Kent Community Health
NHS Foundation Trust

BOARD OF DIRECTORS MEETING IN PUBLIC

18 October 2023, 9am – 11am

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

Agenda and Papers

Kent Community Health NHS Foundation Trust

TRUST BOARD MEETING IN PUBLIC

Wednesday 18 October 2023, 9.00 – 11.00
KCHFT Offices, Rooms 6 and 7, 110 – 120 Upper Pemberton, Kennington, Ashford, Kent, TN25 4AZ

The recording of the meeting will be published on the website

AGENDA

STANDING ITEMS				
1.	Welcome and apologies *The patient story presentation was moved later on the agenda due to the patient's availability.*	Trust Chair	Verbal	9.00
2.	Declaration of interests To note the Board of Directors register of interests and declare any conflicts on items on the agenda	Trust Chair / All	Attached	
3.	Minutes of the Board meeting in public held on 12 July 2023	Trust Chair	Attached	
4.	Action log and matters arising from the meeting held iin public on 12 July 2023	Trust Chair	Attached	
5.	Chair's report	Trust Chair	Verbal	9.05
6.	Chief Executive's report	Chief Executive	Attached	9.10
7.	Board Assurance Framework	Deputy Chief Executive and Chief Operating Officer/ Director of Governance	Attached	9.20
SYSTEM WORKING				
8.	Provider Collaborative update	Chief Executive	Attached	9.25
PERFORMANCE				
9.	Integrated Performance Report	Chief Finance Officer/ Executive Directors	Attached	9.30
COMMITTEE ASSURANCE REPORTS				

10.	Audit and Risk Committee Chair's Assurance Report – meeting of 31 August 2023	Chair of Audit and Risk Committee	Attached	9.40
11.	Finance, Business and Investment Committee Chair's Assurance Report – meetings of 26 July and 12 October 2023	Chair of Finance, Business and Investment Committee	Attached	9.45
12.	People Committee Chair's Assurance Report – meeting of 29 August 2023	Chair of People Committee	Attached	9.50
13.	Quality Committee Chair's Assurance Report – meetings of 20 July, 21 September and 6 October 2023 • Terms of Reference (for approval)	Chair of Quality Committee	Attached	9.55
PATIENT STORY				
14.	Patient Story – Patient who had stroke and had positive experience from Westbrook House	Chief Nursing Officer	Presentation	10.00
ASSURANCE AND COMPLIANCE REPORTS				
15.	Nobody Left Behind Strategy Update	Chief People Officer	Attached	10.15
16.	Approach to 2023/24 Winter Planning	Deputy Chief Executive and Chief Operating Officer	Attached	10.25
17.	Learning from Deaths Quarter One Report and Annual Report	Chief Medical Officer	Attached	10.35
18.	Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation	Chief Nursing Officer	Attached	10.40
19.	Infection Prevention and Control Board Assurance Framework	Chief Nursing Officer	Attached	
20.	DIPC (Director of Infection Prevention and Control) Annual Report	Chief Nursing Officer	Attached	
21.	Safeguarding Annual Report	Chief Nursing Officer	Attached	
22.	Regonition of the Fit and Proper Person Test Framework	Chief People Officer	Attached	
ANY OTHER BUSINESS				

23.	Any other items of business previously notified to the Chair	Trust Chair	Verbal	10.50
QUESTIONS FROM GOVERNORS AND PUBLIC				
24.	Questions relating to the agenda items.	Trust Chair	Verbal	10.55
DATE OF NEXT MEETING				
	Wednesday 17 Januray 2024; KCHFT Offices, Rooms 6 and 7, Trinity House, 110 – 120 Upper Pemberton, Ashford, Kent TN25 4AZ	Trust Chair	Verbal	

Kent Community Health NHS Foundation Trust

Board of Directors' Register of Interests

Board member	Declared interests
John Goulston Trust Chair	• Chair of Steering Board, NHS London Procurement Partnership (LPP) • Chair of West Kent Health and Care Partnership • Member, Kent and Medway Integrated Care Partnership Joint Committee • Vice Chair, Kent and Medway Provider Collaborative Board for Adult Mental Health, Learning Disabilities and Autism • Board Adviser to Medinet Clinical Services (previously known as Remedy Healthcare Solutions)
Pippa Barber Non-executive Director	• Director, THF Health Ltd • Trustee, Demelza House Children's Hospice
Paul Butler Non-executive Director	• None
Pauline Butterworth Deputy Chief Executive and Chief Operating Officer	• None
Ali Carruth Executive Director of Health Inequalities and Prevention (non-voting)	• Governor, Downsbrook Primary School, Worthing
Peter Conway Non-executive Director	• Non-executive director, Kent and Medway NHS and Social Care Partnership Trust (KMPT)
Rachel Dalton Chief Allied Health Professionals (AHP) Office (non-voting)	• None
Gordon Flack Chief Finance Officer	• None
Kim Lowe Non-executive Director	• Non-executive director, Kent and Medway NHS and Social Care Partnership Trust (KMPT) • Lay Member and Senior Independent Governor, University of Kent • Chair of Trust Board, University of Kent Academies Trust
Mairead McCormick Chief Executive	• None
Sarah Phillips Chief Medical Officer	• Newton Place Pharmacy LLP (shareholding)
Victoria Robinson-Collins Chief People Officer	• Independent ambassador, Tropic Skincare
Mercia Spare Chief Nursing Officer	• None
Razia Shariff Non-executive Director	• Chief Executive Officer, Kent Refugee Action Network

Last updated 4 October 2023

Karen Taylor Non-executive Director	• Director of Research and Insights, Centre for Health Solutions, Deloitte LLP
Nigel Turner Non-executive Director	• Owner, Turner Business Solutions

UNCONFIRMED Minutes of the Board of Directors' meeting in public, held on Wednesday 12 July 2023, in The Orchard Suite, The Orchards, New Road, East Malling, Kent ME19 6BJ

Present:	John Goulston	Trust Chair (Chair)
	Pippa Barber	Non-Executive Director
	Paul Butler	Non-Executive Director
	Pauline Butterworth	Deputy Chief Executive and Chief Operating Officer
	Sive Cavanagh	Deputy Chief Nursing Officer (representing Dr Mercia Spare)
	Peter Conway	Non-Executive Director
	Ali Carruth	Executive Director of Health Inequalities and Prevention (non-voting)
	Kim Lowe	Non-Executive Director
	Mairead McCormick	Chief Executive Officer
	Dr Sarah Phillips	Chief Medical Officer
	Victoria Robinson-Collins	Chief People Officer
	Dr Razia Shariff	Non-Executive Director
	Karen Taylor	Non-Executive Director
	Nigel Turner	Non-Executive Director
In attendance:	Gina Baines	Assistant Trust Secretary and Committee Secretary (minutes)
	Marella Capper	Patient Story; KCHFT
	Georgia Denegri	Interim Director of Governance
	Ms Jodi Giddings	Patient Story
	Dr Shami Narendran	Patient Story; Clinical Programme Manager, Community Paediatrics, KCHFT
	Julia Rogers	Director of Communications and Engagement
Apologies:	Gordon Flack	Chief Finance Officer
	Dr Mercia Spare	Chief Nursing Officer

12/07/01 Welcome, introduction and apologies

Mr Goulston welcomed everyone to the Board of Directors' meeting of the Kent Community Health NHS Foundation Trust (the trust) held in public.

Apologies received as noted above. The meeting was quorate.

12/07/02 Patient Story

Ms Cavanagh introduced Ms Giddings to the Board. Dr Shami Narendran was also present to brief the Board on how the service had responded to the complaint.

Ms Giddings shared the letter she wrote to her MP about her son Jack who is autistic. He was attending pre-school and had been told that the waiting list for the initial appointment with the NHS to assess him for autism spectrum disorder (ASD) and attention deficit hyperactivity disorder (ADHD) would be 52 weeks for each. Following those appointments, he would then have to wait up to 3.5 years for a formal diagnosis of each disorder. Because of these delays, he was suffering from a lack of support and the pre-school also lacked the funds to give him the support that he needed. Both Jack's mum and dad worked full-time and arranged their working lives to ensure that he had 24/7 care to protect him from self-harm. Because of the length of the waiting list, Jack would be 11 before he could access the help he required. Combined with the impact of Covid on his education, Jack might not catch up with his peers nor fulfil his potential. Ms Giddings wished to highlight the crisis over the length of the waiting time for an assessment and diagnosis for children like her son, Jack and was asking for emergency government funding to address this.

The MP had shared her letter with the trust and the service had responded but Jack was still on the waiting list. NICE guidelines indicated that the maximum waiting time from referral to being seen should be three months. The majority of children would be waiting longer. The Board was asked to raise this with the commissioners. Ms Giddings requested that the service be more transparent about what was available, and what support could be given if the three-month deadline was missed.

Dr Shami Narendran explained how the service was responding to this high level of demand. Where children were waiting beyond 52 weeks, the service was assessing the impact the wait had had on each and every child and family and was contacting every family on the list to signpost them to support when life became tough at home. With regards to school support, the service had hired an education specialist to advise the service in order to bridge the gap between education and healthcare. The service had also run an event for Special Educational Needs Coordinators (SENCo) to explain what they could do to support this group of children. With regards to those children who have been referred in 2022, each case had been reviewed to clinically prioritise each child.

Ms Butterworth added that a number of actions had been taken to rationalise the follow-up appointments, accept new children and improve capacity. The diagnosis that was sought was essential for families in order that they could access the support they needed for medication, etc. She and Dr Phillips would be meeting with the commissioners and the paediatricians to see how the pathway could be accelerated for a faster diagnosis.

Ms Barber thanked Ms Giddings for sharing her story and confirmed that the Quality Committee would continue to monitor what was happening with reducing the waiting time and changing the way the service was commissioned for the benefit of the families.

Mr Goulston thanked Ms Giddings for coming to the meeting to share Jack's and the family's story. He had raised the issue with the community providers network (England) for neurodevelopmental adults and children. The network had agreed to work together on solutions and raise the issue with NHS England and the government to ensure that they understood the problem and that it needed to be tackled from a national perspective.

12/07/03 Declarations of Interest

Mr Goulston declared that from 1 July for six months he would be working two to three days per month as an advisor to the board of Remedy Healthcare Solutions. The work related to endoscopy and elective surgical contracts of acute trusts and therefore not in conflict with KCHFT's work. The board's declaration of interests register would be updated accordingly.

There were no other interests declared other than those formally recorded.

The Board **NOTED** its Register of Interests.

12/07/04 Minutes of the Kent Community Health NHS Foundation Trust Board meeting held on 19 April 2023

The minutes were read for accuracy.

The Board **AGREED** the minutes of its meeting held on 19 April 2023 as an accurate record.

12/07/05 Action log and matters arising from the Kent Community Health NHS Foundation Trust Board meeting held on 19 April 2023

The action log was reviewed and updated as follows:

With regards to the We Care Strategy implementation plan, Ms McCormick stated that she would cover this in her Chief Executive's report. The action was closed.

The trust's response to 'Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation' would be presented to the Board at its meeting in public on 18 October.

All other actions were closed. There were no matters arising.

12/07/06 Chair's Report

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

NHS England had published two national documents since the Board had last met.

The NHS Long Term Workforce Plan, June 2023 set out to put staffing on a sustainable footing and improve patient care. With regards to the training and development of clinicians, apprenticeships had been highlighted as a key plank of the plan and there was an opportunity for the trust's Nurse Academy to play an important role in delivering the future workforce in the Kent and Medway system. However, the plan had less focus on retention. Mr Goulston suggested that the Board should address this as part of its ambition for the trust to be a great place to work.

The NHS Equality, Diversity and Inclusion (EDI) Improvement Plan, June 2023 aimed to improve EDI within the NHS and to enhance the sense of belonging for NHS staff. It set out six high impact actions for all organisations to take forward, particularly associated with the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). Action one stated that chief executives, chairs and board members must have specific and measurable EDI objectives to which they would be individually and collectively accountable. The aim of the actions was to support organisations to align their data with the lived experience of their staff. This would be discussed further at the October Board meeting. **Action** – Ms Robinson-Collins

The Board **NOTED** the Chair's Report.

12/07/07 Chief Executive's Report

Ms McCormick presented the report to the Board for information.

The Board was updated on how the executive would be implementing the new We Care Strategy. Board members would have the opportunity during their service visits to triangulate how the strategy was landing with staff with the assurance being received at the committees.

An update on the Kent and Medway system financial position was also provided. The cost improvement programmes would be the most challenging they had ever been and their success would depend on system partners working closely together. In addition, the system had identified a number of opportunities where the trust could play a part lowering reference costs through controlling headcount and offering services differently.

Ms McCormick had been nominated to lead the collaborative on community services. Opportunities existed to streamline care and remove duplication. For example, the trust was partnering with Kent County Council in a new home first service to trial if this was a domiciliary care model that could be more widely implemented. In response to a question from Ms Barber regarding measuring the impact of the new service, Ms McCormick confirmed that there would be a high-level dashboard. Scenario planning was also being done to understand the impact of the intervention. The aim of

the service was to bring an improvement in the quality of care delivered, the patient experience and affordability.

The Board **NOTED** the chief executive's report.

12/07/08 Board Assurance Framework (BAF)

Ms Denegri presented the report to the Board for assurance.

The Board Assurance Framework was undergoing a refresh against the trust's breakthrough objectives. It would be presented at the Audit and Risk Committee meeting on 31 August and to the Board at its meeting in public on 18 October.

Mr Conway highlighted that some of the risks were systemic risks. The trust would be limited in what it could do to reduce them. With this in mind, the Board might need to consider whether they should be tolerated instead. This would be discussed at the Audit and Risk Committee in August and a recommendation made to the Board.

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

12/07/09 Quality Committee Chair's Assurance Report - meeting of 18 May 2023

Ms Barber presented the report to the Board for assurance.

In response to a question from Mr Conway regarding the risks associated with the Adult Neurodevelopmental Service, Ms Butterworth explained that currently there was a limited amount that could be done locally with the resources available. She, along with Dr Phillips and Dr Spare, would be meeting with the integrated care board (ICB) to discuss how the pathway could be changed and limit the demand. The meeting would also discuss the potential harm to patients who were on the waiting list. She and Ms Barber would be visiting the service the following week to hear first-hand about the challenges. Mr Goulston highlighted that the ICB had spent £3m more on neurodevelopmental services in 2022 than in the previous year. Ms McCormick commented that this was a national problem which would not be quickly resolved. Ms Taylor expressed her discomfort that there appeared to be so little that could be done and she questioned the impact of the situation on schools and education. Ms McCormick suggested that the health and care partnerships would be a powerful vehicle for some of the work as they would allow for co-design between partners. Dr Phillips underlined how hard the team was working in a context that they were unable to resolve.

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

12/07/10 2022/23 Annual Quality Account including the 2023/24 Quality Priorities

Ms Cavanagh presented the report to the Board for information.

The Board had considered and approved the Quality Account at its Board Part Two meeting on 14 June 2023. As there was no longer a requirement for quality accounts to be audited by the external auditor, the Quality Committee had suggested and the Board agreed to include in the internal audit programme 2023/24 an audit in a quality priority to strengthen its assurance.

The Board **NOTED** the 2022/23 Annual Quality Account including the 2023/24 Quality Priorities.

12/07/11 Audit and Risk Committee Chair's Assurance Report - meetings over 15th May and 13 June 2023

Mr Conway presented the report to the Board for assurance.

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

12/07/12 Finance, Business and Investment Committee Chair's Assurance Report - meeting of 8 June 2023

Mr Butler presented the report to the Board for assurance.

The Board was asked to note that the value of the system deficit which had been agreed with NHS England was £48m rather than £62m as stated in the report. The amendment was due to a later iteration.

In response to a question from Mr Conway as to whether the ICB had clarified the process around the renewal of the contracts due to expire in March 2024, Ms McCormick responded that she expected to hear more information in the next two weeks and clarified that the contracts currently related to community adult services only.

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

12/07/13 Strategic Workforce Committee Chair's Assurance Report - meetings of 26 April and 22 June 2023

Ms Lowe presented the report to the Board for assurance.

Ms McCormick provided an update on the issue with driving licences that related to some nurses that had been recruited to support the trust's community nurses and public health teams in roles that required a driving licence. During the trust's recruitment process, all the nurses had produced an international driving licence but after investigation, it was found that not all nurses had been able to produce evidence of domestic driving licences. As a result, some of the nurses have been dismissed as they were unable to drive. The incident had affected colleagues, and the trust had provided support to them and was now re-recruiting into the teams. Ms McCormick

emphasised that the incident had related to only a proportion of internationally recruited nurses. The majority had followed the application rules and were now providing high quality care and were very much part of their teams. Mrs Lowe added that the Strategic Workforce Committee had received good assurance that the incident had been handled speedily and pastoral care had been offered to all those who have been affected.

Ms Barber commented that she had attended the committee's meeting in June. With regards to engagement with staff around the development and rollout of the Nobody Left Behind Strategy, there was a window of opportunity for the trust to learn; to ask staff how it had felt and where the trust could have done better.

Ms Taylor referred back to the NHS workforce plan. She suggested that retention should be the focus for the time being until the impact of recruitment began to be felt. Ms Lowe agreed and added that retaining staff would be dependent on getting the culture right. The trust's links with education would also be important in growing its workforce. Ms McCormick felt that the work that was being done to reduce the heavy workload that staff were experiencing was also an important factor in retaining them. Staff were looking for clarity about career pathways. Mrs Lowe highlighted the importance of apprenticeships and challenged the board as to whether there was the infrastructure in the organisation to support apprentices as they trained. In addition, the trust's Admin Academy would be playing an important role in supporting the development and careers of the administrative staff.

At the June meeting, the Committee had considered its name and had proposed that it should be changed to the People Committee. The new name was endorsed by the Board.

Mr Goulston confirmed that the Board would receive the Freedom to Speak Up Annual Report at its meeting in public on 18 October.

Ms Taylor suggested that greater awareness of the support that the Freedom to Speak Up Lead could give needed raising with colleagues. Returning to the theme of retention she recalled from a recent service visit the experience of a community nurse and her concern about the running cost of her car to get around. Ms Robinson-Collins responded that the Board had considered this previously. The trust offered a number of benefits to support staff. This included mileage expenses which were set at an enhanced rate and were tracked through the RAC tracker tool. This benefit was advantageous against the national terms and had been put in place to recognise the particular financial pressures that staff in the community faced. The trust also offered a lease car scheme and subsidised electric and hybrid cars.

The Board **RECEIVED** the Strategic Workforce Committee Chair's Assurance Report and **APPROVED** that the Committee would now be called the People Committee.

12/07/14 Charitable Funds Committee Chair's Assurance Report - meeting of 5 July 2023

Mr Turner presented the report to the Board for assurance.

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

12/07/15 Integrated Performance Report (IPR)

Ms Butterworth presented the report to the Board for assurance.

In response to a question from Mr Turner regarding the high temporary staff costs reported, Ms Robinson-Collins explained that there were controls in place and she expected the costs to reduce in the incoming months. Factors that had impacted on the high percentage included some services that had had to stand up teams quickly and also an increased provision of one-to-one care.

Mr Conway indicated that it would be helpful to have some charts on volumes or productivity measures in the report. Ms Butterworth responded that activity levels were being discussed with services at their executive performance reviews. She would arrange for some charts to be included in future reports as well as realigning the report to reflect the four ambitions of the We Care Strategy as requested by Mr Goulston. The realigned report would come to the October Board meeting.
Action – Ms Butterworth on behalf of Mr Flack

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

12/07/16 Emergency Planning, Resilience and Response (EPRR) Annual Report

Ms Butterworth presented the report to the Board for assurance.

Mr Goulston commented Ms Jan Allen, the trust lead for emergency planning, had raised the importance of having non-executive director support. Mr Goulston indicated that he would be happy to take this role.

Ms Butterworth was pleased to report full compliance with the national EPRR core standards 2022/23.

The Board **RECEIVED** the Emergency Planning, Resilience and Response (EPRR) Annual Report.

12/07/17 Any Other Business

There was no other business discussed.

12/07/18 Questions from Governors and public relating to the agenda items

Ms Carol Coleman, Public Governor for Dover and Deal and Lead Governor commented that she had been impressed by the debrief she and the governors had received about the internationally educated nurses. It had been confirmed to the Council that the trust had undertaken its due diligence in recruitment and the subsequent processes.

With regards to recruitment, Ms Carol Coleman asked whether there would be recruitment events in east Kent. Ms Robinson-Collins confirmed that there would be. The Kent and Medway ICB and the trust were committed to widening participation and the trust had a person dedicated to this alongside the recruitment team and services. The events were organised by a third-party and the trust was committed to attending them. Ms Robinson Collins has also forged links with the health and care partnership workforce leads in east Kent. Ms Rogers added that as part of the NHS 75 celebrations, staff were being asked to commit 75 minutes of their time to reach out to the next generation. There were also opportunities for volunteers to access placements to gain more experience to realise their career aspirations. Ms Coleman asked whether the timing of the start of the academic year of the Nursing Academy could be reviewed in order to accommodate school leavers better. Ms Robinson-Collins explained that the start dates were set by the educational institution supporting the trust but they were improving.

Ms Penny Shepherd, Public Governor for Folkestone and Hythe, questioned whether the dashboard relating to the new home first service would take into account those people not receiving family or informal support and care in their own homes. Some patients did not have access to this type of support and they faced a real risk without systematic data monitoring. Ms McCormick agreed that there was very little good data available but she suggested that this would form part of the work of the integrated neighbourhood teams to improve their knowledge of their local areas as they risk stratified their local populations.

Ms Ruth Davies, Public Governor for Tonbridge and Malling commented on the point raised by Ms Taylor around the community nurses and their concerns about their cars and the challenges of visiting their patients. She suggested that the hardship fund which was about to be launched by the trust shortly could support those staff who were struggling with car repairs. Dr Phillips added that the parking issues in east Kent had been raised with the various local authorities. They had not yet been resolved but the east Kent Health and Care Partnership was working with Ashford Borough Council to find a satisfactory arrangement that could be tested and then shared with other councils.

In response to a question from Mr Jide Odumade, Public Governor for Swale, regarding how the trust was focusing on students who had chosen to take the new T-level qualification, Ms Robinson Collins responded that the trust was linking with schools and colleges across Kent and Medway. The trust was aware of the new qualification and that it was a popular alternative

to apprenticeships. Discussions were underway with schools and colleges as to how those individuals could be supported.

12/07/19 Confirmed minutes of committees – for noting

- Quality Committee meeting of 16 March 2023
- Audit and Risk Committee meeting of 6 February 2023
- Finance, Business and Investment Committee meeting of 23 March 2023
- Strategic Workforce Committee meetings of 21 February and 26 April 2023
- Charitable Funds Committee meeting of 8 March 2023

The Board **NOTED** the confirmed minutes of the committees.

12/07/20 Date and venue of the next meeting

Wednesday 18 October 2023; KCHFT Offices, Rooms 6 and 7, Trinity House, 110 – 120 Upper Pemberton, Ashford, Kent TN25 4AZ

This meeting would be broadcast live to the public.

The meeting ended at 11am.

Kent Community Health NHS Foundation Trust

BOARD ACTION TRACKER PART ONE (JULY 2023)

Minute number	Agenda item	Action	Action owner	Update	Action status
19/04/14	Trust Response to 'Reading the Signals: Maternity and Neonatal Services in East Kent – the Report of the Independent Investigation	Schedule an update to the Board in six months' time	Dr Spare	This is scheduled to come to the Board meeting in public on 18 October.	Closed
12/07/06	Chair's Report	Schedule an update to the Board on the WRES and WDES at its October Board meeting.	Ms Robinson-Collins	All actions relating to WRES and WDES are included in the Nobody Left Behind refresh. An update was received by the Board at its September meeting.	Closed
12/07/15	Integrated Performance Report (IPR)	Update the IPR to reflect the Board's comments.	Mr Flack	Action complete.	Closed

Kent Community Health NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Chief Executive Report
Report title:	Item 6
Executive sponsor(s):	Mairead McCormick, Chief Executive
Report author(s):	Julia Rogers, Director of Communications and Engagement
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☐ Assurance ☑ Information
Public/non-public	Public

Executive summary

This report highlights key developments in achieving the four strategic ambitions of KCHFT's *We care strategy* and gives an update since the last public Board report in July.

Report history / meetings this item has been considered at and outcome

N/A

Recommendation(s)

The Board is asked to

- **NOTE** the report.

Link to CQC domain

☑**Safe** ☑**Effective** ☑**Caring** ☑**Responsive** ☑**Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications

Risk and assurance	Yes / No (If yes, provide brief one sentence description of issue)		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐**BAF**	☐**CRR**	☐**DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	No		
Legal and regulatory	No		
Quality	No		
Financial	No		

Executive lead sign off	
Name and post title:	Mairead McCormick, Chief Executive
Date:	11 October 2023

October 2023

CHIEF EXECUTIVE'S REPORT
October 2023

This report highlights some key updates since our previous public Board report in July.

Our we care strategy, executive visits and the importance of listening

Since our last public Board meeting, we have continued to develop our thinking around our new *We care strategy* and I'm pleased with the progress we are making. This has included some Executive Team members and other colleagues, visiting Maidstone and Tunbridge Wells NHS Trust to hear their learning about a new strategic direction, which takes a more focused approach. We have also held our first KCHFT Improvement Board.

There is a huge amount of work progressing to achieve our four ambitions, which includes significant programmes of work to re-think our models of care. I would like to thank every member of KCHFT for their efforts. These achievements – alongside our new direction of travel – were highlighted at our **annual meeting** on Wednesday, 20 September, where we were joined by colleagues, patients, public and partners. You can view it here.

