: 01622 211902 |
| Director of Strategy and Partnerships | Email:Gerard.sammon@nhs.net |

Kent Community Health
NHS Foundation Trust

# Annual Plan 2022/23

## Summary

we care

# Our strategy

NHS
Kent Community Health
NHS Foundation Trust

## Our vision

A community which **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 focus for 2022/23

- **Increase staffing levels** by 132 people by March 2023, including 100 new international recruits and retention activities to retain our staff (reducing turnover to 14.5 per cent).

we care

- **EDI and reigniting the passion,** making KCHFT a place everyone can bring their whole self to work, focus on health and wellbeing, reset services. 75 per cent of staff recommend KCHFT as a place to work.
- **Continual quality improvement** embedded into the culture, empowering staff to deliver changes they want to make.
- **Digital –** use KMCR to give staff a joined up view of patient care and treatment plan, give patients access to My Care record, improve and invest in systems and equipment to help staff do their job.

# Annual Plan 2022/23 Summary

We will focus on improving the quality of care we provide to all our service users and the experience and wellbeing of our staff

Kent Community Health NHS Foundation Trust

## Our focus for 2022/23

### 1. Increasing staffing levels

**Activities to be delivered in 2022/23**

- Reduce turnover rate to below 14.5 per cent by 2023
- Recruit 100 international nurses
- Improve recruitment processes to attract and retain diverse candidates

**Our key achievements will be…**

An additional 132 people employed at KCHFT by March 2023 compared to March 2022

### 2. Equity, Diversity and Inclusion and reigniting the passion

**Activities to be delivered in 2022/23**

- Support staff health and wellbeing
- Start cultural awareness training
- Promote flexible working
- Reset services: urgent response and waiting times, virtual wards

**Our key achievements will be…**

75 per cent of staff recommend KCHFT as a place to work (compared to 70% in 2021/22)

### 3. Continual quality improvement

**Activities to be delivered in 2022/23**

- Use QI tools to support demand and capacity challenges
- Embed QI into processes to drive a culture of continuous improvement and avoid duplication

**Our key achievements will be…**

Six teams identified by July 2022 to drive change with a goal of releasing capacity and sharing evidenced learning by quarter four 2022/23

### 4. Digital

**Activities to be delivered in 2022/23**

- Introduce My Care record for patients in Kent and Medway
- Engage staff to improve and invest in systems to ease use
- Use PowerBI for high-quality data

**Our key achievements will be…**

Patients across Kent and Medway can access their digital care record by March 2023

we care

# People

We will go further and faster with people this year focusing on EDI, reigniting the passion of our staff and recruitment and retention.

**Key outcome**
Improvement in staff survey results across all categories

**Delivery of the People, Equity, Diversity and Inclusion Strategy year one activities and the People Strategy year two activities will be monitored by the Strategic Workforce Committee**

### Recruitment and retention

- Improve staff work-life balance
- Reduce our vacancy rate to 14.5 per cent
- Recruit 100 international nurses to join the 19 already recruited from Ghana/Nigeria
- Continue to 'grow our own' through our academies
- Review recruitment processes and communications to be through EDI lens
- Inclusive recruitment training for managers
- Use ethnically diverse shortlisting panels
- Start targeted and creative recruitment campaigns to attract colleagues with protected characteristics

we care

### Equity, diversity and inclusion

Making KCHFT a place everyone can bring their whole selves to work through:

- continuing the reciprocal and BAME mentoring for inclusion programme
- promoting staff networks to colleagues to become allies
- improving cultural awareness through training for all staff
- promoting flexible working options
- promoting support available to staff, particularly the support for carers

### Reigniting the passion

- A clear focus on staff health and wellbeing and reigniting staff pride in the value of roles and professions
- Supporting staff with the psychological impact of delivering care to patients during the pandemic

### Staff number changes

Service developments utilising ageing-well funding, investments in public health initiatives and service developments will see further growth in our workforce across varying grades and professions in 2022/23. The impact of these workforce changes is an overall increase in WTEs of 132 (a three per cent increase).

# High quality care

We will go further and faster with high quality care this year focusing on Quality Improvement as the way we do things at KCHFT.

**Key outcome**
Devolution of decision making to front line, self-directed teams is business as usual

**Delivery of the Quality Strategy year two activities and the Quality Priorities for 22/23 will be monitored by the Quality Committee**

Quality Strategy has eight components:

1. continual improvement
2. use information to drive improvement
3. promote positive staff experience
4. improving patient and carer experience
5. reduce health inequalities
6. effective use of resources
7. prioritise patient safety
8. promote clinical professional leadership

we care

Focus on continual improvement (QI) by:

- extending QI training options to increase uptake
- using QI tools in areas where demand and capacity are most challenged
- evidencing the impact of QI projects
- embedding QI into processes to drive a culture of continuous improvement, reduce waste and avoid duplication

Quality priorities have been developed by staff. They are:

**1. Improving the safety of the people we care for**

- Prevent pressure ulcers
- Reduce missed/deferred visits
- Improve tongue-tie booking service

**2. Improving clinical effectiveness**

- Increase research
- Pursue innovation
- Improve access to paediatrics

**3. Improve the experience of the people we care for**

- Co-design services with users
- Improve waiting experience for podiatric surgery
- Increase contacts with young people to reduce inequalities in Children's services

**4. Improve the experience of our people**

- Culture where everyone can be themselves
- Recruit staff which represent our community
- Model of clinical supervision in specialist services and public health division

# Operational and activity plans

Focus on resetting services by strengthening workforce, using QI and working collaboratively with service users, carers and partners.

**Key outcome**
Achieve all performance targets

**Operational plans will be overseen through Executive Performance Reviews. Activity and performance against targets will be monitored by the Trust Board. Our plan expects to deliver all national performance targets. Our plans align and support the delivery of the national operating plan guidance and system plans.**

## Specialist Services and Public Health

- Enhance Neurodevelopmental services including new partnership working for adult and children
- Increase time to care and variations in performance through QI and innovation
- Improve and increase collaborative working including Kent County Council, schools and other providers

we care

## Adult services

- Demand and capacity in community nursing
- Virtual wards (respiratory/frailty)
- Two hour urgent care response
- Community hospital strategy
- Therapies capacity
- Partnership delivery of pathways one and three
- Community early supported discharge and stroke rehabilitation
- Development of Urgent Treatment Centres
- Review of specialist pathways

## Dental and planned care

- Partnership working with acute trusts in east and west Kent to facilitate timely discharge to podiatry care
- Digital technology for online booking across the division
- Develop a Single Point of Access for referrals automation and clinical triage to treat patients at the right place/time
- Prison dental and podiatry services
- Demand and capacity planning for all services in the division. Mapping of resources against draft dental specification for east Kent
- Drivability service improvements – marketing, information system and pilots

## Pharmacy

Support to Urgent Treatment Centres, Neurodevelopmental pathway, HIV, overprescribing Kent and Medway system workstream, electronic prescribing and medicines administration.

## Activity

3.2 per cent increase in activity overall with the highest increases expected in:

- planned care primarily in respiratory, podiatry, musculoskeletal (MSK) and orthopaedics
- Urgent Treatment Centres
- Community Hospitals
- Crisis Response 2 hour demand

# Digital, estates and sustainability

We are a system leader in digital rolling out KMCR and MyCare Record as well as internally introducing PowerBI to improve data quality. We are improving the quality and sustainability of our estate.

**Key outcome**
Patients can access their digital care record

**Delivery of the Digital, Estates and Sustainability strategies will be overseen by the Finance, Business and Investment & Strategic Workforce Committees as well as Executive Performance Reviews. Our digital strategy and plans for this year meet the national operating plan guidance for all providers to obtain a core level of digitisation by March 2025.**

## Digital

- Lead digital transformation through Kent and Medway Care Record (KMCR) roll out
- Introduce My Care record – patient accessible part of KMCR
- Adopt PowerBI to improve the quality of data
- Use data to drive continuous quality improvement

Capital plan focuses on:

- My Care Record for Kent and Medway
- further RiO development
- better integrating RiO with other clinical systems
- improving infrastructure and ease of use of technology for our staff

we care

## Corporate Services:

- Reset buildings and services from the impact of Covid by:
  - supporting services to deliver more care digitally
  - making sure spaces meet IP&C standards as well as those of the staff and patients
  - maintaining and improving the quality and safety of the care environment
- Continue to implement National Standard of Cleanliness 2021
- Continue to meet statutory safety compliance requirements for all general working and clinical environments
- Improving environmental sustainability by increasing our green spaces, moving towards green energy, reducing carbon use and supporting education

Capital plan of £2.2m for estates focuses on:

- backlog and proactive maintenance of eight properties owned by NHS Property Services until 2022/23
- sustainability schemes such as solar panels

# Financial plans

We plan to breakeven in 2022/23. Our funded capital plan is £6.9m, savings plan is £6.7m (2.5 per cent of budget) and a stable cash position through 2022/23.

**Key outcome**
Deliver financial plan to breakeven in 2022/23

**Delivery of the financial plan will be monitored by the Finance, Business and Investment Committee (FBI). Any changes to our financial plan in year will be discussed and approved at both FBI and Trust Board.**

## Income and expenditure for 2022/23:Breakeven

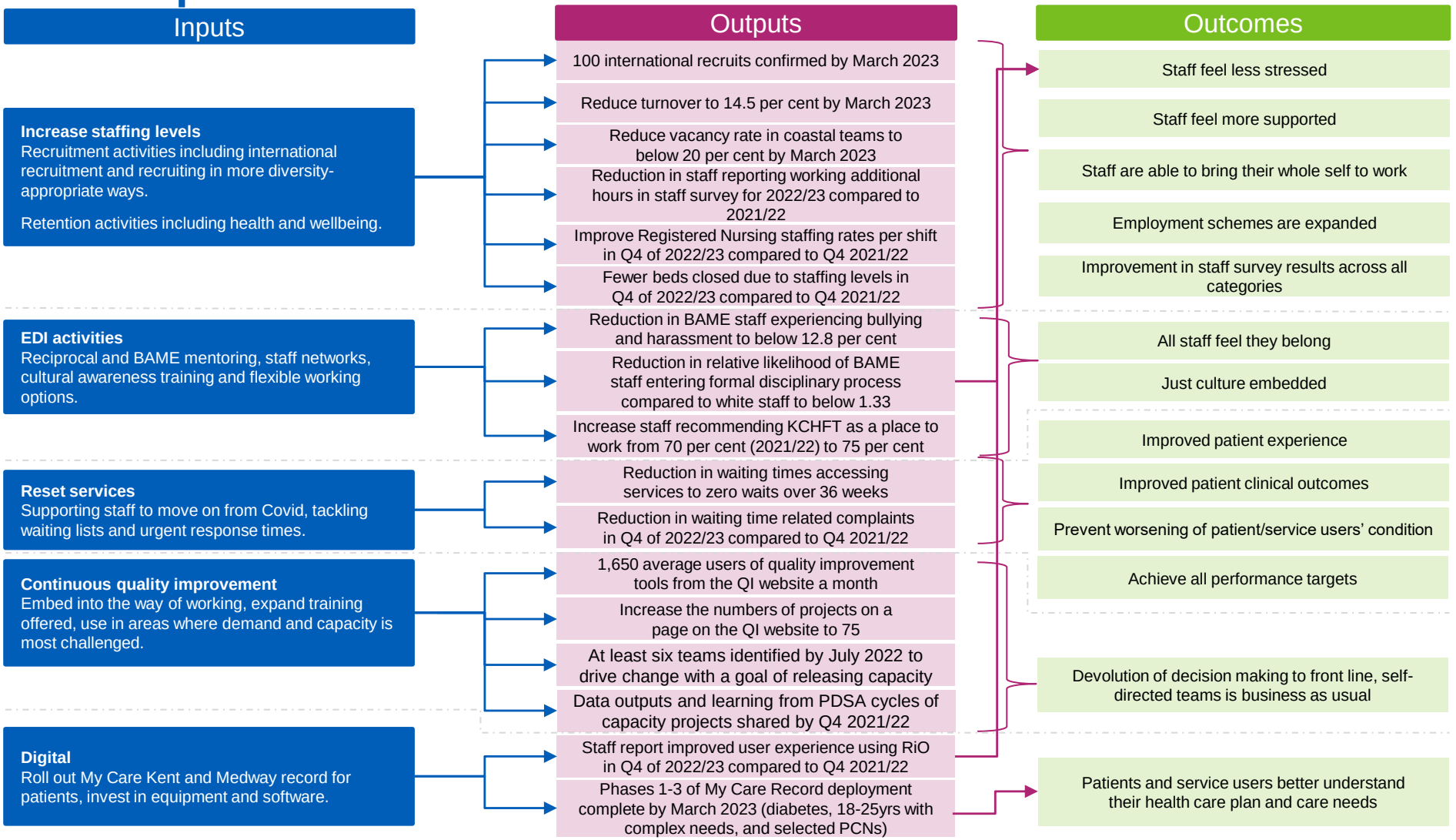
While we expect to breakeven, this is reliant on confirmation of funding from commissioners and achieving a challenging savings programme. We undertake quality impact assessments on our savings plans to make sure there is no negative impact on the wellbeing of our people and the quality of care we provide. Our savings plan is £6.7m (2.5 per cent of trust budget).

| | 2021/22 budget £m | 2022/23 budget £m | Change £m | Change % |
|---|---|---|---|---|
| Income | 258.7 | 273.4 | 14.7 | 5.7% |
| Pay | 194.9 | 202.9 | 8.0 | 4.1% |
| Non-pay | 58.1 | 55.8 | -2.3 | -4.0% |
| EBITDA | 5.7 | 14.7 | 9.0 | 158.1% |
| EBITDA % | 2.2% | 5.4% | | |
| Depreciation and financing | 5.7 | 14.7 | 9.0 | 158.2% |
| Surplus | 0 | 0 | 0 | 0.0% |
| Surplus % | 0.0% | 0.0% | | |

## Capital plan for 2022/23: £6.9m

| Area of capital spend | £m |
|---|---|
| Estates | 2.2 |
| IT | 4.3 |
| Dental | 0.2 |
| Other minor schemes/equipment | 0.2 |
| TOTAL | 6.9 |
| **Funding** | **£m** |
| Provider operational capital allocation | 5.7 |
| Frontline digitisation – EPMA | 0.5 |
| KMCR (external funding) | 0.7 |
| TOTAL | 6.9 |

# Annual plan 2022/23



Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 3.2 |
| **Agenda Item Title:** | Ratification of Terms of Reference of Committees |
| **Presenting Officer:** | John Goulston, Trust Chair |
| **Action – this paper is for:** | ☒ Decision<br>☐ Information<br>☐ 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
- Remuneration Committee
- Strategic Workforce Committee

**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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.** | ☐ Yes *(please attach)*<br><br>☒ No |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| *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 |

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.<br>Update references to CFSMS to NHS Protect in TOR.<br>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.<br>Reallocation of delegated decision- |

| Version | Draft/Final | Date | Author | Summary of changes |
|---|---|---|---|---|
| | | | | making from ARC to FBI Committee.<br>Amendment to Section 5.3 Membership, Removal of reference to attendance. |
| 2.5 | Draft | February 2017 | Gina Baines | Minor amendments:<br>Trust logo updated.<br>Job titles updated. |
| 2.6 | Draft | February 2018 | Gina Baines | Removed reference to resourcing of the clinical audit function in Section 1.2 Objectives.<br>Inclusion of Strategic Workforce Committee in the list of 5.4 Key Relationships<br>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.<br>Deletion of clinical audit assurance. This has been transferred to the Quality Committee.<br>Amendment of External Audit reference from 'Audit Commission rules' to 'ethical standards'.<br>Addition of consideration of any published external reviews which relate to the Trust's services.<br>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 least 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 |
| 2.10 | May 2021 | KCHFT Board | May 2022 |
| 2.10 | February 2022 | Audit and Risk Committee | February 2023 |

## 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<br><br>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.<br>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<br>Key relationships – delete Audit and Risk Committee and replace with Finance, Business and Investment Committee<br>Declarations of interest – further explanation |
| 1.8 | Draft | 04.05.2022 | Gina Baines | Section 5 – Membership: updated to reflect revised committee membership agreed by the Board, March 2022 |

**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 |

| Version | Approved date | Approved by | Next review due |
|---|---|---|---|
| 1.6 | May 2020 | KCHFT Board | May 2021 |
| 1.7 | January 2021 | Charitable Funds Committee | January 2022 |
| 1.7 | May 2021 | KCHFT Board | May 2022 |
| 1.7 | April 2022 | Charitable Funds Committee | January 2023 |

**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 activies 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 | One Non-Executive Director<br>Chief Nurse<br>Director of People and Organisational Development<br>Governor |
| In Attendance | Staff Side Representative<br>Fund Managers<br>Head of Campaigns and Digital |

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

**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<br>Amendment to point 2.2 - A quorum shall be three members, including at least two non-executive directors.<br>Amendment to point 6.1 Finance regarding model contracts<br>Amendment to point 6.3 Investments regarding bank mandates<br>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 |
| V7.0 | Final | May 2021 | KCHFT Board | Removal of paragraph 3.2 regarding NED attendance at meetings. |
| V8.0 | Final | May 2022 | Gina Baines | Section 2: Membership - updated to reflect revised committee membership agreed by the Board March 2022. |

**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 |
| 7.0 | May 2021 | KCHFT Board | May 2022 |
| 8.0 | May 2022 | Finance, Business and Investment Committee | March 2023 |

**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:

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

- Medical Director

The 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.

**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.<br>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<br>Addition of reference to Finance, Business and Investment Committee<br>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.<br>5.0 Governance Standard agenda - removal of reference to red flags and EWTT; inclusion of a number of new regular agenda items.<br>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<br>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 |
| 2.6 | Draft | 10.05.2022 | Gina Baines Assistant Trust Secretary | Membership: addition of Director of Strategy and Partnerships |
| 2.6 | Draft | 19.05.2022 | Mercia Spare, Chief Nurse | Addition of one objective relating to the Quality Committee's responsibility for overseeing the relevant aspects of the NHS publication 'Enhancing Board Oversight'. |

**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 |
| 2.5 | 20.05.2021 | KCHFT Board | May 2022 |
| 2.6 | 19.05.2022 | Quality Committee | March 2023 |

## 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

- In line with the requirements of 'Enhancing Board Oversight' (NHS December 2021) the committee will take responsibility for obtaining assurance on the following elements of quality and safety:

    - Hip Fractures, falls and dementia
    - Palliative and end of life care
    - Resuscitation
    - Learning from deaths
    - Safeguarding
    - Lead for children and young people

- 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, Director of Strategy and Partnership 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<br><br>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

# REMUNERATION COMMITTEE

**Document Control**

| Version | Draft/Final | Date | Author | Summary of changes |
|---|---|---|---|---|
| 1.0 | Draft | 21 March 2011 | Craig Sharples | New document |
| 1.1 | Final | 17 January 2012 | Craig Sharples | Minor amends to reflect organisational change |
| 1.3 | Final | 16 March 2015 | Rob Field | Amended to reflect Foundation Trust status |
| 1.4 | Final | 18 May 2017 | Gina Baines Assistant Trust Secretary | Amended trust logo |
| 2.0 | Draft | May 2018 | Louise Norris, Director of Workforce, Organisational Development and Communication | Revision of content and reformatted |
| 2.1 | Final | November 2019 | Louise Norris, Director of Workforce, Organisational Development and Communication | Committee renamed as Remuneration Committee |
| 2.2 | Final | May 2020 | Louise Norris, Director of Workforce, Organisational Development | Section 4 – Role of the Council of Governors – no longer required to approve the proposed remuneration of the Chief Executive |

| | | | | |
|---|---|---|---|---|
| | | | and Communication | |
| 2.3 | Final | March 2022 | Victoria Robinson-Collins, Director of People and Organisational Development | Updated reference to Monitor<br>Section 6 - Membership<br>Section 7 – Quoracy |
| 2.3 | Final | May 2022 | Gina Baines Assistant Trust Secretary | Document control and review tables updated and included |

**Review**

| Version | Approved date | Approved by | Next review due |
|---|---|---|---|
| 1.0 | 4 April 2011 | KCHT Board | April 2012 |
| 1.1 | 26 January 2012 | KCHT Board | April 2012 |
| 1.2 | 6 April 2013 | Remuneration and Terms of Service Committee | April 2014 |
| 1.3 | 26 March 2015 | KCHFT Board | May 2016 |
| 1.3 | 26 May 2016 | KCHFT Board | May 2017 |
| 1.4 | 25 May 2017 | KCHFT Board | May 2018 |
| 2.0 | 24 May 2018 | KCHFT Board | May 2019 |
| 2.1 | 28 November 2019 | KCHFT Board | May 2020 |
| 2.2 | 21 May 2020 | KCHFT Board | May 2021 |
| 2.2 | 9 September 2021 | KCHFT Board | May 2022 |

Kent Community Health
NHS Foundation Trust

# KENT COMMUNITY HEALTH NHS FOUNDATION TRUST

# REMUNERATION COMMITTEE

# TERMS OF REFERENCE

## 1. ROLE

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

## 2. PURPOSE

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

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

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

## 3. DUTIES

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

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

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

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

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

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

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

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

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

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

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

- Approving any non-contractual payments that have to be reported to the HM Treasury (via NHSE/I);
- Approving any business cases for redundancy for any staff reporting directly to the Chief Executive or any other Executive Director, or where the value exceeds £100k, or where the business case requires reporting to HM Treasury;
- The structure, payment criteria and targets for any bonus or incentive scheme proposed by the executive;

- Approving the terms and conditions for any staff outside of nationally agreed pay frameworks;

- Considering and approving any payments in settlement of an employment tribunal claim

3.12 To undertake any other duties as directed by the Trust Board.

## 4. ROLE OF THE COUNCIL OF GOVERNORS

4.1 The Council of Governors is required to approve the appointment of the Chief Executive.

## 5. ACCOUNTABILITY

5.1 The Remuneration Committee is accountable to the Kent Community Health Foundation Trust Board.

5.2 **Accountable for:**
The Remuneration Committee has no sub committees.

## 6. MEMBERSHIP

6.1 Membership of the Committee includes the Chair, Deputy Chair, Senior Independent Director, Non-Executive Directors and Associate Non-Executive Director.

6.2 The Chief Executive Officer and other Executive colleagues may be invited as appropriate to attend to present papers or answer questions of Committee Members as appropriate. The Director of People and Organisational Development will attend in a note taking or advisory capacity as appropriate.

## 7. QUOROCY

7.1 The Committee will be quorate when comprised of the following members:
- Two attendees from either the Chair, Vice Chair or Senior Independent Director
- A minimum of two other NED colleagues

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 |
| 1.6 | Draft | 22.11.2021 | Victoria Robinson-Collins, Director of People and Organisational Development | Purpose updated to include assurance of monitoring trust wide workforce risks, including BAF workforce risks |
| 1.6 | Draft | 04.05.2022 | Gina Baines Assistant Trust Secretary | Section 5.3 – Membership – updated to reflect revised committee membership agreed by the Board, March 2022 |

**Review**

| Version | Approved date | Approved by | Next review due |
|---|---|---|---|
| 1.1 | 14.11.2017 | Strategic Workforce Committee | March 2018 |
| 1.1 | 30.11. 2017 | KCHFT Board | March 2018 |
| 1.2 | 30.01.2019 | Strategic Workforce Committee | March 2020 |
| 1.2 | 25.07.2019 | KCHFT Board | May 2020 |
| 1.2 | 18.03.2020 | Strategic Workforce Committee | March 2021 |
| 1.2 | 21.05.2020 | KCHFT Board | May 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 |
| 1.5 | 20.05.2021 | KCHFT Board | May 2022 |
| 1.6 | 22.04.2022 | Strategic Workforce Committee | April 2023 |

**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.

- The Strategic Workforce Committee is a sub-committee of the Board and as such provides assurance or exception monitoring of Trust wide risks relating to workforce, including BAF workforce risks.

- 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 | Two Non-Executive Directors<br>Director of People and Organisational Development<br>Chief Operating Officer<br>Chief Nurse<br>Deputy Director of HR (EWD)<br>Deputy Director of HR (Operations)<br>Acting 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:** | 25 May 2022 |
| **Agenda Number:** | 4.1 |
| **Agenda Item Title:** | Integrated Performance Report |
| **Presenting Officer:** | Gill Jacobs, Acting Director of Finance |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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 currently 10 KPIs (26.3%) showing either a high  or low  positive trend (7 or more points above/below the mean or in a positive direction, or outside of the control limits), 15 (39.5%) showing a high  or low  negative trend whilst 13 (34.2%) are in normal variation 

Of the 15 showing a negative trend, 14 are also currently failing to achieve target. KPI 4.6 (remotely delivered activity) is experiencing an expected negative trend but is still above the target level of 25%.

Of the 10 showing a positive trend, 2 KPIs (KPI 1.1 Smoking Quits and KPI 2.8 DNA Rate) are currently off target but the trend is showing a move towards target level.

There are 4 KPIs where the target is negatively outside of control limits  . This suggests achievement is highly unlikely without a process or target change.

These are:

- KPI 2.9 LTC/ICT Response Times Met
- KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times
- KPI 4.2 Income & Expenditure - Surplus (%)
- KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5%.

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

**Quality**

- Two pressure ulcer lapses in care occurred with patients on our caseload that were identified during February and March 2022. One was low harm and one was a moderate harm incident.
- During February and March 2022, 193 falls were reported across the trust with a decrease of 9.4% (20) compared to the last period December 2021 and January 2022. Of the 193 falls, there was one avoidable incident that resulted in no harm to the patient.
- 101 reported medication incidents were considered avoidable to KCHFT during February and March 2022 compared to 88 incidents in December 2021 and January 2022, this represents a 14.7% increase. There was an increase in incident reporting by the immunisation team and community nursing. They were all no harm incidents.

**Workforce**

- Turnover (17.18%) continues to report above the mean and the target, however, since the peak in January 2022 Turnover has decreased. Further analysis of the Turnover metric reports that the Health Care Scientists & Nursing and Midwifery Staff groups experience the highest rate of turnover throughout the last 12 months, closely followed by Allied Health Professional staff.
- At 5.69% the in-month sickness absence rate for March 2022 continues to report above the Mean and the Target, it has once again reached the same peak experienced in the second wave of Covid-19 (Dec 2020).
- From June 2021 the Vacancy rate had continued to decrease, however the last 2 months have increased and in March 2022 the Vacancy rate has reported an increase to 5.3%

**Finance**

- The Trust has a surplus of £9k at the end of the financial year, including £84k of costs for impairment of assets. The adjusted surplus (excluding the impairments) is £93k. The cumulative financial performance is comprised an overspends on pay of £6,020k (including £8,471k on the all ages covid vaccination programme which was not budgeted in line with the planning guidance) and non-pay of £4,046k offset by underspends for depreciation/interest/impairment of £310k and an over-recovery on income of £9,765k.

