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 7 September 2022

Trust Offices
Room 6 and 7, Trinity House
110-120 Upper Pemberton, Kennington
Ashford TN25 4AZ

This meeting will be broadcast to the public

Kent Community Health
NHS Foundation Trust

Agenda

Meeting of the Kent Community Health NHS Foundation Trust Board
to be held between 9am and 11.30am
on Wednesday 7 September 2022
in Rooms 6 and 7, KCHFT Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent TN25 4AZ

This meeting will be broadcast to the public

AGENDA

1.	**STANDARD ITEMS 40 mins**		
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 25 May 2022	Trust Chair	
1.5	Matters Arising from the Kent Community Health NHS Foundation Trust Board meeting held on 25 May 2022	Trust Chair	
1.6	Patient/Service Impact Story	Chief Nurse	Presentation
1.7	Trust Chair's Report	Trust Chair	Verbal
1.8	Chief Executive's Report	Chief Executive	
2.	**BOARD ASSURANCE 40 mins**		
2.1	Board Assurance Framework	Deputy Chief Executive	
2.2	Infection Prevention and Control Board Assurance Framework	Chief Nurse	
2.3	Audit and Risk Committee Chair's Assurance Report	Chair of Audit and Risk Committee	Verbal
2.4	Charitable Funds Committee Chair's Assurance Report • Confirmed minutes of the Charitable Funds Committee meetings of 29 April 2022	Deputy Chair of Charitable Funds Committee	

2.5	Finance, Business and Investment Committee Chair's Assurance Report	Chair of Finance, Business and Investment Committee
2.6	Quality Committee Chair's Assurance Report	Deputy 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
3.	**BOARD APPROVAL 15 mins**	
3.1	Workforce Race Equality Standard	Director of People and Organisational Development
3.2	Workforce Disability Equality Standard	Director of People and Organisational Development
4.	**PERFORMANCE 20 mins**	
4.1	Integrated Performance Report	Director of Finance/Deputy Chief Executive Executive Directors
5.	**GOVERNANCE AND COMPLIANCE 10 mins**	
5.1	Standing Financial Instructions and Schemes of Delegation	Director of Finance
5.2	Board and Committee membership and governance updated from April 2022	Trust Chair
6.	**REPORTS TO THE BOARD 10 mins**	
6.1	2021/22 Annual Report and Accounts	Chief Executive Director of Finance
6.2	2021/22 Quality Account	Chief Nurse
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 December 2022 in Rooms 6 and 7, KCHFT Offices, Trinity House, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent TN25 4AZ. This meeting will be broadcast live to the public.

Kent Community Health
NHS Foundation Trust

UNCONFIRMED Minutes
of the Kent Community Health NHS Foundation Trust (KCHFT) Board Meeting held on Wednesday 25 May 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) Pippa Barber, Non-Executive Director Pauline Butterworth, Chief Operating Officer Gordon Flack, Acting Chief Executive Gill Jacobs, Acting Director of Finance Kim Lowe, Non-Executive Director Dr Sarah Phillips, Medical Director Victoria Robinson-Collins, Director of People and Organisational Development Gerard Sammon, Director of Strategy and Partnerships Dr Razia Shariff, Associate Non-Executive Director Dr Mercia Spare, Chief Nurse Karen Taylor, Non-Executive Director Nigel Turner, Non-Executive Director
In Attendance:	Gina Baines, Committee Secretary (minute-taker) Natalie Davies, Director of Corporate Services

25/05/01 Introduction by Trust Chair

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

25/05/02 Apologies for Absence

Apologies were received from Paul Butler, Non-Executive Director and Peter Conway, Non-Executive Director.

The meeting was quorate.

25/05/03 Declarations of Interest

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

25/05/04 Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 9 February 2022

The minutes were read for accuracy.

The Board **AGREED** the Minutes.

25/05/05 Matters arising from the Kent Community Health NHS Foundation Trust Board meeting held on 9 February 2022

With regards to Mr Cedi Frederick, Chair of the Kent and Medway Integrated Care Board and Mr Paul Bentley, Chief Executive of the Kent and Medway Integrated Care Board (ICB) attending a Trust Board meeting, this would not be going ahead. Instead, they would be attending the Council of Governors day on 20 July 2022. All non-executive directors would be welcome to join the session.

The Board **RECEIVED** the Matters Arising.

25/05/06 Patient/Service Impact Story

Dr Spare explained that the patient story would be deferred as the family member who had planned to join the Board meeting was unwell. It had been agreed that she would bring her story to the September Public Board meeting.

25/05/07 Trust Chair's Report

Mr Goulston presented the report to the Board for information.

The Council of Governors had met on 27 April where members had welcomed a number of new governors. A governor development session had taken place on 30 March. The next Council of Governors meeting would take place on 20 July at the Kent Event Centre, Detling. The Board were invited to attend the Council meeting in the afternoon. Ms Carol Coleman, Public Governor for Dover and Deal had been appointed as the new Lead Governor and Ms Jan Allen, Staff Governor had been appointed as the new deputy Lead Governor. Mr David Price had completed his term of office as Lead Governor and the Board thanked him for the service he had given to Trust. Ms Sue Plummer had also completed her term of office as Deputy Lead Governor and the Board recorded its thanks to her.

We Care visits to services and other service visits were restarting. Dr Razia Shariff and Mr Goulston had visited the acute response team. Mr Goulston had visited the Neurodiversity Disorder Clinic at Coxheath.

Mr Goulston and Ms Davies had attended the ground-breaking ceremony for the new Edenbridge Memorial Health Centre on 13 May. He thanked all those individuals who had been involved in supporting the project, in particular Kent County Council for selling the land and Sevenoaks District Council for their support and Community Infrastructure Levy (CIL) funding.

Mrs Lowe and Mr Goulston had attended the Kent Care Summit on 2 March to discuss the current crisis in the care sector.

Mr Goulston had recently attended his first meeting as Co-Chair and Vice Chair of the Kent and Medway Mental Health, Learning Disabilities and Autism Provider Collaborative Board.

The first meeting of the Kent and Medway Integrated Care Partnership (ICP) in shadow form would take place on 22 June. The four chairs of the four 'places' of which Mr Goulston was the Chair of the West Kent Integrated Care Partnership would be attending.

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

25/05/08 Acting Chief Executive's Report

Mr Flack presented the report to the Board for information.

Ms Mairead McCormick had been appointed as the new Chief Executive of the Trust and she would take up her appointment on 1 July. Ms Davies was thanked for the considerable work she had done in steering the Edenbridge Memorial Health Centre project through to contract award.

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

25/05/09 Board Assurance Framework (BAF)

Ms Davies presented the report to the Board for assurance.

The Audit and Risk Committee had recommended that the Board receive additional reports on the risks that had been scored twenty. This would begin in September. Mr Goulston suggested that risk 123, because of the domiciliary care element, should sit under the 'integration' goal rather than the 'delivering high quality care at home and in the community' goal. He also suggested that a report would only be needed if the risk was not discussed elsewhere in the agenda.
Action – Ms Davies

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

25/05/10 Infection Prevention and Control Board Assurance Framework (IPC BAF)

Dr Spare presented the report to the Board for assurance.

Ms Barber confirmed that the IPC BAF had been discussed by the Quality Committee. It had received assurance on the actions that were in place and the changes around infection prevention and control.

With regards to monkeypox and the role of the sexual health clinics, the IPC Team was supporting them. Dr Spare confirmed that the organisation

had been assessed as a whole for other infection entry points and the published guidance had been reviewed. A message had been issued on Flo. Work had been undertaken with the Sexual Health Team on the British Association for Sexual Health and HIV (BASHH) guidance and they were aligned. Work had also been undertaken with the minor injuries units (MIUs) and a programme of fit testing was in place with the Sexual Health Team staff.

In response to questions from Ms Taylor as to what was meant that the infrastructure was not suitable for point of care testing and what had been done to ameliorate the risk of not having it, Dr Spare explained that the infrastructure that had been put in place in the acute hospitals was not possible in the community hospitals. Very few patients coming into the community hospitals were referred directly from home. There was good turnaround in laboratory support with results being provided within 12 to 24 hours. As a result, it had been deemed that the lack of point-of-care testing did not pose a risk to patients. Dr Phillips added that point of care testing of frail patients was evaluated on a case by case basis.

In response to a question from Mrs Lowe as to how staff were reacting to the reduction in control measures in the workplace, Dr Spare reflected that it was a mixed picture. Some staff were nervous about working without masks but those numbers were small. Patients were not mandated to wear masks either and some relatives had found the recent changes to the advice confusing. There were different rules for different places and once staff had explained this to the relatives, they were put at ease. Mrs Lowe suggested that any aggression towards staff should be monitored. Dr Spare confirmed that she had strengthened the information on visiting community hospitals on the website.

In response to a question from Mr Goulston as to when the IPC BAF would be received by the Quality Committee instead of the Board, Dr Spare advised that it was still the expectation that it would be presented at every Public Board meeting but she would keep Mr Goulston aware of any changes.

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

25/05/11 Audit and Risk Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.

Ms Davies commented that in relation to the internal audit of the estates moves and changes, the fieldwork had taken place in quarter three when there was some turmoil in the Estates Team. She looked forward to the formal follow up audit that wold take place later in the year which would provide helpful insights for the team.

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

25/05/12 Charitable Funds Committee Chair's Assurance Report

Mr Turner presented the report to the Board for assurance.

Ms Barber was pleased to read that the Heron Ward refurbishment at the Queen Victoria Memorial Hospital, Herne Bay (QVMH) would be going ahead and that some of the Mermikides Fund would be used to part fund it. This would help with improving the patient experience, particularly for those in single rooms. In response to a question from her as to whether the temporary closure of the ward was causing any pressures from a system perspective, Ms Butterworth confirmed that it was not, although she was monitoring it closely. Dr Spare confirmed that the transfer of patients to Westbrook House had gone well and that staff were looking forward to returning to a refreshed ward.

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

25/05/13 Finance, Business and Investment Committee Chair's Assurance Report

Mrs Lowe presented the report to the Board for assurance.

The Committee had discussed how service transformation could drive a sustainable cost improvement programme strategy. Mr Flack commented that the digital strategy would play a large part, introducing further automation to change the way staff worked. There would be more benefits for both the organisation and the system where the Trust was leading on digital implementation. Mr Turner added that the Trust's commitment to using a Quality Improvement (QI) approach would bring a freshness and opportunity. Ms Jacobs highlighted how the CIP and workforce challenges were interlinked. In order to overcome them, a different approach was needed such as automation which could deliver both savings and deliver care. Dr Spare emphasised that a new approach should also enhance the quality of the care services delivered. Ms Robinson-Collins confirmed that productive conversations were already underway which were empowering colleagues to come together to institute change.

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

25/05/14 Quality Committee Chair's Assurance Report

Ms Barber presented the report to the Board for assurance.

With regards to the long term service coastal staff challenges, Mr Goulston commented that when he had visited the Acute Response Team in Folkestone on a recent We Care visit, he had discussed the staffing challenges with them. They had highlighted that the main issue related to health care assistants. Staff were joining the bank to undertake extra

hours. That this might become a permanent solution was seen as more of a risk than a risk to quality outcomes.

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

25/05/15 Strategic Workforce Committee Chair's Assurance Report

Mrs Lowe presented the report to the Board for assurance.

Mr Turner added that he supported the use of benchmarking to tackle the Trust's workforce issues. Ms Davies supported the request from Mrs Lowe that a report on progress with the Sustainability Strategy be brought to the Board. Mr Goulston highlighted that the Council of Governors would be receiving a presentation on the progress of the Academy at its morning session on 20 July.

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

25/05/16 Learning from Deaths Report

Dr Phillips presented the report to the Board for assurance.

Mr Goulston highlighted the variation in the number of patient deaths in the east and west Kent community hospitals. He noted that they had all been expected deaths but questioned whether the reason had been analysed. Dr Phillips responded that the reason for the variation was multifactorial but historically there were more complex and end of life patients in the community hospitals in east Kent. Ms Butterworth added that the introduction of new dashboards to monitor health inequalities both on service caseloads and in the community alongside the development of the community hospitals strategy were timely. Although it was still embryonic, the dashboards would provide useful data to services as to how they addressed health inequalities in delivering care in east and west Kent. Dr Spare commented that this linked to the differences in levels of social deprivation and disease between east and west Kent which would have played a part in the patient deaths in the community hospitals.

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

25/05/17 Ockenden Inquiry assurance report

Dr Spare presented the report to the Board for assurance.

Mr Sammon highlighted how the report had talked about the principle of staff working and training together. He suggested that this would be important to reflect on at the Quality Committee as the Trust increasingly had teams working together that had both health and social care components. Through training together there could be a positive impact on quality and safety. Dr Spare suggested that the Health Visiting Service was an example of this as it had a voice in the local maternity system.

Mr Goulston commented on the need for the management of risk 24/7 to be on a consistent basis from handover to handover.
Dr Spare stressed the importance of openness and transparency for the organisation but especially for families to ensure that errors were recognised and learnt from and change implemented.

The Board **RECEIVED** the Ockenden Inquiry assurance report.

25/05/18 Annual plan 2022/23

Mr Sammon presented the report to the Board for assurance.

Ms Barber suggested that the relevant areas needed to be added to the integrated performance report (IPR) and the Trust's ambition and outcome measures around early stroke discharge should be set out. Additionally, she would have liked to have seen a clinical strategy included. Ms Butterworth responded that there were numerous priorities in the adult services. With regards to the virtual wards, the metrics were being set at system and national level. With regards to early stroke discharge and urgent treatment centres (UTCs), she would be happy to increase their visibility through reporting. Mr Flack commented that with regards to integrating services, the system was in flux and services had yet to fully define what part they would play in those pathways. More work was needed and the Board would be briefed on developments.
Action – Ms Butterworth

Mrs Lowe reflected that the executive team should put its energies into its priorities. It would need to communicate a clear message to all staff about what was going to be achieved and how they would contribute to making that happen.

Mr Goulston suggested that at the next Public Board meeting, the Board should set out what aspect of the plan was being monitored and how the IPR would capture that. Mr Sammon would add information about the measurement of the strategic goals to the front end of the report.
Action – Mr Sammon

In terms of gaining assurance of progress with the priorities, some would be overseen by the committees and some by the Board.

The Board **RECEIVED** the Annual plan 2022/23.

25/05/19 Committees' Terms of Reference

Mr Goulston presented the report to the Board for approval.

Dr Shariff suggested that Charitable Funds Committee needed to be explicit about its principle purpose. Every committee should also include in its terms of reference an obligation for equality, diversity and inclusion. Ms Baines would recirculate the terms of reference to the committees to amend their wording.

Action – Ms Baines

The Board **APPROVED** the Committees' Terms of Reference, subject to the amendments.

25/05/20 Integrated Performance Report (IPR)

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

Mr Goulston thanked all those involved for their hard work in delivering the capital programme target.

Ms Barber suggested that there needed to be a board discussion about how Kent County Council (KCC) could be helped in speeding up the process around initial health assessments for looked after children (LAC). Ms Butterworth explained that the service and KCC were working together to bring the number of outstanding assessments down but currently she did not expect an early improvement. Dr Spare confirmed that this was being looked into by the system. Mr Goulston added that he had visited the LAC Service and had been impressed by the work it was doing, despite the challenges it faced.

In response to a question from Ms Barber regarding compliance with basic life support training, Ms Robinson-Collins explained that there were issues for some staff around the location and accessibility of the training. Teams had been reminded to give staff time to attend and this was tracked via the executive performance reviews. The organisational development business partners (ODBPs) had been asked to focus on this in their discussions with their services. An improvement in compliance was expected in June or July. Ms Butterworth added it was a weekly priority at her community services director meetings. Staff who were non-compliant would be contacted to remind them to update their training. Dr Spare was also reminding staff the importance of maintaining their compliance with mandatory training and competencies.

In response to a question from Mrs Lowe as to when Covid would be de-escalated to business as usual alongside a change in the language that was used around burn out, Dr Spare responded that one of the executive team's priorities was to support colleagues re-energise and re-ignite the passion in their work. Mr Flack commented that the Board would see some changes to the content of the IPR in the new financial year. The system would be living with the impact of Covid for some time but reporting would change. The national incident level had moved from level four to level three which had triggered some changes but these had not been seen locally. As to how those elements were described in the IPR was down to local discretion. Ms Robinson-Collins commented that communication messages around wellbeing were ongoing to help shift the mindset of staff to a more positive place.

In response to a question from Mr Goulston regarding including ethnicity in the stability index and turnover metrics, Ms Robinson-Collins confirmed that the analysis of the equality, diversity and inclusion (EDI) data would begin that month. This would feed through to the IPR that the Board received in September.

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

25/05/21 Staff Survey

Ms Robinson-Collins presented the report to the Board for assurance.

Taking account of the recommendations from the Ockenden Report, staff had indicated through the survey that they felt safe in raising concerns about clinical practice.

In response to a question from Ms Barber as to how the ODBPs could support small teams while ensuring that anonymity was not compromised, Ms Robinson-Collins explained that to ensure that the relevant teams received the right support, OBDPs looked to have a positive conversation with line managers and offer opportunities to colleagues to use the right mechanisms such as through the Freedom To Speak Up Guardian, Staff Side, or the OBDPs to raise issues. As part of the reset of coming out of Covid, there was work underway to have a closer partnership with Staff Side and the networks to improve communication flows and respond to issues promptly.

In response to an observation from Mr Turner regarding the limitations of the survey to engage with staff and understand staff experience, Ms Robinson-Collins commented that the Trust continued to use the annual Big Listen event which provided more granular information and qualitative data which could be actioned.

Mr Flack reflected that the Trust could not be reliant on a once-a-year snapshot of how staff felt. The interaction between senior staff and front-line staff on a daily basis was key. Dr Spare was developing a programme of service visits to link executives with teams to build relationships and identify actions which could make a difference. This was in addition to the visits that the non-executive directors and governors would be undertaking to triangulate where the hotspots and emerging hotspots were.

In response to a question from Mr Goulston as to how the Trust was addressing the harassment that colleagues with a disability had reported, Ms Robinson-Collins responded that she had asked the OBDPs to drill down into the data, have conversations with the relevant managers and identity the actions that should be included on the action plan that was overseen by the Workforce Equality Group whose membership included the staff network leads. In response to a question from Ms Barber as to what oversight the Board should have of this particular area, Mr Goulston indicated that compliance with both the Workforce Race Equality Standard

and the Workforce Disability Equality Standard should be monitored by the Board rather than a committee for the time being.
Action – Ms Robinson-Collins

The Board **RECEIVED** the Staff Survey.

25/05/22 Risk Management Policy

Ms Davies presented the report to the Board for assurance.

The Audit and Risk Committee, at its May meeting, had reviewed the policy and suggested a minor amendment. Mr Turner highlighted that there was a lack of reference to the Board in section 4 Risk Ownership and it was agreed that this would be amended.
Action – Ms Davies

The Board **APPROVED** the Risk Management Policy, subject to the amendments.

25/05/23 Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance Statement

Ms Davies presented the report to the Board for assurance.

In response to a question from Dr Shariff as to how the Trust worked with the voluntary sector, Ms Davies explained that the EPRR Team interacted with a number of organisations including the Kent Voluntary Sector Emergency Group and the Salvation Army.

The Board **RECEIVED** the Emergency Preparedness, Resilience and Response Annual Assurance Statement.

25/05/24 Annual budgets 2022/23 – revenue and capital

Ms Jacobs presented the report to the Board for approval.

The budget had previously been approved by the Board on 31 March. There was a further update which was set out in the supplementary paper in the pack.

In response to a question from Mr Goulston as to whether the Board would see the revisions to the financial plan at its meeting in June, Ms Jacobs confirmed that it would.
Action – Ms Jacobs

The Board **APPROVED** the Annual budgets 2022/23 – revenue and capital.

25/05/25 Cost improvement programme 2022/23

Ms Butterworth presented the report to the Board for assurance.

There was still a shortfall in schemes to meet the Trust's target for 2022/23. A supported session with the adult services would take place to identify which schemes were recurrent to avoid a large non-recurrent burden going into the following year.

The Board **RECEIVED** the Cost improvement programme 2022/23.

25/05/26 Quality priorities 2022/23

Dr Spare presented the report to the Board for approval.

The Board **APPROVED** the Quality priorities 2022/23.

25/05/27 Board of directors – committee membership and designations

Mr Goulston presented the report to the Board for approval.

The Council of Governors had received the report at its 21 March meeting. Mr Conway's continued role as Vice Chair was approved as was Ms Barber becoming the Senior Independent Director.

The Board **APPROVED** the Board of directors – committee membership and designations.

25/05/28 Any Other Business

There was no other business to report.

25/05/29 Questions from members of the public relating to the agenda

There were no questions from the public.

The video of the meeting along with how to submit any questions would be available on the public website shortly.

Mr Goulston confirmed that the next Public Board meeting would be in person and members of the public and governors were invited to attend.

The meeting ended at 11.55am.

Date and Venue of the Next Meeting

Wednesday 7 September 2022; Rooms 6 and 7, Kent Community Health NHS Foundation Trust offices, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent TN25 4AZ. This meeting will be broadcast to the public on MS Teams

Kent Community Health NHS Foundation Trust

MATTERS ARISING FROM THE BOARD MEETING OF 25 MAY 2022 (PART ONE)

Minute number	Agenda Item	Action	Action Owner	Status
25/05/09	Board Assurance Framework (BAF)	To reflect the comments of the Board in the next iteration of the BAF.	Ms Davies	Action complete.
25/05/18	Annual plan 2022/23	To increase the visibility of early stroke discharge and urgent treatment centres through reporting in the IPR.	Ms Butterworth	The Assistant Director of Performance and Business Intelligence has confirmed that Urgent Treatment Centre performance is included in the latest integrated performance report. Early stroke discharge performance will be included in the following month's report.
25/05/18	Annual plan 2022/23	To add information about the measurement of the strategic goals to the front end of the report	Mr Sammon	Action complete and included in the July Integrated Performance Report.

Minute number	Agenda Item	Action	Action Owner	Status
25/05/19	Committee Terms of Reference	To update the Charitable Funds Committee terms of reference to state explicitly its principle purpose. To update the Terms of Reference to include an obligation for equality, diversity and inclusion	Ms Baines	The terms of reference will be recirculated to the committees and updated wording suggested as part of the committee effectiveness exercise taking place in quarter three. Action open.
25/05/21	Staff Survey	To bring compliance with the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) to the Board for monitoring.	Ms Robinson-Collins	These were discussed at the July Board meeting. Action complete.
25/05/22	Risk Management Policy	To amend the policy to include reference to the Board in section 4 Risk Ownership.	Ms Davies	Action complete.
25/05/24	Annual budgets 2022/23 – revenue and capital	To bring the revisions to the financial plan to the June Board meeting.	Ms Jacobs	Action complete.

NHS
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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	1.8
Agenda Item Title:	Chief Executive's Report
Presenting Officer:	Mairead Mc Cormick Chief Executive Officer
Action – this paper is for:	☐ Decision ☒ Information ☐ Assurance

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

Proposal and/or recommendation

Not applicable.

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

Name:	Mairead Mc Cormick	Job title:	Chief Executive
Telephone number:	01622 211902	Email	Mairead.mccormick1@nhs.net

NHS
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CHIEF EXECUTIVE'S REPORT
September 2022

This is my first report as chief executive and I wanted to say a huge thank you to everyone for the warm welcome I received on joining the trust. It is an exciting time to join a community trust, particularly as I am also a Kent resident and I believe we are at the heart of creating integrated teams that will shape a model of health and care that helps our local populations to live their best life. The start of July also heralded a change for the way we work together, as it was the day integrated care systems came into force; set up to make it easier for us all to work together. I am hugely encouraged by the willingness of all partners across health and social care to make this all possible.

I am really clear that our staff are the most valuable part of this organisation and I would like to acknowledge the enormity of what they are managing day-to-day and give them my commitment to improve their working lives based on what they have articulated that they need for that improvement. I've heard this first hand through my visits to learn about our services, the staff survey and the various platforms for feedback. My first day coincided with the annual staff awards, it was a great day to join almost 200 colleagues and see their commitment to caring for patients. These achievements are even more exceptional because of what we've been through, so I intend to provide staff with the care they require so they can continue to deliver these high standards.

Executive Team changes

Natalie Davies, Executive Director of Corporate Governance has left the organisation to take up a role as chief of staff at the integrated care board. Natalie has been in the organisation for many years and has contributed enormously across many areas. I would like to offer a massive thank you for all she has done and wish her every success in her new role. There will be an interim arrangement in place, while I review the team's portfolios.

This report highlights some key updates since the previous public board in May.

Current situation and pressures

COVID-19 (SARS-coV-2)

Coronavirus cases are rising across the country and again we are seeing this affect inpatients particularly in the acute trusts, but also our patients and our workforce. We have also been learning about the trends of flu in Australia in their winter season. This will help us shape our preparations for autumn and winter here in the UK.

Winter planning 2022/23 and heatwave

It's extraordinary to think we are now planning for winter considering the heatwave challenges we've just come through. Discussions are under way through health and care partnerships using modelling data and national guidance to agree on a set of priorities that will have the highest impact to support this next set of challenges. We have a huge amount to contribute both to supporting our acute trusts to take patients out of hospital earlier and to use our capacity most effectively. Early intervention, either by preventing admission or a quick turnaround from the hospital front doors, gives patients much better rehabilitation potential and this will be our main focus.

People

Cost of living crisis

Like many people, our staff are being hit hard by rising fuel and energy bills. We are continually reviewing the levels of support we provide and have launched two new financial wellbeing services, Wagestream and Salary Finance, funded the costs of the Blue Light Card, which gives NHS staff access to a range of discounts and have agreed subsidised meals at acute hospitals for staff. In July, we increased mileage expenses by a further three pence on top of the previous increase. We will continue to review the range of measures and support we can offer, while recognising this is a national issue.

National pay deal and potential strike action

While the national pay award announcement in July seeks to recognise the impact of the cost of living crisis and is weighted towards lower grades, it is not in line with inflation for everyone. We are carefully managing the risk of potential strike action, working closely with our unions, which are balloting on a decision whether to strike.

Pulse survey

Nearly 900 colleagues completed the Quarterly Pulse Survey in July, which looked at the health and wellbeing support available. It was great to see the vast majority of colleagues knew how to access the range of support and felt comfortable using it or referring themselves. Colleagues asked for more support with their mental health, and talked about the impact of staffing levels and concerns around finances. I am pleased to report turnover is now within target at 14.45 per cent for the first time in 10 months, as of June 2022.

International AHP and apprentices

In August, we were granted funding from NHS England to support international recruitment for 24 allied health professionals (AHPs), namely radiographers, occupational therapists and podiatrists to join us by March next year. I hope this will provide some welcome support, in addition to our other international nursing recruits who joined in June. A dozen new AHP apprentices have officially started their courses; all while working for the trust in band 4 roles. They will qualify in four years from the University of East London or Canterbury Christ Church University.

Healthy workplaces

We have been awarded the highest accolade in the Kent and Medway Workplace Wellbeing Awards – a platinum award for our work on staff health and wellbeing. Initiatives highlighted were the staff choir, the football team, easy access to counselling and fast track physio for MSK. We also completed this year's Flo Fit Big 50 challenge in July, which was won by the Canterbury Rehab Team. This year 84 teams and 313 people competed for the top spot, clocking up 127,796,527 steps, or 49,702 miles, the equivalent of walking around the world twice.

International Healthcare Estates and Facilities day

The first National Healthcare Estates and Facilities Day on Wednesday, 15 June recognised and celebrated the essential work of our colleagues. The work of our hospital and community teams would be impossible without our army of estates and facilities colleagues and the day was a chance to appreciate the contribution of colleagues in these essential roles.

Patients and service users

Respiratory and frailty virtual wards

NHS England has asked systems to provide 40 to 50 virtual beds, per 100,000 of the population, by December 2023 to support more people to recover at home.

KCHFT will be building on our successes, like our two Hospitals at Home virtual wards set up in response to Covid-19. We are leading on developing a virtual ward for people with acute respiratory infections in east Kent. Working with acute partners, care homes, GP and hospices, we are developing two virtual frailty wards, led by our community geriatricians Shelagh O'Riordan in east Kent and Amy Heskett in west Kent. Dr O'Riordan's blog has been published by NHS England in which she shares her top tips on how to set up a frailty ward and why clinicians should join her as part of NHS England's clinical summit taking place later this year.

New-look ward at Herne Bay hospital

Heron ward at the Queen Victoria Memorial Hospital was closed for a £900,000 makeover in May. The improvements will benefit staff and patients with refurbishments and new facilities. The project has been supported by funding from NHS England, the QVMH League of Friends and a charitable legacy left to KCHFT. During the works, colleagues and patients have been relocated to Westbrook House in Margate. The work is on schedule and the ward is due to reopen to patients in October 2022. I would like to thank staff who worked hard to relocate and enable this important work to take place.

Gloria opens gardens

TV and radio presenter Gloria Hunniford cut the ribbon to open the newly-transformed garden at Sevenoaks Hospital in August. The garden was transformed thanks to two businesses, with financial assistance from the League of Friends and Sevenoaks Lions Club, in memory of Susan Hamilton-Rigby, who worked at the hospital for 28 years. A huge thank you to all including Provender Nurseries and David Stead Landscapes, which came together to provide new planting and a patio with seating for patients, staff and visitors to enjoy.

Supporting our veterans

We are making progress towards meeting the pledges required to sign the Veterans' Health Care Alliance Covenant. We have developed a quality improvement project with the aim of increasing the number of veterans identified on our electronic patient

record and are planning engagement sessions for veterans using our services to understand their experience of our care and any barriers or issues they face. More than 120 leaders joined our conference in June focused on the armed forces community and the first meeting of our new staff network has taken place, chaired by our Head of Corporate Services and veteran, Lisa Sherratt.

Protecting our most vulnerable

I wanted to say a huge thank you to those teams who stepped up to make sure our most vulnerable patients were safe when we were impacted by both water shortages, heatwave and traffic challenges due to the issues at the Port of Dover. Community Nurse Sarah Bell-Nevin, who has been using her electric bike due to an epilepsy diagnosis, has inspired her colleagues to do the same, after some of the worst congestion the port town has ever seen this summer.

Awards

Our Specialist Pharmacy Team is up for a Health Service Journal Patient Safety Award for its work supporting medicine safety in special schools, while KCHFT has also been named a finalist for *Net Zero Innovation of the Year* in the Innovate Awards. The East Kent high dose opioid reduction project, in partnership with the Medicines Optimisation Team at NHS Kent and Medway, has been shortlisted for the Improving Medicines Safety in Medicines Management Award at this year's HSJ Patient Safety Awards, recognising their outstanding contribution to healthcare. Good luck to all.

Covid-19 vaccination

We have continued to act as the lead employer on the Kent and Medway Covid vaccine programme, which has included regular contact with vaccine staff working on the bank and a programme to move people into other bank roles or substantive roles within the Kent and Medway system, if they would like to. We have been operating vaccine centres in Sittingbourne and Sheppey hospitals during the school holidays and at the weekend to provide capacity in areas where take-up is low for first, second or booster vaccines, for all adults and children aged five and over.

i care – Steve's invitation to the Platinum Jubilee party

Steve Bamford, who regularly fundraises for i care's HIV fund through running, walking or cycling challenges, received a personal invitation to attend the Queen's Platinum Jubilee. NHS Charities Together received invitations from the palace to send representatives from each charity and we selected Steve for his heroic

fundraising efforts to help support others living with HIV and raise awareness of the latest research.

Partnerships

Health and care partnerships

The partnerships have agreed priorities for the next year with further workshops in September and October to develop how we deliver these particularly through integrated teams at neighbourhood and localities. Health and care are working closely to understand the needs of particular populations and shape services that are responsive with a major focus on population health management.

Carers Conference

Our first ever joint Carers Conference, with Kent and Medway Social Care Partnership, took place in June. It was an extremely well attended, inspiring and action-focused.

Shift website launch

Finally, SHIFT is a partnership project funded by the Health and Europe Centre and involves KCHFT, Kent County Council, Metro charity, University of Chichester and other partners in France and the Netherlands. It is focused on shifting attitudes towards sex and sexual health in people over 45. The Sexual Health Team is involved in the research and our Communications Team was contracted to design and build the website, which launched in May 2022 and has had more than 3,500 views.

I am looking forward to progressing this work and sharing this with you over the coming months.

Mairead McCormick
Chief Executive
September 2022.

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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	2.1
Agenda Item Title:	Board Assurance Framework
Presenting Officer:	Gordon Flack, Deputy Chief Executive
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

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

The function of the Board Assurance Framework (BAF) is to inform and elicit discussion about the significant risks which threaten the achievement of the Trust's strategic objectives. To provide assurance that these risks are being effectively managed, the BAF details the controls in place to mitigate each risk, any gap in control, assurance of the controls' effectiveness, the actions planned and being executed together with the date by when the actions are due to be completed.

Summary of key points

Since the BAF was last presented all risks and actions have been reviewed and updated.

Proposal and/or recommendation

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

The top two BAF risks are as follows:

- BAF risk 123 – Kent County Council (KCC) Funded Social Care – risk rating 20
- BAF risk 115 – Operational Pressures & Staff Shortages – risk rating 20

New risk added since the BAF was last presented to the Board:

- BAF risk 124 – Potential Strike Action – risk rating 15

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

Name:	Ben Norton	Job title:	Head of Corporate Services Improvement
Telephone number:	01233667700	Email	Ben.norton@nhs.net

Updated 31st August 2022

Appendix 1

Kent Community Health
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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

Strategic Goal	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 Assessm	Appetite	C	L	Target	Target Date (end)
													Actions to reduce risk	Owner	Target Completion (end)	Status						
Intergrated Care	123	May 2022	Pauline Butterworth	**KCC Funded Social Care Risk** There has been a sustained lack of domiciliary care for KCC funded long term packages of care in the system. This is caused by a number of factors including availability of workforce; reduced numbers of Dom. care providers in the market place, variations in rates of pay and LA funding constraints. This is having an impact on system flow as discharges from hospitals are delayed and NFTR numbers have increased. Board Committee Lead on Assurance: **Board**	4	5	20	KCC have developed a plan to address gaps in provision; this has yielded only a small increase in capacity to date, but more capacity is expected to come on line in step changes in October and December 2022. Daily sitrep reporting and system level approach to mutual aid Utilisation of KCHFT trigger and escalation plan and regular implementation of OPEL 4 actions incl: MADE Events; senior oversight of caseload reviews; identification of alternative discharge pathways. HCP winter surge planning underway to model additional bed and Hilton / HWS capacity required for winter in anticipation that Dom care supply issues will not be fully resolved. Working with ICS and Provider partners to take action in response to the national 100 day challenge to improve flow. System plan developed and actions underway.	Internal daily sitrep. System sitrep calls and support from OCC. Shrewd reporting.	4	5	20	Partnership working to respond to the 100 day challenge	Pauline Butterworth	Dec 22	A	Low	3 - Open	3	3	9	April 2023
													Regular MADE events	Pauline Butterworth	Dec 22	A						
													Redesign of KCHFT bed management processes to maximise flow in	Pauline Butterworth	October 22	A						
Prevent ill health	115	February 2021	Victoria Robinson - Collins	**Operational Pressures & Staff Shortages Risk** 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. Board Committee Lead on Assurance:	5	4	20	Active and bespoke recruitment campaigns for key professions i.e. nursing, facilities Weekly staff rota review and escalation paths Patient Safety & Clinical Risk Group IMM meeting - redeployed staff Bank system in place 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 Retention steering group. 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 IMM report to executive Management of vacancy and turnover rates Oversight of recruitment of workforce metrics by quality committee & board Monthly quality report Twice weekly safer staffing review	5	4	20	Q2 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 Victoria Robinson-Collins Mercia Spare	September 22	A	Low	5 - Pro-active	2	3	6	March 2023
													Q2 Recruitment of staff during via range of supply streams including international, national and local recruitment. Utilising pipelines including Step into Health, Return to Practice	Victoria Robinson-Collins	September 22	A						
													Q2 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 Victoria Robinson-Collins Mercia Spare	September 22	A						
													Q2 advertising additional staff support and wellbeing mechanisms utilising regional initiatives and funding streams to maximise benefits	Victoria Robinson-Collins	September 22	A						
													Q2 review of staff turnover, vacancy rates and stability metrics with interventions/ recovery plans tracked through EPR and IPR processes	Victoria Robinson-Collins	September 22	A						
													Q2 task and finish activity of 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	September 22	A						
													Communication campaigns Summer/ Autumn 2022 to support physical and mental health.	Victoria Robinson-Collins	September 22	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

Strategic Goal	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 Assessm	Appetite	C	L	Target	Target Date (end)
Prevent ill health	110	July 2020	Pauline Butterworth	**System Surge & Reset Risk** 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. Board Committee Lead on Assurance: **Quality Committee**	5	3	15	System led, surge and recovery plans monitoring across the system. Weekly COO collaborative meeting in place to ensure providers are working in a joined-up way.. Daily Sitrep reporting - Locally and Nationally. Operational risk and controls logs. Membership of LHRP	System response through LHRP/NHSE Internal and external reporting LRF area ratings	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Medium	3 - Open	3	4	12	**September 2022**
													Recruit against Ageing Well investment which will support the 2 hour UCR and therefore admission avoidance in the approach to next winter and other periods of surge.	Pauline Butterworth	September 22	A						
													Implement virtual ward programme in frailty (east and east Kent) and work as a partner in the wider virtual ward programme (east and west Kent) including delivering the monitoring hub for east Kent. This will deliver additional admission avoidance and discharge support in the approach to winter and periods of surge.	Pauline Butterworth	October 22	A						
Deliver High Quality Care at Home and in the Community	122	May 2022	Victoria Robinson - Collins	**Eqaulity & Inclusion RIsk** Risk that that we are not achieving the level of equality and inclusion aspired to in our strategy. This results in disillusioned staff exiting the Trust impacting levels of turnover and recruitment and undermining our aim to be the best employer Board Committee Lead on Assurance: **Strategic Workforce Comittee**	5	3	15	Use of data. Increased drive on equality monitoring. Workforce equality steering group. Veteran programme group.	Data from ESR and Power BI. EDI strategy with oversight from execs and assurance via Strategic workforce committee and Board.	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Medium	3 - Open	2	3	6	**May 2023**
													Develop reciprocal mentoring programme.	Victoria Robinson-Collins/Ali Carruth	October 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 Workforce EDI.	Victoria Robinson-Collins/Ali Carruth	September 22	A						
													Establishment of inclusion ambassador programme	Victoria Robinson-Collins/Ali Carruth	October 22	A						
													Delivery of year 1 EDI strategy actions, related WRES, WDES, Gender pay gap actions and EDS2 (Q2)	Victoria Robinson-Collins/Ali Carruth	September 22	A						
													Continued Q2 support for established staff networks.	Victoria Robinson-Collins/Ali Carruth	September 22	A						
													Delivery of Q2 equality objectives.	Victoria Robinson-Collins/Ali Carruth	September 22	A						
Deliver High Quality Care at Home and in the Community	124	August 2022	Victoria Robinson - Collins	**Potential Strike Action RIsk** Risk that Trade Union ballots for strike action, or action short of strike, following the announcement of the national pay award for 2022/23 FY, will further impact on capacity and capability to deliver services, staff engagement and morale Board Committee Lead on Assurance: **Strategic Workforce Comittee**	5	3	15	Monthly Staff Partnership Forum with local TU reps. Attendance at regional Staff Partnership Forum with regional TU reps. Regular review of staffing levels in line with Safer Staffing and Roster good practice recommendations. Regular communication and engagement with colleagues either face to face via service visits or using Flo to offer wellbeing support and ensure visibility. Weekly staff rota review and escalation paths Patient Safety & Clinical Risk Group IMM meetings and daily SitRep Bank system in place Wellbeing initiatives for staff Wellbeing conversations Regular review of skill mix to ensure full use of MDT	Daily Sit rep IMM report to executive Twice weekly safer staffing review Weekly staff rota review and escalation paths Regular review of skill mix to ensure full use of MDT	5	3	15	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Medium	3 - Open	4	3	12	**December 2022**
													Refresh emergency and non-emergency caseload lists	Pauline Butterworth	Sep 2022	A						
													Safer staffing reviews for community hospitals and hot spot areas weekly	Mercia Spare	September 2022	A						
													Agree criteria and areas for pickets with staff side	Victoria Robinson-Collins	September 2022	A						
													Report safer staffing to execs monthly	Mercia Spare	December 2022	A						
													Regular review of skill mix to ensure full use of MDT	Pauline Butterworth Victoria Robinson-Collins	December 2022	A						
													Local oversight of the delivery of quality matrix and escalation via PSCRG as indicated	Mercia Spare	December 2022	A						
													Work collaboratively with K&M system HRD's and ICB CPO to ensure system workforce plan and solution to staffing gaps is in place, including arrangements for mutual aid	Victoria Robinson-Collins	September 2022							
													Regularly review and implement any national mandates or legislative changes relating to strike action for healthcare workers	Victoria Robinson-Collins	October 2022	A						
Deliver High Quality Care at Home and in the Community	116	May 2021	Gordon Flack	**Social Care Financial RIsk** 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. Board Committee Lead on Assurance: **Finance Business and Investment Committee**	4	3	12H	KCC have identified budget funding for a 3% average pay award (including NI). 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 Delivery Partnership, delegated to deliver and micro commission all LDA health and social support agreed. KCC public health partnership agreement and governance structure. 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**
													Continue to monitor the financial performance against the budget and service line reporting position. Offsetting any underspend in the services against any income shortfall (Q2)	Gill Jacobs	September 22	A						

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Workforce Report Exceptions – August 2022 Highlight Report

Introduction

The risk number 115 on the Board Assurance Framework (BAF) is currently rated at 20. This risk relates to on-going pressures combined with staff shortages and skill mix issues generating an impact on retention and stability.

This risk is reflected in the themes evident in the current, and previous Workforce Reports to SWC and in the IPR relating to turnover, stability and vacancy rate.

Following a peak in January 2022, total and voluntary turnover metrics have incrementally improved with the positive trend continuing into July 2022.

Voluntary turnover is now at it's lowest since September 2021 at 14.45%. This means that the voluntary turnover rate is now within the target threshold for the first time in 10 months. Total turnover is still slightly outside above target but is now within the upper threshold at 15.67% and is also at its lowest since September 2021.

	Turnover	Voluntary Turnover
Mar-22	17.20%	15.85%
Apr-22	17.18%	15.61%
May-22	16.43%	14.97%
June-22		14.45%
July -22	15.67%	14.23%

Looking at the vacancy rate, a significant spike in April 2022 reflected a annual trend i.e. a marked increase in the vacancy rate each April, as budgets and establishments are reset, and related specifically to an increase to establishment of 82.67 WTE. The vacancy rate improved between the months of May and June 2022 to 7.39% but has spiked again in July to 8.23 % due to an increase of another 40 WTE to the establishment from the reserves budget.

June 2022 saw another month with a significant number of new starters into the organisation (67), with this trend likely to continue into September as vacancies continue to be filled. The international nurse campaign has supported the improved position in relation to new starters, with 40.3% of new starters in June being from a BAME background.

Update on Actions to Mitigate Risk

Workload Demands

A complex piece of work comprising several elements is being led by a sub-group of our Integrated Management Meeting (IMM) to review skill mix, safe staffing levels and demand and capacity modelling across key areas of operational services to ensure role design and distribution of resource best meets the needs of our patients whilst seeking to ameliorate workload pressures.

A rapid piece of focussed Quality Improvement on a solution within community nursing specifically related to insulin administration is due to commence imminently with the aim of assessing the skill mix required to ease the pressure and utilise the full multi-disciplinary team.

Recruitment and Retention

A task and finish group has been established specifically to progress bespoke solutions for facilities recruitment and retention. This includes options to advertise and recruit differently, using widening participation to reach out to all areas of the local community, review of rosters and shift patterns, exploring use of Recruitment Retention Premia (RRP) for hard to fill areas/ roles and consultation with existing colleagues to best understand what measures may support them to remain in their roles.

Cohorts one and two of our International Nurse Recruitment campaign have now landed and are in post, with cohort three expected to land in September 2022. The aim is to achieve 100 WTE new recruits by the end of 2022. Additionally, KCHFT has been successful in a bid for national funding to support international recruitment of 25 AHP posts within the current financial year.

A task and finish group led by the People & OD Business Partners is progressing solutions including review of the 100 day interview, consideration of stay/ itchy feet conversations, complete revision of the way exit data is collected across the Trust to provide relevant, service specific data and qualitative information, review of local induction to encourage welcome meetings and proactive activity from the manager and team to welcome their new colleague, review of job adverts and recruitment collateral to ensure it is attractive and bespoke to each role, review of career conversations and talent management processes.

The Flex for the Future Programme and Reimagine Team Working Programmes both seek to aid retention by improving opportunities for flexible working and by the promotion of self-managed teams respectively. The Reimagine Team Working Programme is nearing completion and Flex for the Future is being reviewed and is subject to extension.

Financial Wellbeing

KCHFT is an accredited Real Living Wage employer and is being publicised via our communications team and in recruitment literature to demonstrate the commitment to supporting all our colleagues to be free from poverty.

Colleagues are able to access free advances against their earnings via Wagestream up to 1 transaction per month. This is promoted as to be used for emergencies only and not to be something for colleagues to rely upon. We know that many colleagues are already utilising expensive Payday loans or doorstep lending facilities and, in this instance, the Wagestream option generates a cost saving which can aid financial recovery.

Other financial packages for colleagues including Salary Finance and Salad Money are now live, where preferential rates for loans available via mainstream and sub-prime lenders respectively, will be available to staff. This accompanies options for preferential savings rates and financial advice/ counselling which is available from both providers.

Business mileage rates have been uplifted temporarily by a further 3p per mile in July 2022 as a local agreement to supplement the existing HMRC rates and 'triangulation' approach to mileage claims. This offers a preferential option to the national arrangements via Agenda for Change. Mileage rates will be assessed each quarter and re-based using the RAC fuel tracker tool to inform future rates to ensure colleagues are supported.

Staff side colleagues are canvassing feedback from colleagues via Flo in relation to other options that may assist them in real terms with the outputs from that consultation exercise being presented to Staff Partnership Forum for consideration.

New solutions being developed to support colleagues include a Hardship Fund, access to acute Trust subsidised restaurants for our colleagues and a test of concept for pool cars.

Recommendation

Committee members are asked to note and receive assurance in relation to efforts taken to mitigate this BAF risk.

It was approved at June 2022 SWC that the BAF risk 115 remains at 20 until risk is mitigated as demonstrated by reduction in total turnover to 16% and voluntary turnover to 14.5%, in conjunction with a vacancy rate of 7.5%. Whilst we see a significantly improved turnover position there is still some way to go in relation to closing the vacancy gap as well as ensuring turnover is sustained, primarily due to the additional investment in established posts in April and July 2022. Therefore, it is proposed this BAF risk remains the same.

Victoria Robinson-Collins
Director of People & Organisational Development
September 2022

Kent Community Health
NHS Foundation Trust

EXCEPTION REPORT – BOARD ASSURANCE FRAMEWORK
RISK 123 WITH A RISK SCORE OF 20

Introduction

The risk number 123 on the Board Assurance Framework (BAF) is currently rated at 20. This risk relates to on-going pressures caused by a limited capacity within the domiciliary care market and the impact this has on a number of KCHFT and system pathways.

Due to the severity of the rating this paper serves as an exception report to offer assurance in relation to the steps being taken to mitigate this risk.

The risk was formally opened on the BAF in May 2022 but the issues described have been ongoing since July 2021. A number of actions plans have been agreed across the Integrated Care System (ICS) and working jointly with the local authority but the impact on KCHFT services and pathways has increased leading to the addition of this risk.

Update on Actions to Mitigate Risk

There is an action plan in place based on working in partnership at an HCP level with the CCG, acute Trust and local authority to:

- maximise the use of pathway 0
- regularly review and cleanse caseloads to ensure that all potential discharge pathways and services are utilised
- manage delayed transfers of care from the acute, community hospitals and pathway 1 services.
- Reduce to use of additional pathway 3 beds in the system.

West Kent:
In West Kent the Integrated Discharge Team (IDT) has been working with Maidstone and Tunbridge Wells Hospitals (MTW) to accurately define the patients by discharge pathways and to review the reasons why patients don't leave the acute on the planned day of discharge. The data feed received for the KCHFT sitrep does now match the data used internally by MTW however there is still work needed to break the data down between complex and simple discharges (pathways 0-3).

The CCG team have completed a deep dive into the use of the pathway 1 provider (Hilton Nursing) and this data has identified opportunities to reduce failed discharges and referrals for patients who are discharged with this service but do not require it within 24 hours. The IDT are working with the local authority and Hilton to address

these issues, this action is ongoing but the IDT now have visibility over the previous days discharges to support this work.

In West Kent there is a small additional bedded resource commissioned as part of the discharge to assess funding (Hawkhurst House) and the IDT are reviewing if this is required going into winter and what the appropriate support to these beds is to ensure that the risk of patients deconditioning is minimised. It is challenging to fill these beds due to location and so alternative locations are being considered. The CCG has secured some winter funding to support this.

The west kent community hospitals have seen a small improvement (reduction) in the number of patients who are no longer fit to reside and waiting for a domiciliary care placement. This appears to be due to improved discharge planning internally rather than an increase in access to domiciliary care and the lessons are being learned and applied to the hospitals across the geography. This work forms part of the wider review of the use of community hospital beds/ community hospital strategy.

The west kent rapid response team continues to hold a number of patients who require personal care only and have been accepted for a package of care. This has been highlighted to the CCG and pathway 1 provider but the numbers have remained stable for several months, as have the numbers being bridged by Hilton.

East Kent:
In east Kent there is a discharge improvement plan agreed across the partners. A key element is to develop a transfer of care hub which is designed to increase the collaborative working on discharge planning on all pathways and reduce hand off or repeat assessments. The hub was launched in August and builds on the existing processes of the Rapid Transfer Service (RTS) but increase acute/ ward level identification of pathway 1 patients and initiation of assessment. It also increases joint assessment with the local authority to reduce handovers.

The number of patients NLFTR in both the community hospitals and the pathway 1 provider (Home with Support) have increased and often represent over 30% of the community hospital bed base and 60% of the HWS caseload. A proposal has been discussed with the CCG to transfer financial responsibility for the packages of care being delivered by home with support after they have been accepted for a package of care to the local authority. This will be built into the negotiations between the CCG and local authority regarding the discharge to assess funding and next steps.

Further system level actions:

For both HCPs the following regular actions are being undertaken.

- Regular formal MADE (multiagency discharge event) on all caseloads to identify alternative pathways
- Regular attendance at board rounds from senior members of the IDT and RTS to reinforce criteria led discharge principles.
- Inclusion of a integrated same day emergency care (SDEC) service in the Emergency Departments to increase the opportunity for admission avoidance for winter.

Recommendation

Board members are asked to note that this remains a significant risk and that despite a collaborative action plan in place in both HCPs, very limited progress is being made on the delays in the system and NLFTR numbers in all pathways.

The board is asked to support system level actions to:

1. Increase visibility of the impact of this risk and likely ongoing impact into the winter surge period
2. Support review of action plans to identify new or innovative approaches to reduce use of interim beds and dependence on pathway 1.

Pauline Butterworth
Chief Operating Officer
August 2022

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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 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 ☐ Information ☒ Assurance

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

The report was received by the Quality Committee at its meeting on 22 July 2022.

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

Following a number of new pieces of guidance in June 2022 the content has been fully updated so changes have not been updated 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.

The UK has now moving to living with COVID-19 IP&C guidance and the following publications have been made since the last presentation of the IP&C BAF:

- Testing for staff has moved from PCR to LFT
- Staff LFT testing for patient facing staff remains at twice a week
- Staff who are not considered patient facing do not need to undertake LFT
- Isolation period for symptomatic staff has reduced to 7 days providing LFT is negative on day 5 and 6.
- Patient testing remains PCR on admission and if symptomatic however, routine testing on day 3 and 6 and where there is an outbreak is by LFT
- Universal mask wearing has ceased for members of the public and staff and the use of masks is based on a risk assessment.
- Staff remain required to wear FFP3 when caring for suspected or confirmed COVID patients and when an outbreak has been declared
- In all other situations staff are required to risk assess the need for a FRSFM

- Staff can continue to wear a FRSFM if they choose to
- Patient isolation and cohorting is only required for suspected, confirmed or directly exposed patients
- Cleaning regimens have moved back to pre-pandemic frequencies however where patients are suspected or confirmed positive enhanced cleaning is undertaken
- Visiting guidance has moved back to pre-pandemic frequency in all areas of healthcare with triage/screening locally prior to visiting to minimise risk.

Proposal and/or recommendation to the Committee or Board
The Quality Committee recommends the report to the Board to receive assurance.

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

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

Infection prevention and control board assurance framework

24 December 2021 Version 1.8

Updates from version 1.6 are highlighted in yellow.