I really welcome the report into **Reading the signals** on our agenda today. It's important we all take the learning from this and from the investigation, which will follow from the conviction of Lucy Letby, a nurse at the **Countess of Chester Hospital**. I have pledged to all colleagues to always listen to any concerns, if people feel they cannot raise an issue with their manager or department lead, they can raise it with me.

Getting out and about and visiting services is incredibly important to me and provides a good sense to the Board and executive team colleagues of how things feel on the ground – there have been **19 executive visits to services**, since the last Board meeting, a summary of these can be found below.

Improving care for patients, carers and their families and meeting the **financial challenge** is one we can only face as a system and one which will only be solved through better integration. The development of provider collaboratives is absolutely key to this and more detail about our East Kent Provider Collaborative is included in the papers. You can also read some of the progress we are making through our work in the east and west Kent health and care partnerships, in the latest newsletters.

The Kent and Medway Integrated Care Board published a prior intention notice, to procure a significant **transformation of its model of care for community services**. We are waiting for the detail of the next steps from the ICB, after Medway Health and Adult Social Care Overview Scrutiny Committee deemed these changes a substantial variation to services.

Executive Team visits

Since July, the Executive Team has visited 19 services. Teams continued to be proud of their quality improvement approach to tackling issues, the wellbeing support provided by the trust and the support within their teams, as well as our approach to listening, while recognising there are areas where we can still improve.

Concerns continue around demand and capacity, including the increasingly complex nature of their caseloads, issues around the quality of our estate, duplication between digital and paper notes, as well as gaps or overlaps in commissioning, in some places.

We're currently reviewing our programme of visits to improve the structure of these to focus on our four strategic ambitions, what colleagues want to talk to us about, tailor support that is needed and improve our response to acting on feedback.

Trust ambition: A great place to work

Our colleagues are valued, feel heard and make changes easily to deliver better care

NHS staff survey 2023: Now live

We have launched our next campaign to encourage colleagues to complete this year's national NHS Staff Survey. By 11 October, our response rate was at 25.2 per cent, higher than the national average for community trusts. Bank colleagues are also included in this year's survey, we have a 10.74 per cent response rate, the **highest response for community trusts** in the country, at time of writing.

Pulse survey results quarter two 2023: We are safe and healthy

The latest pulse survey launched in July. This survey had a particular focus on **rest breaks** and more than 1,330 colleagues responded.

In all three **core** questions, including, 'in my team we support each other (83 per cent agree)', 'my organisation is supporting my health and wellbeing (66 per cent agree)' and 'I feel well-informed about changes taking place (60 per cent agree)', we scored higher than other community trusts and considerably higher than the national average.

However, the health and wellbeing and important changes questions scored lower than our results for the same questions in the previous survey. We are looking carefully at the results to see where we need to provide additional support to teams.

Hardship fund launched

We have introduced a hardship fund for colleagues who find themselves with an unexpected or emergency expense they can't afford. Funds have been made available for this purpose through our charity, *i care*, which supports staff health and wellbeing, as well as patient care. The maximum payment that will be made to any colleague from the fund is £500. Colleagues

will also be given financial counselling and referrals to other schemes which could help them. All applications are dealt with by an external provider – North Kent Citizen's Advice.

Staff vaccinations

Our seasonal vaccinations programme is now underway. We are offering free flu vaccinations for every colleague and Covid boosters to everyone who is eligible.

The programme this year is being delivered by our school-aged immunisation service, with bookable clinics provided across Kent and Medway, via the online booking system. Colleagues in East Sussex and London will be able to use their local provision, if they want to. Bookings in the first two weeks have filled up quickly, with more vaccinators being added to popular dates and venues.

National People Promise in action campaign

Colleagues from our Thanet district nursing and health visiting teams have been featured in this year's national NHS England People Promise campaign.

Developing staff voice model

Engagement with colleagues from across the organisation continues to take place to co-design a new staff voice model, which includes developing a staff council-type approach. A draft model, developed by staff governors, network leads, FTSU guardian, health and wellbeing champions and other colleagues, was tested at our 'We care' conference in June, attended by 250 staff. Feedback has now been analysed and is helping to guide next steps. The model has our staff governors at its heart and one of the next steps is to develop the role descriptions and increase support and training for our staff governors.

Our apprentices

The achievements of 56 apprentices were celebrated at a graduation event in August. We have now trained 222 colleagues through our apprentice scheme since 2018.

Our apprentices include 17 fully-qualified registered nurses and 27 nurse associates, as well as assistant practitioners, physiotherapists, dental nurses, occupational therapists, business administrators and chartered managers.

During the past five years we have more than doubled the number of apprenticeships on offer, including 26 different programmes ranging from level two to level seven Master's degrees. Our next cohort of registered nurse degree apprentices begin in February 2024.

Trust ambition: Better patient experience

Our conversations focus on what matters to the patient, so they get the right care, in the right place

‘We care’ conference showcases plans to transform hospital rehabilitation and recovery

In September, we hosted our ‘We care’ conference, focused on our ‘better patient experience’ ambition and our plans to transform rehabilitation and recovery in our community hospitals, helping people to get home sooner and safely.

More than 175 colleagues joined the conference in person, with another 100 joining online to listen to test our thinking about the case for change. **Ninety-six per cent** of people agreed we needed to change our approach to rehabilitation in our community hospitals. We also heard powerful feedback from colleagues who are striving to improve patient care and provide the best possible experience. We produced a short film to explain the Westbrook Model and how it can benefit patients, colleagues and the wider system.

Integrated neighbourhood working

The first of four ‘early adopter’ Integrated Neighbourhood Teams, Total Health Excellence (THE) east and west, held their launch event on Thursday, 7 September. We are working closely with the PCNs to make sure we play a significant role in plans to provide more joined-up working for patients and residents.

The other PCN early adopters in east Kent; Canterbury North and South, Mid Kent and The Marsh, will also be meeting shortly to discuss their priorities. Discussions are underway with the next cohort of fast followers, including PCNs in Thanet.

Clinical coordination hub for west Kent

We are working with South East Coast Ambulance Service (SECAmb), and other partners to trial the co-location of teams to provide additional support to ambulance crews and reduce transportation to acute hospitals. The hub, at our site near Maidstone Hospital, will be trialled from this week for a period of four weeks. Following the trial, we will jointly evaluate the data to understand the impact this trial has had for staff, patients and our partners.

Awards

The East Kent Community Specialist Respiratory Service has been shortlisted in the Health Service Journal Awards.

The nomination recognises the team's commitment during the pandemic as they continued looking after vulnerable patients and how the team continues to provide innovative solutions to the challenges they face every day.

The team will join other finalists on 16 November at the awards ceremony in London. You can watch a short film of the project here.

Our community chronic pain management team was highly commended in the national PrescQIPP CIC awards, for its work in prisons. We were recognised in the patient safety and overprescribing category, for reducing the use of opiates in prisons.

A new medical centre for Edenbridge

We organised a public meeting in Edenbridge on Saturday, 7 October, to provide an update to the community on the next steps to deliver a new £13.5 million community healthcare hub for the town. More than 140 people attended, including local MP Tom Tugendhat and we fed back what we heard during our listening events in March and how we have responded to their concerns, particularly around x-ray, minor injuries services, travel and transport.

A pilot to provide a minor injuries services from Monday to Friday at the Edenbridge Medical Practice in place of the one at Edenbridge Hospital, has proved successful and will continue at the practice until the new centre is opened later this year.

Trust ambition: Putting communities first

Everyone has the same chance to lead a healthy life, no matter who they are, or where they live.

Increasing ethnicity recording and reducing DNA rates

To achieve our target of increasing ethnicity recording, support sessions are now available for teams, delivered by the RiO and Health Inequalities Team. We have produced a short animation to help describe the purpose and importance of recording ethnicity and other protected characteristics on Rio. Health inequalities

Tackling health inequalities

In September, Rhona Clover and Vita Martin-Achong from our Health Visiting Team attended the Institute of Health Visiting's national excellence in practice conference to deliver a presentation on our innovative Family Partnership Programme. They demonstrated how the programme is supporting parental confidence, child development and improved outcomes for Kent's most vulnerable families through this enhanced Health Visiting offer.

The public health bus welcomed its 1,000 visitor in quarter two. The main reasons for visiting the bus are for school-age immunisation catch up and NHS Health Checks. The bus also supports the rough sleeper service and the sexual health team.

ADHD medicine shortage

We are working with NHS England and the ICB to co-ordinate messaging to parent, patients, primary care and other stakeholders on the national shortage of ADHD medication.

Trust ambition: Sustainable care

We will live within our means to deliver outstanding care, in the right buildings, supported by technology, and reduce our carbon footprint

Staff spend less time on administrative tasks that don't add value

Our flobots automation programme continues to deliver savings for the trust in time and money. More than 100 processes have been automated, representing 15 whole time equivalent (WTE) administrative posts. A further 76 processes are being assessed and worked on, representing an indicative **unvalidated** saving of £1.43m or 87,021 (55.25 WTE) time-releasing hours.

Until recently, we have approached the programme with a focus on releasing time and improving health and wellbeing. While this is still a significant target for us, we have also now started to focus on releasing cash and/or demonstrating a reduction in vacancies/bank spend through automation, for example, reducing time spent on Rio. Our breakthrough objective target to deliver automations is five per cent (£700k) of our efficiency target in 2023-24.

A huge thank you to all our KCHFT colleagues and volunteers for everything they do – and to our partners, without whom, we will not be able to improve care and outcomes for our patients.

M. A McCormick

Mairead McCormick
Chief Executive October 2023

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 7
Report title:	Board Assurance Framework (BAF) – October 2023
Executive sponsor(s):	Pauline Butterworth, Deputy Chief Executive and Chief Operating Officer
Report author(s):	Mercy Kusotera, Director of Governance
Action this paper is for:	☑ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary

The BAF enables the Board to identify and understand the principal risks to achieving its strategic objectives; receive assurance that suitable controls are in place to manage these risks and where improvements are required. It provides evidence and assurance that action plans are in place and are being delivered.

The attached BAF sets out an up to date analysis of the major risks being faced across the Trust and the controls and assurance mechanisms in place to mitigate the risks.

The BAF was last reviewed by the Audit and Risk Committee on 31st August 2023 and Trust Board Part 2 on 20th September 2023 to ensure it was aligned to the Trust strategic objectives for 2023-24. It is attached at Appendix 1 for review and approval of the Board.

Currently, the BAF is being updated to incorporate feedback from the Audit and Risk Committee and Trust Board Part 2. The updated version would be presented to the next Audit and Risk Committee scheduled for November 2023.

Report history / meetings this item has been considered at and outcome

The BAF was reviewed by the Trust Board Part 2 on 20th September 2023.

Recommendation(s)

The Board is asked to

- **REVIEW** and **APPROVE** the revised BAF (Appendix 1).

Link to CQC domain

☑Safe **☑Effective** **☑Caring** **☑Responsive** **☑Well-led**

Strategic ambition this report supports	Please tick
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications			
Risk and assurance	Yes. The BAF highlights the strategic objectives and key evidence of controls and mitigation.		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☑BAF**	**☑CRR**	**☐DRR**
Equality, diversity and inclusion	Yes. The BAF highlights the strategic risks in line with the Trust's annual objectives in the area.		
Patients / carers / public / staff / health inequalities	Yes. The BAF brings together all the relevant information on the risks relating to this area.		
Legal and regulatory	Yes. The BAF and wider risk management process deliver the requirements under KLOE5 of the Well-led framework.		
Quality	Yes. The BAF provides assurance on the controls in place, actions being taken to mitigate the risks in line with the Trust's annual objectives in this area.		
Financial	Yes. The BAF highlights the strategic risks in line with the annual objectives in this area.		

Executive lead sign off	
Name and post title:	Pauline Butterworth, Deputy Chief Executive and Chief Operating Officer.
Date:	10th October 2023

Kent Community Health
NHS Foundation Trust

BOARD ASSURANCE FRAMEWORK
PUBLIC BOARD REPORT - OCTOBER 2023

1. Introduction

1.1 The Board Assurance Framework (BAF) brings together in one place all relevant information on principal risks faced by the Trust in meeting its strategic objectives. The BAF provides the Trust with a clear and comprehensive method of describing:

- the main risks to achieving the Trust's strategic objectives
- the controls, assurance and actions being taken to mitigate the risks and the next steps
- sources of evidence or assurance.

1.2 All BAF risks are mapped to the Trust's strategic objectives and are aligned to the Board or sub-committee for oversight.

1.3 The Trust's revised Risk Management Framework (RMF) sets out the Trust's strategy and processes for managing risk. The RMF overarches both clinical and non-clinical risk management.

1.4 The BAF is maintained by the Director of Governance with the support of the Risk and Datix Manager. It is reviewed at each Audit and Risk Committee meeting. Board sub-committees review relevant risks on an ongoing basis in line with their terms of reference and annual cycle of business.

1.5 Each time the Board meets in public, it receives assurance and detail on the BAF. Work continues to review and update the controls in place to mitigate the strategic risks.

2. BAF Risk Profile Overview

2.1 There are currently 9 strategic risks on the BAF as shown in **Appendix 1.** Of the 9 strategic risks two score 15 and above (BAF 001 – scoring 16 and BAF 003 scoring 15); the remaining 7 are scored 12 high.

3. Recommendation

3.1 The Board is asked to review and approve the Board Assurance Framework within **Appendix 1**.

Mercy Kusotera, Director of Governance
10th October 2023

Last updated 17 August 2023

Appendix 1
Board Assurance Framework

Kent Community Health NHS Foundation Trust

Definitions:

Initial Rating: The risk rating at the time of identification

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

Confidence Assessment: This represents the confidence level of the risk being mitigated by the target completion date. High confidence/medium confidence/low confidence

Risk Appetite score: This reflects the appetite towards the risk in line with 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 register) once this score is achieved.

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

Ambitions: Putting communities first/Better patient experience/A great place to work/Sustainable care

Action status key:

Actions completed	G
On track but not yet delivered	A

Strategic Goal	ID	Opened	SRO	Assuring committee	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Top Five Assurances	C	L	Rating	Planned Actions and Milestones			
Putting Communities First	BAF001	06.06.2023	Pauline Butterworth	People Committee and Quality Committee	**If** we cannot secure the workforce or increase commissioned capacity for services, **then** we will not be able to achieve our target of reducing the number of people who wait more than twelve weeks to be seen, **resulting in** negative impacts on patient outcomes, increased complaints, negative impacts on staff morale and possible wider system impacts.	4	5	20	Divisional monitoring of RTT and RTA reporting to Executive Performance reviews and Highlight Assurance reports to Quality Committee; Harm Review process in place for services with 52 week waiting times challenges; Engagement with System-led transformation programme for services with long waits associated with CYP SEND and Adult Neurodevelopmental needs; Collaboration with Provider partners on developing new models of care.	Executive Performance Reviews monitor RTA performance across all services; Divisional Governance Groups have focus on services requiring targeted support for improvement; KCHFT Transformation Board oversight of breakthrough objectives	4	4	16	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
														Targeted work to identify opportunties to review new to follow up ratios	Pauline Butterworth	December 2023	A
														Targeted work to reduce lost capacity through DNAs	Pauline Butterworth	Dec-23	A
														Implementation of a patient tracker mechanism	Pauline Butterworth	March 2024	A
														Clinical engagement with Provider partners to shape new assessment and review models for ASD and ADHD	Pauline Butterworth	March 2024	A
A Great Place to Work	BAF002	06.06.2023	Victoria Robinson-Collins and Julia Rogers	People Committee	**If** staff do not feel involved and engaged with the strategic objectives, **then** they may not support the changes required to services **resulting in** inability to deliver the trust strategy.	3	5	15	Use of staff networks, champions, NLB Ambassadors and staff governors/ staff side to support engagement Webinars led by Board SRO's for each strategy ambition to engage with colleagues. Use of WeCare conferences to engage and test out ambitions and breakthrough objectives. Use of Executive visits and we care visits to test understanding and level of cascade within the trust relating to the strategy	Staff survey engagement score, staff survey "I am able to making changes" and "I feel listened to" questions, pulse survey engagement score, staff FFT scores, analysis of engagement on flo with blogs, webinars. Level of attendance at we care conferences and Meet with Mairead / Executive sessions. Number of You said, we did examples of listening and acting on feedback.	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
														Maximise use of existing forums for staff voice, including staff networks, governors, NLB ambassadors to engage colleagues locally and provide feedback	Julia Rogers	March 2024	A
														Robust communications and engagement plan using a variety of digital and face-to-face options to engage colleagues across sites, services and co-design new service models, where relevant.	Julia Rogers	March 2024	A
														Development of Staff Voice/ Council as formal mechanism to engage with staff	Julia Rogers	March 2024	A
A Great Place to Work	BAF003	06.06.2023	Victoria Robinson-Collins and Julia Rogers	People Committee	**If** we can't recruit and retain sufficient workforce with the right skills, **then** we will fail to deliver on the strategy, **resulting in** the remaining workforce becoming demoralised and overwhelmed.	**5**	**4**	20	Active and bespoke recruitment campaigns for key professions i.e. nursing, facilities Weekly staff rota review and escalation paths Integrated Governance Steering Group IMM meeting to review staffing risks IPM meeting including regular review of processes for recruitment, retention, organisational change and redeployment of colleagues Bank system in place Wellbeing initiatives for staff Wellbeing conversations and inclusion of career conversation in appraisal process 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 and other workforce metrics by people committee & board Monthly quality report Twice weekly safer staffing review	**5**	**3**	15	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
														Recruitment of staff using range of supply streams including international, national and local recruitment, development of entry level + through career pathways via Academy. Utilising pipelines including Step into Health, Return to Practice.	Victoria Robinson-Collins	March 2024	A
														Continuous review of skill mix to ensure full use of MDT i.e. therapists, and use of assistant grades and blended roles to support registered professionals.	Mercia Spare	March 2024	A
														Ongoing promotion and utilisation of flexible working options, opportunities for reasonable adjustments and access to career conversations to enable staff to work for longer whilst balancing carer, health and family commitments whilst increasing engagement	Victoria Robinson-Collins	March 2024	A
														Advertisement of additional staff support, wellbeing and other locally agreed benefits to maximise opportunities to secure workforce	Victoria Robinson-Collins	March 2024	A
														Monthly review of staff turnover, vacancy rates and stability metrics with interventions/ recovery plans tracked through IPM, EPR, IPR processes with oversight from PC and Board	Victoria Robinson- Collins	March 2024	A
Sustainable Care	BAF004	06.06.2023	Sarah Phillips and Gordon Flack	Quality Committee	**If** the Trust's clinical systems are not efficient and user friendly, **then** staff time will be spent on activities that do not add value to patients **resulting in** reduced time for safe, effective patient care and a negative impact on staff morale.	**4**	**4**	16	CEO/director level discussions with supplier; Rio governance group and clinical champions	Use of automation and programme to reduce inputs and tolerate more risk; increased frequency of new system releases; snap staff surveys of system usability	**4**	**3**	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
														Pilot to reduce clinical documentation using progress notes function rather than forms function in RIO and utilising standard abbreviations in notes	Sarah Phillips	Oct 2023	A
														Performance reviews with system supplier and improvement plan	Gordon Flack	Mar 2024	A
														Review of Wound matrix and its use in community teams	Sarah Phillips	Mar 2024	A
														Automation projects to reduce inputs and create structured data from progress notes	Gordon Flack	Mar 2024	A
														Review use of other systems such as EMIS and Mosaic for some staff	Gordon Flack	Mar 2024	A
Care	BAF005	06.06.2023	Gordon Flack	rd Investment Committee	**If** the current funding constraints continue, **then** KCHFT may be unable to complete estates transformation ambitions, **resulting in** inability to reduce emissions by 80% and failure to reduce poor quality estate by 100%.	4	4	16	Representation on system capital group and CFOs overseeing distribution of resources; capital steering group; Estates and services steering committee; FBI committee.	Capital reports to Board and FBI; reporting of emissions on budget statements and in summary fiance report; reports on estates utilisation to estates and services committee; returns colleate don backlog	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
														Estates optimisation plan being formulated	Philip Griffiths	Mar 2024	A

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

Confidence Assessment: This represents the confidence level of the risk being mitigated by the target completion date. High confidence/medium confidence/low confidence

Risk Appetite score: This reflects the appetite towards the risk in line with 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 register) once this score is achieved.

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

Ambitions: Putting communities first/Better patient experience/A great place to work/Sustainable care

Strategic Goal	ID	Opened	SRO	Assuring committee	Risk Description (Simple Explanation of the Risk)	C	L	Rating	Controls Description	Top Five Assurances	C	L	Rating	Planned Actions and Milestones			
Sustainable			Sarah Phillips and	Finance Business ar						maintenance			⬇	Green travel plan implementation inc lower cost low emissions lease car scheme	Dan Wright	Mar 2024	A
														Disposals to generate additional local funding	Philip Griffiths	Mar 2024	A
														Decarbonisation plan externally funded	Dan Wright	Oct 2023	A
Better Patient Experience	BAF006	06.06.2023	Pauline Butterworth	Quality committee	**If** system stakeholders do not support Kent Community Health NHS Foundation Trust ambitions, **then** we may not be able to deliver or implement the new models of care which could **result** in KCHFT in not achieving targets, continuing with models of care which do not meet the needs of our populations and resources not being used to their maximum.	4	4	16	KCHFT CEO is SRO for System transformation group for Social Care, Primary Care and Community Collaborative; Full engagement with HCP Boards and associated PLACE based transformation workstreams including INT Pilots; Full engagement with System UEC Recovery plan and participation with High Impact initiatives	KCHFT Transformation Group oversight of delivery of Breakthrough Objectives; Oversight of transformation impact through UCDBs	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
													⬇	Full participation in INT Pilots x 5	Ali Carruth	February 2024	A
														Fully embed new integrated approach to P1 delivery in E Kent	Pauline Butterworth	December 2023	A
														Implement new stroke rehabilitation beds in EK to full occupancy	Pauline Butterworth	October 2023	A
														Implement phased approach to Community Hospital transformation; Phase 1: Integrated approach to increase bed utilisation at Westbrook and Westview	Pauline Butterworth	December 2023	A
A Great Place to Work	BAF008	06.06.2023	Executive Team	People Committee	**If** there is further industrial action, **then** this could reduce resource availability and capacity to engage, develop and implement improvements, **resulting in** an impact on delivery timelines and morale	3	5	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 Information Governance Steering 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	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
													⬇	Regular informal meetings with Staff Side Chair, regular local and regional SPF meetings to understand TU intentions and work in partnership locally and regionally	Victoria Robinson-Collins	March 2024	A
														Safer staffing reviews for community hospitals and hot spot areas weekly	Mercia Spare	March 2024	A
														Financial and wellbeing initiatives to support colleagues who are struggling with finances alongside decision to strike or not	Victoria Robinson-Collins	March 2024	A
														Regular review of skill mix to ensure full use of MDT	Mercia Spare	March 2024	A
														Work collaboratively with K&M system and ICB CPOs to ensure system workforce plan and solution to staffing gaps is in place, including arrangements for mutual aid	Victoria Robinson-Collins	March 2024	A
														Ongoing compassionate engagement with all colleagues including briefings, FAQs, local touchpoints to ensure staff feel supported and recognising national not local issue	Victoria Robinson-Collins	March 2024	A
														Regularly review and implement any national mandates or legislative changes relating to strike action for healthcare workers	Victoria Robinson-Collins	March 2024	A
Sustainable Care	BAF009	06.06.2023	Executive Team	Finance Business and Investment Committee	**If** we do not have reliable and appropriate data to inform progress and decision making, **then** we will not know if we are delivering against our ambitions or where there is risk, **resulting in** wasted resource, inability to deliver the strategy and impacting morale.	4	4	16	Transformation Board scrutinising performance; Data Quality and System Group; Executive perfromance reviews	A3 reports and executive leads; Internal and external audit of systems and KPIs; service manager reviews of contemporary local team data	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
													⬇	Pilots to reduce data capture enabling better quality	Sarah Phillips	Jan 24	A
														Performance management framework refresh to codify how data is utilised	Gordon Flack	Sept 23	A
														Data quality and KPI audits	Gordon Flack	Jan 24	A
														Investments in EPR systems and autoimation	Gordon Flack	Jan 24	A
Sustainable Care	BAF010	06.06.2023	Executive Team	Finance Business and Investment Committee	**If** the system deficit results in lack of investment in new models of care, **then** we will not have the resource to deliver the strategy, **resulting in** continued poor system performance, workforce pressures and poor patient outcomes.	5	4	20	System CEOs and CFOs groups overseeing performance; Financial recovery plan for the system; Better Care Fund monitoring group	System FRP has use of beds as a significant improvement scheme requiring new models of care; provider collaboratives to drive the changes; dashboards on discharge delays and scal eof opportunity	4	3	12H	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**
													⬇	Long term system financial plan	Gordon Flack	Sept 2023	A
														Integration of care facilities with social services under KCHFT lead provider model	Pauline Butterworth	Oct 2023	A
														Intermediate care pilot funded by NHSE	Pauline Butterworth	Mar 2024	A
														Community Procurement and provider collaborative development	Mairead McCormick	Mar 2024	A
														Intergrated Neighbourhood team pilots and full use of additional roles scheme	Ali Carruth	Mar 2024	A

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 8
Report title:	Provider Collaborative Update
Executive sponsor(s):	Mairead McCormick, Chief Executive
Report author(s):	Mairead McCormick, Chief Executive
Action this paper is for:	☑ Decision/approval ☐ Discussion and input ☐ Assurance ☐ Information
Public/non-public	Public

Executive summary
The purpose of this paper is to provide an update on progress in relation to provider collaboratives across Kent and Medway with a specific focus on the development, the role of the provider collaboratives in the system and the principles of the provider collaboratives in Kent and Medway.