- The Trust achieved the CIP target of £4,415k in full for the financial year.
- Capital: Spend to March was £8,250k, against a YTD plan of £12,698k. Of the total £8,250k spend, £4,985k was internally funded and £3,355k was funded by PDC. The full year variance of £4,448k is the net effect of the redistribution of the £4,924k ring-fenced funding which was held on behalf of the K&M system for system priorities plus the additional spend of £243k for the KMCR project and new external funded projects totalling £271k. There was also a minimal underspend of £38k on internally funded projects due to Estates minor works schemes not progressing in March 2022 as expected
- Temporary staff costs for March were £1,735k, representing 11.1% of the pay bill. Of the temporary staffing usage in March, £449k related to external agency and locums, representing 2.9% of the pay bill. Contracted WTE decreased by 23 to 4,298 in post in March which includes 10 posts funded by capital projects. Vacancies increased to 242 in March which was 5.3% of the budgeted establishment.

**Operations**

- Expected Health Checks annual target for the service for 2021/22 was 6802 which covered both KCHFT core team and 3rd party providers, with both areas far exceeding this.
- Stop Smoking Quit Dates Set for 21/22 remain on track with current performance around target level. The data will not have finished yet for 2021/22 as new need to wait for all the patients to go assess their 4-week outcomes.
- The Health Visiting new birth visit performance has continued to perform strongly above the mean and target level, with no current areas of concern. Performance for 2021/22 (93.3%) was slightly down on 2020/21 (94.5%), most due to the dip in Q1.
- During Month 12 (March 2022) KCHFT carried out 183,882 clinical contacts, with a total of 2,046,126 for the year. For the financial year to March 2022 KCHFT this was 1.8% above plan for all services (some services have contractual targets, some are against an internal plan). The only negative variance was within Dental and Planned Care Services (-12.2%).
- We continue to achieve the consultant-led Referral to Treatment (RTT) pathway target of 92% of patients beginning treatment within 18 weeks, with the Month 12 position being at 99.9%, with only 3 patients out of 3,795 currently waiting longer than 18 weeks.
- Diagnostics waits compliance for month 12 was 96.9%, which gave the service an annual figure of 97.8%. The service continues to have some capacity issues due to covid related sickness vacancy and maternity leave resulting in short notice cancellations of clinics and this will continue to impact the service performance in Month 1 and compliance is likely to be impacted.

- The Looked after Children's service continues to see higher referrals, with a particular increase in the numbers of Unaccompanied Asylum-Seeking Children (UASC). Initial Health Assessments has seen a dip in performance with 53.8% being completed within 28 days of child becoming looked after. There were 16 requests from KCC in February and only 31% (5) of the requests from KCC were received by the service within 5 working days. However, it is of note that 93.3% were completed within 23 days of KCHFT receiving the referral.
- 2-hour urgent responses - Performance has recently been around the 60% mark (since the implementation of the new standard operating procedure) which is not out of line with national data, which is showing between 60-70%. However, there are signs of an improving trend with 3 consecutive monthly increases to 66.6% for M12.
- Health services are required to provide advice / complete assessment within 6 weeks from date of notification by local authority to proceed with an education, health and care (EHC) assessment to comply with statutory regulation. Compliance against the 6-week statutory response at M12 has improved from the previous month to 74%.
- No longer fit to reside (Community Hospital patients) - Performance continues to be adverse to the target, being rarely achieved in the current climate (twice in the last 25 months) with a current performance above the mean at around 25%.
- Bed Occupancy continues to show a varying trend, with current performance stable around the mean and just below the target threshold of 87-92% (85.8% at month 12).

| **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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.**<br><br>*Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and* | ☐ Yes *(please attach)*<br><br>☒ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |

| | |
|---|---|
| *maternity, race, religion or belief, sex and sexual orientation.* | |
| **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 |

NHS
Kent Community Health
NHS Foundation Trust

# Integrated Performance Report 2021/22

## May 2022 report

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

**UTC** – Urgent Treatment Centre

**RTT** – Referral to Treatment

**GUM** – Genitourinary Medicine

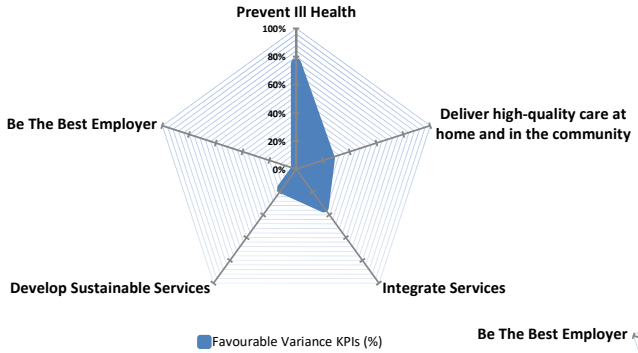
**CQUIN** – Commissioning for Quality and Innovation

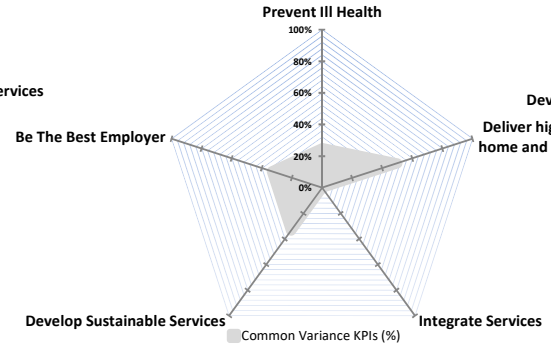
**MTW** – Maidstone and Tonbridge Wells NHS Trust

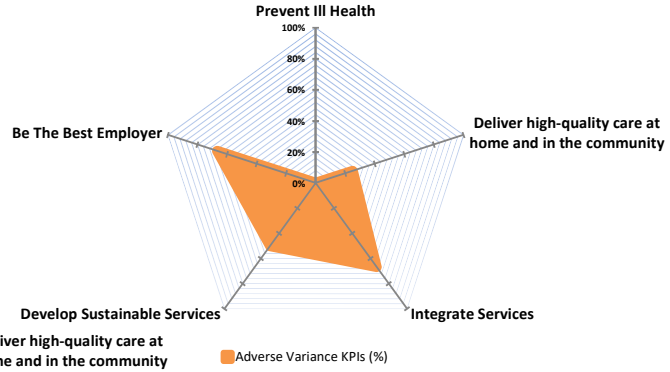
**WTE** – Whole Time Equivalent

we care

## 1.0 Assurance on Strategic Goals



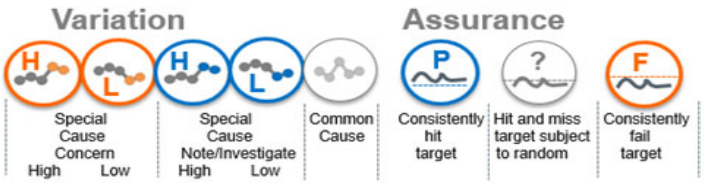




Overall, of the 38 indicators that we are able to plot on a statistical process control (SPC) chart, **26.3% are experiencing either a high or low positive trend (10, KPIs 1.1, 1.2, 1.5, 2.5, 2.8, 2.18, 2.19, 3.2, 3.4 and 4.1), 39.5% are showing a high or low negative trend (15, KPIs 2.9, 2.10, 2.14, 2.16, 3.1, 3.3, 3.5, 3.6, 4.2, 4.5, 4.6, 5.1, 5.3, 5.4 and 5.6)** and the remaining **34.2% (13) are showing normal variation.**

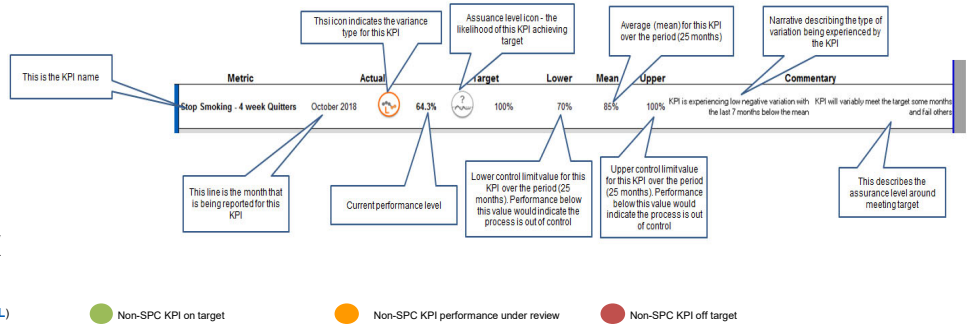
**28.9%** of the KPIs are expected to consistently achieve target as the target is positively outside the control limits **(11, KPIs 2.5, 2.11, 2.12, 2.13, 2.15, 2.20, 3.2, 3.4, 4.6, 5.4 and 5.5),**
**10.5% (4, KPIs 2.9, 2.14, 4.2 and 4.5)** are unlikely to be achieved in the near future without a process or target change (as the target is outside control limits negatively),
with the remaining **60.5% 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.



# 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 | February 2022 | H | 92.2% | ? | 100% | 56% | 85% | 114% | Continued strong performance just below trajectory. Waiting list remains at 0 |
| | KPI 1.2 Health Checks Carried Out | March 2022 | H | 246.1% | ? | 100% | 77% | 123% | 169% | Strong 21/22 performance with overachievement against target. Both KCHFT core checks and third party checks exceeded trajectory |
| | KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days | March 2022 | | 93.7% | ? | 90% | 90% | 94% | 98% | The new birth visit performance is now experiencing normal variation with positive performance above target |
| | KPI 1.4 (N) School Health - Year R and Year 6 Children Screened for Height and Weight | March 2022 | | 37.7% | | 90% (year end) | | | | The 21/22 programme began in Feb-22 |
| | KPI 1.5 Admissions Avoidance (2 Hour Crisis Responses) | March 2022 | H | 873 | ? | 326 | 300 | 453 | 607 | Metric shows demand for 2 hour crisis responses. Now showing positive variation, following sustained performance above the mean. 4% growth expected for 22/23 |

| | Metric | Actual | | | Target | 21/22 YTD Actual | 21/22 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 2022 | | 0 | 1 | 1 | 12 | Target achieved for the month |
| | KPI 2.2 (N) Never Events | March 2022 | | 0 | 0 | 0 | 0 | Target achieved for the month. 0 Never Events recorded this year |
| | KPI 2.3 (N) Infection Control: CDI | March 2022 | | 0 | 0 | 2 | 0 | No cases of Clostridioides 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). |
| | KPI 2.4 (N) Infection Control: MRSA cases where KCHFT provided care | March 2022 | | 0 | 0 | 0 | 0 | Target achieved for the month. 0 cases recorded this year |

# 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 2022 | 0.00 | P | 0.19 | -0.10 | 0.04 | 0.19 | Continuation of 0 moderate and severe harm falls this month. The upper limit is above target so high assurance levels and currently in normal variation |
| | KPI 2.6 Pressure Ulcers - Lapses in Care | March 2022 | 2 | ? | 1 | -2.4 | 3.5 | 9.4 | The data is showing normal variation, with 2 lapses in care during March 2012 |
| | KPI 2.7 Community Activity: YTD as % of YTD Plan | March 2022 | 101.8% | ? | 100.0% | 96.1% | 103.5% | 110.9% | Normal variation with performance stable just above target. Some variation at service and division level but no significant areas of concern. Plans are in place for 22/23 with a small amount of growth expected |
| | KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity | March 2022 | 4.4% | ? | 4.0% | 3.9% | 4.8% | 5.6% | DNA levels are now showing an improved picture, with performance below the mean for a sustained period |
| | KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient) | March 2022 | 84.2% | F | 95.0% | 83.1% | 87.8% | 92.5% | Metric currently showing negative variation with a period below the mean. Exepected to now be showing a true reflection of the actual performance following staff education and improved data accuracy |
| | KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance | March 2022 | 66.6% | ? | 70.0% | 58.5% | 77.3% | 96.1% | Metric currently showing negative variation with a period below the mean. Exepected to now be showing a true reflection of the actual performance following staff education and improved data accuracy. Workign towards 70% national target |
| | KPI 2.11 (N) Total Time in MIUs: Less than 4 hours | March 2022 | 99.3% | P | 95.0% | 99.2% | 99.7% | 100.1% | Metric currently performing with normal variation marginally below the mean. No current realistic risk to failing target |
| | KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways | March 2022 | 99.9% | P | 92.0% | 97.9% | 99.4% | 100.9% | In normal variation with 3 current 18+ weeks waits. |
| | KPI 2.13 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Waiting List Size (>18 weeks) | March 2022 | 3 | P | 532 | -39 | 22 | 83 | In normal variation with 3 current 18+ weeks waits. |
| | KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times (12 week target) | March 2022 | 68.1% | F | 92.0% | 70.1% | 79.6% | 89.0% | Continued negative trend performance this month (period below the mean), although showing an improved performance and plans in place to improve further. Metric shows access waiting times (month end waiting list within 12 weeks) |
| | KPI 2.15 (N) Access to GUM: within 48 hours | March 2022 | 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 2022 | 26.0 | ? | 21.0 | 15.0 | 20.5 | 25.9 | Negative variation, with sustained performance above the target and mean as a result of increased delayed discharges with patients no longer fit to reside, due to social care delays. |
| | KPI 2.17 Research: Participants recruited to national portfolio studies (21-22 Q1) | June 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 for 2020/21 |

# Kent Community Health NHS Foundation Trust - Corporate Scorecard

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

| | Metric | Actual | | | Target | | Lower | Mean | Upper | Commentary |
|---|---|---|---|---|---|---|---|---|---|---|
| 2. Deliver high-quality care at home and in the community | KPI 2.18 Percentage of patient goals achieved upon discharge for planned and therapy services | March 2022 | H | 100.0% | ? | 80.0% | 79.4% | 89.6% | 99.8% | Metric currently showing normal variation with no current concerns of failing to achieve target |
| | KPI 2.19 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT | March 2022 | H | 98.8% | ? | 95.0% | 94.7% | 97.7% | 100.8% | Sustained performance above the mean, currently meeting target |
| | KPI 2.20 (N) NICE Technical Appraisals reviewed by required time scales following review | March 2022 | | 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 2022 | | 96.9% | ? | 99.0% | 94.0% | 98.1% | 102.2% | Metric showing normal variation, with performance just below the mean. Performance continues to fluctuate and miss target some months due to small numbers impacting the ability to meet the tough 99% target. |

| | 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 2022 | H | 19.8% | ? | 9.5% | 5.5% | 16.5% | 27.4% | Negative variation as continues to be above target in-month, and the mean, predominantly as a result of social care issues. |
| | KPI 3.2 Home First impact - reduction in average excess bed days (West Kent) | March 2022 | L | 0.00 | P | 0.20 | -0.06 | 0.04 | 0.14 | Positive special cause variation currently being seen with sustained performance below the mean |
| | KPI 3.3 Average Daily Medically Fit for Discharge Patients (MFFD) - West Kent (Complex and Non complex) | March 2022 | H | 153 | ? | 75 | 41 | 77 | 113 | Metric in negative variation with levels showing an increasing trend above the mean. |
| | KPI 3.4 Rapid Transfer impact - reduction in average excess bed days (East Kent) | March 2022 | L | 0.00 | P | 0.20 | -0.09 | 0.06 | 0.21 | Positive special cause variation currently being seen with sustained performance below the mean |
| | KPI 3.5 Average Daily Medically Fit for Discharge Patients (MFFD) - East Kent (Complex Only) | March 2022 | H | 118 | ? | 100 | 37 | 78 | 119 | Metric in negative variation with levels showing an increasing trend above the mean. |
| | KPI 3.6 East Kent Rapid Transfer Service - Average Commissioned Discharges per day | March 2022 | L | 22.4 | ? | 30 | 23.2 | 27.7 | 32.2 | Below the target and the mean for Month 12, with a sustained period below the mean resulting in movement to special cause variation. |

* 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 2022 | H | 85.8% | ? | 92.0% | 75.3% | 85.0% | 94.6% | Position is in positive variation with performance above the mean level for 11 consecutive months, although is currently sitting just below target range of 87-92%. |
| | KPI 4.2 Income & Expenditure - Surplus (%) | March 2022 | L | 0.0% | F | 1.0% | -0.51% | 0.1% | 0.8% | The Trust has a surplus of £9k at the end of the financial year, including £84k of costs for impairment of assets. The adjusted surplus is £93k. The cumulative financial performance is comprised an overspends on pay of £6,020k and non-pay of £4,046k offset by underspends for depreciation/interest/impairment of £310k and an over-recovery on income of £9,765k. |
| | KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%) | March 2022 | | 100.0% | ? | 100.0% | 63.7% | 83.9% | 104.1% | The Trust achieved the CIP target of £4,415k in full for the financial year. |
| | KPI 4.4 External Agency spend against Trajectory (£000s) | March 2022 | | £449,274 | ? | £491,250 | £234,398 | £476,394 | £718,390 | Currently showing normal variation with performance just below the mean and below target for M12. Agency costs were £449k for March against a target of £491k |
| | KPI 4.5 Percentage based on value of Service Lines with deficits greater than 5% | March 2022 | H | 29.2% | F | 0% | 12.5% | 20.3% | 28.0% | Negative variation above the upper control limit with sustained performance above the mean |
| | KPI 4.6 Percentage of Activity Delivered Remotely (Telephone or Online) | March 2022 | L | 26.8% | P | 25.0% | 25.8% | 31.0% | 36.2% | Currently performing above target but below the mean as a result of decreased levels of virtual appointments following services resetting. In negative variation as performance has a sustained period below the mean, although this is expected. |
| | KPI 4.7 Estates Statutory Compliance (All properties) | March 2022 | | 96.0% | | 95% | | | | New Metric with data available from May 2021 so SPC not yet possible to calculate. Currently achieving target |

| | Metric | Actual | | | Target | Lower | Mean | Upper | Commentary |
|---|---|---|---|---|---|---|---|---|---|
| 5. Be The Best Employer | KPI 5.1 Sickness Rate | March 2022 | H | 5.69% | ? | 4.20% | 3.34% | 4.60% | 5.86% | Above the target and the mean for the month, in negative variation as performance continues to perform above the mean (9 consecutive months). |
| | KPI 5.2 Sickness Rate (Stress and Anxiety) | March 2022 | | 1.11% | ? | 1.15% | 0.97% | 1.31% | 1.66% | Remains below the mean this month following higher levels in previous months. 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 2022 | H | 17.18% | ? | 14.47% | 13.86% | 14.83% | 15.81% | Showing negative variation with performance now above the upper control limit, following a shift in performance above the mean (9 consecutive months) |
| | KPI 5.4 Mandatory Training: Combined Compliance Rate | March 2022 | L | 95.5% | P | 85.0% | 95.1% | 95.9% | 96.6% | Now above the lower control limit (performance had dipped as a result of national guidance change with Safeguarding training). Failure to achieve 85% remains highly unlikely. |
| | KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce) | March 2022 | | 5.3% | P | 6.0% | 3.6% | 4.6% | 5.6% | Continues to be in normal variation although with a small increase this month. Performance remains positively within target, this month just above the mean |
| | KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more) | March 2022 | L | 84.5% | ? | 87.0% | 86.0% | 87.0% | 88.0% | Showing negative variation with performance dropping below the lower control limit |

# 2.0 Quality Report

## 2.1 Assurance on Safer Staffing

| 1.1 RN and HCA staffing Community Hospital February 2022 | Day Fill Rate % | | Night Fill Rate % | |
|---|---|---|---|---|
| | RN's | HCA's | RN's | HCA's |
| Faversham | 83.72 | 94.47 | 94.64 | 98.65 |
| Deal | 96.19 | 82.15 | 96.69 | 96.49 |
| QVMH | 84.12 | 75.14 | 100.00 | 91.80 |
| Whit &Tank | 82.90 | 86.72 | 92.22 | 85.24 |
| West View | 93.19 | 66.56 | 98.31 | 91.28 |
| Westbrook | 100.00 | 100.00 | 100.00 | 100.00 |
| Edenbridge | 69.67 | 62.54 | 82.14 | 82.66 |
| Hawkhurst | 97.12 | 54.29 | 96.96 | 90.71 |
| Sevenoaks | 89.93 | 66.96 | 82.24 | 84.91 |
| Tonbridge | 84.13 | 82.88 | 85.54 | 84.03 |
| Total | 88.11 | 77.17 | 92.90 | 90.58 |

| 1.1 RN and HCA staffing Community Hospital March 2022 | Day Fill Rate % | | Night Fill Rate % | |
|---|---|---|---|---|
| | RN's | HCA's | RN's | HCA's |
| Faversham | 93.31 | 83.76 | 98.35 | 95.39 |
| Deal | 88.41 | 82.00 | 95.16 | 89.71 |
| QVMH | 88.01 | 73.36 | 95.52 | 100.00 |
| Whit &Tank | 89.27 | 79.64 | 98.45 | 95.43 |
| West View | 89.08 | 64.80 | 96.70 | 83.87 |
| Westbrook | 100.00 | 100.00 | 100.00 | 100.00 |
| Edenbridge | 60.28 | 63.74 | 92.19 | 91.33 |
| Hawkhurst | 92.82 | 69.55 | 100.00 | 96.76 |
| Sevenoaks | 81.55 | 66.55 | 91.53 | 89.36 |
| Tonbridge | 84.27 | 87.95 | 93.55 | 88.53 |
| Total | 86.70 | 77.14 | 96.14 | 93.04 |

In February and March, 60% of hospitals had a RN day fill rate of less than 90%. RN night fill rates were better; in February where 70% of hospitals had a RN night fill rate above 90% and in March, 100% of hospitals had a night fill rate above 90%.

Workforce was challenged due to COVID-19 related sickness, as in February 28.9% of all staff sickness was due to exhibiting COVID-19 symptoms.

Trust wide stress absence figures have decreased significantly between December 2021 and February 2022, and stress related absence is now below the 1.15% target.

**To strengthen current mitigations of vacancy and sickness gaps:**

The Deputy Chief Nurse has oversight of hotspot rosters and senior registered staff provide additional support by working clinically where required.

Recruitment of international colleagues within community hospitals continues; KCHFT have committed to recruiting an additional 100 nurses and recruitment is progressing for more than 30 offers to be part of the first cohort.

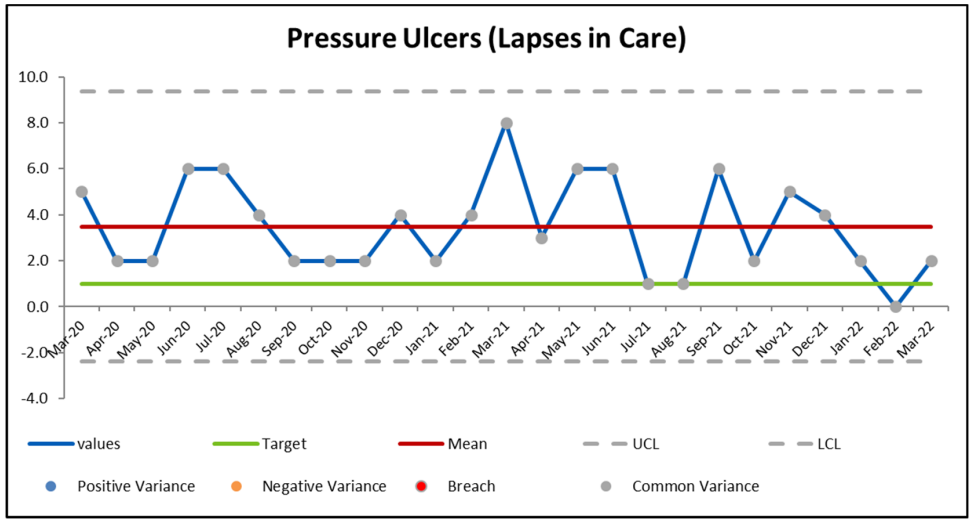
### 2.2 Assurance on Pressure Ulcers

The data is within common cause variation.

Two lapses in care occurred with patients on our caseload that were identified during February and March 2022. One was low harm and one was a moderate harm incident.

The moderate harm incident has not been identified as an SI, however, the local learning identified was the need for top to toe skin assessments regularly and removal of footwear and socks to inspect feet ate least weekly. This has been communicated and discussed within the team

This demonstrates the impact of the work undertaken by the pressure ulcer innovation network group and implemented strategies from the trust wide Pressure ulcer workplan.



### 2.3 Assurance on Falls

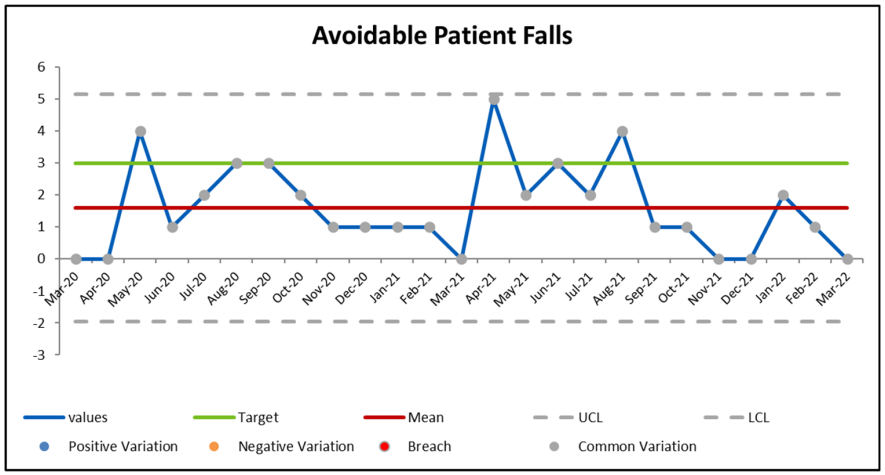
During February and March 2022, 193 falls were reported across the trust with a decrease of 9.4% (20) compared to the last period December 2021 and January 2022. Of the 193 falls, there was one avoidable incident that resulted in no harm to the patient.

National Audit of Inpatient Falls (NAIF) report recommendations are being reviewed at the next KCHFT Falls Prevention Assurance Group (FPAG) meeting and at the local Community Hospital Matrons forum

Following FPAG and staff review, the Datix falls framework questions are now being updated, to gather specific information on preventative measures, how falls occurred and actions taken following the fall. This will help to improve the quality and accuracy of falls reporting and investigations.