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 July 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: • a respiratory season/winter plan is in place: ○ 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 ○ to enable appropriate segregation of cases depending on the pathogen. ○ plan for and manage increasing case numbers where they occur. ○ 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. • 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. • Organisational /employers risk assessments in the context of managing seasonal respiratory infectious agents are: ○ 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. ○ applied in order and include elimination; substitution, engineering, administration and PPE/RPE. ○ communicated to staff. • safe systems of working; including managing the risk associated with infectious agents through the completion of risk assessments have been approved through local governance procedures, for example Integrated Care Systems. • if the organisation has adopted practices that differ from those recommended/stated in the national guidance a risk assessment has been	• Lateral flow testing in place, patient facing staff testing twice per week; electronic system in place to monitor, and results uploaded to PHE POCT centre. • Additionally, where outbreaks identified, contact tracing using LFT tests • Symptomatic patient testing now includes COVID, influenza A, B and RSV where indicated. • Point of care lateral flow testing for patients on day 3, 6 and for outbreak screening. ○ PCR on admission, if symptomatic and discharge to care home ○ All patients are routinely screened on admission and if indicated, isolated until results known.		

completed and it has been approved through local governance procedures, for example Integrated Care Systems. • 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. • 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. • 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. • 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 • there are check and challenge opportunities by the executive/senior leadership teams of IPC practice in both clinical and non-clinical areas. • 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). • the application of IPC practices within this guidance is monitored, eg: ○ hand hygiene. ○ PPE donning and doffing training. ○ cleaning and decontamination. • the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board. • the Trust Board has oversight of ongoing outbreaks and action plans. • 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.	• Patients are isolated/cohorted according to results. • MDT approach is in place with estates and facilities. This includes discussions regarding isolation facilities where indicated. • Hierarchy of controls reflected in current risk assessment. • Operational capacity to care for patients are considered as part of the admission criteria and the twice weekly safer staffing reviews, this includes acuity monitoring. • 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 • 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. • All outpatient departments MIU/UTC, clinics and home visits assessed prior to admission/visit • Staff risk assessments in place to support management of staff which was developed as a system. • National guidance has been implemented as published. • Patients only moved if deteriorate and require admission to Acute OR if their infectious status changes • Director level approval of COVID-19 sitreps in place. • The Board and Governors are		

	visible in operational and infrastructure services and are able to challenge as necessary. • There is a monthly audit of performance with IP&C guidance and facilities management. • The IP&C BAF is presented at the quality committee which is reported to each Board meeting. • The Quality Committee receives updates on outbreaks and reports to the board. • Inpatients are screened on admission, day 3 and day 6. • Screening o of symptomatic patients on onset of symptoms and day 3. • Isolated/cohorted until 2 negative results received (flow chart on intranet – and IPC team daily records of all swabs. • Where cohorting is		

	required, all IPC measures implemented, and when 'stepped down' terminal cleans undertaken – evidenced on deep clean checklist • Discharge letters include information on patient results and length of isolation requirements if positive or exposed. All patients screened 48/72 hours prior to discharge if going to care home / vulnerable people at home • IPC team supporting teams, inpatient visits – checklists and monitoring and audits • Reviewed by IPC team on visits – team leads reviewing • Periodic checks by H&S teams through safer space champions. • Mandatory training programme – current compliance 94.4%		

	• Training in place for donning and doffing PPE and COVID information pages on flo • Comms campaign targets hand hygiene, equipment cleaning, spacing and PPE and links to national resources and posters for local print and display • IPC training provided both electronic and face to face where required. Full PPE info on Flo, and posters available • Fit-testing training programme in place on multiple masks for all staff. • All guidance reviewed, discussed at IMM, and changes implemented where required, through internal cascade system, as well as on internal intranet. • Risks highlighted on Datix and discussed through IMM, any high risks, on Trust BAF • All IPC policies remain in date and		

	reviewed within agreed timescales. • Director level approval of COVID-19 sitreps in place. • Outbreak management team is minuted and common themes reported to DIPC and bimonthly to IPCAS. • Overarching data provided to performance team daily, presented through IPCAS and in daily exec sitrep. Reported to Quality committee and to board. • IP&C audit programme in place. Evidence of compliance assessed bi-monthly • Chief Nurse hosts weekly calls with ward Matrons. • Ward huddles and key focus areas include PPE awareness and key risk information. • 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:
• 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.
• the organisation has systems and processes in place to identify and communicate changes in the functionality of areas/rooms
• cleaning standards and frequencies are monitored in clinical and non-clinical areas with actions in place to resolve issues in maintaining a clean environment.
• increased frequency of cleaning should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas.
• 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.
• 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.
• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products.
• a minimum of twice daily cleaning of:
  ○ patient isolation rooms.
  ○ cohort areas.
  ○ Donning & doffing areas
  ○ 'Frequently touched' surfaces eg, door/toilet handles, patient call bells, over bed tables and bed rails.
  ○ where there may be higher environmental contamination rates, including:
	• IPC training updated to incorporate COVID-19 information, donning and doffing, viral swabbing, and face to face fit test training including. Domestic staff have received training, and where appropriate have been fit tested.
	• Non COVID-19 areas cleaned and visited prior to COVID-19 areas.
	• Patient information available and the offer of masks for patients is risk assessed.
	• Terminal clean checklists - utilising Chlorine 1000 ppm in place
	• Implemented – daily cleaning sheets in place and undertaken twice daily if outbreaks are declared.
	• Chlorclean/titan chlorine-based cleaning solutions are in place
	• National cleaning standards are measured and audited in all areas.		

▪ toilets/commodes particularly if patients have diarrhoea. • A terminal/deep clean of inpatient rooms is carried out: ○ following resolutions of symptoms and removal of precautions. ○ when vacated following discharge or transfer (this includes removal and disposal/or laundering of all curtains and bed screens); ○ following an AGP **if room vacated** (clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room). • reusable non-invasive care equipment is decontaminated: ○ between each use. ○ after blood and/or body fluid contamination ○ at regular predefined intervals as part of an equipment cleaning protocol ○ before inspection, servicing, or repair equipment. • Compliance with regular cleaning regimes is monitored including that of reusable patient care equipment. • As part of the Hierarchy of controls assessment: ventilation systems, particularly in, patient care areas (natural or mechanical) meet national recommendations for minimum air changes refer to country specific guidance. In patient Care Health Building Note 04-01: Adult in-patient facilities. • the assessment is carried out in conjunction with organisational estates teams and or specialist advice from ventilation group and or the organisations, authorised engineer. • a systematic review of ventilation and risk assessment is undertaken to support location of patient care areas for respiratory pathways • where possible air is diluted by natural ventilation by opening windows and doors where appropriate • 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. • 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.	• Area cleaned in line with National cleaning standards (April 2021). • Frequent touch areas cleaned as part of daily schedules and in addition when visibly contaminated. • Ward checklist for daily equipment - evidenced on IPC team checklist • Linen and laundry handled in line with national guidance and checked on all observational audits • Where possible equipment is single use • Equipment cleaning protocols in place – evidenced on checklists by IPC team • Monthly audits by facilities and presented at IPCAS • Mechanical ventilation, air flow and air change compliance has been reviewed and is currently subject to discussions with landlords for any remedial works. • Specialist ventilation is in place at QVMH only. Reviewed in line with HTM. Window opening regime in place.		

	• 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.		
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:
• arrangements for antimicrobial stewardship are maintained
• previous antimicrobial history is considered
• the use of antimicrobials is managed and monitored:
  ○ to reduce inappropriate prescribing.
  ○ to ensure patients with infections are treated promptly with correct antibiotic.
• mandatory reporting requirements are adhered to, and boards continue to maintain oversight.
• 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.
	• PGD audit programme in place undertaken by pharmacy.
	• 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.
			• New Antimicrobial Pharmacist in place with focus on audit.
			• Electronic prescribing being rolled out in the next year.

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: • 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 • national guidance on visiting patients in a care setting is implemented. • restrictive visiting may be considered appropriate during outbreaks within inpatient areas This is an organisational decision following a risk assessment. • there is clearly displayed, written information available to prompt patients' visitors and staff to comply with handwashing, wearing of facemask/face covering and physical distancing. • 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. • visitors with respiratory symptoms should not be permitted to enter a care 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. • visitors are not present during AGPs on infectious patients unless they are considered essential following a risk assessment eg, carer/parent/guardian. 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)	• Guidance on Intranet, reflect national guidance. This has been updated on flo in response to recent updated in guidance in June 2022. • All patients in inpatient units cohorted or in side-rooms as per IP&C guidance. In non-inpatient areas, specific rooms / streaming in place for segregation of potential symptomatic / non-symptomatic patients, and SOP's in local services for this • Available on Internet and Intranet – easy read version in process for most information • Patients and visitors accessing our buildings are asked to wear PPE based on a local risk assessment • Discharge and transfer information identifies COVID-19 status and date of swab. • Patient information leaflets for patients able to read, visual posters from PHE for		

	those who are unable to. • 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: • 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. • 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. • staff are aware of agreed template for screening questions to ask. • 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. • 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. • 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. • there is evidence of compliance with routine patient testing protocols in line with trust approved hierarchies of control risk assessment and approved. • 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. • patients with respiratory symptoms are assessed in a segregated area,	• All services have triage questions and SOPs in place • 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). • Triage questions at entrance to hospitals / services / prior to domiciliary visits • Services have own questions – based on national triage form • Initial triage for allocation of waiting room etc. undertaken by receptionist – clinical staff triage in MIU/UTC as		

ideally a single room, and away from other patients pending their test result. • patients with excessive cough and sputum production are prioritised for placement in single rooms whilst awaiting testing. • 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 families and carers accompanying them for treatments/procedures must be considered. • where treatment is not urgent consider delaying this until resolution of symptoms providing this does not impact negatively on patient outcomes. • face masks/coverings are worn by staff and patients in all health and care facilities. • where infectious respiratory patients are cared for physical distancing remains at 2 metres distance. • 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. • patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly. • isolation, testing and instigation of contact tracing is achieved for all patients with new-onset symptoms, until proven negative. • patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately.	appropriate • All staff has an individual COVID risk assessment completed. This is updated when any changes occur for the individual or / and annually. • Staff wear FFP3 masks when caring for suspected or confirmed COVID patients and when a ward is in outbreak. • TIIR masks are work based on an IP&C risk assessment for all other patients or if they chose to. • Patients are encouraged by staff to wear face masks when mobilising around the ward where appropriate. • All relevant patients are requested to wear masks when unable to socially distance, and when not detrimental to health or care. Posters and leaflets available to encourage this. • Patient information leaflet (for those that can read) Poster visual prompts • All receptions have Perspex screens, high		

	risk patient in urgent care settings do not wait –they are escorted to identified rooms for immediate assessment • Inpatients are screened using PCR on admission and at onset of symptoms, and LFT on day 3 and 6. Patients are isolated / cohorted until 2 negative results received (flow chart on intranet – and IPC team daily records of all swabs. • Direct admissions are Isolated at assessment as required • 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, and visitors. • 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. • 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; • adherence to national guidance on the use of PPE is regularly audited with	• Full IP&C guidance on Flo, shared through communication channels. • IPC training continues, Fit-testing continues, records held centrally by EWD and reported biweekly to IPC team		

actions in place to mitigate any identified risk. • gloves are worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or in line with SICP's and TBP's. • 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. • staff maintaining physical and social distancing of 1 metre or greater wherever possible in theworkplace • staff understand the requirements for uniform laundering where this is not provided for onsite. • 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. • to monitor compliance and reporting for asymptomatic staff testing • 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). • 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.	• Dedicated fit tester in place who maintains compliance on multiple masks. • PPE not re-used unless re-usable or sessional • Decontamination options available (visors) • COVID-19 Datix reporting in place • IPC team visit wards and complete feedback and checklists twice per month • 6 steps hand hygiene posters, respiratory hygiene posters. PPE poster prompts in place • Documented cleaning checked in IPC audits / checklists • 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 • Hand air-dryers in non-clinical areas (offices) have these,		

	none in clinical settings • Posters / soap dispensers have hand hygiene technique in toilets and bathrooms • Staff guidance on intranet and policy for uniform laundering • Staff testing available through LFT and symptoms displayed throughout comms and intranet, updated when nationally updated • 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. • 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: • that clear advice is provided, and monitoring is carried out of inpatients	• Confirmed COVID-19 bays / rooms on inpatients units	• Limited single rooms in some settings	• Non COVID-19 areas cleaned and

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. • 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. • 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. • patients are appropriately placed ie, infectious patients in isolation or cohorts. • 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). • 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 • the principles of SICPs and TBPs continued to be applied when caring for the deceased	identified by isolation posters. MIU's UTC's identified 'Hot' rooms and routes through which patients enter • Cohorts / rooms in inpatient wards, in out-patients areas zoning as appropriate with identified rooms for COVID-19 positive or symptomatic people • 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) • IPC team review placement daily with clinical staff • Policy for caring for the deceased in place and available on flo which includes COVID positive patients.		visited prior to COVID-19 areas. • Lateral flow testing in place for staff twice weekly. • Zoning, identified hot rooms, SOP's for flow SOP's for cleaning if high risk patients attend. • Single rooms prioritised, and cohorting of patients implemented. • 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: • testing is undertaken by competent and trained individuals. • patient testing for all respiratory viruses testing is undertaken promptly and in line with national guidance; • staff testing protocols are in place • 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. • there is regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data). • screening for other potential infections takes place. • that all emergency patients are tested for COVID-19 and other respiratory infections as appropriate on admission. • that those inpatients who go on to develop symptoms of respiratory infection/COVID-19 after admission are retested at the point symptoms arise. • 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. • that sites with high nosocomial rates should consider testing COVID-19 negative patients daily. • 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. • 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 • 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 on admission and processed by external laboratories. No delays in results. • Staff shown and given instructions how to swab • Lateral flow testing in place for staff • Daily reporting of staff positive cases via IMM and for executive sitrep. • MRSA, CDI and UTI/CAUTI protocols in place. • All screening protocols implemented, and audited outbreak screening discussed at outbreak meetings • Swabs taken, and results chased and checked 3 times daily by IPC team • IPC team review results, and chase labs if delays of > 48 hours. • Specialist clinical advice is available from both Acute trusts via clinical microbiologists/virologists. ○ All patients are routinely screened on admission and if		

	indicated, isolated until results known. • Discharge letters include information on patient results and length of isolation requirements if positive or exposed. All patients screened 48/72 hours prior to discharge if going to care home / vulnerable people at home • Elective Podiatric surgery - 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 • 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 contractors). • staff are supported in adhering to all IPC policies, including those for other alert organisms. • safe spaces for staff break areas/changing facilities are provided. • 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. • all clinical waste and linen/laundry related to confirmed or suspected COVID-	• Checklist and audit by IPC team, data reporting for alert organisms • All Guidance reviewed daily, and updated when national changes occur within 24-48 hours. Immediate risks are communicated vis Flo • Dedicated PPE team in place to manage		

19 cases is handled, stored and managed in accordance with current national guidance. • PPE stock is appropriately stored and accessible to staff who require it.	stock and logistics. • Stocks of correct PPE available, information on stock levels reported via Flo for staff. Stored within multiple locations/hubs for ease of access. • Waste audit in place compliant with national guidance. • 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: • staff seek advice when required from their IPCT/occupational health department/GP or employer as per their local policy. • bank, agency, and locum staff follow the same deployment advice as permanent staff. • 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) • staff understand and are adequately trained in safe systems of working, including donning, and doffing of PPE. • a fit testing programme is in place for those who may need to wear respiratory protection. • where there has been a breach in infection control procedures staff are reviewed by occupational health. Who will: • lead on the implementation of systems to monitor for illness and	• Managerial support, OH only for management referrals, not routine OH monitoring, contact tracing for COVID-19 or COVID vaccination. • Individual risk assessments completed for ALL staff, including those in at risk groups • Risk assessments undertaken and completed for ALL BAME and pregnant staff. Updated guidance communicated to managers via		

absence. ○ facilitate access of staff to antiviral treatment where necessary and implement a vaccination programme for the healthcare workforce ○ lead on the implementation of systems to monitor staff illness, absence and vaccination against seasonal influenza and COVID-19 ○ encourage staff vaccine uptake. • 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. • 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. ○ A discussion is had with employees who are in the at-risk groups, including those who are pregnant and specific ethnic minority groups; ○ that advice is available to all health and social care staff, including specific advice to those at risk from complications. ○ Bank, agency, and locum staff who fall into these categories should follow the same deployment advice as permanent staff. ○ A risk assessment is required for health and social care staff at high risk of complications, including pregnant staff. • vaccination and testing policies are in place as advised by occupational health/public health. • 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. • staff who carry out fit test training are trained and competent to do so. • 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. • all staff required to wear an FFP3 respirator should be fit tested to use at least two different masks • a record of the fit test and result is given to and kept by the trainee and centrally within the organisation. • 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. • that where fit testing fails, suitable alternative equipment is provided.	Infrastructure divisional meeting. • Fit-testing in place – recorded through EWD • Trained dedicated fit-testers through fit-test programme utilising approved resources and competency assessments. • Portacount training by company rep and Fit – to – FIT company completed and two machines purchased. • Fit-test results reported and recorded locally and centrally. • Since Nov 2020 all staff trained on multiple masks, as per resilience principles, to enable choice and responsiveness to changes in push stock. • HR processes in place ensure risk assessments are acted upon to limit occupational exposure to COVID-19. • Voluntary staff vaccination programme in place for COVID and Flu with uptake reported to Board and committees. • IPC team report numbers of staff fit-		

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. • 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. • 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. • 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. • 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. • 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. • staff absence and well-being are monitored and staff who are self -isolating are supported and able to access testing. • staff who test positive have adequate information and support to aid their recovery and return to work.	tested in PSCRG report monthly • Guidance information on Flo, shared internally, implemented through SOP's and challenged on IPC team walkabouts, and H&S walkabouts • E-roster reporting tool in place. HR policy on Flo for testing through national portal • Lateral flow testing in place for staff twice weekly.		

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	2.3
Agenda Item Title:	Audit and Risk Committee Chair's Assurance Report
Presenting Officer:	Peter Conway, Chair of Audit and Risk Committee
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

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

A verbal report is given this month to the Board due to the Audit and Risk Committee meeting after the Board papers had been published.

The verbal report summarises the Audit and Risk Committee meeting held on 1 September 2022 and provides assurance to the Board.

Summary of key points

The September meeting covered a range of topics including the board assurance framework, updates from internal audit and the local counter fraud officer, the 2021/22 auditors annual report, cyber security report, legal report update, the standards of business conduct annual report, use of the Trust seal annual report, self-certification of the NHS Provider Licence annual compliance report, the corporate assurance and risk management group report, the health and safety and security management summary report, the estates risk register, director of finance report, losses and special payments including debt write off assurance, single tender waivers and retrospective requisitions report.

Proposal and/or recommendation to the Committee or Board

The Board is asked to receive the verbal Audit and Risk Committee Chair's Assurance Report.

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

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

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	2.4
Agenda Item Title:	Charitable Funds Committee Chair's Assurance Report and Minutes
Presenting Officer:	Paul Butler, Deputy Chair of Charitable Funds Committee
Action – this paper is for:	☐ Decision ☒ Information ☒ Assurance

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

The paper summarise the Charitable Funds Committee meeting held on 21 July 2022 and includes the confirmed minutes of the meeting held on 29 April 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? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo* **If not, describe any equality and diversity issues that may be relevant.** *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	☐ Yes *(please attach)* ☒ No *(please provide a summary of the protected characteristic*

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

Name:	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 21 July 2022.

Agenda item	Assurance and key points to note	Further actions and follow up
Q1 Finance Update	Members discussed a paper clarifying details on the recent £120,000 legacy. Confirmation was provided that the legacy could be added to the general fund.	The fund was available through the normal processes of application and allocation.
Marketing Report	A report was shared on an understanding to heighten the purpose, practices and benefits of the Committee and the objective to disseminate funds.	An undertaking to broaden the marketing message to include staff networks was agreed.
Reserves Policy	Discussion on appropriate levels of reserves.	Guidance sought based on positive discussion.
Cost of Living Support	An extended Any Other Business discussion led to consensus on a number of critical actions.	• Agreement in principle to a capped hardship fund to be administered through the Committee. • A members meeting (prior to the next Committee meeting in November 2022)

Agenda item	Assurance and key points to note	Further actions and follow up
		for key individuals to share thoughts on how such a hardship fund might work. • A paper to be drawn up for the Trust Executive Team approval to structure how the hardship fund might work in conjunction with all other measures under consideration supporting colleagues through the cost of living crisis. •

Nigel Turner. Chair of Charitable Funds Committee
Non-Executive Director
21 July 2022

Kent Community Health NHS Foundation Trust

CONFIRMED Minutes of the Charitable Funds Committee meeting held on Friday 29 April 2022
The Boardroom, The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT and via Microsoft Teams

Present: Nigel Turner Non-Executive Director (Chair)
Paul Butler, Non-Executive Director
Ruth Davies, Public Governor, Tonbridge and Malling
Victoria Robinson-Collins, Director of People and Organisational Development
Dr Mercia Spare, Chief Nurse

In Attendance: Jo Bing, Assistant Financial Accountant
Victoria Cover, Head of Clinical Services Urgent Care & Hospitals (agenda item 2.5)
Fleur Cromarty, Head of Estates Capital Projects (agenda item 2.3)
Gill Jacobs, Acting Director of Finance
Clare Thomas, Community Services Director (agenda item 2.5)
Jo Treharne, Head of Campaigns and Digital (agenda item 2.4)
Carl Williams, Head of Financial Accounting
Helen Grogan, Executive Assistant (minute-taker)

007/22 Welcome and apologies for absence

Nigel Turner welcomed everyone present to the meeting of the Charitable Funds Committee.

Apologies were received from Gina Baines, Committee Secretary; Pauline Butterworth, Chief Operating Officer and Dr Razia Shariff, Non-Executive Director.

The meeting was quorate.

008/22 Declarations of interest

There were no declarations of interest given.

009/22 Minutes of the previous meeting held on 20 January 2022

The minutes were read for accuracy.

The Minutes were **AGREED**.

010/22 Matters Arising of the meeting of 20 January 2022

The Matters Arising Table Actions Closed was agreed.

The outstanding open actions were discussed and updated as follows:

025/21 Any Other Business – Action closed.
034/2020 Mermikides Fund Update (project costs) – Action closed.
020/21 Charitable Funds Marketing Report (Talking Together peer support group) – Action closed.

011/22 Board Assurance Framework (BAF)

Mercia Spare presented the report to the Committee for assurance.

Mercia Spare introduced the BAF and confirmed that no specific risks within the framework were overseen by the Charitable Funds Committee. She explained that the document was reviewed and updated each month.

Paul Butler suggested that there should be a risk assessment for the Charitable Funds Committee to look at key risks at a lower level. The Committee agreed to include this suggestion on the agenda for the July Committee meeting for further discussion.
Action – Mercia Spare

The Committee **NOTED** the Board Assurance Framework.

012/22 Annual Statement for 2021/22

Jo Bing presented the report to the Committee for assurance.

Jo Bing gave an overview of the document, sharing that there had been £139k of income during that year, including £120k left as a legacy in a will which had been added to general funds. Donations had totalled £17k with £2k gained in interest. Expenditure of £93k was noted, with £34k allocated to staff and £39k to patients.

In response to a comment from Paul Butler regarding the most recent legacy of £120k, Jo Bing explained that there had been no restrictions for use in the will and that it had been requested ‘for the benefit of Kent Community Health NHS Foundation Trust (the Trust)’. It was suggested that a paper be brought to the Committee to approve the money going into general funds and where it might need to be spent, as well as the background of why the donation had been made which might assist in deciding how it should be

used. It was agreed that Gill Jacobs would draft a report for the July meeting.
Action – Gill Jacobs

Jo Treharne agreed to prepare the publicity around the donation. Mercia Spare noted that the donation should be marked, as with previous donations, for example with a plaque.

The Committee discussed whether the money would begin to be spent before the next meeting in July and it was agreed that Gill Jacobs and Jo Bing would investigate this promptly.
Action – Gill Jacobs / Jo Bing

Ruth Davies asked how the patient and staff allocations had been spent. Jo Bing explained that the staff had had the Team Treat scheme, health and wellbeing vouchers for £10 each and the Staff Awards. Patients had benefitted from the purchase of a Fun to Go bike for disabled patients. Victoria Robinson-Collins added that garden furniture and staff relaxation rooms were lasting resources which would be enjoyed for longer periods.

Ruth Davies asked for general induction advice for new committee members and Nigel Turner suggested that a Teams call be arranged for Committee members to receive a briefing. Gina Baines would be asked to make the necessary arrangements.
Action – Gina Baines

The Committee **NOTED** the Annual Statement for 2021/22.

013/22

2021/22 Quarter Four Finance Update

Jo Bing presented the report to the Committee for assurance.

It was reported that there had been a fundraising event at Hever Castle which had generated £7,700. The report contained a summary of spending.

The Committee **NOTED** the 2021/22 Quarter Four Finance Update.

014/22

Heron Ward (Queen Victoria Memorial Hospital, Herne Bay) refurbishment

Fleur Cromarty joined the meeting to present a verbal report to the Committee for assurance.

The building that housed Heron Ward had lacked investment over the previous five to ten years before recently becoming Trust property. Plans included both physical and wellbeing improvements for patients and staff which were to be covered by charitable funds.

The total costs and fees for all improvements would be £979k with £215k plus VAT and fees coming from charitable funds. These funds would be allocated for sensory garden upgrades such as ramps and raised beds for accessibility as well as security for the garden. Also included would be bed-head televisions for patients and automated doors to the gardens. The Mermikides donation would be used towards this and Jo Bing explained that the use of unrestricted funds would be authorised by fund managers.

Another improvement, not covered by charitable funds, would be doors from three single-bedrooms allowing for views of the gardens to be enjoyed. This would be funded by the capital plan if there was no donation secured by the hospital's League of Friends.

Paul Butler asked for an explanation of where funds had come from and whether any costs or overheads could be borne by wider Trust funds. Fleur Cromarty explained that the overheads had been apportioned appropriately within other works also being carried out by the contractors and that money in the capital plan was already fully allocated to longstanding issues on the site before it became Trust property. Gill Jacobs agreed that funds had been allocated appropriately.

Fleur Cromarty explained that the overall scheme would cost £80k which was more than the budget available This had been funded through VAT reclaimed on this and the capital claim.

Mercia Spare noted that it would be helpful if Fleur Cromarty could circulate a brief paper giving the breakdown of costs. Fleur Cromarty confirmed that this information was available and she would circulate it to the Committee.
Action – Fleur Cromarty

The Committee **NOTED** the Heron Ward (Queen Victoria Memorial Hospital, Herne Bay) refurbishment report.

015/22

Charitable Funds Marketing Report

Jo Treharne presented the report to the Committee for information and assurance.

The Comms and Marketing report for i care January to March 2022 was presented. The 'Gift of Play' appeal, which was ongoing always received an additional push at Christmas. The appeal allowed people to buy items needed by the Children's Therapy Team for children's improvement via a wish list on Amazon. Also, of note was the Fun to Go Bike, which disabled patients could use to access occupational therapy.

Jo Treharne noted the refurbishment work at Heron Ward, which would be followed as work progressed for future articles. It was explained that there was a standing item to have at least one i care article in every magazine issue as well as promoting these internally via Flomail. This could be ad-hoc but the team was reactive to news as it became available.

Mercia Spare noted that the staff on Heron Ward had shared their excitement that the work was taking place to bring improvements to how the space would be used. The ward would be dementia friendly with better staff spaces and enhancements which would benefit all users.

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

016/22

Bid ideas for 2022/23

Fund managers were invited to update the Committee on spending plans and ideas.

Victoria Robinson-Collins advised that a bid for the Staff Awards and Long Service Awards had been received and approved. She explained that there had also been some requests for garden furniture and improvements to staff rest spaces which would be considered within the context of what teams and areas had/had not previously received. She added that funding per head was a very modest amount.

Gill Jacobs shared that the general funds had reached a sizeable amount but similar consideration needed to be given to how best to use the funds. She noted that cost of living issues raised the question of what people would value most at the current time and Victoria Robinson-Collins added that it was important to be aware of any unintended consequences from spending.

Victoria Cover stressed that donations should be spent and suggested that the Matrons be asked for ideas. She mentioned the ‘Cobot’ which aided the manual handling of patients and could be provided to all sites for the benefit of both patients and staff. She added that when the Heron Ward refurbishment was complete it would have ten new stroke beds in a specialist stroke ward. A bid would be put in for specialist stroke gym equipment.

It was noted that the addition of tea, coffee, sugar and milk to all sites had made a huge difference to staff when introduced and the suggestion of adding fresh fruit boxes for staff to benefit from could be well received as some lower-banded staff were already struggling to feed their families. Mercia Spare responded that staff should be asked what would make the biggest difference rather

than assumptions being made, but added that a neighbouring trust had sent their staff a goodies box. Jo Treharne added that staff had previously been asked for ideas but a further survey could be undertaken.

Nigel Turner asked whether it was appropriate to use the new donation as a starting point to ask staff how best to help with the cost of living crisis. Jo Treharne explained that a hardship fund had been suggested previously but it had been undecided how best to judge needs. Mercia noted that this would be for the Trust and not the Charitable Funds Committee to address.

Mercia Spare reported that she had spoken to the Matrons about the OMI Interactive System and they had confirmed their interest to purchase this item for their own hospitals. Mercia also noted that the dementia boards in the hospitals were in a poor condition and would benefit from an upgrade.

Ruth Davies commented that the Staff Survey had shown that 53 per cent of respondents did not feel valued by the Trust as an organisation which would need to be addressed at a Board level. She suggested that it could be put forward that staff who wished to, could donate their £10 per-head allocation to the Hardship Fund, if they felt they did not need it themselves, as an example.

It was clarified to the Committee that fund managers were empowered to take plans forward with managers agreeing that they were. Nigel Turner noted that the cost of living issue was getting more severe month by month and any ideas to alleviate the problem for staff should be shared with the Board.

017/22

Forward Plan

Nigel Turner presented the report to the Committee for approval.

The Committee **APPROVED** the Forward Plan.

018/22

Terms of Reference Review

Nigel Turner presented the report to the Committee for approval.

The Committee **APPROVED** the Terms of Reference.

[Post – meeting: The terms of reference were amended to reflect the new committee membership from 1 April as agreed by the Board in March 2022.]

019/22 **Any Other Business**

Victoria Cover raised the issue of the funding of project overheads as Tonbridge Community Hospital's sensory garden plan had had a bid of £118k but £10k had been taken for overheads including administration charges. It was explained that these charges were apportioned according to the size of the funds and recharged to the Charitable Fund. Nigel Turner suggested that a paper setting out the rationale be brought to the next meeting. Paul Butler commented that no budget for Charitable Funds should be used for other costs as bids and time taken to utilise funds could result in a disproportionate amount being charged to overheads. Carl Williams agreed that he would prepare a paper for the next meeting with a view to putting an agreement in place this year. It was suggested that Auditor costs should also be included.
Action – Carl Williams

Gill Jacobs left the meeting.

Paul Butler requested for a copy of the previous years' accounts to be forwarded to him. Carl Williams would action this request.
Action – Carl Williams.

The meeting closed at 10.36am.

Date and time of next meeting

21 July 2022 at 12 noon in The Boardroom at The Oast, Hermitage Court, Hermitage Lane, Barming, Maidstone ME16 9NT and via Microsoft Teams.

NHS
Kent Community Health
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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	2.5
Agenda Item Title:	Finance, Business and Investment Committee Chair's Assurance Report
Presenting Officer:	Paul Butler, Chair of Finance, Business and Investment Committee
Action – this paper is for:	☐ Decision ☒ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
The papers summarise the Finance, Business and Investment Committee meetings held on 17 June and 21 July 2022 and provides assurance to the Board.

Summary of key points

The June meeting covered a range of topics including the board assurance framework, how the Trust chooses its commercial partners, business development and service improvement report; the finance report including an update on the cost improvement programme, service line reporting and the revised 2022/23 financial plan; how service transformation drives the cost improvement programme strategy, and the estates strategy.

The July meeting covered a range of topics including the board assurance framework, business development and service improvement report, Dental Services future growth plans; the finance report including an update on the cost improvement programme and service line reporting; the Treasury Management Policy, and service line and reference costs for community hospitals.

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?	☐ Yes *(please attach)*

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

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

Kent Community Health
NHS Foundation Trust

FINANCE, BUSINESS AND INVESTMENT COMMITTEE CHAIR'S ASSURANCE REPORT

This report is based on the Finance, Business and Investment Committee meeting held on Friday 17 June 2022.

Issue	Committee review and assurance	Matters for Board awareness and/or action
Board Assurance Framework	Latest report was presented and noted	
How KCHFT chooses commercial partners	At the request of the Audit and Risk Committee, a paper on the Trust's approach to the selection of commercial partners was presented. The issue regarding non-tenders was discussed and it was agreed that all cases should be referred to the Finance, Business and Investment Committee going forward.	
Business development and service improvement report	The latest report was presented and noted.	

Issue	Committee review and assurance	Matters for Board awareness and/or action
Finance report including service line and cost improvement programme (CIP) (2/12)	The latest report was presented and noted.	
Revised 2022/23 financial plan	The amended budget was presented.	
How service transformation drives the cost improvement programme strategy	A paper setting out the need to consider the CIP across multiple years was presented. The paper also set out an approach to be adopted and the need for a blended approach of an 'in year' and multiple year' efficiency programme.	The Committee supported the need to move the CIP to a multi-year programme of efficiencies to ensure sustainability and effectiveness of the programme. The Committee requested that the approach was presented to the Board as soon as possible.
Estates Strategy	The revised Estates plan for 2022/3 -2024/25 was presented. There was an extensive discussion on its content. Further recommendations were made on the inclusion of additional background/status information.	

Issue	Committee review and assurance	Matters for Board awareness and/or action
	The Committee supported the plan for onward presentation to the Board and offered support to review the next iteration of the plan in advance of its submission to the Board.	

Paul Butler, Chair of the Finance, Business and Investment Committee
Non-Executive Director
18 June 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 Thursday 21 July 2022.

Issue	Committee review and assurance	Matters for Board awareness and/or action
Board Assurance Framework	The latest report was presented and noted.	
Focus items	Mr Flack, Director of Finance/Deputy Chief Executive presented a paper on the new commercial strategy for the NHS with regard to central procurement and the planned establishment of a 'central commercial function' and new service offerings. The paper was noted and the Committee would be advised of developments and its impact on the Trust in subsequent briefings.	
Business development and service improvement report	The latest report was presented and noted.	

Issue	Committee review and assurance	Matters for Board awareness and/or action
Dental services future growth plans	At the request of the Board, the Committee received a paper setting out the current provision of dental services and the possible future for those services. The paper was for information and would input into the wider discussion to be had by the Board on future service provision by the Trust in the new system structure of NHS. There was considerable discussion at the Committee regarding issues raised by a very informative paper; all of which should feed into Board discussion. It was noted that an executive proposal on the future of the New Street Dental Practice should be made and potentially approved by the Board, separate to longer term strategic discussions.	The Committee felt that the decision on future of this practice should be made. (The Committee would suggest this could be achieved before the end of this financial year).
Finance report including service line and cost improvement programme (3/12)	The latest report was presented and noted. The impact of the announced pay award was discussed which would result in an amendment to the budget in due course.	The executive was encouraged to ensure the Board was updated on issues arising from the pay award. The next formal occasion would be the September Board meeting.

Issue	Committee review and assurance	Matters for Board awareness and/or action
Treasury management policy and compliance review	The paper confirmed compliance with the policy for the last twelve months. There had been no change to the policy submitted and reapproval was granted.	
Service line and reference costs - Adult services (community hospitals)	A paper setting out an analysis of deficits in community hospital services was presented. There was an extensive discussion on its content. A strategy to minimise the deficit going forward was currently being prepared and would be submitted to the Committee for review once it had been signed off by the executive team. This should be in the autumn.	
Committee effectiveness	The proforma for the submission of comments on committee effectiveness was included. All members were asked to reply in due course.	

Paul Butler, Chair of the Finance, Business and Investment Committee
Non-executive director
23 July 2022

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	2.6
Agenda Item Title:	Quality Committee Chair's Assurance Report
Presenting Officer:	Karen Taylor, Deputy Chair of Quality Committee
Action – this paper is for:	☐ Decision ☒ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
The report summarises the Quality Committee meeting held on 22 July 2022.

Summary of key points

The meeting covered a range of topics including feedback on visits to services made by non-executive directors, the board assurance framework, the infection prevention and control board assurance framework, the monthly quality report, an operational deep dive into service performance, the End of Life Care Strategy, sub-committee chairs' assurance reports, the Learning From Deaths Report, an update on Thanet Long Term Services and Quality Improvement clinic, the Director of Infection Prevention and Control (DIPC) Annual Report, the Safeguarding Annual Report and Declaration, the Complaints Annual Report, and the Medicines Optimisation Report.

Proposal and/or recommendation to the Committee or Board

The Board is asked to receive the Quality Committee chair's assurance report.

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

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:	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 is founded on the Quality Committee meeting held on 22 July 2022.

Agenda item	Assurance and key points to note	Further actions and follow up
Feedback from Services	Karen Taylor and Pippa Barber, non-executive directors (NEDs), had visited the Podiatry Service at Sevenoaks Hospital and Tonbridge Community Hospital and had been impressed by the enthusiasm of the team and the patient focus. It was identified that there were issues with a lack of space at Sevenoaks and Tonbridge, both of which are being considered by the team. Patients seen were complimentary about their wait-time, however it was noted that those who were not considered urgent with wounds on the waiting list, are waiting for much longer and the team is having discussions with the commissioners about this and criteria for the service.	
Board Assurance Framework	The Committee discussed Risk 123, multi-agency discharges, and the numbers of beds. Assurance was received that as part of the planning process the Trust is	The executives will have further discussions about whether this will be included in the winter planning update to the Board at a future date.

Agenda item	Assurance and key points to note	Further actions and follow up
	considering the bed space and the use of it within community hospitals.	
Infection Prevention and Control Board Assurance Framework	The Committee received the latest infection prevention and control board assurance framework. It was noted that signage was required in public areas giving advice if visitors had respiratory infections and assurance was received that signage is in place and this will be added to the Board Assurance Framework. Screening questions, as per national guidance, are also being undertaken with visitors.	
Update on legislation/regulations	The Care Quality Commission has published a new approach towards inspections.	The Committee will receive a paper at its next meeting which will outline the changes to the inspection procedure and what it would mean for the Trust.
Monthly Quality Report	The Committee received assurance on the actions in place to support the deteriorating patient which had been identified as a recent theme from the serious incident report. Medical devices were now managed through a new single contract. A considerable amount of work had been	The Committee will continue to track compliance through a quarterly report in order to monitor progress against key targets

Agenda item	Assurance and key points to note	Further actions and follow up
	done with additional funding to reconcile the devices with the Trust's asset management log which the executive team was now confident was accurate. Servicing of devices through one provider had also made tracking easier. Compliance was on target.	
Operational Deep Dive	An update on the Sexual Health Services prison clinic waiting times was presented along with an update on compliance with the two-hour urgent community response. The Committee also had the opportunity to hear more around inequalities data and its use to support waiting lists actions. The waiting times in the prison clinics are within the18 week waiting time target with the exception of HMP Rochester. A risk has been added to the risk register with control measures in place. For the urgent care response service, the intention is that the east Kent model will move closer to reflecting that in west Kent so that there is greater harmony across the system. It is likely that, with the introduction of the Virtual Ward, this will help the services to deliver the two-hour response more consistently. However, to achieve this, it will be important that staff feel that they own the process.	The Committee will receive a further update on the Sexual Health Services prison clinic waiting times at its meeting in September. The Committee has asked for further clarity around the timescale for harmonising the Home Treatment Service in West Kent and the Rapid Response services in east Kent.

Agenda item	Assurance and key points to note	Further actions and follow up
	The Trust's Health Inequalities Steering Group has begun to meet regularly and Dr Razia Shariff, a member of the Quality Committee, is a member of the group. A considerable amount of data and the necessary skill set to analyse the data effectively will be needed in order for any meaningful work to be done around inequalities and ethnicity and the delivery of services. This is being put in place.	
End of Life Care Strategy	The strategy was approved by the Committee and Karen Taylor was invited to join the Trust's End of Life Care Steering Group.	Further thought is to be given on outcome measures at the end of the three years.
Patient Safety and Clinical Risk Group Chair's Assurance Report	The staffing levels in the Safeguarding Team had been highlighted as a risk due to the high level of vacancies and bank hours the team had been using. However, recruitment was in progress and the risk was reducing such that it had been removed from the team's risk register. The Ventilation Safety Group had reconvened and assurance was given it would be meeting regularly.	

Agenda item	Assurance and key points to note	Further actions and follow up
Patient and Carer Council Chair's Report	The council was undertaking a considerable amount of proactive engagement with volunteers and carers from the ethnic communities, groups representing those with protected characteristics and individuals from deprived communities in order to increase the diversity of the council and to hear their voices. There was particular focus on encouraging young volunteers to come forward including those from the black, Asian and minority ethnic community and those with a disability.	Further work is being undertaken on the triangulation of complaints, Serious Incidents and impact and this will be reported back to the Committee.
Learning from Deaths Report	The Committee received the Quarter One report (April to June 2022) which included the Learning Disabilities Mortality Review which reported on deaths October to December 2021 and was assured that no deaths were judged more likely than not to have been due to problems in care.	
We Care Report	Equality, diversity and inclusion data was now included in the pre-visit packs and questions had been developed for staff, patients and leaders.	
Thanet Long Term Services and Quality	The Committee received an update on the work that was being undertaken with the Thanet Long Term Services team. Because of the ongoing challenges that the team	The Committee will receive an update on progress at its November meeting.

Agenda item	Assurance and key points to note	Further actions and follow up
Improvement (QI) clinic update	had been facing, considerable investment was being made to support them through a Quality Improvement approach. There would be monthly meetings to share learning and for the teams to then report back progress through the executive performance reviews.	
Director of Infection Prevention and Control (DIPC) Annual Report.	The Committee received the report for assurance and thanked the team. The Committee noted the team's successes in 2021/22 and the huge amount of work that it had undertaken throughout the year.	
Safeguarding Annual Report and Declaration	The Committee received the report for assurance and thanked the team. The Committee noted the significant amount of work that the team had completed over the year.	
Complaints Annual Report	The Committee received the report for assurance and thanked the team. The same report had been received by the Council of Governors on 20 July 2022.	
Medicines Optimisation Report	The report provided assurance to the Committee on the Medicines Optimisation sub-committee oversight of the management of medicines in the Trust.	Further updates will be provided to the Committee on controlled drugs oversight in community hospitals and pharmacy input into the minor injuries unit.

Agenda item	Assurance and key points to note	Further actions and follow up
Quality Impact Assessments of the Cost Improvement Programme schemes (2022/23)	A number of schemes were presented to the Committee that had recently been approved by the Executive Team. They all appeared low risk and were supported.	Further updates will be provided on staff experience, which falls under scheme CS0105 for public health.

Pippa Barber, Chair of Quality Committee
Non-executive director
August 2022

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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 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 ☒ Information ☒ Assurance

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

The report summarises the Strategic Workforce Committee meeting held on 20 June 2022. A verbal report is also given on the Committee meeting held on 1 September 2022.

Summary of key points

A range of topics was discussed at the meetings including recruitment for facilities staff, succession planning, an update on work on equality, diversity and inclusion; and retention. The Committee also received a staff network story.

Proposal and/or recommendation to the Committee or Board

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

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

Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.	*(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in 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 20 June 2022.

Agenda items	Notes	Assurance status. Actions and follow up
• Recruitment – Facilities and assessment centres • Succession planning • Deep dive into exceptions • Draft workforce hotspot reports • Equality, diversity and inclusion (EDI) update • Staff Survey update • Retention • For noting – Workforce Performance Report	The Committee has adapted its emphasis to that of assurance, priorities and exception reporting. The two Board Assurance Framework risks sitting at 20 should remain at that significant risk level until more progress is made to reduce the risk. Positive news that the turnover rate is continuing to slow over the last three months. Vacancies are sitting at a high level due in part to 80 plus additional posts included in the establishment which need to be filled.	Assurance was reached against all agenda items. Further details are set out below by exception. Workforce metrics to be RAG rated.

Agenda items	Notes	Assurance status. Actions and follow up
Recruitment – Facilities and assessment centres	Facilities – a deep dive was conducted. A task and finish group is progressing actions. Assessment centres – issues raised by Staff Governors are fully addressed in the paper.	Both significant assurance. ACTION – The paper to be shared with Staff Governors.
Succession planning	Immediate actions and direction of travel were endorsed but the Committee suggested that it needed to see the detail of the plan.	Limited assurance in relation to the direction of travel. The plan needs to provide significant assurance. ACTION -On forward plan for October 2022 Committee meeting.
Equality, Diversity and Inclusion (EDI) update	A very positive response to reset and re-engage proposals, understanding that this will have a time commitment and impact if we are to make significant progress.	Assurance received in terms of direction of travel. Limited assurance on progress as it generates a re-set requirement. ACTION - Requires Board development and leadership.
Retention	A key priority that requires holistic oversight of the many and varied levers the organisation needs to pull on.	Limited assurance – work in progress and there is a plan in place, as yet unknown is the level of traction albeit a positive trend in data.

Agenda items	Notes	Assurance status. Actions and follow up
		ACTION – To review data of leavers / age within one to two years' service.
Staff network story	There is continued pressure to resolve national system issues relating to data capture on protected characteristics.	ACTION – Ms Robinson-Collins, Director of People and Organisational Development to continue to raise nationally.

Kim Lowe, Chair of the Strategic Workforce Committee
Non-executive director
20 June 2022

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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 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 ☐ Information ☒ Assurance

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

The report was received by the Quality Committee at its meeting on 22 July 2022.

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 Qualiyt Committee was asked to note Quarter 1's data and learning points described in this report, for assurance. Following submission to the Quality Committee, the report is published on the Trust's public website.

Summary of key points

Mortality review processes has 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 Quality Committee of the evolution of these processes and presents learning and actions from mortality reviews carried out in Quarter 1. Areas for improvement emerging from reviews include advance care planning and missed opportunities to identify end of life, medicines issues, and general documentation and team communication. The age, gender and ethnicity of all patients dying with COVID-19 are now collected and this quarter's data is included in the report although this data set is not of sufficient size or breadth to be statistically significant on its own. All our mortality and ethnicity data feeds into larger national and regional data sets.

All Trust HCAI COVID-19 inpatient deaths will be reviewed in line with national guidance with a focus on generating insights to underpin effective and sustainable improvements in care to reduce future risks to patients and engagement of duty of candour.

Proposal and/or recommendation to the Committee or Board
For Assurance.

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

Name:	Dr Sarah Phillips	Job title:	Medical Director
Telephone number:	07391 861077	Email	sarahphillips4@nhs.net

Kent Community Health
NHS Foundation Trust

Learning from Deaths Report 2022-2023 Quarter 1 (April - June 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 1 2022-2023: Results and Analysis

During Q1 2022-2023, 5 deaths were reported at community inpatient sites. In the previous quarter, Q1 2021-2022, 8 deaths were reported.

Number of Comminity Hospital Inpatient Deaths Reviewed - Including Deaths Occuring <28 days post Transfer of Care (ToC) in Q1								
Number of Inpatient Community Hosptials Deaths			Inpatient Community Hosptials Deaths Reviewed			Number of deaths considered more likely than not due to problems in care		
June	May	April	June	May	April	June	May	April
1	**2**	**3**	**1**	**7**	**8**	**0**	**0**	**0**
Quarter 1	Prev. Quarter 4		Quarter 1	Prev. Quarter 4		Quarter 1	Prev. Quarter 4	
6	**22**		**16**	**18**		**0**	**0**	
Year to Date	Last Year		Year to Date	Last Year		Year to Date	Last Year	
6	**54**		**16**	**60**		**0**	**0**	

Number of Community Hospital Deaths	
East - Deal	4
East – Faversham Cottage Hospital	0
East – Westview	0
East – Whitstable and Tankerton	0
East – Queen Victoria Memorial Hospital	1
West - Edenbridge	1
West - Hawkhurst	0
West - Sevenoaks	0
West - Tonbridge	0
Total	**6**

Community Hospital Inpatient Mortality Data	
Deaths reviewed by Structured Judgement Review (SJR) %	100% (40% completed and closed)
Gender (%) Female Male	60% 40%
Age range (years)	77 - 95
Mean Age (years)	86.6
Ethnicity (%) White British White Irish	80% 20%
Length of stay range (days)	1 - 40
Length of stay mean (days)	17.33
Number of cases where resuscitation documentation not in place at time of death	0
COVID-19 deaths recorded	2
Nosocomial deaths Recorded	0
Cause of Deaths including Frailty and Advanced Frailty	2

During Q1 the coroner was consulted for one death as the patient had a recent fracture. The coroner has concluded and closed the case.

The Medical examiner process was introduced for all community hospitals in East Kent in May 2021. Introduction of the process in West Kent is scheduled for 2022. The Medical Examiner made one recommendation for a structured judgement review for the case mentioned above referred to the coroner. All other inpatient deaths have been continued to be reviewed by the Structured Judgement Review (SJR) process in accordance with Trust policy.

Primary causes of death included; Ischaemic Heart Disease and Coronary Artery Atheroma, Covid 19 Infection, Acute Kidney Injury and Urinary Tract Infection, Aspiration Pneumonia, Covid Pneumonitis and Chronic Obstructive Pulmonary Disease.

No cases reviewed in Q1 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 from May was identified as an unexpected death, the case has been investigated by our Patient Safety team and does not meet the criteria for a Serios Incident and therefore will undergo the normal SJR process.

During Q1 a coroner's inquest for a death in Q2 2021-22 has been concluded, there was no specific learning identified for the Trust.

A score of excellent was given 19 times in cases reviewed in Q1, 48 times the care was rated as good and 13 gradings of adequate were agreed. No cases reviewed in Q1 were judged as poor or very poor for any of the phases of care.

One case from Westview hospital received scores of excellent across all phases of 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	0		11	5
Ongoing Care Phase	0	0	2	11	3
End of Life (EoL) Care Phase	0	0	1	10	5
Overall Care Phase	0	0	5	6	5
Patient record quality	0	0	5	10	1

3. Evidence of Good Practice recognised in Community Hospital reviews

74 elements of good practice have been recorded from the reviews in Q1, with the comments being evenly split between the three phases of care; Admission and Initial Assessment, Ongoing and End of Life Care.

Excellent clinical judgement and reasoning when the patient arrived and staff noted her to be in retention – acted on quickly. Excellent example of documented evidence of care and treatment planning and communication between cardiac nurse, patient, HTS and community nurses prior to admission by cardiac nurse Excellent entry within progress notes by ACP regarding assessment, planning and communication with the patient and family regarding active dying. Excellent documentation including almost fully completed end of life on RIO. Highly compassionate care given to patient and his family addressing physical, emotional and spiritual needs. Good recognition of deterioration to patient's health by ward nurses and person-centred advance care planning initiated. Prompt recognition and good communication with patient's family, with anticipatory medication prescribed and clinical observations stopped, concluded with patient having peaceful death, including keeping family regularly updated.

4. Learning from Mortality Reviews for Community Hospital Deaths

All deaths have been reviewed against the RCP problem categories. Two cases have had problems identified in Q1. The problems have all been shared with the patient safety team and the problems that were concluded as probable harm by the Virtual Mortality Review Panel have been investigated individually by the patient safety team.

Problems in Care and Themes Identified for Learning from Deaths Review in Q4
1. Problems in assessment, investigation of diagnosis Including assessment of pressure ulcer risk, Ventricular Tachycardia (VT) risk, history of falls
• Advanced care planning to be fully reviewed and recorded at assessment.
2. Problems with medication including administration of oxygen
• Holistic assessment of EOL care needs, to fully explore reasons for agitation, consider; pain, terminal decline, constipation, urinary retention, environmental etc? • Consider local HTS/ART team referral to help with medical care at home. • Lack of clarity around the consideration of a Novel Anticoagulants vs Warfarin for bleeding control.