Report history / meetings this item has been considered at and outcome
This report links to system work across Kent and Medway and the health and care partnership delivery committee

Recommendation(s)
The Board is asked to • Support the approach

Link to CQC domain				
☐**Safe**	☑**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☑

Sustainable care	☑

Implications			
Risk and assurance	Yes / No (If yes, provide brief one sentence description of issue)		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐**BAF**	☐**CRR**	☐**DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	Yes – A lead provider will generate different ways of working.		
Legal and regulatory	Yes- A section 75 is being formulated.		
Quality	No		
Financial	Yes – This will support the better use of beds which is part of the financial recovery programme.		

Executive lead sign off	
Name and post title:	Mairead McCormick, Chief Executive
Date:	11 October 2023

Kent and Medway Provider Collaboratives

Supporting paper for:

Provider Chairs/CEOs

10th October 2023

Kent and Medway Integrated Care System

Attain

In this document you will find…

Context of provider collaborative development in Kent and Medway
- How provider collaboratives have been developed
- Role of provider collaboratives in the system
- Principles of provider collaboratives in Kent and Medway

Proposed **governance** (supported by Provider Collaborative Board Terms of Reference (separate Word document))

Areas of responsibility, authority, governance, membership and leadership of the proposed four at-scale provider collaboratives in Kent and Medway

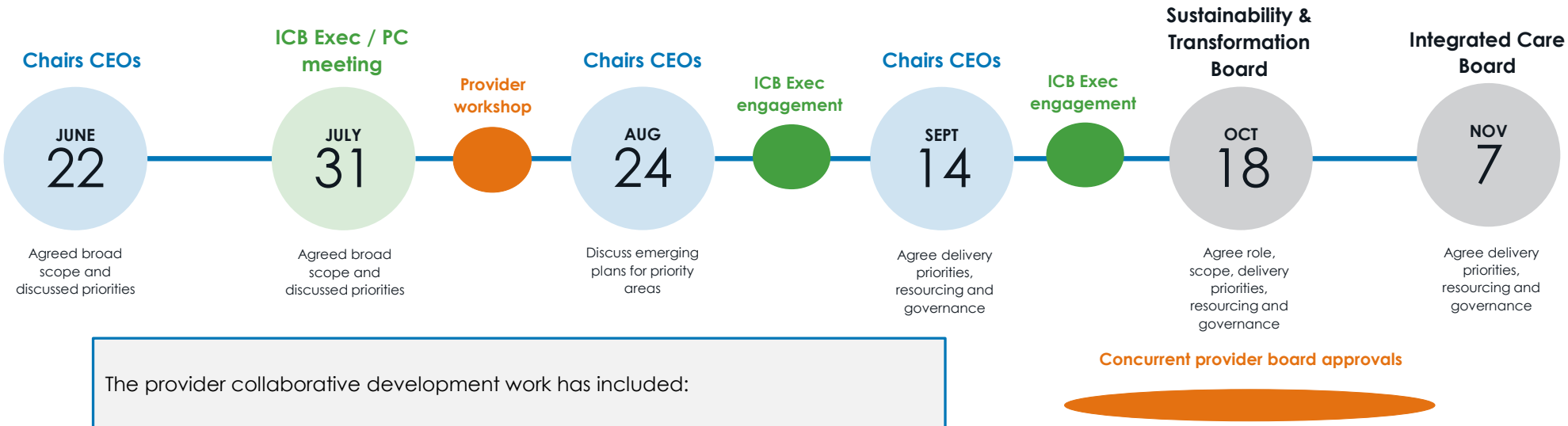
Resourcing

Early assessment and next steps of the at scale provider collaboratives' maturity against the NHS England **Provider Collaborative Maturity Matrix**

Milestone Plan

Attain

The design of Provider Collaboratives has been a partnership between the leaders of providers and the ICB



The provider collaborative development work has included:

- Support with early development work from the Kings Fund
- Leadership from provider Chairs and CEOs
- Wide engagement and contribution from provider executive teams
- Extensive engagement with the ICB Executive Team, including the ICB's Financial Recovery Programme and alignment to the ICB's pathway programmes

The principles of provider collaboration that were agreed in late 2022 have underpinned this development work

- any collaboration must be justified on the basis of its ability to demonstrate measurable improvements in patient and population outcomes, patient experience, efficiency/productivity, and the reduction of inequalities
- any collaboration needs to have decision making located at the appropriate level in the system and involve the appropriate individuals
- any collaboration should be based on the principles of subsidiarity and taking decisions as close to the patient and citizen as possible
- any collaboration must recognise that it may create 'winners and losers' and therefore encompass a commitment to manage the impact of any such problems
- any collaboration must be clear about the problems it is attempting to resolve and avoid creating additional tiers of bureaucracy
- any collaboration must demonstrate that it is added value over and above any existing approach
- any collaboration must be based on strong clinical and care professional engagement that has provided an evidence base for its work programme and a platform for its implementation
- any collaboration needs to be based recognise staffing and workforce issues as a driver to set priorities and as a conscious restriction on the pace and scope of its work programme
- any collaboration should recognise the time frames in which it may operate - delivering quick tactical benefits and longer term more strategic solutions
- any collaboration should operate by doing only what it can do best, and be coherent with work at HCP level and at the ICB level

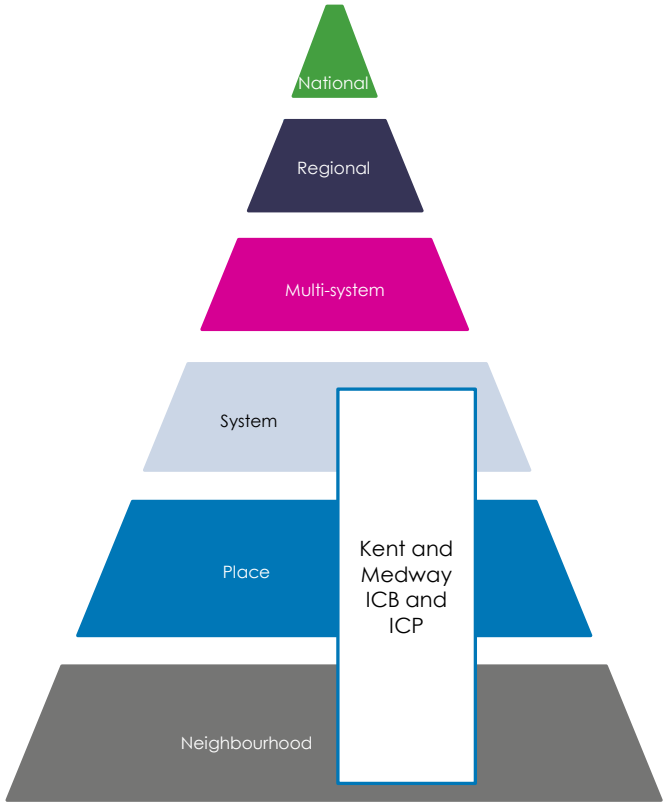
Recent engagement has added the following:

- any collaboration will only be to the depth required to have an impact
- any collaboration should start with the simple stuff, building complexity with our maturity – and keeping the list of priorities small
- any collaboration should be supported by the right resources and supporting governance – to enable us to deliver the ambition
- Any collaboration will support the Kent and Medway system to deliver its efficiency targets (Financial Recovery Programme)

The functions of the provider collaboratives in Kent and Medway

Scope of this paper, including how they relate to H&CPs and Neighbourhoods

System levels



Collaborative delivery of health services

Provider collaborative arrangements	Purpose of collaboration	Kent and Medway collaboratives	Partners	Example services
AHSNs, AHSCs, public-private partnerships	Collaborative arrangements to deliver specialised services across the region	E.g. Kent Surrey Sussex Academic Health Science Network	Specialist providers Research universities Industry	Highly specialist services Specialised services
Specialist clinical networks Provider collaboratives	Collaborative arrangements to deliver specialised services across **multiple systems**	E.g. Provider Collaborative Kent, Surrey and Sussex Kent and Sussex CAMHS Tier 4	Providers (including from outside Kent and Medway)	Highly specialised services Community and MH
Provider collaboratives	Collaboration between providers to work together **at scale** to benefit their populations	**Provider Collaborative Board** **MHLDA Collaborative** **Community Collaborative** **Acute Collaborative**	Providers, GPs, KCC and Medway Council, VCSE	Secondary care Community care (physical and mental)
H&CPs	Providers of health and care, collaborating to deliver **smaller 'place based' geographies**	Dartford & Gravesham H&CP East Kent H&CP West Kent H&CP Medway H&CP	Providers GPs KCC and Medway Council Voluntary sector	Community health Social care Urgent care
Neighbourhood Teams PCNs	Hyper local collaboration of **front-line teams** to delver integrated care to the population	Neighbourhood Teams PCNs	GPs Voluntary sector KCC and Medway Council Providers	Primary care Prevention, public health and wellbeing Community health Social care

What will be different? Provider collaboratives will supplement existing delivery mechanisms in the Kent and Medway ICS

*Provider collaboratives can take responsibility for delivering elements of the ICB's ambitions – including the ICB's **Financial Recovery Programme** and areas of system complexity that require providers to work together to tackle difficult problems*

ICB

Provider Boards

*Provider collaboratives will support their constituent provider organisations to **tackle areas where collaboration with other local providers will support them to address challenges** and provide improved services, more efficiently*

Existing provider collaboratives and networks

*A more strategic approach to provider collaboratives will provide a **mechanism for existing provider collaborative activity to be consolidated** (e.g., Diagnostics and Pathology Network)*

Kent and Medway at-scale health service provider collaboratives

*Provider collaboratives will be responsible for supporting **local delivery at an H&CP and neighbourhood level** by creating mechanisms for the sharing of resources (e.g., holding Section 75s with local authorities)*

H&CPs

Neighbourhoods

Where we can tackle complex problems better together **at scale, as providers of health services** we will collaborate to deliver (or enable the delivery of) improved outcomes, transformation and efficiencies for the population and system of Kent and Medway.

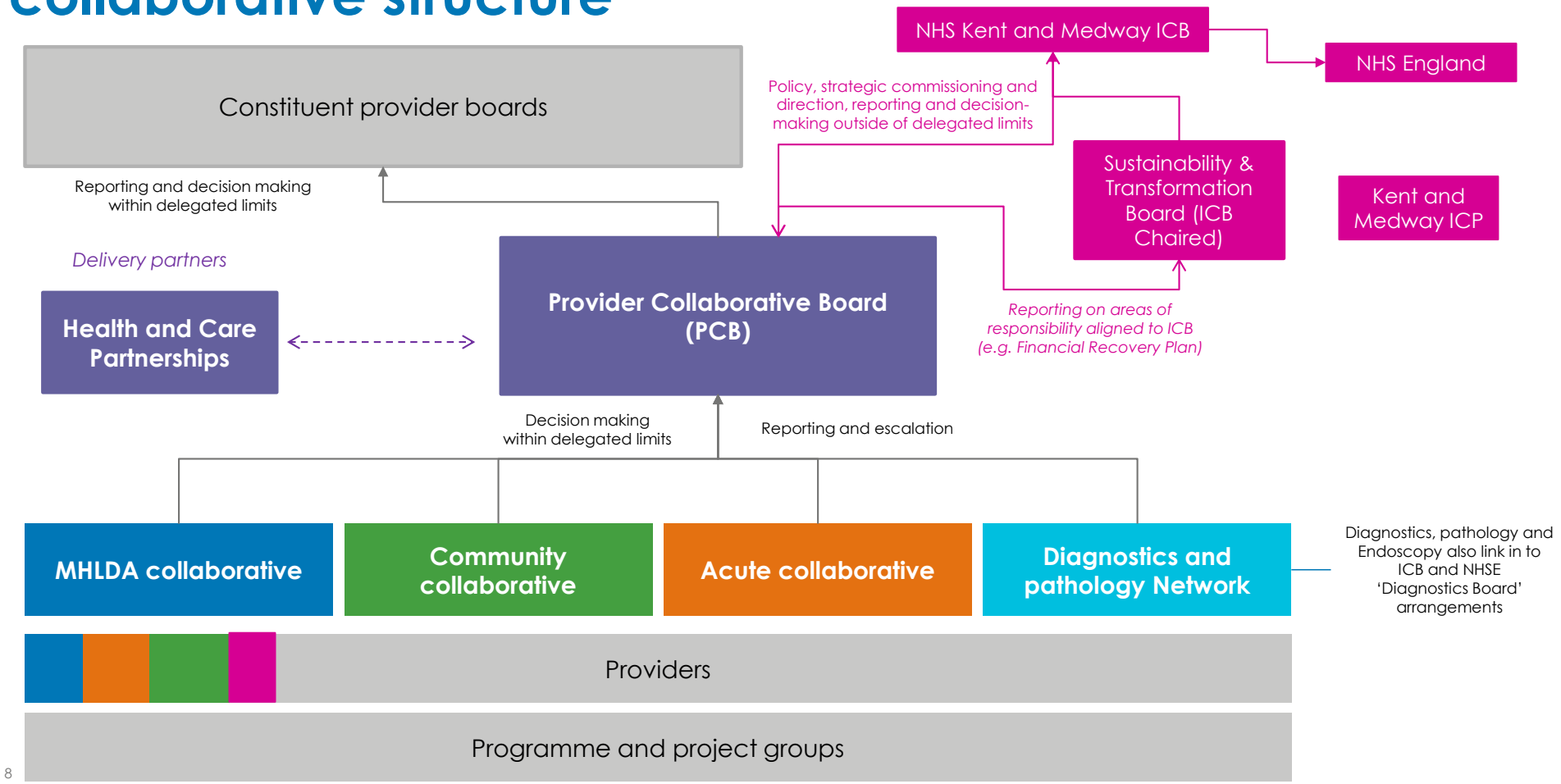
Four at scale collaboratives of health providers will provide a design, delivery and enabling function to supplement the existing delivery infrastructure in the system. These four provider collaboratives will be:

1. **[All] Provider Collaborative Board**
2. **MHLDA Provider Collaborative**
3. **Community Collaborative**
4. **Acute Collaborative**

Kent and Medway are proposing the development of four at scale provider collaboratives

Provider Collaborative Board	MHLDA	Community	Acute
To drive the delivery of collaborative programmes of work across all providers in Kent and Medway To provide leadership and assurance of and support to the work and development of the three provider collaboratives and the Diagnostics & Pathology Network	Building on the current collaborative and it's work programme, together tackle complex MHLDA services where a joined-up approach will drive improved outcomes for the population and system	To drive a collaborative approach to the delivery of complex community and primary care services at scale, including with our local authority partners	To drive transformation of secondary care services where collaboration will deliver improved outcomes for the population and the system
All providers • KMPT • Medway Community • HCRG • EKHUFT • KCHFT • MTW • DG • Medway • SECAM	**MHLDA partners** • KMPT • KCC • Medway Council • VCSE • KCHFT • Medway Community • ICB • Primary care • NELFT • SECAM	**Community partners** • KCHFT • Medway CT • HCRG • VCSE • KCC • Medway Council • ICB • Primary care • SECAM	**Acute partners** • EKHUFT • MTW • DG • Medway • ICB • SECAM

Proposed governance of the at scale provider collaborative structure



Provider Collaborative Board

Responsibility for the delivery of…

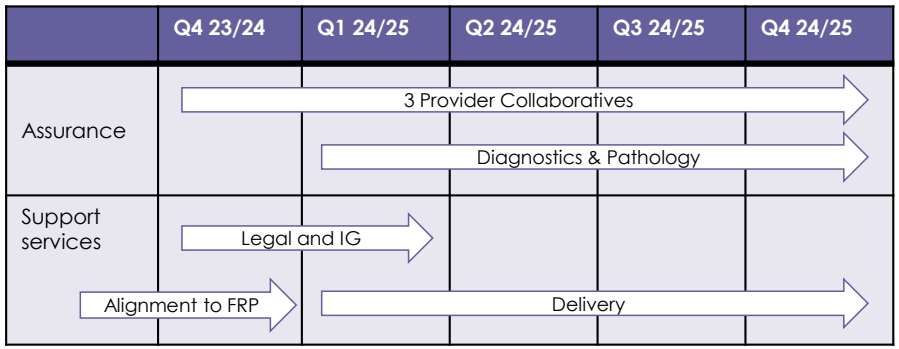
Assurance of work of other collaboratives and their development (through the maturity matrix)

Support Services Programme to drive efficiencies of a share approach to these organisational functions (**aligned to the ICB's Financial Recovery Programme**), including:

1. Legal and IG
2. One Public Estate (inc. LAs)
3. Procurement

Assurance of the work of the Diagnostics and Pathology Network

Plan for 2024/25



Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Chairs and CEOs). **It does not have delegated authority from the ICB or from the Trust Boards. Delegation from provider boards, on specific issues related to the scope of this Board, will be explored in the coming weeks to ensure the effectiveness of this Board**
- For decisions outside the scope of these individuals (e.g., material in scope / significant financial impact / requiring public consultation (e.g., would not secure HOSC approval)), the Board will make recommendations to the provider boards and / or the Sustainability & Transformation Board.
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning.
- The Board will have no commissioning responsibilities
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- ICB membership will be non-voting and will reflect delegated areas of responsibility / the nature of the decision(s) in scope

Partners and membership

Chairs and CEOs from all eight providers – KMPT, Medway Community, HCRG, KCHFT, EKHUFT, SECAMB, MTW, DG and Medway and ICB

Leadership

Chair: David Highton

Exec Lead: Sheila Stenson

Exec Lead Support Services: Chris Wright

MHLDA Provider Collaborative

Responsibility for the delivery of…

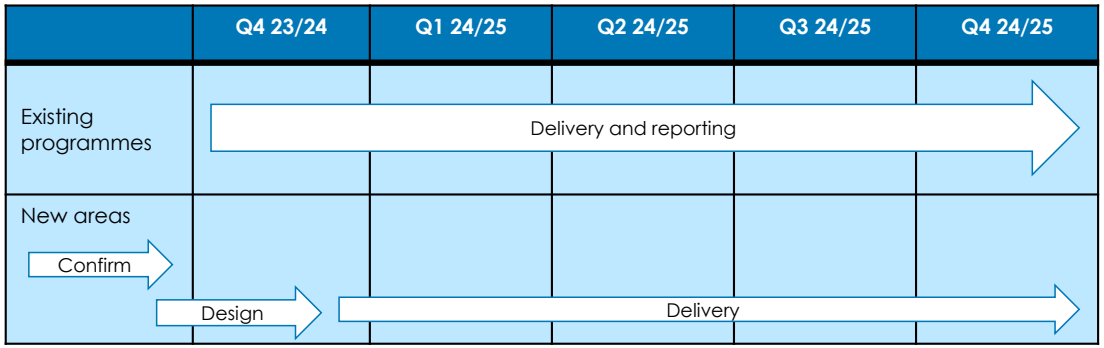
Continued delivery of programme areas that have historically sat with the MHDLA Provider Collaborative Board, including:

1. Community Mental Health Transformation Programme
2. LDA out of area placements Project
3. CYP transitions and out of area placements Project
4. Suicide Prevention Project
5. Mental health urgent and emergency care

Other areas in scope that may be delivered over a longer period, and require further development include:

1. Mental health frequent attenders project
2. Delivery of the Mental Health Digital Strategy
3. Neurodiversity project

Plan for 2024/25



Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold. It does not have delegated authority from the Provider Collaborative Board, ICB or from provider boards
- For decisions outside the scope of these individuals, recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

KMPT, KCC, Medway Council, VCSE, KCHFT, Medway Community, ICB, Primary care, NELFT

Leadership

Chair: Sheila Stenson

Exec Lead: TBC

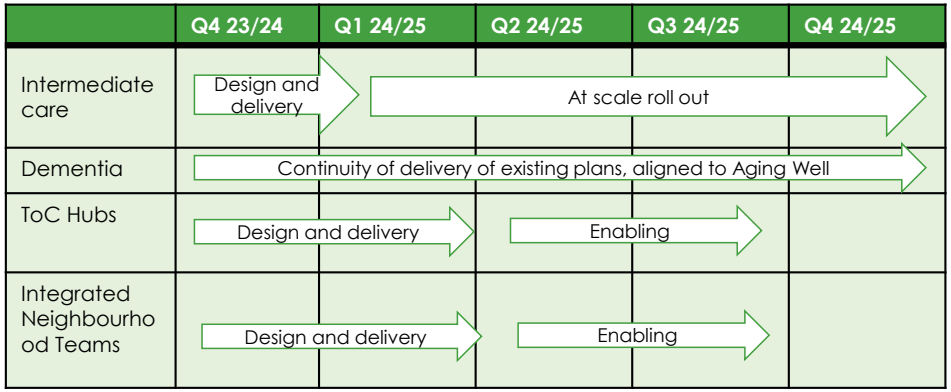
Community Provider Collaborative

Responsibility for the delivery of…

At-scale delivery of:

- Intermediate care model – building on the East Kent pilot of a winter integrated bed model to improve provision of short-term services (and reduce spot purchasing of beds) (**aligned to FRP's Better Use of Beds**)
- Transfer of care hubs
- Dementia improvement project (final collaborative 'home' TBC through discussion with clinical colleagues – may be MHLDA provider collaborative)
- Enabling deployment of resources to the Integrated Neighbourhood Teams (with LA partners through Section 75s)

Plan for 2024



- In time, the delivery of the community transformation will be delivered through this forum

Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold. It does not have delegated authority from the Provider Collaborative Board, ICB or from provider boards
- For decisions outside the scope of these individuals, recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

KCHFT, Medway CT, HCRG, VCSE, KCC, Medway Council, ICB, primary care providers (PCNs/Confeds)

Leadership

Chair: Mairead McCormick

Exec Lead: TBC

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Acute Provider Collaborative

Responsibility for the delivery of…

Service review (**aligned to the ICB's Financial Recovery Programme**)of all acute services (including, where significant, the interface with community, mental health and independent sector services) and specialised commissioning to establish the sustainability of services and opportunity for improvement of this position. Delivery of recommendations from review could be through individual providers, PCs, HCPs or ICB. Recommendations may include service improvement, service redesign and/or service reconfiguration

Service Review - factors of sustainability

Early focus on ENT and Dental GA to drive improvements in the service

Support to deliver the system's endoscopy work programme (including bids for estates)

Plan for 2024/25

	Q4 23/24	Q1 24/25	Q2 24/25	Q3 24/25	Q4 24/25
Service Review	Service Review	Service Review: Detailed design and delivery Quick win delivery			
ENT	Discovery and design	Delivery of impact			
Endoscopy	Review and sign-off proposals				

Authority and governance

- The Board has the decision-making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Trust Executive Team members). It does not have delegated authority from the Provider Collaborative Board, ICB or from the Trust Boards
- For decisions outside the scope of these individuals' recommendations will be made to the Provider Collaborative Board for approval or escalation
- Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined
- Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning
- Priorities will be reviewed annually. Governance may evolve in time, by mutual agreement of the providers and ICB, as required to deliver priorities
- Includes ICB membership

Partners and membership

Executive Team members from each of the four acute trusts and the Director of Delivery of the ICB

Leadership

Chair: Jayne Black

Exec Lead: TBC

The resourcing of the at scale provider collaboratives

ICB

Provider Collaborative Board	MHLDA	Community	Acute
Chair: David Highton Executive Lead: Sheila Stenson Executive Leadership of Support Services Programme: Chris Wright	Chair / Executive Lead: Sheila Stenson	Chair / Executive Lead: Mairead McCormick	Chair / Executive Lead: Jayne Black

Provider Collaborative Programme Director – JD drafted for a substantive, went to advert in September
Interim support is being provided by Attain

Additional provider resources to be determined as more detailed workplan emerges

External support provided to deliver elements of the Service Review

TBC (after restructure) | TBC (after restructure) | TBC (after restructure)

Population health

Information governance

13

Kent and Medway Provider Collaborative maturity – measured against the NHS England Provider Collaborative Maturity Matrix

Domain	Objective	Provider Collaborative Board	MHLDA Provider Collaborative	Community Collaborative	Acute Collaborative
Outcomes and benefits	Reduce unwarranted variation and inequalities in patient outcomes, access and experience Improve resilience Enhance productivity and value for money	**Emerging** Identifying areas for improvement with shared data sets and committing to addressing the challenges together – including sharing resources and mutual aid	**Developing** Co-designing collaborative transformation plans and programmes to address challenges	**Emerging/Developing** In some areas, co-designing collaborative transformation plans and programmes to address challenges	**Emerging** Identifying areas for improvement with shared data sets and committing to addressing the challenges together – including sharing resources and mutual aid
Governance and Leadership	Implement shared vision and governance Build a culture of mutual support and accountability Embed multi-professional clinical and care leadership	**Emerging/Developing** Developing and implementing shared governance, committing to an open culture, identifying shared approach to managing risks and collaborative resources	**Developing** Shared vision, implementing shared governance, identifying programmes for shared risk (CMHT), transformation designed with strong clinical leadership	**Emerging/Developing** Developing and implementing shared governance, committing to an open culture, identifying shared approach to managing risks and collaborative resources, strong clinical leadership	**Emerging** Agreeing governance, agreeing to share risk, committing to an open culture and data sharing, agreeing shared approach to continuous improvement, establishing links with clinical groups
System working	Support ICSs to deliver priorities Build strong relationships with partners Engage and co-design with people and communities	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners	**Emerging/developing** Establishing regular communication between partners and ICB, developing aligned plans, building relationships between partners

There are existing areas of provider collaboration (e.g., Diagnostics and Pathology Network) where there is greater maturity. This maturity matrix is focusing on the new Provider Collaborative Boards, but is actively seeking to learn the lessons from historic provider collaboration.