Visits by the East Kent Falls Coordinators to the East Kent Community Hospital's and Community Rehabilitation Teams are restarting following a break due to Business Continuity Plans

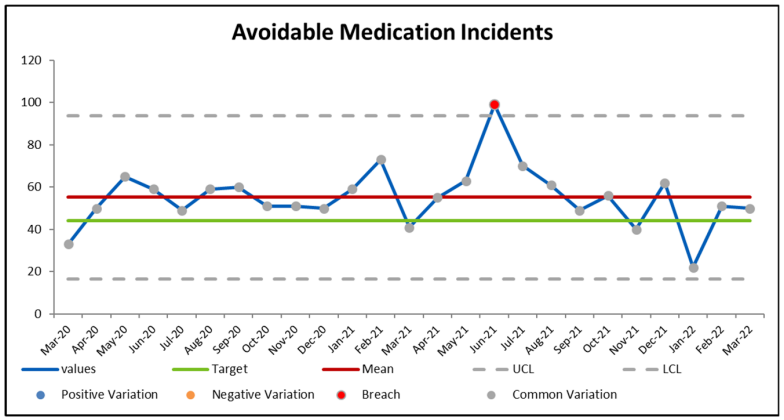
A Falls Strategy meeting was planned for 10 May 2022 to start reviewing a proposal for the 2022/2023 Falls Strategy for the organisation.

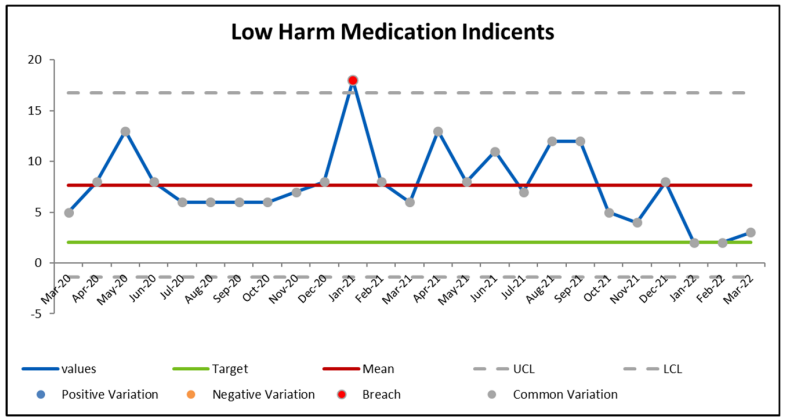


## 2.4 Assurance on Medication incidents

101 reported medication incidents were considered avoidable to KCHFT during February and March 2022 compared to 88 incidents in December 2021 and January 2022, this represents a 14.7% increase. There was an increase in incident reporting by the immunisation team and community nursing. They were all no harm incidents

4.9% (5) of the reported medication incidents were classed as low harm during February and March 2022 compared to 11.3% (10) in the previous two months.




**Further analysis showed that;**

The data is within common cause variation.

Community nursing team – Low harm incidents was 11% (2), a decrease compared to 12% (3) from previous period.

Community hospitals – Low harm incidents was 6% (2), a decrease compared to 9.0% (3) from previous period.

Omitted medicines - Low harm incidents was 4.7% (2), a decrease compared to 10.3% (3) from previous period.

The pharmacy team continues to provide medicines management support to the wards. This includes timely medicines reconciliation and interventions (such as wrong dose and wrong frequency on charts) to prevent errors

Continue to promote the PREPARE across the teams. PREPARE leaflet and posters sent out to teams on request.

## 2.5 Assurance on Patient Experience

### 2.5.1 Meridian Patient Experience survey results

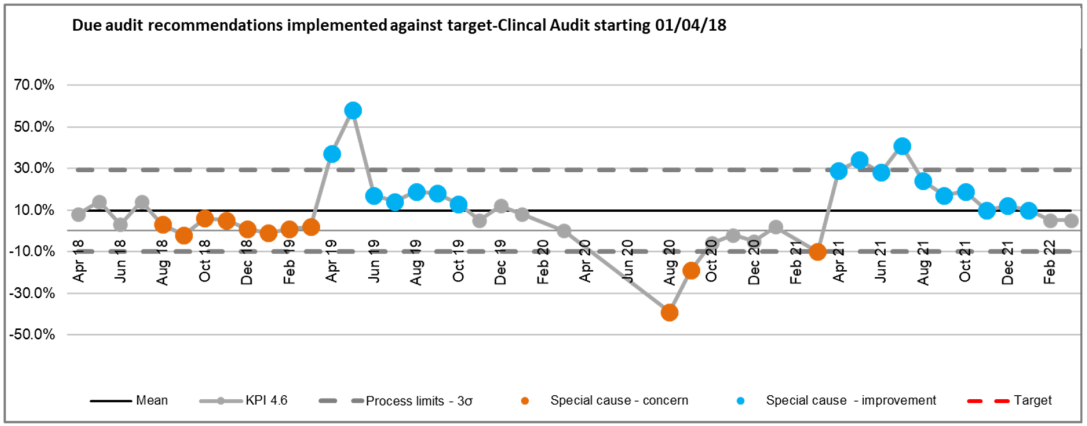
February and March 2022: 9,051 surveys were completed. This is an good increase in survey completions, when compared with the previous two months data.

### 2.5.2 The NHS Friends and Family Test (FFT)

The FFT score remains high, with 98.9% of people rating their overall experience of the service they received as good or very good.

## 2.6 Assurance on Clinical Audit and Research

### 2.6.1 Clinical Audit Reporting




Over the last year all points have been above target. The below target performance from March to October 2020 was caused by reduction in audit activity during COVID while targets for completion of actions continued to rise. Implementation of action plans restarted in September 2020. The slight drop from July to February 2022 reflects steady completion of actions against gradual 40% rise in target. The target has stayed at 95% and 100% of due actions from audit have been completed within the agreed timeframe.

Despite COVID teams have participated in 100% of eligible national clinical audits on the quality accounts list. These national audits included: The National Diabetes Footcare Audit, Sentinel Stroke National Audit Programme, National Asthma and COPD Audit Programme (Pulmonary Rehab), National Audit of Cardiac Rehabilitation and Falls and Fragility Fracture Programme. The Trust has also participated in the Child Health Outcome Review Programme (NCEPOD) Transition from children to adult health services study which equates to 100% of National Confidential Enquiries which it was eligible to participate in.

Virtual training and support :Monthly Clinical Audit Guru drop in advice sessions are available to support staff who have any questions on clinical audit or need support.

Reducing audit workload –While staff continue to use progress notes in RIO rather than forms to record patient data any audit data collected this way will be inaccurate and require a manual check of progress notes to verify practice. Project & Service Development Manager Adults Operations is continuing to stress the importance of reporting via forms to improve data quality.

**2.7 Infection Prevention and Control**

There were no MRSA bacteraemia's reported in this reporting period.

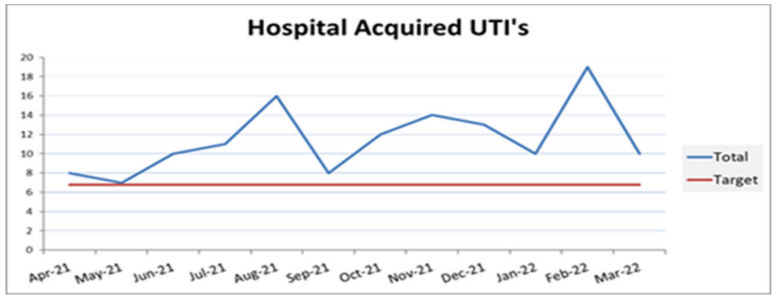
100% compliance for MRSA screening In this reported period.

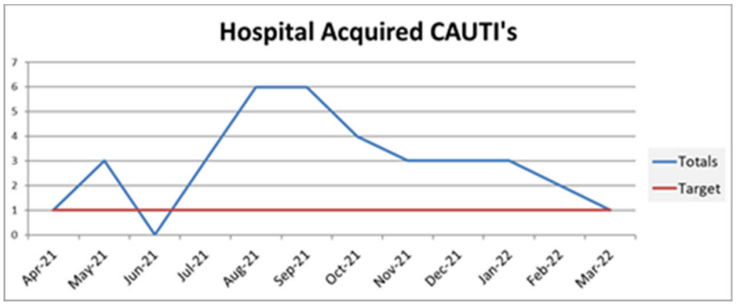
There was 1 Clostridioides cases during March 22. (Westbrook House) (The case was classified as UNAVOIDABLE COHA. Nil antibiotics prescribed by KCHFT.

There were 33 nosocomial COVID-19 acquisitions in this reporting period. February: 3 Westbrook House, 1 Westview East with no onward transmission, 1 Tonbridge with no onward transmission, 1 Deal with no onward transmission & 2 Edenbridge. March: 6 Sevenoaks, 3 Westbrook house, 11 Tonbridge, 4 Whit & Tank & 1 QVMH with no onward transmission.

CAUTI data: In February there were 2 CAUTIs and March 1 CAUTIs were reported, Therefore 1 over target in this period. All patients had specimens taken and treated appropriately.

UTI's in February there were 19 UTIs (There were 2 additional sites in this reporting period) and March there were 10 UTIs. 15.4 cases above planned trajectory, an increase of 6 from previous reporting period. All patients had specimens taken and treated appropriately. The IPC team have met with the QI team to plan QI project to tackle hydration that may impact on reducing UTI/CAUTI numbers. This is part of IPC work plan for April 2022. All CAUTI are investigated using RCA to capture any learning. RCA tool reviewed and amended to ensure more meaningful investigation/ lessons identified captured. IPC visit the wards fortnightly.



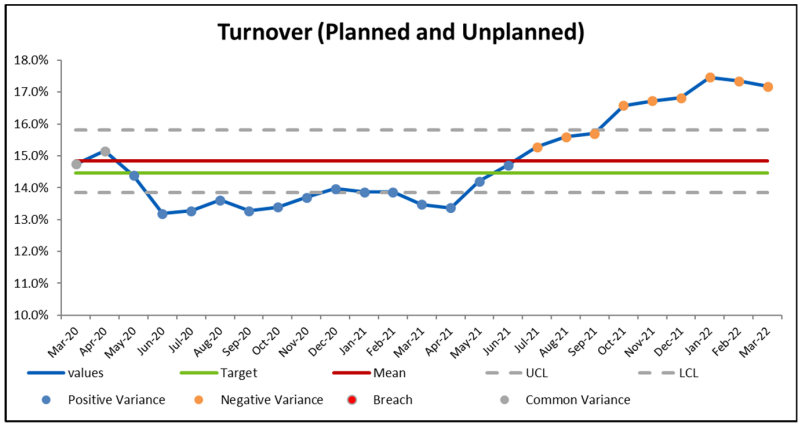



# 3.0 Workforce Report:

## 3.1 Assurance on Retention

### 3.1.1 Turnover

Turnover continues to report above the mean and the target, however, the peak in January 2022 Turnover has decreased. Further analysis of the Turnover metric reports that the Health Care Scientists & Nursing and Midwifery Staff groups experience the highest rate of turnover throughout the last 12 months, closely followed by Allied Health Professional staff.




**Voluntary Turnover**

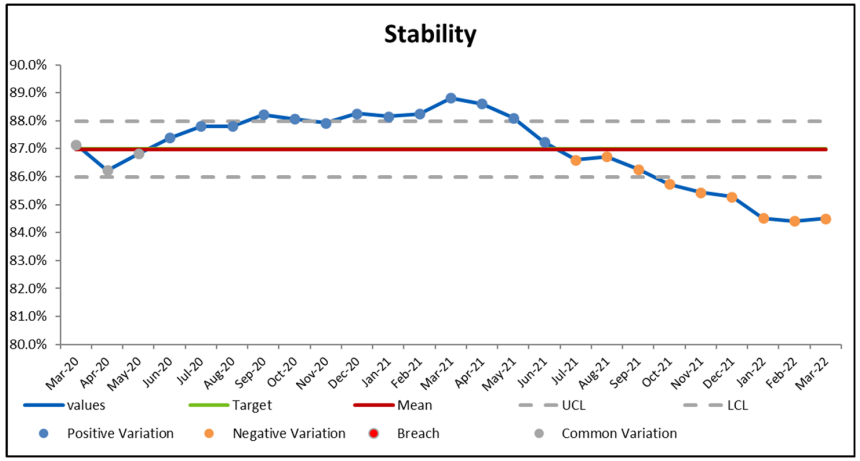
The following table provides further analysis to reflect the Voluntary Turnover – people leaving the trust through their own decision; the Voluntary Turnover metric excludes leaving reasons such as Death in Service, Dismissal, End of Fixed Term contracts & Redundancy. By excluding these reasons, the Trust Turnover Rate would reduce to 15.85% and give a true reflection of the rate of voluntary turnover across the organisation.

It is evident from the table that the higher rates of voluntary turnover are found in clinical staff groups and within the Operations Directorate, Clinical Care and Quality Directorate and within HR, OD & Communications.

| | Turnover - All | Turnover - Voluntary | Turnover (Clinical Voluntary) |
|---|---|---|---|
| 846 300 L3 Operations Directorate | 17.59% | 16.45% | 16.37% |
| 846 325 L3 IT | 12.72% | 11.31% | NA |
| 846 330 L3 Clinical, Care and Quality Directorate | 19.58% | 18.18% | 18.42% |
| 846 335 L3 Medical Director | 10.00% | 10.00% | 0.00% |
| 846 350 L3 HR, OD & Communications | 16.24% | 15.23% | 10.53% |
| 846 355 L3 Finance Directorate | 9.18% | 6.12% | NA |
| 846 370 L3 Corporate Services Directorate | 13.53% | 9.02% | 0.00% |
| 846 375 L3 Estates | 17.44% | 14.34% | 0.00% |

### 3.1.2 Stability

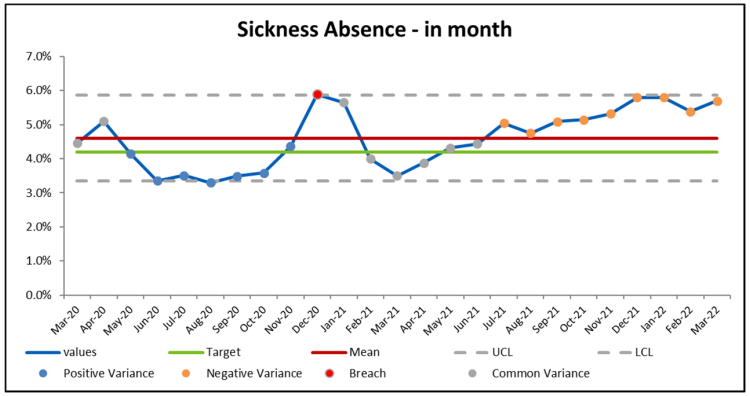
In March 2022 the Stability rate is once again at its lowest rate over the 24 month reporting period at 84.51%, 2.49% below the target of 87%. From July 2021 the stability rate is reported below the mean and target, the organisation has seen a downward trend since March 2021.



### 3.2 Assurance on Sickness

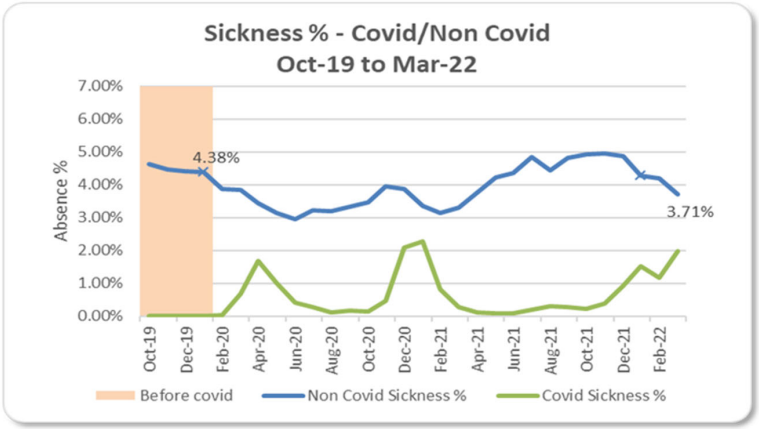
#### 3.2.1 Sickness Absence

At 5.69% the in-month sickness absence rate for March 2022 continues to report above the Mean and the Target, it has once again reached the same peak experienced in the second wave of Covid-19 (Dec 2020). The highest level of sickness absence is reported in the Epilepsy Team at 22.24%.



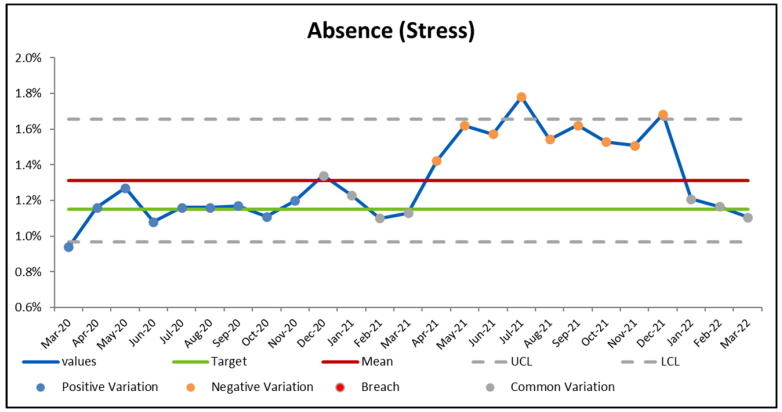

**Covid-19 Related absence**

575 employees were recorded as sick in March due to exhibiting COVID-19 symptoms, this account for 41.6% of the total number of staff (1383) off sick in the month.



### 3.2.2 Stress Absence

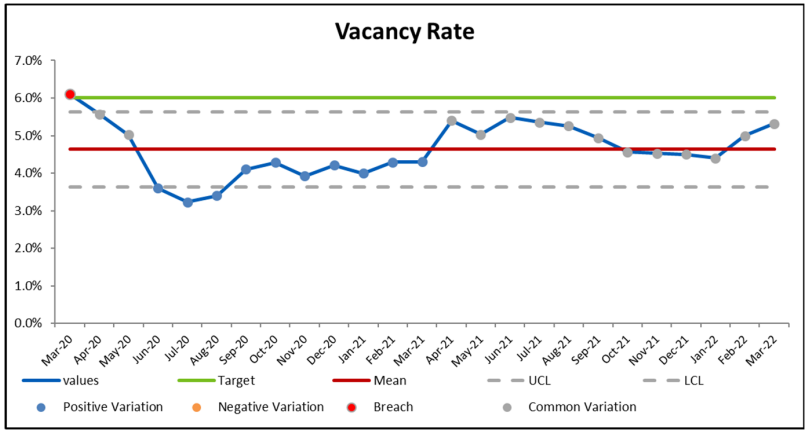
In-month stress absence figures have reported another decline and for the second month have reported under the target at 1.11%. This is the lowest rate of stress related absence for 12 months. The highest level of stress absence is seen in the Tissue Viability team at 12.40%.




## 3.3 Assurance on Filling Vacancies

### 3.3.1 Establishment and Vacancies

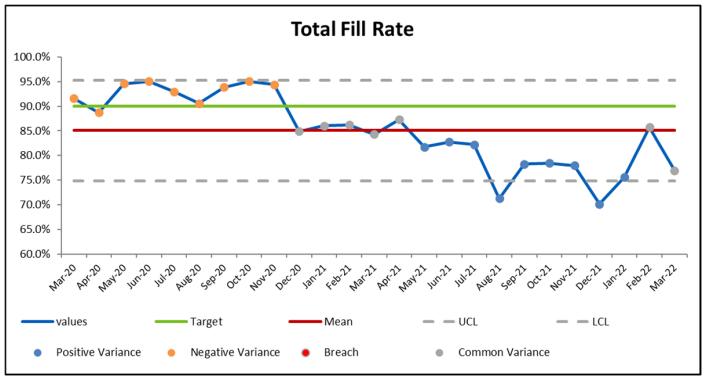
From June 2021 the Vacancy rate had continued to decrease, however the last 2 months have increased and in March 2022 the Vacancy rate has reported an increase to 5.3%. The Vacancy rate continues to remain below the revised target of 6%.

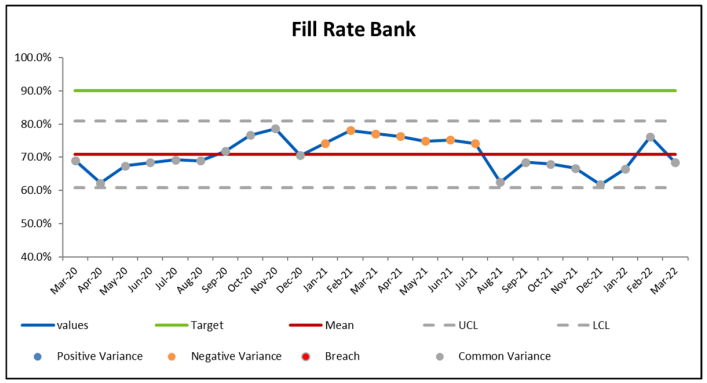


### 3.3.2 Temporary Staff Usage

The Total fill rate has shown a drop in 2021, specifically in holiday periods such as August and December 2021. There were also challenges filling shifts and high shift cancellations due to Self Isolation and Covid Symptoms, however, the fill rate has increased significantly in February 2022 to above the Mean. In March 2022 the Total fill rate has dropped again to 74.96%, the trust saw an increase in sickness and self isolation but also a significant increase in the number of duties required.

The Bank fill rate followed a similar pattern and remains below the mean at 68.43%.



### 3.4 Mandatory Training

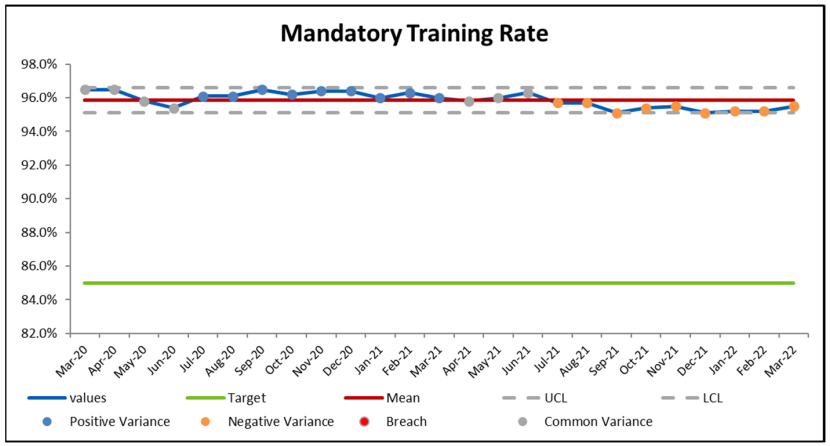
Mandatory Training figures have continued to hover below the mean experiencing common cause variation. . The same areas of pressure exist and continue to get close attention.

BLS continues to be the highest outlier at 78.7% although this is an increase on last month.  As we run constantly with empty spaces should demand increase this is likely to create a bottle neck of staff needing training.

We have changed the way in which staff are assessed for training compliance for fire in community hospitals and are now including their induction orientation in these figures.  This has increased the figures by 2.6% to 81.8% compliance.

On a positive note Moving and handling Level 4 has reached the target with a 0.6% increase in month.

End of year appraisals are currently taking place with a deadline of 30 April 2022.



# 4.0 Finance Report:

## 4.1 Key Messages

**Surplus:** The Trust has a surplus of £9k at the end of the financial year, including £84k of costs for impairment of assets. The adjusted surplus (excluding the impairments) is £93k. The cumulative financial performance is comprised an overspends on pay of £6,020k (including £8,471k on the all ages covid vaccination programme which was not budgeted in line with the planning guidance) and non-pay of £4,046k offset by underspends for depreciation/interest/impairment of £310k and an over-recovery on income of £9,765k.

**Continuity of Services Risk Rating**: The Trust has scored overall the maximum 1 rating against the Use of Resource rating metrics for M12 2021-22. The YTD I&E margin % has returned a rating of 2 as a result of the current break-even regime.

**CIP**: The Trust achieved the CIP target of £4,415k in full for the financial year.

**Cash and Cash Equivalents**: The cash and cash equivalents balance was £35,979k, equivalent to 51 days expenditure. The Trust recorded the following YTD public sector payment statistics: 84% for volume and 87% for value.

**Capital:** Spend to March was £8,250k, against a YTD plan of £12,698k. Of the total £8,250k spend, £4,985k was internally funded and £3,355k was funded by PDC.

The full year variance of £4,448k is the net effect of the redistribution of the £4,924k ring-fenced funding which was held on behalf of the K&M system for system priorities plus the additional spend of £243k for the KMCR project and new external funded projects totalling £271k. There was also a minimal underspend of £38k on internally funded projects due to Estates minor works schemes not progressing in March 2022 as expected.

**Staff**: Temporary staff costs for March were £1,735k, representing 11.1% of the pay bill. Of the temporary staffing usage in March, £449k related to external agency and locums, representing 2.9% of the pay bill. Contracted WTE decreased by 23 to 4,298 in post in March which includes 10 posts funded by capital projects. Vacancies increased to 242 in March which was 5.3% of the budgeted establishment.

## 4.2 Dashboard

**Surplus** — Rag rating: Green

| | Actual | Budget | Variance |
|---|---|---|---|
| Full Year £k | 9 | 0 | 9 |

The Trust has a surplus of £9k at the end of the financial year, including £84k of costs for impairment of assets. The adjusted surplus (excluding the impairments) is £93k.

Pay and non-pay overspent by £8,020k and £3,697k respectively and there has been an impairment of £84k, offset by an underspend on depreciation/ interest of £394k and an over-recovery on income of £9,417k.

**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 | 1 | 1 |
| Overall Rating | 1 | 1 |

The Trust has scored overall the maximum 1 rating against the Use of Resource rating metrics for M12 2021-2022. The YTD I&E margin % has returned a rating of 2 as a result of the current break-even regime.

**CIP** — Rag rating: Green

| | Actual | Plan | Variance |
|---|---|---|---|
| Full Year £k | 4,415 | 4,415 | 0 |

The Trust achieved CIPs of £4,415k at the end of the financial year achieving the target in full.

**Cash and Cash Equivalents** — Rag rating: Green

| | Actual | Forecast | Variance |
|---|---|---|---|
| Full Year £k | 35,979 | 35,679 | 300 |

Cash and Cash Equivalents as at M12 close stands at £35,979k equivalent to 51 days operating expenditure.
The Trust recorded the following YTD public sector payment statistics 84% for volume and 87% for value.

**Capital Expenditure** — Rag rating: Green

| | Actual | Plan | Variance |
|---|---|---|---|
| Full Year £k | 8,250 | 12,698 | 4,448 |

Spend to March was £8,250k, against a YTD plan of £12,698k. Of the total £8,250k spend, £4,985k was internally funded and £3,355k was funded by PDC.
The full year variance of £4,448k is the net effect of the redistribution of the £4,924k ring-fenced funding which was held on behalf of the K&M system for system priorities plus the additional spend of £243k for the KMCR project and new external funded projects totalling £271k. There was also a minimal underspend of £38k on internally funded projects due to Estates minor works schemes not progressing in March 2022 as expected.