Problems in Care and Themes Identified for Learning from Deaths Review in Q4
2. Problems with medication including administration of oxygen
• Earlier consideration of syringe driver to improve quality of patients last days as PRN medication was used for 6 days in respect of agitation. Decision not to implement a syringe driver until 2 days before the patient died, administering PRN use is suggestive of reactive care rather than pro-active. • Problems with medication - During the ongoing phase pain control was not optimal - Dual prescribing of oxycodone and codeine might have been a barrier of titration and not ideal - no documentation of rationale behind this decision to prescribe both. Increased improvement needed with pain management responses which pt. may have challenged as thoughts of addiction but these may have been explored to achieved good pain management; if these where explored the documentation was not evident. Action: Patient Safety Team Bulletin to be distributed.
3. Problems related to treatment and management plan
• Documentation could have been more robust could have eliminated delay in actioning of plans in TEP. Documentation could be clearer as noted that patient was not expected to die but had proactive JIC meds were prescribed. Action: RTS will complete an in-depth case study of this patient's referral, as referral from the acute was for the #NOF rehab pathway and could potentially have already moved into EoL phase and acute may not have recognised the softer signs. • Ensure EoL care planning recorded on RiO, by completing Last days or My Plan sections. • Problem identified during the ongoing phase of care -TEP not updated and DNAr could have been reviewed. Action: Discussed at the Community Hospital Matrons meeting with the Head of Service confirming this will be a focus going forwards. The End of Life Consultant Nurse meet with hospital matrons to discuss staff feeling confident with the process and the completion of TEPs. • Earlier consideration of Fast Track could may have seen patient in their preferred place for care before dying.
4. Problems with infection management
• Problem with infection management regarding lack of early diagnosis and unable to avoid progression of infection leading lack of End of life recognition. Action: The RTS team aims to challenge referrals where patient could potentially be EoL. Ideally conversations for EoL need to start in the Acute to build confidence in both patient and family.
5. Problems related to invasive procedure
No Improvements Identified
6. Problems in clinical monitoring
• Documentation of assessments and management planning with respect to hydration issues required on RiO in accordance with NICE guidelines for hydration in end of life care. • End of life meds could have been prescribed earlier when dramatic decline noted. Delay in deciding to stop observations. • Decision should have been made whether or not to complete NEWs. Incomplete so unable to score and potentially recognise EOL. • Not recognising EOL - dual approach of dove tailing of active care and EoL care needed. Action: The Community Consultant Geriatrician for West Kent sites has initiated a forum for discussion of cases, to provide support and training for Doctors. The focus of the initial meetings is to work on determining the cut off point for transfer of patients to the acute and balance the benefit to patient.

Problems in Care and Themes Identified for Learning from Deaths Review in Q4
7. Problems in resuscitation following cardiac or respiratory arrest
No Improvements Identified
8. Problems of any other type not fitting other categories
• **Improved documentation –**Clinical evidence of frailty not clearly noted in patient record. Clearer documentation of Fast Track CHC first consideration and action with referral required in order to track progress and record/any delays in Fast Track CHC referrals process are affecting patient outcomes. Clearer documentation needed to better communicate picture of patient and plan for care in case of handovers. Importance of documenting positive actions of decisions not to intervene and why. Ensure documentation on Rio of End of Life and Verification of death. Minor Note: Remember to write out acronyms in full. • **Team communication issues -** Help staff feel empowered stop clinical observations where these are documented as not supporting care management plans at end of life. Missed opportunity to use information gathered from other disciplines to drive patient centred support. • **Patient related communication Issues -** Consideration of spiritual needs/chaplaincy - Holistic assessment could have prompted these conversations. Identify early/as soon as possible the patient's wishes and expectations. To have joint discussion involving patient regarding high risk of further deterioration if transferred home, allowing the patient to be aware of their choices and options. Missed opportunity for patient's high anxiety to allow access to emotional support with family visits. Action: Deputy Chief Nurse to promote awareness to all staff including bank and agency that is patient has high anxiety and is infectious family visits call still be offered for emotional support.

A total of 37 areas of improvement were identified from the 16-community hospital inpatient deaths reviewed during Q1 that have been collated and closed.

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	**Feb-22**	**Mar-22**	**Total 2021-22**	**Apr-22**
Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls			**11**	**1**
Ineffective recognition of end of life	0	0	**8**	1
Issues relating to physical needs	0	0	**3**	0
Problems with medication including administration of oxygen			**39**	**5**
Issues relating to medications and/or symptom control	6	4	**39**	5
Problems related to treatment and management plan			**81**	**3**
Lack of involvement in care decisions	2	1	**7**	0
Lack of respect of patient and family wishes in decision making	0	0	**2**	0
Lack of documentation around capacity and best interests	0	0	**6**	0

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	**Feb-22**	**Mar-22**	**Total 2021-22**	**Apr-22**
Issues relating to Personalised Care Plans and other documentation	5	4	**60**	3
Issues relating to Fast Track and palliative care support	0	0	**6**	0
Problems with infection management	0	0	**3**	**0**
Problems related to invasive procedures	0	0	**0**	**0**
Problems related to clinical monitoring			**7**	**0**
Reversible causes of deterioration not considered/excluded and/or documented	0	0	**7**	0
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			**21**	**1**
Issues relating to emotional, psychological, social, spiritual, cultural and religious needs	1	0	**2**	1
Issues relating to support of families and those important to the dying person	0	1	**6**	0
Patient related communication issues	0	0	**1**	0
Team related communication issues	2	1	**12**	0
No. deaths by month with completed reviews	7	7	**50**	2
Total number of issues arising by month	**16**	**11**	**162**	**10**

5. Community Deaths Mortality Data

Community Mortality Data	
Number of	**Q1**
Community Deaths reported via Datix	24
Community Deaths referred for full SJR	13
Complaints	4
Patient Safety Raised SIs/AAR	1
MEO recommendations for an SJR	0

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.

During Q1 an external SI was concluded for a death in Q2 2021-22 the specific learning for the trust was where One to One care and/or other requirements for a safe transfer of care has been identified (i.e. equipment) on the Rapid Transfer Service referral, the Community Assessment Bed team will send an email to care homes confirming the clinical Hand Over between ward and care home has included consideration of One to One care etc and to ask the care home to confirm if it is

required or not. This learning has been implemented and embedded in the team as a standard process.

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

A total of 49 areas of improvement were identified from the ten community deaths during Q1 that have been collated from reviews closed at the time of report. No cases in Q1 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	**Feb-22**	**Mar-22**	**Total 2021-22**	**Apr-22**
Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls			**23**	
Ineffective recognition of end of life	0	0	**12**	1
Issues relating to physical needs	0	0	**11**	0
Problems with medication including administration of oxygen			**42**	
Issues relating to medications and/or symptom control	5	0	**42**	3
Problems related to treatment and management plan			**90**	
Lack of involvement in care decisions	1	2	**8**	0
Lack of respect of patient and family wishes in decision making	1	0	**2**	0
Lack of documentation around capacity and best interests	1	1	**7**	0
Issues relating to Personalised Care Plans and other documentation	9	4	**72**	8
Issues relating to Fast Track and palliative care support	0	0	**1**	0
Problems with infection management	0	0	**1**	0
Problems related to invasive procedures	0	0	**1**	0
Problems related to clinical monitoring			**7**	
Reversible causes of deterioration not considered/excluded and/or documented	0	0	**7**	2
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			**67**	
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	2	1	**15**	0
Patient related communication issues	2	1	**11**	0
Team related communication issues	0	4	**41**	1
Number of deaths this month with completed reviews	3	4	**42**	3
Total number of issues arising	**21**	**13**	**231**	**15**

All deaths have been reviewed against the RCP problem categories. Two cases have had problems identified in Q1. The problems have all been shared with the patient safety team and the problems that where concluded as probable harm by the Virtual Mortality Review Panel have been investigated individually by the patient safety team.

Problems in Care identified in Community Cass Mapped to the RCoP problem categories
1. Problems in assessment, investigation of diagnosis Including assessment of pressure ulcer risk, VT risk, history of falls
• Lack of assessments could possibly have led to pressure ulcer development, nil by mouth for 3-4days leading up to the pressure ulcers being discovered, Moving and handing not reviewed. MUST not completed and purpose T not reviewed with patients' deterioration. Action: Referred to Patient Safety Team for Investigation.
2. Problems with medication including administration of oxygen
• End stage with stat doses of medications given. Patient nil by mouth. Patient presenting with pain. More long term/slow release analgesia needed at this time - no documented consideration for syringe driver. Action: Patient Safety Team Bulletin to be distributed.
3. Problems related to treatment and management plan
• Not prioritising a recently discharged patient. From the beginning care may have improved throughout the patents journey if a management plan/ACP had been created and forward planning of visits, instead of urgent visits. Action: Feedback to team for local action and investigation for improved triage of discharged patients. • No MDT discussions to make sure ACP and TEP in place early. Action: A new initiative is underway to rebuild relationships with Hospices to organise better referrals and support the Hospices to lead conversations regarding Advance Care Planning including TEPs.
6. Problems in clinical monitoring
• One day had x3 stat doses of medication, onward plan/booking of next visit not mentioned until the next urgent visit. Action: Patient Safety Team Bulletin to be distributed. • Recognise the deteriorating patient, aided by use of NEWS 2 tool. Action: EoL care training has been confirmed as essential to all HCAs working in Urgent Care Teams. Team leads have recognised that the NEWS2 scoring is a good tool and have plans to train all non-registered staff to be able to use NEWS 2 tool. The ART team also plan to roll out a medical model for the service alongside the personal care packages they currently offer.

7. Learning Disability (LD) Mortality Reviews Report

LeDeR Internal Q1 Report 2022.docx

Tatum Mallard
Mortality Review Project Lead
1 July 2022

LeDeR Review Programme
Quarter 1 Report

April - June 2022
(reporting on deaths October - December 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 which have now been resolved.

There is now a process in place for focused reviews to be heard at panel; this occurs on average twice a month where the panel take SMART actions from the reviews.
This causes some occasional back-log to the reviews as some have to be placed on hold before going to the Focused Review Panel Meetings.
There is currently 1 review breaching from May 2022 and 2 from June due to awaiting a Focused Review Panel.

We now have bi-monthly Operational Groups to bring forward any objectives/ actions and learning from reviews; these meetings include internal KCHFT colleagues and those from Acute Trusts and Social Care. We also have our bi-monthly Steering Groups to discuss key areas on a strategic level with involvement from the CCG Leads and Clinical Service Managers within KCHFT. These meetings are providing SMART objectives and actions which link to our 3-year LDA Plan.

Completion of Reviews

To date we have completed a total of 165 reviews for the time frame October 2020 – June 2022, 24 of these were in Q1 (deaths recorded between October - December 21) with a staff capacity of 100% and the trajectory being overachieved every month (with the exception of 3 reviews breaching due to awaiting a Focused Review Panel Meeting which have been scheduled for July 2022)

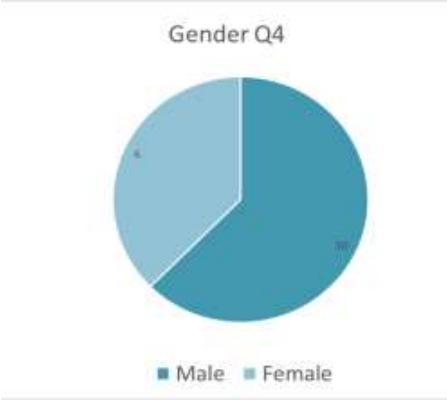
Below, the table shows the number of reviews completed for Quarter 1. There was a slight increase in the number of deaths in December, as we approached the Winter months.

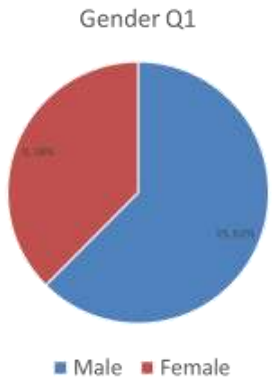
Oct-21	Nov-21	Dec-21
6	**7**	**11**
6	6	9
0	0	0
0	0	0
0	0	0
0	1	1
0	0	2
0	0	0
0	**1**	**2**
Apr-22	**May-22**	**Jun-22**

2. Personal Demographic Trends

Gender

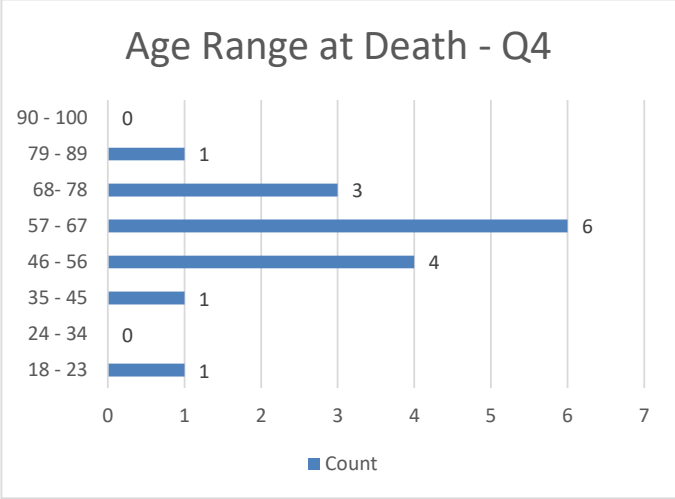
The table below shows that there were more Male to Female deaths in Q1 with Male deaths at 62%; the same percentage of deaths as Q4.

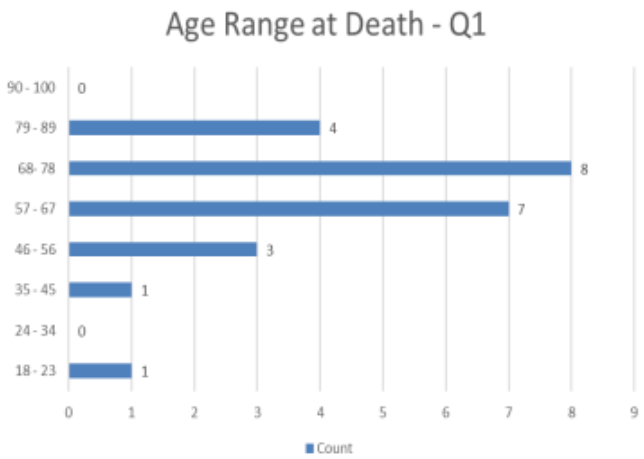




Age

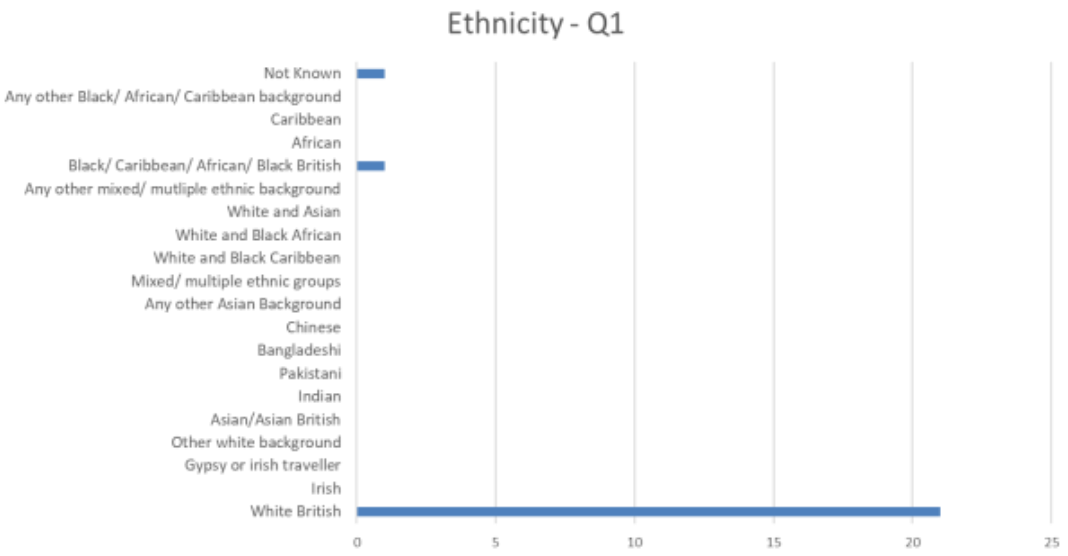
In Q1, the graph below shows that the highest age range at death was 68-78 years old which is the first time in 3 quarters we have seen this change. In Q4 and other previous quarters, the highest age range at death was between 57 – 67 year olds.





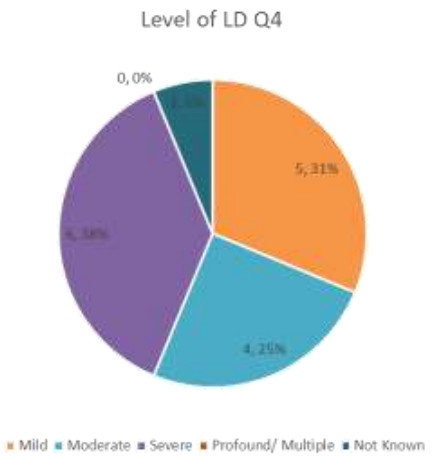
Ethnicity

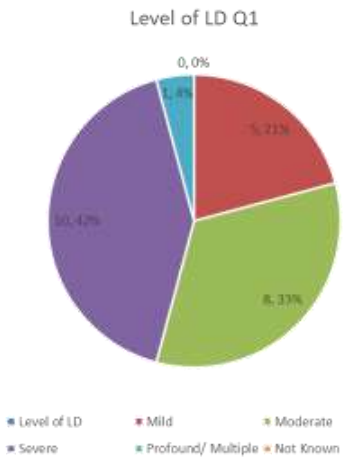
Out of the 24 reviews completed in Q1, there were 21 people recorded as White British. There was 1 recording of Black/ Caribbean/ African/ Black British, 1 person preferred not to say and 1 ethnicity was not known. This recording is similar to Q4, where 14 out of 16 deaths were recorded as White British, and 2 were Caribbean.



Severity of LD

In Q1, the highest level of LD was 'Severe' at 42%, closely followed by Moderate at 33%. Similar to Q4 where the highest level of LD was also Severe at 38%, closely followed by Mild with 31%

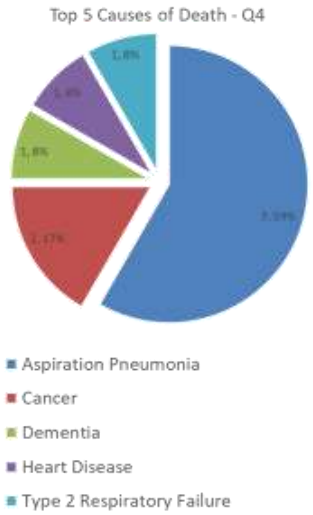


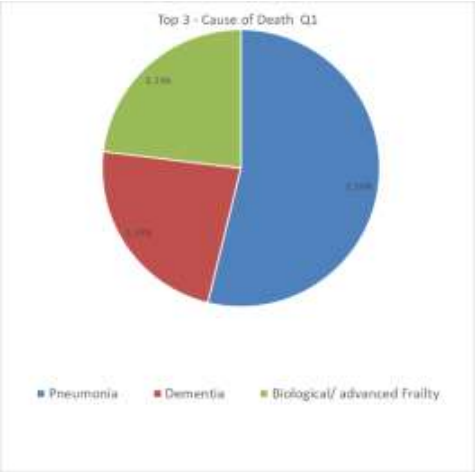


3. Causes of Deaths

Pneumonia (including Aspiration and Broncho) still remains the highest cause of death, with 54% in Q1, compared to 59% in Q4. There were only 3 significant causes of death in Q1, all other causes of death only had 1 recording.

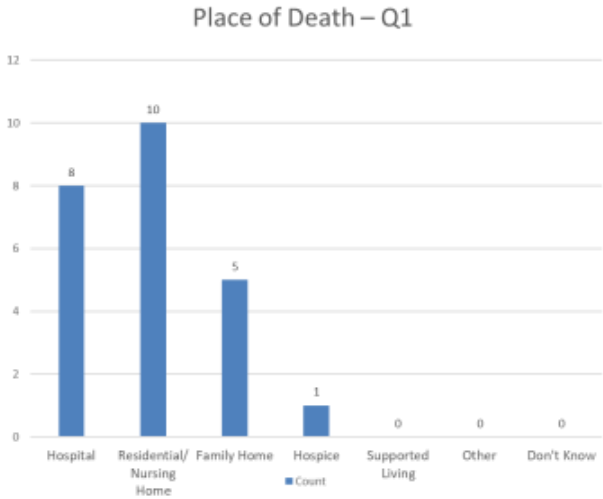
Across the quarters, we are seeing a huge reduction in Covid-19 related deaths due to the decrease in Covid-19 cases and the roll out of the vaccine.





4. Place of Death

In Q1, the highest place of death was Residential/ Nursing Homes with 10 out of 24 deaths. This is the first quarter since last year we have seen deaths in Hospitals to be lower than any other place of death. In Q4, there was an equal number of Hospital and Residential/ Nursing Home deaths at 7.



5. Those Open to KCHFT

The graph below shows those open to KCHFT at the time of death for reviews completed in Q1 (October – December 2021 deaths)

We can see that the Adult Learning Disabilities team had the highest number of people open to them with 19 out of the 24 deaths recorded for Q1; 4 of these were open to Nursing, 1 for Occupational Therapy (OT) and 2 for Physiotherapy.

There was also 2 for the Community Adult Nursing Team and 6 were recorded as not open to KCHFT.

Some people were open to more than 1 service, which is why the figures are higher than those who died within Q1.

Open to KCHFT	
LD Team	12
LD Team - Nursing	4
LD Team - OT	1
LD Team - SLT	0
LD Team - Physio	2
Dietetics	0
Community SALT Team	0
Community Adult Nursing Team	2
Continence Team	0
Dental Services	0
Epilepsy Service	0
Falls Prevention Service	0
Frailty Service	0
Lymphoedema Service	0
One You Service	0
Podiatry	0
Public Health Service	0
Respiratory Team	0
Sexual Health	0
Urgent Treatment	0
Not open to KCHFT	6

6. 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 4 remains relevant for quarter 1, 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. The acute trusts are also looking to incorporate this process in their "Was Not Brought" strategy.
- 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. This is proving useful so far, more specific themes will be highlighted and communicated.
- 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.
- A group has been set up with the senior reviewer and all the Acute Trust LD Liaison nurses for Kent & Medway. This group looks at themes and trends and any learning from all reviews where the person had died in Hospital.

Positive Practice

- The LeDeR team have attended Provider Conferences and held workshops.
- Offered presentations to private providers, outside agencies and services within KCHFT.
- 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 and other relevant services within KCHFT.
- Deep Dives will occur on themes and trends that have been identified in the initial reviews.
- A Task & Finish Group will be held at QEQM regarding DNACPR's.
- There will be promoting LD Champions in GP Practices.
- Bulletins now go out to CLDT's GP's and Safeguarding Boards.

- The Locality Clinical Managers will now sit on the focused review panels, local learning will be passed on and actioned more efficiently.

KCHFT Learning Actions and Positive Practice:

- From the 24 deaths reviewed, 19 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 2 people was Adult Community Nursing.
- 2 deaths out of those 19 who were open to KCHFT were unexpected and have been progressed to Focused Reviews for further discussion.
- No issues or deaths have been attributed to services within KCHFT.
- Each CLDT will have a link reviewer who will take back any learning and actions to the teams from the initial reviews.

NHS
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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	3.1
Agenda Item Title:	Workforce Race Equality Standard (WRES) Report
Presenting Officer:	Victoria Robinson-Collins, Director of People and Organisational Development
Action – this paper is for:	☒ Decision ☐ Information ☐ Assurance

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

The report was received by the Board at its Part Two meeting on 14 July 2022.

The purpose of this paper is to provide detail of the WRES metric outcomes for 2021 and to seek approval for the WRES data to be submitted as per national requirements and for the report to be simultaneously published on our website. It is also to highlight to the Board that the action plan will follow in due course this year (usually published at the same time as the report) following the refresh of the EDI action plan as previously agreed.

Summary of key points

KCHFT has made some positive progress against many of the metrics in the past 12 months, but there is still work to do.

Some positive findings are:

- Equalities monitoring declaration rates have improved, showing the Trust, as a whole, is representative of the communities it serves.
- BME colleagues are still less likely than their white counterparts to enter the formal disciplinary process. This has been the case for three reporting periods in a row.
- BME colleagues are slightly more likely to access non-mandatory training than their white counterparts.

Progress in the last 12 months include:

- The Trust was awarded £190,000 by NHSE/I to recruit nurses internationally. Nineteen nurses were recruited, resulting in an increased number of BME staff employed by the Trust. The Trust has since committed to an investment of £800,000 to support ongoing international recruitment and we are also in the process of expanding this international recruitment beyond nursing into AHPs and are currently preparing a business case to support this.
- A mentoring programme for BME took place from September 2021 to February 2022. Participants of 6 different NHS organisations positively received the programme. Participants made important comments and recommendations when asked about barriers to progress in the organisation and this will be fed into our revisions of our action plans moving forward to ensure these are addressed.
- Several workstreams with workforce representatives have been established to deliver the action plan of the Equality, Diversity and Inclusion Strategy. Many of the actions from the strategy are directly related to improving the WRES parameters.

The identified areas for improvement arising following an analysis of the WRES data are:

- BME applicants are less likely to be appointed at interview than white applicants; however, this year, there has been an improvement on last year's results but there is undoubtedly a lot of work needed to improve this metric and the experience of BME applicants. Further work is already in progress.
- White nurses at band 5 are disproportionately more likely to be appointed than BME nurses. However, we have an ambitious international recruitment campaign underway this year which should rectify this disparity.
- BME colleagues remain less likely than white colleagues to feel that the Trust provides equal opportunities for career progression or promotion. Turnover for BME colleagues is 5.6% higher than for white colleagues (May-21 to Apr-22). The link between access to career progression and promotion and the higher BME turnover rate will be a key area of focus for the next 12 months.
- BME colleagues are still more likely to feel they have experienced discrimination at work from a manager/team leader or other colleagues than their white counterparts.
- The Trust Board and senior management, although diverse, are not representative from a BME perspective of the workforce at KCHFT nor of the local communities the Trust serves. There are currently no BME voting members on the Board.

Proposal and/or recommendation to the Committee or Board
The Board is asked to approve this year's WRES data and report and action plan for submission and publication on the Trust website. The action plan will be added to the website once complete.

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

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

Name:	Sarah Hayden	Job title:	Deputy Director of HR (Operations)
Telephone number:	07789 941879	Email	shayden@nhs.net

Kent Community Health
NHS Foundation Trust

WORKFORCE RACE EQUALITY STANDARD (WRES) REPORT
July 2022

1. Introduction

1.1 The workforce race equality standard (WRES) was introduced in 2015 as part of the NHS standard contract. It was the first-time workforce race equality had been made mandatory in the NHS.

1.2 The WRES was introduced to enable employees from black and minority ethnic (BME) backgrounds to have equal access to career opportunities and receive fair treatment in the workplace. Evidence shows a motivated, included and valued workforce helps deliver high-quality patient care, increased patient satisfaction and better patient safety; it also leads to more innovative and efficient organisations.

1.3 The WRES encourages the development of a more diverse, empowered and valued workforce and implementing it supports NHS organisations in complying with the provisions of the Equality Act 2010. All staff should be able to look at their leaders and see themselves represented, and patients deserve the same[1].

1.4 The WRES requires every NHS organisation to publish data annually. The main purpose of the WRES is:

a. to help local and national NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
b. to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
c. to improve BME representation at the Board level of the organisation.

1.5 Historically, the WRES statistics have been reported as "white" or "BME". In the updated 2021 report, the data is split into gender and stratified by workforce type. In addition, the data is arranged by ethnicity to reflect the diverse ethnicities of the workforce.

1.6 The NHS WRES 2021 Data Analysis report shows that BME staff make up 22.4%of the workforce in NHS Trusts[2]. This is an increase from 19.1% in 2018.

Table 1. National NHS WRES 2021 Data Breakdown

	2018	2019	2020	2021
BME	19.1 %	19.9%	21.1%	22.4%
White	76.3%	75.4%	74.2%	73.1%
Unknown	4.6%	4.7%	4.7%	4.6%

[1] NHS Workforce Race Equality Standard: technical guidance

1.7 The National NHS WRES 2021 Data Analysis Report for all NHS Trusts shows the following:

- White applicants were 1.61 times more likely to be appointed from shortlisting than BME applicants; this is the same as 2020. While there has been year-on-year fluctuation, there has not been an overall improvement over the past six years.
- BME staff were 1.14 times more likely to enter the formal disciplinary process compared to white staff. This is little change from 2020 (1.16), an improvement in 2019 (1.22) and a significant improvement from 2017 (1.37) and 2015 (1.56).
- 28.6% of BME women were most likely to have experienced harassment, bullying or abuse from other staff
- White Gypsy or Irish Traveller men (51.1%) and women (44.4%) experienced the highest levels of harassment, bullying or abuse from other staff.
- 36.2 % of "other black women" and 33.6% of women from "any other" background experience high levels of abuse.
- There has been a decrease in the proportion of BME staff who believe their Trust provided equal opportunities for career progression, with South East of England showing the most significant drop from 74.9% (2017) to 70.4% (2020). London has the lowest percentage of BME staff who believed that their Trust provided equal opportunities for career progression or promotion (65.4%).
- 10% of AFC pay band 8c and above were from a BME background, which is significantly lower than the 22.45% of all BME staff in the NHS.
- Overall there has been an increase in the number of BME very senior managers with a fall in the number of BME executives.

1.8 In 2021, the disparity ratio by region has been reported for the first time. The disparity ratio reflects staff progression in terms of representation through bands, comparing BME and white staff. A ratio of 1 reflects parity of progression and values higher than "1" reflects inequality, with a disadvantage for BME staff.

Table 2. Disparity Ratio Comparison

	Disparity Ratio 2020			Disparity Ratio 2021		
AFC Band	Band < 5	Band 6 -7	Band > 8a	Band < 5	Band 6 -7	Band > 8a
South East	1.52	1.69	2.57	1.51	1.66	2.50

2. WRES indicators

2.1 For each of the first four workforce indicators, the WRES compares the data for white and BME staff. These indicators are**:**

1) Percentage of staff in each of the AFC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated by:
   - Non-Clinical staff
   - Clinical staff - of which
     - Non-Medical staff
     - Medical and Dental staff

2) Relative likelihood of staff being appointed across all posts
3) Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. (This indicator will be based on data from a two-year rolling average of the current year and the previous year)

4) Relative likelihood of staff accessing non-mandatory training and CPD

For each of the next four NHS staff survey indicators, a comparison of the outcomes of the responses for white and BME staff is undertaken:

5) Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months
6) Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months
7) Percentage believing that the Trust provides equal opportunities for career progression or promotion
8) In the last 12 months, have you personally experienced discrimination at work from any of the following a manager/team leader or other colleagues

For the Board representation indicator, the difference between white and BME staff should be compared

9) Percentage difference between the organisations' Board membership and its overall workforce disaggregated:
    - By voting membership of the Board
    - By executive membership of the Board

2.2 The data used to report on the workforce Indicators is taken from ESR either as a snapshot on 31st March 2022 or as data for the year up to this date.

2.3 The information used to report against the Indicators concerned with the staff survey is taken from the 2021 NHSS.

2.4 For the first time, WRES 2021 data for indicator 1, comes from two different data sources:

- 2016 and 2017 data are from the NHS workforce statistics website
- 2018 - 2021 data are from the Strategic Data collection Service (SDCS).

3. Demographics

3.1 Data from the National Office of Statistics for 2011 showed that 80.5%of the population across England described themselves as white British. People of other white origins made up just over 4.4% of the population and visible BME people made up the remaining 15.1%.[2]

3.2 According to the 2011 Census, 6.33% of residents in Kent were from a visible BME background[3]; in East Sussex, it was 8%[4] and in North East London, it was 45.43%[5].

3.3 The first results from Census 2021 in England and Wales were released on 28th June 2022[6]. However, the Census ethnicity data will be released at a later date which is why the 2011 Census information is still being referred to.

[2] Ethnicity and National Identity in England and Wales: 2011
[3] 2011 Census: Cultural diversity in Kent
[4] 2011 Census Equalities… in brief
[5] Ethnicity and National Identity in England and Wales: 2011
[6] First results from the 2021 Census in England and Wales

4. Workforce

4.1 At KCHFT, the total BME workforce is 11%(557) compared to 9.73% in 2021 and 8.58% in 2019. The proportion of staff describing their ethnicity as "White" is 83.2%. We do not have ethnic origin recorded for the remaining 5.8% of the workforce, which is an improvement on the figure last year recorded as being 9.8%. Efforts continue to improve data quality and collection. This will be done by making equalities monitoring mandatory fields when new recruits complete new starter paperwork before joining the Trust and through targeted requests to colleagues to check and update their data where information is missing.

Figure 1

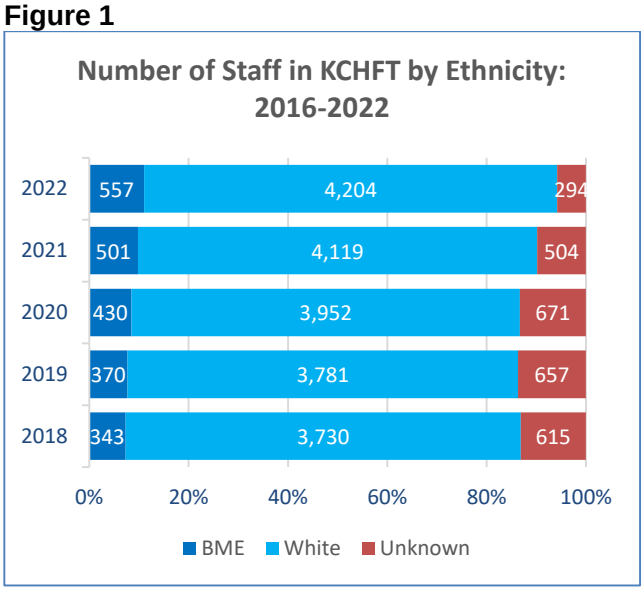
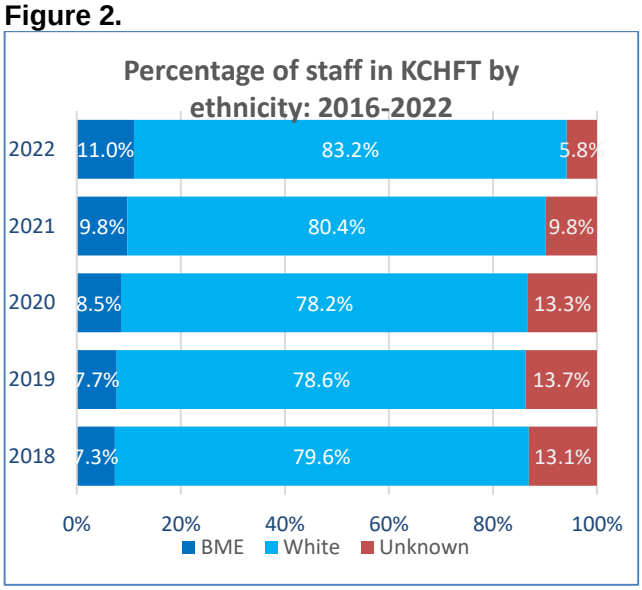


Figure 2.

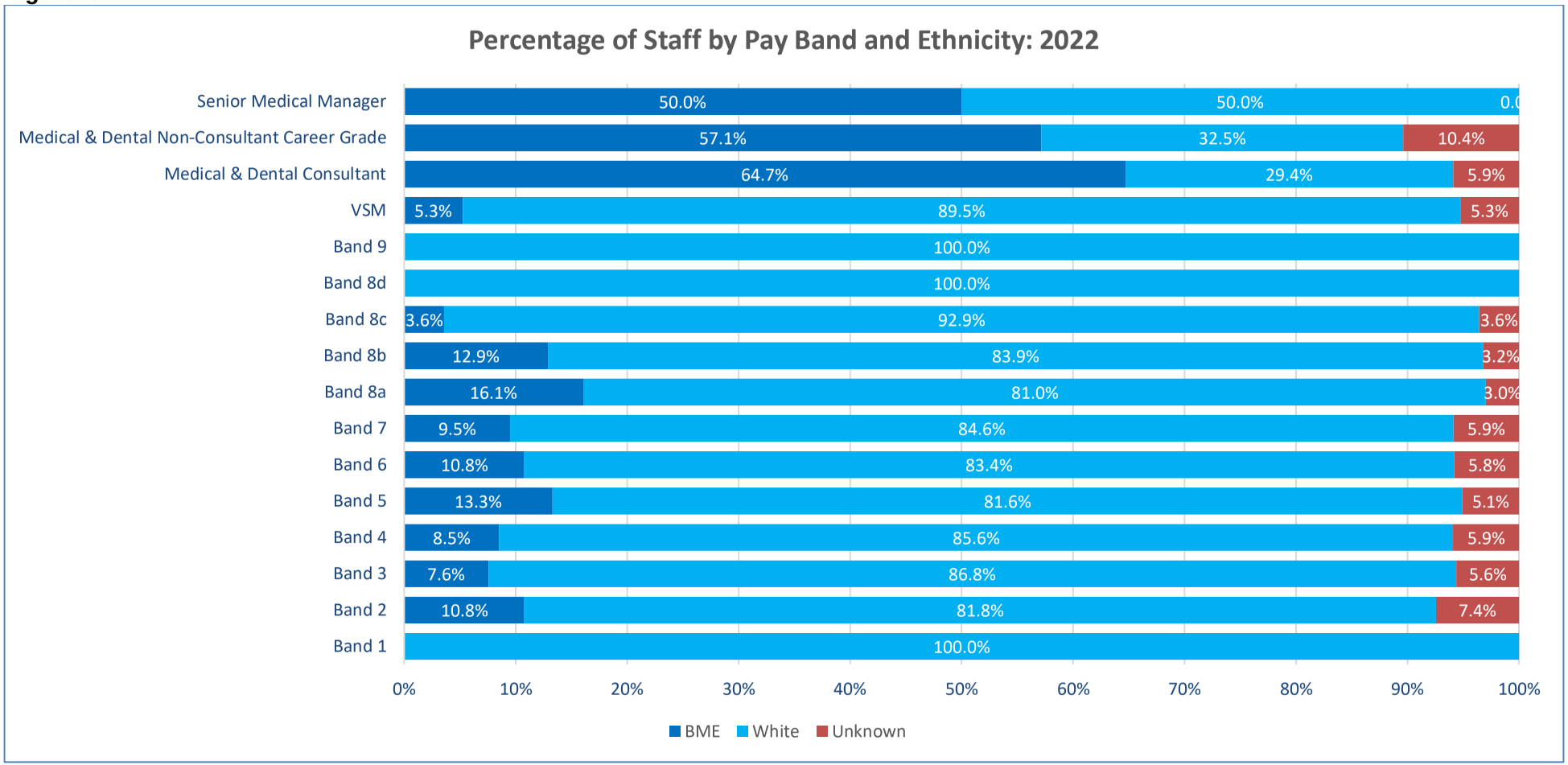


5. Trust results

5.1 Indicator one

5.1.1 Percentage of staff in each of the AFC Bands 1-9 or Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce disaggregated.

Figure 3

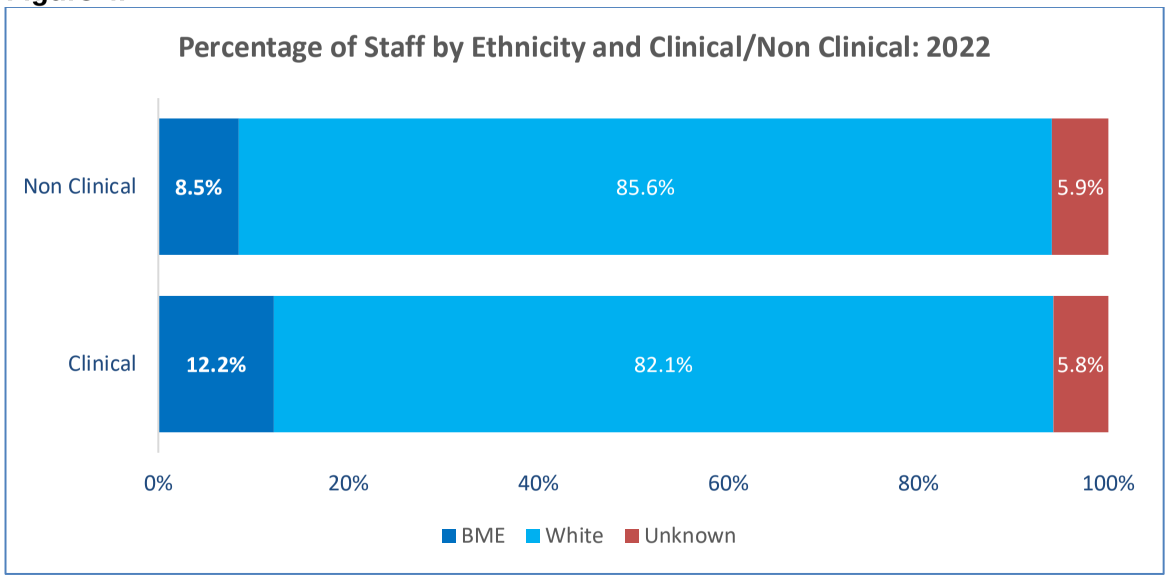


5.1.2 Comparing the figures published for 2021 against the 2022 figures, there are several points to note:

- The Band 1 pay scale was removed in December 2018 and colleagues in a role on this salary banding were moved into Band 2 roles with appropriate support. Colleagues had the choice to remain in their Band 1 role under national terms and conditions and 1 colleague chose to do so which is why this category remains.

5.1.3 Figure 4 and Tables 3 and 4 show the percetage and number of colleagues by ethnicity split between clinical and non-clinical groups and in each of the grades.

Figure 4.



- Further analysis shows the following:
  - The clinical staff group with the highest proportion of BME staff is Medical and Dental, with 57.7% BME
  - The clinical staff group with the lowest proportion of BME staff is healthcare scientists, with 6.3% BME (although the Trust only employed 16 healthcare scientists on 31st Mar 2022).
  - Overall, 8.5% of non-clinical staff are BME, so further work is underway to achieve parity to ensure this group is representative of the workforce overall

Table 3: Non clinical staff pay scale

	31/03/2020			31/03/2021			31/03/2022		
Payscale	**BME**	**White**	**Unknown**	**BME**	**White**	**Unknown**	**BME**	**White**	**Unknown**
Band 1		1			1			1	
Band 2	44	438	69	42	402	49	44	399	36
Band 3	26	317	52	37	356	39	39	386	25
Band 4	12	164	25	16	174	16	17	174	11
Band 5	17	75	13	12	81	8	8	93	6
Band 6	9	87	11	7	86	7	6	91	5
Band 7	6	82	17	7	81	11	10	90	6
Band 8a	8	41	10	5	38	5	3	42	2
Band 8b	1	25	2	3	25	1	5	32	1
Band 8c	1	9	2	1	13		1	13	
Band 8d		15	1		13	1		11	
Band 9		3	1		1			7	
VSM		10			10			6	1
Ad hoc payscales - Apprentice	1		2						
Total	**125**	**1,267**	**205**	**130**	**1,281**	**137**	**133**	**1,345**	**93**

Table 4: Clinical staff - Payscale

	31/03/2020			31/03/2021			31/03/2022		
Payscale	**BME**	**White**	**Unknown**	**BME**	**White**	**Unknown**	**BME**	**White**	**Unknown**
Band 1		1							
Band 2	21	170	35	26	161	29	27	140	13
Band 3	21	361	78	27	390	54	27	373	24
Band 4	33	409	65	40	448	51	49	491	35
Band 5	44	445	61	56	466	62	81	453	28
Band 6	74	666	133	92	719	91	98	714	51
Band 7	48	472	68	57	493	56	58	516	36
Band 8a	14	84	7	19	88	8	24	94	3
Band 8b	3	21	2	3	23	1	3	20	1
Band 8c		12	1		8	1		13	1
Band 8d		3			3			3	
VSM	1	7	1	1	7	1	1	11	
Medical & Dental Consultant	9	4	2	10	4	1	11	5	1
Medical & Dental Non-Consultant Career Grade	37	28	13	40	27	12	44	25	8
Senior Medical Manager		1			1		1	1	
Ad hoc payscales - Apprentice		1							
Total	**305**	**2,685**	**466**	**371**	**2,838**	**367**	**424**	**2,859**	**201**

- In the medical grades, the number of non-consultant career grade doctors from a BME background has increased (+4) and the number of white doctors in this category has decreased (-2).
- A review of tables 3 and 4 above, helps to identify where more detailed analysis needs to be focused to plan targeted recruitment campaigns to attract more applicants from a BME background for the higher banded roles.

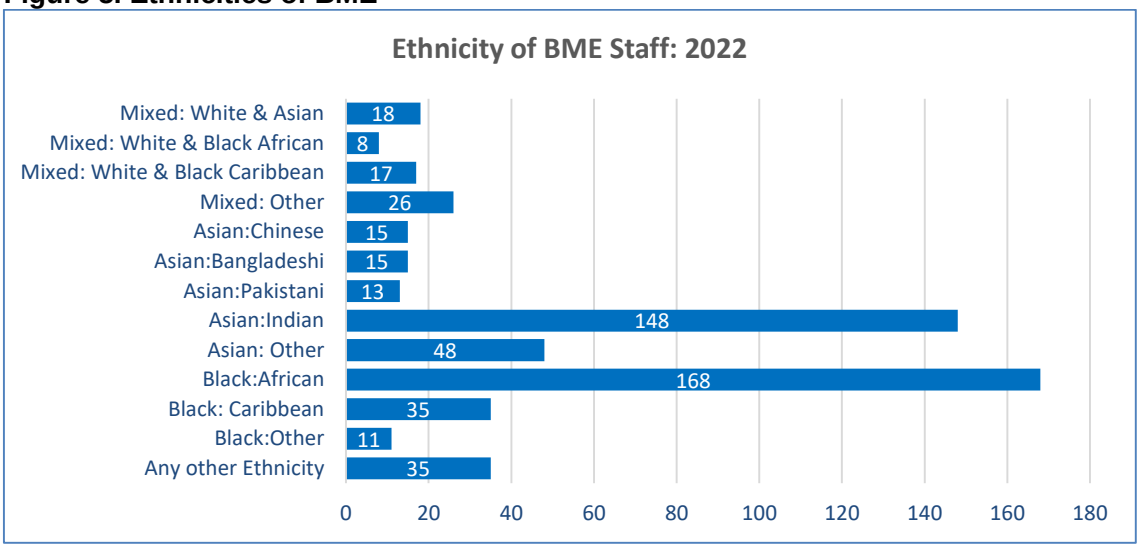
Table 5. Year on Year comparison

Year on Year comparison, Bands 8a to Band 9

	31/03/2021						31/03/2022						Year on Year Comparison (green = increase/red= decrease)					
WRES Banding	BME		White		Unknown		BME		White		Unknown		BME		White		Unknown	
Band 8a	24	14.7%	126	77.3%	13	8.0%	27	16.1%	136	81.0%	5	3.0%	3	1.3%	10	3.7%	-8	-5.0%
Band 8b	6	10.7%	48	85.7%	2	3.6%	8	12.9%	52	83.9%	2	3.2%	2	2.2%	4	-1.8%	0	-0.3%
Band 8c	1	4.3%	21	91.3%	1	4.3%	1	3.6%	26	92.9%	1	3.6%	0	-0.8%	5	1.6%	0	-0.8%
Band 8d		0.0%	16	94.1%	1	5.9%		0.0%	14	100.0%		0.0%	0	0.0%	-2	5.9%	-1	-5.9%
Band 9		0.0%	1	100.0%		0.0%		0.0%	7	100.0%		0.0%	0	0.0%	6	0.0%	0	0.0%

- Table 5 above shows that there has been positive progress made in increasing BME representation in bands 8a and 8b but work remains ongoing to ensure this is mirrored for bands 8c, 8D and 9.
- Overall the data is showing the following:
  - The increase in colleagues declaring their ethnicity with less colleagues using the "Not stated" category has been maintained, with more colleagues declaring their ethnicity. This is the result of the work that has been done to encourage colleagues to update ESR.
  - The number of clinical band 8d has not changed in the past three years. This is different from the non-clinical staff, where there has been a decrease of white colleagues appointed to band 8d from 15 in 2020, 13 in 2021 and 11 in 2022.
  - There has been an increase in the number of White band 9 colleagues this year, the reasons for which are Wlisted below:
    - Two posts resulted from re-grading and benchmarking to other comparable posts and job descriptions across Kent and Medway.
    - Two posts were the result of operational restructuring
    - One post is hosted at KCHFT but based at the CCG
    - One post was moved from the Very Senior Manager position due to the restructure mentioned above.
  - 3.6% of staff in Band 8c roles are BME which is a small decrease last year. was mentioned above, work is in progress to address this disparity for bands 8c-9.
  - However, 16.1% of Band 8a and 12.7% of Band 8b roles are taken by BME employees. These pay bands have seen an increase in the proportion of BME staff of 1.3% and 2.2%, respectively, compared to last year.
  - The data quality in ESR has much improved since last year. Only 5.8% of staff do not have their ethnicity recorded in ESR, compared to 9.8% last year and work remains ongoing to continue this improvement in data quality.
  - 12.2 % of clinical staff are BME from a variety of different ethnicity groups (Figure 4).

Figure 5. Ethnicities of BME



- Figure 5 above shows the breakdown of our BME colleagues by ethnicity.

5.2 **Indicator two**

5.2.1 Indicator two measures the relative likelihood of staff being appointed across all posts. The figure of 2.33 in 2022 indicates that BME staff are still less likely to be appointed from shortlisting than white applicants. This is a slight improvement since 2021 when the figure was 2.35. The figure of 2.33 for 2022 is the result of our international recruitment campaign. The national WRES report shows that all regions have seen a deterioration in this indicator for BME applicants.

Table 5

		2020	2021	2022
		RELATIVE LIKELIHOOD		
Relative likelihood of staff being appointed across all posts	Total	2.68	2.35	2.33

5.2.2 A further breakdown of the data shows that students are the only group of staff where recruitment favours BME. This is because the 19 nurses recruited from Africa were employed as student nurses at band 4.

Figure 6

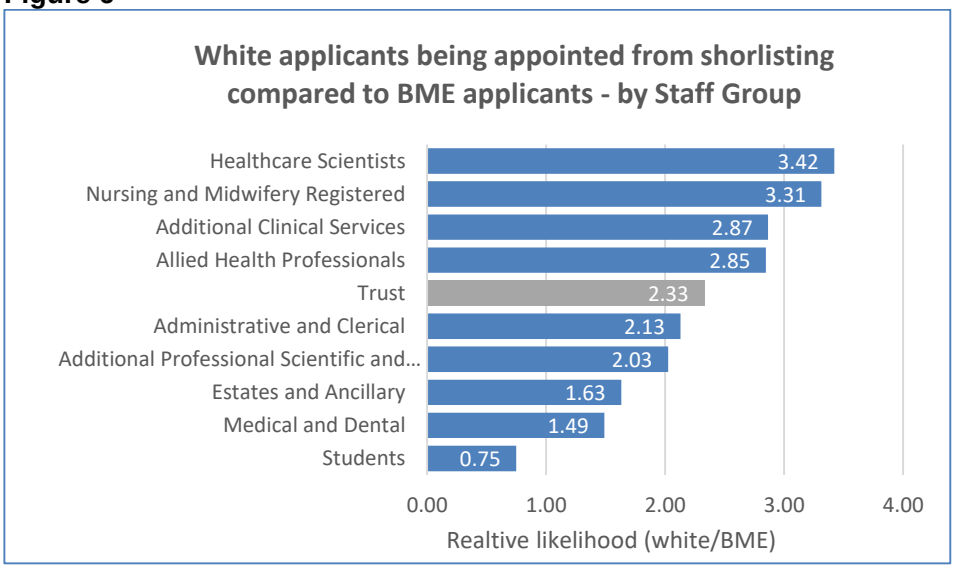
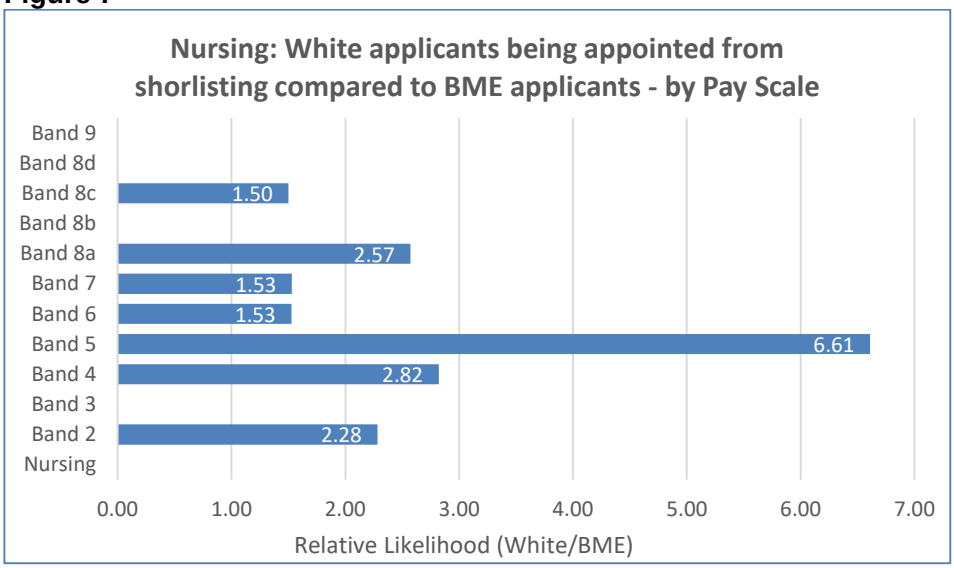


Figure 7



5.2.3 Figures 6 and 7 above shows that we have work to do as an organisation to address this and a paper is being prepared currently to introduce an Inclusive Recruitment Champion role to sit on interviews to ensure equity. Weare also exploring a number of other options and linking with our BME network colleagues to understand how we can change the dial on this.