Attain

The Provider Collaborative Board will lead and support the collaboratives to develop

Domain	Objective	Provider Collaborative Board	MHLDA Provider Collaborative Board	Community Collaborative Board	Acute Collaborative Board
Outcomes and benefits	Reduce unwarranted variation and inequalities in patient outcomes, access and experience Improve resilience Enhance productivity and value for money	Working towards: • Delivering programmes to reduce inequalities, address fragile services and deliver efficiencies • Co-design of transformation plans • systematic approach to mutual aid and sharing resources • delivery of joint corporate functions			
Governance and Leadership	Implement shared vision and governance Build a culture of mutual support and accountability Embed multi-professional clinical and care leadership	Working towards: • Shared vision that drives all transformation programme • financial risk sharing • ensuring the fullest range of clinical and care leadership • delegation/decisions that are in the system interest and independent of all sovereign interests • Embedded common QI methodologies and embedding of best practice • Ensure member Boards are routinely abreast of outcomes			
System working	Support ICSs to deliver priorities Build strong relationships with partners Engage and co-design with people and communities	Working towards: • Defined and maturing interfaces and relationships with HCPs and local authorities • Integration of programmes with population health disciplines • Work with partners outside Kent and Medway • Routine evaluation and population engagement			

The development journey of provider collaboratives will be informed by the learning and experiences of the arrangements as they rollout, deliver and evolve.

There are already areas to be explored in the coming months, and then further into 24/25.

These will form part of a Provider Collaborative Operating Model and Development Plan to be developed in Q4 23/24.

Attain

Milestone Plan

Sustainability & Transformation Board

OCT 18

Agree role, scope, delivery priorities, resourcing and governance

Integrated Care Board

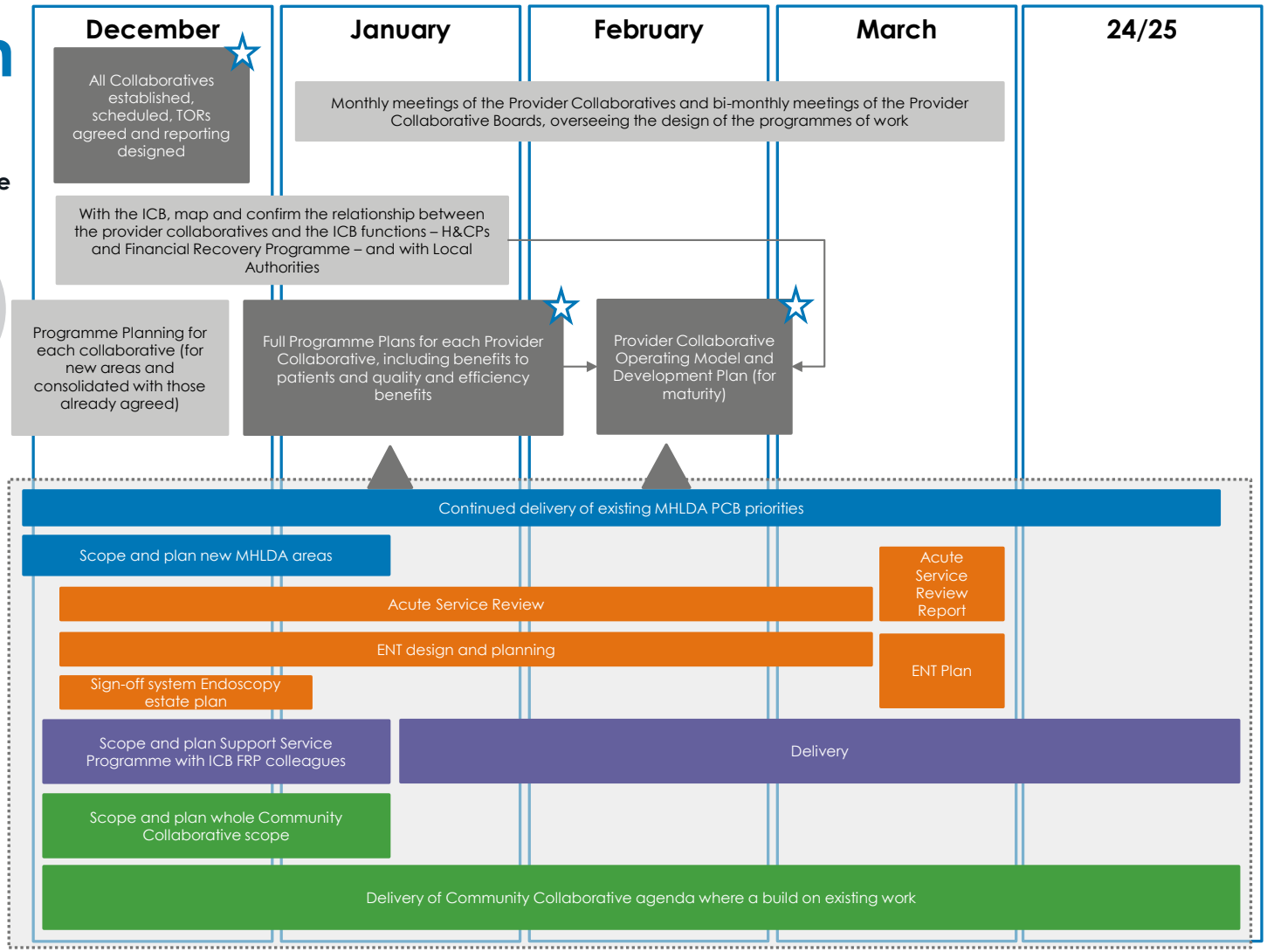
NOV 7

Agree delivery priorities, resourcing and governance

Concurrent provider board approvals

Milestones

- All Collaboratives established, scheduled, TORs agreed and reporting designed
- Full Programme Plans for each Provider Collaborative, including benefits to patients and quality and efficiency benefits
- Provider Collaborative Operating Model, to include a development plan (for maturity)



For further information please contact:

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KENT & MEDWAY – PROVIDER COLLABORATIVE BOARD

Terms of Reference

October 2023

Document History

Version	Date	Author	Comments
V0.1	06/09/23	Helen Pyecroft	Initial Draft
V0.2	07/09/23	Helen Pyecroft	With comments from David Highton, Provider Collaborative Chair
V0.3	08/09/23	Helen Pyecroft	With comments from Mike Gilbert, governance lead for K&M ICB
V0.4	12/09/23	Helen Pyecroft	With comments from Sheila Stenson, Provider Collaborative SRO
V0.5	18/09/23	Helen Pyecroft	With comments from the Chairs/CEO meeting on the 14th September
V0.6	05/10/23	Helen Pyecroft	With comments from K&M ICB and SROs
V0.7	10/10/23	Helen Pyecroft	With final comments from the provider Chairs/CEOs

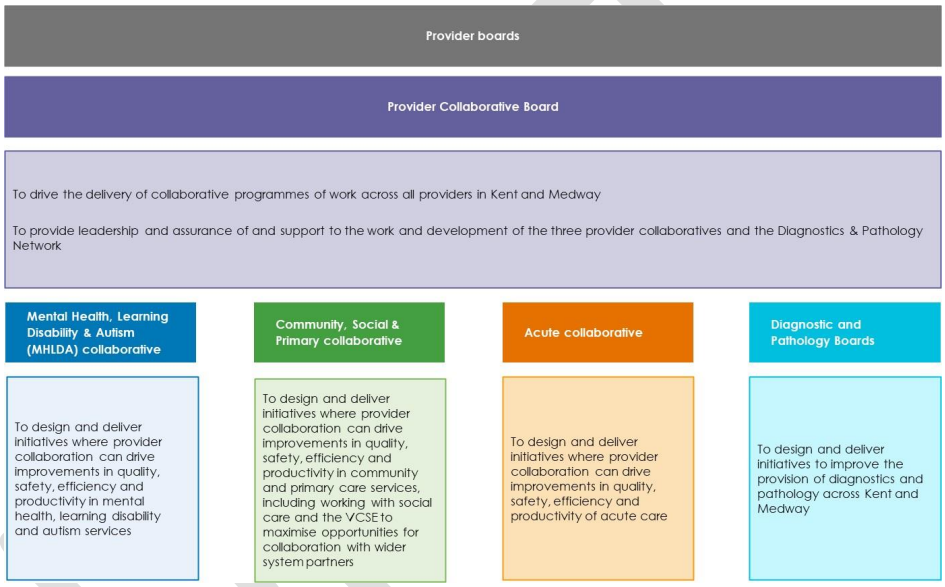
CONTENTS

INTRODUCTION AND CONTEXT

Collaboration between health and care providers already exists across Kent and Medway in various formats. Building on this to design structures for formal at scale provider collaboration is in line with the national context set out in the Health and Care Bill 2021 and furthers the goals set out in the creation of Integrated Care Systems (ICS).

In early 2023 Kent and Medway ICS partners agreed to create an at scale provider collaborative structure that will bring together partner organisations to collaborate on the design and delivery of care where collaboration supports delivering greater impact for the population and health and care system.

The provider collaborative structure in Kent and Medway



The scope of these Terms of Reference are for the Provider Collaborative Board.

In developing these Terms of Reference, and designing the scope and workplans for the provider collaboratives, it has been important to ensure that they are aligned to:

- Individual provider priorities and strategies
- NHS England published its Provider Collaborative Maturity Matrix
- ICS operating model – including the development of the scope of Health & Care Partnerships (H&CPs)
- The ICB Financial Recovery Programme (FRP)
- ICS Strategy
- ICB Pathway Programmes

1.PURPOSE

1.1. The Board exists to formally bring together providers across Kent and Medway to collaborate effectively and drive improvements in the delivery of services at scale. Strategic in nature, the Board will seek to continually improve the function and delivery of care in Kent and Medway, ensuring that it's work aligns with existing programmes without overlap or duplication. The Board will:

- To drive the delivery of collaborative programmes of work across all providers in Kent and Medway
- To provide leadership and assurance of and support to the work and development of the three provider collaboratives and the Diagnostics & Pathology Network
- Take decisions relating to the delivery of projects in its own portfolio, but also those required to enable the constituent provider collaboratives to deliver their programmes of work

1.2. Specifically, the Board will:

- provide leadership, oversight, and enable partnership working to improve care outcomes of the population of Kent & Medway
- ensure a strategic focus, acknowledging wider development of the Kent and Medway system and the collaboration required to deliver our Long-Term Plan ambitions
- support strategic thinking about the ongoing development of provider collaboratives in Kent and Medway
- delivery of financial efficiencies
- maintain effective working relationships with other ICB and ICS groups, including the H&CPs and ICB, recognising interdependencies and other priorities across Kent and Medway
- identify risks and issues to delivery and agree to mitigations to effectively resolve these
- empower providers to deliver shared solutions that meet the needs of Kent and Medway collectively by providing a framework within which to operate where appropriate
- ensure that programmes of work are being delivered effectively, reviewing any specific reporting by exception

More detailed responsibilities are set out at 3.0 below.

2. PRINCIPLES

2.1. In October 2022, the Kent and Medway providers and ICB came together to develop a set of working principles for the establishment of provider collaboratives at scale. The principles agreed were:

- any collaboration must be justified on the basis of its ability to demonstrate measurable improvements in patient and population outcomes, patient experience, efficiency/productivity, and the reduction of inequalities
- any collaboration needs to have decision making located at the appropriate level in the system and involve the appropriate individuals
- any collaboration should be based on the principles of subsidiarity and taking decisions as close to the patient and citizen as possible

- any collaboration must recognise that it may create 'winners and losers' and therefore encompass a commitment to manage the impact of any such problems
- any collaboration must be clear about the problems it is attempting to resolve and avoid creating additional tiers of bureaucracy
- any collaboration must demonstrate that it is added value over and above any existing approach
- any collaboration must be based on strong clinical and care professional engagement that has provided an evidence base for its work programme and a platform for its implementation
- any collaboration needs to be based recognise staffing and workforce issues as a driver to set priorities and as a conscious restriction on the pace and scope of its work programme
- any collaboration should recognise the time frames in which it may operate - delivering quick tactical benefits and longer term more strategic solutions
- any collaboration should operate by doing only what it can do best, and be coherent with work at HCP level and at the ICB level.

2.2. These principles will guide the work of the Provider Collaborative Board.

3.SCOPE AND RESPONSIBILITIES

3.1. In designing the scope of the priorities for the at scale provider colalboratives, including the Provider Collborative Board, the following principles were applied:

- We collaborate where we can do better together (and can demonstrate so, including what will be better than current arrangements) – and only to a depth required to have an impact
- We are clear about the nature of the collaboration – e.g., agreeing shared standards, colalborating to deliver discreet projects and/or delegating authority for the delivery of services
- We collaborate where the evidence supports the decision to do so
- We collaborate on the simple stuff to start with
- We collaborate where the right resources and supporting governance can and will follow

Scope and responsibilities for 2023-2024

Scope	Description	Responsibilities
Coordinate and assure the work of the Kent and Medway provider collaboratives, signing off and taking decisions on	The Provider Collaborative Board will oversee the work of the MHLDA, Community, Social and Primary Care, Acute, Diagnostic and Pathology provider collaboratives	• Hold the provider collaboratives to account for the delivery of their workplans • Make decisions on behalf of our constituent provider Boards where we have the relevant authority - to enable and support delivery of those workplans • Escalate decisions to Provider Boards and the Sustainability and

Scope	Description	Responsibilities
matters required to ensure they deliver their programmes of work		Transformation Board (and ICB) where required • Support the allocation of resources and management of risk to enable the delivery of the workplans • Continue to identify and develop evidence-based priorities for the Board and constituent provider collaboratives, with ICB colleagues
Support the design and delivery of the FRP Support Services programme and wider initiatives to improve the efficiency, productivity and quality of support services	The Board will design and deliver a series of initiatives, including: • Legal and IG • One Public Estate (inc. LAs) • Procurement • Digital Some areas will overlap with the ICB's FRP programme and will, therefore need to be aligned.	• Agree scope and targets with the ICB before delivery • Agree detailed workplans for each area, with appropriate parties • Deliver workplans • Make decisions on behalf of our trust's Boards where we have the relevant authority - to enable and support delivery of those workplans • Escalate decisions to Provider Boards and the Sustainability and Transformation Board (and ICB) where required • Support the allocation of resources and management of risk to enable the delivery of the workplans

3.2. Further priorities for the Board will be identified through analysis of an evidence-base and in agreement with Provider boards and the ICB.

4. MEMBERSHIP

4.1. The Board will be chaired by David Highton, Chair of Maidstone & Tunbridge Wells NHS Provider. David Goulston, Chair of KCHFT, is Vice Chair.

4.2. It is recognised that a number of individuals undertake dual roles across Kent and Medway representing both their own organisations and system roles. For the purposes of the Board, broad representation of views is required, and as such some members will be expected to represent the partnership(s) they represent (e.g., local Health and Care Partnership (H&CP)) as opposed to their employing organisation.

4.3. To ensure clarity, the organisation each member is expected to represent is indicated in the membership list below:

Name	Role Title	Employing Organisation	Representing at Board

David Highton (Chair)	Chair	Maidstone & Tunbridge Well NHS Provider	Maidstone & Tunbridge Well NHS Trust
Niall Dickinson	Chair	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust
Joanne Palmer	Chair	Medway NHS Foundation Trust	Medway NHS Foundation Trust
Jackie Craissati	Chair	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust	Kent & Medway NHS and Social Care Partnership Trust Dartford & Gravesham NHS Trust
John Goulston (Vice Chair)	Chair	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Bruce Potter	Chair	Medway Community Healthcare	Medway Community Healthcare
David Astley	Chair	South East Coast Ambulance Service	South East Coast Ambulance Service
Simon Weldon	Chief Executive	South East Coast Ambulance Service	South East Coast Ambulance Service
Sheila Stenson	Chief Executive of KMPT and SRO of Provider Collaboratives	Kent & Medway NHS and Social Care Partnership Trust	Kent & Medway NHS and Social Care Partnership Trust
Miles Scott	Chief Executive	Maidstone & Tunbridge Well NHS Trust	Maidstone & Tunbridge Well NHS Trust
Jayne Black	Chief Executive	Medway NHS Foundation Trust	Medway NHS Foundation Trust
Mairead McCormick	Chief Executive	Kent Community Health NHS Foundation Trust	Kent Community Health NHS Foundation Trust
Martin Riley	Chief Executive	Medway Community Healthcare	Medway Community Healthcare
Jon Wade	Chief Executive	Dartford & Gravesham NHS Trust	Dartford & Gravesham NHS Trust
Tracey Fletcher	Chief Executive	East Kent Hospitals University NHS Foundation Trust	East Kent Hospitals University NHS Foundation Trust

Debbie Lindon Taylor	Head of HCRG Care Groups North Kent	Health Care Resourcing Group	Health Care Resourcing Group
In Attendance – Non-Voting Members			
Provider Collaborative Programme Director	TBA		
TBC	TBC	ICB	ICB

4.4. Deputies may be accepted with prior agreement of the Chair.

4.5. The Board may call additional individuals to attend adhoc meetings or to attend on a regular basis. Attendees may present at Board meetings and contribute to discussions, but are not allowed to participate in any decision making.

4.6. The Board may invite or allow people to attend meetings as observers. Observers may not present or contribute to any Board discussion unless invited by the Chair and may not participate in any decision making.

5. QUORUM

5.1. There is a requirement for a minimum number of members to be present to enable the business of the Board to be effectively undertaken. For the purposes of these Terms of Reference this shall be known as the quorum and shall be noted as such in meeting agendas and minutes.

5.2. For the meeting to be considered quorate at least one representative from each member organisation needs to be in attendance, one of whom will be the Chair or Vice Chair of the Board.

5.3. Deputies may be appointed in the absence of a member, subject to the agreement of the Chair, but may not be another member of the Board or represent more than one member.

5.4. Members who are not physically present at a meeting but are present through the means of teleconference or other acceptable digital media shall be deemed to be present.

5.5. If any representative is conflicted on a particular item of business they may not participate in the discussion and may be asked to leave the meeting at the discretion of the Chair. These individuals shall not count towards the quorum for any decision/recommendation made. If this renders a meeting or part of a meeting non-quorate, subject to the discretion of the Chair:

- a non-conflicted person may be temporarily appointed or co-opted to satisfy the quorum requirements; or
- the requirement for that category of member to be present may be relaxed.
- Members have a collective responsibility for the operation of the Board. They will participate in discussion, review evidence, and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

6. MEETING FREQUENCY

6.1. Meetings shall be held bi-monthly – with every other meeting being in person.

6.2. The Board Chair may request additional meetings if they consider it necessary, including facilitating the function of assurance to the ICB and partner organisations.

7. AGENDA AND PARTICIPATION

7.1. The agenda and associated papers will be issued five working days in advance of each meeting.

7.2. Requests for agenda items should be sent a minimum of two weeks in advance of the meeting. The Chair will decide if items can be added, depending on previous commitments and time constraints.

7.3. To ensure that meetings run smoothly and effectively, members will be expected to:

- Read circulated papers and other materials in advance of meetings
- Follow planned agendas
- Show respect by listening to others and not interrupting
- Operate on a consensus and aim to seek general agreements
- Identify actions that result from discussions and commit to following through those actions
- Address items through the Chair of the meeting.

8. DECISION MAKING

8.1. The Board has the decision making authority of the individuals on the Board and the powers delegated to them by the positions they hold (Chairs and CEOs).

8.2. For decisions outside the scope of these individuals (e.g. material in scope / significant financial impact / requiring public consultation (e.g. would not secure HOSC approval)), the Board will make recommendations to the provider boards and / or the Sustainability & Transformation Board.

8.3. Any actions or recommendations made by the Board will be through consensus. Where consensus cannot be achieved, agreement of 75% of those present will be sufficient, subject to the meeting being quorate, for a matter to be determined.

8.4. Any decisions endorsed will be shared with the provider executive teams, Sustainability & Transformation Board, and four H&CPs to support local planning.

8.5. The Board will have no commissioning responsibilities.

9. DISPUTE RESOLUTION

9.1. Where a dispute or concern arises regarding the operation or management of the Provider Collaborative, this should be brought to the attention of the Chair in the first instance. The Chair will consider what appropriate action to take and whether the matter should be discussed with other partners, including Provider Boards and/or the ICB. Where a dispute or

concern arises relating to the actions of the Chair, where possible the matter should be discussed with the Chair or Vice Chair and progressed as above.

9.2. For clarity, any decision made by the Board, including decisions not to support a proposal, cannot be challenged where the proposal has been put to a vote in accordance with these terms of reference, i.e. a concern cannot be formally escalated by a member simply because they do not like the outcome.

10. REPORTING PROCEDURE AND MINUTES

10.1. Actions and key decisions will be note at each meeting by the Provider Collaborative Managing Director and distributed to Board members no later than a week after each meeting.

10.2. The Board will provide quarterly progress reports to Provider Boards and the Kent and Medway Sustainability & Transformation Board. Routine highlight reports will be shared with local Health and Care Partnership across Kent & Medway to ensure at scale improvement and transformations are aligned with local place-based priorities.

11. POLICY AND BEST PRACTICE

11.1. The Board may instruct professional advisors and request the attendance of individuals and authorities with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its responsibilities.

11.2. The Board is authorised to establish such sub- groups as it deems appropriate in order to assist in discharging its responsibilities.

11.3. Unless stated otherwise in these terms of reference, the Board will be conducted in accordance with the Chair's organisations Standing Orders and Standards of Business Conduct and Managing Conflicts of Interest Policy. Specifically:

- There must be transparency and clear accountability
- The Group will hold a Register of Interests in accordance with good governance practice
- Members must declare any interests and /or conflicts of interest at the start of the meeting. Where matters on conflicts of interest arise, the Chair will determine what action to take in discussion with the lead executive officer as appropriate. This may include requesting that individuals withdraw from any discussion/voting until the matter is concluded.
- The Board shall undertake a self-assessment of its effectiveness bi-annually at the face to face board development meetings.
- Members of the Board should aim to attend all scheduled meetings, but must attend at least 75% of scheduled meetings in any financial year.
- Members, attendees and/or invited observers must maintain the highest standards of personal conduct and in this regard must comply with:
    - The laws of England and Wales
    - The spirit and requirements of the NHS Constitution
    - The Nolan Principles

- The standards of behavior set out in their employing organisation's policies, as they would be reasonably expected to know

12. CONFIDENTIALITY

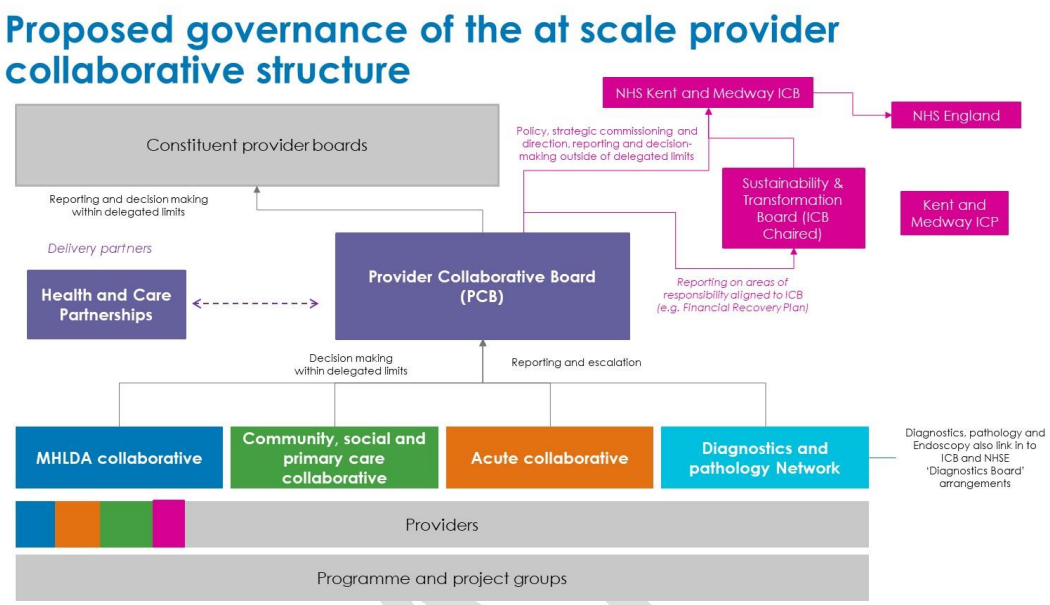
12.1. Members of the Board shall respect the confidentiality requirements set out in relevant corporate policies and these Terms of Reference, unless separate confidentiality requirements are set out for the Board, in which event these shall be observed.

12.2. Recommendations and actions of the Board will be detailed in the minutes of the meeting, and these shall be disclosable under the Freedom of Information Act, except where matters under consideration or when decisions made are of a confidential nature, in which case they will be excluded from any public record and shall not be publishable.

13. REVIEW

13.1. The Terms of Reference of the Board shall be reviewed at regular intervals to reflect the priorities of the Board and the environment within which it is operating as part of the Kent and Medway ICS.

Apendix One – Kent and Medway at scale provider collaborative governance structure



Kent Community Health NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 9
Report title:	Integrated Performance Report
Executive sponsor(s):	Gordon Flack, Chief Finance Officer
Report author(s):	Nick Plummer, AD Performance and BI
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary

There are currently 14 KPIs off target for the month, which is 34% of the metrics. Of these, the KPIs of most concern are KPIs 5.1 Sickness Rate, 5.2 Absence – Stress and 5.5 Vacancy Rate due to their current performance and trend.

2.14 AHP Access Wait times is off target but showing positive variation with a period above the mean, and a focus for the breakthrough objective work.

Additionally, there are 6 further metrics with special variation in a positive direction, with highlights being sustained good performance for KPI 2.10 2-Hour Crisis Response, as well as Turnover (KPI 5.3) and Stability (KPI 5.6) performing positively.