**Agency Targets** — Rag rating: Green

| | M12 | | | Full Year | | |
|---|---|---|---|---|---|---|
| | Actual £k | Target £k | Variance £k | Actual £k | Target £k | Variance £k |
| External Agency Excluding Covid-19 Expenditure £k | 491 | 491 | 0 | 3,861 | 5,895 | 2,034 |
| External Agency Including Covid-19 Expenditure £k | 449 | 491 | 42 | 4,386 | 5,895 | 1,509 |

External agency and locums excluding Covid-19 expenditure was £491k against £491k target in March. (Full year £3,861k against £5,895k target). Figures include the hospital discharge programme.
External agency and locums including Covid-19 expenditure was £449k against £491k target in March. (Full year £4,386k against £5,895k target). Figures include the hospital discharge programme.
*(Agency costs for covid were negative values in March)*

### 4.3 Income and Expenditure Position

The year-end position is a surplus of £9k. The March performance comprised underspends on pay and depreciation/interest of £273k and £29k respectively and an over-recovery on income of £2,890k offset by a non-pay overspend of £3,099k and impairment of £84k. The summary income and expenditure statement is shown in the table below:

| | MARCH ACTUAL £'000 | MARCH BUDGET £'000 | MARCH VARIANCE £'000 | % VARIANCE | YTD ACTUAL £'000 | YTD BUDGET £'000 | YTD VARIANCE £'000 | % VARIANCE |
|---|---|---|---|---|---|---|---|---|
| Charitable and Other Contributions to Expenditure | 1 | 4 | -2 | -62.8% | 18 | 43 | -25 | -59.0% |
| Clinical Commissioning Groups | 15,369 | 13,812 | 1,556 | 11.3% | 166,576 | 165,748 | 828 | 0.5% |
| Department of Health | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Education and Training | 1,068 | 157 | 911 | 578.9% | 2,902 | 1,889 | 1,014 | 53.7% |
| Injury Cost Recovery Scheme | 25 | 32 | -7 | -21.1% | 237 | 381 | -145 | -38.0% |
| Income in respect of employee benefits accounted on a gross basis | -421 | 66 | -488 | -735.5% | 1,172 | 825 | 347 | 42.0% |
| Local Authorities | 3,694 | 3,918 | -224 | -5.7% | 44,170 | 47,020 | -2,850 | -6.1% |
| NHS England | 2,083 | 1,896 | 186 | 9.8% | 23,798 | 23,804 | -6 | 0.0% |
| NHS England - Covid-19 Vaccinations Income | 831 | 0 | 831 | 0.0% | 10,517 | 0 | 10,517 | 0.0% |
| NHS Foundation Trusts | 97 | 186 | -89 | -47.9% | 2,201 | 2,236 | -35 | -1.6% |
| NHS Other | 0 | 0 | 0 | -100.0% | 15 | 5 | 10 | 100.0% |
| NHS Trusts | 607 | 462 | 145 | 31.5% | 5,112 | 5,543 | -431 | -7.8% |
| Non NHS: Other | 275 | 196 | 78 | 39.9% | 2,527 | 2,343 | 184 | 7.8% |
| Non NHS: Private Patients | 11 | 14 | -3 | -23.3% | 63 | 172 | -109 | -63.5% |
| Non-Patient Care Services to Other Bodies | 563 | 174 | 389 | 223.6% | 2,889 | 2,235 | 654 | 29.3% |
| Other | -25 | 71 | -96 | -135.6% | 705 | 742 | -37 | -5.0% |
| Rental revenue from operating leases | -249 | 39 | -287 | -745.3% | 112 | 462 | -350 | -75.8% |
| Research and Development | 14 | 19 | -5 | -26.1% | 161 | 229 | -68 | -29.6% |
| CIP Savings - Income | 0 | 7 | -7 | -100.0% | 0 | 79 | -79 | -100.0% |
| **INCOME Total** | **23,944** | **21,054** | **2,890** | **13.7%** | **263,173** | **253,756** | **9,417** | **3.7%** |
| Allied Health Professionals | 2,372 | 2,474 | 102 | 4.1% | 29,064 | 29,591 | 528 | 1.8% |
| Apprenticeship Levy | 62 | 65 | 3 | 4.5% | 770 | 783 | 12 | 1.6% |
| Chairman & Non-Executive Directors | -13 | 14 | 27 | 188.5% | 165 | 171 | 6 | 3.7% |
| Consultants | 352 | 286 | -66 | -23.1% | 3,220 | 3,475 | 255 | 7.3% |
| Heath Care Scientist | 41 | 60 | 19 | 31.4% | 716 | 716 | 0 | 0.0% |
| Medical Career/Staff Grades | 614 | 653 | 39 | 6.0% | 6,647 | 7,734 | 1,087 | 14.1% |
| Medical Trainee Grades | 18 | 19 | 1 | 5.8% | 213 | 234 | 21 | 9.0% |
| NHS Infrastructure Support | 4,086 | 3,949 | -138 | -3.5% | 50,103 | 47,234 | -2,869 | -6.1% |
| Non-Executive Directors | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Other Scientific, Therapeutic and Technical Staff | 576 | 623 | 47 | 7.5% | 7,326 | 7,452 | 126 | 1.7% |
| Registered Nursing, Midwifery and Health Visiting Staff | 4,827 | 5,227 | 399 | 7.6% | 62,548 | 62,469 | -79 | -0.1% |
| Support to Allied Health Professionals | 457 | 445 | -12 | -2.7% | 5,330 | 5,318 | -12 | -0.2% |
| Support to Nursing Staff | 1,920 | 1,907 | -13 | -0.7% | 25,661 | 21,800 | -3,861 | -17.7% |
| Support to Other Clinical Staff | 335 | 371 | 35 | 9.5% | 4,045 | 4,414 | 369 | 8.4% |
| Redundancy Costs | 47 | 0 | -47 | -100.0% | 171 | 0 | -171 | -100.0% |
| Salary Sacrifice | 0 | -16 | -16 | -100.0% | 0 | -148 | -148 | -100.0% |
| CIP Holding Account - Pay | 0 | 8 | 8 | 100.0% | 0 | 92 | 92 | 100.0% |
| CIP Savings - Pay | 0 | -94 | -94 | -100.0% | 0 | -1,125 | -1,125 | -100.0% |
| Contract Savings - Pay | 0 | -21 | -21 | -100.0% | 0 | -252 | -252 | -100.0% |
| **PAY Total** | **15,697** | **15,970** | **273** | **1.7%** | **195,979** | **189,959** | **-6,020** | **-3.2%** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Audit Fees Payable to the External Auditor | 7 | 5 | -2 | -34.0% | 78 | 58 | -20 | -34.0% |
| Clinical Negligence - Amounts Payable to NHS Resolution | 83 | 83 | 0 | 0.0% | 998 | 998 | 0 | 0.0% |
| Consultancy | 334 | -126 | -460 | 365.6% | 888 | 223 | -665 | -298.1% |
| Drugs Costs | 313 | 359 | 46 | 12.9% | 4,235 | 4,380 | 146 | 3.3% |
| Education and Training - Non-Staff | 270 | 146 | -125 | -85.5% | 1,309 | 1,730 | 421 | 24.3% |
| Establishment | 643 | 984 | 342 | 34.7% | 7,964 | 7,385 | -579 | -7.8% |
| Increase/(Decrease) in Impairment of Receivables | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | -100.0% |
| Movement in credit loss allowance on receivables and financial assets | 77 | 0 | -77 | -100.0% | 77 | 0 | -77 | -100.0% |
| Operating Lease Expenditure | 1,101 | 718 | -383 | -53.4% | 9,567 | 8,601 | -966 | -11.2% |
| Operating Lease Expenditure (net) | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Other | 4 | 104 | 100 | 96.6% | 1,199 | 1,243 | 44 | 3.6% |
| Premises - Business Rates Payable to Local Authorities | -11 | 0 | 11 | 0.0% | 851 | 712 | -139 | -19.5% |
| Premises - Other | 2,035 | 168 | -1,867 | -1112.2% | 7,059 | 5,707 | -1,352 | -23.7% |
| Research and Development - Non-Staff | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Supplies and Services – Clinical (excluding drugs costs) | 2,405 | 1,895 | -510 | -26.9% | 22,118 | 22,782 | 665 | 2.9% |
| Supplies and Services - General | 99 | 114 | 15 | 13.2% | 2,021 | 1,417 | -604 | -42.6% |
| Transport | 337 | 452 | 115 | 25.4% | 3,436 | 5,576 | 2,140 | 38.4% |
| CIP Savings - Non Pay | 0 | -302 | -302 | -100.0% | 0 | -2,695 | -2,695 | -100.0% |
| CIP Holding Account - Non Pay | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| Contract Savings - Non Pay | 0 | -1 | -1 | -100.0% | 0 | -15 | -15 | -100.0% |
| **NONPAY Total** | **7,698** | **4,599** | **-3,099** | **-67.4%** | **61,799** | **58,102** | **-3,697** | **-6.4%** |
| EBITDA | 549 | 485 | 64 | 13.1% | 5,395 | 5,696 | -301 | -5.3% |
| EBITDA % | 2.3% | 2.3% | 0.0% | | 2.1% | 2.2% | -3.2% | |
| Amortisation | 41 | 35 | -5 | -15.4% | 444 | 404 | -40 | -9.9% |
| Depreciation | 392 | 413 | 21 | 5.0% | 4,514 | 4,842 | 328 | 6.8% |
| Finance Income | 18 | 0 | 18 | 0.0% | 37 | 0 | 37 | 100.0% |
| Interest on Late Payment of Commercial Debt | -5 | 0 | 5 | 100.0% | 2 | 0 | -2 | -100.0% |
| Losses on Disposal of Property, Plant and Equipment | 0 | 0 | 0 | 0.0% | 0 | 0 | 0 | 0.0% |
| PDC Dividend Charge | 46 | 38 | -9 | -22.7% | 380 | 450 | 70 | 15.6% |
| PPE Net Impairments | 84 | 0 | -84 | 0.0% | 84 | 0 | -84 | 0.0% |
| **SURPLUS/(DEFICIT)** | **9** | **0** | **9** | **0.0%** | **9** | **0** | **9** | **0.0%** |
| SURPLUS % | 0.0% | 0.0% | 0.0% | | 0.0% | 0.0% | 0.0% | |

## 4.4 Trust Wide variance against baseline budget in month and YTD

Statement of Financial Position and Capital

| | At 31 Mar 21 £000s | At 28 Feb 22 £000s | At 31 Mar 22 £000s | Variance Analysis Commentary |
|---|---|---|---|---|
| **NON CURRENT ASSETS:** | | | | |
| Intangible assets | 1,453 | 1,460 | 1,984 | |
| Property, Plant & Equipment | 24,650 | 30,876 | 33,682 | **Property, Plant & Equipment** |
| NHS Accrued Debtors | 71 | 71 | 93 | The year to date increase includes the take-on of Deal Victoria Hospital from |
| Other debtors | 167 | 280 | 190 | NHS Property Services as of 1 April 2021, plus the further transfer of Vicarage Lane Clinic |
| **TOTAL NON CURRENT ASSETS** | **26,340** | **32,687** | **35,949** | and Molehill Copse Clinic from NHS Property Services as of 1 January 2022. |
| **CURRENT ASSETS:** | | | | |
| NHS & Non NHS - Invoiced Debtors (net of bad debt provision) | 10,375 | 10,426 | 12,032 | **Total Debtors** |
| NHS Accrued Debtors | 3,442 | 4,721 | 2,460 | The in-month decrease primarily relates to overdue contract invoices with KCC and invoices |
| Other debtors | 3,948 | 5,920 | 2,663 | raised to Health Education England being paid in M12. |
| **Total Debtors** | **17,766** | **21,067** | **17,155** | |
| Cash at bank in GBS accounts | 42,824 | 38,026 | 35,948 | |
| Other cash at bank and in hand | 35 | 80 | 31 | |
| Deposit with the National Loan Fund (Liquid Investment) | - | - | - | |
| **Total Cash and Cash Equivalents** | **42,859** | **38,106** | **35,979** | |
| **TOTAL CURRENT ASSETS** | **60,625** | **59,173** | **53,134** | |
| **CURRENT LIABILITIES:** | | | | |
| NHS & Non NHS - Invoiced Creditors falling due within 1 year | -602 | -1,270 | -853 | |
| NHS - accrued creditors falling due within 1 year | -7,850 | -5,475 | -2,491 | **NHS - accrued creditors falling due within 1 year** |
| Non NHS - accrued creditors falling due within 1 year | -14,844 | -13,296 | -12,928 | The in-month decrease in the main relates to the payment of an o/s accrual with K&M CCG |
| Other creditors | -13,172 | -13,689 | -11,972 | in relation to STP hosting. |
| Provisions | -367 | -274 | -648 | **Other Creditors** |
| **Total current liabilities** | **-36,835** | **-34,004** | **-28,892** | The in-month decrease principally relates to the release of deferred growth funding income in M12. |
| **NET CURRENT ASSETS** | **23,789** | **25,169** | **24,242** | |
| **TOTAL ASSETS LESS CURRENT LIABILITIES** | **50,130** | **57,856** | **60,191** | |
| **NON CURRENT LIABILITIES:** | | | | |
| Other creditors | - | - | -244 | |
| Provisions | -718 | -765 | -1,109 | |
| **Total non-current liabilities** | **-718** | **-765** | **-1,353** | |
| TOTAL ASSETS EMPLOYED | 49,412 | 57,091 | 58,838 | |
| **FINANCED BY TAXPAYERS EQUITY:** | | | | **Public dividend capital** |
| Public dividend capital | -6,587 | -8,746 | -9,943 | The in-month increase follows receipt of further external funding for capital projects. |
| Income and expenditure reserve | -41,658 | -44,268 | -44,277 | **Income and expenditure reserve / Revaluation Reserve** |
| Revaluation Reserve | -1,166 | -4,077 | -4,618 | The year to date movement includes the net increase following the transfer of Deal Victoria |
| TOTAL TAXPAYERS EQUITY | - 49,412 | - 57,091 | - 58,838 | Hospital, Vicarage Lane Clinic and Molehill Copse Clinic |

### 4.5 Cash and Equivalents

Cash and Cash equivalents totalled £35,979k as at M12 close, equivalent to 51 days expenditure:

**Total Cash and Cash Equivalents as at period end:**

| | £000's |
|---|---|
| Cash with the Government Banking Service | 35,948 |
| Cash at Commercial Banks and in hand | 31 |
| Deposits with the National Loan Fund | 0 |
| Total Cash and Cash Equivalents as at period end | 35,979 |

| All figures £000's | Mar 22 Actual | Apr 22 F/cast | May 22 F/cast | Jun 22 F/cast | Jul 22 F/cast | Aug 22 F/cast | Sept 22 F/cast | Oct 22 F/cast | Nov 22 F/cast | Dec 22 F/cast | Jan 23 F/cast | Feb 23 F/cast |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | |
| Opening Balance | 38,106 | 35,979 | 35,437 | 36,355 | 36,135 | 36,275 | 36,110 | 35,550 | 36,277 | 36,744 | 37,313 | 37,058 |
| SLA | 19,309 | 16,494 | 17,846 | 17,846 | 17,846 | 17,846 | 17,846 | 17,846 | 17,846 | 17,846 | 17,846 | 17,846 |
| NHS Debtors | 3,915 | 1,936 | 3,116 | 2,165 | 2,287 | 2,147 | 2,093 | 2,203 | 2,187 | 2,060 | 2,060 | 2,060 |
| Non NHS | 3,047 | 751 | 2,511 | 1,950 | 1,950 | 1,950 | 1,950 | 1,950 | 1,950 | 1,950 | 1,950 | 1,950 |
| PDC | 1,197 | 0 | 0 | 0 | 0 | 0 | 0 | 520 | 0 | 0 | 0 | 0 |
| VAT Refund | 400 | 0 | 250 | 250 | 250 | 250 | 250 | 250 | 250 | 250 | 250 | 250 |
| Interest Receivable | 12 | 18 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 | 12 |
| Total receipts | 27,880 | 19,199 | 23,735 | 22,223 | 22,345 | 22,205 | 22,151 | 22,781 | 22,245 | 22,118 | 22,118 | 22,118 |
| Net Payroll | 10,192 | 9,102 | 9,800 | 9,800 | 9,800 | 9,800 | 9,800 | 9,800 | 9,800 | 9,800 | 9,800 | 9,800 |
| Pensions | 2,624 | 2,624 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 | 2,672 |
| Tax.&NI | 3,695 | 3,735 | 3,700 | 3,700 | 3,700 | 3,700 | 3,700 | 3,700 | 3,700 | 3,700 | 3,700 | 3,700 |
| Payment Runs | 10,693 | 3,617 | 5,317 | 5,589 | 4,982 | 5,524 | 5,106 | 5,199 | 4,933 | 4,983 | 5,396 | 4,761 |
| PDC Dividends | 139 | 0 | 0 | 0 | 0 | 0 | 413 | 0 | 0 | 0 | 0 | 0 |
| Other | 142 | 121 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 | 120 |
| Capital | 2,522 | 542 | 1,208 | 562 | 931 | 554 | 900 | 563 | 553 | 274 | 685 | 685 |
| Total payments | 30,007 | 19,741 | 22,817 | 22,443 | 22,205 | 22,370 | 22,711 | 22,054 | 21,778 | 21,549 | 22,373 | 21,738 |
| Closing Cash Balance | 35,979 | 35,437 | 36,355 | 36,135 | 36,275 | 36,110 | 35,550 | 36,277 | 36,744 | 37,313 | 37,058 | 37,438 |

### 4.6 Capital

The Trust's total expenditure on capital projects for 2021-22 was £8,250k, of which, £4,895k was internally funded and £3,355k was funded externally via PDC.

The Trust's initial capital plan submitted included £4,924k ring-fenced monies reserved for Kent & Medway system priorities, which was to be managed separately as part of the wider system capital plans and released on identification and approval of Kent & Medway priority schemes. This resulted in an in-year reduction of the Trust's system capital control of £4,924k.

In addition, the Trust's system capital control total was further reduced in November 2021 by £2,841k to £4,933k, following a successful external capital funding application for the Kent & Medway Care Record.

As set out in the tables below, the Trust's total capital spend on internally funded projects was £4,895k and reflects a minimal underspend of £38k against the revised system capital control total of £4,933k. The Trust's total capital spend on externally funded projects was £3,355k

| | | | £000s | | | £000s | |
|---|---|---|---|---|---|---|---|
| Planned Funding Method | Plan Area | Plan Reference | YTD Plan | YTD Actual | YTD Variance | Intitial FY Plan | Adjusted Plan |
| Internally Funded | Estates | Backlog Maintenance incl. Health, Safety & Security Compliance Measures | 487 | 200 | 287 | 487 | 487 |
| Internally Funded | Estates | Energy Efficiency | 260 | 372 | -112 | 260 | 260 |
| Internally Funded | Estates | Capitalisable Responsive Maintenance incl. Leasehold Improvements | 137 | 137 | -0 | 137 | 137 |
| Internally Funded | Estates | Estates Developments - CIP Enabling | 360 | 240 | 120 | 360 | 360 |
| Internally Funded | Estates | Estates Developments | 100 | 251 | -151 | 100 | 100 |
| | | **Estates - Total** | **1,344** | **1,200** | **144** | **1,344** | **1,344** |
| Internally Funded | IT | K&M Digital Priority Scheme - Kent & Medway Care Record | - | 7 | -7 | 2,841 | - |
| Internally Funded | IT | IT Developments - Innovation and Strategy | 347 | 720 | -373 | 347 | 347 |
| Internally Funded | IT | IT Rolling Replacement - Hardware | 997 | 1,894 | -897 | 997 | 997 |
| Internally Funded | IT | IT Infrastructure and Networks | 708 | 553 | 155 | 708 | 708 |
| Internally Funded | IT | IT Developments - Clinical Systems | 337 | 80 | 257 | 337 | 337 |
| Internally Funded | IT | IT Developments - EPMA System | 800 | 10 | 790 | 800 | 800 |
| | | **IT - Total** | **3,189** | **3,264** | **-75** | **6,030** | **3,189** |
| Internally Funded | Dental | Dental Services | 150 | 89 | 61 | 150 | 150 |
| | | **Dental - Total** | **150** | **89** | **61** | **150** | **150** |
| Internally Funded | Other | Other Minor Schemes & Equipment Purchases | 250 | 342 | -92 | 250 | 250 |
| | | **Other - Total** | **250** | **342** | **-92** | **250** | **250** |
| | | **Total 2021-22 Internally Funded Capital Expenditure** | **4,933** | **4,895** | **38** | **7,774** | **4,933** |

| | |
|---|---|
| *K&M Capital - Ring-fenced for K&M System Priorities* | **4,924** |
| **Total Initial FY Plan Submitted** | **12,698** |

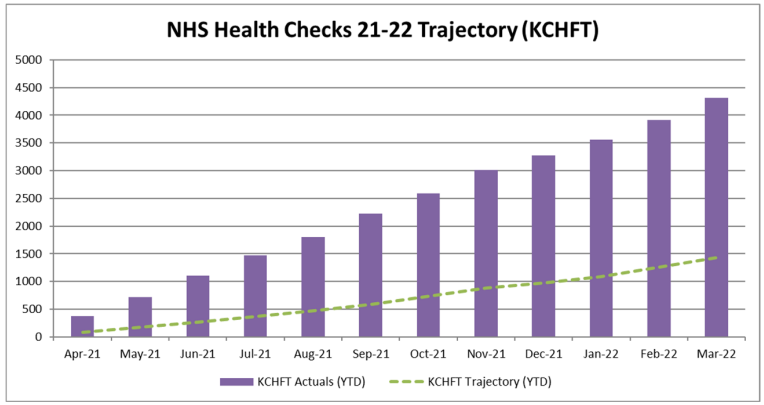
| Planned Funding Method | Plan Area | Plan Reference | YTD Actual |
|---|---|---|---|
| PDC (Shared Care Record) | IT | K&M Digital Priority Scheme - Kent & Medway Care Record | 3,084 |
| PDC (TIF Funding) | IT | Video Consultation - TIF Funding | 82 |
| PDC (Unified Tech Fund) | IT | Unified Tech Fund - Robotic Process Automation | 130 |
| PDC (Digital Health Partner | IT | WoundMatrix - Digital Health Partnership | 60 |
| | | **Total 2021-22 PDC Funded Capital Expenditure** | **3,355** |
| | | **Total 2021-22 Capital Expenditure** | **8,250** |

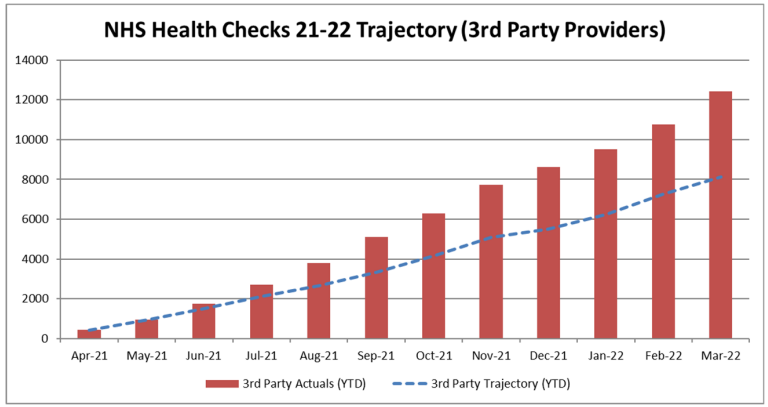
# 5.0 Operational report:

## 5.1 Assurance on National Performance Standards and Contractual Targets

### 5.1.1 Health Checks and Stop Smoking Quits

#### Health Checks

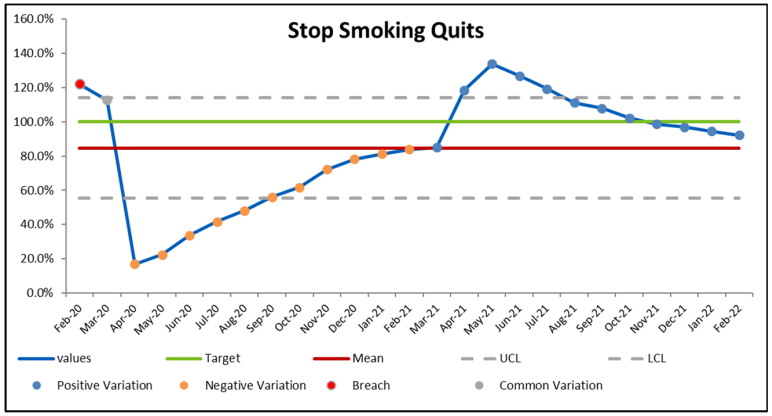



The graphs above show activity in 2021/22 against trajectory for both KCHFT core checks and 3rd party providers. We had a realistic target of a consistent 20% increase on a quarterly basis and this was achieved

Expected annual target for the service for 2021/22 was 6802 which covered both KCHFT core team and 3rd party providers, with both areas far exceeding this.

### Stop Smoking Quits



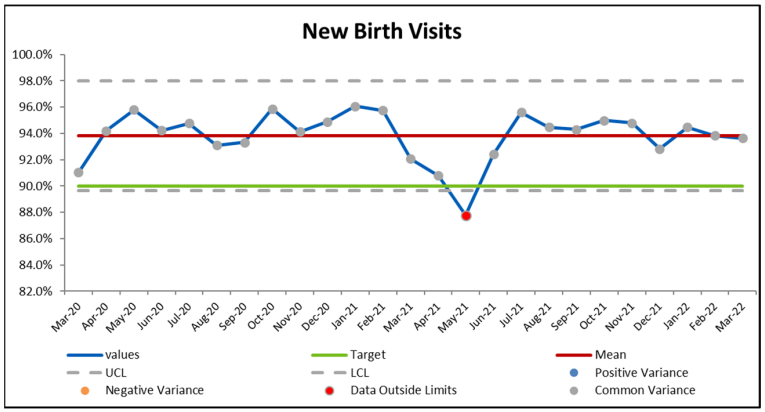

*Reporting period 1 month behind other metrics due to need to wait for 4 week outcomes

Quit Dates Set for 21/22 remain on track with current performance around target level. The data will not have finished yet for 2021/22 as new need to wait for all the patients to go assess their 4 week outcomes.