5.2.4 This was felt to be an area that needed some further indepth analysis to understand the issues in more detail. The following findings were made:

Figure 8

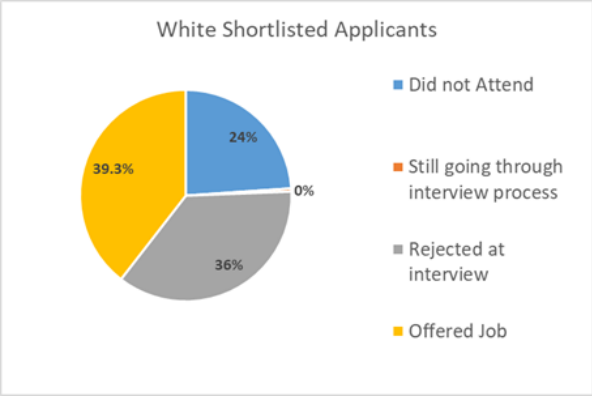
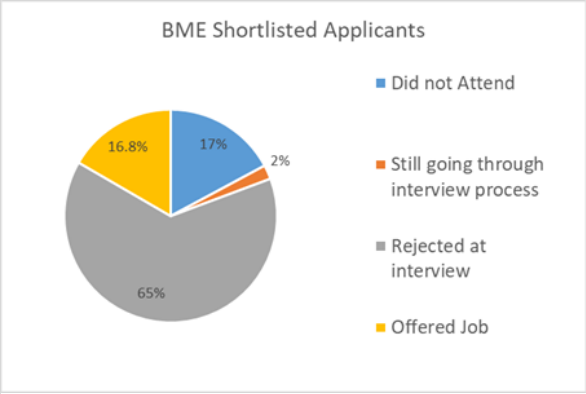


Figure 9



5.4.4 From the 4,295 shortlisted White applicants, 39.3% went on to be offered a job. The relative likelihood of shortlisting/appointed for white applicants = 0.393

5.4.5 From the 2,067 shortlisted BME applicants, 16.8% BME applicants went on to be offered a job. The relative likelihood of shortlisting/appointed for BME applicants = 0.168. Interesting BME are less likely to fall into the 'Did not Attend' category and substantially more likely to be 'Rejected at Interview'. This is an area of focus for us for the coming year and the introduction of our inclusive recruitment champions will hopefully have a significant positive impact on this metric.

5.4.6 Benchmarking data is only available for 2020. However, looking at last year's data, we appear to have one of the highest relative likelihood figures compared to other Community Trusts and also compared to other Trusts in the South East.

Figure 10

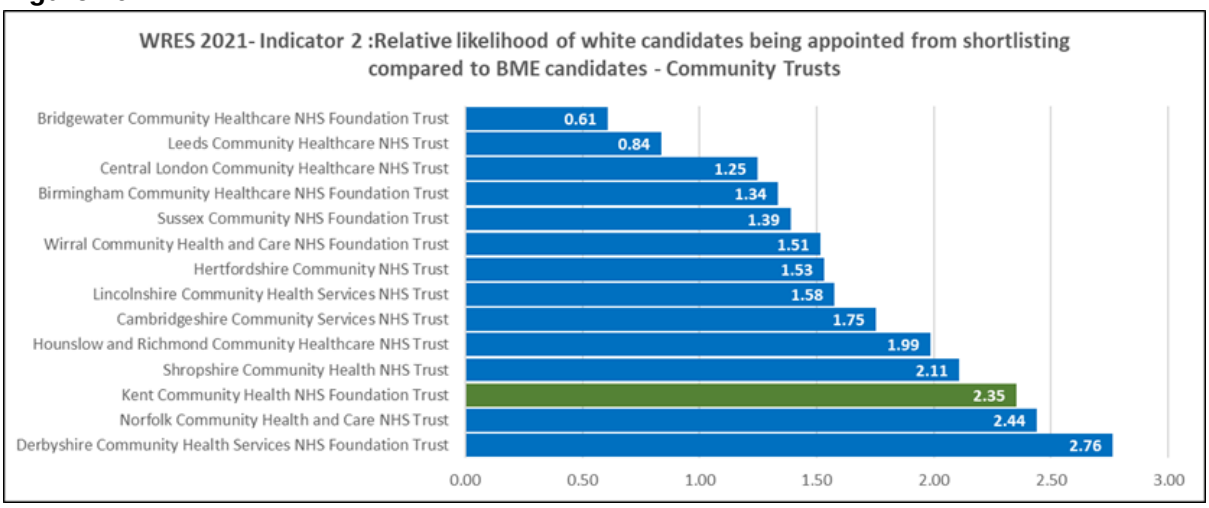
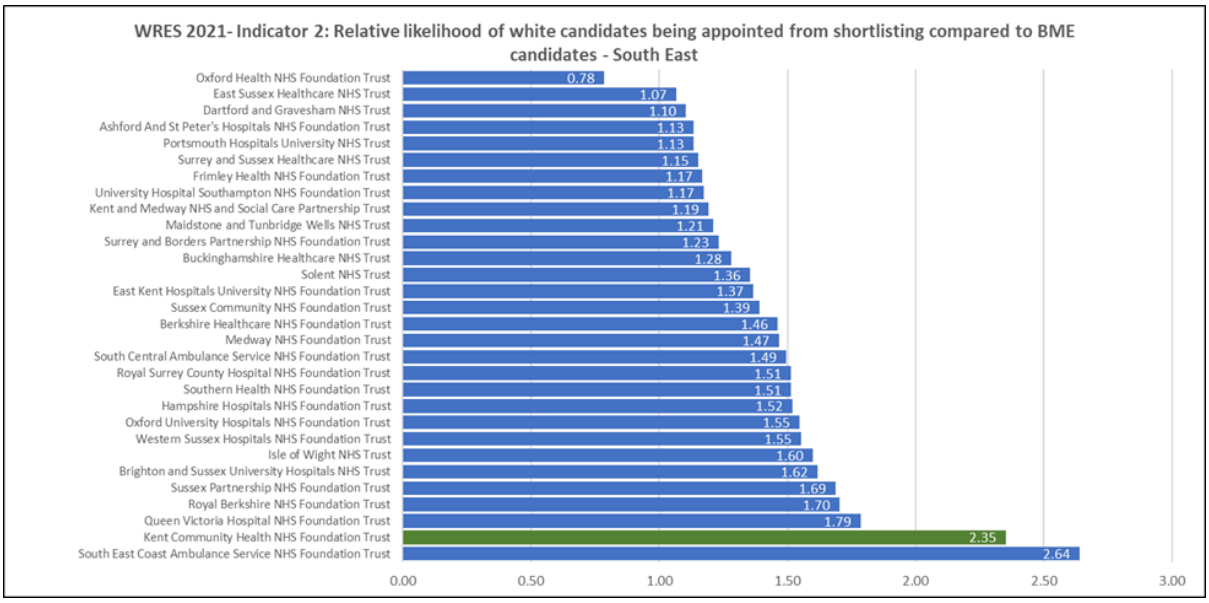


Figure 11



5.4.7 With the recently implenmented changes to remove assessment centres in their current form, monitoring will be undertaken to assess the impact of this as anecdotal evidence has suggested that this was causing a large drop out rate from shortlisting to interview stage for senior posts.

5.4.8 We will also be exploring additional training for panel members who particiate in recruitment to ensure we can improve our conversation rate and also do some further education around positive discrimination during selection processes.

5.4.9 There is undoubtedly work we need to do to improve this metric moving forward.

5.3 Indicator three

5.3.1 Indicator three looks at the relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. The calculation has been changed from using a two-year rolling average to using the year-end figure. A figure above "1" would indicate that BME staff members are more likely than white staff to enter the formal disciplinary process.

5.3.2 The relative likelihood of BME colleagues entering the formal disciplinary process at the end of the financial year (31st March 2022) is 0.60, meaning BME staff remain less likely than their white counterparts to enter formal disciplinary proceedings. This is an improvement from last year's results and a really positive position for our colleagues at KCHFT.

Table 6

		2018/2020	2019/2021	2022
		RELATIVE LIKELIHOOD		
Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation	Total	0.46	0.77	0.60

5.4 **Indicator four**

5.4.1 Indicator four asks about the relative likelihood of staff accessing non-mandatory training and CPD. The data a small improvement since last year, meaning BME colleagues are slightly more likely to access non-mandatory training and CPD than their White colleagues. Anything less than 1 is positive, so this outcome is to be celebrated and monitoring will continue to ensure we maintain this position and improve it further.

Table 7

		2020	2021	2022
		RELATIVE LIKELIHOOD		
Relative likelihood staff accessing non-mandatory training and CPD	Total	1.00	0.98	0.96

5.5 **Indicator five**

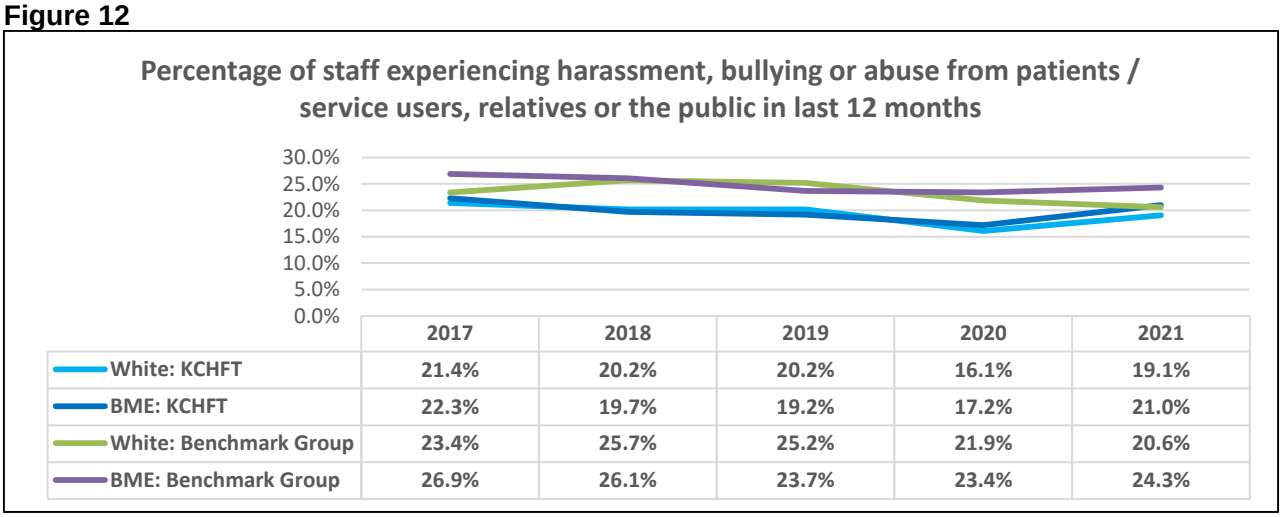
5.5.1 Indicator five looks at the percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public. This metric shows an increased number of BME and White colleagues experiencing harassment, bullying or abuse from patients, relatives or the public. The national WRES data and KCHFT results for 2021 show a decrease in the proportion of BME and white staff who experienced harassment, bullying or abuse from patients and relatives. In 2022, there was an increased of KCHFT staff that experienced harassment, bullying or abuse from patients and relatives.

Table 8

		2020		2021		2022	
		BME	WHITE	BME	WHITE	BME	WHITE
Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Total	19%	20%	17%	16%	21%	19%

5.5.2 Figure 12 below shows a comparison of KCHFT against our benchmarking group* in the staff survey. It evidences that white and BME KCHFTstaff experience less harassment, bullying, or abuse from patients/service users, relatives or the public than our benchmarking cpmparators.

Figure 12



	2017	2018	2019	2020	2021
White: KCHFT	21.4%	20.2%	20.2%	16.1%	19.1%
BME: KCHFT	22.3%	19.7%	19.2%	17.2%	21.0%
White: Benchmark Group	23.4%	25.7%	25.2%	21.9%	20.6%
BME: Benchmark Group	26.9%	26.1%	23.7%	23.4%	24.3%

*Benchmarking Group: Shropshire Community Health NHS Trust, Isle of Wight NHS Trust (community sector), Sussex Community NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Norfolk Community Health and Care NHS Trust, Hertfordshire Community NHS Trust, Lincolnshire Community Health Services NHS Trust, Leeds Community Healthcare NHS Trust, Wirral Community Health and Care NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, Hounslow and Richmond Community Healthcare NHS Trust, Dudley Integrated Health and Care Trust, Cambridgeshire Community Services NHS Trust, Birmingham Community Healthcare NHS Foundation Trust, Central London Community Healthcare NHS Trust, Kent Community Health NHS Foundation Trust

5.6 Indicator six

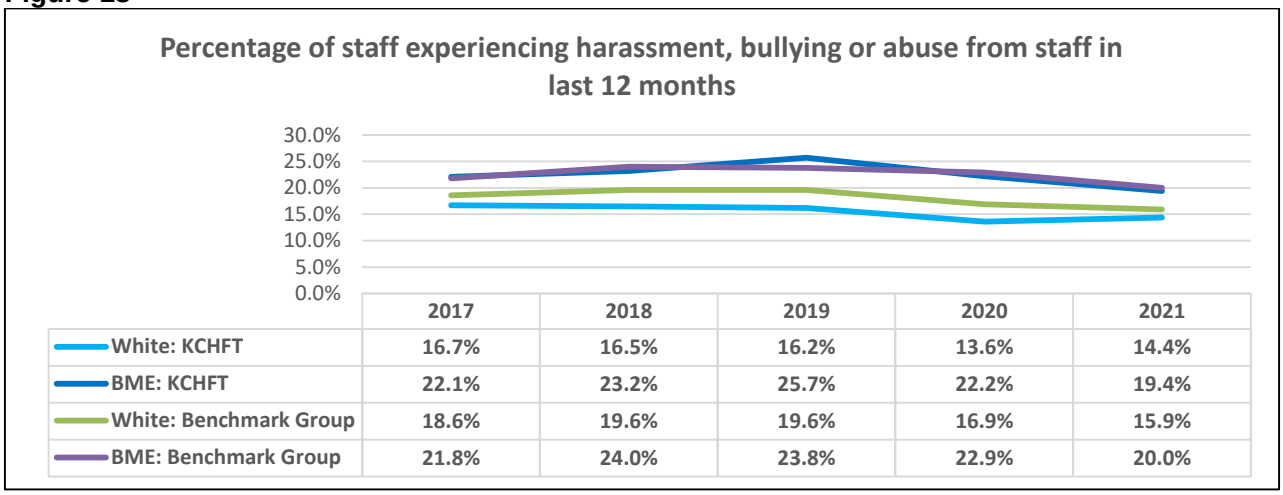
5.6.1 Indicator six looks at the percentage of staff experiencing harassment, bullying or abuse from other staff. The results show an improved position compared to last year. Still, like the national results, a higher proportion of BME staff continue experiencing bullying, harassment, or abuse compared to white staff.

Table 9

		2020		2021		2022	
		BME	WHITE	BME	WHITE	BME	WHITE
Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	Total	26%	16%	22%	14%	19%	14%

5.6.2 Figure 13 below shows a comparison of KCHFT against our benchmarking group* in the staff survey. It evidences that white and BME KCHFT staff experience less harassment, bullying, or abuse from colleagues than our benchmarking comparators.

Figure 13



	2017	2018	2019	2020	2021
White: KCHFT	16.7%	16.5%	16.2%	13.6%	14.4%
BME: KCHFT	22.1%	23.2%	25.7%	22.2%	19.4%
White: Benchmark Group	18.6%	19.6%	19.6%	16.9%	15.9%
BME: Benchmark Group	21.8%	24.0%	23.8%	22.9%	20.0%

5.7 Indicator seven

5.7.1 Indicator seven looks at the percentage of BME staff that believed the Trust provides equal opportunities for career progression or promotion compared to their White counterparts. There is a decrease in the percentage for both BME and white staff and the gap percentage between BME and white staff has slightly increased. The results mirror the national average. Work is underway within the Trust to improve this metric.

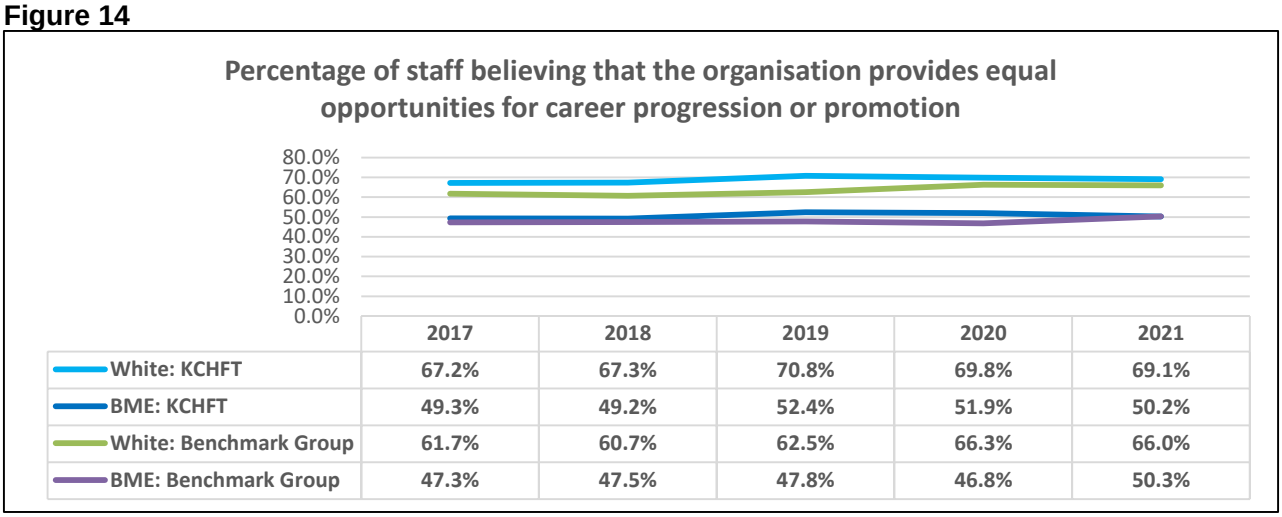
Table 10

		2020		2021		2022	
		BME	WHITE	BME	WHITE	BME	WHITE
Percentage believing that the Trust provides equal opportunities for career progression or promotion	Total	52%	714%	52%	70%	50%	69%

*Please note that the methodology for producing this metric has altered since 2020. An answer of 'Don't know' is now included in the denominator when in 2020 it was excluded. The figures for 2020 and 2021 have been restated using the new methodology to allow for comparison.

5.7.2 Figure 14 below shows a comparison of KCHFT against our benchmarking group* in the staff survey. It evidences that KCHFT has a better percentage of white colleagues who believe that the Trust provides equal opportunities for career progression or promotion and our BME colleagues have a comparable experience in this metric to those nationally.

Figure 14



5.8 Indicator eight

5.8.1 Indicator eight shows the percentage of BME staff compared to white staff that had, in the last 12 months, personally experienced discrimination at work from a manager/team leader or other colleagues. The data shows a slight improvement for BME colleagues, no change for white colleagues and a similar disparity between BME and white colleagues. This, therefore, needs to continue to be an area of focus in the coming year.

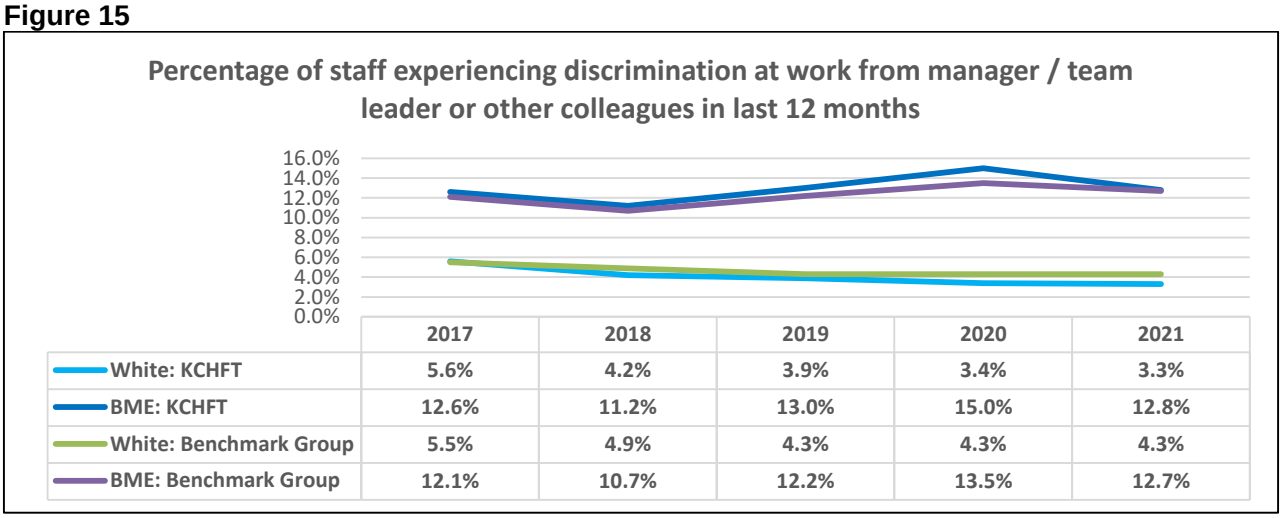
Table 11

		2020		2021		2022	
		BME	WHITE	BME	WHITE	BME	WHITE
In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues	Total	13%	4%	15%	3%	13%	3%

5.8.2 Figure 15 below shows a comparison of KCHFT against our benchmarking group* in the staff survey. It evidences that white colleagues at KCHFT experienced less discrimination that the

national benchmark, whilst the experience of our BME colleagues was compariable to the national picture.

Figure 15



5.9 Indicator nine

5.9.1 Indicator nine looks at the percentage difference between the organisations board voting membership and the organisations overall workforce. On the 31st March 2022, there were 17 Board members. There are usually 16 Board members, but one of the outgoing Executive Directors left on the 31st of March and after the replacement started. The Board is split into 9 Executive Directors, 7 Non-executive Directors and 1 Associate Non-executive Director. At KCHFT, all Non-executive board members are voting members; however, in 2022, there is no BME voting member as the only BME representative is the Associated Non-executive Director, who has no voting rights.

The percentage difference between the organisation's Board membership and its overall workforce disaggregated is represented below in Table 12:

Table 12

	2020			2021			2022		
	White	BME	Not Stated	White	BME	Not Stated	White	BME	Not Stated
By voting membership of the Board	86.7%	6.7%	6.7%	86.7%	6.7%	6.7%	93.3%	0.0%	6.7%
By executive membership of the Board	100%	0%	0%	100%	0%	0%	87.5%	0.0%	12.5 %
Difference (Total Board – Overall workforce)	9.0%	-2.1%	-6.9%	7.4%	-3.5%	-4.0%	5.1%	-5.1%	0.1%

6. Areas for improvement

6.1 The identified areas for improvement arising following an analysis of the WRES data are:

- BME applicants are less likely to be appointed at interview than white applicants; however, this year, there has been an improvement on last year's results but there is undoubtedly a lot of work needed to improve this metric and the experience of BME applicants. Further work is already in progress.
- White nurses at band 5 are disproportionately more likely to be appointed than BME nurses. However we have an ambitious international recruitment campaign underway this year which should rectify this disparity.
- BME colleagues remain less likely than white colleagues to feel that the Trust provides equal opportunities for career progression or promotion. Turnover for BME colleagues is 5.6% higher than for white colleagues (May-21 to Apr-22). The link between access to career progression and promotion and the higher BME turnover rate will be a key area of focus for the next 12 months.
- BME colleagues are still more likely to feel they have experienced discrimination at work from a manager/team leader or other colleagues than their white counterparts.
- The Trust Board and senior management, although diverse, are not representative from a BME perspective of the workforce at KCHFT nor of the local communities the Trust serves. There are currently no BME voting members on the Board.

7. Progress in the previous 12 months

7.1 The Trust was awarded £190,000 by NHSE/I to recruit nurses internationally. Nineteen nurses were recruited, resulting in an increased number of BME staff employed by the Trust. The Trust has since committed to an investment of £800,000 to support ongoing international recruitment and we are also in the process of expanding this international recruitment beyond nursing into AHPs and are currently preparing a business case to support this.

7.2 A mentoring programme for BME took place from September 2021 to February 2022. Participants of 6 different NHS organisations positively received the programme. Participants made important comments and recommendations when asked about barriers to progress in the organisation and this will be fed into our revisions of our action plans moving forward to ensure these are addressed.

7.3 Several workstreams with workforce representatives have been established to deliver the action plan of the Equality, Diversity and Inclusion Strategy. Many of the actions from the strategy are directly related to improving the WRES parameters.

8. Conclusion

8.1 In conclusion, KCHFT has made progress against many of the metrics of the WRES in the past 12 months. The main areas of improvement are the recruitment process and representation of BME staff at higher AFC bands, VSM and Board level.

8.2 Some positive findings are:

- Equalities monitoring declaration rates have improved, showing the Trust, as a whole, is representative of the communities it serves.

- BME colleagues are still less likely than their white counterparts to enter the formal disciplinary process. This has been the case for three reporting periods in a row.
- BME colleagues are slightly more likely to access non-mandatory training than their white counterparts.

8.3 There is still lots more to do. However, we have an ambitious programme of work that will lead to tangible improvements for our BME colleagues and improve their lived experience at work. We believe this will have a positive impact for the wider workforce and ultimately improve the experience of the patients' we serve.

8.4 A review of our existing EDI action plan, in light of the findings in this report, our WDES report and other feedback, is going to commence imminently with the view of a large scale engagement with networks and colleagues to ensure the actions identified not only address the areas for improvement but resonate and are owned by those that live the experience within KCHFT.

9. Recommendation

9.1 The Board is asked to approve this years WRES data and report for submission and publication on the Trust website. The action plan will be added to the website once complete.

NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	3.2
Agenda Item Title:	2022 Workforce Disability Equality Standard (WDES) report
Presenting Officer:	Victoria Robinson-Collins, Director of People and Organisational Development
Action – this paper is for:	☒ Decision ☐ Information ☐ Assurance

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

The report was received by the Board at its Part Two meeting on 14 July 2022.

The purpose of this paper is to provide detail of the WDES metric outcomes for 2021 and to seek approval for the WDES data to be submitted as per national requirements and for the report to be simultaneously published on our website. It is also to highlight to the Board that the action plan will follow in due course this year (usually published at the same time as the report) following the refresh of the EDI action plan as previously agreed.

Summary of key points

KCHFT has made some positive progress against many of the metrics in the past 12 months, but there is still work to do.

Some positive findings are:

- The percentage of disabled respondents reporting they felt pressured to come to work despite not feeling well enough to do decreased.
- The representation of disabled colleagues at Trust Board and/or Executive Team level has increased when compared to 2021.

The identified areas for improvement arising after analysing the WDES data are:

- ESR is not reflective of the disability status of trust colleagues, although there has been a 1.3% increase in last year's reported figures. Focus must be given to improving the accuracy and quality of the data within ESR, including encouraging and reassuring colleagues to share their status if they are reticent

and to update their status if they become disabled or experience a long term health condition during their career at KCHFT. It is important to remember that status may change from recruitment / entry to the NHS and during the lifetime of a colleague's career.

- Disabled staff are slightly more likely to be appointed from shortlisting.
- Disabled colleagues are more likely to enter the formal capability process when compared to their non-disabled colleagues. However, because of the small numbers involved, the results do not have statistical validity and should therefore be read with caution.
- Disabled colleagues responding in the NHSSS reported experiencing higher levels of harassment, bullying or abuse from patients, relatives or the public and that they were less likely to report this.
- In comparison to last year, there was a slight decrease in the number of disabled staff compared with non-disabled staff reporting levels of satisfaction with the extent to which the organisation values their work. However, a gap between the two groups must be addressed.

Proposal and/or recommendation to the Committee or Board
The Board is asked to approve this year's WDES data and report and action plan for submission and publication on the Trust website. The action plan will be added to the website once complete.

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

Kent Community Health
NHS Foundation Trust

Name:	Sarah Hayden	Job title:	Deputy Director of HR (Operations)
Telephone number:	07789 941879	Email	shayden@nhs.net

Kent Community Health
NHS Foundation Trust

WORKFORCE DISABILITY EQUALITY STANDARD (WDES) REPORT
July 2022

1. Introduction

1.1 The NHS long term plan commits Trusts to becoming a model employer for disabled people. This is seen as essential to guaranteeing the highest standards of care for patients. As an inclusive employer, KCHFT knows the value of a diverse workforce. We also recognise that the experience of our colleagues with a disability is not always as positive as that of our colleagues without a disability and are committed to changing this for the better. This is seen as essential to guaranteeing the highest standards of care for patients.

1.2 The national NHS workforce disability equality standard (WDES) report for 2021 published in May 2022 stated that 52,000 people in the NHS workforce (3.7%) declared a disability through the NHS Electronic Staff Record. This is an increase of 6,870 (0.3%) compared to 2020.

1.3 Results of the national annual NHS staff survey (NHSSS) for 2020 show that disabled staff consistently report higher levels of bullying and harassment and less satisfaction with appraisals and career development opportunities[1].

1.4 The WDES encourages the development of a more diverse, empowered and valued workforce and implementing it will support NHS organisations in complying with the provisions of the Equality Act 2010. It's purpose is to improve the experience of disabled staff working for, and seeking employment in the NHS.

1.5 The WDES became mandatory following the revision to the 2018 NHS standard contract and came into force on 1 April 2019.

1.6 Underpinning the WDES is the "social model of disability"[2]. This recognises that disabled people face a range of societal barriers and these create disability rather than the impairment or long-term condition.

1.7 There is a requirement for every NHS organisation to publish data annually showing the workplace experience of disabled staff compared to non-disabled staff following analysis of workforce information, staff survey results and disability representation on Trust Boards. The analysis is undertaken against ten metrics.

[1] Workforce Disability Equality Standard 2021
[2] https://www.scope.org.uk/about-us/social-model-of-disability/

2. WDES metrics

2.1 There are 10 WDES metrics:

- Three metrics focus on workforce data
- Five are based on questions from the national NHS Staff Survey (NHSSSS)
- One metric focuses on disability representation on Boards
- One metric (metric 9) focuses on the voices of disabled staff, 9b asks for evidence to be provided in the WDES annual report

2.2 The data used to report on the workforce metrics is taken from ESR either as a snapshot on 31 March 2022 or as data for the year up to this date.

2.3 The information used to report against the metrics concerned with the staff survey is taken from the 2020 NHSSS.

3. Demographics

3.1 Data from the National Office of Statistics for 2011, which asks people whether their day to day activities are limited because of a health problem or disability which has lasted, or is expected to last, at least 12 months, shows that across England 17.9% of the population in England and Wales reported a disability that limited their daily activities[3].

3.2 According to the 2011 Census, 17.6% of residents in Kent have a health problem or disability which limits their day-to-day activities[4], in East Sussex it is 20.3%[5] and in North East London it is 14.7%[6].

4. Workforce

4.1 At KCHFT an accurate picture is difficult to ascertain. Data held in the Electronic Staff Record (ESR) suggests that only 6.2% of colleagues have declared they have a disability. This is an improvement on last years' figure of 4.9%. However, of those colleagues that completed the 2021 staff survey (836) 26% indicated they have a physical or mental health condition, disability or illness that has lasted or is expected to last for 12 months or more. Work is currently underway aimed at addressing the difference in results reported on ESR compared to the results reported on the NHSSS. This includes encouraging colleagues to regularly review and update their ESR personal information via the self service portal as their status may change throughout the life of their NHS career. However it is important to note that the question in the staff survey is broader than the declaration of a disability. Another important factor to understand is what is driving colleague reticence to reflect their disability in their ESR record status.

[3] Office for National Statistics
[4] Disability in Kent Bulletin 2018
[5] 2011 Census Equalities… in brief
[6] 2011 Census: Long-term health problem or disability, local authorities in England and Wales

5. Trust results

5.1 Metric one

5.1.1 Metric one represents the percentage of staff in AfC pay bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce that have declared their disability status. The data in Tables 1 and 2 below shows the breakdown for clinical and non-clinical staff and grouped in different clusters.

Table 1

Non-Clinical Staff		DISABLED	NON-DISABLED	DISABILITY UNKNOWN OR NULL
Cluster 1 (Band 1 - 4)	Total	6.6%	89.2%	4.2%
Cluster 2 (Band 5 - 7)	Total	9.8%	86.3%	3.8%
Cluster 3 (Band 8a - 8b)	Total	4.7%	89.5%	5.8%
Cluster 4 (Band 8c - 9 & VSM)	Total	10.3%	89.7%	0.0%

Table 2

Clinical Staff		DISABLED	NON-DISABLED	DISABILITY UNKNOWN OR NULL
Cluster 1 (Band 1 - 4)	Total	4.7%	90.4%	4.9%
Cluster 2 (Band 5 - 7)	Total	6.7%	90.0%	3.2%
Cluster 3 (Band 8a - 8b)	Total	4.1%	93.1%	2.8%
Cluster 4 (Band 8c - 9 & VSM)	Total	0.0%	93.8%	6.3%
Cluster 5 (Medical & Dental Staff, Consultants)	Total	5.9%	88.2%	5.9%
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	Total	1.3%	93.4%	5.3%
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	Total	N/A	N/A	N/A

NB figures are rounded to 1 decimal place to total %'s may not always total 100%

5.1.2 Figures 1 and 2 show an increase in the number of staff declaring a disability over the years in ESR from 3.8% in 2018 to 6.2% in 2022 . Whilst this is an improvement, it is recognised that more work needs to be done to match the level of disclosure evident in the staff survey of 26%.

5.1.3 Figure 3 breaks down the percentage of staff by disability and staff group, while figure 4 breaks the data down by disability for clinical and non-clinical staff.

5.1.4 Figure 5 compares the data of disabled and non-disabled staff across the different pay bands in the Trust.

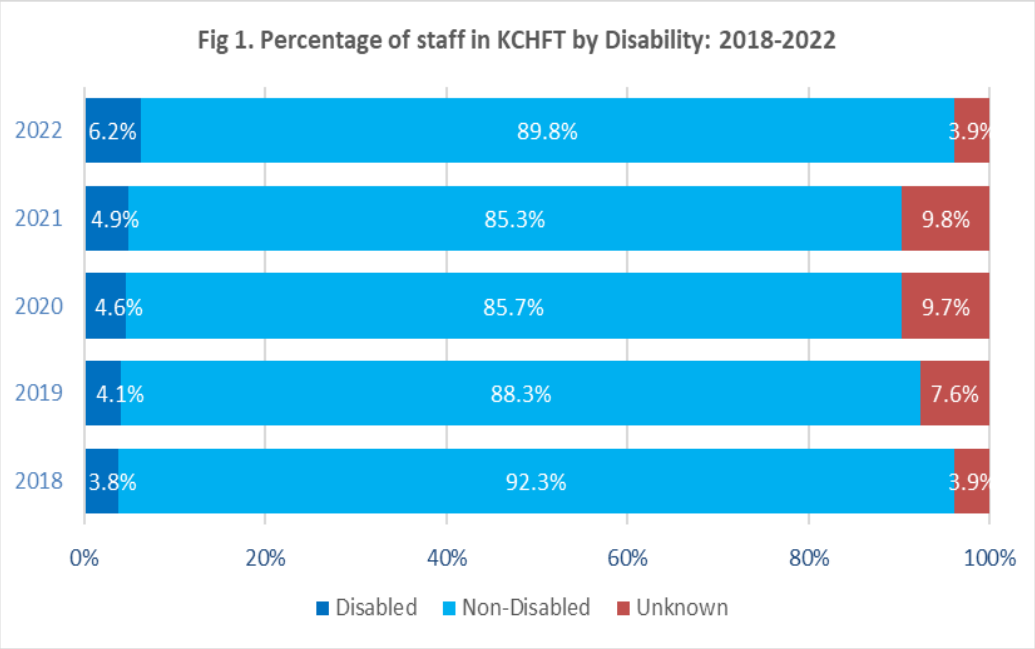


Fig 1. Percentage of staff in KCHFT by Disability: 2018-2022
2022
6.2%
89.8%
3.9%
2021
4.9%
85.3%
9.8%
2020
4.6%
85.7%
9.7%
2019
4.1%
88.3%
7.6%
2018
3.8%
92.3%
3.9%
0%
20%
40%
60%
80%
100%
Disabled
Non-Disabled
Unknown

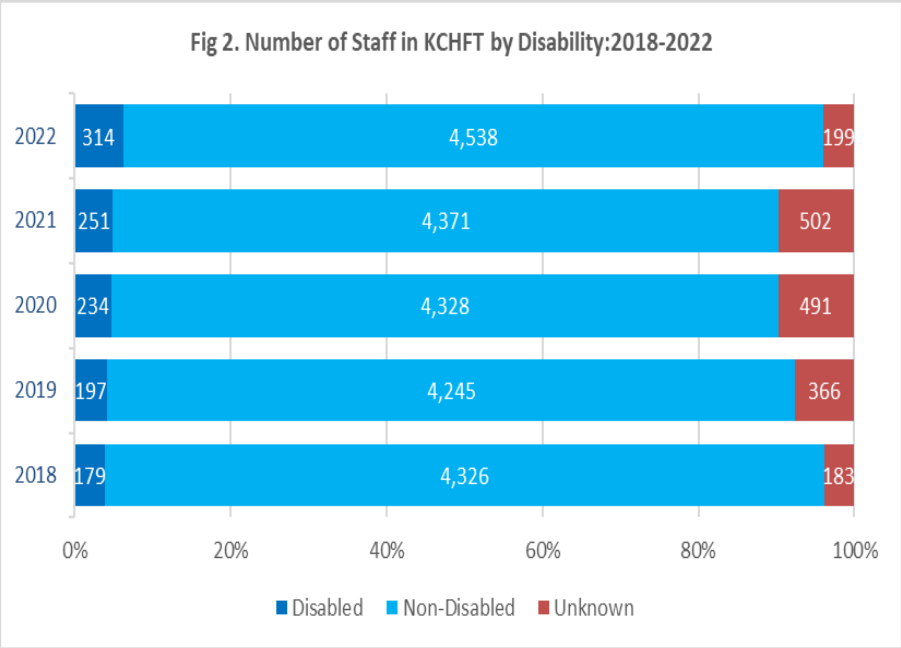


Fig 2. Number of Staff in KCHFT by Disability:2018-2022
2022
314
4,538
199
2021
251
4,371
502
2020
234
4,328
491
2019
197
4,245
366
2018
179
4,326
183
0%
20%
40%
60%
80%
100%
Disabled
Non-Disabled
Unknown

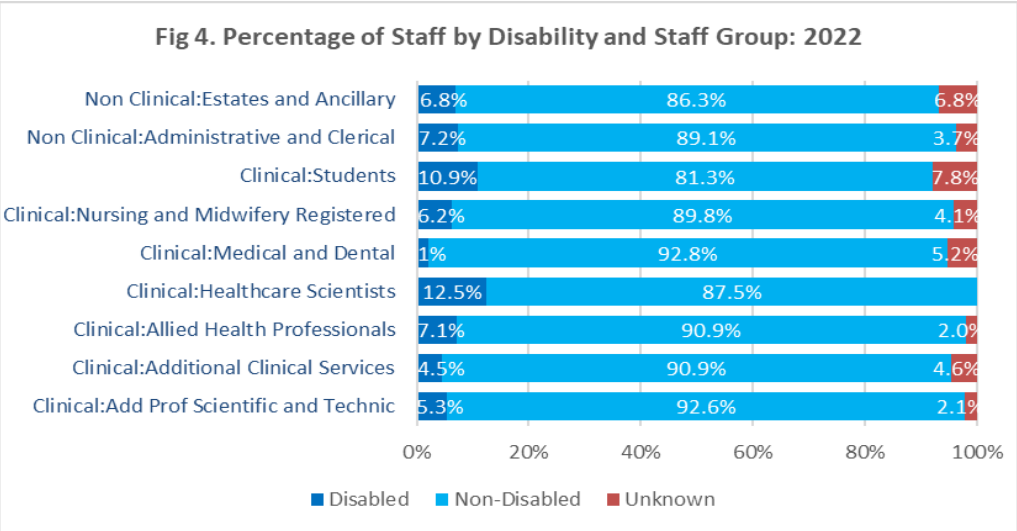


Fig 4. Percentage of Staff by Disability and Staff Group: 2022
Non Clinical:Estates and Ancillary
6.8%
86.3%
6.8%
Non Clinical:Administrative and Clerical
7.2%
89.1%
3.7%
Clinical:Students
10.9%
81.3%
7.8%
Clinical:Nursing and Midwifery Registered
6.2%
89.8%
4.1%
Clinical:Medical and Dental
1%
92.8%
5.2%
Clinical:Healthcare Scientists
12.5%
87.5%
Clinical:Allied Health Professionals
7.1%
90.9%
2.0%
Clinical:Additional Clinical Services
4.5%
90.9%
4.6%
Clinical:Add Prof Scientific and Technic
5.3%
92.6%
2.1%
0%
20%
40%
60%
80%
100%
Disabled
Non-Disabled
Unknown

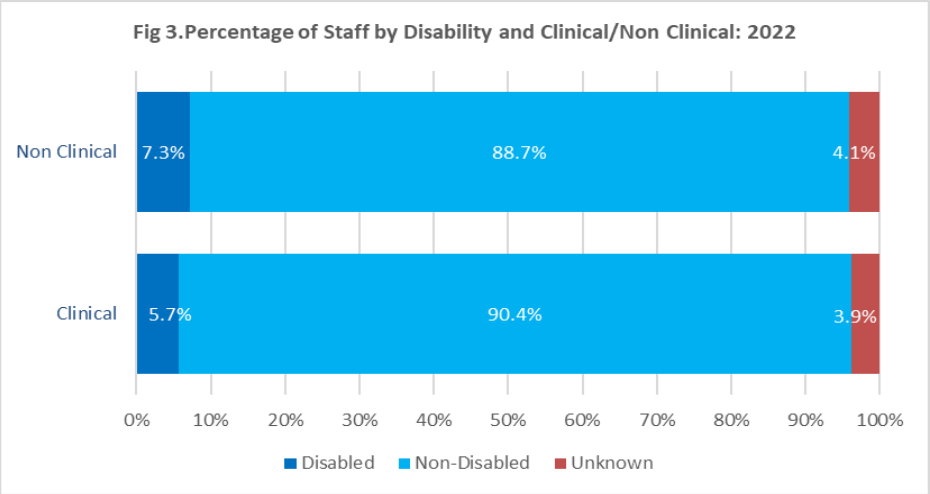


Fig 3.Percentage of Staff by Disability and Clinical/Non Clinical: 2022
Non Clinical
7.3%
88.7%
4.1%
Clinical
5.7%
90.4%
3.9%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Disabled
Non-Disabled
Unknown

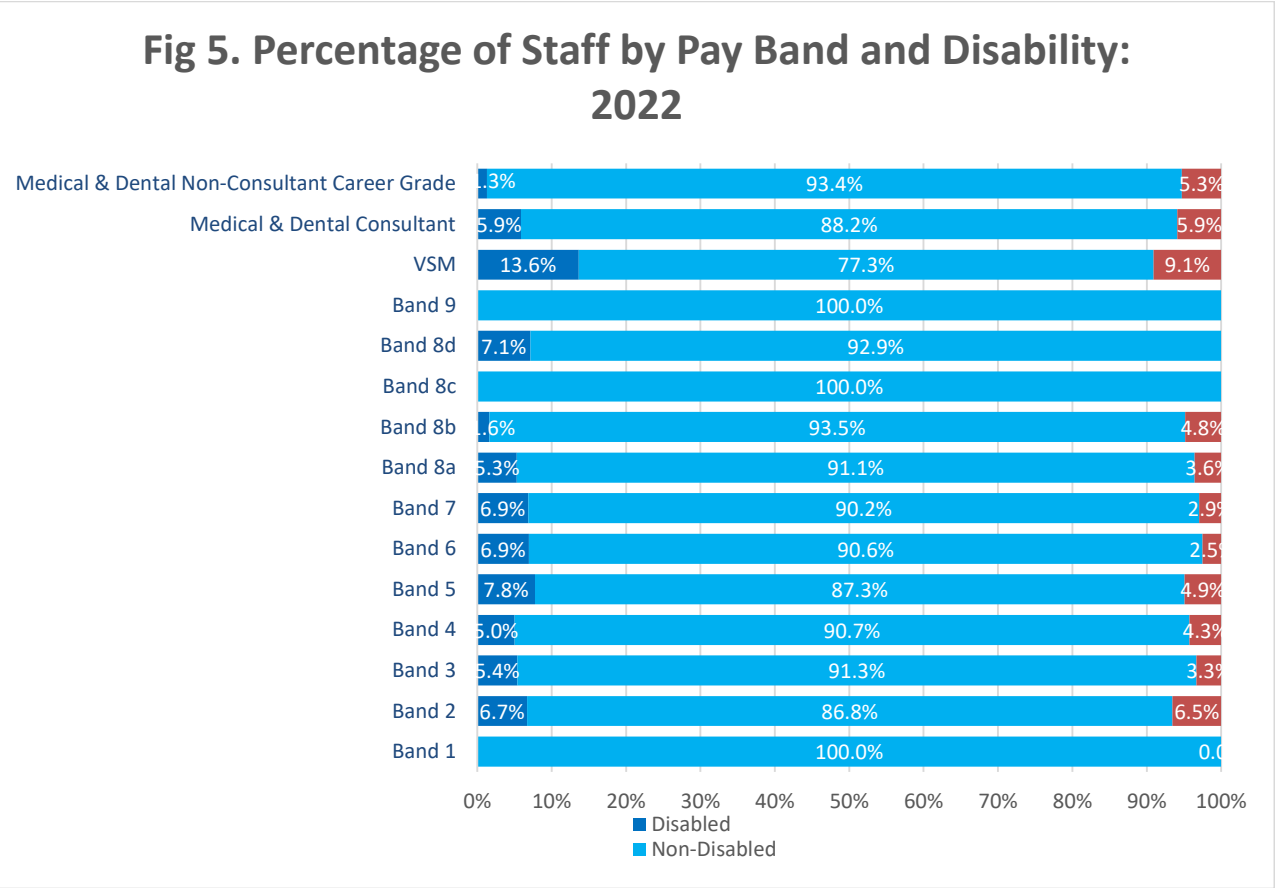


Fig 5. Percentage of Staff by Pay Band and Disability: 2022
Medical & Dental Non-Consultant Career Grade
Medical & Dental Consultant
VSM
Band 9
Band 8d
Band 8c
Band 8b
Band 8a
Band 7
Band 6
Band 5
Band 4
Band 3
Band 2
Band 1
93.4%
5.3%
88.2%
5.9%
13.6%
77.3%
9.1%
100.0%
7.1%
92.9%
100.0%
93.5%
4.8%
91.1%
6.9%
90.2%
6.9%
90.6%
7.8%
87.3%
4.9%
90.7%
4.3%
91.3%
3.3%
86.8%
6.5%
100.0%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Disabled
Non-Disabled

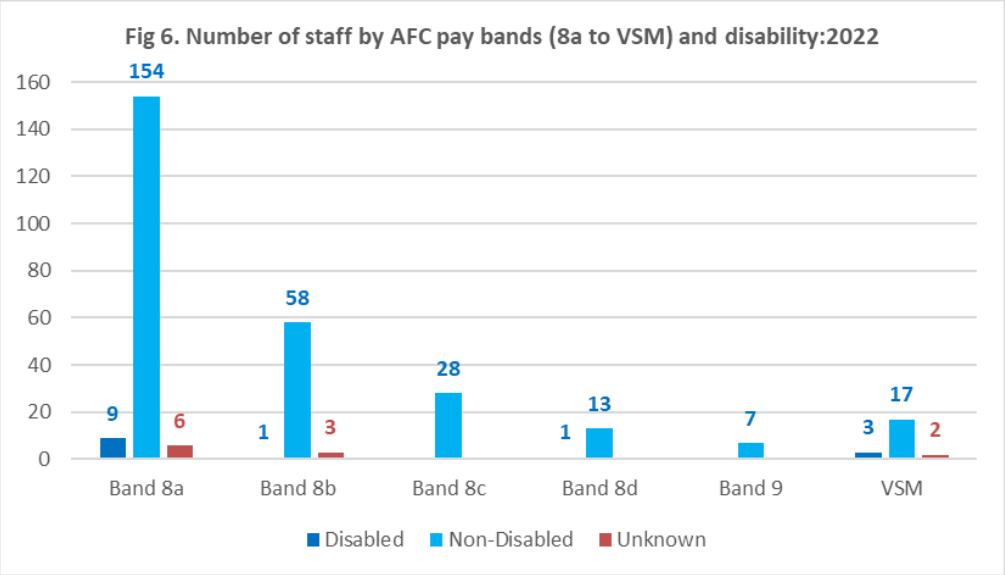


Fig 6. Number of staff by AFC pay bands (8a to VSM) and disability:2022
160
140
120
100
80
60
40
20
0
9
154
6
1
58
3
28
1
13
7
3
17
2
Band 8a
Band 8b
Band 8c
Band 8d
Band 9
VSM
Disabled
Non-Disabled
Unknown

5.2 Metric two

5.2.1 Metric two examines the relative likelihood of disabled people compared to non-disabled people being appointed from shortlisting across all posts. The data refers to both internal and external posts advertised. The figure of 0.92 indicates that disabled applicants are more likely to be appointed from shortlisting than non-disabled applicants. This is really positive.

Table 3

		2020/2021	2021/2022
		RELATIVE LIKELIHOOD	
Relative likelihood of Disabled staff compared to non-Disabled staff being appointed from shortlisting across all posts	Total	1.12	0.92

5.3 Metric three

5.3.1 Metric three looks at the relative likelihood of disabled colleagues compared to non-disabled colleagues entering the formal capability process, as measured by entry into the formal capability procedure based on data from a two-year rolling average of the current and previous years. The data excludes staff going through health-related capability processes.

5.3.2 The relative likelihood of disabled colleagues entering a formal capability process compared to their non-disabled colleagues is 2.28. This means disabled colleagues are more likely to enter this process than their non-disabled colleagues. There seems to be a big difference from the results reported last year of 0.915. However, one additional member of staff that may enter the capability process will greatly affect results. This may cause large fluctuations from year to year based on a difference of a small number of people. The information used to arrive at this figure is taken from the employee relations case management system, which contains equalities data taken from ESR. Therefore this result may not be representative of the true picture because of the low declaration rates.

Table 4

		2020/2021	2021/2022
		RELATIVE LIKELIHOOD	
Relative likelihood of Disabled staff compared to non-Disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	Total	0.915	2.28

5.3.3 To provide greater assurance in relation to this metric, the table below shows the actual number of cases for disabled and non-disabled colleagues in the capability process over the last two years. It shows that there were 3 cases over the last two-year period. So although this significantly impacts on the likelihood score, it is low numbers of individuals and therefore has limited statistical validity.

Table 5

	Average over two years		
	Capability Cases	**Staff In Post**	**Likelihood of Staff Entering Capability**
Disabled	3	314	0.010
Non-Disabled	19	4,538	0.004

5.4 Metric four

5.4.1 Metric four looks at the percentage of staff experiencing harassment, bullying or abuse. The period covered by the 2021 survey shows that disabled respondents still reporting higher levels of harassment, bullying or abuse compared to non-disabled respondents in all three aspects of the question on this topic.

Table 6

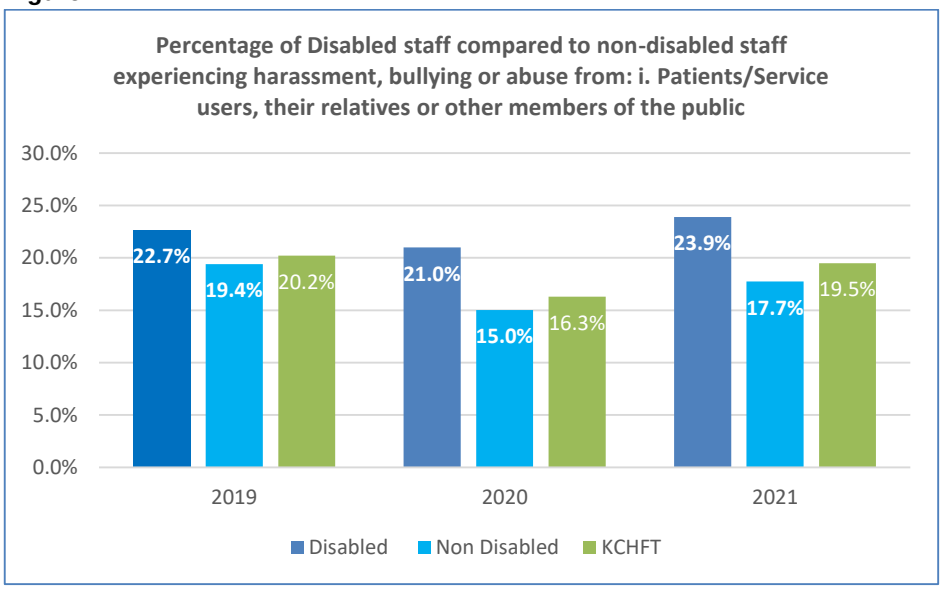
		2020		2021	
a) Percentage of Disabled staff compared to non-Disabled staff experiencing harassment, bullying or abuse from:		DISABLED	NON-DISABLED	DISABLED	NON-DISABLED
i. Patients/service users, their relatives or other members of the public	Total	21.0%%	15.0%%	23.9%	17.7%
ii. Managers	Total	12.2%	6.4%	9.9%	6.4%
iii. Other colleagues	Total	13.8%	9.2%	15.9%	9.3%
b) Percentage of Disabled staff compared to non-Disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. The data for this Metric should be a snapshot as at 31 March 2020	Total	59.6%	61.0%%	62.1%	59.0%

5.4.2 There was an increase of 2.9 % in the number of disabled staff experiencing bullying, harassment or abuse from patients, relatives and service users. There was also a 3.2%

increase of all staff being harassed by patients, relatives and service users. This seems like a large increase, however proportionately the position for disabled colleagues has improved.