Benchmarks have been added where currently available (highlighted light blue) to give national context to KCHFT performance, with KPI 2.8 now split between Adults (KPI 2.8a) and CYP (KPI 2.8b) to align to the benchmarking metrics.

Highlights

- Three lapses in care occurred with patients on our caseload that were identified during August 2023.
- The Trust is in a breakeven financial position to the end of August once adjusted for £15k of depreciation on donated assets. The YTD financial performance is comprised underspends on pay and depreciation / interest of £3,653k and £54k respectively offset by an overspend on non-pay of £1,290k and an under-recovery on income of £2,432k.
- The Trust achieved CIPs of £4,769k to the end of August against a plan of £6,016k which is £1,247k (20.7%) behind target. The forecast is for the target of £14,439k to be achieved in full.

- Capital: Spend to August was £706k, against a YTD plan of £1,521k (46% achieved). The YTD underspend is primarily due to the delayed commencement of IT projects
- Temporary staff costs for August were £1,249k, representing 6.9% of the pay bill. Of the temporary staffing usage in August, £229k related to external agency and locums, representing 1.3% of the pay bill. The agency target for the month was £292k meaning costs were £63k below target. Cumulatively agency costs are £1,323k against a target of £1,460k and so costs are £137k below target.
- Contracted WTE was unchanged remaining at 4,529 in post in August which includes 17 posts funded by capital projects. Vacancies increased to 352 in August (from 346 in July) which was 7.2% of the budgeted establishment. Budgeted establishment increased by 6 WTE from July.
- Smoking Quits - The service recorded 481 quit dates and achieved 250 quits (53.6% success rate) with 15 outstanding outcomes, Total service recorded quits to date (month 1-4) is 889 currently we are just under our trajectory target of 1000 quits by end of month 4 (however, crude trajectory of 250 per month does not take into account ebbs and flows in activity during quieter summer months).
- BCG Vaccinations - BCG programme performance continues a positive shift from 22/23 performance, currently at 70% in north Kent and 66% in east Kent.
- During Month 5 (August 2023) KCHFT carried out 177,436 clinical contacts. For the financial year to August 2023, KCHFT is 1.8% 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 (-5.7%) and Specialist and ALD services (-9.4%)
- Referral to Treatment (RTT Target 92%) - The national reportable KCHFT position at M5 improved to 99.8% and is in normal variation.
- Diagnostics waits: There have been some challenges with Audiology staff capacity in August with a number of staff on annualised hours and 3 on maternity leave which reduced capacity. Therefore, the service did not meet DM01 in August and it is reported at 92.87%.
- Looked After Children Initial Health Assessments (IHAs): Compliance with the 28 day target, excluding Unaccompanied Asylum Seeking Children (USAC) has improved and was 84.2% for month 4. There were no breaches attributable to KCHFT.
- No Longer Fit to Reside - Performance has decreased slightly to 20.1% for month 5. This is still above the 15% target although performing with normal variation.
- 12 Week Access Waits have dipped slightly to 72.5%, primarily due to waits within Community Paediatrics. A number of other services (such as IMSK) are on an improving trajectory.

Report history / meetings this item has been considered at and outcome
N/A

Recommendation(s)
The Board is asked to receive this report.

Link to CQC domain				
☑Safe	☑Effective	☑Caring	☑Responsive	☑Well-led

Strategic ambition this report supports	Please tick
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications			
Risk and assurance	Yes/No (If yes, provide brief one sentence description of issue)		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐BAF	☐CRR	☐DRR
Equality, diversity and inclusion	Yes – Ethnicity Appointment from Shortlisting disparity in favour of white candidates		
Patients / carers / public / staff / health inequalities	Yes – poorer performance in DNAs in higher deprivation groups		
Legal and regulatory	Yes - statutory timelines impacted by capacity for Unaccompanied Asylum Seeker Children assessments		
Quality	Yes – waiting times and potential harms in Community Paediatrics and Adult Neurodevelopmental service		
Financial	Yes – cost improvements and capital plan behind target		

Executive lead sign off	
Name and post title:	Gordon Flack, Chief Finance Officer

Date:	11 October 2023

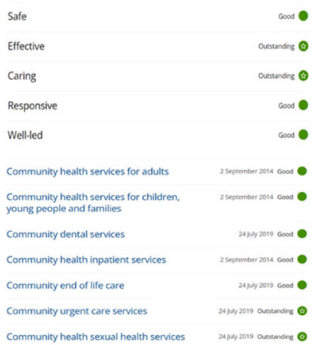
Kent Community Health
NHS Foundation Trust

Integrated Performance Report

2023/24 Month 5 report

October 2023

Overall CQC Rating – Outstanding (July 2019)



Safe		Good
Effective		Outstanding
Caring		Outstanding
Responsive		Good
Well-led		Good
Community health services for adults	2 September 2014	Good
Community health services for children, young people and families	2 September 2014	Good
Community dental services	24 July 2019	Good
Community health inpatient services	2 September 2014	Good
Community end of life care	24 July 2019	Good
Community urgent care services	24 July 2019	Outstanding
Community health sexual health services	24 July 2019	Outstanding

we care

Kent Community Health
NHS Foundation Trust

Contents

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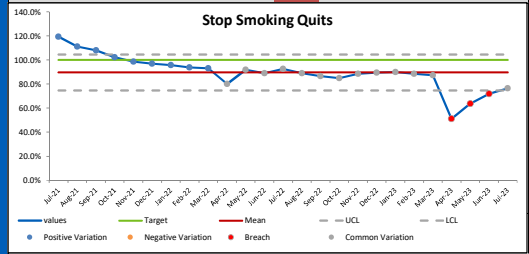
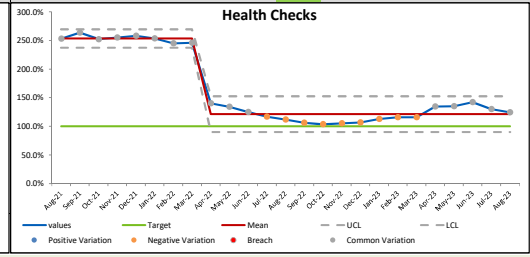
Kent Community Health NHS Foundation Trust - Corporate Scorecard

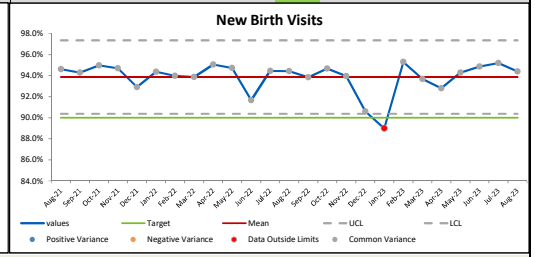
*NOTE: National Targets are denoted by (N) in the KPI name.

1. Prevent Ill Health

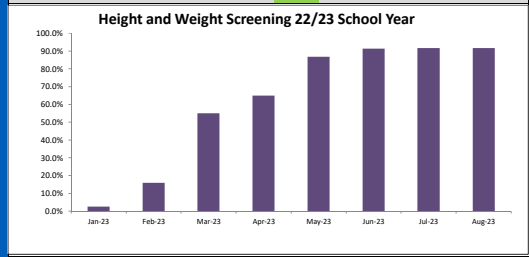
Metric	Actual		Target	Lower	Mean	Upper
KPI 1.1 Stop Smoking - 4 week Quitters	July 2023	76.4%	100%	75%	90%	104%
KPI 1.2 Health Checks Carried Out	August 2023	124.5%	100%	90%	121%	152%
KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days	August 2023	94.4%	90%	90%	94%	97%

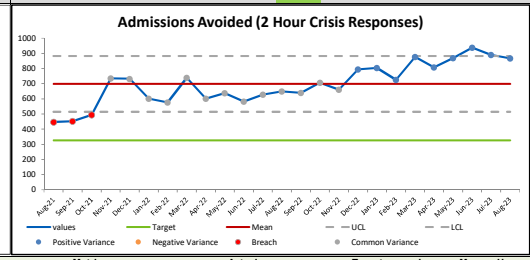


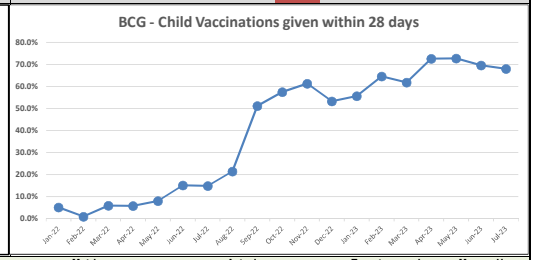




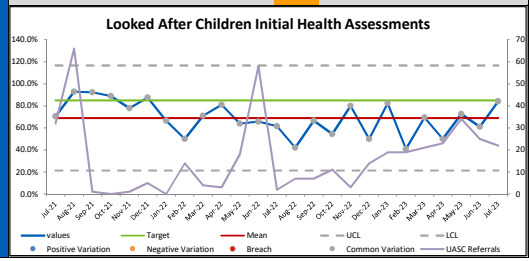
Metric	Actual		Target	Lower	Mean	Upper
KPI 1.4 (N) School Health - Year R and Year 6 Children Screened for Height and Weight	August 2023	91.6%	90% (year end)			
KPI 1.5 Admissions Avoidance (2 Hour Crisis Responses)	August 2023	866	326	514	698	882
KPI 1.6 (N) Percentage of child BCG vaccinations given within 28 days	July 2023	68.0%	95.0%			

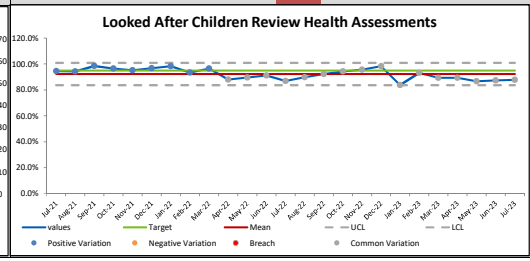


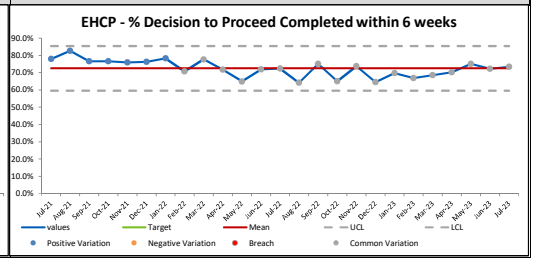




Metric	Actual		Target	Lower	Mean	Upper
KPI 1.7 (N) Looked After Children - Initial assessments completed within timescale	July 2023	84.2%	85%	21%	69%	117%
KPI 1.8 (N) Looked After Children - Review assessments completed within timescale	July 2023	87.8%	95%	84%	92%	101%
KPI 1.9 (N) Education and Health Care Plan (EHCP) - Completed within 6 weeks	July 2023	73.4%	N/A	60%	72%	85%







Kent Community Health NHS Foundation Trust - Corporate Scorecard

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

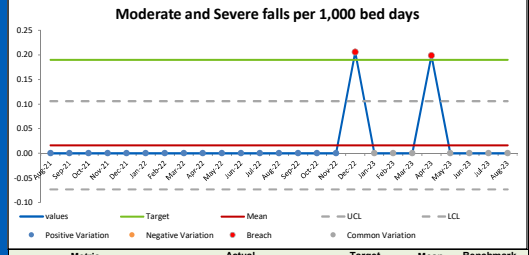
2. Deliver high-quality care at home and in the community

Metric	Actual		Target	23/24 YTD Actual	23/24 YTD Target
KPI 2.1 Number of Teams with an Amber or Red Quality Scorecard Rating	August 2023	0	1	3	12
KPI 2.4 (N) Infection Control: MRSA cases where KCHFT provided care	August 2023	0	0	0	0

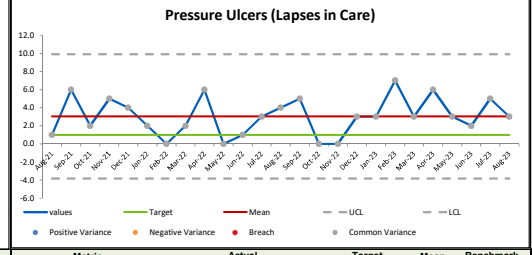
Metric	Actual		Target	23/24 YTD Actual	23/24 YTD Target
KPI 2.2 (N) Never Events	August 2023	0	0	0	0

Metric	Actual		Target	23/24 YTD Actual	23/24 YTD Target
KPI 2.3 (N) Clostridioides difficile infection (CDI) level 3 lapses in care	August 2023	0	0	0	0

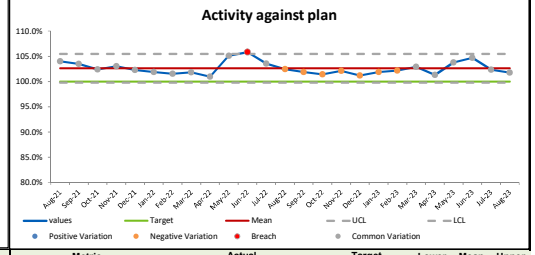
Metric	Actual		Target	Lower	Mean	Upper
KPI 2.5 Inpatient Falls (Moderate and Severe Harm) per 1000 Occupied Bed Days	August 2023	0.00	0.19	-0.07	0.02	0.11



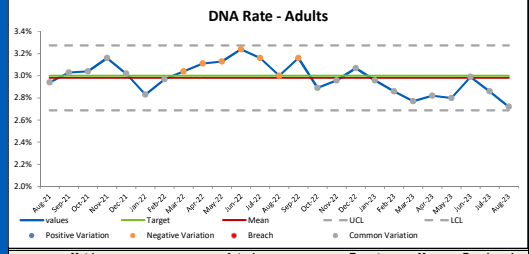
Metric	Actual		Target	Lower	Mean	Upper
KPI 2.6 Pressure Ulcers - Lapses in Care	August 2023	3	1	-3.8	3.0	9.9



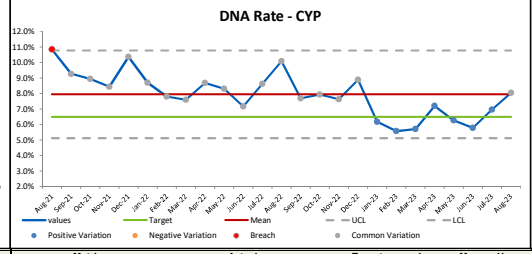
Metric	Actual		Target	Lower	Mean	Upper
KPI 2.7 Community Activity: YTD as % of YTD Plan	August 2023	101.8%	100.0%	99.8%	102.6%	105.5%



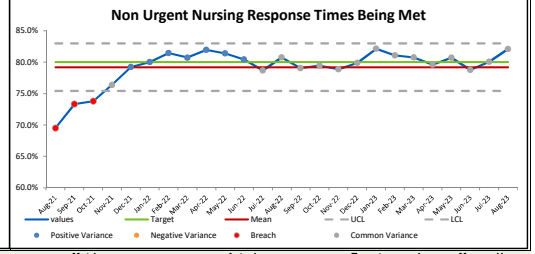
Metric	Actual		Target	Mean	Benchmark
KPI 2.8a Trustwide Did Not Attend Rate: DNAs as a % of total activity - ADULTS	August 2023	2.7%	3.0%	3.0%	3.7%



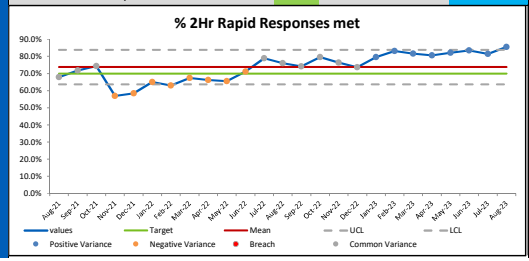
Metric	Actual		Target	Mean	Benchmark
KPI 2.8b Trustwide Did Not Attend Rate: DNAs as a % of total activity - CYP	August 2023	8.0%	6.5%	7.9%	6.9%



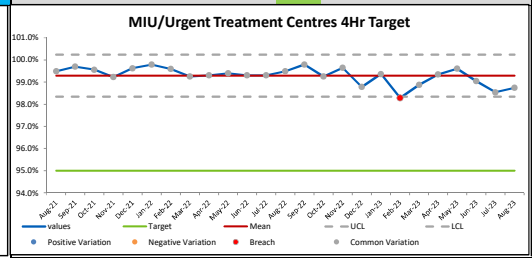
Metric	Actual		Target	Lower	Mean	Upper
KPI 2.9 Non-Urgent Response Times Met (%) (required time varies by patient)	August 2023	82.1%	80.0%	75.4%	79.2%	83.0%



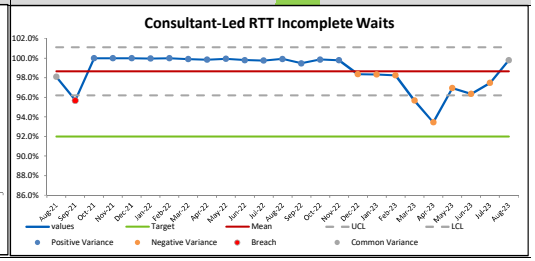
Metric	Actual		Target	Mean	Benchmark
KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance	August 2023	85.5%	70.0%	73.7%	79.1%



Metric	Actual		Target	Lower	Mean	Upper
KPI 2.11 (N) Total Time in MIUs: Less than 4 hours	August 2023	98.7%	95.0%	98.3%	99.3%	100.2%



Metric	Actual		Target	Lower	Mean	Upper
KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways	August 2023	99.8%	92.0%	96.2%	98.7%	101.1%

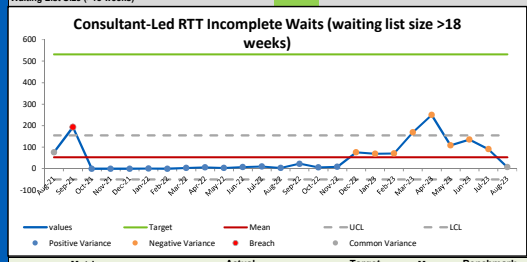


Kent Community Health NHS Foundation Trust - Corporate Scorecard

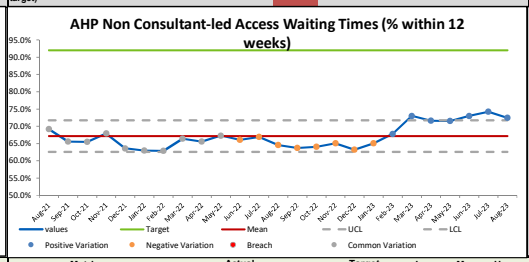
*NOTE: National Targets are denoted by (N) in the KPI name.

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

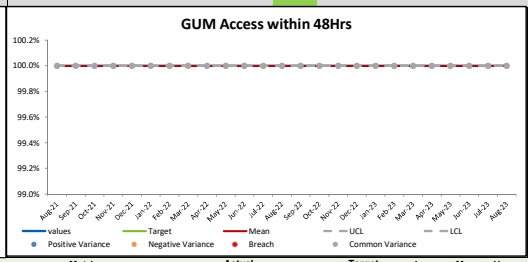
Metric	Actual	Target	Lower	Mean	Upper
KPI 2.13 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Waiting List Size (>18 weeks)	August 2023	8	532	-49	53	155



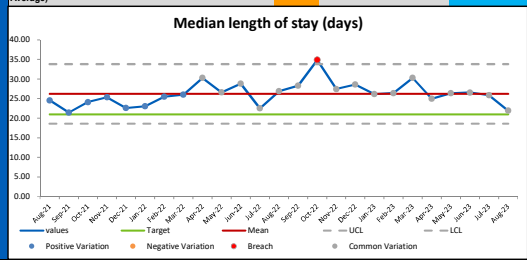
Metric	Actual	Target	Lower	Mean	Upper
KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times (12 week target)	August 2023	72.5%	92.0%	62.6%	67.2%	71.8%



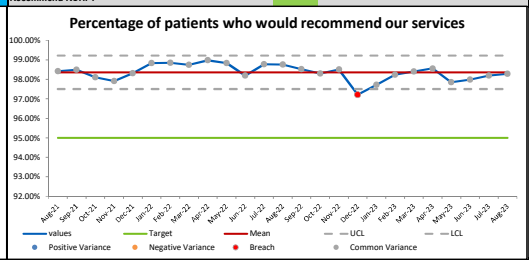
Metric	Actual	Target	Lower	Mean	Upper
KPI 2.15 (N) Access to GUM: within 48 hours	August 2023	100.0%	100.0%	100.0%	100.0%	100.0%



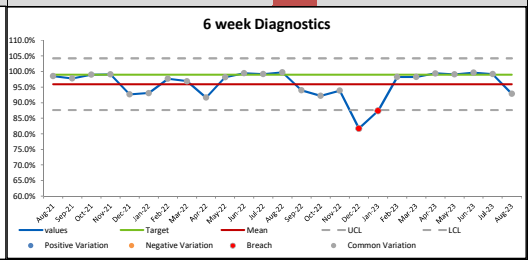
Metric	Actual	Target	Mean	Benchmark
KPI 2.16 Length of Community Hospital Inpatient Stay (Median Average)	August 2023	22.0	21.0	26.2	25.6



Metric	Actual	Target	Lower	Mean	Upper
KPI 2.17 (N) Friends and Family - Percentage of Patients who would Recommend KCHFT	August 2023	98.3%	95.0%	97.5%	98.4%	99.2%



Metric	Actual	Target	Lower	Mean	Upper
KPI 2.18 (N) 6 Week Diagnostics	August 2023	92.9%	99.0%	87.6%	95.9%	104.2%

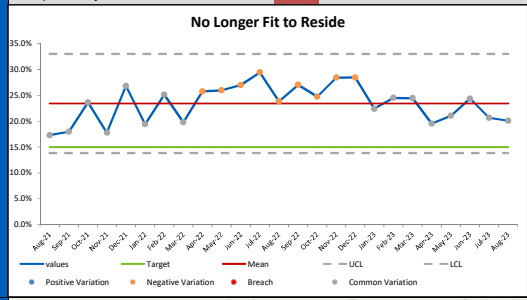


Kent Community Health NHS Foundation Trust - Corporate Scorecard

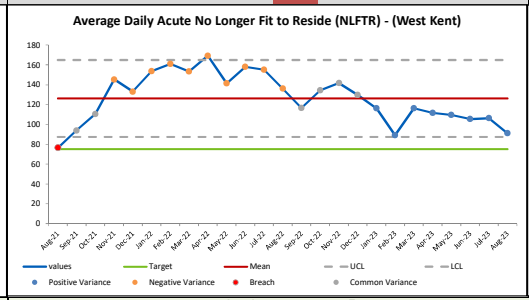
*NOTE: National Targets are denoted by (N) in the KPI name.

3. Integrate Services

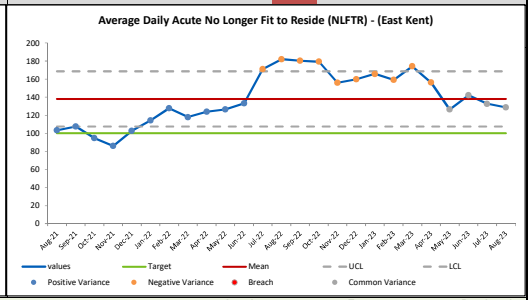
Metric	Actual		Target	Lower	Mean	Upper
KPI 3.1 No Longer Fit to Reside in a Community Hospital bed as a % of Occupied Bed Days	August 2023	20.1%	15.0%	13.8%	23.4%	33.0%



Metric	Actual		Target	Lower	Mean	Upper
KPI 3.2 Average Acute Daily No Longer Fit to Reside (NLFTR) - West Kent (Complex and Non complex)	August 2023	91	75	87	126	165

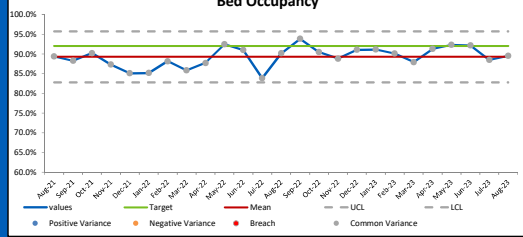


Metric	Actual		Target	Lower	Mean	Upper
KPI 3.3 Average Acute Daily No Longer Fit to Reside (NLFTR) - East Kent (Complex Only)	August 2023	129	100	107	138	169

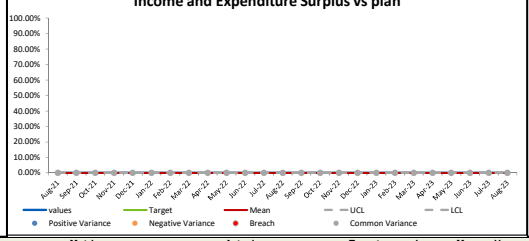


4. Develop sustainable services

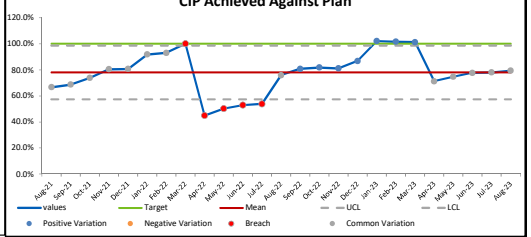
Metric	Actual		Target	Mean	Benchmark
KPI 4.1 Bed Occupancy: Occupied Bed Days as a % of available bed days	August 2023	89.5%	92.0%	89.2%	89.3%



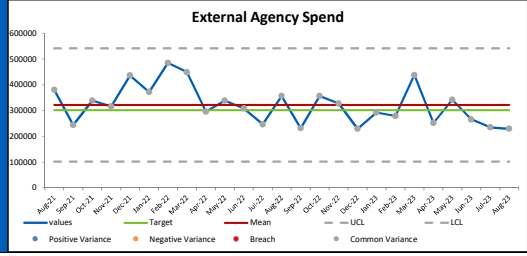
Metric	Actual		Target	Lower	Mean	Upper
KPI 4.2 Income & Expenditure - Surplus (%)	August 2023	0.0%	0.0%	0.00%	0.0%	0.0%



Metric	Actual		Target	Mean	Benchmark
KPI 4.3 Cost Improvement Plans (CIP) Achieved against Plan (%)	August 2023	79.3%	100.0%	78.0%	87.0%



Metric	Actual		Target	Lower	Mean	Upper
KPI 4.4 External Agency spend against Trajectory (£000s)	August 2023	£229,235	£301,353	£101,558	£321,669	£541,779



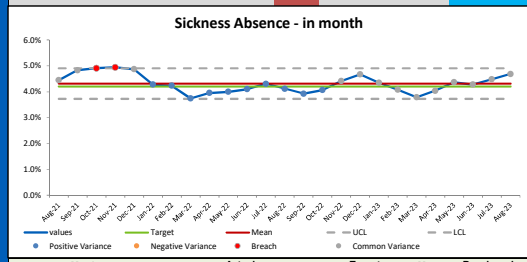
Metric	Actual	Target	Lower	Mean	Upper
KPI 4.5 Estates Statutory Compliance (All properties)	November 2022	Not Currently Available			

Kent Community Health NHS Foundation Trust - Corporate Scorecard

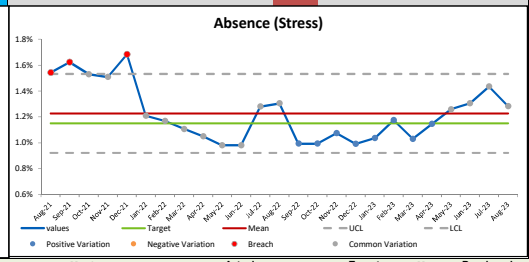
*NOTE: National Targets are denoted by (N) in the KPI name.