## 5.1.2 Health Visiting

### New Birth Visits

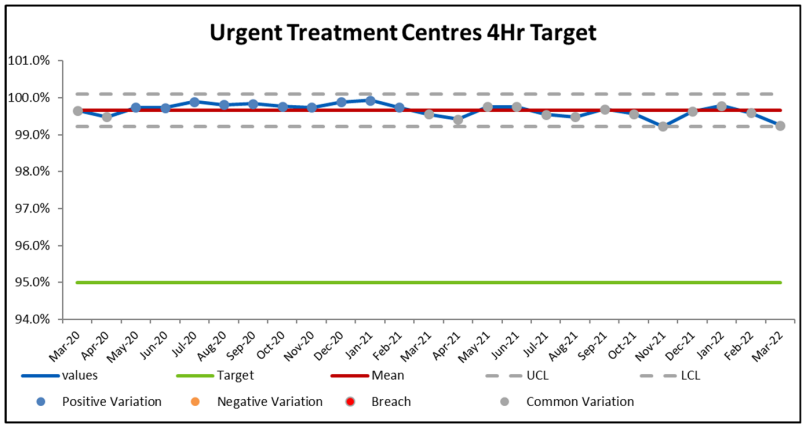
The new birth visit performance has continued to perform strongly above the mean and target level, with no current areas of concern. Performance for 2021/22 (93.3%) was slightly down on 2020/21 (94.5%), most due to the dip in Q1



### 5.1.3 National Child Measurement Programme (NCMP)

The 2021/22 measurement programme for Year R and 6 pupils commenced from February 2022 and was at 37.7% at the end of the month (on track).

### 5.1.4 Urgent Treatment Centres (UTCs) 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 the pandemic and continue to do so, with activity now at pre-covid levels. Utilisation rate for M12 was up to 86.4% against maximum capacity when taking into account the UTC delivery model, showing a positive increase as we divert activity away from emergency departments.

### 5.1.5 GUM 48hr

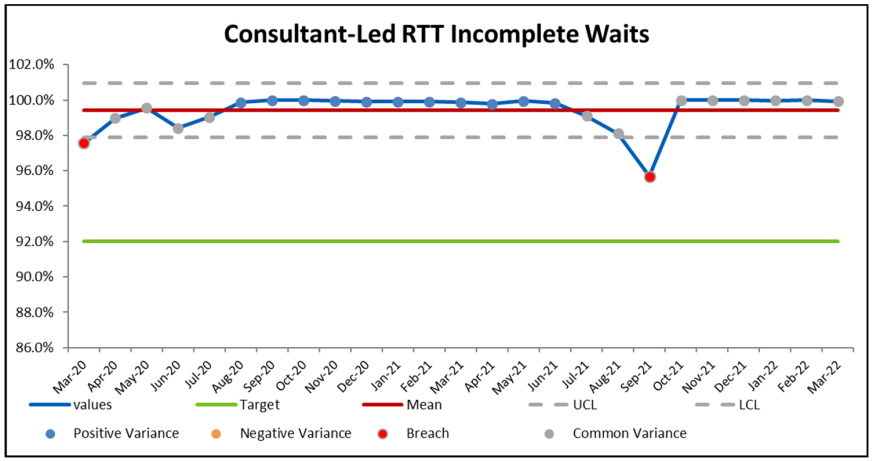
Access to GUM clinics within 48hrs has been consistently 100%, with no reported breaches

### 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% of patients beginning treatment within 18 weeks, with the Month 12 position being at 99.9%, with 3 patients out of 3,795 currently waiting longer than 18 weeks.

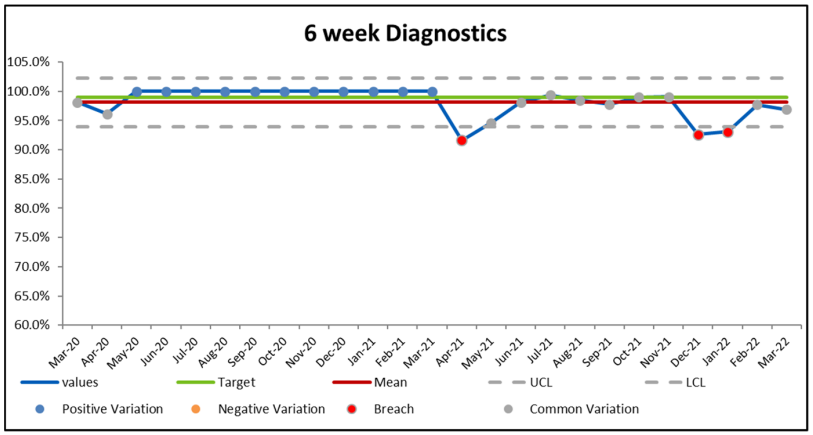
| | 0-12 Wks | 12-18 Wks | 18-36 Wks | 36-52 Wks | 52+ Wks | < 18 Weeks |
|---|---|---|---|---|---|---|
| Chronic Pain | 285 | 15 | 1 | 0 | 0 | 99.7% |
| Orthopaedics | 3194 | 298 | 2 | 0 | 0 | 99.9% |
| KCHFT Total | 3479 | 313 | 3 | 0 | 0 | 99.92% |

The above table shows the current breakdown of the waiting list for both services on a consultant-led pathway, with both meeting target



### 5.1.7 6 Week Diagnostics (Audiology)

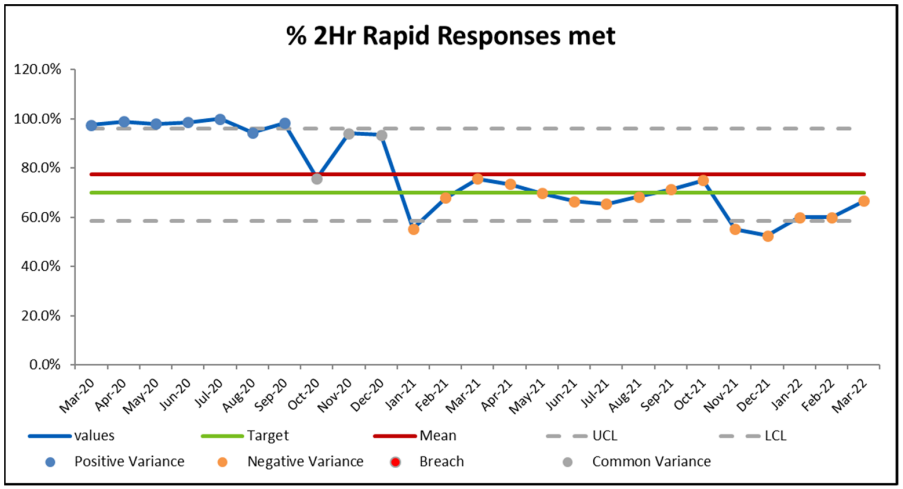
Compliance for month 12 the service achieved 96.9%, which gave the service an annual figure of 97.8%. The service continues to have some capacity issues due to covid related sickness vacancy and maternity leave resulting in short notice cancellations of clinics and this will continue to impact the service performance in Month 1 and compliance is likely to be impacted. The service is utilising bank shifts to support service delivery.



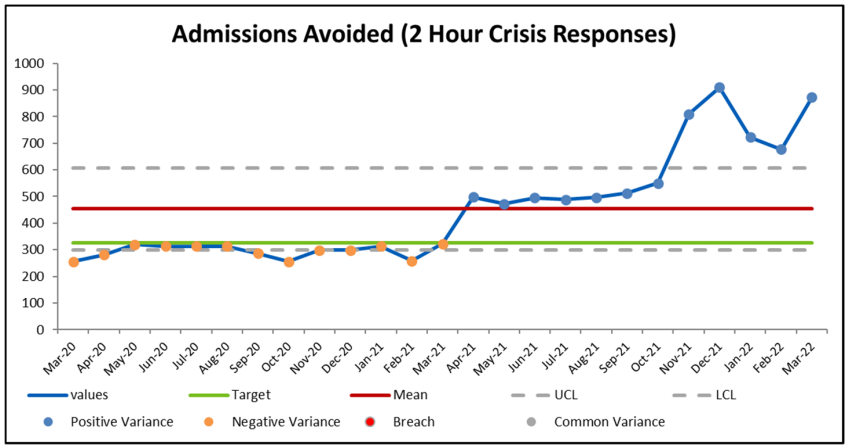
### 5.1.8 Urgent Crisis Response referrals seen within 2 hours

Performance has recently been around the 60% mark (since the implementation of the new standard operating procedure) which is not out of line with national data, which is showing between 60-70%. However there are signs of an improving trend with 3 consecutive monthly increases to 66.6% for M12.

The 2022-23 Operational Guidance states that an objective to “Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3”. Therefore the target has been adjusted in line with this, from 95% to 70%. It is expected that this will be achieved ahead of time given current performance levels and the upward trajectory.



### 5.1.9 Urgent Crisis Response Demand (admission avoidance)




The above chart is showing that overall there has been a demand increase since the beginning of Covid-19 and there has also been a spike as a result of the new SOP being introduced. Demand has averaged 757 per month over the last 6 months compared to 494 for the period before

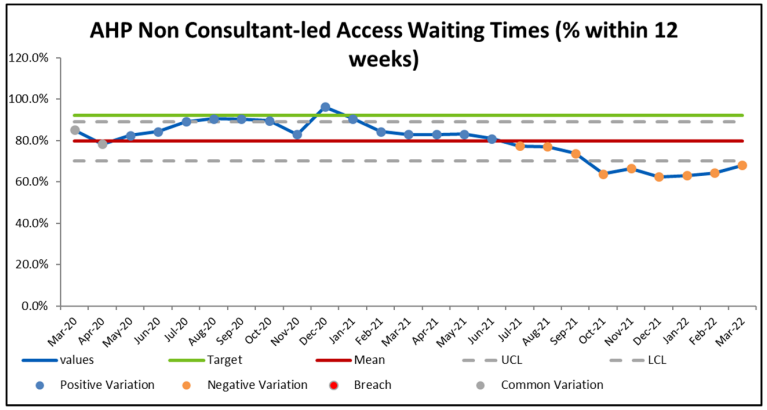
We still receive a number of referrals which specify that an urgent response is required, which upon triage, are not appropriate and/or necessary. The SOP enables staff to downgrade the inappropriate requests, thus excluding both from the demand and the response rates. Unfortunately, this has also been the limiting factor on the data accuracy as the completeness of this form had not been as it should be, resulting in the above variable demand in months 7-12.

111 referrals are likely to increase referrals by 12% over three years. We haven't yet seen the impact of the 111 increase and we are arranging communications to support that. We estimate a 4% increase in activity this year

### 5.1.10 Assurance on Local Wait Times

Completed access wait times across non-consultant-led AHP services are currently in negative variation and below the aspirational level of 92% within 12 weeks (internal benchmark target). However there are encouraging signs of improvement with incremental increases over the last 3 months, to 68.1% in month 12.

The main contributors to this level of performance is that we are currently experiencing significant wait times in some high volume services, such as in MSK Physiotherapy services, where demand is increasing and work plans have been developed to improve activity and performance (52.5%), Kent Podiatry (61.2%), Neuro Rehab (68.5%) and Paediatrics (45%).




A weekly report is shared with the Chief Operating Officer, Deputy Chief Operating Officer and CSDs showing the current position with waiting list size, 12 week % and longest waits, at service level. This gives oversight and progress on improvements at a granular level on a regular basis

| Top 3 | |
|---|---|
| East Sussex CITS | 98.64% |
| Children's Hearing Service | 97.44% |
| Adult Speech and Language Therapy | 96.41% |

| Bottom 3 | |
|---|---|
| Community Paediatrics | 45.04% |
| Adult MSK Physiotherapy | 52.50% |
| Kent Podiatry | 61.20% |

**Adult MSK Physiotherapy**

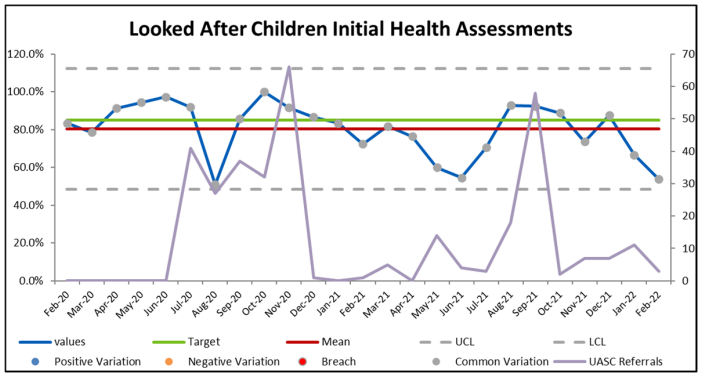
- Demand is expected to increase by 5-10% over the next 6 months, which coupled with vacancy-affected capacity, has resulted in a revised forecast of a sustainable waiting list volume by January 2023.
- Urgent referral capacity is ring-fenced and accounts for c.30% of demand.

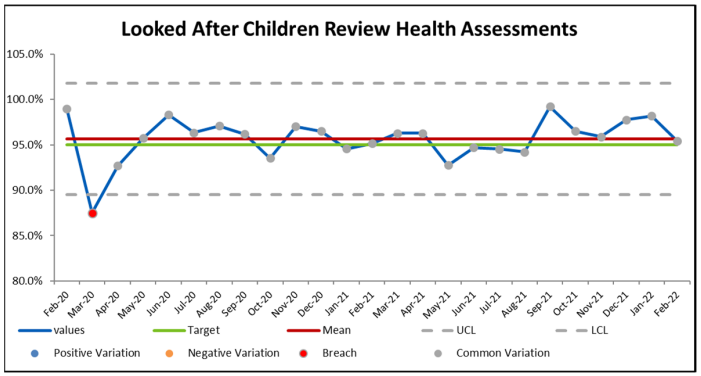
- Waits over 18 weeks have reduced by nearly 500 (22%) since the end of February. Current average time on the waiting list has reduced from 14 to 13 weeks since the end of February
- Trajectory to reduce longest wait to less than 30 weeks by end of June is ahead of schedule and may be achieved by end of May 2022
- Current waiting list within 12 weeks performance of 52.5% is forecast to improve to 85% by March 2023, with the longest wait forecast to be within 25 weeks by October 2022.

**Podiatry**

- Referral demand has increased and is predicted to show 5% growth in 2022/23 compared to 2021/22. 12-week waits are expected to be at 75% by October 2022 (61% at end of 21/22), with un-booked waits over 26 weeks down from 166 at the end of March to 72 currently.
- Ongoing capacity work has increased forward bookings to 20.5% from 14.5%. The longest wait is currently 39 weeks (this is due to a patient DNA)
-

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



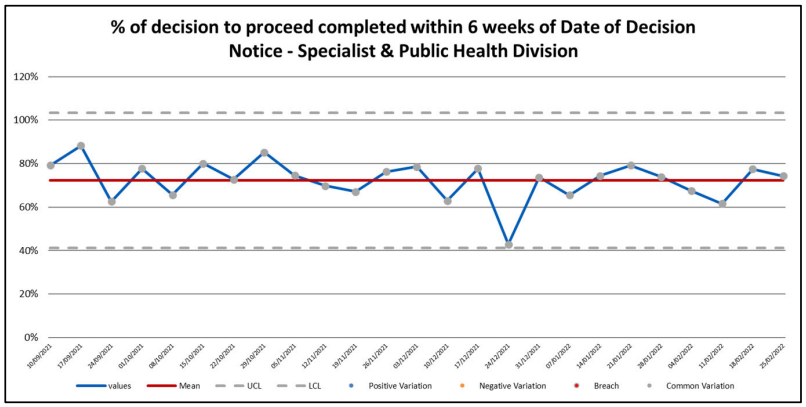



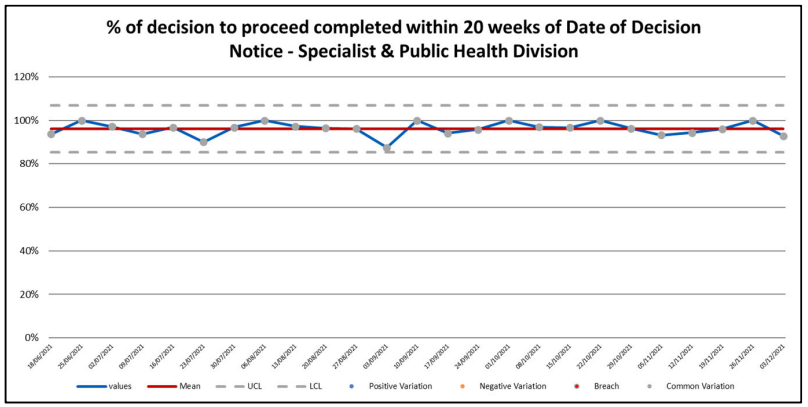

*Reporting period 1 month behind other metrics due to need to wait for 28 day outcomes

As predicted there has been a decrease in the compliance of Kent IHAs and 53.8% being completed within 28 days of child becoming looked after. There were 16 requests from KCC in February and only 31% (5) of the requests from KCC were received by the service within 5 working days. However, it is of note that 93.3% were completed within 23 days of KCHFT receiving the referral.

The Service continues to meet the statutory timeframe for review health assessments.

### 5.1.12 Education Health Care Plan (EHCP) Wait Times




Health services are required to provide advice / complete assessment within 6 weeks from date of notification by local authority to proceed with an education, health and care (EHC) assessment to comply with statutory regulation. Compliance against the 6 week statutory response at M12 has improved from the previous month to 74%.

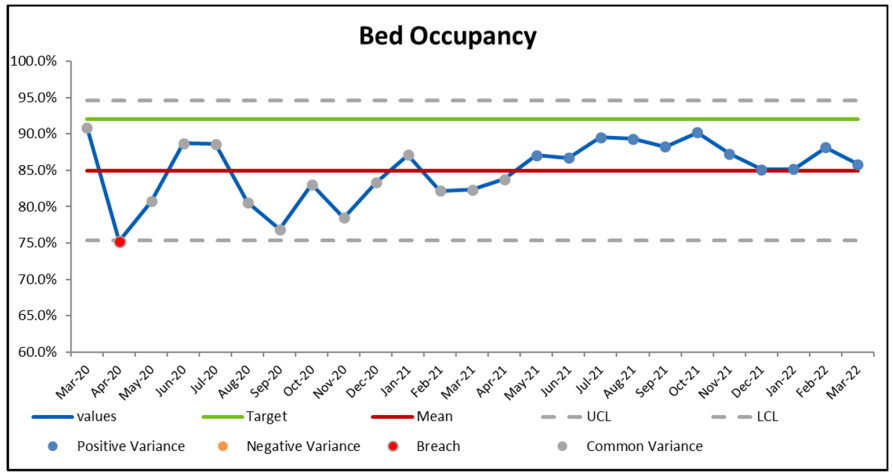
Services working to improve 6 week compliance rate based on average rate in 2019-2020 however this is impacted by the increase in demand. Redirecting resource to meet the 6 week target is also impacting on the service capacity to deliver the therapy provision detailed in the EHC plans.

The clinicians work with special educational needs (SEN) officers in the local authority to ensure advice is provided to meet overall statutory timeline for completion of EHC plan of 20 weeks. Compliance against the 20 week statutory response time at M12 remains at 93%.

### 5.1.13 Bed Occupancy

Bed Occupancy continues to show a varying trend, with current performance stable around the mean and just below the target threshold of 87-92% (85.8% at month 12). The annual average was 87.2%, up from 82.3% in 2020/21

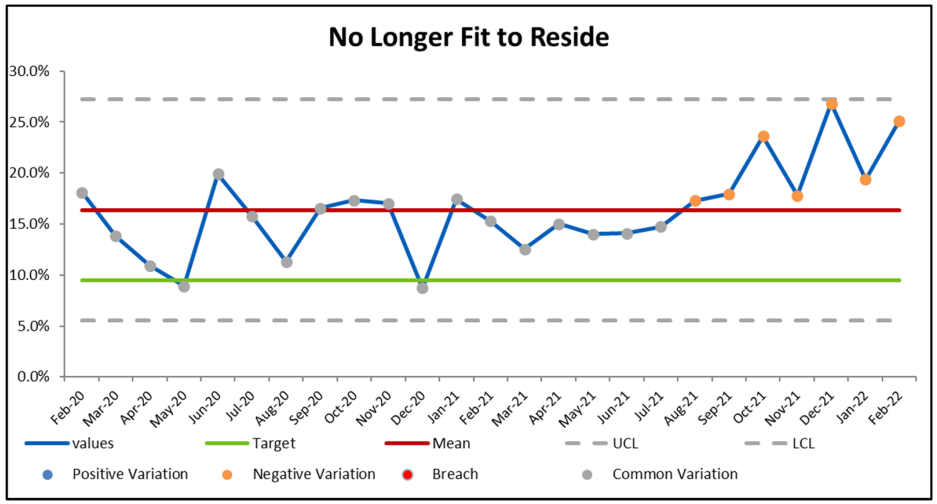
An increase in bed occupancy is expected over the coming months, although we continue to manage IPC measures very closely to minimise impact of bed closures associated with isolation or cohorting of patients.



### 5.1.14 No Longer Fit to Reside

Performance continues to be adverse to the target. The target level (KCHFT's target for the proportion of patients who are no longer fit to reside is to achieve an average of 14 per day across Kent, which equates to around 9.5% as a rate of occupied bed days) continues to be rarely achieved in the current climate (twice in the last 25 months) with a current performance above the mean at around 25%

The prime driver for high NFtR numbers continues to be difficulty in accessing sufficient and timely domiciliary care packages to support safe discharge. This is a system-wide challenge. We continue to work closely with the CCG and KCC to review capacity challenges; improve patient flow and support effective discharge.




### 5.1.15 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 UTC attendances.

### 5.1.16 CQUIN

CQUIN programme currently paused due to the Covid-19 pandemic but is being restarted for 22/23 and is currently being developed.

## 5.2 Assurance on activity and outcomes

### 5.2.1 Activity

As part of the Operational Plan, activity plans for are monitored at service and locality level and shown below in divisional summaries.

During Month 12 (March 2022) KCHFT carried out 183,882 clinical contacts, with a total of 2,046,126 for the year. For the financial year to March 2022 KCHFT this was 1.8% above plan for all services (some services have contractual targets, some are against an internal plan). The only negative variance was within Dental and Planned Care Services (-12.2%).

| Service Type | M12 Actual | YTD Actual | YTD Plan | YTD Variance | Movement | Internal BRAG | Contract BRG |
|---|---|---|---|---|---|---|---|
| Adults - Long Term Care | 70,115 | 804,655 | 771,888 | 4.2% | Positive | | |
| Adults - Urgent Care | 29,524 | 327,766 | 305,923 | 7.1% | Positive | | |
| Adults - Community Hospitals | 2,089 | 25,787 | 23,519 | 9.6% | Positive | | |
| Adults - Rehab | 16,945 | 191,556 | 185,683 | 3.2% | Positive | | |
| Dental and Planned Care | 15,075 | 167,142 | 190,415 | -12.2% | Positive | | |
| Specialist and Public Health Services | 50,135 | 529,220 | 532,082 | -0.5% | Positive | | |
| **Trust Total Activity against plan** | **183,883** | **2,046,126** | **2,009,510** | **1.8%** | 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

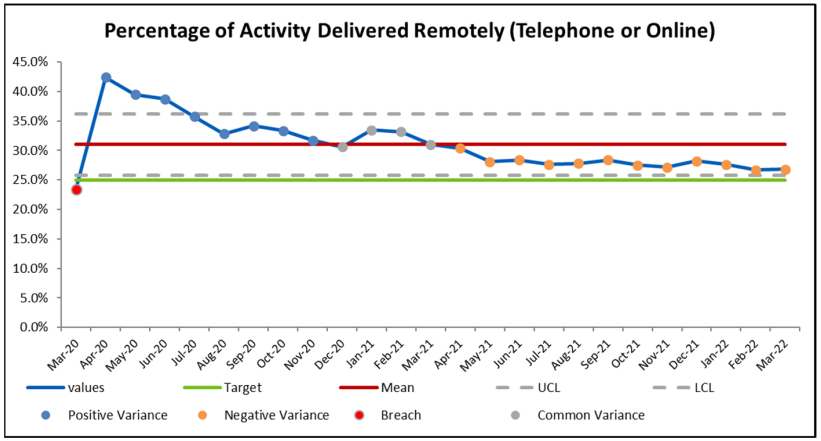
**Dental and Planned Care Services –** The largest variances contributing to the overall 12.2% deficit against plan remain within MSK Physio and Podiatry. While these services are improving in terms of overall volume, they had not yet reached the levels planned for the year. However, service modelling and recruitment have predicted much higher activity in 2022/23 in both services

Activity plans for 2022/23 are in place, with the below summarising the change in plans for the new year.