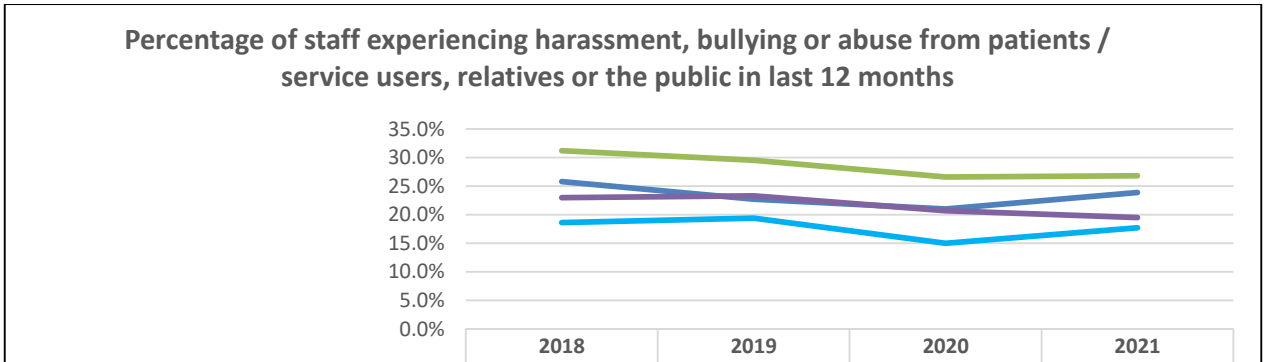
5.4.3 In 2020 disabled staff were 1.4 times more likely to be harassed compared to non-disabled staff. In 2021, disabled staff were 1.35 times more likely to be harassed compared to non-disabled staff.

Figure 7



5.4.4 When comparing KCHFT against our comparators in our staff survey benchmarking group*, disabled and non-disabled KCHFT staff experience less harassment, bullying, or abuse from patients/service users, relatives or the public.

Figure 8

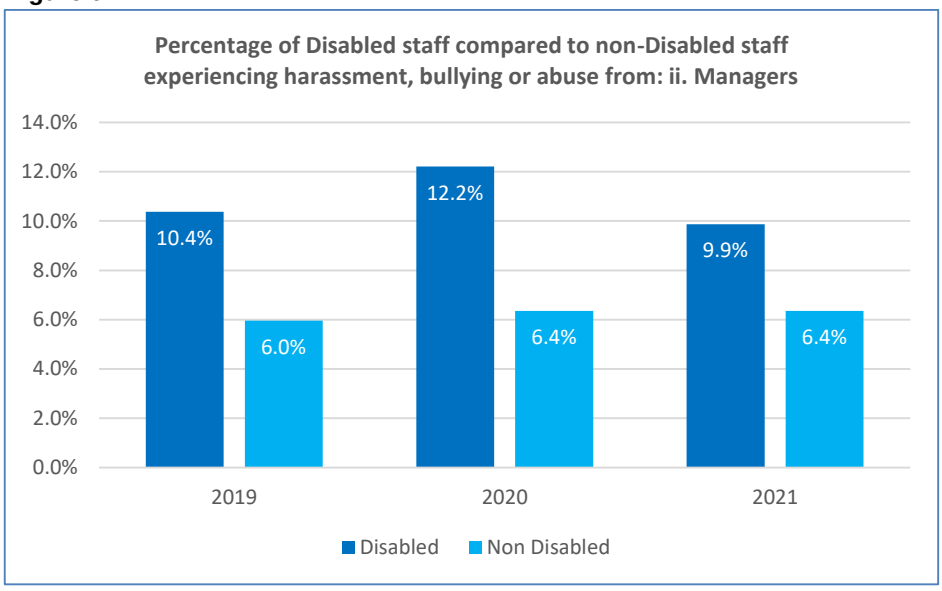


	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	25.8%	22.7%	21.0%	23.9%
Staff without a LTC or illness: KCHFT	18.6%	19.4%	15.0%	17.7%
Staff with a LTC or illness:Benchmark Group	31.2%	29.5%	26.6%	26.8%
Staff without a LTC or illness:Benchmark Group	23.0%	23.3%	20.7%	19.5%

*Benchmarking Group: Shropshire Community Health NHS Trust, Isle of Wight NHS Trust (community sector), Sussex Community NHS Foundation Trust, Bridgewater Community Healthcare NHS Foundation Trust, Norfolk Community Health and Care NHS Trust, Hertfordshire Community NHS Trust, Lincolnshire Community Health Services NHS Trust, Leeds Community Healthcare NHS Trust, Wirral Community Health and Care NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust, Hounslow and Richmond Community Healthcare NHS Trust, Dudley Integrated Health and Care Trust, Cambridgeshire Community Services NHS

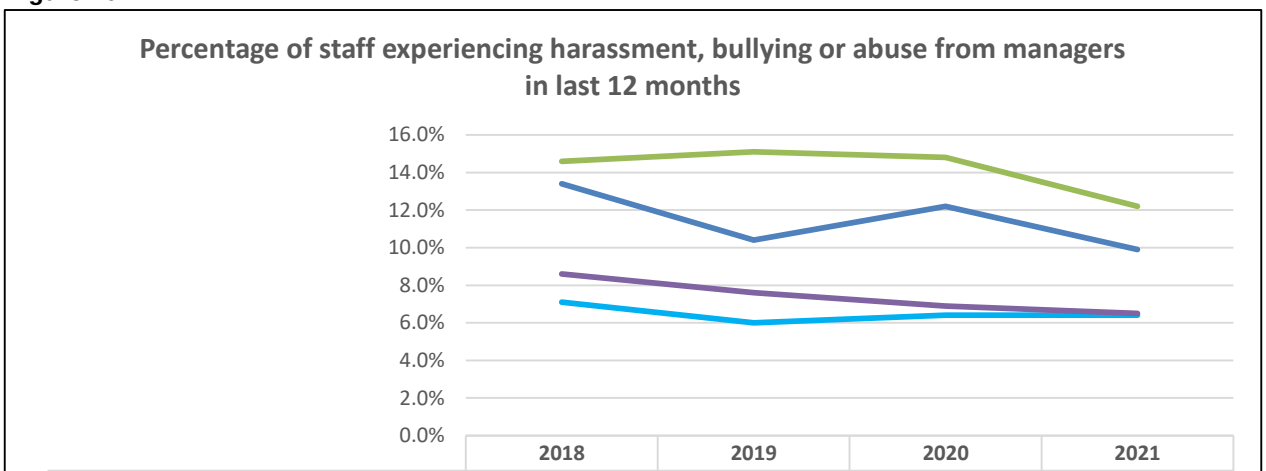
5.4.5 There was a improvement from last year, with fewer disabled staff experiencing bullying, harassment or abuse from managers compared to non-disabled staff.

Figure 9



5.4.6 When comparing KCHFT against our comparators in our staff survey benchmarking group*, disabled and non-disabled KCHFT staff experience less harassment, bullying, or abuse from managers.

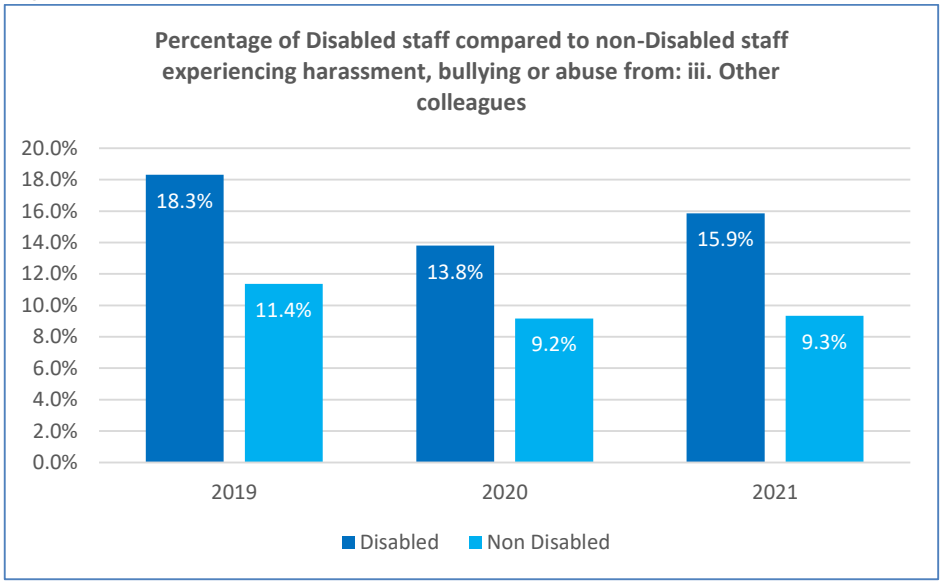
Figure 10



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	13.4%	10.4%	12.2%	9.9%
Staff without a LTC or illness: KCHFT	7.1%	6.0%	6.4%	6.4%
Staff with a LTC or illness:Benchmark Group	14.6%	15.1%	14.8%	12.2%
Staff without a LTC or illness:Benchmark Group	8.6%	7.6%	6.9%	6.5%

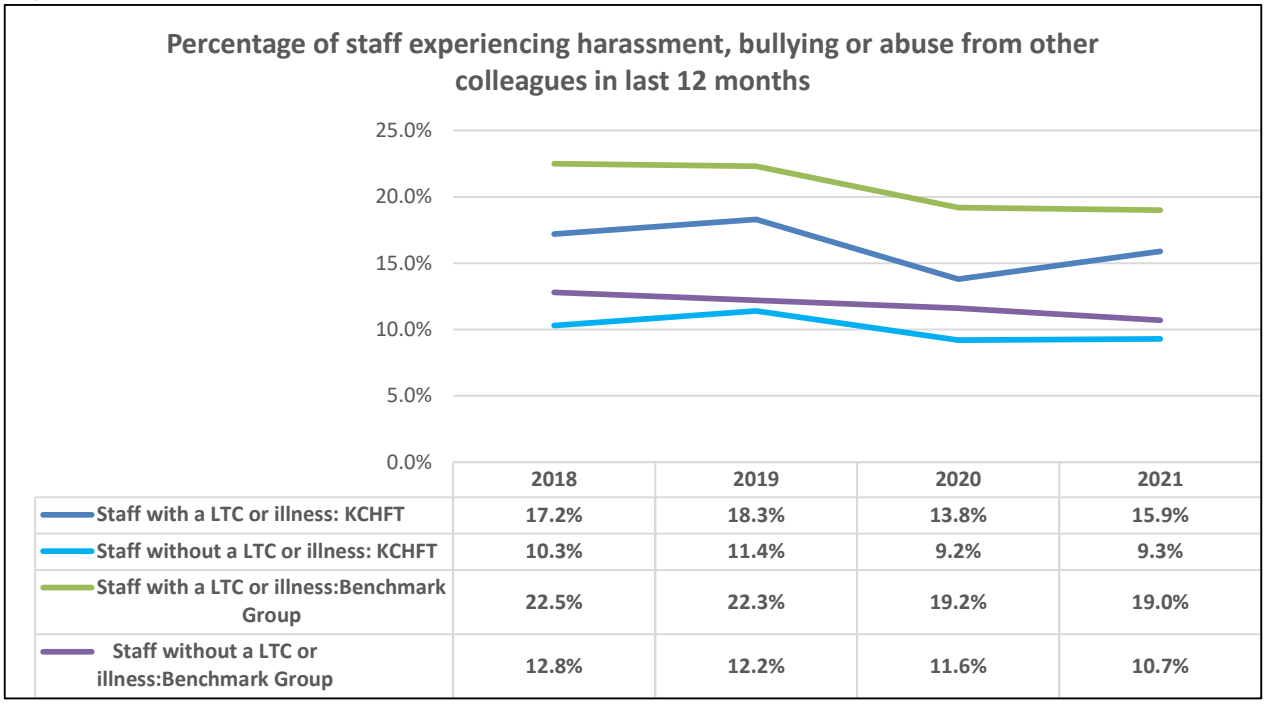
5.4.6 There was a deterioration when examining the percentage of disabled staff experiencing bullying and harassment from other colleagues.

Figure 11



5.6.7 When comparing KCHFT against our comparators in our staff survey benchmarking group*, disabled and non-disabled KCHFT staff experience less harassment, bullying, or abuse from other colleagues.

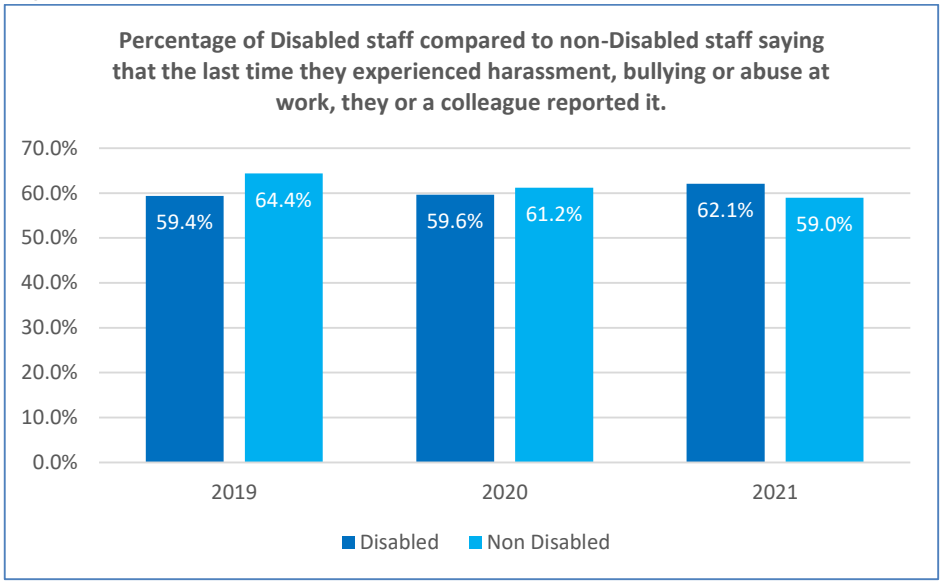
Figure 12



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	17.2%	18.3%	13.8%	15.9%
Staff without a LTC or illness: KCHFT	10.3%	11.4%	9.2%	9.3%
Staff with a LTC or illness:Benchmark Group	22.5%	22.3%	19.2%	19.0%
Staff without a LTC or illness:Benchmark Group	12.8%	12.2%	11.6%	10.7%

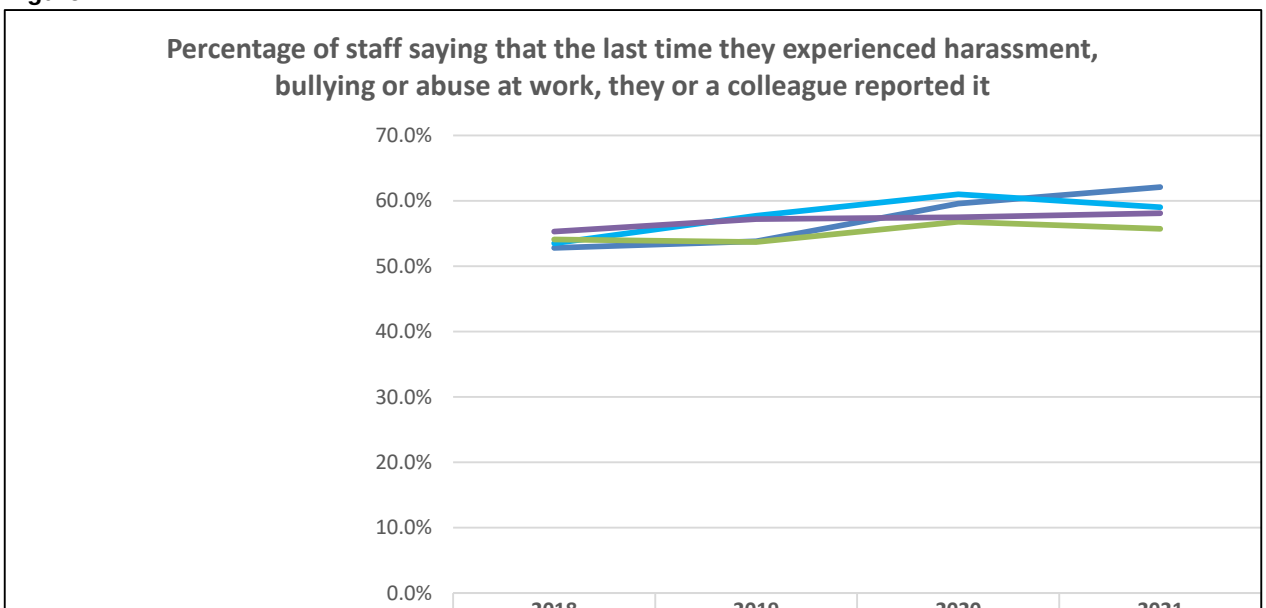
5.4.8 Disabled staff also indicated they or their colleagues were more likely, compared to their non-disabled counterparts, to report when they had experienced bullying, harassment or abuse at work.

Figure 13



5.4.9 When comparing KCHFT against our comparators in our staff survey benchmarking group*, staff at KCHFT are more likely to report abuse which is really positive.

Figure 14



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	52.8%	53.8%	59.6%	62.1%
Staff without a LTC or illness: KCHFT	53.5%	57.7%	61.0%	59.0%
Staff with a LTC or illness:Benchmark Group	54.1%	53.7%	56.8%	55.7%
Staff without a LTC or illness:Benchmark Group	55.3%	57.2%	57.5%	58.1%

5.5 Metric five

5.5.1 Metric five asks what percentage of disabled colleagues compared to non-disabled colleagues believe that the Trust provides equal opportunities for career progression or promotion. There is little difference in the perception of promotions between disabled and non-disabled colleagues.

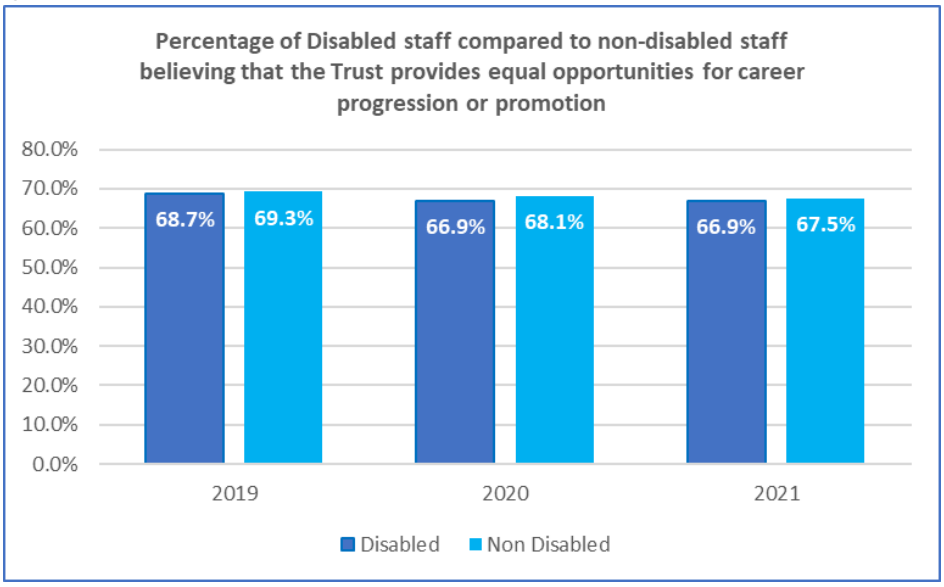
Table 7

		2020*		2021	
		DISABLED	NON-DISABLED	DISABLED	NON-DISABLED
Percentage of Disabled staff compared to non-Disabled staff believing that the Trust provides equal opportunities for career progression or promotion.	Total	66.9%*	68.1%*	66.9%	67.5%

*Please note that the methodology for producing this metric has altered since 2020. An answer of 'Don't know' is now included in the denominator when in 2020 it was excluded. The figures for 2020 have been restated using the new methodology to allow for comparison.

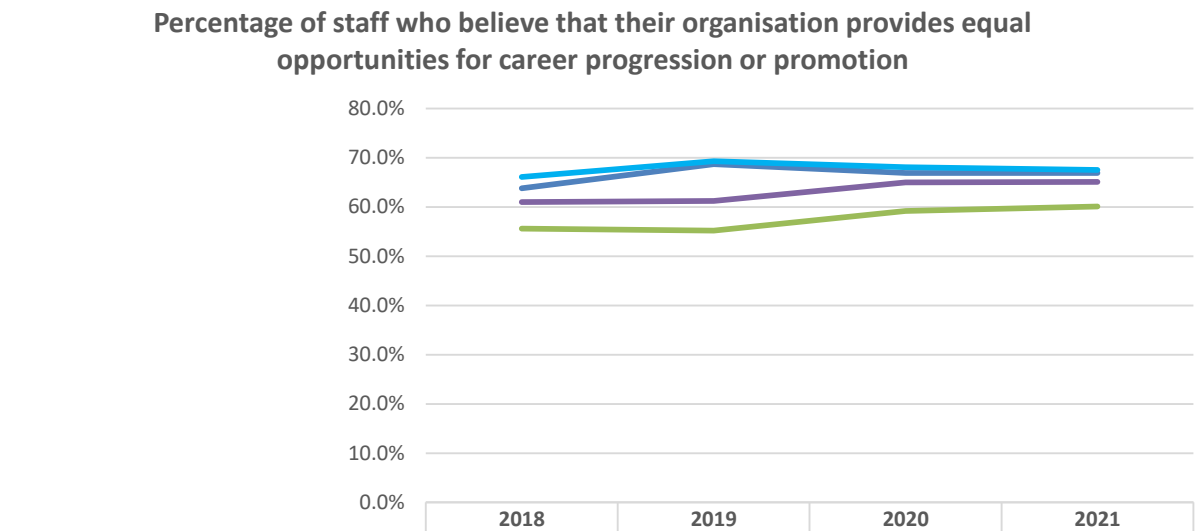
5.5.2 In 2021, there was little or no change in this metric for both disabled and non-disabled colleagues compared to last year.

Figure 15



5.5.3 Disabled and non-disabled colleagues who are employed by KCHFT favourably believe the Trust provides equal opportunities for career progression or promotion when compared to other benchmarked organisations*.

Figure 16



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	63.8%	68.7%	66.9%	66.9%
Staff without a LTC or illness: KCHFT	66.1%	69.3%	68.1%	67.5%
Staff with a LTC or illness:Benchmark Group	55.6%	55.2%	59.2%	60.1%
Staff without a LTC or illness:Benchmark Group	61.0%	61.2%	65.0%	65.1%

5.6 Metric six

5.6.1 Metric six asked what percentage of disabled colleagues compared to non-disabled colleagues said that they had felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. 18.2% of disabled respondents to the survey reported they had. This is lower than the previous year, and the disparity between disabled and non-disabled colleagues' experiences has narrowed. The Trust intends to continue to focus on how the experience of disabled colleagues can be improved and how, overall, the Trust culture reinforces the need for rest, recuperation and a step away from presenteeism.

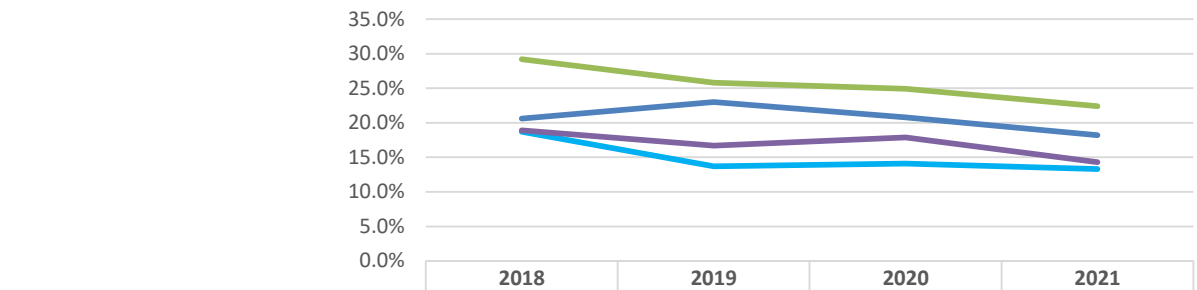
Table 8

		2020		2021	
		DISABLED	NON-DISABLED	DISABLED	NON-DISABLED
Percentage of Disabled staff compared to non-Disabled staff saying that they have felt pressure from their manager to	Total	20.8%	14.1%	18.2%	13.3%

come to work, despite not feeling well enough to perform their duties.					

5.6.2 When comparing KCHFT against our comparators in our staff survey benchmarking group*, KCHFT staff felt less pressure from their manager to come to work, despite not feeling well enough to perform their duties.

Figure 17



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	20.6%	23.0%	20.8%	18.2%
Staff without a LTC or illness: KCHFT	18.7%	13.7%	14.1%	13.3%
Staff with a LTC or illness:Benchmark Group	29.2%	25.8%	24.9%	22.4%
Staff without a LTC or illness:Benchmark Group	18.9%	16.7%	17.9%	14.3%

5.7 Metric seven

5.7.1 Metric seven looked at the percentage of disabled colleagues compared to non-disabled colleagues saying that they are satisfied with the extent to which their organisation values their work. The results have worsened for 2021 overall for both disabled and non-disabled colleagues. The gap in perception between disabled and non-disabled colleagues has reduced but further work in still needed in this area.

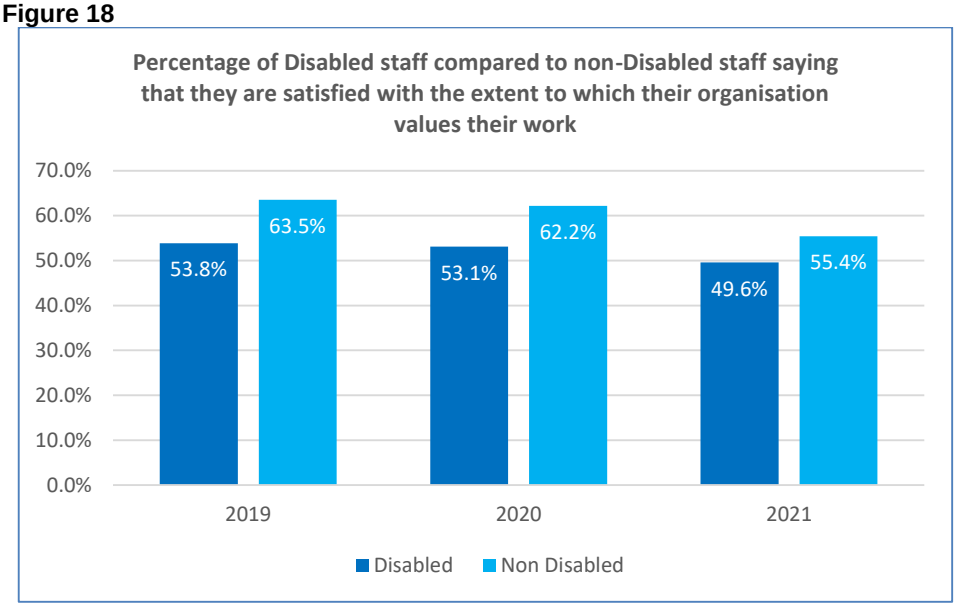
Table 9

		2020		2021	
		DISABLED	NON-DISABLED	DISABLED	NON-DISABLED
Percentage of Disabled staff compared to non-Disabled staff saying that they are satisfied with the extent to which their	Total	53.1%	62.2%	49.6%	55.4%

organisation values their work.					

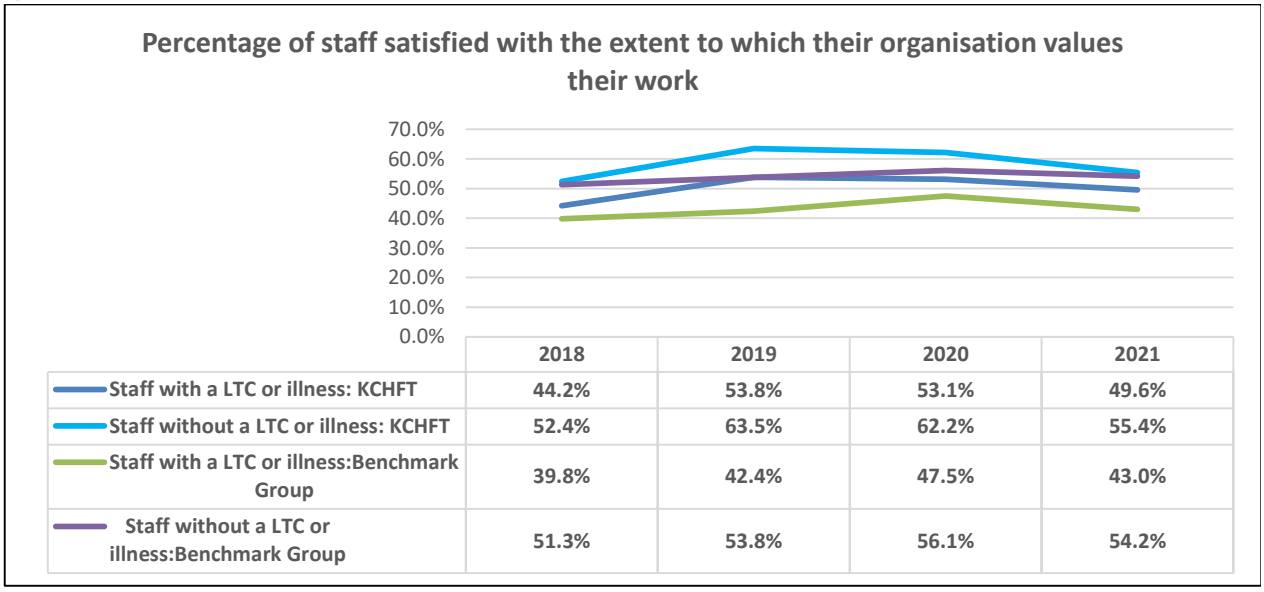
5.7.2 The disparity in the perception between disabled and non-disabled staff has narrowed from 9.1% in 2020 to 5.8% in 2021.

Figure 18



5.7.3 When comparing KCHFT against our comparators in our staff survey benchmarking group*, KCHFT results are better than the benchmark.

Figure 19



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	44.2%	53.8%	53.1%	49.6%
Staff without a LTC or illness: KCHFT	52.4%	63.5%	62.2%	55.4%
Staff with a LTC or illness:Benchmark Group	39.8%	42.4%	47.5%	43.0%
Staff without a LTC or illness:Benchmark Group	51.3%	53.8%	56.1%	54.2%

5.8 Metric eight

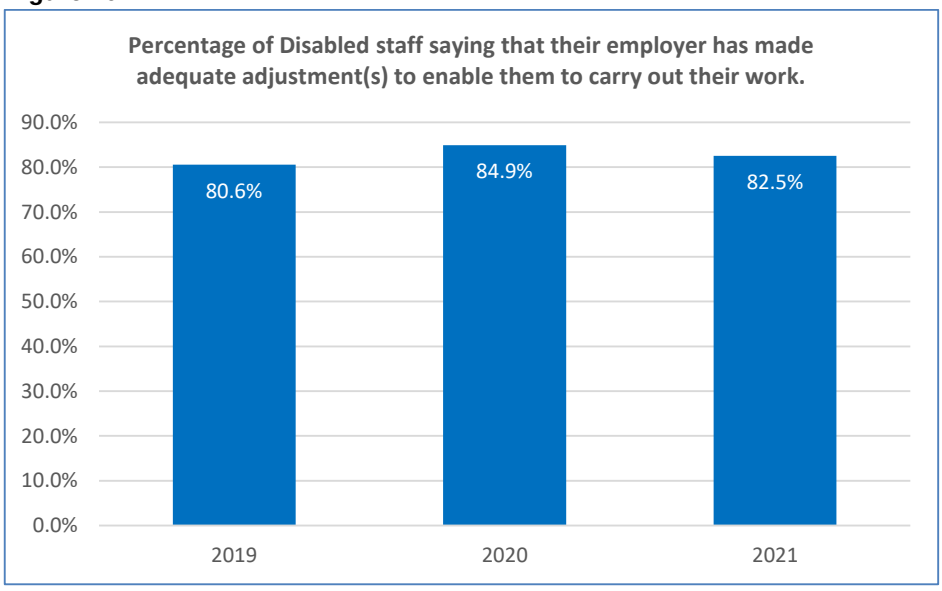
5.8.1 Metric eight asked about the percentage of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. 82.5% of disabled colleagues responded that the Trust had made the adjustments needed. This figure has slightly worsened since the previous year, when 84.9% reported this to be the case. It is important for the Trust to explore whether this is a disproportionate impact of Covid-19, i.e. a step for many services into virtual or hybrid working, and the impact of PPE on colleagues with disabilities.

Table 10

		2020	2021
Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	Total	84.9%	82.5%

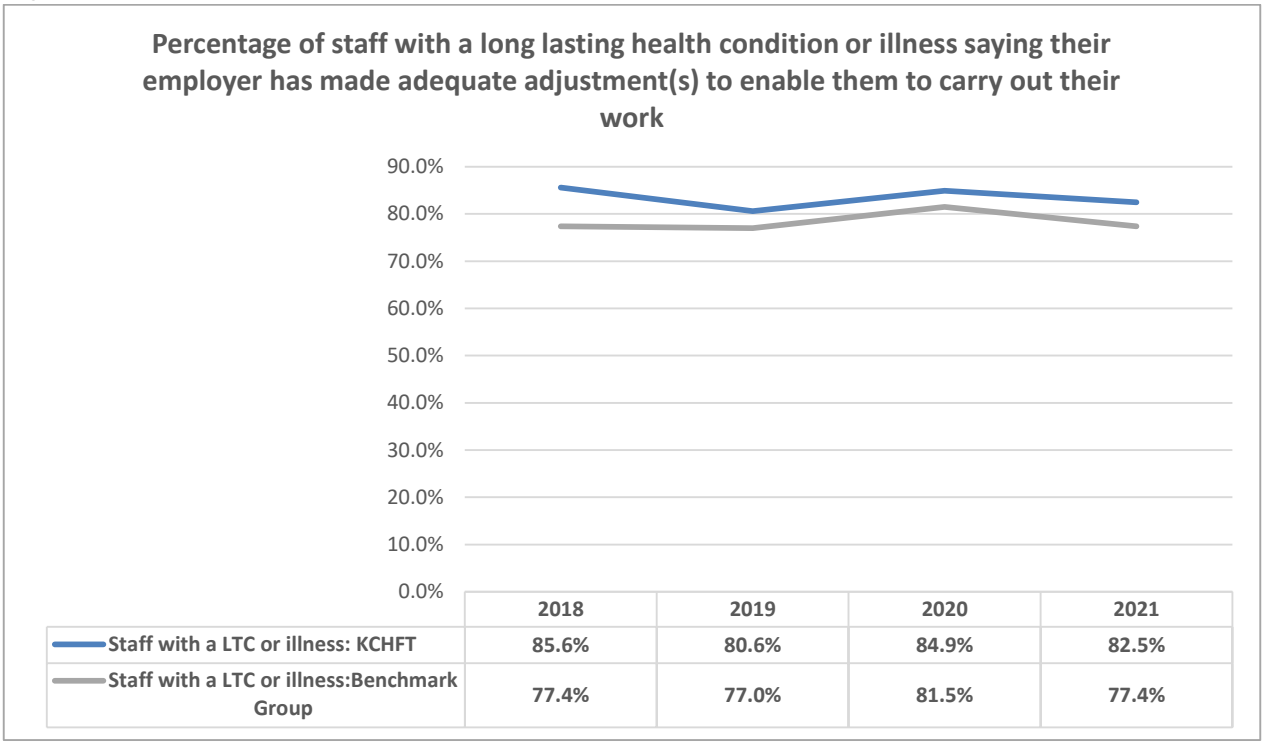
5.8.2 Overall, the results have not changed significantly over the past three years.

Figure 20



5.8.3 When comparing KCHFT against our comparators in our staff survey benchmarking group*, a larger percentage of KCHFT staff believe that the Trust has made adequate adjustment(s) to enable them to carry out their work than those of our benchmark comparators.

Figure 21



5.9 Metric nine

5.9.1 Metric nine is made of two parts. Part (a) compares the Trust's staff engagement score for disabled staff and non-disabled staff. Part (b) asks for evidence that the Trust has taken action to facilitate the voices of Disabled staff.

5.9.2 Part (a)

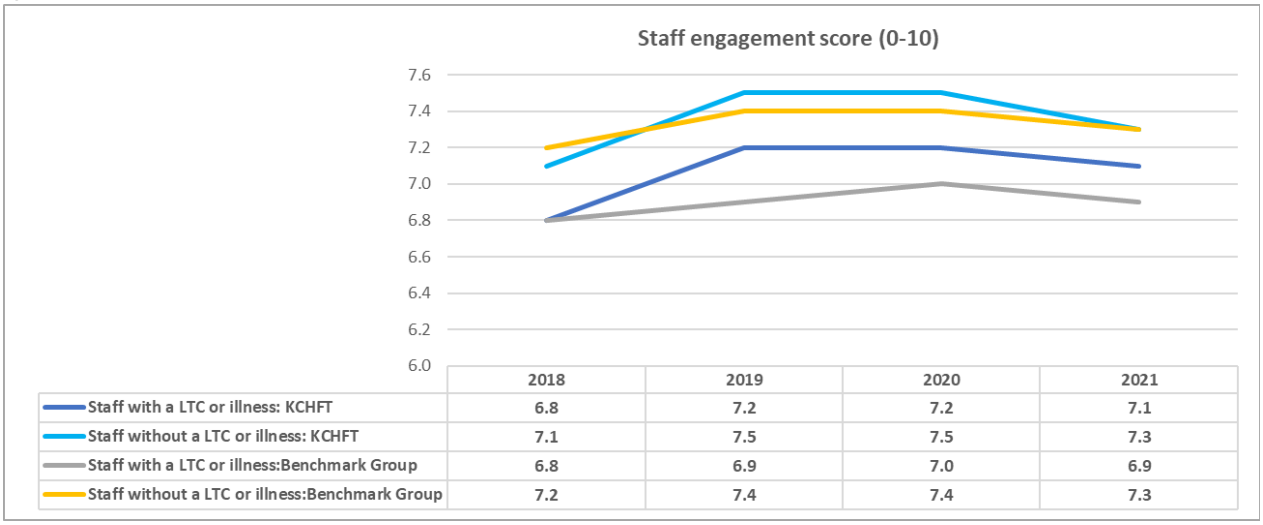
5.9.2.1 As can be observed in the table below there has been litte change in engagement levels of disabled colleagues in 2021 in comparison to the 2020 response.

Table 11

	2020		2021	
	DISABLED	NON-DISABLED	DISABLED	NON-DISABLED
a) The staff engagement score for Disabled staff, compared to non-Disabled staff	7.2	7.5	7.1	7.3

5.9.2.2 KCHFT results are very similar to those in our benchmarking group*.

Figure 22



	2018	2019	2020	2021
Staff with a LTC or illness: KCHFT	6.8	7.2	7.2	7.1
Staff without a LTC or illness: KCHFT	7.1	7.5	7.5	7.3
Staff with a LTC or illness:Benchmark Group	6.8	6.9	7.0	6.9
Staff without a LTC or illness:Benchmark Group	7.2	7.4	7.4	7.3

5.9.3 Part (b)

5.9.3.1 KCHFT is a Disablity Confident Leader employer. The achievement was awarded in 2021 after providing evidence of how the Trust supports and empowers Disabled staff.

Table 12

	DISABLED
b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (yes) or (no)	Yes

5.9.3.2 KCHFT has a workforce equality group comprised of HR, a Trade Union representative, management and staff network representatives, including the chair of the Disability and Carers network. The group meets bi-monthly to discuss issues related to workforce equality, diversity and inclusion and the staff network chairs are able to raise any issues or concerns from their network members.

5.9.3.3 Additionally, network chairs, including the chair of the Disability and Carers network, regularly meet with the Trust Chair, CEO and Director of People & OD to share issues and ideas and attend Strategic Workforce Committee on a rotational basis.

5.9.3.4 The Trust has an active Disability and Carers staff network. An executive sponsor supports the network and the members meet quarterly. Early discussions are ongoing to explore the creation of a Neurodiversity staff network.

5.10 Metric 10

5.10.1 Metric 10 asks about the percentage difference between the organisation's Board voting membership and its organisation's overall workforce. The data held in ESR suggests that disabled colleagues are proportionally represented on the Board.

Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated is shown in Table 12 below:

Table 13

	2021			2022		
	DISABLED	NON DISABLED	UNKNOWN	DISABLED	NON DISABLED	UNKNOWN
Workforce	4.6%	85.6%	9.8%	6.2%	89.8%	3.9%
Voting Board Membership	6.7%	60.0%	33.3%	13.3%	80.0%	6.7%
Executive Membership of the Board	25.0%	75.0%	0.0%	37.5%	62.5%	0.0%
Difference (Voting Board Membership - Overall Workforce)	**2.0%**	**-25.6%**	**23.5%**	**7.1%**	**-9.8%**	**2.7%**
Difference (Executive Membership of the Board - Overall Workforce)	**20.4%**	**-10.6%**	**-9.8%**	**31.3%**	**-27.3%**	**-3.9%**

6. Areas for improvement

6.1 The identified areas for improvement arising after analysing the WDES data are:

- ESR is not reflective of the disability status of trust colleagues, although there has been a 1.3% increase in last year's reported figures. Focus must be given to improving the accuracy and quality of the data within ESR, including encouraging and reassuring colleagues to share their status if they are reticent and to update their status if they become disabled or experience a long term health condition during their career at KCHFT. It is important to remember that status may change from recruitment / entry to the NHS and during the lifetime of a colleagues career.
- Disabled staff are slightly more likely to be appointed from shortlisting.
- Disabled colleagues are more likely to enter the formal capability process when compared to their non-disabled colleagues. However, because of the small numbers involved, the results do not have statistical validity and should therefore be read with caution.
- Disabled colleagues responding in the NHSSS reported experiencing higher levels of harassment, bullying or abuse from patients, relatives or the public and that they were less likely to report this.
- In comparison to last year, there was a slight decrease in the number of disabled staff compared with non-disabled staff reporting levels of satisfaction with the extent to which the organisation values their work. However, a gap between the two groups must be addressed.

6.2 KCHFT are currently working on an action plan to respond to the issues highlighted in this report, which will be published in the coming months.

7. Conclusion

7.1 In conclusion, KCHFT has made some positive progress against many of the metrics in the past 12 months, but there is still work to do. We expect to see more rapid progress in the coming 12 months now that we have a dedicated resource in our Workforce EDI Manager, EDI Specialist and EDI Analyst.

7.2 Some positive findings are:

- The percentage of disabled respondents reporting they felt pressured to come to work despite not feeling well enough to do decreased.
- The representation of disabled colleagues at Trust Board and/or Executive Team level has increased when compared to 2021.

7.3 A review of our existing EDI action plan, in light of the findings in this report, our WRES report and other feedback, is going to commence imminently with the view of a large scale engagement with networks and colleagues to ensure the actions identified not only address the areas for improvement but resonate and are owned by those that live the experience within KCHFT.

8. Recommendation

8.1 The Board is asked to approve this year's WDES data and report and action plan for submission and publication on the Trust website. The action plan will be added to the website once complete.

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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	4.1
Agenda Item Title:	Integrated Performance Report
Presenting Officer:	Gordon Flack, Director of Finance
Action – this paper is for:	☐ Decision ☐ Information ☒ Assurance

What is the purpose of the paper and the ask of the Committee or Board?
(include reference to any prior board or committee review) Has the paper been to any other committee?
The Integrated Performance Report is produced to give an overview of performance against a number of national, contractual and internal key performance indicators. This report is presented with the use of Statistical Process Control (SPC) charts. It should be noted that the full Finance, Workforce and Quality reports are presented at their respective committees. The report has been produced in collaboration with the Executive Team and their support teams.

Summary of key points

There are currently 9 KPIs (25%) 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), 10 (27.8%) showing a high or low negative trend whilst 17 (47.2%) are in normal variation

Of the 10 showing a negative trend, 8 are also currently failing to achieve target. KPIs 4.6 (remotely delivered activity) and KPI 4.2 (Income and Expenditure Surplus) are experiencing a negative trend but still achieving target.

Of the 9 showing a positive trend, 2 KPIs - 2.8 DNA Rate and 4.2 Sickness Stress are currently off target but the trend is showing a move towards target level.

There are 3 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 2.8 DNA Rate – this has been consistently higher since the start of the pandemic and is impacted by increased virtual appointments (which have show to carry higher DNA rates)
- KPI 2.9 LTC/ICT Response Times Met – underperforming since the introduction of RiO and changes in reporting of this metric, although showing signs of improvement.
- KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times – impacted by the shift to a 12-week target and while stable and seeing some improvements (especially with the longest waits), staffing and demand challenges have resulted in sustained underperformance.

Of the 7 indicators not measured by SPC charts, 86.7% (6) are achieving target

Quality

- Four lapses in care occurred with patients on our caseload that were identified during June and July 2022. Two were low harm and two were moderate harm incidents.
- During June and July 2022, 197 falls were reported across the trust with a decrease of 4.4% (9) compared to the last period April and May 2022. Of the 197 falls, there were six avoidable incidents, three resulted in no harm to the patient and three resulted in low harm to the patient.
- 86 reported medication incidents were considered avoidable to KCHFT during June and July 2022 compared to 108 incidents in April and May 2022, this represents a 20.4% decrease.

Workforce

- Turnover continues to report above the mean and the target. However, since January 2022 Turnover has continued on a downward trajectory. The Voluntary Turnover rate is reported at 14.23% which is now within the target threshold for the first time since September 2021
- At 4.18% the in-month sickness absence rate (non-covid related absence) for July 2022 is reporting 0.02% below the target, and the highest rate since February 2022. An annual pattern where sickness increases during school holidays is normal and we expect it to reduce in September figures.
- From January 2022 the vacancy rate has continued to increase each month. The vacancy rate is reporting at 8.23% which is the highest rate over the reporting period following an increase of 40 WTE this month in the reserves budget (in addition to the 83 WTE added from April 2022).

Finance

- The Trust is in a breakeven position to the end of July. The cumulative financial performance is comprised an underspend on pay of £2,663k offset by overspends on non-pay and depreciation/interest of £1,071k and £291k respectively and an under-recovery on income of £1,292k.
- The Trust achieved CIPs of £1,202k to the end of July against a plan of £2,233k which is £1,030k (46%) behind target.

- Capital: Spend to July was £1,072k, against a YTD plan of £2,559k (42% achieved). The reported year to date underspend is primarily due to the delayed commencement of IT schemes. At M4, the full year forecast is £6,891k, and the Trust expects to utilise the forecast in full.
- Temporary staff costs for July were £1,408k, representing 8.7% of the pay bill. Of the temporary staffing usage in July, £247k related to external agency and locums, representing 1.5% of the pay bill. Agency is below target (green RAG rating) which is currently the same as last year's target, a new target for 2022/23 is expected to be notified to the Trust from NHSEI.
- Contracted WTE decreased by 4 to 4,287 in post in July which includes 10 posts funded by capital projects. Vacancies increased to 385 in July (from 342 in June) which was 8.3% of the budgeted establishment.

Operations

- Health Checks annual target for the service for 2022/23 is 21,677 which covers both KCHFT core team and 3rd party providers, with both areas exceeding target to month 4.
- Stop Smoking Quits at M3 is 88.2% of target – target to have quit at M3 is 718, and the actual quits at M3 is 633. The main challenge continues to be the lack of third-party provision.
- 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 M4 of 2022/23 (94.5%) was slightly up on the previous month but performing with normal variation.
- During Month 4 (July 2022) KCHFT carried out 174,247 clinical contacts. For the financial year to July 2022, KCHFT is 2.1% above plan for all services (some services have contractual targets, some are against an internal plan). The main negative variance was within Dental and Planned Care Services (-19.2%), although this area had the highest planned growth for 22/23.
- 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 4 position being at 99.76%, with only 10 patients out of 4,121 currently waiting longer than 18 weeks.
- Diagnostics waits compliance for Month 4 has continued to improve with the service performing at 99.44% against the 99% target. Compliance will be maintained in Month 5.
- The TB Service has been working on a recovery programme to increase their compliance with the number of babies vaccinated (BCG) within 28 days. There is an action plan in place (approved by NHSE/I) with a trajectory to meet the 85% compliance against the 28-day standard by December 2022 with all actions on track. Performance is currently at 13.5%

- In month 3, the Looked after Children's service completed 62.86% of Initial Health Assessments within the statutory time frame. KCC compliance with processing and sending across the referrals within 5 working days was 55% which has impacted KCHFT's ability to meet its statutory requirements resulting in 10 breaches. (no breaches were attributable to KCHFT).
- There are currently 2,552 children waiting on the Autistic Spectrum Diagnostic pathway (ASD) and the longest wait for diagnosis is 3.5 years. The service has had capacity for 25-30 assessment per month which is reduced due to 5.5 WTE Dr vacancies. The service has contracted with a private provider to deliver an additional minimum of 30 ASD diagnostic assessment per month from September till March 2023 which will increase capacity to 60 ASD assessments a month. Current demand is approximately 50 referrals a month
- 2-hour urgent responses - Performance has continued to show monthly improvements, against the target to achieve 70% by Q3, with the month 4 position above the trajectory at 79.3% and moving out of special cause variation. There is still some geographical variation with west Kent performing above 85% currently and east Kent at 69.8%.
- 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 M4 has reduced to 59%, impacted by the increase in demand for statutory assessment and the request health services to contribute information to this process, especially in the Children's Therapy service
- No longer fit to reside (Community Hospital patients) - Performance continues to be adverse to the target and with a negative trend of 8 months above the mean. Current performance is above the mean at 26.9% against the target for 22/23 of 15%
- Bed Occupancy continues to show a varying trend, with current performance stable around the mean and just outside the target threshold of 87-92% (83.8% at month 4).