5. Be The Best Employer

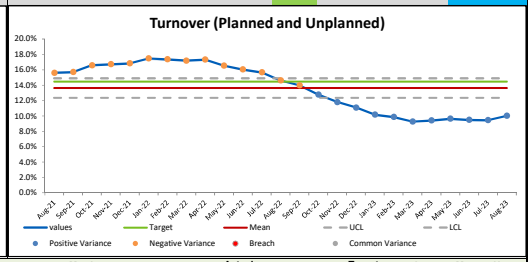
Metric	Actual		Target	Mean	Benchmark
KPI 5.1 Sickness Rate	August 2023	4.68%	4.20%	3.72%	5.29%



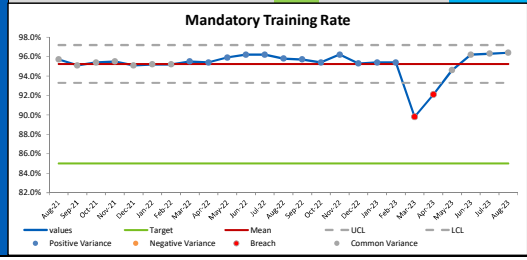
Metric	Actual		Target	Lower	Mean	Upper
KPI 5.2 Sickness Rate (Stress and Anxiety)	August 2023	1.28%	1.15%	0.92%	1.23%	1.53%



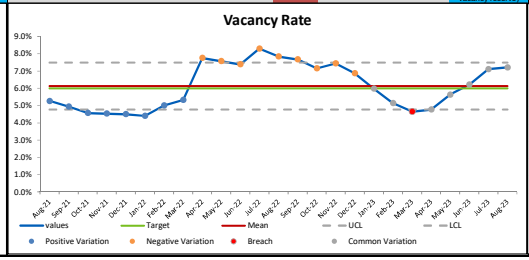
Metric	Actual		Target	Mean	Benchmark
KPI 5.3 Turnover (planned and unplanned)	August 2023	10.02%	14.47%	13.62%	11.66%



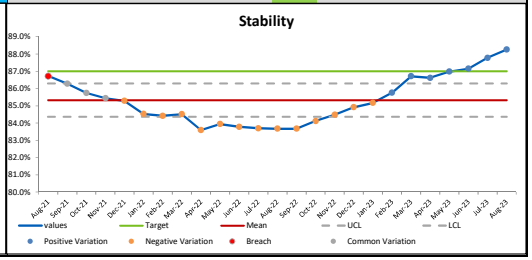
Metric	Actual		Target	Mean	Benchmark
KPI 5.4 Mandatory Training: Combined Compliance Rate	August 2023	96.4%	85.0%	93.30%	89.61%



Metric	Actual		Target	Mean	Benchmark
KPI 5.5 Gross Vacancy Factor (% of the budgeted WTE unfilled by permanent workforce)	August 2023	7.21%	6.0%	6.1%	6.95% (Reduced from 8.95% to account for 2% vacancy reserve)



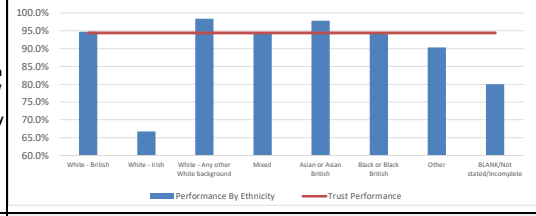
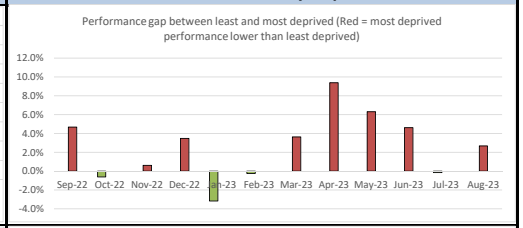
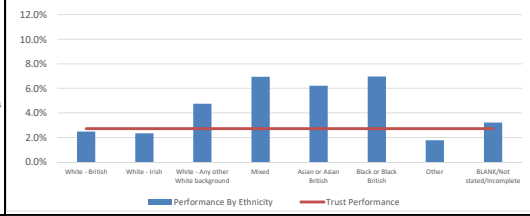
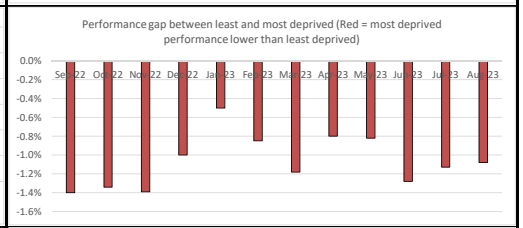
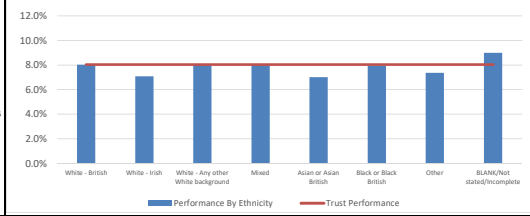
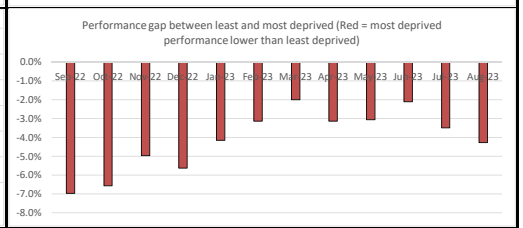
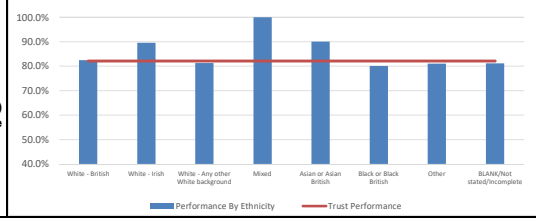
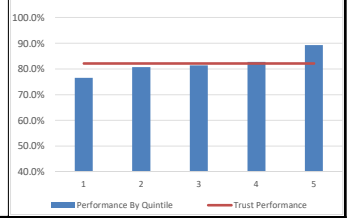
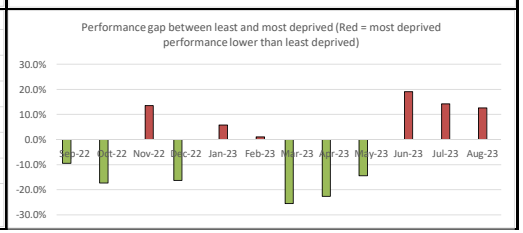
Metric	Actual		Target	Lower	Mean	Upper
KPI 5.6 Stability (% of workforce who have been with the trust for 12 months or more)	August 2023	88.3%	87.0%	84.4%	85.3%	86.3%



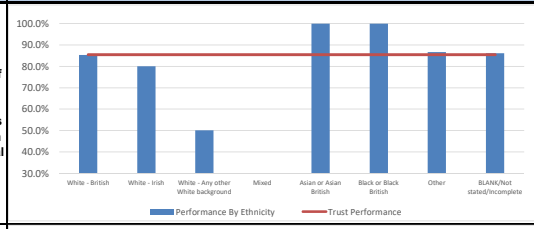
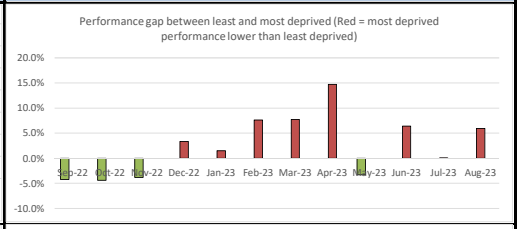
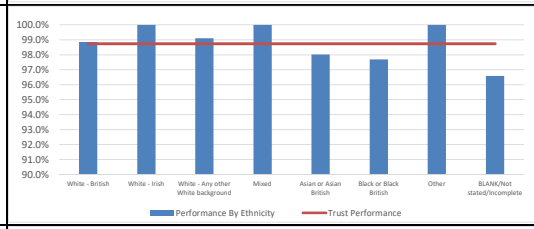
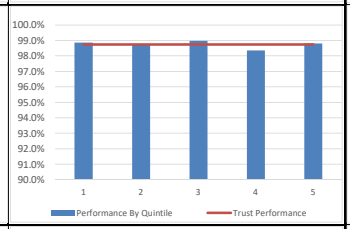
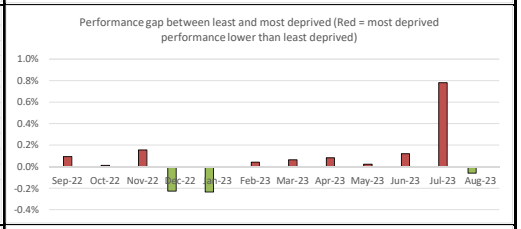
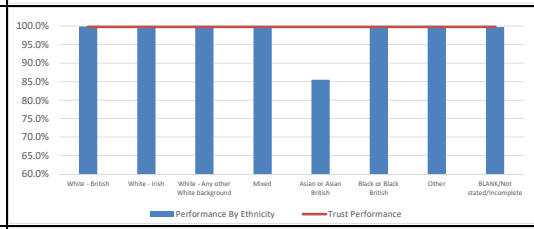
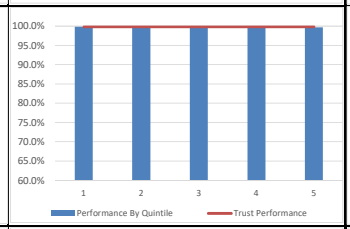
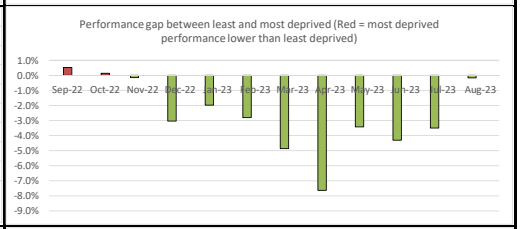
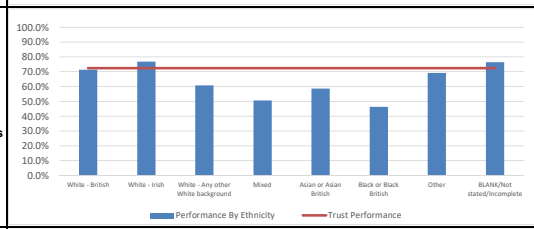
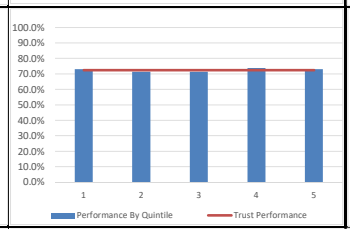
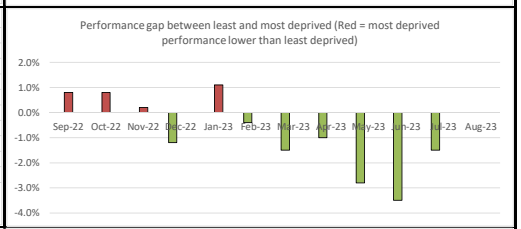
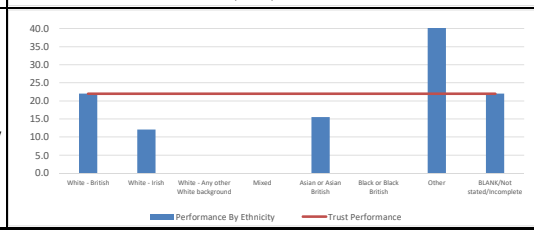
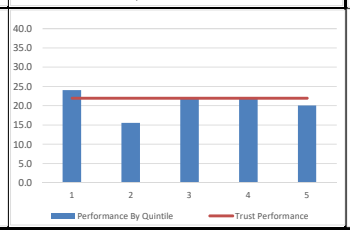
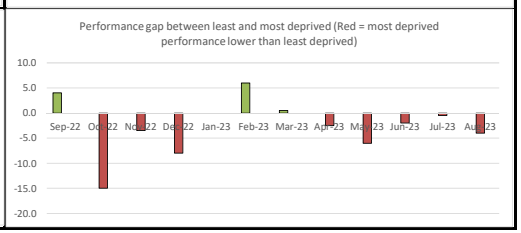
KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 5)

	KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days		KPI 2.8a Trustwide Did Not Attend Rate: DNAs as a % of total activity - Adults		KPI 2.8b Trustwide Did Not Attend Rate: DNAs as a % of total activity - CYP		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	94.4%		2.7%		8.0%		82.1%		85.5%		98.7%		99.8%		72.5%		22.0	
Target	90%		3%		3%		80%		70%		95%		92%		92%		21.0	
Performance by Ethnicity																		
	%	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**Days**	**No.**
White - British	94.7%	887	2.5%	83228	8.0%	107623	82.4%	1742	85.2%	473	98.9%	13070	99.8%	2373	71.2%	7075	22.0	133
White - Irish	66.7%	3	2.3%	906	7.1%	991	89.5%	19	80.0%	5	100.0%	20	100.0%	1287	76.7%	8560	12.0	2
White - Any other White background	98.4%	122	4.7%	1476	8.0%	3477	81.3%	16	50.0%	4	99.1%	445	100.0%	5	60.8%	60	N/A	0
Mixed	94.4%	91	6.9%	447	8.1%	2145	100.0%	4	N/A	0	100.0%	103	100.0%	16	50.5%	275	N/A	0
Asian or Asian British	97.8%	91	6.2%	969	7.0%	2353	90.0%	20	100.0%	3	98.0%	656	85.5%	47	58.6%	259	15.5	2
Black or Black British	94.4%	71	7.0%	345	8.0%	1527	80.0%	5	100.0%	1	97.7%	390	100.0%	17	46.2%	238	N/A	0
Other	90.3%	31	1.8%	3045	7.4%	3575	81.0%	58	86.7%	15	100.0%	28	100.0%	15	69.0%	168	112.0	1
BLANK/Not stated/Incomplete	80.0%	60	3.2%	34793	9.0%	41931	81.1%	900	86.1%	345	96.6%	439	99.7%	2497	76.3%	7653	22.0	38
% Completeness	**95.6%**	**1356**	**72.2%**	**125209**	**74.4%**	**163622**	**67.4%**	**2764**	**59.2%**	**846**	**97.1%**	**15151**	**60.1%**	**6257**	**68.5%**	**24288**	**78.4%**	**176**
Performance by Deprivation Quintile																		
	%	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**Days**	**No.**
Quintile 1 - Most Deprived	92.6%	255	3.4%	20643	10.4%	8881	76.5%	413	80.8%	73	98.9%	2541	99.8%	613	72.9%	2637	24.0	25
Quintile 2	94.2%	259	2.8%	24527	7.8%	8424	80.7%	481	84.4%	122	98.7%	3323	100.0%	785	71.3%	3350	15.5	26
Quintile 3	95.2%	371	2.7%	31095	8.1%	10466	81.4%	697	86.0%	200	99.0%	3608	99.6%	933	71.3%	4269	22.0	36
Quintile 4	94.9%	253	2.6%	30598	7.3%	7787	82.7%	693	85.7%	216	98.4%	2977	99.9%	841	73.7%	3888	22.0	43
Quintile 5 - Least Deprived	95.2%	188	2.3%	21409	6.1%	5254	89.2%	470	86.8%	234	98.8%	1751	99.7%	600	72.9%	3066	20.0	45

KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 5)

KPI	M5 Performance By Ethnicity	M5 Performance by Deprivation Quintile	Last 12 months Performance by Deprivation Quintile
KPI 1.3 Health Visiting - New Birth Visits Undertaken by 14 days			
KPI 2.8a Trustwide Did Not Attend Rate: DNAs as a % of total activity - ADULTS			
KPI 2.8b Trustwide Did Not Attend Rate: DNAs as a % of total activity - CYP			
KPI 2.9 LTC/ICT Response Times Met (%) (required time varies by patient)			

KCHFT Equality Monitoring - Performance by Ethnicity and Deprivation (Month 5)

KPI	M5 Performance By Ethnicity	M5 Performance by Deprivation Quintile	Last 12 months Performance by Deprivation Quintile
KPI 2.10 (N) Percentage of Rapid Response Consultations started within 2hrs of referral acceptance			
KPI 2.11 (N) Total Time in UTCs: Less than 4 hours			
KPI 2.12 (N) Consultant Led 18 Week Referral to Treatment (RTT) - Incomplete Pathways			
KPI 2.14 AHP (Non-Consultant Led) Access Waiting Times (12 week target)			
KPI 2.16 Length of Community Hospital Inpatient Stay (Median Average)			

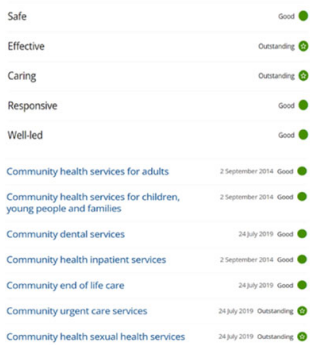
Kent Community Health
NHS Foundation Trust

Integrated Performance Report

2023/24 Month 5 report

October 2023

Overall CQC Rating – Outstanding (July 2019)



Safe		Good
Effective		Outstanding
Caring		Outstanding
Responsive		Good
Well-led		Good
Community health services for adults	2 September 2014	Good
Community health services for children, young people and families	2 September 2014	Good
Community dental services	24 July 2019	Good
Community health inpatient services	2 September 2014	Good
Community end of life care	24 July 2019	Good
Community urgent care services	24 July 2019	Outstanding
Community health sexual health services	24 July 2019	Outstanding

we care

Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPI 1.1 - Stop Smoking Quits

In Month 4 The service recorded 481 quit dates and achieved 250 quits (53.6% success rate) with 15 outstanding outcomes, Total service recorded quits to date (month 1-4) is 889 currently we are just under our trajectory target of 1000 quits by end of month 4 (however, crude trajectory of 250 per month does not take into account ebbs and flows in activity during quieter summer months). The service is confident that with staffing issues resolved in our CAT team, temporary increases in our core smoke free team and streamlining the referral process that the service will get even closer to the KPI as the year progresses.

KPI 1.6 - BCG Vaccinations (95% Target)

For Month 4, 70% of eligible babies were vaccinated within timeframe in North Kent. There were 112 babies eligible for BCG vaccination of which 78 were vaccinated within timeframe and 12 vaccinated outside of timeframe. The reasons for vaccination outside of timeframe includes, 13 declined vaccination, 5 postponed by parents, 4 late referrals, and x3 lack of clinic capacity. This data reflects a 80.4% uptake.

66% of babies born in Month 4 were vaccinated within timeframe within East Kent. There were 82 babies eligible for BCG vaccination of which 54 babies were vaccinated within 28 days and 11 babies were vaccinated outside of timeframe. The reasons for vaccination outside of timeframe includes lack of clinic capacity, parent postponement, late referrals, premature and still in hospital. This data reflects a 79.3% uptake.

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Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPIs 1.7 & 1.8 – Looked After Children (LAC)

Health services have a statutory responsibility and target to complete 85% Initial Health Assessment (IHA) and circulate the report to the responsible officer within 28 days from date of the child becoming looked after. Compliance with the 28 day target, excluding Unaccompanied Asylum Seeking Children (USAC) has improved and was 84.2% There were no breaches attributable to KCHFT.

Unaccompanied Asylum Seeker Children (UASC)

No referrals for UASC children were received within 5 working days meaning compliance with the 28 day target was reported at 48%. Compliance with the internal target of the report being circulated with in 23 days was reported at 100%.

There has been a high court ruling that confirms that all USAC children will come under the care of KCC whilst in Kent and all require an IHA, even if they are on the national dispersal scheme. KCC is struggling to process the new arrivals, and we are awaiting the final numbers that will require an IHA from KCC.

The ICB are fully aware of the impact of the High Court judgement and while they have indicated that they will expect the performance for initial health assessment compliance to deteriorate during this time, there are no plans to support compliance or how we manage the additional demand.

Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPI 1.9 – Education and Health Care Plans (EHCP)

Statutory health services are required to provide advice / complete assessment within six-weeks from date of notification by local authority to proceed with an EHCP assessment. Demand for EHCPs continues to be high and this is resulting in KCHFT not meeting this timeframe with current resources but continues to maintain overall compliance at 73%. Greater compliance at the 20 weeks response time when the report goes to a panel is reported at 89%.

The ICB is leading system meetings to address the actions from the SEND review and improve parental confidence in the process. KCHFT has an internal action plan that feeds into the system accelerated action plan. The system accelerated action plan has been published and is available on KCC website.

Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPI 2.14 – 12 Week Access Waits (92% Target)

Community Paediatrics and Adult Neurodevelopmental service (Adult Neurodevelopmental service is excluded from the overall figure for this metric) continue to have challenges with meeting the level of referral demand and are adversely impacting on the overall performance within specialist services.

Community Paediatrics backlog of initial assessments is due to an increase in referrals during Covid-19 pandemic combined with a reduction in medical capacity with a resulting 12 week RTA compliance of 23.7%.

A test for change nurse-led pilot commenced in August-23 and will run for a period of 3 months. Since the pilot commenced in August, the number of children on the initial pathway has decreased from 3,416 to 3,325. The pilot has increased capacity by 100 slots per month for initial assessments and it is anticipated by October no children will be waiting over 65 weeks and by January 2024 no children will be sitting above 52 weeks. However during this period there will be no improvement in the RTA and it may continue on a downward trajectory.

Comparing the service's activity 1st August -31st January 2019/20 vs 2022/23 showed a 11.5% reduction, the main impact being 4 WTE medical vacancies. Activity continues to be reviewed alongside the impact of increased capacity from job planning the nurses, which has increased their capacity by 2 in the majority of clinics. In August, the service's activity was 220 higher than August last year. The position is expected to improve further with the new staff coming into post in September/October.

Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPI 2.18 – 6 Week Diagnostics DM01 (92% Target)

Audiology service has a requirement for 99% of children to receive a diagnostic assessment within six weeks of referral into the service (DMO1 National Submission). This is a challenging target as it only takes a very small number of breaches depending on the number of referrals to dip below the KPI target.

There have been some challenges with Audiology staff capacity in August with a number of staff on annualised hours and 3 on maternity leave which reduced capacity. Therefore the service did not meet DM01 in August and it is reported at 92.87%. All babies have been prioritised. The capacity will improve in September and compliance should be above 97%.

NHSE has written to the ICB as a review of trusts has been undertaken who have diagnosed significantly fewer babies with a permanent childhood hearing impairment (PCHI) than expected following initial hearing screening assessment.

Recognising the system wide nature of the issues identified, a National Paediatric Hearing Improvement Programme has been established by NHS England to support providers and ICBs to improve the quality of these services. The programme is undertaking work to understand the scale of the problem and the number of children who have been affected, and to develop the strategic tools and interventions to support sustainable improvements. An assessment template has been developed which KCHFT is completing and providing evidence of compliance against the criteria. This has been submitted on 4th October.

Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPI 3.1 – No Longer Fit To Reside (15% Target)

Performance has decreased slightly to 20.1% for month 5, continuing to be in normal variation and above the 15% target.
An increased level from April 2022, primarily caused by issues within the domiciliary care sector and ability to discharge patients home with a care package in a timely manner continues to be an issue, although increased capacity (escalation beds) within KCHFT and additional funding into social care increasing capacity are aiding flow.

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Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

KPI 4.3 – Cost Improvement Programme (CIP)

The Trust achieved CIPs of £4,769k to the end of August against a plan of £6,016k which is £1,247k (20.7%) behind target. The forecast is for the target of £14,439k to be achieved in full.

KPIs 5.1 (Sickness Absence) and 5.2 Sickness – Stress

Sickness absence has increased over the previous 4 months to 0.24% above the target and the highest rate reported since December 2022. Absence for males within the organisation has had a steady increase since March 2023, and is reporting its highest absence rate over the last 2 years at 4.54%.