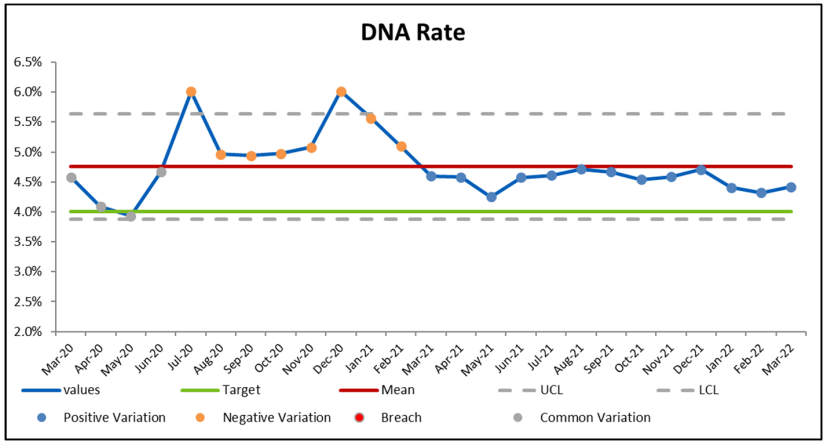
| Service Area | Plan | | Plan Change (from 21-22 to 22-23) |
|---|---|---|---|
| | 2021/22 | 2022/23 | |
| **Children's Specialist and LD Services** | 248,858 | 240,663 | -3.3% |
| **Public Health Services** | 283,224 | 291,682 | 3.0% |
| **Planned Care** | 184,745 | 204,415 | 10.6% |
| **Adult Long Term Services** | 771,888 | 793,283 | 2.8% |
| **Adult Rehab Services** | 185,683 | 185,337 | -0.2% |
| **Adult Urgent Care Services (Exc UTCs)** | 188,126 | 190,345 | 1.2% |
| **Urgent Treatment Centres** | 117,797 | 137,096 | 16.4% |
| **Community Hospitals (OBDs)** | 53,943 | 57,168 | 6.0% |
| **KCHFT Total** | 2,034,264 | 2,099,988 | 3.2% |

### 5.2.2 Activity Delivery Method

Levels have now stabilised with consistent performance above the 25% target with the last 12 months averaging 27.9%. this is made up of 22.4% via telephone and 5.5% by other methods (i.e. web based)



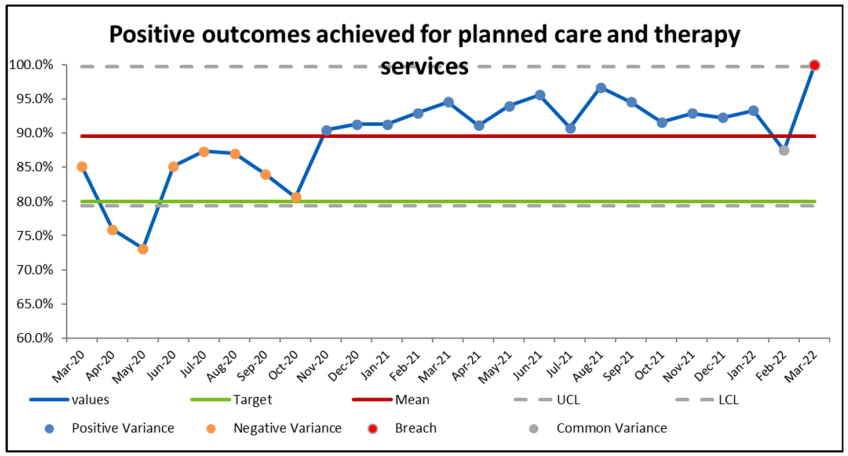

### 5.2.3 DNA rates




As a result of the offer of more virtual appointments, which carry a higher DNA rate, levels are generally higher than the pre-pandemic rate (3-3.5% range). However, increased focus and national guideline changes has driven levels back down from 2020 levels. The average over 2020/21 was 5.0% but this has reduced to 4.5% in 2021/22

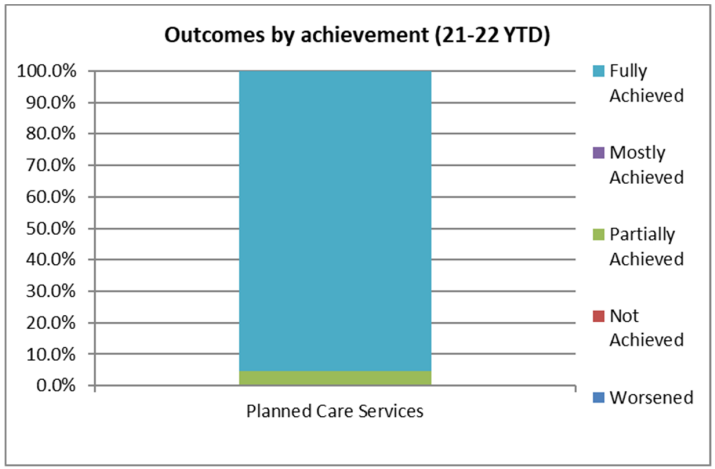
### 5.2.4 Outcomes

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 following chart does show that achievement of target is always likely to occur unless a process change or significant event occurs as the control limits indicate the range of performance varying month to month should not normally fall low enough to breach target.



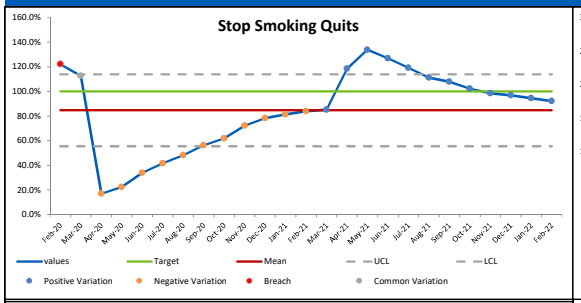

The following table and chart shows the proportion of the grading of each outcome for the year to date. Each outcome will be specific to the patient and will be personalised, therefore not allowing further detail to be summarised.

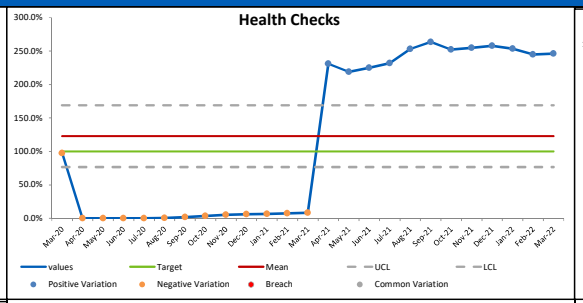
| | Planned Care Services |
|---|---|
| **Worsened** | 0.0% |
| **Not Achieved** | 0.5% |
| **Partially Achieved** | 4.3% |
| **Mostly Achieved** | 0.0% |
| **Fully Achieved** | 95.2% |

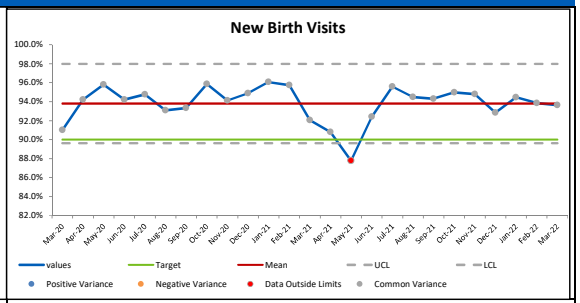


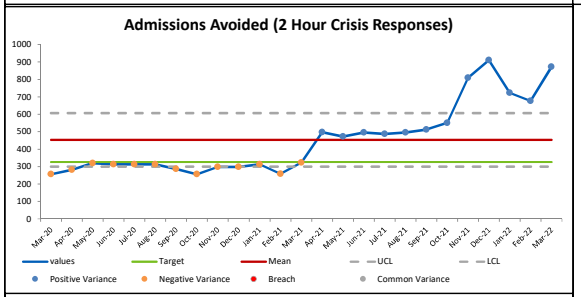
## Appendix - Scorecard SPC Charts

### 1. Prevent Ill Health



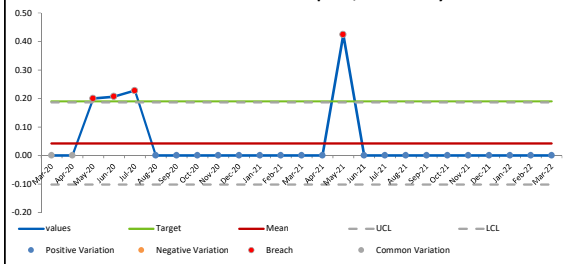



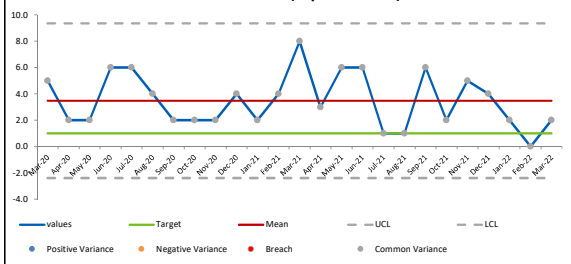



## 2. Deliver high-quality care at home and in the community

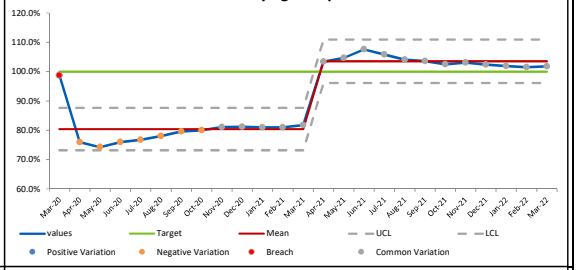
### Moderate and Severe falls per 1,000 bed days



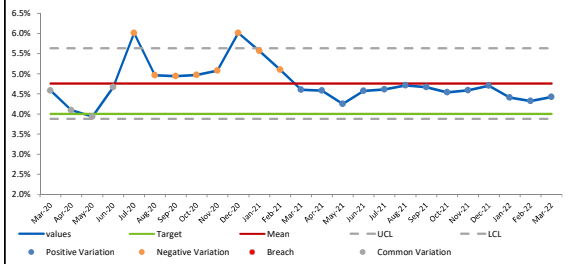

### Pressure Ulcers (Lapses in Care)



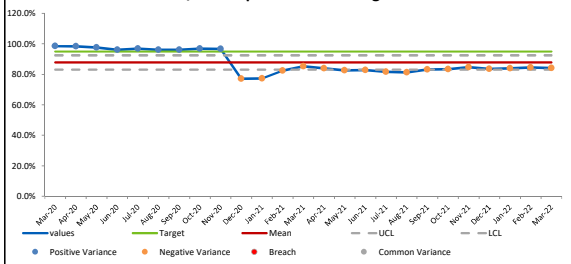

### Activity against plan



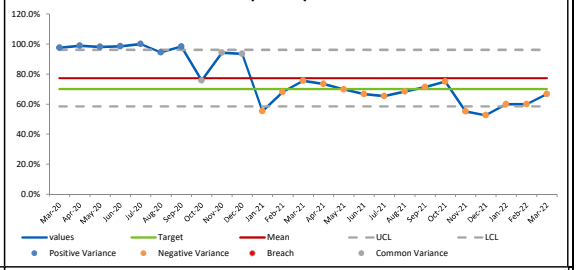

### DNA Rate



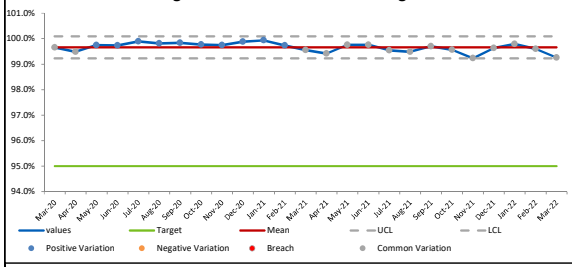

### LTC/ICT Response Times Being Met



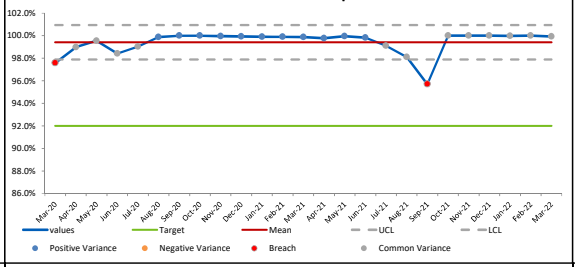

### % 2Hr Rapid Responses met



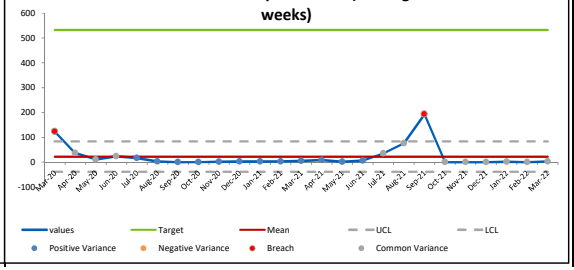

### Urgent Treatment Centres 4Hr Target




### Consultant-Led RTT Incomplete Waits

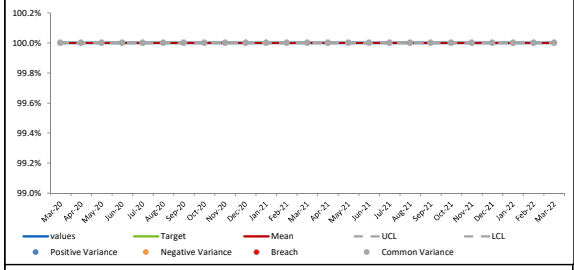



### Consultant-Led RTT Incomplete Waits (waiting list size >18 weeks)

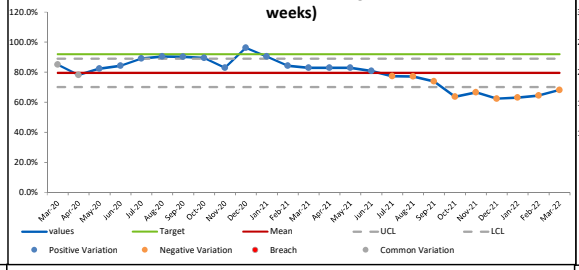


## 2. Deliver high-quality care at home and in the community

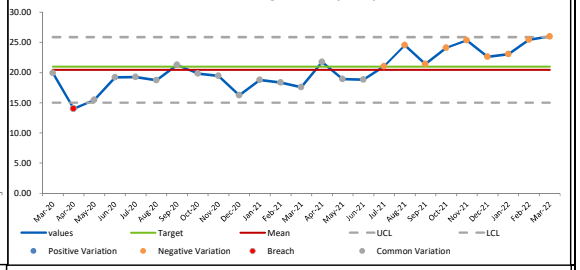
### GUM Access within 48Hrs



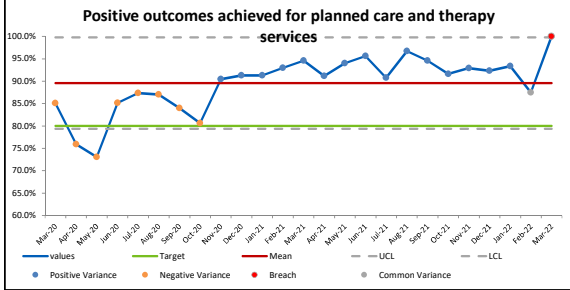

### AHP Non Consultant-led Access Waiting Times (% within 12 weeks)



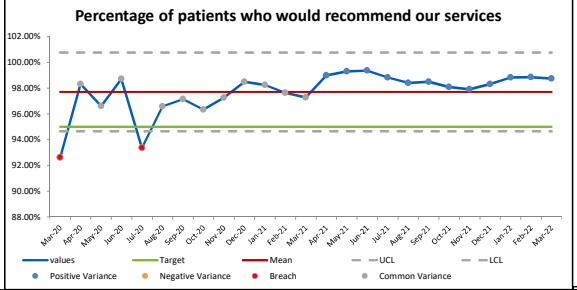

### Median length of stay (days)



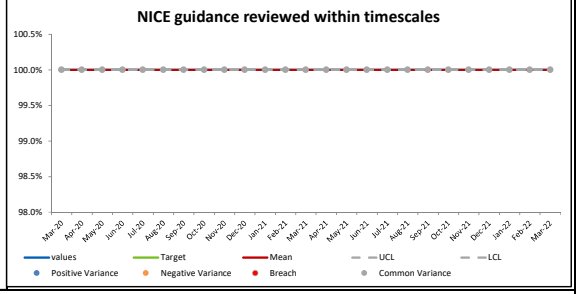

### Positive outcomes achieved for planned care and therapy services



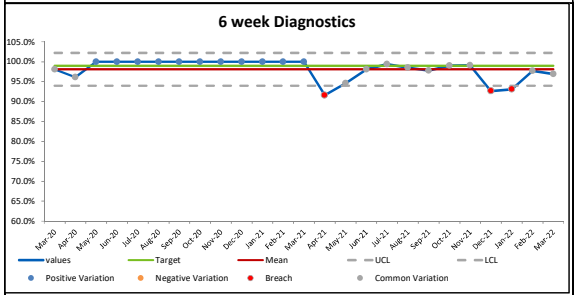

### Percentage of patients who would recommend our services



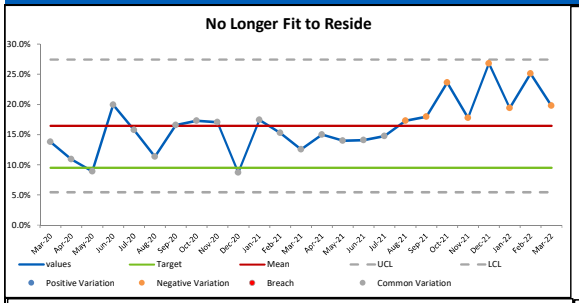

### NICE guidance reviewed within timescales

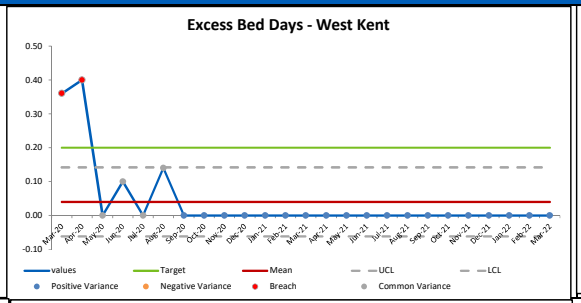


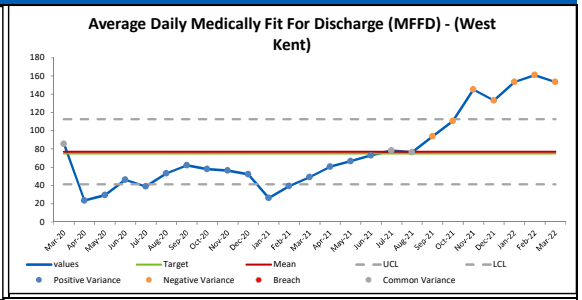

### 6 week Diagnostics

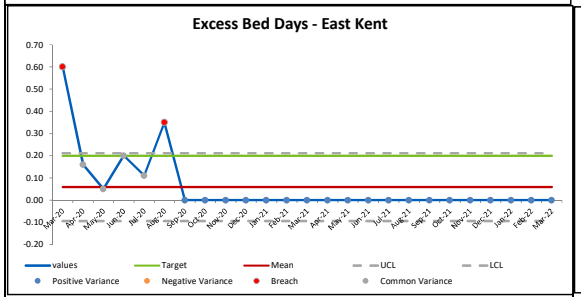


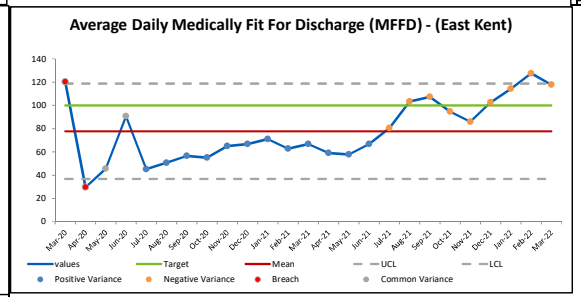
## 3. Integrate Services



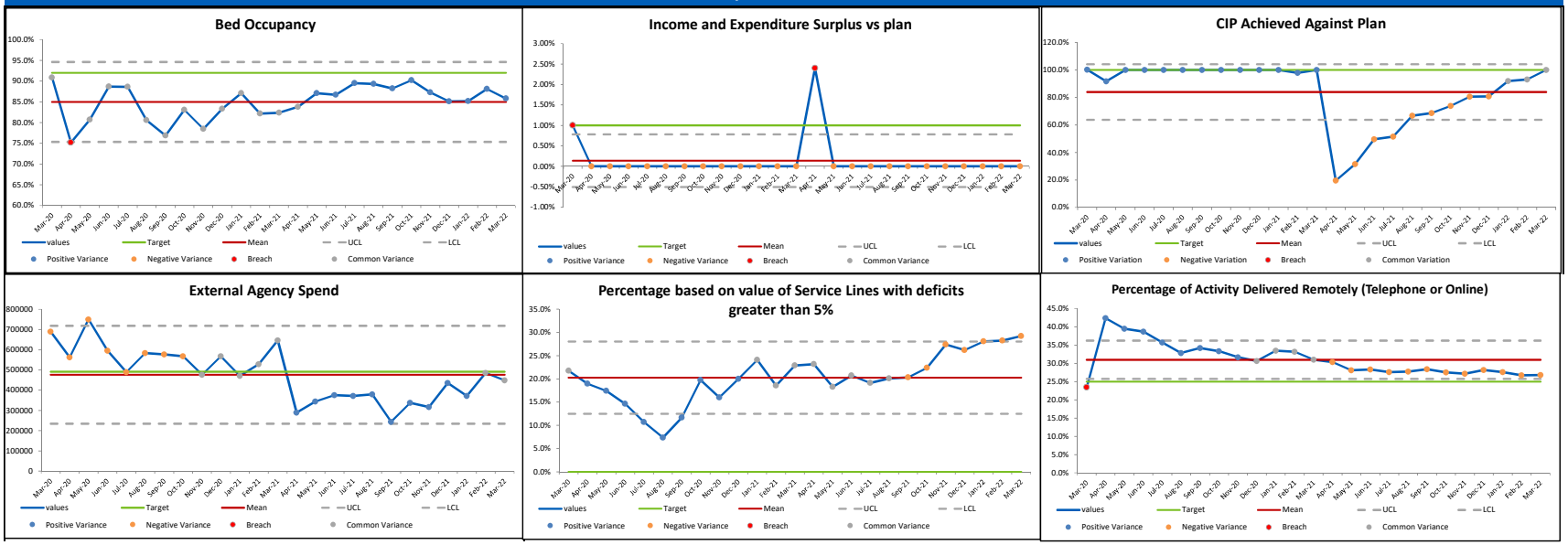



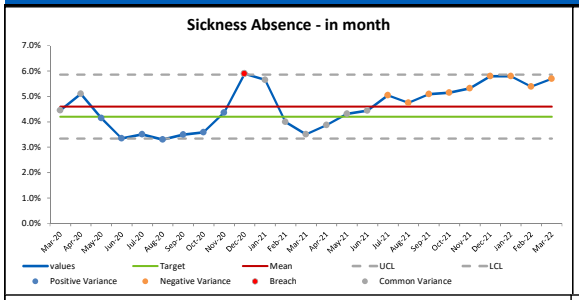



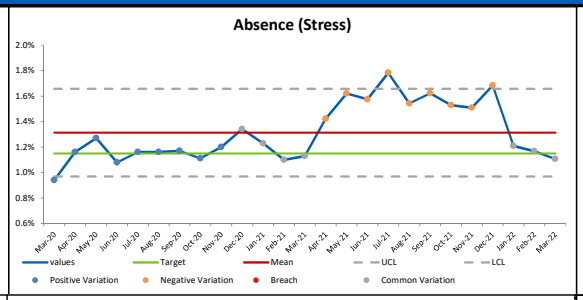



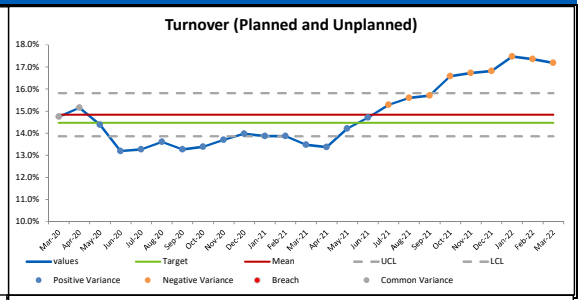
## 4. Develop sustainable services

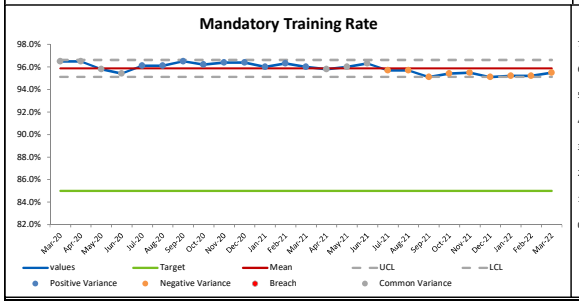


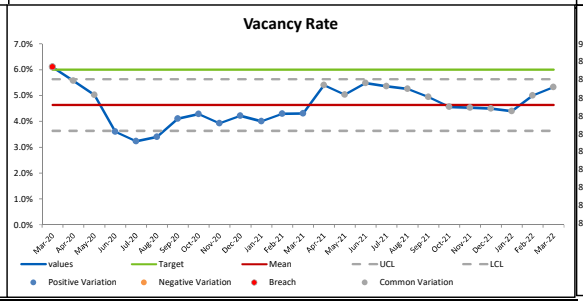
## 5. Be The Best Employer

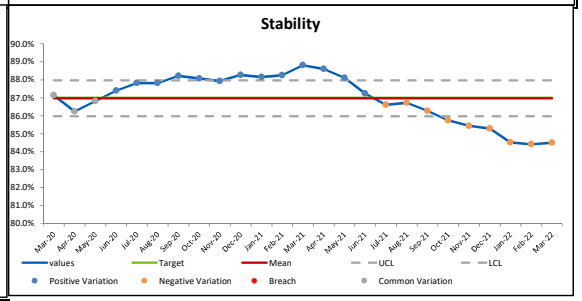


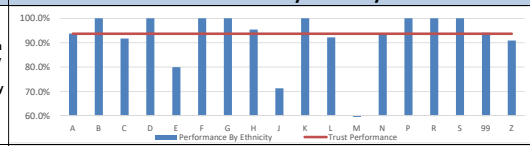
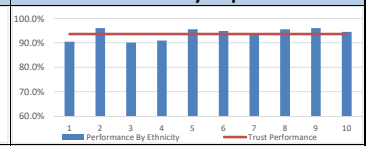
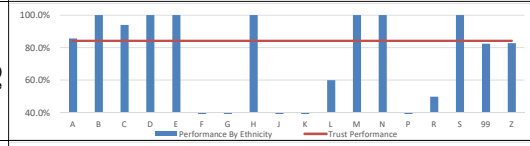
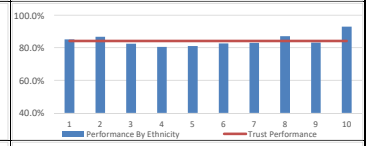
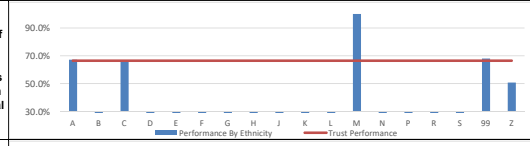
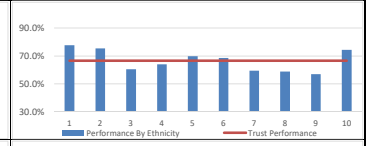
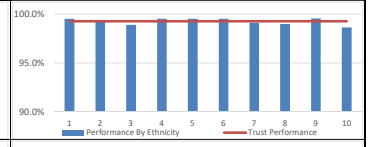
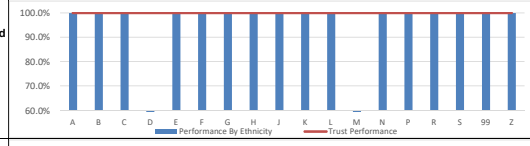
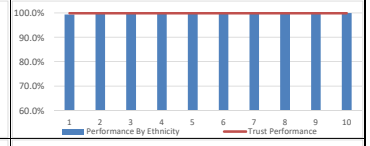
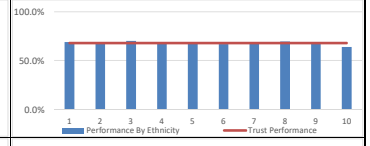
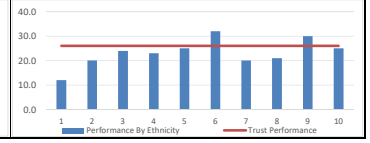



## KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 12)

| | KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days | | KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity | | KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient) | | KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance | | KPI 2.11 (N) Total Time in UTCs: Less than 4 hours | | KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways | | KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times (12 week target) | | KPI 2.16 Length of Community Hospital Inpatient Stay (Median Average) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust Performance | 93.7% | | 4.4% | | 84.2% | | 66.6% | | 99.3% | | 99.9% | | 68.1% | | 26.0 | |
| Target | 90% | | 4% | | 95% | | 70% | | 95% | | 92% | | 92% | | 21.0 | |
| **Performance by Ethnicity** | | | | | | | | | | | | | | | | |
| | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | Days | No. |
| A - White - British | 93.8% | 875 | 4.3% | 88511 | 85.7% | 1200 | 67.4% | 291 | 99.3% | 9880 | 99.9% | 786 | 71.3% | 6047 | 25.5 | 106 |
| B - White - Irish | 100.0% | 1 | 2.6% | 623 | 100.0% | 7 | 0.0% | 1 | 100.0% | 17 | 100.0% | 2 | 68.0% | 25 | 8.0 | 1 |
| C - White - Any other White background | 91.8% | 98 | 7.9% | 2477 | 94.1% | 17 | 66.7% | 3 | 99.8% | 472 | 100.0% | 26 | 67.2% | 287 | 46.0 | 1 |
| D - Mixed - White and Black Caribbean | 100.0% | 10 | 13.5% | 252 | 100.0% | 1 | N/A | 0 | 100.0% | 13 | N/A | 0 | 62.8% | 43 | N/A | 0 |
| E - Mixed - White and Black African | 80.0% | 10 | 6.4% | 249 | 100.0% | 1 | N/A | 0 | 95.5% | 22 | 100.0% | 1 | 76.5% | 34 | N/A | 0 |
| F - Mixed - White and Asian | 100.0% | 11 | 4.8% | 270 | N/A | 0 | N/A | 0 | 100.0% | 15 | 100.0% | 2 | 70.3% | 37 | N/A | 0 |
| G - Mixed - Any other mixed background | 100.0% | 31 | 11.5% | 715 | N/A | 0 | N/A | 0 | 100.0% | 60 | 100.0% | 3 | 64.5% | 93 | N/A | 0 |
| H - Asian or Asian British - Indian | 95.5% | 22 | 5.7% | 628 | 100.0% | 1 | N/A | 0 | 99.2% | 263 | 100.0% | 17 | 63.6% | 121 | N/A | 0 |
| J - Asian or Asian British - Pakistani | 71.4% | 7 | 12.5% | 120 | 0.0% | 1 | N/A | 0 | 100.0% | 18 | 100.0% | 1 | 89.5% | 19 | N/A | 0 |
| K - Asian or Asian British - Bangladeshi | 100.0% | 6 | 9.4% | 138 | 0.0% | 1 | N/A | 0 | 100.0% | 17 | 100.0% | 1 | 64.0% | 25 | N/A | 0 |
| L - Asian or Asian British - Any other Asian background | 92.3% | 26 | 6.7% | 647 | 60.0% | 5 | N/A | 0 | 100.0% | 171 | 100.0% | 3 | 82.9% | 82 | N/A | 0 |
| M - Black or Black British - Caribbean | 50.0% | 2 | 5.1% | 157 | 100.0% | 1 | 100.0% | 5 | 100.0% | 21 | N/A | 0 | 78.9% | 19 | N/A | 0 |
| N - Black or Black British - African | 93.8% | 16 | 8.8% | 560 | 100.0% | 1 | N/A | 0 | 97.1% | 201 | 100.0% | 3 | 65.9% | 132 | N/A | 0 |
| P - Black or Black British - Any other Black background | 100.0% | 6 | 13.0% | 162 | N/A | 0 | N/A | 0 | 99.2% | 119 | 100.0% | 4 | 83.9% | 31 | N/A | 0 |
| R - Other Ethnic Groups - Chinese | 100.0% | 1 | 4.9% | 82 | 50.0% | 2 | N/A | 0 | 100.0% | 17 | 100.0% | 2 | 83.3% | 12 | 27.0 | 1 |
| S - Other Ethnic Groups - Any other ethnic group | 100.0% | 21 | 7.0% | 472 | 100.0% | 3 | N/A | 0 | 98.8% | 169 | 100.0% | 5 | 71.4% | 49 | N/A | 0 |
| 99 - BLANK | 94.2% | 206 | 5.1% | 56851 | 82.5% | 895 | 68.1% | 285 | 100.0% | 2 | 100.0% | 2325 | 65.0% | 11801 | 22.0 | 45 |
| Z - Not stated/Incomplete | 90.9% | 44 | 3.9% | 12049 | 82.9% | 199 | 51.0% | 49 | 95.5% | 22 | 99.9% | 884 | 77.3% | 1686 | 30.0 | 11 |
| **% Completeness** | **82.1%** | **1393** | **58.2%** | **164963** | **53.1%** | **2335** | **47.3%** | **634** | **99.8%** | **11499** | **21.1%** | **4065** | **34.3%** | **20543** | **66.1%** | **165** |
| **Performance by Deprivation Decile** | | | | | | | | | | | | | | | | |
| | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | Days | No. |
| Decile 1 - Most Deprived | 90.6% | 106 | 7.8% | 847 | 85.3% | 129 | 77.8% | 18 | 99.5% | 815 | 99.4% | 313 | 69.1% | 1238 | 12.0 | 7 |
| Decile 2 | 96.1% | 153 | 4.9% | 936 | 86.9% | 199 | 75.4% | 57 | 99.4% | 1094 | 100.0% | 341 | 68.7% | 1973 | 20.0 | 13 |
| Decile 3 | 90.2% | 112 | 4.8% | 754 | 82.5% | 217 | 60.5% | 38 | 98.9% | 1104 | 100.0% | 375 | 70.1% | 1717 | 24.0 | 11 |
| Decile 4 | 91.0% | 166 | 4.2% | 922 | 80.6% | 237 | 64.0% | 50 | 99.5% | 1464 | 100.0% | 440 | 68.7% | 2233 | 23.0 | 12 |
| Decile 5 | 95.6% | 183 | 4.6% | 1073 | 81.2% | 341 | 69.9% | 83 | 99.5% | 1649 | 100.0% | 508 | 68.8% | 2554 | 25.0 | 16 |
| Decile 6 | 94.9% | 175 | 4.2% | 816 | 82.8% | 279 | 68.7% | 83 | 99.5% | 1221 | 100.0% | 497 | 67.0% | 2526 | 32.0 | 16 |
| Decile 7 | 93.7% | 174 | 4.2% | 875 | 83.1% | 320 | 59.5% | 84 | 99.1% | 1461 | 99.8% | 489 | 68.1% | 2564 | 20.0 | 22 |
| Decile 8 | 95.6% | 113 | 3.9% | 619 | 87.1% | 233 | 59.0% | 61 | 99.0% | 786 | 100.0% | 339 | 69.6% | 1941 | 21.0 | 20 |
| Decile 9 | 96.1% | 102 | 3.4% | 424 | 83.2% | 184 | 57.1% | 56 | 99.5% | 653 | 100.0% | 289 | 67.8% | 1686 | 30.0 | 25 |
| Decile 10 - Least Deprived | 94.6% | 93 | 2.8% | 373 | 93.1% | 188 | 74.5% | 102 | 98.6% | 731 | 100.0% | 325 | 64.0% | 1863 | 25.0 | 18 |

## KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 12)

| KEY | KPI | Performance By Ethnicity | Performance by Deprivation |
|---|---|---|---|
| **Ethnic Categories**<br>**A** - White - British<br>**B** - White - Irish<br>**C** - White - Any other White background<br>**D** - Mixed - White and Black Caribbean<br>**E** - Mixed - White and Black African<br>**F** - Mixed - White and Asian<br>**G** - Mixed - Any other mixed background<br>**H** - Asian or Asian British - Indian<br>**J** - Asian or Asian British - Pakistani<br>**K** - Asian or Asian British - Bangladeshi<br>**L** - Asian or Asian British - Any other Asian background<br>**M** - Black or Black British - Caribbean<br>**N** - Black or Black British - African<br>**P** - Black or Black British - Any other Black background<br>**R** - Other Ethnic Groups - Chinese<br>**S** - Other Ethnic Groups - Any other ethnic group<br>**99** - BLANK<br>**Z** - Not stated/Incomplete<br>**Deprivation Deciles**<br>1 = Most Deprived<br>10 = Least Deprived | **KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days** |  |  |
| | **KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity** |  |  |
| | **KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)** |  |  |
| | **KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance** |  |  |
| | **KPI 2.11 (N) Total Time in UTCs: Less than 4 hours** |  |  |
| | **KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways** |  |  |
| | **KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times (12 week target)** |  |  |
| | **KPI 2.16 Length of Community Hospital Inpatient Stay (Median Average)** |  |  |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 4.2 |
| **Agenda Item Title:** | Staff Survey |
| **Presenting Officer:** | Victoria Robinson-Collins, Director of People and Organisational Development |
| **Action – this paper is for:** | ☐ Decision<br>☒ Information<br>☒ Assurance |

**What is the purpose of the paper and the ask of the Committee or Board?**

The slides that support this agenda item offers information in relation to corporate or Trust wide headlines from the 2021 staff survey results. Board members are asked to note the Trust wide actions already taking place as well as the actions to deep dive into actions against reported hot spots at divisional and team level.

**Summary of key points**

- We scored better than the average in all categories bar one where we were equal to the average
- We were the best in our benchmarking group in two areas.
- We had the highest response rate the organisation has ever achieved
- Colleagues feel secure in raising concerns about unsafe clinical practice
- Responses offer a positive view of staff experience, including feeling valued by their team, having managers who care about their health and wellbeing and being respected.
- Nationally, results have deteriorated when compared to 2020, including KCHFT
- Pressure remains high on NHS services; colleagues feeling burnt out and exhausted, in line with the national picture
- Number of unpaid and paid additional hours worked has increased
- Levels of emotional exhaustion and frustration with work have increased
- Reflected in areas where results have declined:
    - There are enough staff at this organisation for me to do my job properly (-14.15 per cent)
    - I look forward to going to work (-7.19 per cent)
    - I am satisfied with the extent to which my organisation values my work (-6.59 per cent)
    - I am able to meet all the conflicting demands on my time at work (-6.1 per cent)
    - I am able to make suggestions to improve the work of my team / department (-5.44 per cent)
- Number of colleagues reporting harassment, bullying and aggression from patients and members of the public has increased
- Colleagues with a disability reporting harassment is an outlier

Our plans to address areas of concern and engage with colleagues include:

- Toolkit for leaders and managers to use to engage with colleagues as Big Conversations
- Individual services review their local information to understand hot spots and share with teams using toolkit
- The workforce equality group will focus on WDES, WRES and carer results.
- Results shared to all colleagues by Executive Director in an all-staff e-bulletin and vlog.
- Team Talks: Any insights from local conversations will shared via the Communications Team.
- Quality Improvement task and finish groups will be set up for any new solutions
- Case study examples of improvements at Executive Performance Reviews.

| **Proposal and/or recommendation to the Committee or Board** |
|---|
| Board members are asked to note the Trust wide actions already taking place as well as the actions to deep dive into actions against reported hot spots at divisional and team level. |

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis (EA) for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br><br>**If not describe any equality and diversity issues that may be relevant.**<br><br>*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)*<br><br>☐ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |

| **Highlights relating to protected characteristics in paper** |
|---|
| • Number of colleagues reporting harassment, bullying and aggression from patients and members of the public has increased<br>• Colleagues with a disability reporting harassment is an outlier |

| | | | |
|---|---|---|---|
| Name: | Victoria Robinson-Collins | Job title: | Director of People and Organisational Development |
| Telephone number: | x1905 | Email | victoria.robinson-collins@nhs.net |

Kent Community Health
NHS Foundation Trust

# Trust Board
# Staff Survey 2021 - Results

**Victoria Robinson-Collins**
**Director of People & OD**
**May 2022**

we care

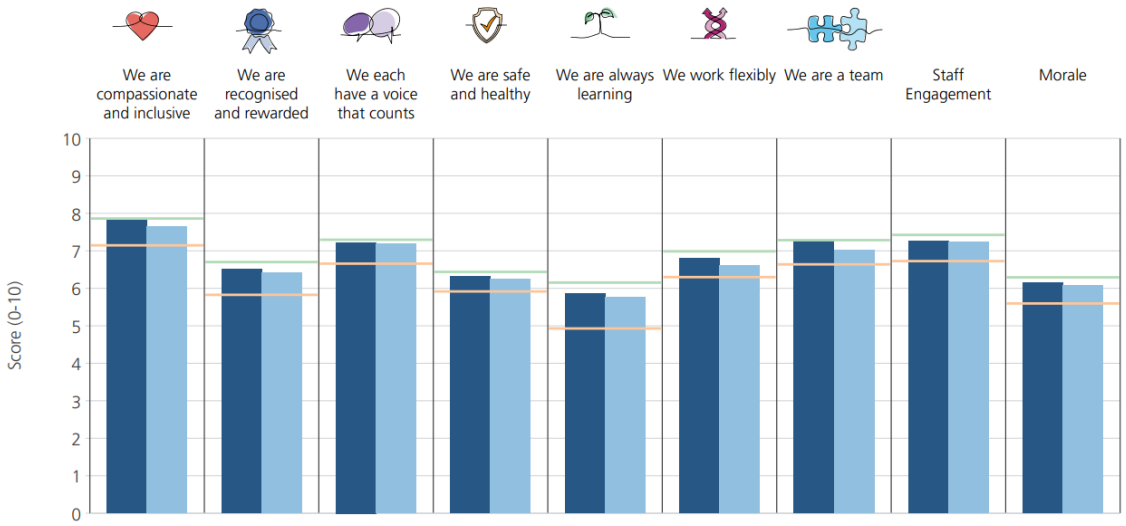
Kent Community Health
NHS Foundation Trust

# Staff Survey Results

- This year show the survey results grouped into seven people promises and two themes.

- The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.
- The response rate to the 2021 survey was 65%, the highest the organisation has ever achieved.

- Scores for each indicator together with that of the survey benchmarking group (other community trusts) for this year are presented below.
- A three-year comparison of data is not available in this format.




| | We are compassionate and inclusive | We are recognised and rewarded | We each have a voice that counts | We are safe and healthy | We are always learning | We work flexibly | We are a team | Staff Engagement | Morale |
|---|---|---|---|---|---|---|---|---|---|
| Best | 7.9 | 6.7 | 7.3 | 6.4 | 6.2 | 7.0 | 7.3 | 7.4 | 6.3 |
| Your org | 7.9 | 6.5 | 7.2 | 6.3 | 5.9 | 6.8 | 7.3 | 7.3 | 6.2 |
| Average | 7.6 | 6.4 | 7.2 | 6.2 | 5.8 | 6.6 | 7.0 | 7.2 | 6.1 |
| Worst | 7.1 | 5.8 | 6.7 | 5.9 | 4.9 | 6.3 | 6.6 | 6.7 | 5.6 |

we care

Kent Community Health
NHS Foundation Trust

# Staff Survey Results

Key data highlights:

- We scored better than the average in all categories bar one where we were equal to the average
- We were the best in our benchmarking group in two areas.
- We had the highest response rate the organisation has ever achieved
- Colleagues feel secure in raising concerns about unsafe clinical practice
- Responses offer a positive view of staff experience, including feeling valued by their team, having managers who care about their health and wellbeing and being respected.

we care

Kent Community Health
NHS Foundation Trust

# Staff Survey Results

- KCHFT colleagues said:
    - The people they work with are polite and treat each other with respect
    - Leaders listen, make colleagues feel valued and have a positive interest in their health and wellbeing
    - They can talk openly about flexible working and have the opportunity to work flexibly if needed.
- Seven out of ten people said they would recommend the organisation as a place to work – six per cent higher than other community trusts.
- In five out of the seven ‘people promises’ contained in the survey, KCHFT scored significantly higher when compared to similar organisations. The five areas are:
    - We are compassionate and inclusive
    - We are recognised and rewarded
    - We are always learning
    - We work flexibly
    - We are a team.

we care

Kent Community Health
NHS Foundation Trust

# Staff Survey Results

- Nationally, results have deteriorated when compared to 2020, including KCHFT
- Pressure remains high on NHS services; colleagues feeling burnt out and exhausted, in line with the national picture
- Number of unpaid and paid additional hours worked has increased
- Levels of emotional exhaustion and frustration with work have increased

- Reflected in areas where results have declined:
  - There are enough staff at this organisation for me to do my job properly (-14.15 per cent)
  - I look forward to going to work (-7.19 per cent)
  - I am satisfied with the extent to which my organisation values my work (-6.59 per cent)
  - I am able to meet all the conflicting demands on my time at work (-6.1 per cent)
  - I am able to make suggestions to improve the work of my team / department (-5.44 per cent)

- Number of colleagues reporting harassment, bullying and aggression from patients and members of the public has increased
- Colleagues with a disability reporting harassment is an outlier

we care

Kent Community Health
NHS Foundation Trust

# Staff Survey Results

Our plans to address areas of concern and engage with colleagues include:

•Toolkit for leaders and managers to use to engage with colleagues as Big Conversations
•Individual services review their local information to understand hot spots and share with teams using toolkit
•The workforce equality group will focus on WDES, WRES and carer results.
•Results shared to all colleagues by Executive Director in an all-staff e-bulletin and vlog.
•Team Talks: Any insights from local conversations will shared via the Communications Team.
•Quality Improvement task and finish groups will be set up for any new solutions
•Case study examples of improvements at Executive Performance Reviews.

we care

Kent Community Health
NHS Foundation Trust

# Questions

we care

NHS
Kent Community Health
NHS Foundation Trust

Compassionate Aspirational Responsive Excellent

In everything we do, we care

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 5.1 |
| **Agenda Item Title:** | Risk Management Policy |
| **Presenting Officer:** | Natalie Davies, Director of Corporate Services |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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**

**Proposal and/or recommendation to the Committee or Board**

The Board is asked to note the Trust's Risk Management Policy.

| | |
|---|---|
| **If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.**<br><br>*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)*<br><br>☐ No<br>*(please provide a summary of the protected characteristic highlights in your paper)* |

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Highlights relating to protected characteristics in paper** | |
| | |

| | | | |
|---|---|---|---|
| Name: | Shane Webber | Job title: | Deputy Director of Corporate Services |
| Telephone number: | 01233 667700 | Email | shane.webber@nhs.net |

Kent Community Health
NHS Foundation Trust

# Risk Management Policy

| | |
|---|---|
| **Document Reference No.** | CQS029 |
| **Status** | Approved |
| **Version Number** | Version 1.6 |
| **Replacing/Superseded policy or documents** | Risk Management Policy Version 1.5 (draft – not published) |
| **Number of Pages** | 15 |
| **Target audience/applicable to** | All staff |
| **Author** | Corporate Assurance Risk Management Group |
| **Acknowledgements** | |
| **Contact Point for Queries** | Risk and Incident Team |
| **Date of Implementation/distribution** | May 2022 |
| **Copyright** | Kent Community Health NHS Foundation Trust 2022 |
| **Governance group responsible for developing document** | Corporate Assurance and Risk Management Group (CARM) |
| **Circulation group** | Flo (KCHFT staff intranet), Policy Distribution |
| **Authorised/Ratified by Governance Group/Board** | Audit and Risk Committee |
| **Committee** | Audit and Risk Committee |
| **Authorised/ratified on** | 21 January 2021 |
| **Review Date** | January 2024 |
| **Review criteria** | This document will be reviewed prior to review date if a legislative change or other event dictates. |

**Key References**

| |
|---|
| Annual Governance Statement – Guidance (Department of Health, 2012) |
| Governing the NHS: A guide for NHS boards (Department of Health and NHS Appointments Commission, 2003) |
| Management of Risk: Guidance for Practitioners (Office of Government Commerce) |

**Document Tracking Sheet**

| Version | Status | Date | Issued to/approved by | Comments / summary of changes |
|---|---|---|---|---|
| 1.1 | Approved | August 2019 | | New Policy |
| 1.2 | Approved | February 2020 | | Updated Policy |
| 1.3 | Approved | November 2020 | CARM (virtual) | Minor amendments |
| 1.4 | Approved | January 2021 | CARM | Minor amendments |
| 1.5 | Draft | February 2022 | | Minor amendments |
| 1.6 | Approved | May 2022 | CARM | Amendment to Risk Appetite |

**CONTENTS**

**FOREWORD**

As accountable officer, the Chief Executive has overall responsibility for risk management. Specific responsibilities are delegated to senior managers throughout the organisation. The Board oversees risks, establishes a risk appetite for high level risks on a risk by risk basis and encourages proactive identification and mitigation of risks.

The top risks identified through the risk management process that have a significant impact on the ability of the trust to deliver its strategic goals are documented in the Board Assurance Framework.

Risk management is a core component of job descriptions within the trust. A range of risk management training is provided to members of staff and there are procedures in place which describe roles and responsibilities in relation to the identification, management process of escalation and de-escalation to be followed. All relevant risk policies and procedures are available to colleagues on the intranet.

Leadership and co-ordination of risk management activities is provided by the corporate services director, deputy director of corporate services and the Risk Management Team with support from all members of the Executive Team. Risk management training is part of staff induction and training updates for existing colleagues are also provided.

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

Risk identification, prioritisation, mitigation or elimination occurs through assessment and grading using a nationally-recognised matrix of impact and likelihood. Incident reporting is a factor in the ongoing assessment of risk and results in the instigation of changes in practice. (19-20 Annual Report (Parliament)).

## 1.0 Purpose and Scope

**1.1** The purpose of the Policy is to define the framework and systems the Trust will use to identify, manage and eliminate or reduce to a reasonable level risks that threaten the Trust's ability to meet its objectives and achievement of its values. The Policy applies equally to all staff, patients and areas of the Trust with regard to all types of risk, both clinical and non-clinical and seeks to provide a consistent and reasoned approach to risk management to support taking decisions in the best interest of staff, patients and the public.

## 2.0 Risk Management

**2.1** Risk management refers to the proactive process for identifying and assessing risks, and then planning and implementing the appropriate response to control the risk. To be effective, a consistent approach needs to be adopted to allow risks of all sources to be identified, assessed and appropriately responded to.

Risk management must be integrated into the normal business processes and practiced continuously; it is not a one-off exercise.

To be successful, colleagues at all levels must be aware of their responsibilities and be committed to them.

## 2.2 What is a risk?

Risk is the possibility that loss or harm will arise from a given situation. In the context of this policy, this encompasses anything from the possibility of injury to an individual patient or member of staff, to anything which impacts upon the Trust's ability to fulfil its aims and objectives.

## 2.3 Why manage risk?

Risk taking is inherent in everything the Trust does: treating patients, determining service priorities, managing a project, purchasing new medical equipment, taking decisions about future strategies, or even deciding not to take any action at all. In the NHS risks are managed continuously – sometimes consciously and sometimes without realising it.

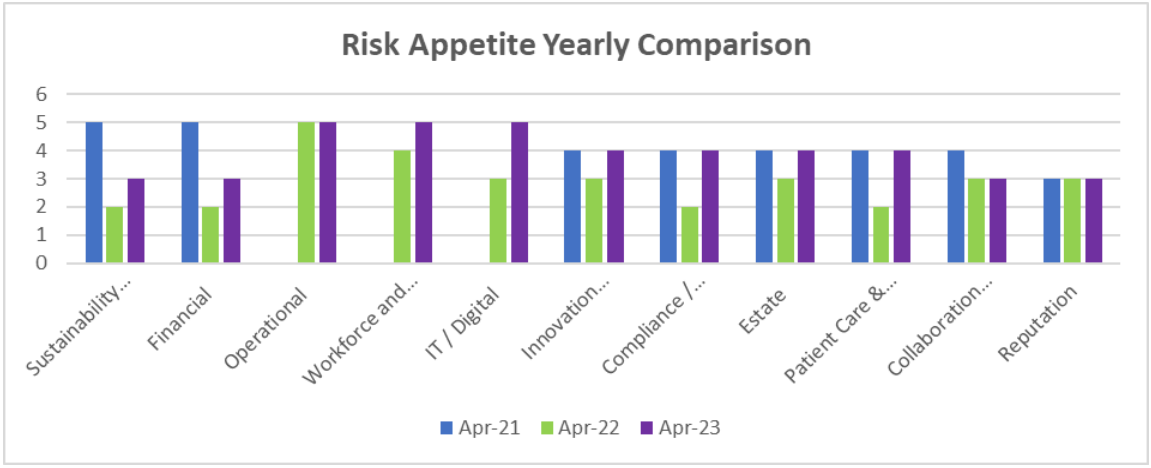
Risk appetite is the amount and type of risk that an organisation is willing to accept in order to meet its objectives (Strategic Goals).

The Trust recognises that:

- It is not possible to deliver services and achieve positive outcomes for service users without risk; however, these risks must be managed in a structured and controlled way.
- Methods of controlling risks must support innovation and learning to achieve maximum benefit.
- The Trust may accept some high risks where the controls are not yet in full mitigation.

## 2.4 Trust Appetite:

| Risk Aspect | Target score | Narrative |
|---|---|---|
| Sustainability (Green) | (2) 3 | Longer term benefits will generally out way short term problems with innovations sought and potential opportunities pursued to support the long term future of the planet, our staff and the trust. |
| Financial | (2) 3 | Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself. |
| Operational | (5) 5 | The organisation will be eager to explore new models of service delivery where this provides patient benefit this will include staff working at the limit of their competency and our openness to innovation |
| Workforce and recruitment | (4) 5 | We want to have a culture in place which supports assessed risk in the use of workforce skills and competencies, looking at what is needed rather than the traditional approaches |
| IT / Digital | (3) 5 | IT will be used to support clinical innovation. Preferred risk in this area to clinical risk |
| Innovation | (3) 4 | Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. |
| Compliance / Regulatory | (2) 4 | Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. |
| Estate | (3) 4 | Our estates will be used for the benefit of our population and staff even when this may not directly benefit the sovereign organisation |
| Patient care & Quality | (2) 4 | We will respond to the patient and carer voice take opportunities to empower a patient centred culture |
| Collaboration with system partners | (3) 3 | Opportunities for focused and targeted system leadership and collaboration will be sought and implemented where it is judged the trust is best placed to deliver it and it can add significant value. |
| Reputation | (3) 3 | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. |



## 2.5 Risk Capacity

Current risk capacity has been taken into consideration for the risk appetite to be wholly formed. Risk capacity will vary and be dependent on a number of environmental and contextual factors, the table below illustrates a view of current risk capacity within four key areas of trust priority:

| Category | Context |
|---|---|
| Workforce | **Limited capacity for holding further risk without actively creating it through ceasing or amending other work.** |
| Financial | **Limited capacity for holding further risk without actively creating it through ceasing or amending other work.** |
| Quality | **Some capacity for formally holding further risk with careful consideration.** |
| System Leadership | **Limited capacity for holding further risk without actively creating it through ceasing or amending other work. Could consider an increased focus of the area of work resulting in a narrower spread of initiatives.** |

## 2.6 Priorities Risk Appetite and Decision-Making Framework

The table below sets out the Trust risk appetite in the context of the Trust post pandemic priorities. These support the consideration of risk in these areas and will seek to promote the implementation of the new trust priorities. Now that risk appetites have been set, workshops will be held with varying departments in the trust between June 2022 and August 2022 to develop our risk ambitions, benefits and risks which will in term form what this means for the Trust now and the next 12 months.