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

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local*	☐ Yes *(please attach)* ☒ No

Kent Community Health NHS Foundation Trust

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

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

Kent Community Health
NHS Foundation Trust

Integrated Performance Report 2022/23

September 2022 report

Overall CQC Rating – Outstanding (July 2019)
Safe – Good
Effective – Outstanding
Caring – Outstanding
Responsive – Good
Well-Led – Good

we care

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Contents

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Glossary of Terms

SPC – Statistical Process Control

LTC – Long Term Conditions Nursing Service

ICT – Intermediate Care Service

Quality Scorecard – Weighted monthly risk rated quality scorecards

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

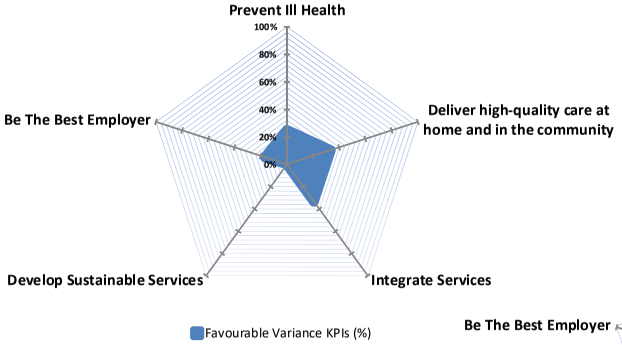
MTW – Maidstone and Tonbridge Wells NHS Trust

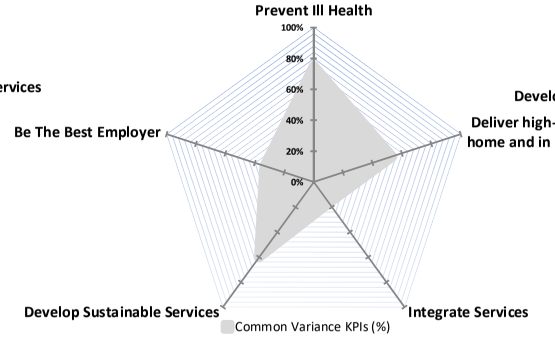
WTE – Whole Time Equivalent

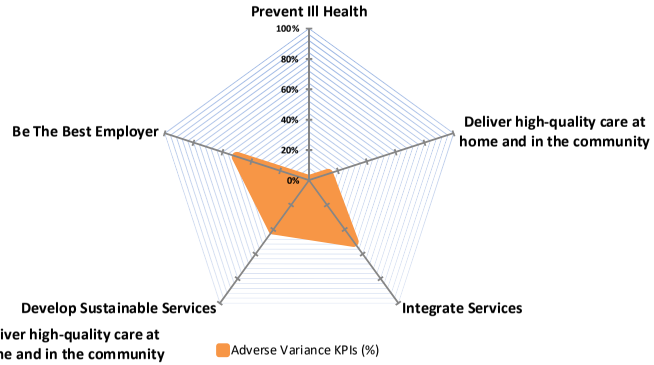
UTI - Urinary tract infection

CAUTI - Catheter-associated urinary tract infection

1.0 Assurance on Strategic Goals



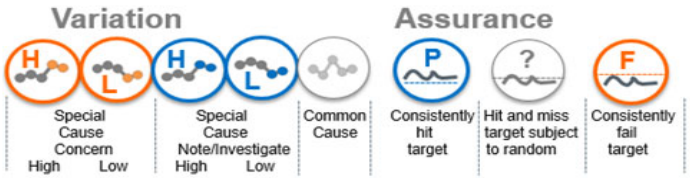


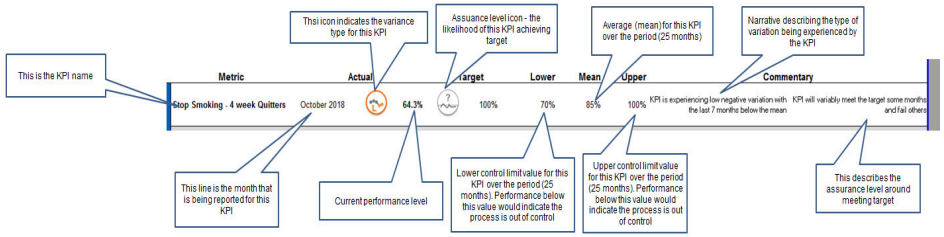


Overall, of the 36 indicators that we are measuring on a statistical process control (SPC) chart, **25% are experiencing either a high or low positive trend (9, KPIs 1.5, 2.5, 2.8, 2.12, 2.13, 2.17, 3.2, 3.4 and 5.2), 27.8% are showing a high or low negative trend (10, KPIs 2.9, 2.14, 3.1, 3.3, 3.5, 4.2, 4.5, 5.3, 5.5 and 5.6)** and the remaining **47.2% (17) are showing normal variation.**

30.6% 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, 2.17, 2.18, 3.2, 3.4, 4.5 and 5.4),**
8.3% (3, KPIs 2.8, 2.9 and 2.14) 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 **61.1% are variably achieving target** with no trend of consistent achievement/failure.

Of the 7 indicators where an SPC chart is not currently appropriate, **85.7% (6) have achieved the in-month target.**





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

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

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

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name.

	Metric	Actual			Target		Lower	Mean	Upper	Commentary
1. Prevent Ill Health	KPI 1.1 Stop Smoking - 4 week Quitters	June 2022		88.2%		100%	69%	88%	107%	Month 3 performance is below trajectory but should pick up slightly once further quits have had their outcome. Still impacted by third party delivery
	KPI 1.2 Health Checks Carried Out	July 2022		118.2%		100%	90%	140%	189%	Strong performance with overachievement against target. Both KCHFT core checks and third party checks are exceeding trajectory
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	July 2022		94.5%		90%	90%	94%	98%	The new birth visit performance is 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	July 2022		87.4%		90% (year end)				The 21/22 programme began in Feb-22 and is on trajectory
	KPI 1.5 Admissions Avoidance (2 Hour Crisis Responses)	July 2022		628		326	308	452	596	Metric shows demand for 2 hour crisis responses is increasing and therefore positive variation, following sustained performance above the mean. 4% growth expected for 22/23
	KPI 1.6 (N) Percentage of child BCG vaccinations given within 28 days	June 2022		13.5%		95.0%				New metric added for 2022/23 with data currently available from January 2022. Current low performance, however capacity is being increased and an improvement trajectory is being implemented.

	Metric	Actual			Target		22/23 YTD Actual	22/23 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	July 2022		0		1	0	4	Target achieved for the month
	KPI 2.2 (N) Never Events	July 2022		0		0	0	0	Target achieved for the month. 0 Never Events recorded this year
	KPI 2.3 (N) Infection Control: CDI	July 2022		0		0	0	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	July 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.

	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	July 2022	L	0.00	P	0.19	-0.09	0.03	0.15	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	July 2022		3	?	1	-3.3	3.3	9.8	The data is showing normal variation with a decrease this month to below the mean.
	KPI 2.7 Community Activity: YTD as % of YTD Plan	July 2022		102.1%	?	100.0%	96.2%	103.3%	110.4%	Normal variation with performance now 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	July 2022	L	4.7%	F	4.0%	4.2%	4.8%	5.4%	DNA levels are now showing an improved picture, with performance below the mean for a sustained period and therefore positive variation
	KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)	July 2022	L	79.1%	F	95.0%	80.2%	85.1%	90.0%	Metric currently showing negative variation as below the lower control limit, but is improving. 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	July 2022		79.3%	?	70.0%	53.5%	73.4%	93.2%	Metric currently showing normal variation following a period below the mean. Exepected to now be showing a true reflection of the actual performance following staff education and improved data accuracy. 2 consecutive months achieving the 70% national target
	KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	July 2022		99.3%	P	95.0%	99.2%	99.6%	100.0%	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	July 2022	H	99.8%	P	92.0%	98.5%	99.6%	100.8%	Positive variation with trend above the mean. 10 current 18+ weeks waits.
	KPI 2.13 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Waiting List Size (>18 weeks)	July 2022	L	10	P	532	-33	15	63	Positive variation with trend above the mean. 10 current 18+ weeks waits.
	KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times (12 week target)	July 2022	L	67.6%	F	92.0%	69.3%	77.4%	85.5%	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	July 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)	July 2022		20.3	?	21.0	16.1	21.8	27.6	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.

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name.

	Metric	Actual			Target		Lower	Mean	Upper	Commentary
2. Deliver high-quality care at home and in the community	KPI 2.17 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT	July 2022	H	98.8%	P	95.0%	96.5%	98.1%	99.6%	Currently in normal variation and above the mean and consistently meeting target
	KPI 2.18 (N) NICE Technical Appraisals reviewed by required time scales following review	July 2022		100.0%	P	100.0%	100.0%	100.0%	100.0%	Metric currently showing normal variation and consistently achieving the target
	KPI 2.19 (N) 6 Week Diagnostics	July 2022		99.2%	?	99.0%	92.9%	97.9%	102.8%	Metric showing normal variation, with performance just above the mean and marginally above target. 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	July 2022	H	26.9%	?	15.0%	8.1%	18.3%	28.4%	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)	July 2022	L	0.00	P	0.20	-0.03	0.01	0.04	Positive special cause variation currently being seen with sustained performance below the mean
	KPI 3.3 Average Acute Daily No Longer Fit to Reside (NLFTR) - West Kent (Complex and Non complex)	July 2022	H	155	?	75	62	95	127	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)	July 2022	L	0.00	P	0.20	-0.05	0.02	0.08	Positive special cause variation currently being seen with sustained performance below the mean
	KPI 3.5 Average Acute Daily No Longer Fit to Reside (NLFTR) - East Kent (Complex Only)	July 2022	H	171	?	100	63	88	114	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	July 2022		22.0	?	30	21.7	26.6	31.5	Below the target and the mean for Month 4, although in normal variation.

Kent Community Health NHS Foundation Trust - Corporate Scorecard

*NOTE: National Targets are denoted by (N) in the KPI name.

	Metric		Actual		Target	Lower	Mean	Upper	Commentary
4. Develop sustainable services	KPI 4.1 Bed Occupancy: Occupied Bed Days as a % of available bed days	July 2022		83.8%		92.0%	77.3%	85.5%	93.6%	Position is in normal variation with performance around the mean level, although is currently sitting just below the target range of 87-92%.
	KPI 4.2 Income & Expenditure - Surplus (%)	July 2022	L	0.0%		0.0%	-0.44%	0.1%	0.6%	The Trust is in a breakeven position to the end of July. The cumulative financial performance is comprised an underspend on pay of £2,663k offset by overspends on non-pay and depreciation/interest of £1,071k and £291k respectively and an under-recovery on income of £1,292k
	KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	July 2022		53.8%		100.0%	50.8%	76.3%	101.7%	The Trust achieved CIPs of £1,202k to the end of July against a plan of £2,233k which is £1,030k (46%) behind target
	KPI 4.4 External Agency spend against Trajectory (£000s)	July 2022		£246,553		£505,279	£209,704	£419,998	£630,292	Currently showing normal variation with performance positively below the mean and below target for M4. Agency costs were £247k for July against a target of £505k
	KPI 4.5 Percentage of Activity Delivered Remotely (Telephone or Online)	July 2022	L	26.2%	P	25.0%	26.6%	29.4%	32.1%	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 4.6 Estates Statutory Compliance (All properties)	July 2022		97.0%		95%				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	July 2022		4.18%		4.20%	3.37%	4.02%	4.67%	Below the target and the mean for the month, in normal variation as performance continues to perform fluctuate around the mean.
	KPI 5.2 Sickness Rate (Stress and Anxiety)	July 2022	L	1.24%		1.15%	0.98%	1.30%	1.63%	Sustained performance below the mean. Target around the mean level so likely to continue to achieve target some months and fail others.
	KPI 5.3 Turnover (planned and unplanned)	July 2022	H	15.66%		14.47%	14.27%	15.14%	16.02%	Showing negative variation with sustained performance above the mean. Although now below the upper control limit.
	KPI 5.4 Mandatory Training: Combined Compliance Rate	July 2022		96.2%	P	85.0%	95.2%	95.8%	96.5%	Performing within the control limits and above the mean currently. Failure to achieve 85% remains highly unlikely.
	KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce)	July 2022	H	8.3%		6.0%	4.0%	5.1%	6.2%	In negative variation following an increase this financial year to above the upper control limit and above target
	KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	July 2022	L	83.7%		87.0%	85.6%	86.5%	87.4%	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 June 2022	Day Fill Rate %		Night Fill Rate %		Shifts with 1RN
	RN's	HCA's	RN's	HCA's	
Faversham	93.50	96.03	96.67	96.82	11%
Deal	99.67	95.19	97.80	91.80	4%
QVMH					
Whit &Tank	96.51	88.06	100.00	98.46	6%
West View	98.82	64.75	98.46	91.67	4%
Westbrook House	92.19	84.89	96.67	100.00	28%
Edenbridge	80.19	89.04	89.06	94.16	8%
Hawkhurst	98.58	82.78	98.17	96.35	0%
Sevenoaks	88.79	84.07	87.44	98.15	0%
Tonbridge	95.07	93.17	97.01	95.79	0%
Total	**93.70**	**86.42**	**95.70**	**95.91**	**4%**

1.1 RN and HCA staffing Community Hospital July 2022	Day Fill Rate %		Night Fill Rate %		Shifts with 1RN
	RN's	HCA's	RN's	HCA's	
Faversham	96.18	93.21	98.41	95.74	8%
Deal	92.96	88.74	95.67	96.87	6%
QVMH					
Whit &Tank	93.27	88.92	95.31	94.51	11%
West View	95.54	81.07	99.93	92.06	3%
Westbrook House	95.43	82.38	87.39	92.31	15%
Edenbridge	86.21	88.81	95.12	94.57	10%
Hawkhurst	98.55	87.22	98.94	86.72	3%
Sevenoaks	88.12	84.81	86.65	93.67	0%
Tonbridge	93.84	84.60	90.32	88.97	0%
Total	**93.39**	**86.64**	**94.19**	**92.82**	**5%**

In June and July, 78% of hospitals had an RN day and night fill rate over 90%, compared to 72% in the previous period.

HCA day shift staffing continues to be a challenge; however, this has improved from 81.05% in the previous reporting period to 86.64% in July.

QVMH continues to undergo refurbishment and patients are being directed to Westbrook House. QVMH staff have been relocated to staff the unit.

Vacancy rates at Sevenoaks (40.18%) and Edenbridge (47.55) are the highest of all community hospitals and are being supported by agency and use of international recruits. Sevenoaks sickness rate was 5.91% for the period

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.

Supervisor shifts have increased to manage increasing COVID-19 infections and support infection prevention and control nursing requirements.

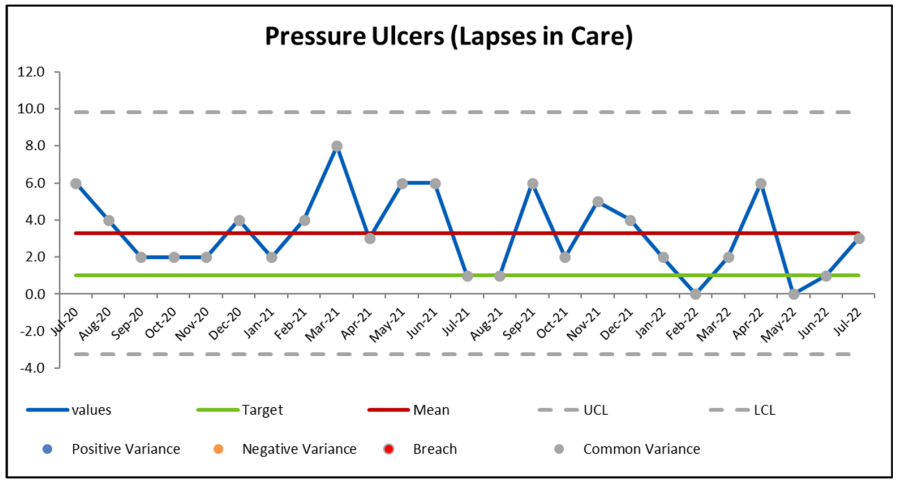
2.2 Assurance on Pressure Ulcers

The data is within common cause variation.

Four lapses in care occurred with patients on our caseload that were identified during June and July 2022. Two were low harm and two were moderate harm incidents.

Both moderate harm incidents have been reviewed and not deemed to be SIs however the learning review identified a delay in implementing suitable pressure relieving equipment following on from the initial assessment, once this was in place the patient's pressure areas went on to show healing.

This has been reflected back to the teams to discuss in their huddles and highlight early intervention can prevent initial pressure damage.



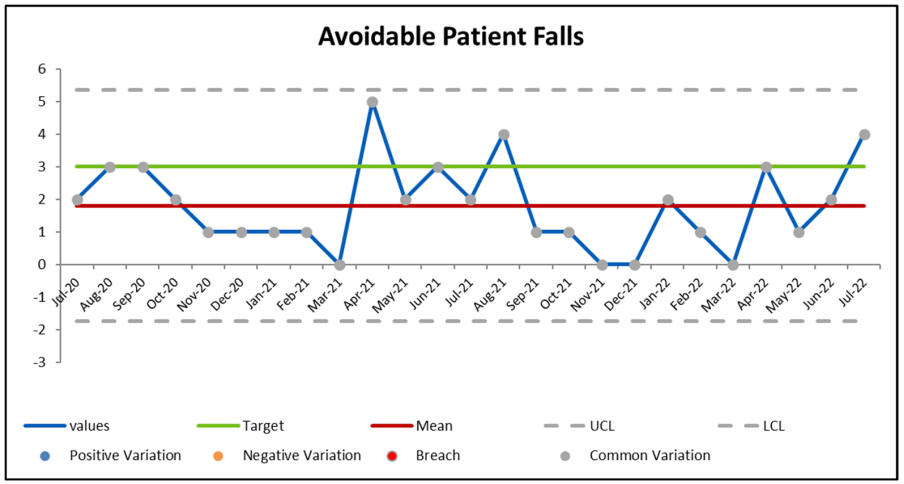
2.3 Assurance on Falls

During June and July 2022, 197 falls were reported across the trust with a decrease of 4.4% (9) compared to the last period April and May 2022. Of the 197 falls, there were six avoidable incidents, three resulted in no harm to the patient and three resulted in low harm to the patient.

The low harm incidents related to: a patient slipped from their chair and sustained an injury to their right ankle; a patient walking towards the nursing station without their Zimmer Frame and fell before staff could reach them. This resulted in tenderness to the left hip and a patient constantly attempting to climb out of bed had an unwitnessed fall during handover as they were left momentarily so the staff member could answer another call bell.

Falls training task and finish group continues, work is in progress to update the falls training package available for staff to ensure a full awareness of patient's falls risks and preventative measures.

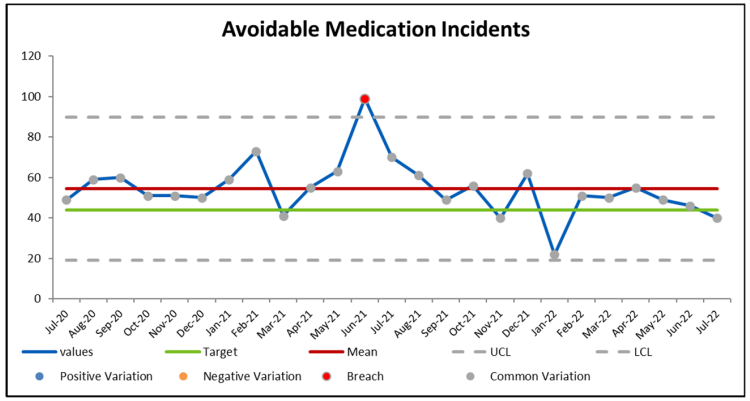
The next Falls Prevention Network meeting on 12 September 2022, will be chaired by the Chief Nurse and the plan is to support the Community Hospital Falls Prevention with areas of focus for the next 12 months.

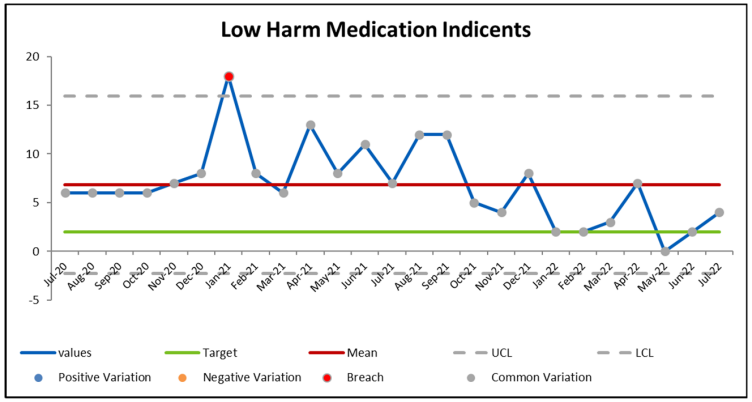


2.4 Assurance on Medication incidents

86 reported medication incidents were considered avoidable to KCHFT during June and July 2022 compared to 108 incidents in April and May 2022, this represents a 20.4% decrease.

6.9% (6) of the reported medication incidents were classed as low harm during June and July 2022 compared to 6.5% (7) in the previous two month period.





Further analysis showed that;

The data is within common cause variation.

Community Hospitals and Outpatients Services – 29 (33.7%) of the 86 incidents, an increase compared to 27.8% in the previous period.

Long Term and Specialist Conditions – 34 (39.5%) of the 86 incidents, a decrease compared to 44.4% in the previous period.

41.9% (36) of the incidents were categorised as Omitted medicines - an increase compared to 30.6% in the previous period.

2.5 Assurance on Patient Experience

2.5.1 Meridian Patient Experience survey results

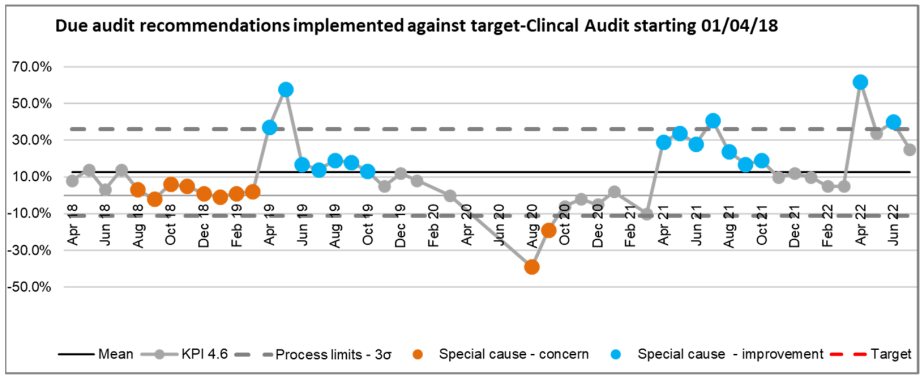
8,189 surveys were completed during June/July 2022, a reduction when compared with the previous two months data, though in line with the drop seen in service bespoke survey volumes during the summer holiday period in previous years.

2.5.2 The NHS Friends and Family Test (FFT)

The FFT score remains high, with 98.8% 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



81 of 90 due actions have been completed, 25% above the target for July. This is within the process limits.

Virtual training and support: The Clinical Audit Guru drop in advice session was run on 12 July to support staff who have any questions on clinical audit or need support. This is poorly utilised and will be reviewed. Clinical Audit: an overview was run on 8 June and Leading Improvement through Clinical Audit on July 13. Feedback on both was very positive. Audit Actions for Positive Change will be delivered on September 19.

Reducing audit workload –RIO reporting was used to supply some data for the CQUIN audits but a large number of gaps in the data and the requirement for qualitative data necessitated some manual data collection, particularly in CCG15; assessment and documentation of pressure ulcer risk. We are continuing to work with Performance and the RIO operational lead to try and reduce manual data collection where possible. It is hoped that the new version of wound matrix will be able to supply more data for the leg wound audit (CCG14) in quarters 3 and 4. Audit team members are part of the task and finish group looking at reducing forms on RIO to assess the impact on audit.

Focusing the audit programme – There are 105 original audits on the programme. 31 of those are not supported by the service e.g. infection control audits or drug management audits. The audit programme for 22/23 has 61 audits carried forward from last year's programme, including audits deferred from 20/21 and 21/22, and 12 new audit topics. There are 19 re-audits completing their audit cycle.

2.7 Infection Prevention and Control

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

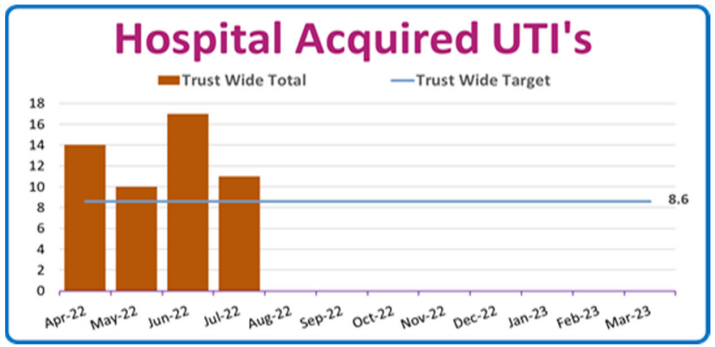
100% compliance for MRSA screening in this reporting period;

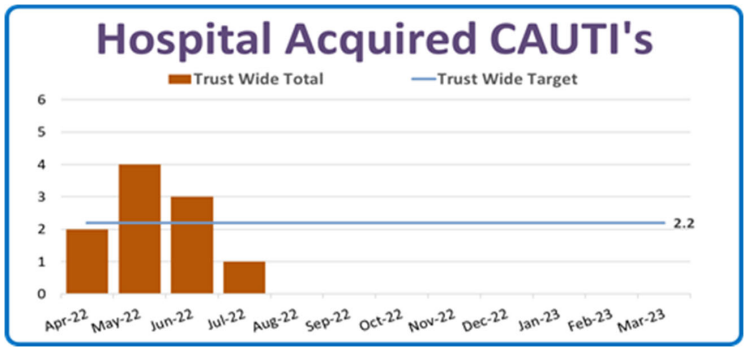
There were 4 Clostridioides cases in this reporting period. 1 in June & 3 in July. 1 case still awaiting RCA to be completed. 1 case identified within 48 hours of admission and 2 cases UNAVOIDABLE with no level 3 lapses in care.

There were 26 nosocomial COVID-19 acquisitions in this reporting period. June; 1 case at Sevenoaks & 7 Cases at Hawkhurst. July; 1 case at Edenbridge, 1 case at Whitstable & Tankerton, 5 cases at Tonbridge, 5 cases at Westbrook House & 6 cases at Sevenoaks.

CAUTI data: In June there were 3 & 1 in July. All patients had specimens taken and treated appropriately. This is 0.4 below trajectory in this reporting period. We are 1.2 above trajectory to date. 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.

UTI's in June there were 17 & 11 in July. This is 10.8 above trajectory in this reporting period. We are 17.6 above trajectory to date. IPC are reviewing the representation at the CAUTI /UTI reduction steering group meetings. Representation to include; nutrition & hydration champions, IPC link workers, MIUs, School nurses Professional Lead nurses in order to ensure there is wider representation across KCHFT to facilitate the messages for CAUTI & UTI reduction being shared more widely with all teams.



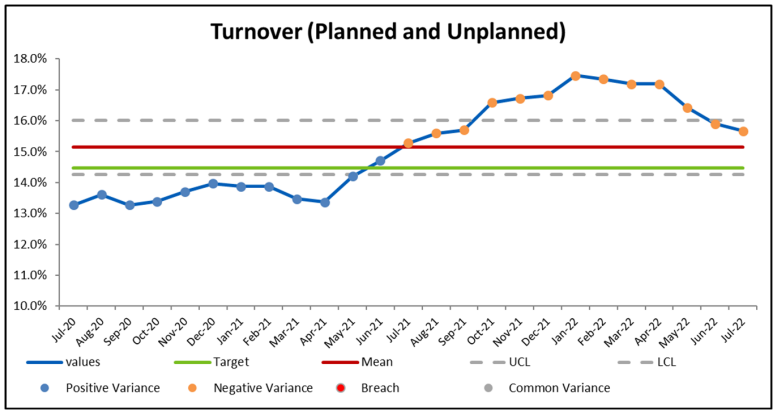


3.0 Workforce Report:

3.1 Assurance on Retention

3.1.1 Turnover

Turnover continues to report above the mean and the target. However, since January 2022 Turnover has continued on a downward trajectory. The below reports the turnover at 15.67% for both planned and unplanned leaving reasons which is reported to NHSI/E, this is the lowest rate since September 2021. The Voluntary Turnover rate is reported at 14.23% which is now within the target threshold for the first time since September 2021. The Turnover rate for International recruits is 0.00%.



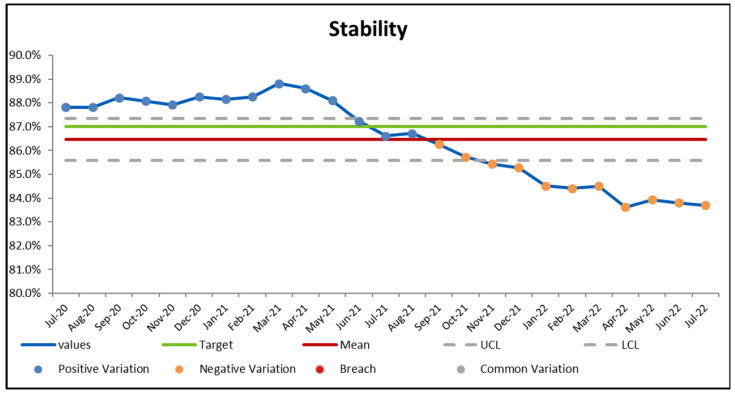
The tables below demonstrate that the highest levels of turnover are found within our people with over 30 years service and in our staff under the age of 20. In conclusion, this represents staff retirements and under 20s taking entry jobs.

Turnover - Voluntary by Length of Service	
Length of Service Band	Turnover Rate %
<1 Year	20.11%
1 to 2 Years	20.43%
2 to 5 Years	14.12%
5 to 10 Years	10.87%
10 to 15 Years	10.61%
15 to 20 Years	8.37%
20 to 25 Years	18.80%
25 to 30 Years	20.16%
>=30 Years	25.71%

Turnover - Voluntary by Age Band	
Age Band	Turnover Rate %
<=20 Years	45.45%
21-25	23.02%
26-30	20.22%
31-35	14.49%
36-40	12.64%
41-45	9.38%
46-50	9.94%
51-55	10.47%
56-60	16.08%
61-65	20.22%
66-70	31.79%
>=71 Years	29.27%

3.1.2 Stability

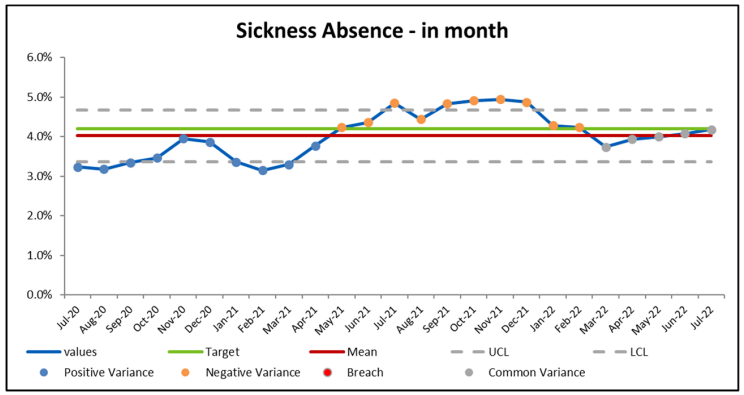
In July 2022 the Stability rate is reporting at 83.69%, this continues to be below the mean and the target, and the organisation continues to report a decreasing trend. People and Organisational Development Business Partners (PODBPs) continue to embed identified actions from retention task and finish group activity, including face to face 100-day reviews with new colleagues. POBDPs are doing 100 day conversations with new starters to ensure support is in place and supporting managers with coaching compassionate conversations.



3.2 Assurance on Sickness

3.2.1 Sickness Absence

At 4.18% the in-month sickness absence rate (non-covid related absence) for July 2022 is reporting 0.02% below the target, and the highest rate since February 2022. An annual pattern where sickness increases during school holidays is normal and we expect it to reduce in September figures. There are MSK issues in some teams but deep dives are taking place and managers are being supported by POBDPs.

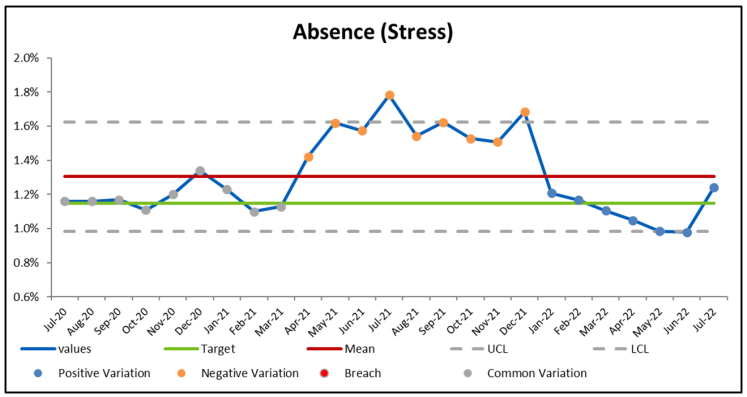


The below table shows the absence rate by ethnicity group over the last year, you can see from the below that the higher sickness absence rates are usually found in colleagues within the white ethnicity category.

Ethnic Origin	2021 / 07	2021 / 08	2021 / 09	2021 / 10	2021 / 11	2021 / 12	2022 / 01	2022 / 02	2022 / 03	2022 / 04	2022 / 05	2022 / 06
BME	3.92%	3.80%	3.99%	4.61%	3.68%	4.11%	4.32%	4.09%	3.67%	3.29%	2.25%	2.38%
White	4.78%	4.42%	4.85%	4.91%	5.12%	5.01%	4.30%	4.27%	3.76%	3.94%	4.18%	4.27%

3.2.2 Stress Absence

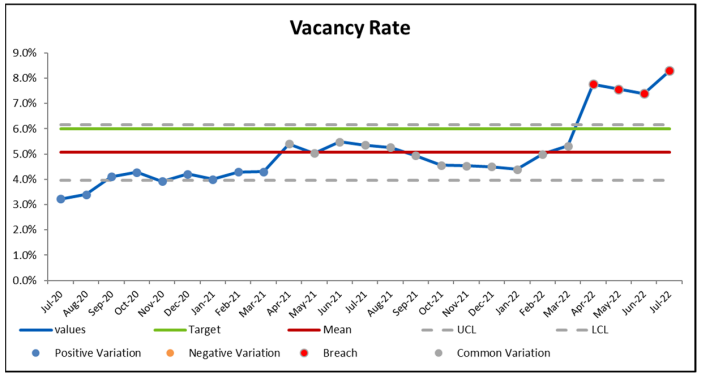
In-month stress absence figures have reported a significant increase from 0.97% to 1.24%. This is reporting above the target and it is the highest rate of stress related absence since January 2022. There is ongoing work led by the PODBPs to refresh line managers on how to support stress absence cases.



3.3 Assurance on Filling Vacancies

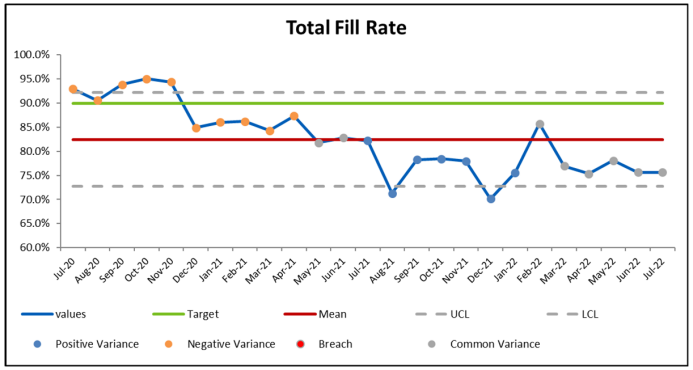
3.3.1 Establishment and Vacancies

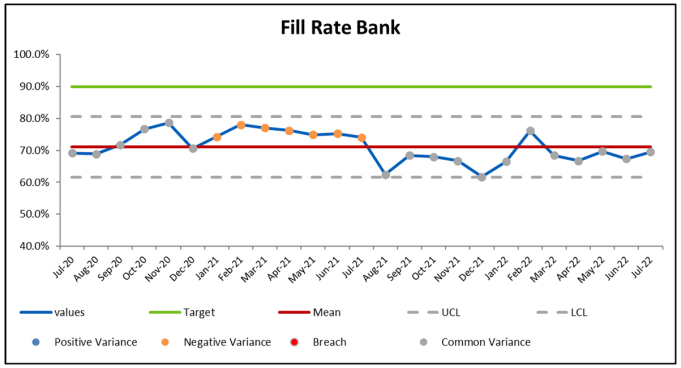
From January 2022 the vacancy rate has continued to increase each month. The vacancy rate is reporting at 8.23% which is the highest rate over the reporting period following an increase of 40 WTE this month in the reserves budget (in addition to the 83 WTE added from April 2022).



3.3.2 Temporary Staff Usage

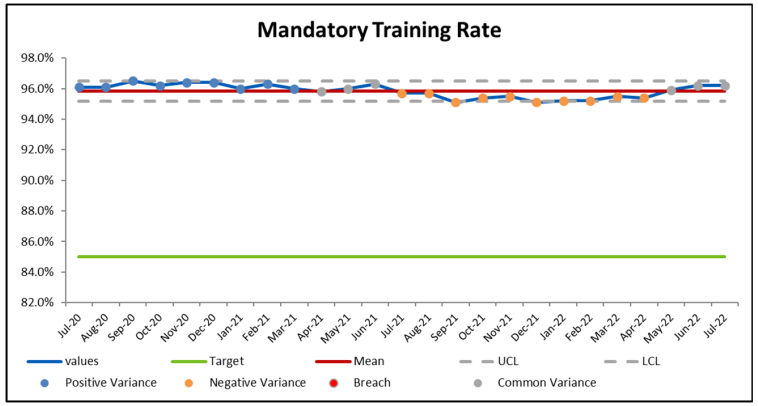
The Total fill rate & Bank Fill rate have both reported an increase in fill rate in July 2022. July also reported an increase in requested shifts; 11,436 shifts requested and 8,870 were filled by Bank and Agency.





3.4 Mandatory Training

General compliance is good. We have had an overall mandatory compliance rate of above 85% for the past 2 months (June and July).



Fire safety for ward staff continue to be above compliance target as predicted.

Basic life support has moved for the past 2 months from being below to above the target.

Care certificate is below target but has improved since last month, it is now 84.3%, increase from 80.8% last month.

The main area now needing attention is moving and handling level 4, which continues to be below target at 81.4%. Having conducted a deep dive, prior to the pandemic this area was regularly at or above target. In year one it dropped significantly and did not reach the target at any point. In year 2 it increased but only rarely reached 85% and since April this year compliance has now dropped to broadly the same levels as during year 1 of the pandemic and has been consistently below target. A further deep dive into hotspots areas will be shared with the People and OD Business Partners for discussion at the Divisional governance groups and for consideration at the Integrated Operational Meeting.

4.0 Finance Report:

4.1 Key Messages

Surplus: The Trust is in a breakeven position to the end of July. The cumulative financial performance is comprised an underspend on pay of £2,663k offset by overspends on non-pay and depreciation/interest of £1,071k and £291k respectively and an under-recovery on income of £1,292k.

Continuity of Services Risk Rating: The Trust has scored overall the maximum 1 rating against the Use of Resource rating metrics for M4 2022-23. The YTD I&E margin % has returned a rating of 2 as a result of the current break-even regime.

CIP: The Trust achieved CIPs of £1,202k to the end of July against a plan of £2,233k which is £1,030k (46%) behind target.

Cash and Cash Equivalents: The cash and cash equivalents balance was £36,583k, equivalent to 53 days expenditure. The Trust recorded the following YTD public sector payment statistics: 92% for volume and 95% for value.

Capital: Spend to July was £1,072k, against a YTD plan of £2,559k (42% achieved). The reported year to date underspend is primarily due to the delayed commencement of IT schemes. At M4, the full year forecast is £6,891k, and the Trust expects to utilise the forecast in full.

Staff: Temporary staff costs for July were £1,408k, representing 8.7% of the pay bill. Of the temporary staffing usage in July, £247k related to external agency and locums, representing 1.5% of the pay bill. Agency is below target (green RAG rating) which is currently the same as last year's target, a new target for 2022/23 is expected to be notified to the Trust from NHSEI.

Contracted WTE decreased by 4 to 4,287 in post in July which includes 10 posts funded by capital projects. Vacancies increased to 385 in July (from 342 in June) which was 8.3% of the budgeted establishment.

4.2 Dashboard

Surplus — Rag rating: Green

	Actual	Budget	Variance
Year to Date £k	0	0	0
Year End Forecast £k	0	0	0

The Trust is in a breakeven position to the end of July.

Pay costs have underspent by £2,663k offset by overspends on non-pay and depreciation/interest of £1096k and £291k respectively, and an under-recovery on income of £1,276k.

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 M4 2022-2023. The YTD I&E margin % has returned a rating of 2 as a result of the current break-even regime.

CIP — Rag rating: Red

	Actual	Plan	Variance
Year to Date £k	1,202	2,233	-1,030
Year End Forecast £k	6,698	5,476	1,222

The Trust achieved CIPs of £1,202k to the end of July against a risk rated plan of £2,233k and so CIP is £1,030k behind plan to date.

53.9% of the total annual CIP target has been removed from budgets at month four.

The Trust is forecasting to achieve only £5,476 by the end of the year. The shortfall of £1,222 relating to the Adults Service though this is expected to be met non-recurrently from Trust-wide travel and pay underspends.

Cash and Cash Equivalents — Rag rating: Green

	Actual	Forecast	Variance
Year to Date £k	36,583	35,978	605
Year End Forecast £k		36,444	

Cash and Cash Equivalents as at M4 close stands at £36,583k equivalent to 53 days operating expenditure.
The Trust recorded the following YTD public sector payment statistics 92% for volume and 95% for value.

Capital Expenditure — Rag rating: Amber

	Actual/Forecast	Plan	Variance
YTD Expenditure £k	1,072	2,559	1,487
Year End Forecast £k	6,891	6,891	0

Spend to July was £1,072k, against a YTD plan of £2,559k (42% achieved). The reported year to date underspend is primarily due to the delayed commencement of IT schemes.

As at M4, the full year forecast is £6,891k, and the Trust expects to utilise this in full.

Agency Targets — Rag rating: Green

	M4			YTD		
	Actual £k	Target £k	Variance £k	Actual £k	Target £k	Variance £k
External Agency Excluding Covid-19 Expenditure £k	245	491	246	1,172	1,964	792
External Agency Including Covid-19 Expenditure £k	247	491	244	1,189	1,964	775

External agency and locums excluding Covid-19 expenditure was £245k against £491k target in July. (£1,172k expenditure against £1,964k target YTD).
External agency and locums including Covid-19 expenditure was £247k against £491k target in July. (£1,189k expenditure against £1,964k target YTD).

4.3 Income and Expenditure Position

There was a breakeven position in-month and YTD. The July performance comprised an underspend on pay of £714k offset by an under-recovery on income of £433k, overspends on non-pay and depreciation/interest of £165k and £107k. The summary income and expenditure statement is shown in the table below:

	JULY ACTUAL £'000	JULY BUDGET £'000	JULY VARIANCE £'000	% VARIANCE	YTD ACTUAL £'000	YTD BUDGET £'000	YTD VARIANCE £'000	% VARIANCE
Charitable and Other Contributions to Expenditure	7	4	3	90.3%	8	14	-6	-40.8%
Clinical Commissioning Groups	-2	0	-2	0.0%	45,230	45,237	-7	0.0%
Department of Health	0	0	0	0.0%	0	0	0	0.0%
Education and Training	266	250	16	6.4%	926	1,051	-125	-11.9%
Injury Cost Recovery Scheme	25	32	-6	-20.2%	67	127	-61	-47.7%
Income in respect of employee benefits accounted on a gross basis	62	70	-8	-11.6%	340	282	59	20.8%
Integrated Care Boards	14,962	15,107	-145	-1.0%	14,962	15,107	-145	-1.0%
Local Authorities	3,784	4,003	-219	-5.5%	15,071	16,000	-929	-5.8%
NHS England	1,966	1,974	-8	-0.4%	7,608	7,807	-199	-2.6%
NHS England - Covid-19 Vaccinations Income	85	0	85	0.0%	538	0	538	0.0%
NHS Foundation Trusts	272	293	-21	-7.1%	1,086	1,174	-88	-7.5%
NHS Other	0	0	0	-100.0%	0	2	-2	-100.0%
NHS Trusts	434	483	-49	-10.2%	1,750	1,932	-182	-9.4%
Non NHS: Other	209	214	-5	-2.2%	828	846	-18	-2.1%
Non NHS: Private Patients	5	14	-10	-68.0%	20	57	-37	-64.9%
Non-Patient Care Services to Other Bodies	136	168	-32	-19.0%	892	786	106	13.5%
Other	72	51	20	39.0%	217	206	11	5.3%
Rental revenue from operating leases	77	132	-55	-41.6%	308	527	-219	-41.6%
Research and Development	15	13	2	16.3%	56	51	6	11.0%
CIP Savings - Income	0	-2	2	-100.0%	0	-8	8	-100.0%
INCOME Total	**22,374**	**22,807**	**-433**	**-1.9%**	**89,906**	**91,198**	**-1,292**	**-1.4%**
Allied Health Professionals	2,369	2,700	331	12.3%	9,481	10,614	1,132	10.7%
Apprenticeship Levy	61	69	8	11.2%	248	274	27	9.7%
Chairman & Non-Executive Directors	14	15	0	1.7%	54	58	4	6.7%
Consultants	291	238	-53	-22.3%	967	1,094	127	11.6%
Heath Care Scientist	52	69	17	24.2%	228	274	46	16.9%
Medical Career/Staff Grades	589	686	96	14.1%	2,137	2,611	474	18.1%
Medical Trainee Grades	21	19	-2	-12.3%	73	76	3	4.1%
NHS Infrastructure Support	4,152	4,259	107	2.5%	16,982	17,351	369	2.1%
Non-Executive Directors	0	0	0	0.0%	0	0	0	0.0%
Other Scientific, Therapeutic and Technical Staff	599	651	52	8.0%	2,390	2,589	199	7.7%
Registered Nursing, Midwifery and Health Visiting Staff	5,207	5,495	287	5.2%	20,588	21,680	1,092	5.0%
Support to Allied Health Professionals	461	520	59	11.3%	1,845	1,967	122	6.2%
Support to Nursing Staff	1,966	1,912	-54	-2.8%	7,823	7,476	-347	-4.6%
Support to Other Clinical Staff	348	349	1	0.2%	1,405	1,492	87	5.8%
Redundancy Costs	-6	0	6	100.0%	-13	0	13	100.0%
Salary Sacrifice	0	-11	-11	-100.0%	0	-45	-45	-100.0%
CIP Holding Account - Pay	0	36	36	100.0%	0	22	22	100.0%
CIP Savings - Pay	0	-160	-160	-100.0%	0	-641	-641	-100.0%
Contract Savings - Pay	0	-6	-6	-100.0%	0	-23	-23	-100.0%
PAY Total	**16,125**	**16,839**	**714**	**4.2%**	**64,207**	**66,870**	**2,663**	**4.0%**
Audit Fees Payable to the External Auditor	7	7	0	0.8%	30	26	-3	-12.9%
Clinical Negligence - Amounts Payable to NHS Resolution	102	102	0	0.0%	410	410	0	0.0%
Consultancy	50	19	-31	-163.4%	238	103	-136	-131.9%
Drugs Costs	292	292	0	-0.1%	1,133	1,159	26	2.2%
Education and Training - Non-Staff	62	153	91	59.3%	253	551	298	54.1%
Establishment	1,316	998	-318	-31.9%	5,555	4,043	-1,512	-37.4%
Increase/(Decrease) in Impairment of Receivables	0	0	0	-100.0%	0	0	0	-100.0%
Lease Expenditure	79	60	-19	-100.0%	299	284	-16	-100.0%
Movement in credit loss allowance on receivables and financial assets	0	0	0	-100.0%	0	0	0	-100.0%
Operating Lease Expenditure	0	41	41	100.0%	0	167	167	100.0%
Operating Lease Expenditure (net)	0	0	0	0.0%	0	0	0	0.0%
Other	90	93	3	2.9%	393	375	-18	-4.7%
Premises - Business Rates Payable to Local Authorities	60	78	18	23.4%	343	380	37	9.6%
Premises - Other	429	496	67	13.6%	2,356	2,002	-354	-17.7%
Research and Development - Non-Staff	0	0	0	0.0%	0	0	0	0.0%
Supplies and Services – Clinical (excluding drugs costs)	1,971	1,963	-9	-0.4%	7,811	8,266	455	5.5%
Supplies and Services - General	107	100	-6	-6.1%	409	403	-6	-1.5%
Transport	354	407	52	12.9%	1,264	1,592	328	20.6%
CIP Savings - Non Pay	0	-49	-49	-100.0%	0	-315	-315	-100.0%
CIP Holding Account - Non Pay	0	4	4	0.0%	0	17	17	0.0%
Contract Savings - Non Pay	0	-10	-10	-100.0%	0	-40	-40	-100.0%
NONPAY Total	**4,919**	**4,754**	**-165**	**-3.5%**	**20,495**	**19,424.046**	**-1,071**	**-5.5%**

EBITDA	1,330	1,214	116	9.5%	5,204	4,904	300	6.1%
EBITDA %	5.9%	5.3%	-0.6%		5.8%	5.4%	-23.2%	
Amortisation	139	58	-81	-141.0%	502	233	-269	-115.4%
Depreciation	1,088	1,066	-22	-2.1%	4,297	4,283	-15	-0.3%
Finance Income	38	14	25	179.0%	122	55	67	100.0%
Gain/(Loss) on disposal of Property, Plant and Equipment	0	0	0	-100.0%	-9	0	9	100.0%
Interest on Late Payment of Commercial Debt	0	0	0	-100.0%	0	0	0	-100.0%
Interest on Leases	61	33	-28	-83.2%	242	160	-82	-51.3%
PDC Dividend Charge	71	71	0	-0.2%	284	283	-1	-0.2%
PPE Net Impairments	0	0	0	0.0%	0	0	0	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 Cash and Equivalents

Cash and Cash equivalents totalled £36,583k as at M4 close, equivalent to 53 days expenditure:

Total Cash and Cash Equivalents as at period end:

	£000's
Cash with the Government Banking Service	36,555
Cash at Commercial Banks and in hand	28
Deposits with the National Loan Fund	0
Total Cash and Cash Equivalents as at period end	**36,583**

4.5 Capital

The table below shows the Trust's total expenditure on capital projects for the year to date 2022-23 and reflects a £1,487k underspend in terms of the year to date plan. The reported underspend is in the main due to delayed commencement of IT schemes, with a number of schemes' procurement now scheduled to commence over the next quarter. The EPMA scheme is also behind plan as a result of the IT team not being able to recruit and fill the project roles required.

As at M4 the full year forecast is in line with the agreed full year plan value of £6,891k. In addition to the Trust capital expenditure plan of £6,891k, the Trust is also holding £2,295k ring-fenced funding on behalf of the K&M system for agreed system priorities.

2022-23 Capital Plan - July 2022 Update

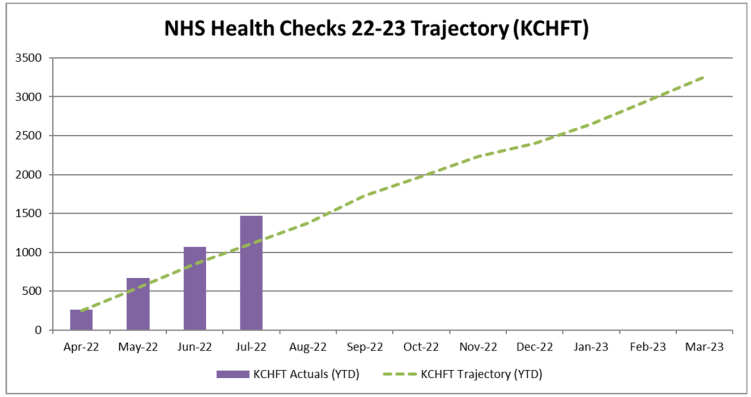
		YTD £000s			Plan & FOT £000s		
Plan Area	**Plan Reference**	**YTD Plan**	**YTD Actual**	**YTD Variance**	**FY Plan**	**Forecast Outturn**	**FY Variance**
Estates	Backlog Maintenance incl. Health, Safety & Security Compliance Measures	19	2	17	860	860	-
Estates	Capitalisable Responsive Maintenance incl. Leasehold Improvements	22	-1	23	165	165	-
Estates	Estates Developments	363	475	-112	780	780	-
Estates	Energy Efficiency	36	-2	38	380	380	-
	Estates - Total	**440**	**475**	**-35**	**2,185**	**2,185**	**-**
IT	K&M Digital Priority Scheme - Kent & Medway Care Record	242	92	150	726	726	-
IT	IT Developments - Innovation and Strategy	267	-35	302	597	597	-
IT	IT Developments - Clinical Systems	109	16	93	507	507	-
IT	IT Developments - EPMA System	514	27	487	820	820	-
IT	IT Infrastructure and Networks	175	-32	207	520	520	-
IT	IT Rolling Replacement - Hardware	487	405	82	776	776	-
IT	Cyber Security	200	154	46	360	360	-
	IT - Total	**1,994**	**627**	**1,367**	**4,306**	**4,306**	**-**
Dental	Dental Services	50	-	50	150	150	-
	Dental - Total	**50**	**-**	**50**	**150**	**150**	**-**
Other	Other Minor Schemes & Equipment Purchases (IMM)	75	-30	105	250	250	-
Other	K&M Capital - Ring-fenced for K&M System Priorities	-	-	-	2,295	2,295	-
	Other - Total	**75**	**-30**	**105**	**2,545**	**2,545**	**-**
	Total 2022-23	**2,559**	**1,072**	**1,487**	**9,186**	**9,186**	**-**

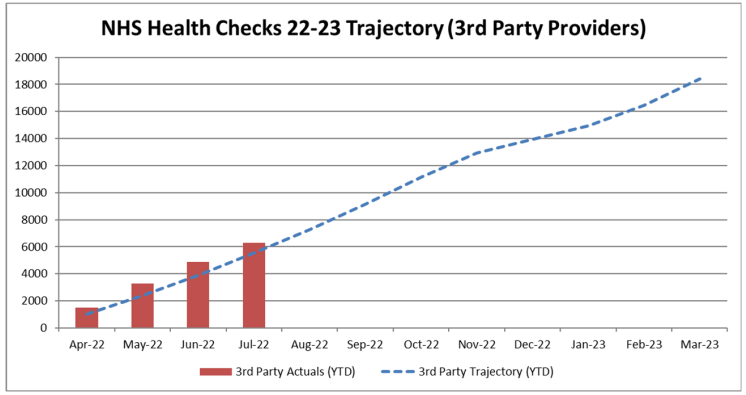
5.0 Operational report:

5.1 Assurance on National Performance Standards and Contractual Targets

5.1.1 Health Checks and Stop Smoking Quits

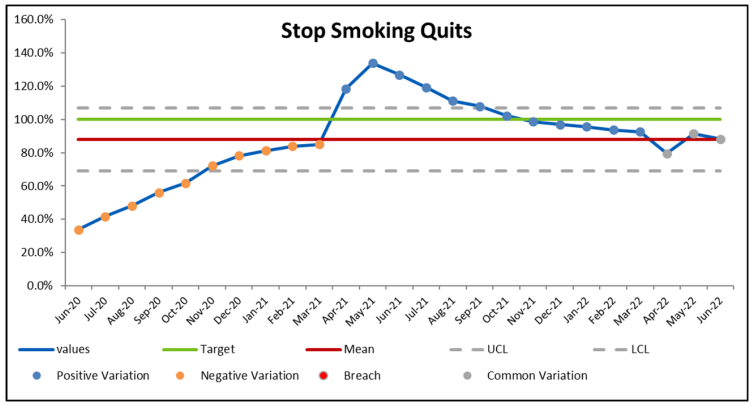
Health Checks





The graphs above show activity in 2022/23 against the agreed trajectory for both KCHFT core checks and 3rd party providers. Continued monitoring of activity and performance within KCHFT and 3rd party providers, with a particular focus on increasing delivery within GP practices.