From March 2023 to July 2023 stress related absence reported an upward trend which reached its peak at 1.44%. August has reported a reduction in stress related absence at 1.28%, remaining 0.13% above the target

KPI 5.5 Vacancy Rate

Contracted WTE was unchanged remaining at 4,529 in post in August which includes 17 posts funded by capital projects. Vacancies increased to 352 in August (from 346 in July) which was 7.2% of the budgeted establishment. Budgeted establishment increased by 6 WTE from July.

Operational Performance Highlights and Exceptions

Kent Community Health NHS Foundation Trust

Additional Highlight Areas

ASD Waits

KCHFT has 2,647 children waiting list for ASD diagnostic assessment. The longest wait for diagnosis has increased and is reported at 3.5 years. The diagnostic conversion rate averages 80% - 85%.

There is an understanding both nationally and across the Kent and Medway System of the demand challenges for services. Reduction of the ASD waiting times is a key aim of the SEND review. In response, the ICB has developed a neurodevelopmental services plan.

KCHFT is working in collaboration with NELFT and KMPT, supported by mutual ventures: Working up a proposal to address current waiting list which has included waiting list validation (which is now complete), and waiting list stratification using same screening criteria.

An ICB led workshop held on 11 September – proposing a new model. A frame work has been agreed and the detail is being worked up in collaboration with the ICB and all the providers in Kent and Medway. A Senior responsible officer has been identified for each element of the framework to drive system working

EDI Dashboard

Kent Community Health NHS Foundation Trust

The EDI Dashboard is provided to support the ambitions of the Nobody Left Behind Project.
Explanations of the graphs are as follows:

BAME Ethnicity: This compares the current proportion of BAME staff at KCHFT to the BAME population in the South East from the 2021 Census
BAME Representation: This compares the proportion of BAME staff in specific areas of the trust (Clinical, Non-Clinical and in Band 8c+) over time, to the BAME population in the South East from the 2021 Census
Ethnicity Disparity Ratio (split by Clinical and Non-Clinical): This shows the difference in proportion of BAME staff at various AfC bands in the trust compared to proportion of white staff at those bands. A ratio of '1' reflects parity of progression, and values higher than '1' reflect inequality, with a disadvantage for BAME staff.
Ethnicity Appointment from Shortlisting Ratio: This shows the relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants. A figure above '1' indicates that white candidates are more likely than BAME candidates to be appointed from shortlisting.
Ethnicity Formal Disciplinary Ratio: This shows the relative likelihood of BAME staff entering the formal disciplinary process compared to white staff. A figure above 1' indicates that BAME staff members are more likely than white staff to enter the formal disciplinary process.
Disability Status: This compares the current proportion of Disabled staff at KCHFT to the Disabled population in the South East from the 2021 Census
Disability Representation: : This compares the proportion of Disabled staff in specific areas of the Trust (Clinical and Non-Clinical) over time, to the Disabled population in the South East from the 2021 Census
Sex: This compares the current proportion of staff by sex at KCHFT to the sex profile in the South East from the 2021 Census
LGBO Sexual Orientation: This compares the current proportion of staff by sex at KCHFT to the sex profile in the South East from the 2021 Census
Age: This compares the current proportion of staff by age at KCHFT to the age profile of the working age population in the South East from the 2021 Census

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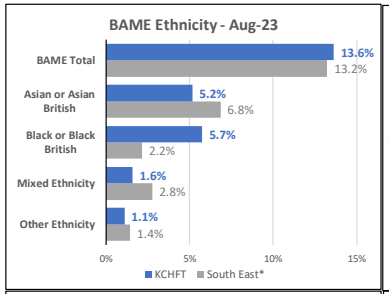
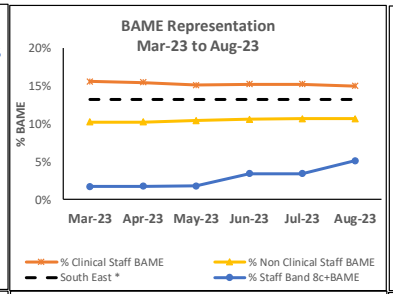
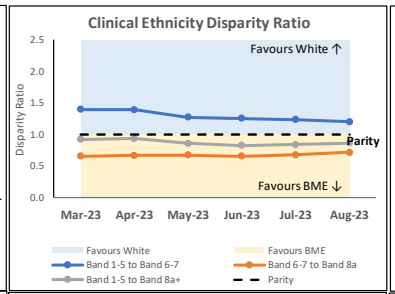
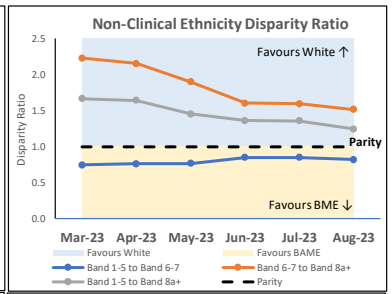
EDI Dashboard

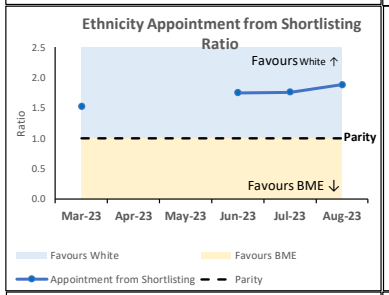
Kent Community Health
NHS Foundation Trust

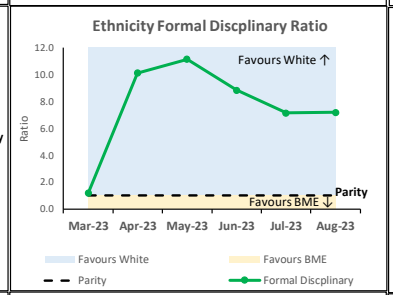


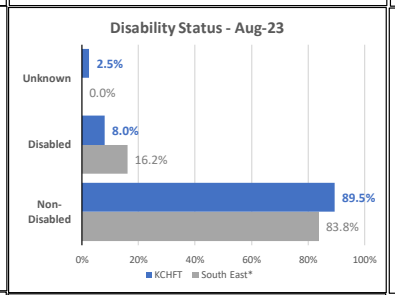


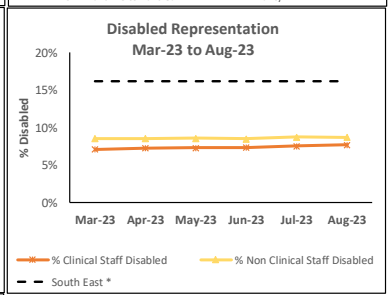


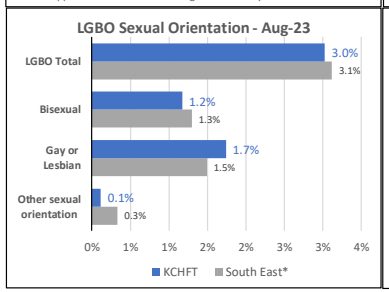


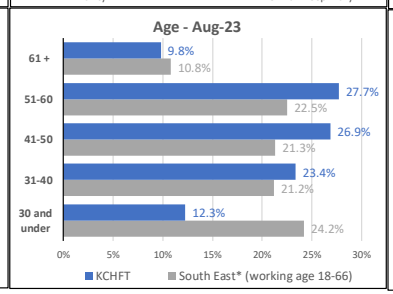


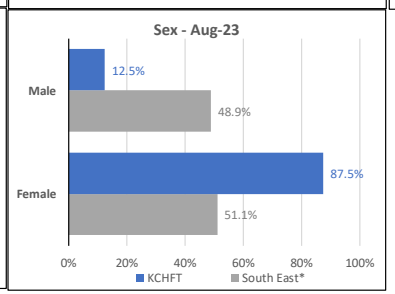












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EDI Dashboard

Kent Community Health NHS Foundation Trust

*** 2021 Census - NHS England Region South East**

ETHNICITY		Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Trend	Notes
Relative likelihood of White staff compared to BAME staff being		1.52			1.75	1.76	1.88	↑	Data for Apr-23 and May-23 not
Relative likelihood of BAME staff entering the formal discplinary		1.18	10.11	11.14	8.83	7.14	7.19	↑	
Trust	% of Staff who are BAME	13.9%	13.8%	13.6%	13.7%	13.7%	13.6%	↓	
	% of Staff who are BAME and Band 8a+	13.1%	12.9%	13.4%	14.0%	13.8%	13.5%	↓	
	% of Staff who are BAME and Band 8c, 8d, 9 & VSM	1.7%	1.7%	1.8%	3.4%	3.4%	5.1%	↑	
Clinical	% of Staff who are BAME	**15.6%**	**15.5%**	**15.1%**	**15.2%**	**15.2%**	**15.0%**	↓	
	% of Staff who are BAME and Band 8a+	**17.6%**	**17.1%**	**17.3%**	**17.8%**	**17.5%**	**16.8%**	↓	
	Disparity Ratio: Band 1-5 to Band 6-7	1.40	1.39	1.27	1.26	1.24	1.20	↓	
	Disparity Ratio: Band 6-7 to Band 8a+	0.66	0.67	0.68	0.66	0.68	0.72	↑	
	Disparity Ratio: Band 1-5 to Band 8a+	0.92	0.94	0.86	0.83	0.84	0.87	↑	
Non Clinical	% of Staff who are BAME	**10.2%**	**10.2%**	**10.4%**	**10.6%**	**10.6%**	**10.6%**	-	
	% of Staff who are BAME and Band 8a+	**6.5%**	**6.6%**	**7.4%**	**8.1%**	**8.2%**	**8.8%**	↑	
	Disparity Ratio: Band 1-5 to Band 6-7	0.75	0.76	0.77	0.85	0.85	0.82	↓	
	Disparity Ratio: Band 6-7 to Band 8a+	2.23	2.15	1.90	1.60	1.60	1.52	↓	
	Disparity Ratio: Band 1-5 to Band 8a+	1.67	1.64	1.46	1.36	1.36	1.25	↓	
DISABILITY		**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Trend**	**Notes**
Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting		1.04			0.94	0.98	0.97	↓	Data for Apr-23 and May-23 not available
Trust	% of Staff who are Disabled	7.6%	7.7%	7.7%	7.7%	7.9%	8.0%	↑	
	% of Staff who are Disabled and Band 8a+	6.1%	5.8%	5.2%	4.9%	4.8%	4.8%	-	
Clinical	% of Staff who are Disabled	7.1%	7.2%	7.3%	7.4%	7.5%	7.7%	↑	
	% of Staff who are Disabled and Band 8a+	5.9%	5.9%	5.4%	4.9%	4.8%	4.9%	↑	
Non Clinical	% of Staff who are Disabled	8.5%	8.6%	8.6%	8.5%	8.7%	8.7%	-	
	% of Staff who are Disabled and Band 8a+	6.5%	5.7%	5.0%	4.9%	4.9%	4.8%	↓	
SEXUAL ORIENTATION		**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Trend**	**Notes**
Trust	% LGBO	2.9%	2.9%	2.9%	2.9%	3.0%	3.0%	-	
	% LGBO Band 8a+	4.5%	4.5%	4.2%	4.2%	4.2%	4.5%	↑	
Clinical	% LGBO	2.9%	3.0%	2.9%	2.9%	3.1%	3.1%	-	
	% LGBO Band 8a+	3.7%	3.7%	3.2%	3.2%	3.2%	3.2%	-	
Non Clinical	% LGBO	2.9%	2.9%	2.9%	2.9%	2.8%	2.9%	↑	
	% LGBO Band 8a+	5.6%	5.7%	5.8%	5.7%	5.7%	6.4%	↑	
AGE		**Mar-23**	**Apr-23**	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Trend**	**Notes**
Clinical	Under 30	12.3%	12.1%	11.6%	11.5%	11.5%	11.6%	↑	
	31-40	25.5%	25.6%	25.7%	25.7%	25.8%	25.7%	↓	
	41-50	28.7%	28.9%	29.0%	29.0%	28.8%	28.8%	-	
	51-60	26.3%	26.3%	26.6%	26.5%	26.6%	26.4%	↓	
	61+	7.1%	7.1%	7.1%	7.2%	7.4%	7.5%	↑	
Non Clinical	Under 30	13.4%	13.4%	13.3%	13.3%	13.2%	13.6%	↑	
	31-40	19.3%	19.5%	19.1%	18.8%	18.7%	18.4%	↓	
	41-50	22.5%	22.4%	22.3%	22.6%	22.8%	22.6%	↓	
	51-60	30.2%	30.2%	30.7%	30.6%	30.6%	30.6%	-	
	61+	14.5%	14.4%	14.5%	14.7%	14.6%	14.8%	↑	

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Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 10
Report title:	Audit and Risk Committee Chair's Assurance Report
Executive sponsor(s):	Gordon Flack, Chief Finance Officer Mercy Kusotera, Director of Governance
Report author(s):	Peter Conway, Non-Executive Director
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary
The reports summarise the Audit and Risk Committee meeting held on 31 August 2023.

Report history / meetings this item has been considered at and outcome
Not applicable

Recommendation(s)
The Board is asked to • **RECEIVE** the Audit and Risk Committee Chair's Assurance Report and note the assurances that effective systems of control are in place.

Link to CQC domain				
☑**Safe**	☑**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☐
Better patient experience	☐
A great place to work	☐
Sustainable care	☑

Implications	
Risk and assurance	Yes. See Risk Management and Internal Controls – Auditors and Trust

Is the risk included on the Corporate Risk Register or Directorate risk register?	**☑BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	Yes. See Internal Controls - Auditors		
Patients / carers / public / staff / health inequalities	No		
Legal and regulatory	Yes. See Internal Controls – Trust and Governance		
Quality	No		
Financial	Yes. See Financial Controls		

Executive lead sign off	
Name and post title:	Gordon Flack, Chief Finance Officer
Date:	31 August 2023

Kent Community Health
NHS Foundation Trust

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

This report is founded on the Audit and Risk Committee meeting held on 31 August 2023.

Area	Assurance	Items for Board's consideration and/or next steps
Risk Management	Limited Assurance	Improvements made to the Board Assurance Framework (BAF), Corporate Risk Register (CRR) and Risk Management Framework. The Committee supported the proposed replacement of the Corporate Assurance and Risk Management Group (CARM), Patient Safety and Clinical Risk Group (PSCRG) and Clinical Effectiveness Group (CEG) with a new Integrated Governance and Risk Management Group (IGRM) but with concerns regarding the potential size and scope of the new committee. Various ideas were suggested to further improve risk management, while reducing the trust's tendency to over-assure (per The Good Governance Institute (GGI) observation). Overall, positive progress and direction of travel.
Financial Reporting		Grant Thornton, external auditors, not in attendance and nothing to report.

Area	Assurance	Items for Board's consideration and/or next steps
		Kent and Medway Integrated Care System (K & M ICS) M4 financial position £20mA to Plan (£31m deficit ytd). The ICS's performance benchmarks to mid-table nationally.
Financial Controls	Reasonable Assurance	Single tender waivers, retrospective requisitions and losses and special payments controls all operating effectively.
(1) Internal Controls - Auditors	Reasonable Assurance	1) TIAA Progress Report and Annual Plan 2023/24: 2x substantial assurance reports (Serious Incidents and Patient Safety Framework, Data Security and Protection Toolkit), 2x reasonable assurance reports (ICT Infrastructure Review and Assurance Framework and Risk Management) and 1x limited assurance report (Equality Impact Assessment (EqIA) Processes). The Committee will follow up on the specific recommendations of this audit and recommends that the Board is briefed on what constitutes a good EqIA and what assurances it provides. The TIAA Audit Plan was agreed but will be subject to further changes regarding scopes of the risk management and Estates audits plus possible inclusion of continence assessments processes/outcomes. 2)Counter Fraud Progress Report and Annual Plan 2023/24: Noted and agreed.
(2) Internal Controls - Trust	Reasonable Assurance	1)Corporate Assurance and Risk Management; Group (CARM) Report - Future reporting on high value claims to include trust learnings and actions being taken. 2)Legal Report - Follow up report analysing claims data - Dental Services appears a national outlier so further analysis requested.

Area	Assurance	Items for Board's consideration and/or next steps
		3)Cyber Security – 6-month review. For confidentiality reasons, I will cover this verbally as required. 4)Data Integrity Annual Report - continuing improvements from an already good position.
Risk Deep Dive		Not undertaken as time spent on considering the new risk registers and Risk Management Framework.
Governance	Reasonable Assurance	Self-certification of NHS Provider Licence and Use of Trust Seal annual reports - both satisfactory.

Peter Conway
Chair, Audit and Risk Committee
31 August 2023

Kent Community Health NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 11
Report title:	Finance, Business and Investment Committee Chair's Assurance Report
Executive sponsor(s):	Gordon Flack, Chief Finance Officer
Report author(s):	Paul Butler, Non-Executive Director
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary
The reports summarise the Finance, Business and Investment Committee meeting held on 26 July 2023.

Report history / meetings this item has been considered at and outcome
Not applicable

Recommendation(s)
The Board is asked to • **RECEIVE** the Finance, Business and Investment Committee Chair's Assurance Report.

Link to CQC domain				
☐**Safe**	☑**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☐
Better patient experience	☑
A great place to work	☐
Sustainable care	☑

Implications	
Risk and assurance	Yes

Is the risk included on the Corporate Risk Register or Directorate risk register?	**☑BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	Yes		
Legal and regulatory	Yes		
Quality	No		
Financial	Yes		

Executive lead sign off	
Name and post title:	Gordon Flack, Chief Finance Officer
Date:	29 September 2023

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 26 July 2023.

Issue	Committee review and assurance	Matters for Board awareness and/or action
Kent and Medway system financial position (3/12)	The Chief Finance Officer gave the Committee an update on the system's Q1 financial position, reporting a deficit £11m adverse to plan - £6m of which is a ytd shortfall in the efficiency programme. The Committee discussed the implications for the system and the trust for a continuation/increase in deficit as the year progresses.	Board should continue to be updated on current system financial performance and implications of shortfall
Finance and pay controls	The Chief Finance Officer presented a paper on the additional controls which had been introduced to meet the requirements of the extra finance and pay controls recently requested by NHS England	
Business development and	The Committee received the report. Post meeting note: With regards to the Medway Sexual Health Service contract, the Trust has agreed to continue	

service improvement item	with the service in discussion with the commissioner after the halting of the tender process as per the letter received from Medway Council's Strategic Head of Public Health.	
Edenbridge Memorial Health Centre project update	The Committee was given an updated on the financial forecast for the project. It was noted that the clinical model would be submitted to Quality Committee for review.	
Finance report including service line and cost improvement programme (3/12)	The latest report was presented and noted.	
HFMA self-assessment action plan	An update on progress against the HFMA self-assessment was presented and noted by the Committee.	
Treasury management policy and compliance review	The treasury management compliance review and policy were presented to the Committee. The Committee **APPROVED** the Treasury Management policy.	

Procurement Policy	The revised Procurement Policy was presented to the Committee. A timing issue necessitated its presentation and approval by the Executive the subsequent week. The Committee **APPROVED** the policy, **SUBJECT TO** approval, as is, by the Executive.	
Committee effectiveness review	It was noted that some additional time was required of the Committee to further discuss Committee effectiveness and any actions required.	

Paul Butler
Chair; Finance, Business and Investment Committee
29 September 2023

Kent Community Health NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 12
Report title:	People Committee Chair's Assurance Report
Executive sponsor(s):	Victoria Robinson-Collins, Chief People Officer
Report author(s):	Kim Lowe, Non-Executive Director
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary
The reports summarise the People Committee meeting held on 29 August 2023.

Report history / meetings this item has been considered at and outcome
Not applicable

Recommendation(s)
The Board is asked to • **RECEIVE** the People Committee Chair's Assurance Report.

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☐
Better patient experience	☑
A great place to work	☑
Sustainable care	☐

Implications			
Risk and assurance	Yes		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☑BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	Yes		

Patients / carers / public / staff / health inequalities	Yes
Legal and regulatory	No
Quality	No
Financial	No

Executive lead sign off	
Name and post title:	Victoria Robinson-Collins, Chief People Officer
Date:	7 September 2023

Kent Community Health NHS Foundation Trust

STRATEGIC WORKFORCE COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the People Committee meeting held on 29 August 2023.

Agenda items
• Focus items – updates on legislation/regulations/national changes and impacts including the Fit and Proper Person Test framework (FPPT) and the trial of Lucy Letby • Update on industrial action • Community Nursing demand and capacity programme • Edenbridge Memorial Health Centre Project Update • Nobody Left Behind Engagement and action plan • People and Organisational Development (OD) Directorate Priorities 2023/24 Update • Workforce Performance Report including Board Assurance Framework assurance • Appraisal Update • Talent management • Recruitment timelines • Recruitment and Retention Report • NHS Staff Survey Communication Plan

Agenda item	Assurance and key points to note	Further actions and follow up
NHS England Fit and Proper Person Test (FPPT) Framework	The Committee was notified of the regulatory changes that are being brought in from 1 September 2023 in relation to the Fit and Proper Person Test for board members. The full Board was notified of the changes at its meeting in September.	Paper will to go to the full Trust Board to discuss and agree any relevant actions.
Edenbridge Memorial Health Centre Project Update	With the move to a new clinical model at the site, the Committee received assurance that the impact on staffing was in hand. Staff engagement and mitigations are in place.	Committee sought to ensure that clear ownership was defined, as this is the first true collaborative site and welcomed updates when the site goes live. ACTION - Update in six Months
Nobody Left Behind Engagement and Action Plan	A huge amount of work has been undertaken since October 2022. The various elements are being drawn together into a final set of actions. These are far-reaching across the organisation and the Committee recognised that some will take a number of years to deliver, although there are a number of early quick wins. The Committee also envisages that there will be a long programme of culture change which will need a significant commitment from the trust in terms of values, finance and resource. In order to make these gains, it will require a whole Board commitment and ownership of the Nobody Left Behind Engagement and Action Plan.	Substantial assurance on the work that has gone in to create the action plan. Co-created with the wider workforce and networks. Many actions already in train. A request to ensure we prioritise, timeline and cross reference to ensure these actions are owned and delivered. Some will be longer term and Committee requested that communications be open

Agenda item	Assurance and key points to note	Further actions and follow up
	The Committee also received the trust's Workforce Sexual Orientation Equality Standard (WSOES) Report 2023. This is a new report and aims to mirror similar reports for the Workforce Race Equality Standard and the Workforce Disability Equality Standard. The trust is one of a very small number of trusts to lead the way in developing such a standard.	and honest on what we can do quickly and what we can't. That we adopted a 'you said- we did' approach which is shared. Action - update built in to forward plan already WSOES is an excellent piece of work and unique within the system. Victoria Robinson-Collins, Chief People Officer intends to share with the wider system.
People and Organisational Development (OD) priorities 2023/24 update	The Committee received an update on the priorities that sit within the portfolio of the Chief People Officer and the plan of work that will be followed. Many of the priorities will be under the Equality, Diversity and Inclusion umbrella and link to the People Strategy and the We Care Strategy. The Committee's workplan will be updated to reflect these priorities and will be under continuous review over the year.	Substantial Assurance that all strategic priorities are included from across both a local, system and national source. Good evidence of matrix working across the Executive team.
Appraisal Update	The role and quality of appraisals contribute to the trust achieving its ambition to be a great place to work. Compliance remained high for completing appraisals in	Committee were assured that focus on appraisals had made improvement, but this was seen as 'work in progress'.

Agenda item	Assurance and key points to note	Further actions and follow up
	spring 2023. The Committee noted that 70% of appraisals had taken place on line and there were differing views on the benefits of having an appraisal in person. The next NHS Staff Survey results will provide valuable feedback on the quality and impact of the appraisal process for staff and how this contributes to their attitude about their work and the organisation.	Committee raised concerns about how many appraisals were done online this year, as opposed to face to face Appraisee choice was seen as an important factor. The Committee requested more detail on how we measure quality of appraisals going forward. How fail safe are we that managers are not opting for virtual over the appraisee's wishes for face to face? Add to Action Log - future update.
Talent Management	The Committee received an update on how the trust was progressing on its journey. There are processes in place but the particular focus will be on talent development and succession planning with some further areas and actions for organisational debate and decision.	Committee were pleased that this work was receiving a focus. Would welcome an update on progress as new thinking is embedded. Work in progress
Recruitment Key Performance Indicators (KPIs)	Inroads have been made in speeding up the time to recruit and achieving the KPIs. There are still some hotspots, some of which are within the control of the	Excellent progress in speeding up time to recruit.

Agenda item	Assurance and key points to note	Further actions and follow up
	recruitment team and some which are not. The recruitment team is positive about what it has achieved and determined to show further improvement. The Committee would like to commend the team to the Board for its hard work in improving its outputs to support services.	Team is now focussed on how they embed super users in teams and improve outlying KPIs ACTION- update progress when next due.
Recruitment and Retention Report	Mitigations are in place to bolster the trust's recruitment and retention such as the new starter and leaver surveys and also a 100 days survey. They seem to be having a positive impact but it is a long-term piece of work and it is hard to say which actions are having an impact. More broadly, the trust benchmarks strongly for retention in the system.	ACTION - The Committee will discuss this again in December.
NHS Staff Survey Communications Plan	There will be a communications campaign to support the NHS Staff Survey this autumn. The executive has agreed that to encourage engagement with a view to driving up responses, the first four weeks of the survey will be incentivised. This will be combined with a comms programme of You Said We Did to highlight how the trust has responded to staff feedback over the last year.	The Committee supported the agreed approach. Increasing participation and acting faster on findings at local and Trust level is welcomed.

Agenda item	Assurance and key points to note	Further actions and follow up
Any Other Business	The Committee will meet six times in the coming year. It was agreed to move away from a hybrid meeting and instead experiment with four virtual only meetings and two in person with the intention that the in-person meetings will be followed by a committee development session.	We committed to continue to build on improving the efficiency of the Committee. Taking a reporting by exception style. Reducing the length of papers and using appendixes for data and information. Strengthening the front pages by bringing issues of concern forward. Committee members are keen to hear from outside organisations working in the people sphere. Keeping abreast of new approaches and ways of working. We will use the development session as a platform for this twice a year.