## 3.0 Risk Management Framework and Monitoring

The risk management framework is collected policies, systems and tools that the organisation uses to manage risk. This policy is an important part of the Framework.

Intrinsic to the framework is the need to learn lessons for incidents and near misses, feeding that back into the assessment of risk. The Risk Framework is set out in the Annual Governance Statement of the organisation.

## 3.1 Risk assessment and management process

The process outlined below will ensure substantial risks to the achievement of strategic objectives are escalated to the relevant group and beyond if necessary.

A consistent and on-going approach throughout the organisation will ensure risks can be effectively discussed and communicated, with a common basis of

understanding, and will ensure actions to treat risk are prioritised correctly. The steps of risk assessment are described below:

### 3.2 Identifying risk

Everyone is responsible for identifying risk within their area of responsibility.

Risks can be identified after an adverse event has occurred, known as reactive risks, or before an event has occurred, known as potential risks.

Risks can be identified from a variety of sources. The following is an example of different methods of identifying risk. (Please note this list is not exhaustive):

Potential non-achievement of objectives | Claims | Complaints | Audits | Incidents | Near misses | Health and safety Legislation | Patient feedback.

A risk assessment form is available on the health and safety pages of Kent Community Health NHS Foundation Trust's intranet. These documents can be used before adding risks to Datix.

### 3.3 Analysing risk

When describing the risk, the cause and impact of the risk occurring, in relation to a specified objective should be clearly stated. Once a risk has been clearly written, controls can be identified and plans can be put into place to reduce the likelihood or the consequence of it occurring.

If there are plans in place already to reduce the risk, these are known as "controls". If plans will be put in place in the future, this is known as the "action plan".

### 3.4 Assessing risk

Risks are rated based on controls already in place; the action plan to gain further control in the future does not affect the current risk rating so should not be considered.

The risk rating is established by looking at the two elements of the risk: the severity level of the impact between 1 and 5, (with 1 being insignificant and 5 being catastrophic) and the likelihood of the consequence occurring between 1 and 5, (with 1 being rare and 5 being almost certain).

When considering the severity level of the impact, the most likely impact should be used. In most cases this would not be the most extreme level.

Multiplying the severity level of the impact by the likelihood of the impact occurring provides the risk rating. The risk rating will therefore be a value between 1 and 25.

When risks are initially assessed, both the initial and current risk rating will be the same, but as actions progress and the risk is reassessed, the current rating should reduce. In exceptional circumstances, if actions are unsuccessful or circumstances change, the residual rating may increase.

## 3.5 Categorising risk

Risks will be categorised according to their effect: a full list of potential risk effect categories is on flo here.

The categorisation determines the functional area to which the risk is reported to and allows integrated reporting across incidents, complaints, claims and risk.

| | | ← *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 |

## 3.6 Treating risk

Based on the risk assessment, the head of service (or delegated responsible person) will decide an appropriate risk response:

- Treat the risk (the most common response) – in which case an action plan to gain further control will be written.
- Tolerate the risk - in which case no further action will be taken to reduce the risk, although the risk should still be documented along with a detailed description of the controls, as the effectiveness of these will need to be monitored.
- Terminate the activity giving rise to the risk.
- Transfer the risk – place the hazard and associated risks under the control of a body outside the organisation who have the necessary system and competencies to effectively manage the risk. It may also be possible to transfer risk actions between directorates if the risks can be more easily addressed with the skill set in the alternative directorate. This will be determined and agreed at the Corporate Assurance and Risk Management Committee.

- These decisions must be documented on Datix

Action plans must include a deadline for completion, and a named individual responsible for completing the actions. Where deadlines are not met, it is acceptable for these to be extended, but deadlines should not be extended routinely. The extension of action plans is monitored by the Risk Management Team and reported to the Corporate Assurance and Risk Management Group.

As actions are completed, they become additional controls. As controls change the risk should be reassessed. If the controls are effective than the current risk rating should decrease. The Risk Management Team will monitor the effectiveness of action plans by comparing the initial risk rating with the current risk rating.

### 3.7 Adding / updating a risk on a risk register

The Risk Register is a 'live' document that is maintained electronically on the Datix Risk Management System. All staff including Directors and heads of service have access to Datix and amendments can be made at any time to ensure the information is current.

Risks must be reviewed regularly and at least on a quarterly basis. Where review deadlines lapse, the Risk Management Team will follow this up through the bimonthly risk meetings with services/directorates.

## 4.0 Management responsibility for different levels of risk in the organisation

Heads of service are responsible for validating all risk assessments and for ensuring sufficient controls are in place. Risks which are rated as high will be reported to the director responsible for the service raising the risk by exception. The head of service should ensure an action plan to gain further control is documented, taking advice from the subject matter expert where applicable.

Where risks cannot be immediately mitigated, they should be added to the relevant risk register.

**Risk Ownership**

### 4.1 Chief Executive

The Chief Executive, as the accountable officer, is the individual with overall responsibility for ensuring an effective risk management system is in place and resourced.

### 4.2 Corporate Services Director

The Corporate Services Director has accountability delegated from the Chief Executive to ensure robust risk management systems and processes are in place.

### 4.2.2 Directors

Directors are responsible for:

- Ensuring the risk management process is being used in their directorate and understood by staff.
- Reviewing risk registers and all high-level risks and ensuring a plan to implement adequate controls within appropriate timescales is in place.
- Approving the decision to terminate an activity which is giving rise to a risk which cannot be adequately controlled.

- Reviewing and disseminating the triangulation report to AD/CSD.

### 4.3 Heads of Service, Team leaders and Manager

These officers are responsible for implementing this policy within their areas and across departments.

### 4.4 All employees

All employees are responsible for:

- Familiarising themselves with this policy
- Reporting risks and incidents as per the policy.
- Being aware of known risks in their working environment. Team/department managers will be able to inform employees of these.
- Attending any relevant training as advised by their line manager.

### 4.5 Head of Head of Corporate Operations

The development and implementation of risk management processes will be overseen by the Head of Corporate Operations who will work with and gain additional support from other members of Trust leadership.

## 5.0 Committees and Groups

### 5.1 Audit and Risk Committee

The committee is responsible for the oversight of the system of control in the Trust and for providing assurance to the Board that the model of risk management is effective.

**5.2** The Board has delegated responsibility for the detailed scrutiny of the Board Assurance Framework (BAF) to its Audit and Risk Committee (ARC). The committee seeks to assure the Board that effective risk management systems are in place. It achieves this by managing the development of the risk management policy, internal and external audit reviews, calling executive directors to account for their risk portfolios and by monitoring the BAF at each of its meetings.

### 5.3 Strategic Workforce Committee

The committee provides assurance to the Board on the organisational priority of creating and maintaining Kent Community NHS Foundation Trust as the place where people want to work, delivering high quality care to our patients.

This will include the identification of risks in these areas and ensuring these risks are escalated to the Board as appropriate through direct reporting, the Executive Team and the assurance framework.

### 5.4 Quality Committee

The committee has delegated responsibility from the Board for the risk management of patient safety and clinical effectiveness. The operational directorates' quality groups meet monthly and report their outputs to the Quality Committee, providing assurance that clinical risks are managed appropriately.

### 5.5 Finance, Business and Investment Committee

The committee provides assurance relating to business and investment activity within the trust on behalf of the Board. Provision of assurance in relation to these areas will be given. This will include the identification of risks and ensuring these risks are escalated to the Board as appropriate through direct reporting, the Executive Team and the assurance framework.

### 5.6 Executive Team meeting

The meeting is chaired by the Chief Executive. The operational management of risk is central to the Executive Team's role which performance manages the BAF by reviewing it in detail on a monthly basis.

The purpose of the review is to establish for each risk:

- Whether the risk is accurately described,
- Whether the ratings represent the organisation's exposure to the risk, given the current controls,
- Whether the risk meets the BAF threshold,
- Whether the risk can be linked in a parent/child relationship to an existing risk on the BAF
- Whether the actions identified are sufficient and suitable for the appropriate mitigation of the risk where appropriate

In addition, the Executive Team will review the risks described on the BAF to ensure they accurately describe the organisation's risk exposure. Where new high risks arise, the director responsible for mitigating the risk should ensure this is added to the BAF through the executive team meetings and on advice of the Corporate Assurance and Risk Management Group.

### 5.7 Integrated Management Committee

The Integrated Management Committee (IMM) will monitor and review all high risks that are not described on the Board Assurance Framework and escalate local risks which are in relation to the Trust's strategic priorities ensuring risks are accurately detailed and rated with effective action plans.

### 5.8 Corporate Assurance and Risk Management Group

The Corporate Assurance and Risk Management (CARM) Group reviews risks and incidents identified from all directorates across the Trust and ensures they are adequately described on the risk register. Additionally the group identifies themes and trends among medium and above graded risks, which, when combined may present a higher risk than indicated by their individual risk rating. Risk/incident deep dives are also periodically performed in conjunction with the review of the triangulation report. Areas of concern are escalated to the Executive Team as appropriate.

### 5.9 Patient Safety and Clinical Risk Group

The Patient Safety and Clinical Risk Group reviews, by service, their top three risks based on need for escalation. Additionally the group identifies themes and trends throughout clinical services. Areas of concern are escalated to the Executive Team as appropriate.

### 5.10 Links between assurance committees

For the risk process to be effective, clear links are established between the Board committees (ARC, Quality, FBI, SWC). This is achieved in several ways:

There is joint membership between the Audit and Risk Committee, the Quality Committee and the FBI Committee.

The BAF is considered by Board committees, ensuring a shared understanding of risk across the organisation.

All committee minutes are a standing item on the Board agenda.

## 6.0 Business continuity (e.g. pandemic plans and decision process)

6.1 Directorate risks and incidents were documented via the new ‘COVID-19 Reset Risk Register’ to capture them in a centralised repository. This offered complete transparency in addition to full sight of risks across the board which in turn resulted in greater learning and ‘best practice’ in terms of mitigating and controlling similar risks. Risk and Incident management dashboards provide bespoke local live dynamic data which offers full risk and incident oversight. This has been designed to use in conjunction with reports which provide a wider general trust picture. Risks continued to be reviewed in detail and escalated via meetings such as Patient Safety and Clinical Risk Group (PSCRG) and Corporate Assurance and Risk Management (CARM).

## 7.0 Training and Awareness

**7.1** A key challenge in implementing this policy is ensuring all staff is aware of what this policy requires of them.

The head of risk meets individually with executive directors to ensure risk management remains an effective on-going process in their directorate. Advice and support is provided with regard to implementing the processes defined within

this policy and all high-graded risks are reviewed and updated as appropriate. Where the need is identified, additional training sessions are arranged.

Risk management awareness training sessions are tailored to individuals, services and directorates and delivered by the Risk Management Team. This training is provided on a targeted basis and on request.

Online 'How to' training is available through flo.

## 8.0 Glossary & abbreviations

### 8.1 Glossary:

| Term | Meaning |
|---|---|
| Action plan | Something that is going to be done to mitigate the risk (to reduce the likelihood or the consequence of it occurring). An action plan will be on-going over a specified period of time and will be owned by an individual. |
| Board Assurance Framework (BAF) | The Board Assurance Framework (BAF) is a tool to assist the Board in assessing and mitigating the principal risks to the achievement of strategic objectives. The tool also identifies gaps in control measures and gaps in assurances, as well as providing a means to monitor the work that is being done to mitigate the risk.<br><br>The BAF is comprised of strategic risks identified against the strategic goals and objectives of the Trust.<br><br>To provide assurance 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. Each action on the BAF is given a red, amber, and green (RAG) status. This enables actions that have either breached their initial target completion date or are considered unachievable to be identified more readily, and enables action owners to be held to account. |
| Control | Something that is already in place to reduce the consequence or likelihood of a risk effect occurring. If a control will be put in place in the future then this forms part of an "action plan" and is not considered a control. |
| Datix | Datix is the computerised risk management tool used by KCHFT. It brings together information from risk, incidents, complaints and claims and facilitates reporting between these disciplines. |
| Gross risk rating | The risk identified at the point the risk is initially recorded. This rating will reflect controls in place at the time the risk was identified. |
| Net risk rating | The level of risk currently remaining, given the controls currently in place. This risk rating should reduce as actions identified are implemented. |
| Risk rating | Once the impact and likelihood of a risk being realised has been evaluated, multiplying the consequence score by the likelihood score will give the risk rating: a value between 1 and 25. |

| Term | Meaning |
|---|---|
| Risk register | A risk register summarises information gained from the risk management process. It provides a description of the risk, the current controls in place, the current risk rating, a summary of the action plan, the date by when the actions are due to be completed by, the person responsible for completing the actions as well as the residual risk rating. It is used to communicate information about risk around the organisation.<br><br>Risk registers are produced from Datix, the computerised risk management tool used by KCHFT. |
| Risk response | Describes whether the risk will be treated, tolerated, terminated or transferred. Commonly known as the "four T's". |
| Tolerated risk | KCHFT tolerates risks under the following circumstances:<br>• The risk score is in line with the corporate risk appetite.<br>• Further controls are prohibitive for reasons of cost, resources or operational constraints.<br>• The trust has developed all possible internal controls and is reliant upon third party activity to further reduce the risk.<br><br>Where risks are tolerated above the corporate risk appetite, they remain under review. The trust will implement further controls as soon as circumstances allow. |

### 8.2 Abbreviations:

| Abbreviation | Meaning |
|---|---|
| ARC | Audit and Risk Committee |
| BAF | Board Assurance Framework |
| CARM | Corporate Assurance and Risk Management Group |
| FBI | Finance, Business and Investment Committee |
| PSCRG | Patient Safety and Clinical Risk Group |
| SWC | Strategic Workforce Committee |

Kent Community Health
NHS Foundation Trust

| | |
|---|---|
| **Committee / Meeting Title:** | Board Meeting - Part 1 (Public) |
| **Date of Meeting:** | 25 May 2022 |
| **Agenda Number:** | 5.2 |
| **Agenda Item Title:** | Emergency Preparedness, Resilience and Response Annual Assurance Statement |
| **Presenting Officer:** | Natalie Davies, Director of Corporate Services |
| **Action – this paper is for:** | ☐ Decision<br>☐ Information<br>☒ 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**

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.

**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?**<br><br>*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.*<br>*You can find out more about EAs here on flo*<br>**If not, describe any equality and diversity issues that may be relevant.** | ☐ Yes *(please attach)*<br><br>☒ No |

Kent Community Health NHS Foundation Trust

| | |
|---|---|
| *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 Service |
| Telephone number: | 01622 211900 | Email | Natalie.Davies1@nhs.net |

Kent Community Health NHS
NHS Foundation Trust

# EMERGENCY PREPAREDNESS RESILIENCE AND RESPONSE (EPRR)

# ANNUAL REPORT APRIL 2021 – MARCH 2022 Final

## 1. Introduction

This report describes the work undertaken in 2021/22 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

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.

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 2021/22, 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 Sevenoaks Safety Advisory Group and the EPRR manager for Dover

The EPRR team are facilitating community EPRR meetings attended by a wide range of EP leads from Community Trusts across the South East. The Terms of Reference and the administration for the meetings will be owned by KCHFT.

**Joint working with Maidstone and Tunbridge Wells NHS Trust (MTW)Trust EPRR Team**

As the local health economy continues with the significant change and the integration of services the Director of MTW EPRR and KCHFT Head of EPRR are planning the formal integration of MTW and KCHFT EPRR teams in 2022.This will provide a greater resource pool and future proof the arrangements against organisational change in the future.

An Informal working network focusing on Chemical, Biological, Nuclear and Radiation training and exercising is in place with East Kent Hospitals.

As part of the integration work plan between MTW and the Trust, KCHFT Head of EPRR will be delivering Command Foundation training in partnership with MTW EPRR colleagues, dates have been arranged for 2022 with 10 spaces allocated to KCHFT strategic and tactical commanders

### 4.1 Student Placement

The EPRR team in partnership with Maidstone and Tunbridge Wells NHS Trust are facilitating an EPRR student placement from Spring 2022 for a period of one year. The student will experience 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 January 2022 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 (BIA) and associated action cards. A BCP is required for Tier One services however this plan may be written to incorporate more than one service. Tiers two and three service must have a BIA.

### 5.3 Heatwave Plan

The Heatwave Plan for the Trust was updated as required for 2021/22. The Trust received health watch alerts for the period 1 June - 15th September 2021. 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. One of the Trusts Urgent Treatment Centres is managed from a KCHFT owned site, the remaining six are located on National Health Service Property Services (NHSPS) sites or a Private Financed Initiative (PFI) site, the aim of each of these is to develop and embed multi occupancy Lockdown Plans, this has proved challenging with limited 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.

### 5.6 Covid 19

Following the rise in cases in early 2022 due to the new variant Omicron the UK government declared a level 4 incident. The declared Level 4 incident immediately activated Command, Control and Coordination at regional and national levels. At each stage, in advance of national directive, the Trust activated its plans in response to Covid-19. Governance structures were implemented, including strategic and tactical levels of command and staff

were asked if their job allows to actively work from home. The trust has participated in the regional and national cells and actions.

The Trust continues to support the national vaccine programme. A pop-up vaccine site in Canterbury was operational for one day on the 20th June and multiple communities have been reached using the roving model. A large number of volunteers affiliated to KVSEG and other voluntary organisations have continued to support the day to day operation of the vaccine programme.

The Salvation Army continue to provide support and food to teams across the Trust throughout the reporting period.

## 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; please see below examples of exercises facilitated by the EPRR team:

### Exercises

### Communication test every six months

Multi-Agency Communications Exercise Thursday 2nd December 2021 11:00 hours

Aim: To participate in a multiagency communication exercise involving the Kent Community Health NHS Foundation Trust (KCHFT) on call services during normal core working hours

Objective: To ensure that the on-call services respond to the initial phone call / pager message within 30 minutes (in line with Director and Senior Manager's On-Call Protocol V1.7)

Scenario**:** The Director on call was contacted and informed that SECAmb were declaring a Major Incident Standby at 11:00 hours, this was due to the impact of the ongoing traffic disruption being seen in Kent. More information was shared if known. The short straits boarder between France and the United Kingdom has been severely compromised due to industrial action and protests on the French side. A major impact on the Kent and Medway road network was expected. Tap 24 has been implemented, there was a risk Op Brock would also be implemented.

The following KCHFT services participated in the exercise:

| |
|---|
| Director |
| Estates |
| West Kent |
| East Kent |
| Pharmacy |
| Press Office |
| IT |
| IPC |

Services responded within the timeframe required and were informed relating to the escalation process and what was required of them and their service.

**Table top exercise once a year**

Aim: To facilitate a table top exercise to test the Estates Business Continuity arrangements involving the Kent Community Health NHS Foundation Trust (KCHFT) estates team. The EPRR team facilitated this exercise on 6th May 2021

Objective: To ensure that the Estates Team were robust in knowledge and a clear understanding of who and when to escalate to including knowledge of the Trust incident flowchart, and fuel plan. To provide assurance their ability and confidence in the co-ordination of an estate's response during an incident / emergency.

Scenario: The exercise focused on the month of December with extreme cold and snow in the forecast. A member of staff reported a power failure at a community hospital. A second call reporting the Generator hadn't come on. A third call was received from the manager who was contemplating evacuation

The table top exercise was well received and those present fully engaged. Following the exercise discussions took place and the learning from the exercise was put into an action plan and worked through with a timeframe of completion within three months.
The exercise offered the opportunity for Estates Service to test elements of the business continuity plan, review the estates action cards and identify learning.

**Live exercise every three years**

The EPRR team facilitated Exercise Ultraviolet on 24th March 2022 at Deal Urgent Treatment Centre (UTC)

Aim: To test the Trust's response and action cards to a Radiation incident at an Urgent Treatment Centre

Objectives:

- To test the initial response at UTC when presented with a patient affected by suspected radiation
- For those present to develop their understanding of their role within an incident of this type
- To test the Locking down of the hospital
- To test the upward communication to on call Managers and Director on call
- To test the communication process with external agencies

Participation:

- UTC staff
- KRFS Deal Station Leader & fire officer
- Head of Emergency Preparedness Resilience Response for KCHFT
- Volunteer Self-Presenters (KCHFT EPRR Manager and Trust Staff Member)

The Exercise was a no notice live exercise activated by patients self-presenting at the UTC. The patients (EPRR Manager and staff volunteer) complained of headache, vomiting and generally feeling very unwell since working at Dungeness Power Station the previous week.

The exercise was well received, all staff were fully engaged. Following the exercise, a debrief took place, the learning from the exercise was entered into an action plan with a timeframe of

completion within three months of the exercise. The action plan will be reviewed at the quarterly EPRR/On call meeting.

Additional, walk through familiarisation exercises focussing on patients presenting with contamination from either a chemical or radiation exposure have recently been facilitated at the following Minor Injury Units/Urgent Treatment Centres; Sheppey, Sittingbourne, Sevenoaks and Deal.

**Command Post exercise every three years;**

An Incident Coordination (ICC) exercise took place on 30th June 2021.

The exercise was attended by two members of staff from the Directors on call rota, three Loggists and on call managers from the Estates Team.

The scenario focussed on a power failure declared in the Sevenoaks area affecting the Hospital. The power failure was protracted resulting in the inability to use the PCs or any of the other IT equipment.

The coordination centre was activated, staff worked within command roles.

The exercise offered the opportunity to become familiar with the ICC, and importantly build a effective working relationship with colleagues.

A further ICC exercise is planned for 29th June 2022.

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 2022) of 99 % compliance for the mandatory element of EPRR training for staff that joined the Trust since March 2021.

The directors/executives on the on-call rota participated in the Strategic Legal awareness course, this was facilitated by David Burrows-Sutcliffe (Barrister/Advocate).
In addition, further training focussing on Public Enquiries and Media has been undertaken by the colleagues on the On-Call directors rota.
Eleven colleagues joined the on-call directors rota in March 2022, a programme of support is in place. Bespoke training was delivered to colleagues on 22nd March 2022 by the Head of EPRR, the Deputy Chief Operating Officer, the Community Services Director Adult Clinical Services and the Assistant Director of Performance and Business Intelligence.

Within the reporting period members of the Estates team attended a training event focussing on setting up the Incident Coordination Centre (ICC) at Gravesham Hospital, the staff who attended agreed the value of this training. Following on from this a further event took place involving one of the on-call Directors, loggists and staff from the estates team, this allowed staff the opportunity to familiarise themselves with the ICC.

The Head of EPRR has developed and is delivering joint Command training with the EPRR team from Maidstone and Tunbridge Wells NHS Trust. The training is facilitated at an external venue twice per calendar year. Excellent feedback from participants has been received.

**Loggists**

The EPRR manager recruited and developed a training module for 12 members of staff to train as Loggists. Logging incident information and decisions is an essential part of incident management and is required at all levels within an organisation. The training gave staff the essential skills required to record decisions and actions which. The Corporate Service Director opened the training event and the Head of EPRR attended.

**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;

**Fire – Sevenoaks Hospital**

On the 2nd September 2021 the Sevenoaks hospital fire alarm sounded, the staff checked the fire panel and followed the processes and procedures in place to ensure staff and patient safety. Horizontal evacuation of the inpatients took place. No fire could be located only the distinct smell of smoke could be smelt by ward staff. Upon further investigation it was found that a neighbouring property was having a bonfire. The incident was reported to the Head of EPRR who attended the hospital site.
The debrief took place 9th September 2021 via MS Teams facilitated by Head of Emergency Preparedness Resilience and Response. Lessons identified at the debrief are being jointly actioned by the EPRR team and the Fire Manager.

**Fuel Incident**

24th September 2021 Reports of staffs concerns relating to a fuel shortage were escalated to the Head of EPRR. The background to the fuel shortage was simply a shortage of fuel in petrol stations as a direct impact of a shortage of lorry drivers, Trust Business continuity arrangements were put in place. A fuel group took the lead to manage the incident.

**Sevenoaks Hospital Outpatient Department (OPD) Water Ingress**

At 07.45 hours 14th December 2021 the Head of EPRR received a call from the on-call manager informing her of significant ingress of water overnight in OPD. The Head of EPRR attended site and implemented command of the incident. The site was not safe to be accessed.
The OPD Matron met with the Head of EPRR to review the OPD building users, to make sure all were allocated an alternative space.
Partners from Maidstone Tunbridge Wells NHS Trust, KMPT and NHSPS worked effectively together, the site remained closed for a period of five weeks.

**Road Closure**

Due to an unplanned gas leak in the Margate locality in February 2022 a main road was immediately closed for a period of days, Business continuity arrangements were implemented, the immediate activation of such ensured effective delivery of patient care.

**Storms**

The United Kingdom experience storms in February 2022, Kent received a 'Red' warning. A Red Warning indicates a risk to life as extremely strong winds expected, providing the potential for flying debris and damage to buildings; homes were left without power.

Three KCHFT in patient facilities experienced power loss, the generators automatically replaced the electrical source. No impact on the delivery of patient care was reported.

**Port of Dover**

Hundreds of P&O workers were sacked without notice on 17th March 2022. The shock move caused delays around Britain's busiest port, Dover.

To assist in the management of this incident Operation Brock was put in place on 22nd March 2022.

Operation Brock is a contraflow system and designed to keep traffic on the M20 and other roads in Kent moving when there is disruption to travel across the English Channel, it is anticipated this will be in place until April 23rd 2022.

**Ukraine response**

Russians invasion of Ukraine has abruptly transformed the world. Millions have fled with refugees expected in the United Kingdom.

Dover District Council is leading on a Reception Centre, at the time of writing the report the NHS has not been requested to be part of the Reception Centre. The Head of EPRR is supporting the wider health economy with planning health support for people entering UK from Ukraine.

**Summary**

The Trust continued to develop its resilience arrangements throughout 2021/22 which was a year of significant challenge in the field of emergency planning. During 2022/23 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.
An example of good practice was participation in the Trust Schwartz round held on 19th August 2021, this involved the Head of EPRR as one of the story tellers, the story related to the ingress of water at Tonbridge Cottage Hospital (TCH) and the explosion incident in Ashford.

The focus for the continued development of the service in 2022/23 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 2021/22 and endorse the continued development of the service for 2022/23.

**Jan Allen**
**Head of Emergency Preparedness, Resilience and Response**
**29.03.2022**