Stop Smoking Quits



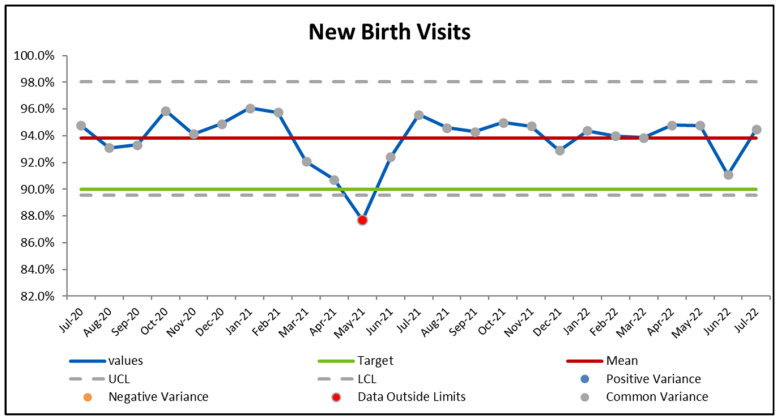
*Reporting period 1 month behind other metrics due to need to wait for 4-week outcomes

The 4-week quit rate YTD at M3 is 88.2% of target – target to have quit at M3 is 718, and the actual quits at M3 is 633. The main challenge continues to be the lack of third-party provision.

5.1.2 Health Visiting

New Birth Visits

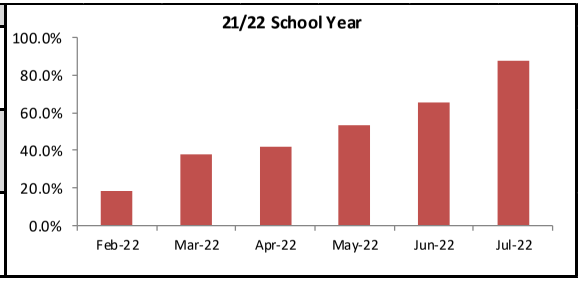
The new birth visit performance has continued to perform strongly above the mean and target level, with no current areas of concern. Performance for month 4 of 2022/23 (94.5%) is in line with recent performance and comfortably above target (90%).



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 87.4% at the end of July 2022

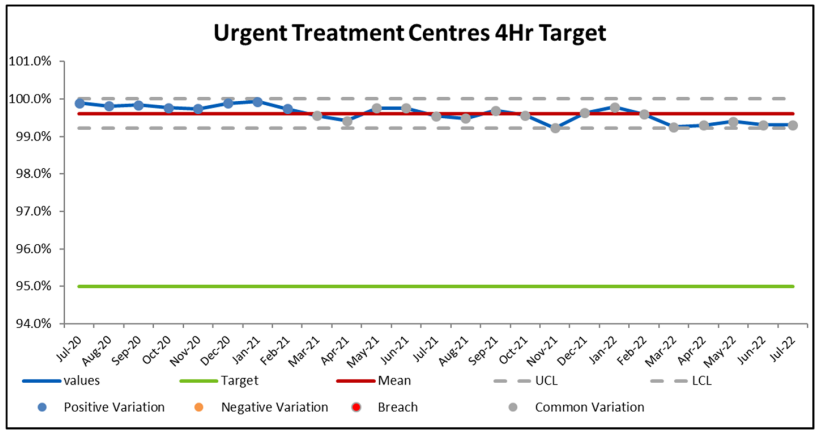
	Year R/6
21/22 School Year to Jul-22	87.4%
20/21 School Year	46.9%
Annual Target	90%



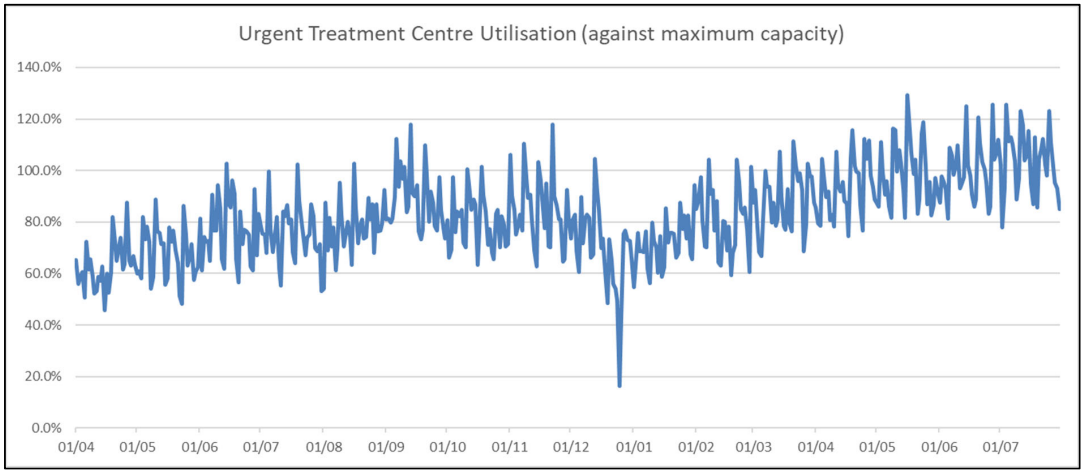
5.1.4 GUM 48hr

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

5.1.5 Urgent Treatment Centres (UTCs) 4 Hour Wait Target



KCHFT's achievement of the 4-hour wait target (95% target) for UTCs and MIUs has consistently been high, with very little variation from the mean. These units continue to form an integral part in managing non-elective demand and activity continues to grow above pre-Covid levels. Utilisation rate for M4 was up to 109.7% against baseline capacity when considering the UTC delivery model, showing a positive increase as we divert activity away from emergency departments.

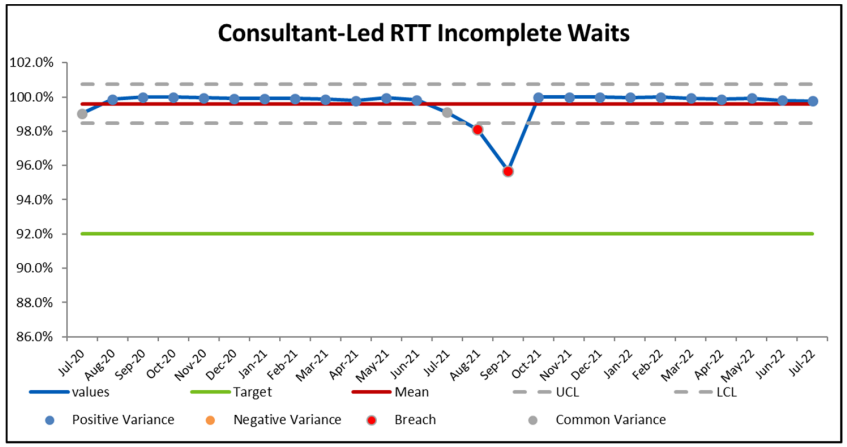


5.1.6 Consultant-Led RTT Incomplete Waits Over 18 weeks

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 4 position being at 99.76%, with 10 patients out of 4,121 currently waiting longer than 18 weeks.

	0-12 Wks	12-18 Wks	18-36 Wks	36-52 Wks	52+ Wks	< 18 Weeks
Chronic Pain	455	6	0	0	0	100.00%
Orthopaedics	3169	481	10	0	0	99.73%
KCHFT Total	3624	487	10	0	0	99.76%

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

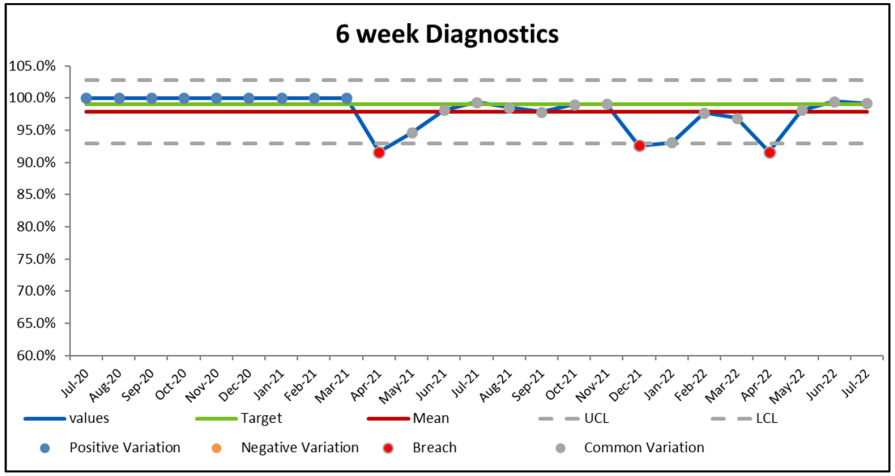


5.1.7 6 Week Diagnostics (Audiology)

Audiology service has a requirement for 99% of children receive a diagnostic assessment within six weeks of referral into the service. (DMO1 National Submission)

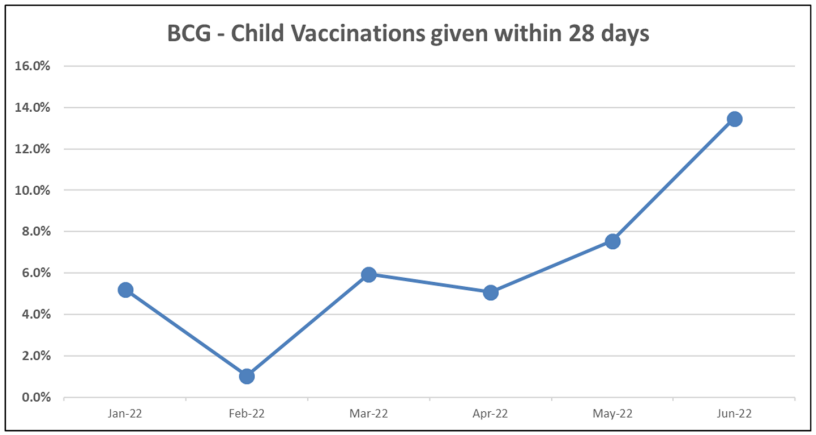
Compliance for Month 4 has continued to improve with the service performing at 99.44% against the 99% target. Compliance will be maintained in Month 5.

The service is aware that there has been an increase in the failure rate from the school health screening programme that will impact on the Audiology service ability to meet DMO1 in Month 6.



5.1.8 Child BCG Vaccinations

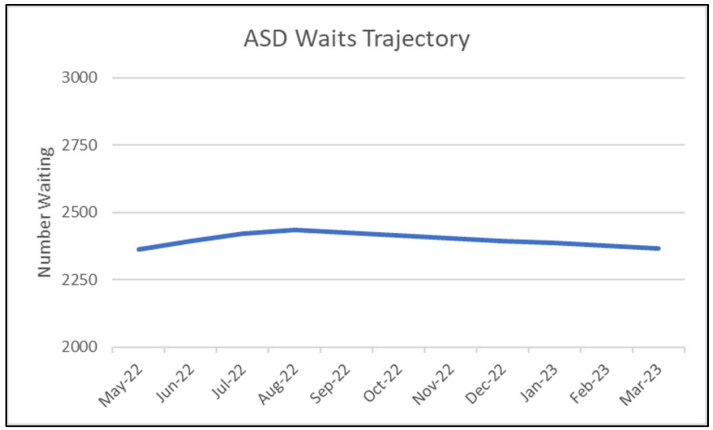
N.B. This is a new metric included in the report, with data currently available from January 2022

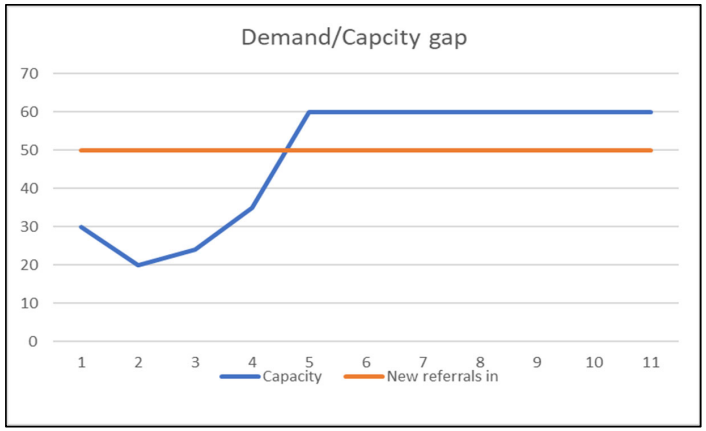


The TB Service has been working on a recovery programme to increase their compliance with the number of babies vaccinated within 28 days. There is an action plan in place (approved by NHSE/I) with a trajectory to meet the 85% compliance against the 28-day standard by December 2022 with all actions on track. Benchmarking has been completed against other providers and the TB Service is reflecting feedback from these areas within their operating model in the work done within Kent to improve performance against the KPI.

The M3 position for 2022/23 shows an improving trajectory for Kent babies. The increased position has been facilitated by a change in the referral and appointment booking process which has significantly improved the number of booked appointments on the caseload from 45% at the start of M2 to 91.3% at the start of M3 2022/23. The service continues to work to increase capacity against the demand and capacity model focusing on individual localities with increased demands.

5.1.9 Autistic Spectrum Disorder (ASD) Waiting Times





There are currently 2,552 children waiting on the Autistic Spectrum Diagnostic pathway (ASD) and the longest wait for diagnosis is 3.5 years. The service has had capacity for 25-30 assessment per month which is reduced due to 5.5 WTE Dr vacancies. The service has contracted with a private provider to deliver an additional minimum of 30 ASD diagnostic assessment per month from September till March 2023 which will increase capacity to 60 ASD assessments a month. Current demand is approximately 50 referrals a month.

All children have initial assessment before being placed on the ASD pathway where they will be risk-assessed and prioritised as well as being signposted to support mechanisms. The capacity within the Community Paediatric service is allocated across all pathways including Looked after Children statutory assessments, ADHD diagnostic and medication reviews as well aiming to meet the 12-week referral to access standard. These pathways are of higher importance based on risk therefore capacity cannot be refocused. ASD is a focus both nationally and across the Kent and Medway System.

Actions Taken by the service

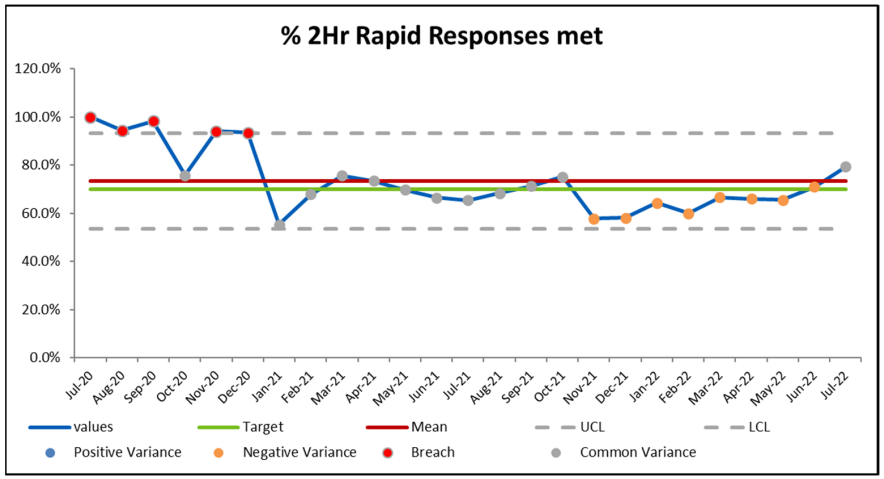
- Working with the Integrated Care Board (ICB) to look at different ways of working to increase capacity (West Kent pilot) to be evaluated March 2023
- Recruitment plan in place and KCHFT task and finish group established to review medical recruitment to date 1.5 Drs have been recruited
- Focus on reduction of DNA to maximise capacity within the service
- Streamlining of the triage process to identify the children that have adequate information available so that a diagnosis can be made without placing the child on the ASD pathway.

The adult Neurodevelopmental (autism and ADHD) service commenced ON 1 April 2022 reporting for demand, capacity and waiting times will be available in month 7

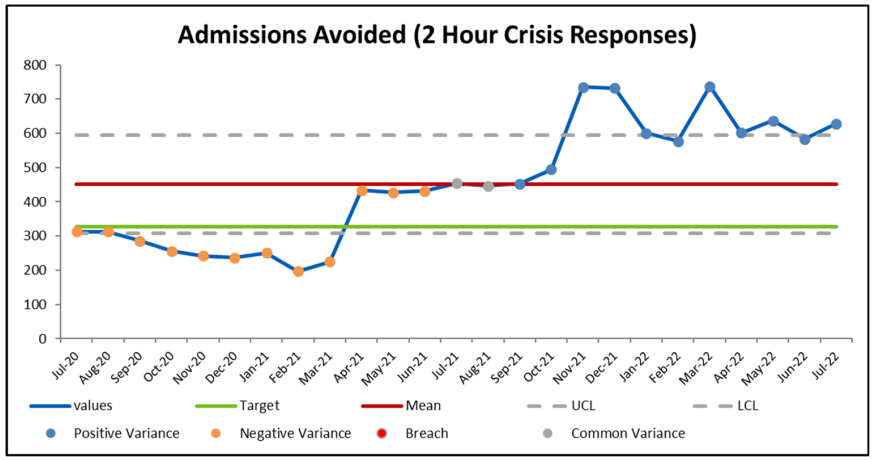
5.1.10 Urgent Crisis Response referrals seen within 2 hours

Performance has continued to show monthly improvements, against the target to achieve 70% by Q3, with the month 4 position above the trajectory at 79.3% and moving out of special cause variation. There is still some geographical variation with west Kent performing above 85% currently and east Kent at 69.8%.

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". We are on track to achieve this.



5.1.11 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 noticeable increase as a result of the new SOP being introduced in Nov-21. Demand continues to be above the upper control limit at 600+ per month.

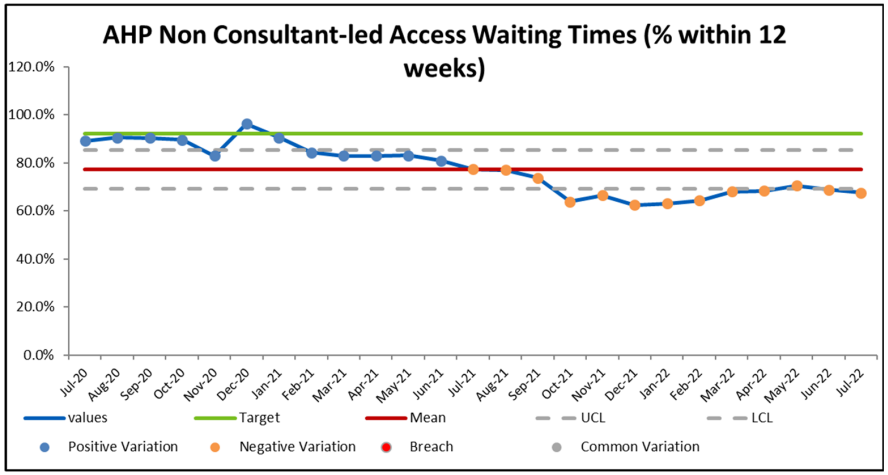
We continue to receive a number of referrals which specify that an urgent response is required, which upon triage, are not appropriate and/or necessary. The SOP enables staff to downgrade the inappropriate requests, thus excluding both from the demand and the response rates. A number of referrals are also received out of hours or just before shift end and we are looking into updating the calculations to take this into account.

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

5.1.12 Assurance on Local Wait Times

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, while in negative variation the performance is relatively stable.

The main contributors to the adverse level of performance is that we are currently experiencing significant, albeit improving, wait times in some high-volume services, such as in MSK Physiotherapy services (83.3%), Medway Podiatry (66.3%), Neuro Rehab (74.3%), Children's Therapies (71.9%) and Paediatrics (34.5%).

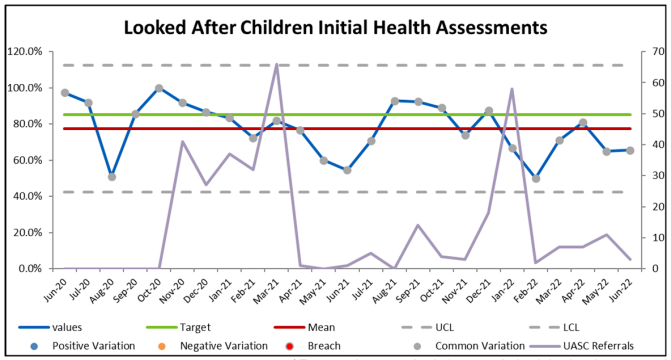


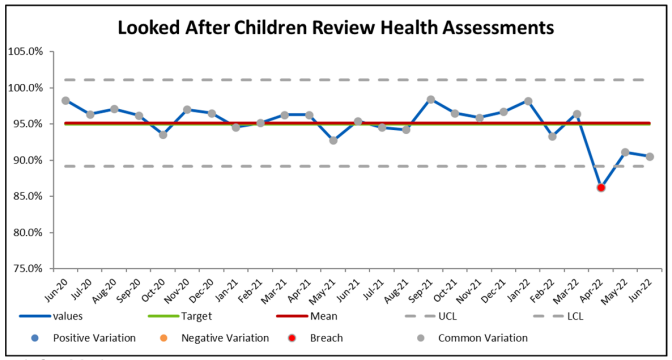
A weekly report is shared with the Chief Operating Officer, Deputy Chief Operating Officer and CSDs showing the current position with waiting list size, 12 week % and longest waits, at service level. This gives oversight and progress on improvements at a granular level on a regular basis.

Service	18 - 36 weeks	36 - 52 weeks	52+ weeks
Adult MSK Physio	874	2	1
Clinical Nutrition and Dietetics	1209	175	0
Intermediate Care Services	73	19	0
Podiatry - Kent	173	2	1
Podiatry - Medway	133	0	1
Kent Children's Therapies	150	1	0
Community Paediatrics	1050	175	0

N.B. All teams have access to PowerBI to see their daily waiting list picture and are able to see at a granular level as well as compare across ethnicities and deprivation

5.1.13 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

N.B. Both metrics are now reported as a combined Kent and Medway position following the start of the Medway contract

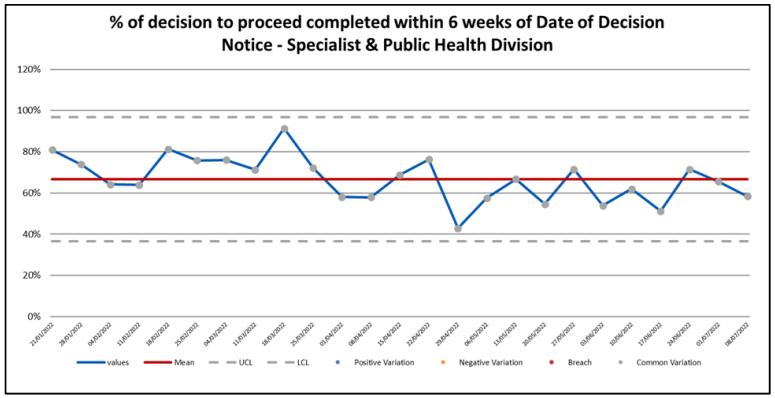
Health services have a statutory responsibility to complete an Initial Health Assessment (IHA) and circulate the report to the responsible officer within 28 Days from date of the child becoming looked after. To comply with the statutory regulation 85% of children need to be seen with in this time frame. To support KCHFT in meeting its statutory obligations KCC have a KPI to process the referral and send it to KCHFT within 5 days of the child coming into care.

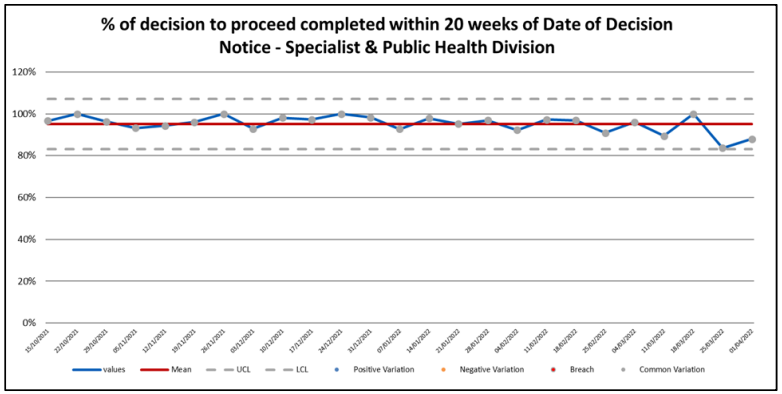
In month 3, 62.86% of IHA were completed within the statutory time frame. KCC compliance with processing and sending across the referrals within 5 working days was 55% which has impacted KCHFT's ability to meet its statutory requirements resulting in 10 breaches. (no breaches were attributable to KCHFT)

The service continues to work with KCC to support them in making referrals within 5 working days of the child coming into care and an improvement plan for providers and KCC is being supported by the chief nurse in the IBC

Health services also have a statutory responsibility whilst children are in the care of the local authority to undertake Review Health Assessments (RHA). To comply with the statutory regulation 95% of children need to have an RHA completed. In month 3, 92.11% of RHAs were completed within the statutory time frames. There were 9 breaches; 4 were non-attributable to KCHFT and 5 were attributable (these were due to administration processes in Medway). The service is harmonising both Kent and Medway administration processes and this will mitigate the risk of this happening, with work due to be completed by September 2022

5.1.14 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 M4 is 59%.

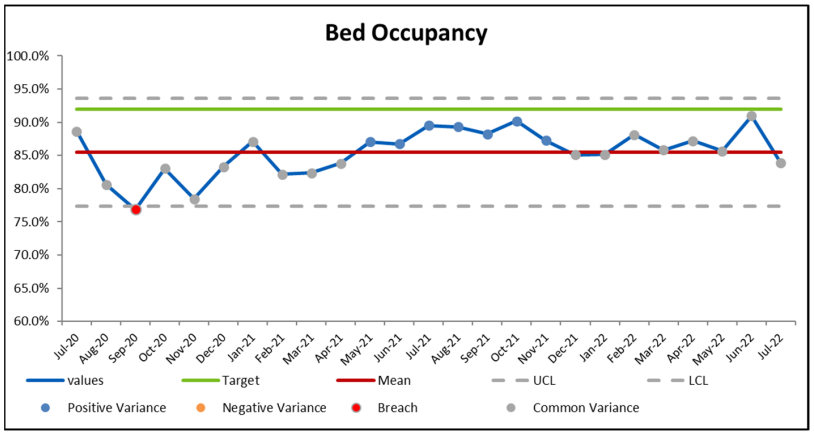
Compliance with the 6-week target is challenged by the increase in demand for statutory assessments and the request that health services contribute information to this process, especially in the Children's Therapy service. Redirecting resource within the Children's Therapies Team to meet the 6-week target 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 M4 is reported at 87%

An internal task and finish group is in place to monitor KCHFT compliance

5.1.15 Bed Occupancy

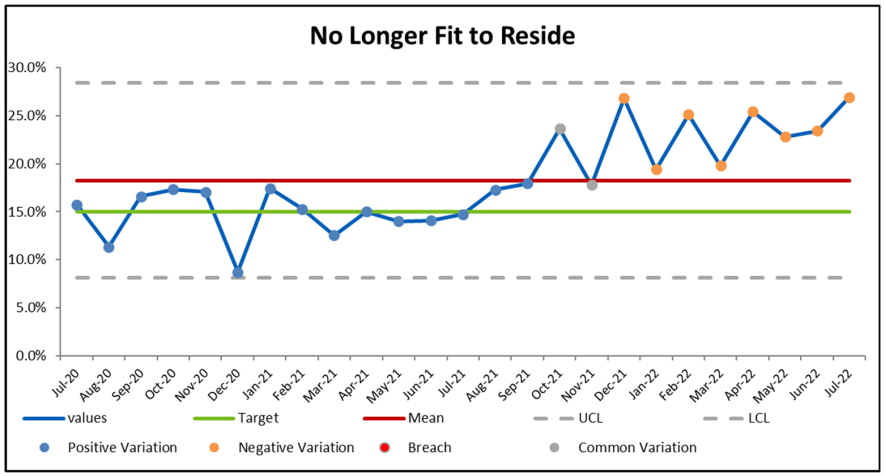
Bed Occupancy continues to show a varying trend, with current performance stable around the mean and just below the target threshold of 87-92% (83.8% at month 4).



5.1.16 No Longer Fit to Reside (NLFTR)

Performance continues to be adverse to the target. The target level has been revised to 15% in line with the operational plan but continues to be difficult to achieve in the current climate with a current performance above the mean between 20-25%

The prime driver for high NLFTR 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 ICB and KCC to review capacity challenges; improve patient flow and support effective discharge.



5.1.17 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.

5.1.18 CQUIN

CQUIN programme currently paused due to the Covid-19 pandemic but has 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 are monitored at service and locality level and shown below in divisional summaries.

During Month 4 (July 2022) KCHFT carried out 174,247 clinical contacts. For the financial year to July 2022, KCHFT is 2.1% above plan for all services (some services have contractual targets, some are against an internal plan). The main negative variance was within Dental and Planned Care Services (-19.2%), although this area had the highest planned growth for 22/23.

Service Type	M4 Actual	YTD Actual	YTD Plan	YTD Variance	Movement	Internal BRAG	Contract BRG
Adults - Long Term Care	67,709	273,008	263,115	3.8%	Negative		
Adults - Urgent Care	30,347	120,754	103,813	16.3%	Positive		
Adults - Community Hospitals	4,255	18,222	19,056	-4.4%	Negative		
Adults - Rehab	14,185	61,366	62,040	-1.1%	Negative		
Dental and Planned Care	14,159	57,324	70,985	-19.2%	Negative		
Specialist and Public Health Services	43,592	181,840	178,879	1.7%	Negative		
Trust Total Activity against plan	**174,247**	**712,514**	**697,888**	**2.1%**	Static		

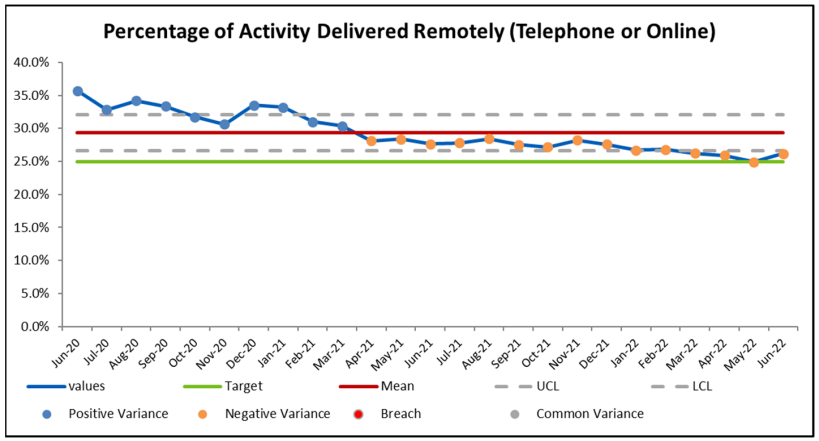
	Internal	Contract
	>+5%	>+10%
	>-5%	>-10%
	+/- 2.5-5%	n/a
	<+/- 2.5%	<+/- 10%
		No Target

*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 19.2% deficit against plan are within MSK Physio (-39.4%) and New Street Dental (-36.3%). Service modelling and recruitment have predicted much higher activity in 2022/23 in MSK but have not yet reached these levels, although improving.

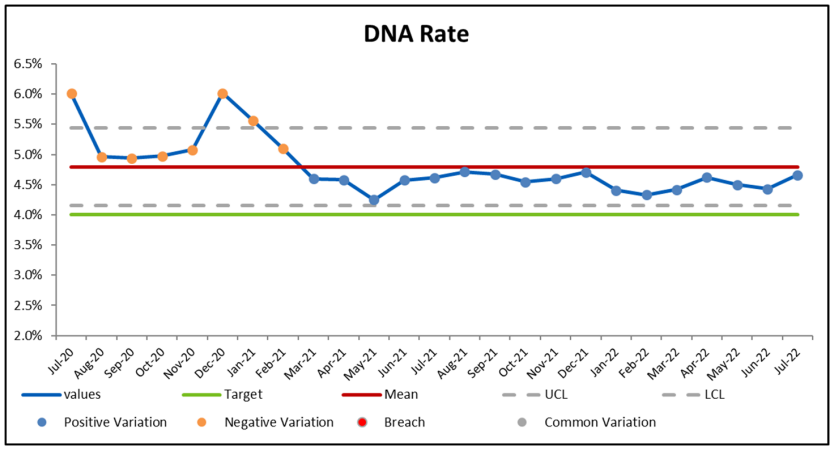
5.2.2 Activity Delivery Method

Levels are stable with consistent performance just above the 25% target with the last 12 months averaging >26%, although showing a slight decreasing trend.



5.2.3 DNA rates

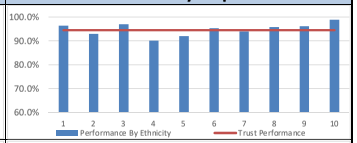
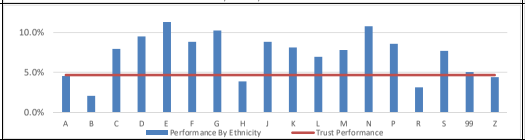
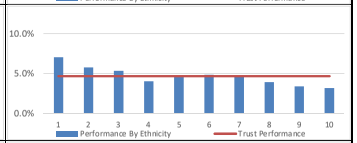
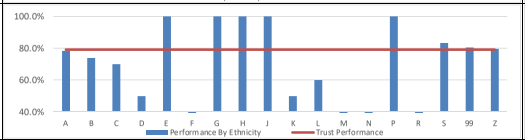
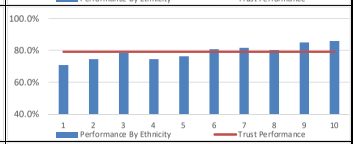
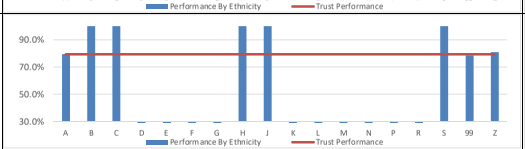
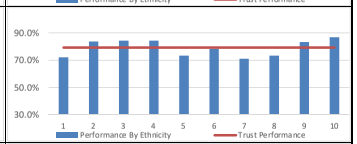
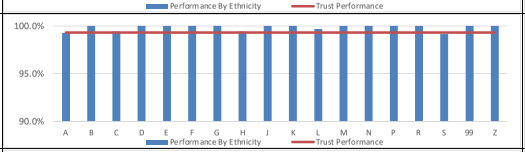
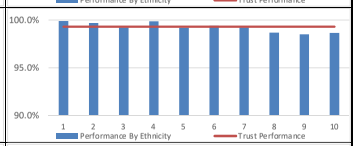
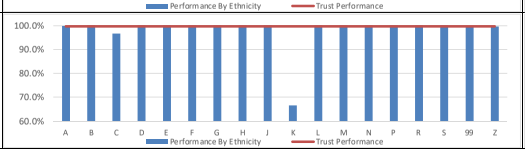
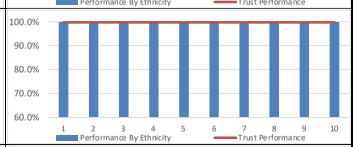
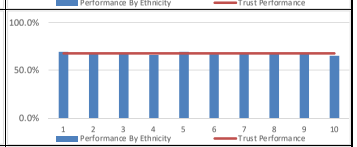
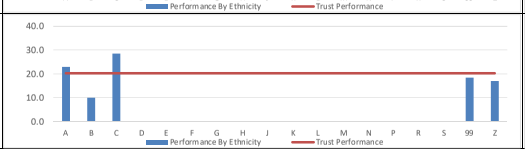
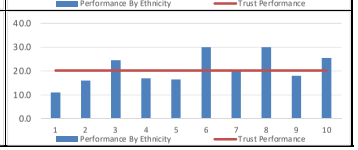
As a result of the offer of more virtual appointments, which carry a higher DNA rate, levels are generally higher than the pre-pandemic rate (3-3.5% range). However, increased focus and national guideline changes has driven levels back down from 2020 levels and are showing a stable position around 4.5%.



KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 4)

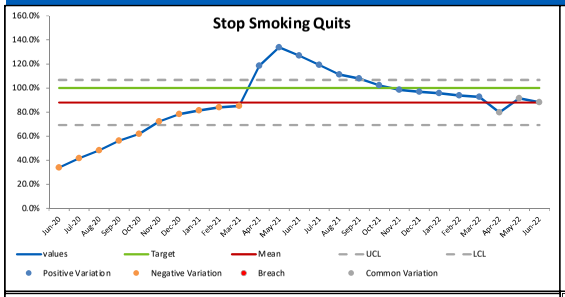
	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days		KPI 2.8 Trustwide Did Not Attend Rate: DNAs as a % of total activity		KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)		KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance		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	94.5%		4.7%		79.1%		79.3%		99.3%		99.8%		67.6%		20.3	
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	94.6%	953	4.6%	89384	78.3%	1620	79.5%	317	99.3%	12249	99.9%	1143	70.1%	7968	23.0	102
B - White - Irish	100.0%	6	2.1%	774	73.9%	23	100.0%	1	100.0%	28	100.0%	5	70.5%	44	10.0	2
C - White - Any other White background	94.0%	117	8.0%	2809	70.0%	20	100.0%	1	99.4%	530	96.7%	30	68.9%	354	28.5	2
D - Mixed - White and Black Caribbean	88.9%	9	9.5%	304	50.0%	2	N/A	0	100.0%	12	100.0%	3	50.0%	48	N/A	0
E - Mixed - White and Black African	75.0%	12	11.4%	273	100.0%	1	N/A	0	100.0%	22	100.0%	4	60.0%	35	N/A	0
F - Mixed - White and Asian	100.0%	8	8.9%	282	N/A	0	N/A	0	100.0%	18	100.0%	4	60.4%	48	N/A	0
G - Mixed - Any other mixed background	95.2%	42	10.3%	905	100.0%	2	N/A	0	100.0%	54	100.0%	3	68.9%	135	N/A	0
H - Asian or Asian British - Indian	100.0%	34	3.9%	751	100.0%	2	100.0%	1	99.4%	339	100.0%	24	61.8%	152	N/A	0
J - Asian or Asian British - Pakistani	100.0%	7	8.8%	147	100.0%	3	100.0%	2	100.0%	18	100.0%	1	63.9%	36	N/A	0
K - Asian or Asian British - Bangladeshi	100.0%	9	8.1%	172	50.0%	2	N/A	0	100.0%	21	66.7%	3	78.6%	28	N/A	0
L - Asian or Asian British - Any other Asian background	93.9%	33	7.0%	746	60.0%	5	N/A	0	99.7%	301	100.0%	11	63.7%	102	N/A	0
M - Black or Black British - Caribbean	100.0%	3	7.8%	102	N/A	0	N/A	0	100.0%	22	100.0%	3	55.0%	20	N/A	0
N - Black or Black British - African	93.0%	43	10.8%	582	0.0%	1	N/A	0	100.0%	254	100.0%	3	67.3%	162	N/A	0
P - Black or Black British - Any other Black background	87.5%	8	8.6%	232	100.0%	1	N/A	0	100.0%	108	100.0%	2	71.4%	35	N/A	0
R - Other Ethnic Groups - Chinese	100.0%	3	3.1%	96	N/A	0	0.0%	1	100.0%	23	100.0%	2	65.0%	20	N/A	0
S - Other Ethnic Groups - Any other ethnic group	100.0%	16	7.7%	518	83.3%	6	100.0%	4	99.2%	239	100.0%	4	72.4%	58	N/A	0
99 - BLANK	92.0%	50	5.1%	43552	80.6%	1025	78.7%	253	100.0%	3	99.8%	2225	66.8%	10949	18.5	42
Z - Not stated/Incomplete	81.3%	16	4.4%	9164	79.6%	255	81.1%	53	100.0%	16	99.7%	650	63.9%	2309	17.0	9
% Completeness	**95.2%**	**1369**	**65.0%**	**150793**	**81.5%**	**2968**	**51.7%**	**633**	**99.9%**	**14257**	**30.2%**	**4120**	**41.1%**	**22503**	**67.5%**	**157**
Performance by Deprivation Decile																
	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	Days	No.
Decile 1 - Most Deprived	96.4%	111	7.1%	750	70.8%	168	72.2%	18	99.9%	1031	100.0%	150	69.5%	1367	11.0	7
Decile 2	93.0%	143	5.8%	931	74.5%	259	83.7%	43	99.7%	1356	99.7%	345	67.3%	2286	16.0	11
Decile 3	97.1%	102	5.3%	728	78.5%	256	84.4%	64	99.3%	1355	99.7%	318	68.1%	1882	24.5	12
Decile 4	90.1%	152	4.0%	773	74.7%	284	84.3%	51	99.9%	1682	99.6%	351	66.0%	2468	17.0	14
Decile 5	92.0%	188	4.6%	961	76.3%	401	73.3%	75	99.2%	2033	99.8%	451	69.4%	2791	16.5	16
Decile 6	95.4%	174	4.9%	905	80.7%	353	78.5%	65	99.4%	1509	99.6%	486	67.0%	2711	30.0	19
Decile 7	94.1%	170	4.7%	853	81.7%	355	71.1%	76	99.2%	1715	99.8%	447	68.0%	2763	20.0	19
Decile 8	95.8%	119	3.9%	602	80.3%	355	73.3%	75	98.7%	919	100.0%	511	67.8%	2118	30.0	19
Decile 9	96.2%	105	3.4%	416	85.0%	240	83.3%	66	98.5%	942	99.7%	374	67.8%	1790	18.0	11
Decile 10 - Least Deprived	98.9%	90	3.2%	381	86.0%	285	86.9%	99	98.7%	889	100.0%	327	65.2%	2023	25.5	26

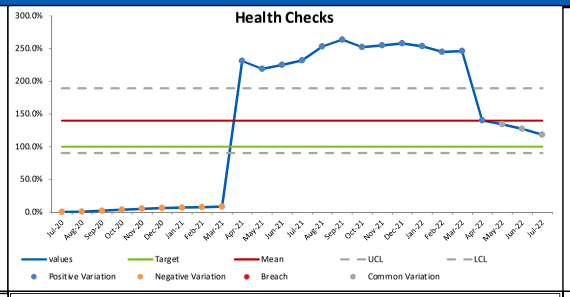
KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 4)

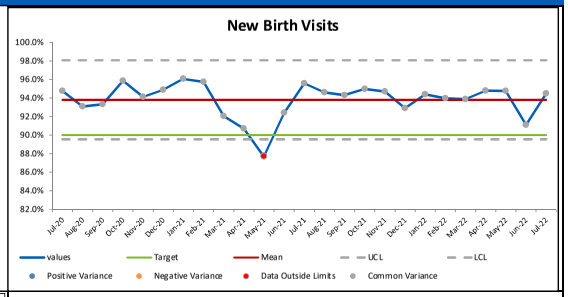
KEY	KPI	Performance By Ethnicity	Performance by Deprivation
Ethnic Categories **A** - White - British **B** - White - Irish **C** - White - Any other White background **D** - Mixed - White and Black Caribbean **E** - Mixed - White and Black African **F** - Mixed - White and Asian **G** - Mixed - Any other mixed background **H** - Asian or Asian British - Indian **J** - Asian or Asian British - Pakistani **K** - Asian or Asian British - Bangladeshi **L** - Asian or Asian British - Any other Asian background **M** - Black or Black British - Caribbean **N** - Black or Black British - African **P** - Black or Black British - Any other Black background **R** - Other Ethnic Groups - Chinese **S** - Other Ethnic Groups - Any other ethnic group **99** - BLANK **Z** - Not stated/Incomplete **Deprivation Deciles** 1 = Most Deprived 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)		

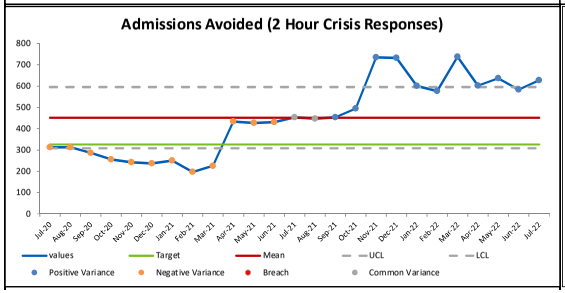
Appendix - Scorecard SPC Charts

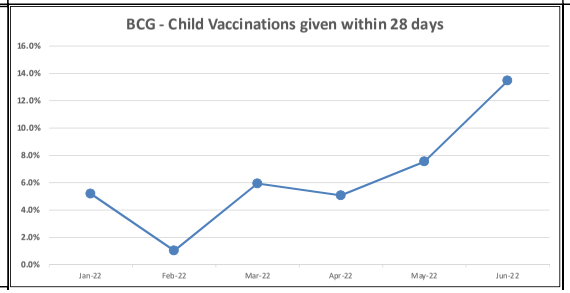
1. Prevent Ill Health



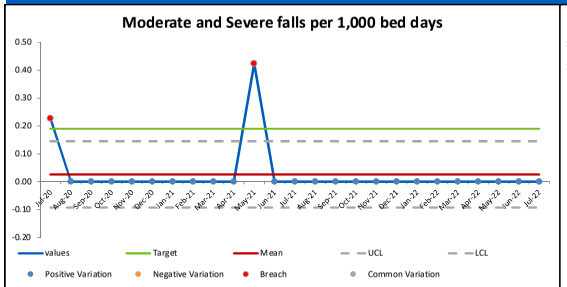


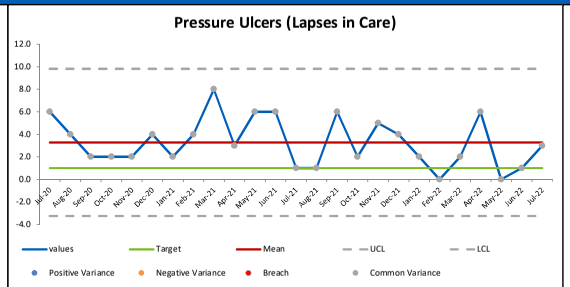


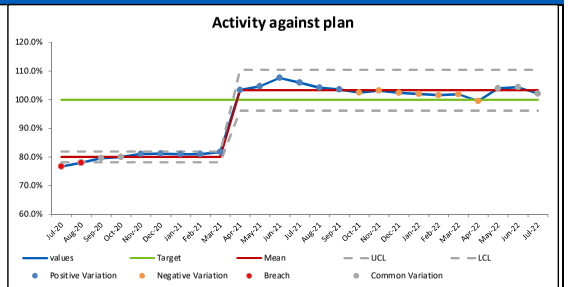


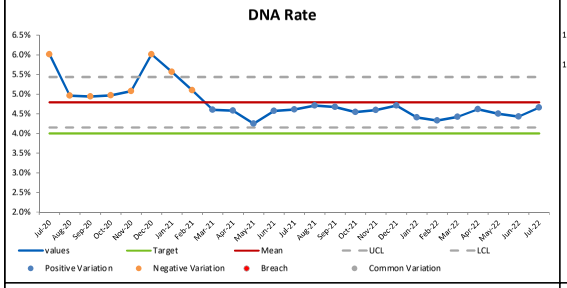


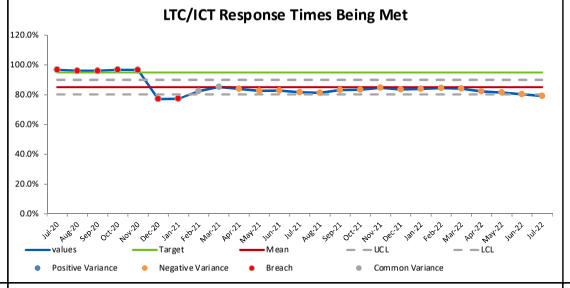
2. Deliver high-quality care at home and in the community

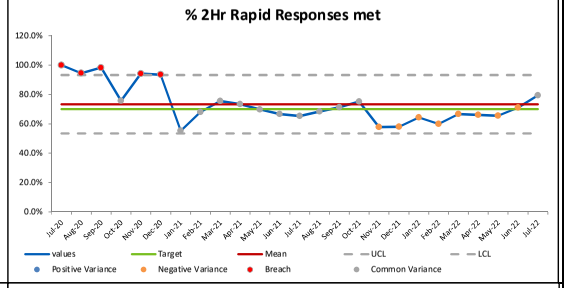


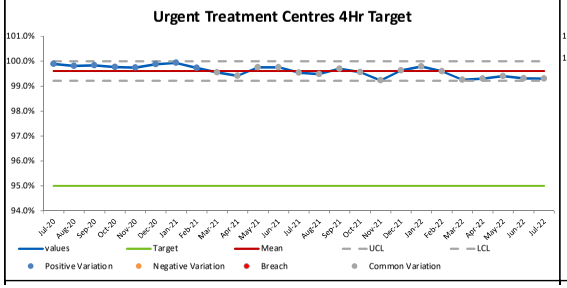


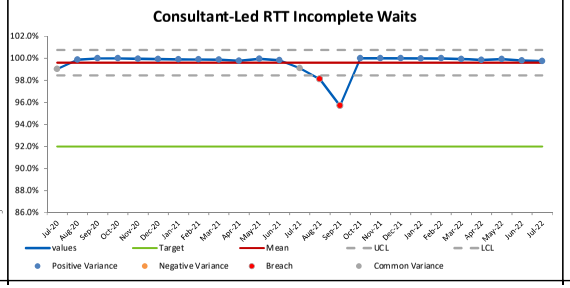


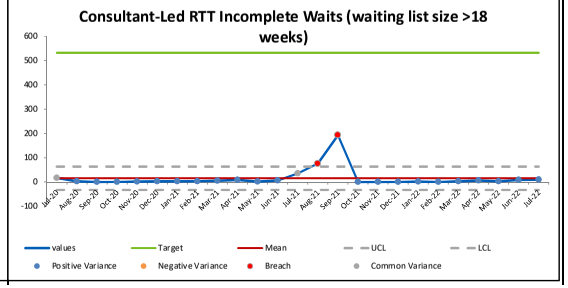




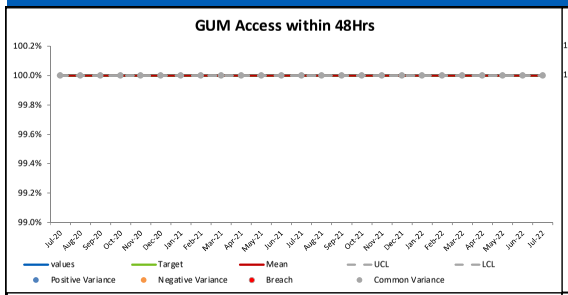


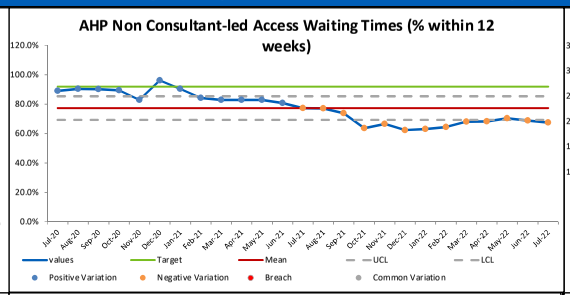


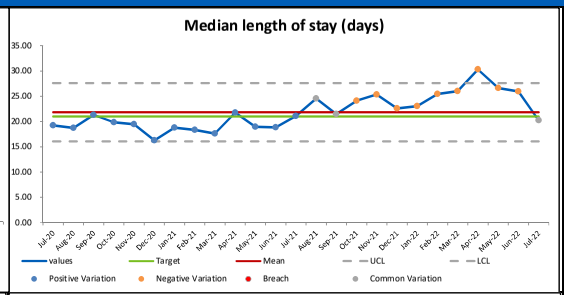


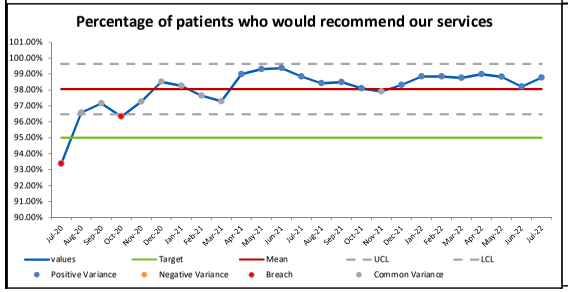


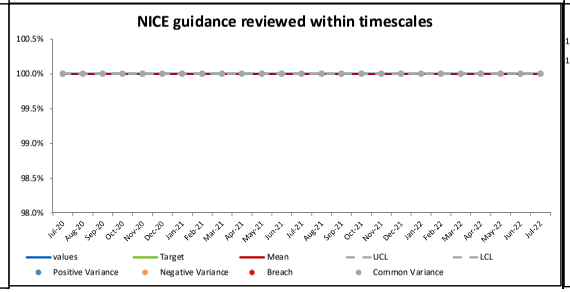
2. Deliver high-quality care at home and in the community

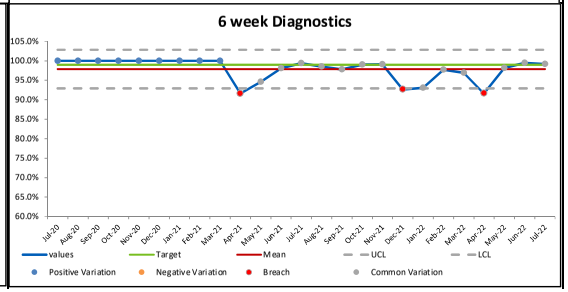




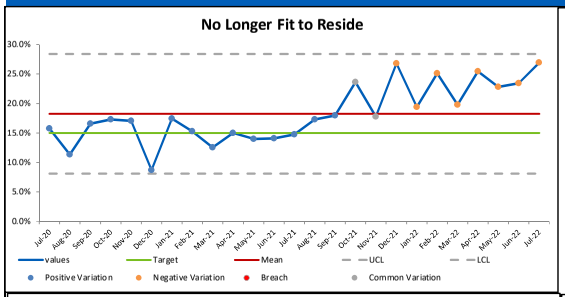


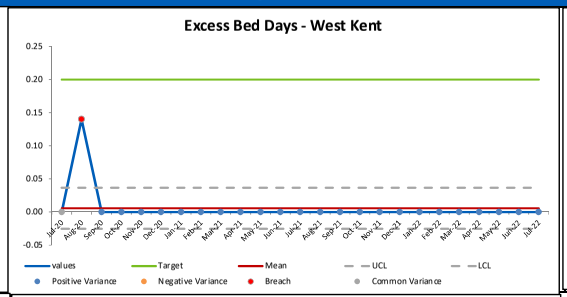


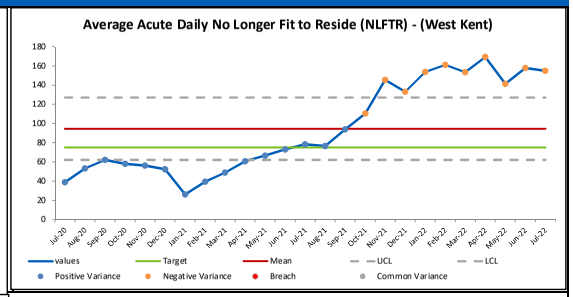


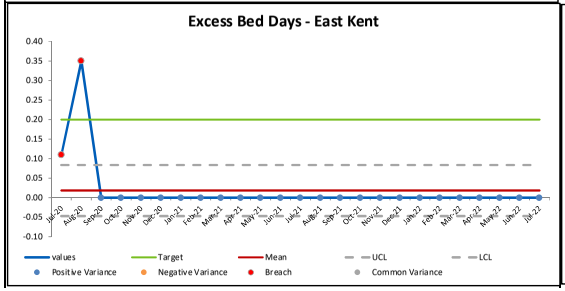


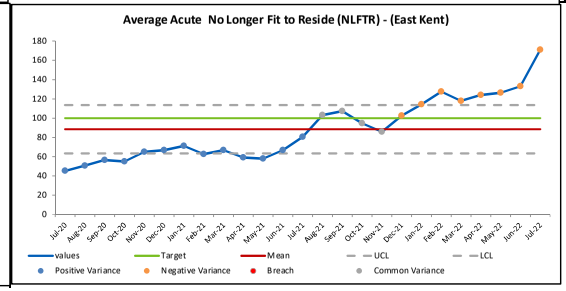
3. Integrate Services



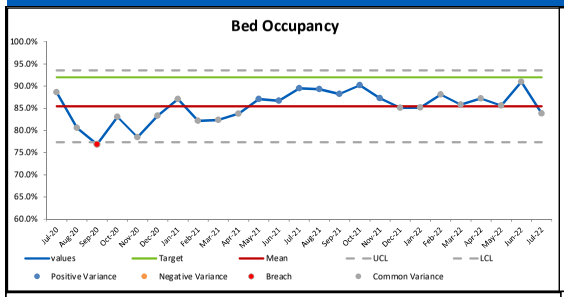


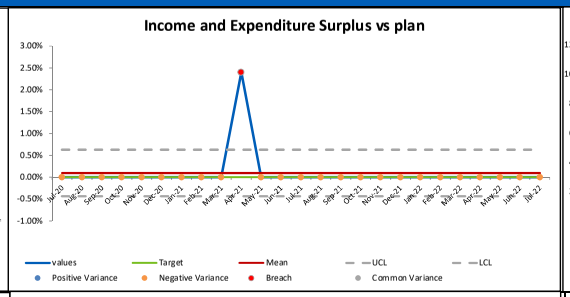


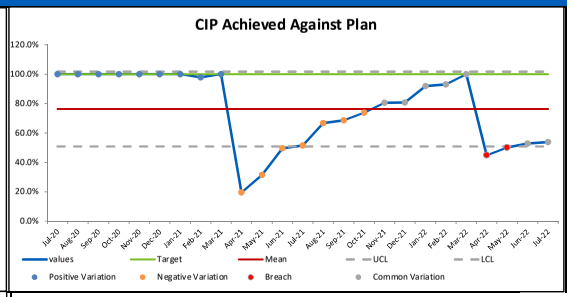


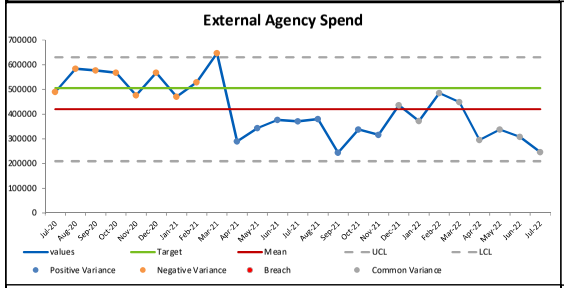


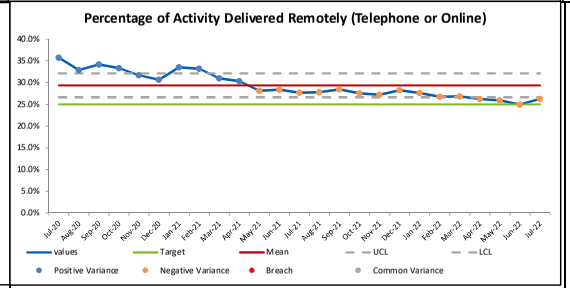
4. Develop sustainable services



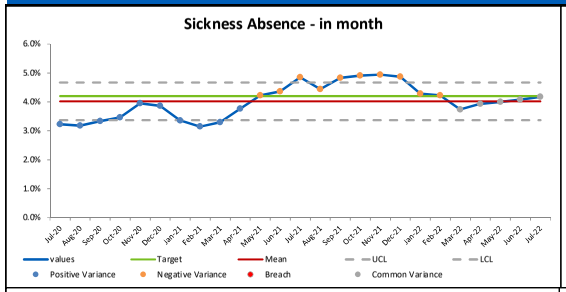


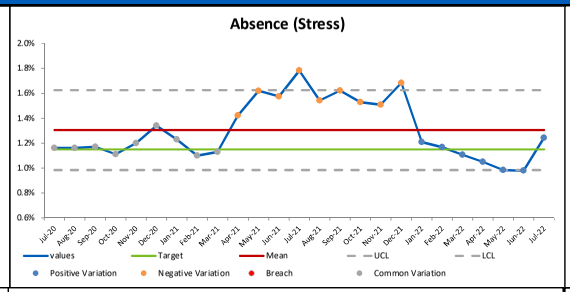


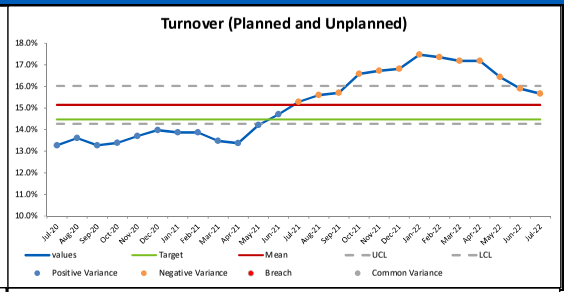


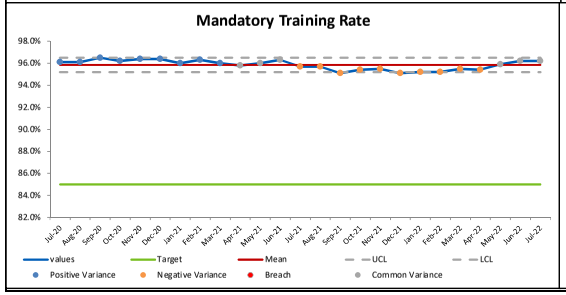


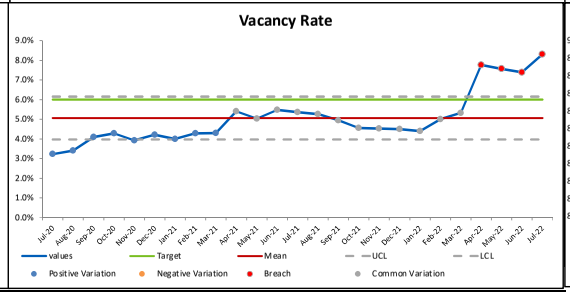
5. Be The Best Employer

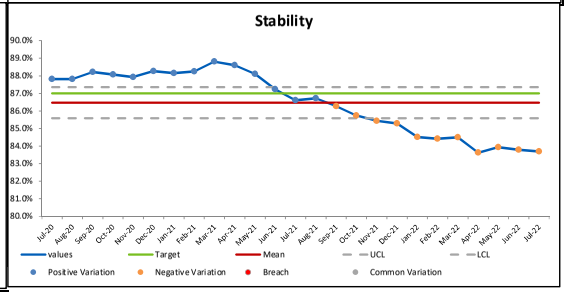












NHS
Kent Community Health
NHS Foundation Trust

Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	5.1
Agenda Item Title:	Standing Financial Instructions and Schemes of Delegation
Presenting Officer:	Gordon Flack, Director of Finance and Deputy Chief Executive Officer
Action – this paper is for:	☒ Decision ☐ Information ☐ Assurance

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

Summary of key points

The Standing Financial Instructions have been updated as follows:

- Removal of section 7.20 Private Finance for Capital Procurement

The Scheme of Delegation has been updated to incorporate IT, Estates and Corporate Services delegated authority and have also been adjusted as follows:

- A recognition of the role of Community Services Director (CSD) and the changes within the Operations directorate to include Divisions.
- Director of Estates replaced by Director responsible for management of Estates.
- Recognition that the receipt and opening of tenders has moved to an electronic process management by the procurement team rather than a postal process
- Authority to fill funded post on the establishment with permanent staff- changed to budget holder from line manager
- Authority to appoint staff to post not on the formal establishment i.e. unfunded- changed from budget holder to Assistant/Deputy/CS Director
- Approval of leave without pay- changed from line manager to Head of service
- Authorisation of retire and return and other flexible retirement applications options- changed from Line Manager to Assistant/Deputy/CS Director
- Suspension of staff- changed from Assistant/ Deputy to Executive Director or nominated Deputy.
- Approval limits for IMM in respect of revenue and capital transactions increased from £100k to £250k

Proposal and/or recommendation to the Committee or Board
To approve the Standing Financial Instructions

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

Name:	Gill Jacobs	Job title:	Deputy Director of Finance
Telephone number:	01622 939751	Email	g.jacobs@nhs.net

Kent Community Health
NHS Foundation Trust

Standing Financial Instructions

1 Introduction

1.1 General

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

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

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

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

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

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

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

1.2 Responsibilities and delegation

The Board of Directors

1.2.1 The Board exercises financial supervision and control by:

1.2.1.1 formulating the financial strategy;

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

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

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

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

The Chief Executive and Director of Finance

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

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

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

The Director of Finance

1.2.6 The Director of Finance is responsible for:

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

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

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

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

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

1.2.6.4.1 the provision of financial advice to Directors and Officers;

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

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

1.2.7 **Directors and Officers**

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

1.2.7.1 the security of the property of the Trust;

1.2.7.2 avoiding loss;

1.2.7.3 exercising economy and efficiency in the use of resources;

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

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

Contractors and their employees

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

2 Audit

Audit and Risk Committee

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

2.1.2 overseeing internal and external audit services;

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

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

2.1.5 monitoring compliance with SOs and SFIs;

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

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

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

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

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

2.4 Director of Finance

The Director of Finance is responsible for:

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

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

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

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

2.4.4.1 a clear opinion on the effectiveness of internal control in accordance with current Assurance Framework guidance issued by NHS

England and NHS Improvement including for example compliance with control criteria and standards;

2.4.4.2 major internal financial control weaknesses discovered;

2.4.4.3 progress on the implementation of internal audit recommendations;

2.4.4.4 progress against plan over the previous year;

2.4.4.5 strategic audit plan covering the coming 3 years; and

2.4.4.6 a detailed plan for the coming year.

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

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

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

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

2.5.4 explanations concerning any matter under investigation.

2.6 Role of internal audit

Internal audit will review, appraise and report upon:

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

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

2.6.3 the suitability of financial and other related management data;

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

2.6.4.1 fraud and other offences;

2.6.4.2 waste, extravagance, inefficient administration;

2.6.4.3 poor value for money or other causes.

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

2.7 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the

exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

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

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

2.10 External audit

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

Fraud and corruption

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

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

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

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

Security management

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

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

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

2.18 The FBI committee has responsibility for the following ;

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

2.18.2 Monitor performance against Cost Improvement Plans;

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

2.18.4 Approve treasury management policy and scrutinise implementation.

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

Preparation and approval of plans and Budgets

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

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

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

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

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

3.2.2 accord with workload and manpower plans;

3.2.3 be produced following discussion with appropriate Budget Holders;

3.2.4 be prepared within the limits of available funds; and

3.2.5 identify potential risks.

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

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

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

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

3.7 Budgetary delegation

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

3.7.1.1 the amount of the Budget;

3.7.1.2 the purpose(s) of each Budget heading;

3.7.1.3 individual and group responsibilities;

3.7.1.4 authority to exercise virement;

3.7.1.5 achievement of planned levels of service; and

3.7.1.6 the provision of regular reports.

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

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

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

3.11 Budgetary control and reporting

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

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

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

3.11.1.2 movements in working capital;

3.11.1.3 movements in cash and capital;

3.11.1.4 capital project spend and projected outturn against plan;

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

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

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

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

3.11.4 monitoring of management action to correct variances; and

3.11.5 arrangements for the authorisation of Budget transfers.

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

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

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

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

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

3.12 Capital expenditure

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

3.13 Monitoring returns

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

4 Annual accounts and reports

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

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

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

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

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

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

5 Bank and Government Banking Service (GBS) accounts

5.1 General

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

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

5.2 Bank and GBS accounts

The Director of Finance is responsible for:

5.2.1 bank accounts and GBS accounts;

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

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

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

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

Banking procedures

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

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

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

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

Tendering and review

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

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

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

Income systems

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

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

Fees and charges

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

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

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

Debt recovery

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

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

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

Security of cash, cheques and other negotiable instruments

6.9 The Director of Finance is responsible for:

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

6.9.2 ordering and securely controlling any such stationery;

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

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

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

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

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

7 Tendering and contracting procedure

7.1 Duty to comply with SOs and SFIs

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

7.2 EU Directives governing public procurement

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

7.3 Reverse eAuctions

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

7.4 Other Department of Health and Social Care guidance

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

Formal competitive tendering

7.5 General applicability

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

7.5.1.1 the supply of goods, materials and manufactured articles;

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

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

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

7.6 Health care services

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

Exceptions and instances where formal tendering need not be applied

7.7 Formal tendering procedures need not be applied where:

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

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

7.7.3 regarding disposals as set out in SFI 7.25 below;

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

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

7.8.2 where the requirement is covered by an existing contract;

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

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

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

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

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

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

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

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

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

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

7.11 Fair and open procurement process

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

7.12 Building and engineering construction works

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

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

7.13 Items which subsequently breach thresholds after original approval

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

7.14 Contracting/tendering procedure

Invitation to tender

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

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

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

Receipt and safe custody of tenders

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

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

Opening tenders and register of tenders

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

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

7.15 Admissibility

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

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

7.16 Late tenders

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

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

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

7.17 Acceptance of formal tenders

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

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

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

7.17.3.1 experience and qualifications of team members;

7.17.3.2 understanding of client's needs;

7.17.3.3 feasibility and credibility of proposed approach;

7.17.3.4 ability to complete the project on time.

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

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

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

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

7.17.6.2 that best value for money was achieved.

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

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

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

7.18 Quotations: competitive and non-competitive

7.18.1 **General position on quotations**

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

7.18.2 **Competitive quotations**

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

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

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

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

7.18.3 **Non-competitive quotations**

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

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

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

7.18.3.3 miscellaneous services, supplies and disposals;

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

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

Competitive quotation need not be applied where:

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

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

7.18.5 **Quotations to be within financial limits**

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

7.18.6 **Authorisation of tenders and competitive quotations**

Providing all the conditions and circumstances set out in these SFIs have been fully complied with, formal authorisation and awarding of a contract may be decided by the Officers in line with the Scheme of Delegation.

7.18.6.1 The levels of authorisation may be varied or changed by the Board at its sole discretion. Formal authorisation must be put in writing. In the case of authorisation by the Board of Directors, this shall be recorded in its minutes.

7.19 Preferred procurement route

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

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

7.20 Compliance requirements for all contracts

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

7.20.1 the Trust's SOs and SFIs;

7.20.2 EU Directives and other statutory provisions;

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

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

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

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

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

7.21 Personnel and agency or temporary staff contracts

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

7.22 Health care services agreements

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

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

7.23 Disposals

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

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

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

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

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

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

7.24 In-house services

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

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

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

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

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

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

7.24.4 The evaluation team shall make recommendations to the Board.

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

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

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

8 NHS service agreements for provision of services

8.1 Service Contracts

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

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

8.1.2.1 the standards of service quality expected;

8.1.2.2 the relevant national service framework (if any);

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

8.1.2.4 the NHS Oversight Framework; and

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

8.2 Reports to Board of Directors on Service Contracts

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

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

9.1 Remuneration and terms of service

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

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

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

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

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

9.1.2.1.3 arrangements for termination of employment and other contractual terms;

9.1.2.2 making such recommendations to the Board on the remuneration and terms of service of Directors and senior Officers to ensure they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such members and staff where appropriate;

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

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

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

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

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

9.2 Funded establishment

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

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

9.3 Staff appointments

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

9.3.1.1 authorised to do so by the Chief Executive; and

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

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

9.4 Processing payroll

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

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

9.4.1.2 the final determination of pay and allowances;

9.4.1.3 making payment on agreed dates; and

9.4.1.4 agreeing method of payment.

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

9.4.2.1 verification and documentation of data;

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

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

9.4.2.4 security and confidentiality of payroll information;

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

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

9.4.2.7 methods of payment available to various categories of Officers;

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

9.4.2.9 procedures for the recall of cheques and bank credits;

9.4.2.10 pay advances and their recovery;

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

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

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

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

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

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

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

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

9.5 Contracts of employment

The Board shall delegate responsibility to an Executive Director for:

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

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

10 Non-pay expenditure

10.1 Delegation of authority

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

10.1.2 The Chief Executive will set out:

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

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

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

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

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

10.3 System of payment and payment verification

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

10.4 The Director of Finance will:

10.4.1 advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in the SOs and SFIs and/or Scheme of Delegation (as appropriate) and regularly reviewed;

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

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

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

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

10.4.4.2 certification that:

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

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

10.4.4.2.3 in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the

materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

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

10.4.4.2.5 the account is arithmetically correct;

10.4.4.2.6 the account is in order for payment;

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

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

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

10.5 Prepayments

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

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

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

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

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

10.6 Purchase orders

Purchase orders for goods and/or services must:

10.6.1 be consecutively numbered;

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

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

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

10.7 Duties of Officers

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

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

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

10.7.3 where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Department of Health and Social Care and NHS England and NHS Improvement;

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

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

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

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

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

10.7.5.3 the Code of Conduct for NHS Managers 2002; and

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

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

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

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

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

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

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

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

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

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

11 External borrowing

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

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

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

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

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

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

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

12 Investments

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

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

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

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

13.1 Capital investment

The Chief Executive:

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

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

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

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

13.2.1 that a business case is produced setting out:

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

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

13.2.1.3 appropriate project management and control arrangements;

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

13.2.3 that for capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the Department of Health and Social Care.

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

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

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

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

13.6.1 specific authority to commit expenditure;

13.6.2 authority to proceed to tender;

13.6.3 approval to accept a successful tender.

13.7 The scheme of delegation for capital investment is included in Appendix 1.

13.8 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account any current delegated limits for capital schemes.

13.9 Asset registers

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

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

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

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

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

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

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

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

13.9.6 Where a full valuation of assets has not been undertaken, the value of each material asset shall be indexed to current values in accordance with the most up-to date BCIS Index (Building Cost Information Service of RICS). The BCIS Index fulfils the requirement of being current and is approved by the Royal Institution of Chartered Surveyors. Where the BCIS Index is not appropriate for a class of asset i.e. Land, an assessment of current valuation will be provided by an approved External Chartered Surveyor. Non-Property assets, those assets which have short useful lives or low values (or both) are not re-valued.

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

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13.10 Security of assets

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

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

13.10.2.1 recording managerial responsibility for each asset;

13.10.2.2 identification of additions and disposals;

13.10.2.3 identification of all repairs and maintenance expenses;

13.10.2.4 physical security of assets;

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

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

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

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

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

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

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

14 Stores and receipt of goods

14.1 General position

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

14.1.1 kept to a minimum;

14.1.2 subjected to proper control and recording; and

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

Control of stores, stocktaking, condemnations and disposal

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

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

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

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

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

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

14.8 Goods supplied by NHS Supply Chain

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

15 Disposals and condemnations, losses and special payments

Disposals and condemnations

15.1 Procedures

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

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

15.1.3 All unserviceable articles shall be:

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

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

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

Losses and special payments

15.2 Procedures

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

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

corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the relevant CFS.

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

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

15.2.4.1 the Board of Directors; and

15.2.4.2 the external auditor.

15.2.5 Within delegated limits, the Integrated Management Team and the Executive Team shall approve the writing-off of losses.

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

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

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

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

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

16 Information technology

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

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

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

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

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

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

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

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

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

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

16.4.1 details of the outline design of the system; and

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

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

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

16.6 Risk assessment

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

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

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

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

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

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

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

17 Patients' property

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

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

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

17.2.2 hospital admission documentation and property records; and

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

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

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

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

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

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

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

18 Funds held on trust

18.1 Corporate trustee

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

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

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

18.2 Accountability to Charity Commission and Secretary of State

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

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

18.3 Applicability of SFIs to funds held on trust

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

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

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

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

20 Retention of records

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

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

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

21 Risk management and insurance

Programme of Risk Management

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

21.2 The programme of risk management shall include:

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

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

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

21.2.4 contingency plans to offset the impact of adverse events;

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

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

21.2.7 arrangements to review the risk management programme.

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

21.4 Insurance: risk pooling schemes administered by NHS Resolution

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

21.5 Insurance arrangements with commercial insurers

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

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

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

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

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

Appendix 1 - Scheme of Delegatic

Appendix 1 – Scheme of Delegation

Delegated Matter	Lowest Level of Authority
Budgetary Control	
Revenue Spending Approval Limits; - up to £19,999 - - from £20,000 to £49,999 - - - from £50,000 to £99,999 - - up to £250,000 up to a total maximum of 20% of Trust contingency budget - - from £100,000 to £499,999 - from £500,000 to £999,999 per annum and up to £5,000,000 for a 5-year contract. No limit on income contract renewals. - from £1,000,000 to £2,999,999 per annum and up to £15,000,000 for a 5-year contract. - over £3,000,000 per annum and over £15,000,000 for a 5-year contract For property capital equivalent transactions see Capital Scheme Approval Limits	Budget Holder (individual limits can be set by the Assistant/Deputy/Community Services Director) Assistant/Deputy/Community Services Director Board Director Integrated Management Team Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors
Management of Budgets; - Individual Budget Level - - Service Level - Division sub-set services - Division - Directorate	Budget Holder Assistant/Deputy Director and Heads of Service will oversee the budgetary position for the services within their remit and take corrective action where necessary, in conjunction with the budget holder. Community Services Manager Community Services Director Director of Service

- Trust Level	Board of Directors
Budget Virement (transfer of budget from one budget to another, financial limits to be set by Head of Financial Management):	
Transfer within cost centre (under 20%)	Budget Holder
Transfer within cost centre (over 20%)	Budget Holder and Head of Service
Cost Centre mergers/splits with no change to subjective budgets	Budget Holder
Between cost centres but within the same directorate	Budget Holder and Head of Service for minor changes, Head of Service and Community Service Manager for larger changes
Between directorates	Clinical Service Director/Assistant Director from both directorates
Any non-pay to pay transfer	Budget Holder and Head of Services (and Head of Financial Management where change is significant)
Any transfer involving income	Budget Holder (Clinical Services Manager for Clinical Services) (and Deputy Director of Finance where change is significant)
Significant restructure to budgets	Clinical Service Director/Assistant Director & Director
Capital Investment	
Approval of Annual Capital Programme	Board of Directors
Capital Scheme Approval Limits (on receipt of a business case approved by Head of Service);	
- Up to £250,000	Integrated Management Team
- up to £999,999	Capital Steering Group
- property capital equivalent transactions up to £5,000,000 e.g. long-term leases of 25 years would be limited to £200,000 per annum.	Chief Executive
- from £1,000,000 to £2,999,999	Chief Executive and Finance, Business & Investment Committee
- property capital equivalent transactions over £5,000,000 and up to £10,000,000 e.g. long-term leases of 25 years would be limited to £400,000 per annum.	Chief Executive and Finance, Business & Investment Committee

- over £3,000,000 - over £10,000,000 for a property capital equivalent transaction e.g. long-term leases over 25 years over £400,000 per annum.	Board of Directors Board of Directors
Capital Expenditure Approval Limits (once capital scheme has been approved as per above); - up to £19,999 - from £20,000 to £49,999 - - from £50,000 to £99,999 - from £100,000 to £499,999 - - from £500,000 to £999,999 - from £1,000,000 to £2,999,999 - over £3,000,000	 Designated Capital Project Lead Assistant/Deputy/Community Services Director Board Director Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors
Selection of architects, quantity surveyors, consultant engineers and other professional advisers.	Director with responsibility for management of Estates subject to tender limits
Financial monitoring and reporting on all capital scheme expenditure.	Director of Finance
Entering, granting, varying or termination of property leases held under deed	Chief Executive and Director of Finance
Overview; - For expenditure below £10,000 competitive quotations are not required, however Budget Holders are responsible for ensuring value for money. - 3 competitive written quotations required for expenditure from £10,000 to £50,000. - Formal tendering procedures are required where the intended expenditure is in excess of £50,000.	
Approval to waive competitive quotation process for expenditure in excess of £10,000 but below £50,000	Assistant/Deputy/Community Services Director
Approval to waive formal tendering procedures for expenditure in excess of £50,000	Director of Finance
Receipt of Tenders	Procurement Secure Mailbox
Opening of Tenders	All tender responses are electronic and are opened by the Procurement Team from the secure Procurement mailbox.

Formal authorisation and awarding of a contract; - up to £19,999 - from £20,000 to £49,999 - - from £50,000 to £99,999 - from £100,000 to £499,999 - from £500,000 to £999,999 - from £1,000,000 to £2,999,999 - over £3,000,000	 Budget Holder Assistant/Deputy/Community Services Director Board Director Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors
Letting of premises to outside organisations	Director of Finance
Approval of rent based on professional assessment	Director of Finance
Condemning and Disposal	
Items obsolete, obsolescent, redundant, irreparable or not cost-effective to repair (liaison with the Procurement and Finance team is required to ensure safe and compliant disposal and value for money); - Estimated replacement cost <£5,000 - Estimated replacement cost >£5,000	 Budget Holder In line with Revenue Spending Approval limits
Disposal of Plant and Machinery, Vehicles and Medical equipment in excess of £5,000	In line with Revenue Spending Approval limits
Sale of Property (Land and Buildings)	Board of Directors
Losses and Special Payments	
Losses and Special Payments (within limits delegated by the Department of Health)	Head of Service and Director of Finance (report presented to Audit and Risk Committee)
Petty Cash Disbursements	
Purchases from Petty Cash should not exceed £20	Budget Holder
Personnel and Pay	
Authority to fill funded post on the establishment with permanent staff	Budget holder
Authorisation of payment of removal expenses incurred by recruits taking up new appointments (providing consideration was promised at interview);	Budget holder and Deputy Director of HR
Authority to appoint staff to post not on the formal establishment i.e. unfunded	Assistant/Deputy/Community Services Director
All requests for upgrading / regrading via job evaluation panel	Budget holder
Authority to complete confirmation of appointment forms, identifying appropriate starting salary (in line with Salary on Appointment policy)	Line Manager

Authority to complete change forms effecting pay and variations to terms and conditions within funded establishment	Line Manager
Authority to confirm successful probationary period has been completed	Line Manager
Authority to extend probation or refer to a probationary review hearing	Line Manager
Authority to authorise temporary staffing	Budget holder
Authority to authorise travel and subsistence expenses	Line Manager
Authority to offer and confirm acting up arrangements in funded establishment	Line Manager
Authority to approve staff secondments within funded establishment	Line Manager
Approval of annual leave	Line Manager
Approval of, changes to and finalisation of rosters	Line Manager
Approval of requests to buy additional annual leave	Line Manager
Approval of requests to sell annual leave	Budget holder
Approval of special leave (carers, unexpected events, jury service or compassionate leave)	Line Manager
Approval of leave without pay	Head of Service
Approval of time off in lieu	Line Manager
Approval of maternity leave, adoption, surrogacy, shared parental and maternity support (paternity) leave	Line Manager
Approval of career breaks	Head of Service
Approval of study leave	Line Manager
Authorisation for funding for conferences, courses and further education	Training Panel
Medical staff revalidation	Responsible Officer
Nursing revalidation	Line Manager
Proposing changes that impact on structure, roles, terms and conditions	Line Manager
Renewal of fixed term contract in funded establishment	Line Manager
Authorisation of retire and return and other flexible retirement applications options	Assistant/Deputy/Community Services Director
Authorising retirement gifts and contribution to parties	Budget holder
Agreeing flexibility or support requested by staff in relation to the staff work and wellbeing passport	Line Manager
Making referrals to Occupational Health	Line Manager
Making referral to the Trust Fast track physiotherapy services for staff	Member of staff
Implementing reasonable adjustments for staff with disabilities	Line Manager

Authorising additional counselling sessions for members of staff payable by the service	Line Manager
Appraisal ratings that impact on eligibility for incremental progression	Line Manager
Award of Clinical Excellence awards for Consultants	Local Award Committee (in accordance with Trust Clinical Excellence awards procedure)
Informal action in relation to capability, grievance, sickness absence or disciplinary issues	Line Manager
Issue of informal recorded warnings (that do not impact incremental pay)	Line Manager
Suspension of staff	Executive Director or Nominated Deputy
Exclusion of medical or dental staff	Medical Director (or an appropriate Deputy or Executive Director in the absence of the Medical Director)
Issue of disciplinary warnings that impact on incremental pay and progression	In accordance with the Trust disciplinary procedure and authority to take action table
Approval of posts for redundancy	Board Directors
Support for Ill Health Retirement applications	Line manager
Termination of employment	In accordance with the Trust disciplinary, capability, managing sickness policies and authority to take action table.
Provision of references	Line Manager
Acknowledging and accepting staff resignation	Line Manager
Completion of leavers forms	Line Manager (including returning leaver's IT / telephony equipment to the IT Department).
IT	
The systems below relate to those managed by the IT service. Other services who manage systems with have their own levels of approval for access which should be set at the lowest level of authority possible and in line with our CUB principles.	
Access to clinical systems e.g. • RiO • Lillie • EMIS • Symphony • SystmOne	Line Manager
IT system access – new users and amendments: • Smartcards • Windows Active Directory • NHS Mail (including mailbox increases) • TopDesk • Email to SMS	Line Manager
IT / telephony equipment requests: • Laptop	Line Manager

• Desktop • Tablet • Tablet accessories • Mobile phone • Landline / 8x8 Virtual Office licence	
Telephony equipment requests: • 8x8 Virtual Call Centre licence • MiFi	Budget Holder
Access to a shared / network drive	Nominated individuals who must understand the IG implications of holding data and allowing access to this data.
Request for new shared / network drive to be created	Nominated individuals who must understand the IG implications of holding data and allowing access to this data.
3rd party system supplier request for access to IT network	Assistant/Deputy/Community Services Director
Access to another users NHS Mail account / personal drive	SIRO (Senior Information Risk Owner)
ESTATES	
Room bookings	Staff member
Moves & Changes - up to £19,999 - from £20,000 to £49,999 - - from £50,000 to £99,999 - from £100,000 to £499,999 - from £500,000 to £999,999 - from £1,000,000 to £2,999,999 - over £3,000,000	 Budget Holder Assistant/Deputy/Community Services Director Board Director Director of Finance Chief Executive Chief Executive and Finance, Business & Investment Committee Board of Directors
Authorising Openspace accounts	Budget Holder
Authority to issue ID badge, fob application including access to electric charging	Line Manager
Ordering furniture outside the moves and changes process	Budget Holder
Corporate Services	
Risk and Incident Management Datix Account Raise a Risk Risk Sign off and Ownership Raise an Incident Investigate an Incident	 Member of staff Member of staff Head of Service Member of staff Line Manager
Information Governance • DPIA • Data flow map • • Archiving	 Member of staff Head of Service/Community Services Manager Member of staff

• Policy	Member of staff – Sign off by relevant Governance Group
Legal Services • Legal Advice • • Legal Supporting Statements • • Consent	 Head of Service/Community Services Manager Head of Service/Community Services Manager Member of staff
EPRR • Action Cards • BIA • BCP	 Member of staff Head of Service Head of Service
Health Safety • Risk Assessment	 Member of staff

NHS
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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	5.2
Agenda Item Title:	Board of Directors – Committee membership and designations September 2022
Presenting Officer:	John Goulston, Trust Chair
Action – this paper is for:	**X** Decision ☐ Information ☐ Assurance

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

This paper provides an update following recent chief executive and executive director changes to the Board of Directors, since April 2022. This report presents the proposal for Board membership and Non-Executive Director and Executive Director responsibilities with the required approval where appropriate. The paper also presents proposals for Board recommendation

Summary of key points

Mairead McCormick commenced on 1 July 2022 as chief executive and accounting officer of the Trust. Gordon Flack has returned to his substantive role as Director of Finance. In addition, Natalie Davies has been appointed as Chief of Staff of Kent & Medway Integrated Care Board and left the Trust for her new role on 31 August 2022.

Ali Carruth, Director of Patient Participation, Engagement & Involvement, will inherit health inequalities, Emergency Response Planning Preparation (EPRR), Freedom to Speak Up and Governors. This includes a title change to Director of Participation, Experience and Equalities and membership of the Trust Board as a non-voting member. The Chief Executive has appointed an interim Board Secretary to support the Governance of the Board and Council of Governors.

The Chief Executive has engaged an external review of executive portfolios.

An external well led review will take place this autumn. The Trust is currently in the process of procuring a preferred supplier for the review.

Proposal and/or recommendation to the Committee or Board
The Board is asked to approve the following proposals: 1. From 1 September 2022, the Non-Executive and Executive Director membership of committees as set out in Table 1. 2. From 1 September 2022, the Chairs and Deputy Chairs of the Committees as set out in Table 2 and section 4. 3. The changes to the executive directors' designations with the appointment of Mairead McCormick as Chief Executive and with Natalie Davies, Director of Corporate Services leaving the Trust (see section 2.2).

If this paper relates to a proposed change linked to any of the below, have you completed an equality analysis for this paper? *National guidance or legislative change, organisational or system redesign, a significant impact to patients, local policy or procedural change, local impacts (service or system) or a procurement process.* *You can find out more about EAs here on flo*	☐ Yes *(please attach)*
If not, describe any equality and diversity issues that may be relevant. *Protected characteristics are: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.*	**X** No *(please provide a summary of the protected characteristic highlights in your paper)*
Highlights relating to protected characteristics in paper	
The Chair and Chief Executive recognise the importance of increasing the diversity of the Trust's senior leadership with regard to the proportion of staff in senior positions from black, asian and ethnic minorities. The Board has an externally facilitated development session on 7 September 2022 to examine what we need to do to achieve a positive step change to ensuring "nobody is left behind".	

Name:	John Goulston	Job title:	Trust Chair
Telephone number:		Email	j.goulston@nhs.net

Kent Community Health
NHS Foundation Trust

BOARD OF DIRECTORS - COMMITTEE MEMBERSHIP AND DESIGNATIONS

1. Introduction

The Constitution of Kent Community Health NHS Foundation Trust (the Trust) sets out the composition and makeup of the Board of Directors (the Board) both in terms of Executive and Non-Executive Directors roles. In addition, there are several other roles which are either required by Trust regulators or recommended as part of a system of good governance.

As the Board members are fully aware, there have been several changes to the Membership of the Board over the past year. In concert with this, further changes have been signalled and proposed for consideration.

This paper provides an update following recent chief executive and executive director changes to the Board of Directors, since April 2022. This report presents the proposal for Board membership and Non-Executive Director and Executive Director responsibilities with the required approval where appropriate. The paper also presents proposals for Board recommendation to the Council of Governors as necessary.

2. Board Membership

The Constitution sets out that the Board is made up of a maximum of seven Non-Executive Directors and a Chair in addition to this number. Equally, the maximum number of Executive Directors is seven.

2.1. Non-Executive Directors (NED)

From 1 February 2022, the Non-Executive membership of the Board is as follows;

Chair: John Goulston

1. Pippa Barber
2. Peter Conway
3. Nigel Turner
4. Paul Butler
5. Karen Taylor
6. Kim Lowe

Razia Shariff is an Associate Non-Executive Director, a non-voting member of the Board.

2.2. Executive Directors

Mairead McCormick commenced on 1 July 2022 as chief executive and accounting officer of the Trust. Gordon Flack has returned to his substantive role as Director of Finance. In addition, Natalie Davies has been appointed as Chief of Staff of Kent & Medway Integrated Care Board and left the Trust for her new role on 31 August 2022. Ali Carruth, Director of Patient Participation, Engagement & Involvement, will inherit health inequalities, Emergency Response Planning Preparation (EPRR), Freedom to Speak Up and Governors. This includes a title change to Director of Participation, Experience and Equalities and membership of the Trust Board as a non-voting member.

As at 1 September 2022, the executive directors are as follows;

Chief Executive - Mairead McCormick

1. Gordon Flack, Deputy Chief Executive & Executive Director of Finance
2. Sarah Phillips, Medical Director
3. Pauline Butterworth, Chief Operating Officer
4. Mercia Spare, Chief Nurse
5. Victoria Robinson-Collins, Director of People, Organisation Development
6. Gerard Sammon, Director of Strategy & Partnerships

Ali Carruth, Director of Participation, Experience & Equalities is a non-voting member of the Board.

The Chief Executive has appointed an interim Board Secretary to support the Governance of the Board and Council of Governors. The Chief Executive has also engaged an external review of executive portfolios.

An external well led review will take place this autumn. The Trust is currently in the process of procuring a preferred supplier for the review

The constitution allows the Board to have “up to a maximum of 7 other Non-Executive Directors (and)…7 Executive Directors” 8.2.2,3. It goes on to say that “In the event that the number of Non-Executive Directors (including the Chair) is equal to the number of Executive Directors, the Chair (and in his absence, the Deputy Chair), shall have a second or casting vote at meetings of the Board of Directors in accordance with the Standing Orders for the Board of Directors.” (8.8) and finally that there shall be a majority of NEDs including the chair (8.10.2). The above shows that we are in the position of having an equal number of NEDs and EDs. In the interim the chair therefore has a casting vote if we ever need a vote. In the meantime a NED vacancy is acceptable without standing down any ED from voting.

3. Membership of Board Committees

3.1 From **1 September 2022**, the membership of Board Committees is set out in table 1 below. 'C' is used to signify the chairperson of the Committee; 'M' is used to signify a member of the Committee (changes since 1 April are shown in bold).

Table 1 - Membership of Board Committees from 1 April 2022

Board member	**Audit & Risk Committee** *(2 NED's required for quoracy)*	**Charitable Funds Committee** *(1 NED required for quoracy)*	**Finance Business & Investment Committee** *(2 NED's required for quoracy)*	**Quality Committee** *(2 NED's required for quoracy)*	**Strategic Workforce Committee** *(2 NED's required for quoracy)*	**Remuneration and Terms of Service Committee**
Pippa Barber	M			C		M
Peter Conway	C		M			M
Nigel Turner	M	C			M	M
Paul Butler			C	M		M
Karen Taylor				M	M	M
Kim Lowe			M		C	M
Razia Shariff		**M**		M		Attends but not a member
Sarah Phillips			M	M		
Pauline Butterworth			M	M	M	
Mercia Spare		M		M	M	
Victoria Robinson-Collins		M			M	
Gerard Sammon			M	M		
Gordon Flack	Attends but not a member of ARC		M		M	

3.2 Executive directors will utilise their deputies where necessary to ensure attendance and utilise specific expertise.

3.3 As part of good governance, all non-executive directors, the Chair and the Chief Executive are encouraged to attend at least one meeting per annum of the Board Committees that they are not formal members of.

4. Chairs and Deputies of Board Committees

4.1 As detailed in Table 1, each of the Board committees has a chair. In the interests of good governance, each committee should also have a deputy chair. Table 2 proposes deputy chair for each Board committee. This will be reviewed on an annual basis in order to ensure that we take account of succession planning. **The only change since April 2022 is Razia Shariff becoming vice chair of the Charitable Funds Committee.**

Table 2 - Chairs and Deputy Chairs of Board Committees

Committee	Chair	Deputy Chair
Audit and Risk	Peter Conway	Pippa Barber
Finance Business and Investment	Paul Butler	Kim Lowe
Charitable Funds	Nigel Turner	**Razia Shariff**
Quality	Pippa Barber	Karen Taylor
Strategic Workforce	Kim Lowe	Nigel Turner
Remuneration and Terms of Service	John Goulston	Pippa Barber

4.2 The Remuneration Committee will continue to be chaired by the Chair of the Trust with the Senior Independent Director as the Deputy Chair of the Committee. Where the Chair proposes an agenda item to the Committee e.g. salary change or appraisal of the Chief Executive, the Deputy Chair of the Committee will chair the relevant item.

5. Other Non-Executive Board Leadership Responsibilities

There have been no changes from 1 April to the other Non-Executive board leadership responsibilities. Thus section 5 of this paper is unchanged from the 1 April 2022 version. For completeness section is repeated below.

5.1. Deputy Chair and Senior Independent Director

Paragraph 13.1 of the Trust's Constitution states that "The Council of Governors at a formal meeting of the Council of Governors shall appoint one of the Non-Executive Directors as a Deputy Chair for such period not exceeding their term of office as a Non-Executive Director, as the Council of Governors may specify on appointment."

Deputy Chair means the Non-Executive Director appointed by the Council of Governors to take on the Chair's duties in accordance with paragraph 13.2 of the Constitution if the Chair is absent for any reason.

The Council of Governors at its meeting on 21 March 2022 approved the continued appointment of Peter Conway as Deputy Chair of the Trust. Peter is also the Chair of the Audit and Risk Committee. The Chair proposes that Peter Conway continues as Deputy Chair.

The Senior Independent Director is appointed by the Council of Governors. The Council of Governors on 21 March 2022 approved the appointment of Pippa Barber as Senior Independent Director.

5.2. Non-Executive Director Champion Roles

In addition to the responsibilities in table 2 and excluding the Vice Chair and the Senior Independent Director; there are the following assigned NED lead roles / responsibilities:

- Staff Health & Wellbeing – Kim Lowe
- Freedom to Speak Up – Karen Taylor
- Security Management - Paul Butler

In addition, under the 2003 Maintaining High Professional Standards in the modern NHS: A Framework for the Initial Handling of Concerns about Doctors and Dentists in the NHS and the associated Directions on Disciplinary Procedures 2005, there is a requirement for chairs to designate a NED member as "the designated member" to oversee each case to ensure momentum is maintained. There is no specific requirement that this is the same NED for each case. The framework was issued to NHS foundation trusts as advice only. Kent Community Health NHS Foundation Trust follows the framework.

The above reflects the new guidance issued by the NHS in December 2021 on NED champion roles Reference: "A new approach to Non-Executive director champion roles" December 2021 - https://www.england.nhs.uk/wp-content/uploads/2021/12/B0994_Enhancing-board-oversight-a-new-approach-to-non-executive-director-champion-roles_December-2021.pdf
This guidance sets out a new approach to ensuring board oversight of important issues by discharging the activities and responsibilities previously held by some NED champion roles, through committee structures. It also describes which roles should be retained and provides further sources of information on each issue.

Table 3 – Committee leadership roles

Role	Committee	Guide suggests
Hip fractures, falls and dementia	Quality	Quality
Palliative and end of life care	Quality	Quality
Resuscitation	Quality	Quality
Learning from deaths	Quality	Quality
Health and safety	Audit and Risk	Quality
Safeguarding	Quality	Quality
Safety and risk	Audit and Risk	Quality
Lead for children and young people	Quality	Quality
Counter fraud	Audit and Risk	Audit and Risk
Emergency preparedness	Audit and Risk	Audit and Risk
Procurement	Finance	Finance
Cyber security	Audit and Risk	Finance/ Board
Security management – violence and aggression	Workforce	Workforce

Health and Safety and safety and risk currently are led by the Audit and Risk Committee which already has an effective link to the corporate assurance management arrangements. It is not therefore proposed to change this arrangement.

Similarly, cyber security is effectively overseen by the Audit and Risk Committee and whilst the Finance and Investment Committee oversee digital the risk component sits best with Audit and Risk.

6. Non-Executive Director Terms of Office

The Council of Governors on 20 July 2022 approved the extension of Pippa Barber's term of office by 2 years to 30 November 2024. The terms of office for the Non-Executive Directors are detailed in table 3 below.

Table 4 - terms of office for the Non-Executive Directors

First name	Surname	Start date	(Re) Appointment to the Board	Period of appointm't	End date appointm't
Peter	Conway	01/03/2015	01/04/2021 (R2)	3 years	31/03/2024
Pippa	Barber	01/12/2016	01/12/2022 (R2)	3 years	**30/11/2024**
Nigel	Turner	01/10/2018	01/10/2021 (R)	3 years	30/09/2024
Paul	Butler	01/03/2020		3 years	28/02/2023
Karen	Taylor	01/02/2022		3 years	31/01/2025
Kim	Lowe	01/02/2022		3 years	31/01/2025
John	Goulston	01/11/2018	01/11/2021 (R)	3 years	31/10/2024
Associate NED Razia	Shariff	01/02/2022		2 years	31/01/2024

NB R – reappointed to the Board of Directors by the Council of Governors for a second term of 3 years. Non-Executive Directors and the Chair can stand for two 3-year terms of office and be offered up to a further 3 years by the Council (R2). The maximum term for a NED is 9 years.

Appointments of Non-Executive Directors are the responsibility of the Council of Governors. The Council of Governors has formed the Nomination Committee to consider the appointment and re-appointment of Non-Executive Directors and make recommendations to the Council.

7. Associate Non-Executive Director

Following the NED recruitment process in the autumn of 2021, the Council of Governors approved the appointment of Razia Shariff as an Associate Non-Executive Director from 1 February 2022. The appointment is to support succession planning and add to the diversity of thinking on Board of Directors.
An Associate NED provides additional support to the Board and constructively challenges the Trust's ambitious vision for integrated care focused on improved public health outcomes, both in terms of strategy and successful execution of service change. The Associate NED role is used successfully in the NHS to support Board succession strategy and achieving a balance of Board level skills. Associate Non-executive directors cannot participate in any formal vote at Board.

8. Recommendations

The Board is asked to approve the following proposals;

8.1 From 1 September 2022, the Non-Executive and Executive Director membership of committees as set out in Table 1.

8.2 From 1 September 2022, the Chairs and Deputy Chairs of the Committees as set out in Table 2 and section 4.

8.3 The changes to the executive directors designations with the appointment of Mairead McCormick as Chief Executive and with Natalie Davies, Director of Corporate Services leaving the Trust (see section 2.2).

The Board is asked to note;

- the composition of the Board and its voting membership as set out in section 2 and
- that the Chief Executive has appointed an interim Board Secretary to support the Governance of the Board and Council of Governors.
- The Chief Executive has engaged an external review of executive portfolios.
- An external well led review will take place this autumn. The Trust is currently in the process of procuring a preferred supplier for the review.

30 August 2022

Chair

John Goulston

Kent Community Health NHS Foundation Trust

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Committee / Meeting Title:	Board Meeting - Part 2 (Confidential)
Date of Meeting:	07 September 2022
Agenda Number:	6.1
Agenda Item Title:	Trust Annual Report and Accounts 2021/22
Presenting Officer:	Mairead McCormick, Chief Executive Gordon Flack, Director of Finance/Deputy Chief Executive
Action – this paper is for:	☐ Decision ☒ Information ☐ Assurance

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

The report was received and approved by the Board at its Part Two meeting on 16 June 2022 in order to meet the statutory deadlines.

The report and accounts can be found in the supplementary pack.

Summary of key points

The Trust Annual Report was reviewed by Grant Thornton auditors.

The report was submitted to the Audit and Risk Committee on 13 June 2022 for comment and assurance and the final version updated to reflect comments made by Committee members.

The auditors and the Board have completed the formal signing.

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?	☐ Yes *(please attach)*

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

Name:	Lisa Sherratt	Job title:	Head of Corporate Operations
Telephone number:	07506044623	Email	lisa.sherratt@nhs.net

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Committee / Meeting Title:	Board Meeting - Part 1 (Public)
Date of Meeting:	07 September 2022
Agenda Number:	6.2
Agenda Item Title:	2021/22 Quality Account
Presenting Officer:	Dr Mercia Spare, Chief Nurse
Action – this paper is for:	☐ Decision ☒ Information ☐ Assurance

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

This report was received and approved by the Board at its Part Two meeting on 14 June 2022 to meet the requirement to publish and share the document with NHS Providers by 30 June.

Providers of NHS healthcare are required to publish a quality account each year.

The Quality Account can be found in the supplementary pack.

Summary of key points

The 2021/22 Quality Account has been prepared in accordance with the NHS Improvement reporting manual which incorporates quality account regulations to include:

Part 1: Statement on quality from the chief executive
Part 2: Priorities for improvement and statements of assurance from the board – the statements of assurance have been prepared in the exact format as specified by the quality account regulations.
Part 3: Overview of quality of care.

Where 2021/22 quality priorities were not achieved, or partially achieved, the work will continue and will be monitored bi-monthly at the Quality Committee to make sure the full benefit to patients will be realised.

The 2022/23 quality priorities were presented to at an extraordinary Quality Committee on 7 June. The recommendations made by the committee for the 2021/22 quality account have been included in the report and suggestions for how the account may be developed for 2022/23 will be incorporated in this year's preparations.

Quality Account requirements for 2021/22 state there is not requirement for NHS trusts to obtain external auditor assurance, however KCHFT is assured that the data contained within the account is accurate, as these have been provided by the KCHFT Business Intelligence team, validated by internal audit processes and observed through KCHFT governance including the Executive Management team, the Quality Committee and Executive Performance Review.

Proposal and/or recommendation to the Committee or Board
The KCHFT Board is asked to note the 2021/22 Quality Account.

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

Name:	Dr Mercia Spare	Job title:	Chief Nurse
Telephone number:	01622 211923	Email	mercia.spare@nhs.net