Kim Lowe
Chair, Strategic Workforce Committee
August 2023

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 13
Report title:	Quality Committee Chair's Assurance Report
Executive sponsor(s):	Dr Mercia Spare, Chief Nursing Officer
Report author(s):	Pippa Barber, Non-Executive Director
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary
The reports summarise the Quality Committee meetings held on 20 July and 21 September 2023; and the Extraordinary meeting held on 6 October 2023. The report includes the Quality Committee Terms of Reference which the Committee approved at its meeting on 21 September.

Report history / meetings this item has been considered at and outcome
Not applicable

Recommendation(s)
The Board is asked to • **RECEIVE** the Quality Committee Chair's Assurance Report • **APPROVE** the Terms of Reference.

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications

Risk and assurance	Yes		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☑BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	Yes		
Legal and regulatory	No		
Quality	Yes		
Financial	No		

Executive lead sign off	
Name and post title:	Dr Mercia Spare, Chief Nursing Officer
Date:	10 October 2023

Kent Community Health NHS Foundation Trust

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Quality Committee meeting held on 20 July 2023.

Agenda item	Assurance and key points to note	Further actions and follow up
Relevant feedback from other committees and service visits	The following visits have taken place: Ms Karen Taylor, Non-Executive Director – We care visit - Tunbridge Wells Long Term Service Ms Karen Taylor – End of Life Care Steering Group meeting Ms Pippa Barber – Adult Neurodevelopmental Service visit with Ms Butterworth, Deputy Chief Executive / Chief Operating Officer. An informative visit to understand the service and the different patient pathways available to manage the very long waiting list challenges. Waiting times are increasing. Discussions with commissioners and partner organisations continue. Ms Pippa Barber – Research Champions meeting. We care visit - Queen Victoria Memorial Hospital; Maidstone South. Dr Razia Shariff, Non-Executive Director – We care visit - Victoria Hospital, Deal	Common themes from community visits were challenges for staff with vehicle costs / parking. The Executive team is reviewing, including benchmarking support and communications with teams. The Committee recommends that the Board is updated on research activity as advised by guidance at a joint development session with the Council of Governors.

Agenda item	Assurance and key points to note	Further actions and follow up
Monthly Quality Report	Safer staffing work is underway both locally and at system level on improving the recruitment and retention of health care support workers. A review of the trust's approach to the CQUINs has taken place. There has been a particular focus on getting the approach to data collection right to measure the programme's impact on improving clinical practice and patient outcomes. This will also focus staff time to bringing benefits to patient outcomes but may not meet all of the CQUIN process measures. The Committee noted that the overall reported number of patient safety incidents appeared to have increased between April and May. As these numbers are revised once the patient safety team has completed its investigation, an SPC chart will be used in future to provide more accurate information to the Committee. A community hospital falls prevention improvement plan has been agreed with the integrated care board (ICB). It will apply across all hospitals. A falls hot debrief pilot has also commenced at four community hospital sites. The lying and standing blood pressure (BP) metric was reported to be improving after low levels of performance in April and May. Wards will need to assess their individual	The People Committee will have oversight of progress on the recruitment and retention of health care support workers. The chief nurse to ensure local protocols are in place for each community hospital to enable effective delivery of the enhanced falls observation policy.

Agenda item	Assurance and key points to note	Further actions and follow up
	environments and make local arrangements to ensure that patients remain safe. Following a discussion at the Council of Governors meeting around having greater clarity about the renewal of DBS checks by staff, this is being addressed. Discussions are ongoing about community acquired urinary tract infections (CAUTIs) and urinary tract infections (UTIs) definitions in frail patients and the implications for clinical practice. End of Life Care Steering Group: there has been more focus on good news stories as there are good examples of practice to discuss. The group has been addressing themes and trends and sharing the practice and learning.	The People Committee will receive an update on the DBS renewal checks. The Quality Committee will receive an update on the outcome of the discussions on CAUTI and UTIs at its September meeting.
Operational Deep Dive SEND	The Committee had a detailed and helpful discussion on the different pathways which contribute to the overall Special Educational Needs and Disability (SEND) programme. An overview of the various system level workstreams was also received. The demand for adult ADHD assessments continues to increase and the service is now holding a seven-year waiting list for adult's assessments and 2.5 year waiting list for children's assessments. For the under 5s, the pathway has been changed which means that diagnosis will happen sooner. For the over 5s, discussions are still	Further updates will come to the Committee through the integrated performance report and the board assurance framework. These areas remain a risk.

Agenda item	Assurance and key points to note	Further actions and follow up
	under way with the system about how receiving the diagnosis can be speeded up. For those patients who are waiting more than 52 weeks to see a clinician, the service will undertake a harm review. The trust has continued to meet with commissioners to explore how waiting times can be shortened.	A process for undertaking adult harm reviews to be put in place by the Trust.
Learning from Deaths quarterly report	The Committee received the quarter four report which set out good practice care and learning for the trust. There were no cases of death considered more likely than not due to problems in care.	The Committee recommends the report to the Board.
Patient Safety Incident Response Report including patient safety response plan	The Committee considered two patient safety incident investigations (PSII). Both were shared incidents with partners. The trust is working closely with Kent and Medway NHS and Social Care Partnership Trust (KMPT) on one of them. The Committee also received the patient safety incident response plan that the Trust will follow. It was well-received and sets out the process that the trust will undertake to implement the new patient safety incident framework.	As the term Serious Incident is being removed, the Committee recommends that the Board and Council of Governors are updated on the patient safety incident framework and response plan at a joint development session at their October meeting.
Quality Impact Assessments of the 2023/24 Cost Improvement Programme Schemes	The Committee gained assurance of schemes from the Adults and Specialist services to the value of £196k. No high risks were identified.	

Agenda item	Assurance and key points to note	Further actions and follow up
Quality Priorities Quarterly Report	Received and noted.	
Medicines Optimisation Annual Report	Received and noted.	
Director of Infection and Control (DIPC) Annual Report	Received and noted.	
Safeguarding Annual Report	Received and noted.	
Complaints Annual Report	Received and noted.	
Engagement and Volunteers Annual Report	Received and noted.	
VTE Serious Incident Deep Dive and Thematic Review of Never Events Kent And Medway System April 2021 – June 2022	Received and noted.	
Structure and Quality Committee terms of reference	The Committee received and considered an update to the Quality governance structure and the Terms of Reference of the Quality	The Terms of Reference will come to the September meeting for approval.

Agenda item	Assurance and key points to note	Further actions and follow up
	Committee. A number of suggestions and recommendations were made.	

Pippa Barber
Chair, Quality Committee
July 2023

Kent Community Health NHS Foundation Trust

QUALITY COMMITTEE CHAIR'S ASSURANCE REPORT

This report is founded on the Quality Committee meeting held on 21 September 2023 and the Extraordinary Committee meeting on 6 October 2023.

Agenda item	Assurance and key points to note	Further actions and follow up
TB Service Presentation	The Committee received an excellent presentation from the TB Service. Assurance was received on progress with delivering the BCG vaccination programme in East and North Kent. The service has met its target of 100% of the eligible cohort offered the vaccination; and 100% of staff trained to the national standard and updated annually. With regards to the uptake of the BCG vaccination, the national target is 80% within 28 days. In North Kent this was met. However, in East Kent the service achieved a 60% uptake. The data indicates good progress has been made in North Kent but with challenges in East Kent which relates to the geography of the area and the numbers of babies coming to the clinics. The service is in discussion with commissioners on the service model in place in Kent and Medway to continue to improve uptake.	Benchmark data will be obtained on achievement of 28 days access target

Agenda item	Assurance and key points to note	Further actions and follow up
Matters Arising	The challenges for the Adult Neurodevelopmental Service and the Looked After Children Service remain which the Committee will continue to monitor. The Committee continues to monitor the training of the emergency nurse practitioners at the urgent treatment centres. This is being considered as part of a wider system review which the trust is supporting.	The Committee will receive an update on adult and children neuro-developmental pathways at its November meeting. This will include an update on progress with harm reviews for those on the adult pathway. An update will also be brought on the waiting times for looked after children to receive their initial health assessments and the impact of the recent high court ruling which it is anticipated may increase demand. Non-executive director members will be attending a Community Paediatrics meeting on 17 October to hear from staff about the impact of the waiting lists.
Non-executive feedback from service visits	Two services had been visited. Karen Taylor reported back on her visit to the community paediatric nursing service. There were many positive aspects to the visit and from the team. Two areas of challenge were discussed. The need for supervision/time for development; and support for the teams with increasing caseloads and complexity which was identified and is being taken forward by the Chief Nursing	Updates on both of these areas will be considered in November.

Agenda item	Assurance and key points to note	Further actions and follow up
	Officer. Also, the challenges with accessing medication out of hours was also raised. Kim Lowe reported back on a positive visit to the Westbrook House stroke ward where she had observed great vison with patient centred care, good MDT working and good rehab facilities.	
Quality Report	Good progress is reported on staffing in the community hospitals. With regards to falls, further work is being done to increase the number of multifactorial risk assessments (MFRA) completed within 72 hours and improve the capture on Rio of actions that support the assessment. Issues have been identified around the recording on Rio of the patient's lying and standing blood pressure. These are being addressed. The Committee asked for more details on the actions that are being taken to support the delivery of the lower limb assessment at both team and trust level.	The Committee will receive a further update MFRA at its November meeting. The Committee will receive a further report on how services are performing in delivering lower limb assessments at its November meeting.
Patient Safety and Clinical Risk Group	Four risks relating to inpatient Estate had been reported to the group. The Director of Estates and Facilities was investigating the risks and would keep the group updated on the work to mitigate them.	

Agenda item	Assurance and key points to note	Further actions and follow up
	For the East Kent Community Dental Service, the risk around securing enough regular GA theatre slots at the local acute trust has increased, following a period of good progress. Waiting times for patients are growing again. The risk has been raised at system level and the service is looking at capacity in operating theatres outside of the locality.	Progress will need to be tracked through the integrated performance report (IPR).
Population Health Group Assurance Report	Good progress is being made and the Committee was updated on the excellent service provided by the One You Shop in Ashford. The success of this service is due in large part to the support of Ashford Borough Council, a unique partnership which the Committee would encourage other local councils to consider replicating in improving the health of their communities.	The One You Service has been invited to give a presentation at the November Quality Committee.
Learning from Deaths Report	The Committee received the 2022/23 Learning from Deaths Annual Report alongside the 2023/24 Quarter One report. Areas of good practice and learning were identified. Of those deaths in the community hospitals that were reviewed by the trust in Quarter One of 2023/24, none were judged more likely than not to have been due to problems in care. Of those deaths in the community that were reviewed by the trust in Quarter One of 2023/24, one is being further investigated and the outcome is awaited.	An update on the investigation will be received at the November Quality Committee meeting.

Agenda item	Assurance and key points to note	Further actions and follow up
Quality Committee Terms of Reference	The Committee agreed its terms of reference, subject to some minor amendments.	The Board is asked to approve the Terms of Reference. The terms of reference of the Quality Committee's sub-committees will be brought to the November meeting to check that they align with the Committee's terms of reference.
Population Health Group Terms of Reference	It was formally recorded that the Committee had previously approved the group's terms of reference.	
Patient-Led Assessments of the Care Environment (PLACE) report	As previously reported, the trust had scored well against all the PLACE assessment criteria apart from the disability element. Assurance was received that actions are in place at all sites to address this particular area with the exception of West View Integrated Care Centre. The Committee will receive an update in March 2024 on progress with completing the actions and how the trust is working with Kent County Council to address the issues at West View Integrated Care Centre.	

Pippa Barber
Chair, Quality Committee
28 September 2023

Kent Community Health NHS Foundation Trust

TERMS OF REFERENCE

QUALITY COMMITTEE

Document Control

Version	Draft/ Final	Date	Author	Summary of changes
0.1	Draft	13 10 2011	Karen Proctor Director of Nursing and Quality	
0.2	Draft	17 01 2012	Stephen Robinson Director of Corporate Services	Format into KCHT Template. Amend to clarify role as Assurance Committee role.
0.3	Draft	12.7.2012	Karen Proctor Director of Nursing /Quality	Addition of groups reporting to committee and membership
0.4		27.09.2012	Director of Nursing/Quality	Changed membership and committee groups
0.5		27.09.2012	Director of Nursing/Quality	Changed reasonability for accountability to assurance
0.6		29.01.2013	Head of Risk Management	Amended to reflect NHSLA requirements
0.7		14.02.2013	Corporate Secretary	Amended Head of Health and Wellbeing to Health and Wellbeing Director
0.8	Draft	10.12.13	Corporate Secretary	Amended secretarial references Addition of reference to Finance, Business and Investment Committee Updating of HR Director title
0.9	Draft	5.5.14	Director of Nursing/Quality	Amended to reflect changes and assurance
1.0	Draft	16.3.15	Assistant Director of Assurance	Amended to reflect Foundation Trust status

Version	Draft/ Final	Date	Author	Summary of changes
1.1	Draft	07.03.2017	Gina Baines, Assistant Trust Secretary	Amended Trust logo, job titles.
2.0	Draft	06.06.2017	Ali Strowman, Chief Nurse	Full revision
2.1	Draft	March 2018	Ali Strowman, Chief Nurse	Membership section – to add Deputy Chief Nurse. Confidentiality section removed from Section 5. Strategic Workforce Committee added to Section 5 Governance – Key Relationships.
2.2	Draft	February 2019	Dr Mercia Spare, Chief Nurse (Interim)	Transfer of responsibilities for clinical audit from Audit and Risk Committee Terms of Reference to Quality Committee Terms of Reference.
2.2	Draft	06.06.2019	Gina Baines, Assistant Trust Secretary	Objectives – addition of role in considering any published external relevant reviews related to Trust services and oversight of specific risks on the Board Assurance Framework. 5.0 Governance Standard agenda - removal of reference to red flags and EWTT; inclusion of a number of new regular agenda items. Frequency of meetings changed to 'no more than eight meetings a year.'
2.3	Draft	29.04.2020	Gina Baines, Assistant Trust Secretary	4.0 Monitoring and Reporting - Amended to reflect changes to Board and committee governance arrangements 5.0 Governance – standard agenda- changed for accuracy 5.0 Governance Membership – Amended to reflect changes to Board and committee governance arrangements 7.0 – Frequency – change to quarterly

Version	Draft/ Final	Date	Author	Summary of changes
2.4	Draft	27.10.2020	Pippa Barber, Chair of the Committee and Committee members	Changes made to objectives; clinical audit; reporting arrangements; standard agenda; membership; key relationships to reflect the refresh of the governance arrangements agreed by the Board July 2020.
2.5	Draft	15.03.2021	Pippa Barber, Chair of the Committee and Committee members	Addition of two objectives relating to equality considerations and system quality issues
2.6	Draft	10.05.2022	Gina Baines Assistant Trust Secretary	Membership: addition of Director of Strategy and Partnerships
2.6	Draft	19.05.2022	Mercia Spare, Chief Nurse	Addition of one objective relating to the Quality Committee's responsibility for overseeing the relevant aspects of the NHS publication 'Enhancing Board Oversight'.
2.7	Draft	14.07.2023	Georgia Denegri, Interim Director of Governance	Updated annual strategic objectives 2023/24; reviewed committee duties; tidied up governance and administrative arrangements

Review

Version	Approved date	Approved by	Next review due
0.2	26.01.2012	KCHT Board	April 2012
0.5	27.09. 2012	Quality Committee	September 2013
0.9	03.06.2014	Quality Committee	June 2015
1.0	26.03.2015	KCHFT Board	April 2016
1.0	08.03.2016	Quality Committee	March 2017
1.1	07.03.2017	Quality Committee	March 2018
1.1	25.05.2017	KCHFT Board	March 2018
2.0	12.09.2017	Quality Committee	March 2018
2.0	28.09.2017	KCHFT Board	May 2018
2.1	17.04.2018	Quality Committee	March 2019
2.1	24.05.2018	KCHFT Board	May 2019
2.2	19.03.2019	Quality Committee	March 2020
2.2	14.05.2019	Quality Committee	March 2020
2.2	25.07.2019	KCHFT Board	May 2020
2.3	17.03.2020	Quality Committee	March 2021
2.3	21.05.2020	KCHFT Board	May 2021
2.4	17.11.2020	Quality Committee	March 2021
2.5	23.03.2021	Quality Committee	March 2022
2.5	20.05.2021	KCHFT Board	May 2022
2.6	19.05.2022	Quality Committee	March 2023
2.6	25.05.2022	KCHFT Board	May 2023
2.7	21.09.2023	Quality Committee	March 2024
2.7	Insert date	KCHFT Board	Insert date

TERMS OF REFERENCE

QUALITY COMMITTEE

1. PURPOSE

The Quality Committee is established as a committee of the Board of Directors (the Board) of Kent Community Health NHS Foundation Trust (the Trust) to scrutinise the robustness of and provide assurance to the Board that there is an effective system of quality governance and internal control across the clinical activities of the organisation that supports the Trust to deliver its strategic objectives and provide excellent care.

The relevant objectives assigned to the Quality Committee for 2023/24 are:

Ambitions	Targets	Breakthrough objectives 2023/24
Putting communities first	There is no significant difference in did not attend (DNA) or 'was not brought' rates between patients living in the most and least deprived areas or ethnic group by April 2026.	80% of all contacts have their ethnicity recorded on electronic patient records by March 2024
		Reduce the total DNA rate for patients from deprived localities by 25% by October 2024
	Reduction in people who wait longer than 12 weeks to be seen compared with March 2023	All services with waiting times of more than 12 weeks have a plan in place by October 2023
Sustainable care	Staff spend 50% less time on admin processes that don't add value to patient care.	20% reduction in time completing Rio through reduction of input and automation.

2. DUTIES:

Quality and clinical governance assurance

The Quality Committee will:

- Oversee and monitor the delivery of the annual strategic objectives assigned to it;
- Oversee and monitor the delivery of the key priorities of the Trust's quality strategy;
- In line with the requirements of 'Enhancing Board Oversight' (NHS December 2021), receive assurance on the following elements of quality and safety:
    - Hip Fractures, falls and dementia
    - Palliative and end of life care
    - Resuscitation
    - Learning from deaths
    - Safeguarding
    - Lead for children and young people
- Receive risks escalated from clinical directorates and clinical governance groups through the Integrated Governance and Risk Management Group to ensure:

  - safety and excellence in patient care
  - effective and efficient use of resources through evidence-based clinical practice

- Receive assurance that there are processes in place that safeguard children and adults within the Trust.

- Receive assurance that the Trust identifies lessons learned from all relevant sources, including incidents, never events, complaints and claims and ensures that learning is disseminated and embedded.

- In respect of Patient Experience:

  - agree the annual patient experience plan and monitor progress
  - assure that the Trust has reliable and up-to-date information about what it is like being a patient experiencing care provided by the Trust, so as to identify areas for improvement and ensure that these improvements are affective
  - monitor trends in complaints received by the Trust and commission actions in response to adverse trends where appropriate
  - consider ethnicity data in relation to patient groups and their experience of care.
  - ensure that the strategic priorities for quality assurance are focused on those which best support delivery of the Trust's quality priorities in relation to patient experience (including equitable accessibility to services), safety of patients and service users and effective outcomes for patients and service users.
  - ensure equality considerations and analysis are an integral feature of quality impact assessments, performance and risk reporting

- Ensure there is an effective clinical audit function established by the executive team

- Receive assurance that the clinical audit plan meets Trust identified risk priorities and that management responses to clinical audit reports are acted upon effectively and in a timely manner, and drawing any deficiencies to the attention of the committee.

- Make recommendations to the Audit and Risk Committee concerning the annual programme of internal audit work, to the extent that it applies to matters within these Terms of Reference;

- Receive assurance on End of Life care, NICE guidance and research through the quality report.

- Approve the Trust's Quality Account before submission to the Board for ratification.

- Provide assurance to the Board on system quality issues as they relate to the Trust.

- Seek to ensure that the quality agenda leads to improvements in quality, productivity and prevention through innovation

- Receive assurance that the Trust is taking action to meet the needs of the local population, prevent ill-health and to ensure equity of access, outcome and experience related to its service delivery.

Regulatory Compliance

The Quality Committee will:

- Assure itself that all regulatory requirements relating to the Care Quality Commission's fundamental standards of quality and safety are complied with, with proven and demonstrable assurance, and that immediate and effective action is taken where there is variation.

- Promote within the Trust a culture of open and honest reporting of any situation that may threaten the quality of patient care and compliance with the requirements of the Duty of Candour.

- Consider and receive assurance on any published external reviews which relate to the Trust's services within the scope of the Committee.

- Oversee the ratification of clinical policies and any other formal clinical documents where mandatory compliance is required.

Clinical Risk Management

The Quality Committee will:

- Monitor progress against actions to mitigate quality and safety risks on the Board Assurance Framework and Corporate Risk Register in line with the Board's risk appetite.

- Review and monitor those risks on the Corporate Risk Register which relate to quality including operational risks which could impact on patient care and ensure the Board is kept informed of significant risks and mitigation plans in a timely manner.

- Oversee Deep Dive reviews of identified risks to quality and performance identified by the Board or the Committee, particularly patient safety incidents and how well any recommended actions have been implemented. This will include cost improvement programme quality impact assessment deep dives.

3. AUTHORITY

The Quality Committee is directly accountable to the Board of Directors.

The Committee has no delegated powers other than those specified in these Terms of Reference.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference and all Trust employees are directed to cooperate with any request made by the Committee.

The Quality Committee is authorised by the Board to obtain external independent professional advice and to secure the attendance of specialists with relevant experience and expertise as it considers necessary in accordance with these Terms of Reference.

All procedural matters in respect of conduct of meetings shall follow the Trust's Standing Orders.

4. SUB-GROUPS

Patient Experience and Learning Council
Population Health Group

5. MEMBERSHIP AND ATTENDANCE

The Committee will be appointed by the Board and shall consist of:

- Three Non-Executive Directors (one of whom will be its Chair and another its Deputy Chair)
- Chief Nursing Officer (executive lead)
- Chief Medical Officer
- Chief Operating Officer
- Executive Director for Health Inequalities and Prevention
- Chief Allied Health Professions Officer

In addition to members of the Committee the following will normally attend all meetings and may contribute, but have no voting rights nor contribute to the quorum:

- Deputy Chief Nursing officer
- Head of patient safety

The Board will review membership of the Committee annually to ensure that it meets the evolving needs of the Trust.

All committee members are expected to attend all meetings and such attendance will be reported in annual report.

In the absence of the Committee Chair, the Deputy Chair of the Committee or a nominated Non-Executive Director will chair the meeting.

Other executive directors and staff will be invited to attend by the Committee Chair when the Committee is discussing areas of risk or operation that fall under their direct responsibility.

Attendance at the meeting may be face to face or by videoconferencing at the discretion of the Committee Chair.

An executive member of the Quality Committee may appoint a named deputy to attend a particular meeting in their place, subject to the Chair's pre-approval. A deputy should be nominated only in exceptional circumstances, for a particular meeting.

The Quality Committee reserves the right to hold discussions in private (Part 2).

The Committee may invite non-members to attend all or part of its meetings, including governors, as it considers necessary and appropriate, at the discretion of the Committee Chair. The Trust Chair, Chief Executive, and other non-members of the committee may attend any meeting of the Committee with the prior agreement of the committee Chair.

6. QUORUM

The quorum shall be four members, of which at least two must be Non-Executive Directors and two must be Executive Directors.

7. FREQUENCY OF MEETINGS

The Quality Committee will hold no more than eight meetings each year to ensure it is able to discharge all its responsibilities.

8. ACCOUNTABILITY AND REPORTING ARRANGEMENTS

Meetings of the Quality Committee will be formally recorded and once approved, submitted to the Board at the next meeting in public.

After each meeting of the committee, the Chair of the Committee will make a report to the next meeting of the Board and draw to its attention areas of good practice and any issues that require its particular attention, or require it to act. Where the Chair of the Committee considers appropriate, s/he will escalate immediately any significant issue to the Chief Executive or Trust Chair.

The representative of the Quality Committee appointed to the Audit and Risk Committee shall draw specific attention to any issues that require notification to the Audit Committee.

The Quality Committee will work with the Audit and Risk Committee specifically when issues arise in relation to the Audit and Risk Committee's role in ensuring that effective systems of governance, risk management and internal control operate within the Trust.

9. KEY RELATIONSHIPS

Population Health Group
Audit and Risk Committee
Finance, Business and Investment Committee
People Committee
Executive Team
Trust Board

10. ADMINISTRATIVE SUPPORT

The Committee will be supported administratively by the Director of Governance or their nominated member of staff, whose duties in this respect will include:

- Agreement of the agenda with the Committee Chair, collation and distribution of papers one week before each meeting.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.
- Providing support to the Chair and members as required.

The committee will establish an annual work programme, summarising those items that it expects to consider at forthcoming meetings.

The agenda will be prepared for the Committee Chair with input from the Committee members and other regular attendees, who may propose items for inclusion in the agenda. Items for inclusion in the agenda will be submitted a minimum of two weeks prior to the meeting.

The date for the next meeting will be arranged and distributed to all members within one month of the meeting together with the draft minutes.

A standard agenda as follows will be used by the Quality Committee and may include the following items:

- Apologies for absence
- Declarations of interest
- Minutes of last meeting
- Action log
- Progress and risks identified with Trust strategic goals
- Progress against Quality Priorities
- Board Assurance Framework
- Corporate Risk Register and clinical directorate risks escalated from the Integrated Governance and Risk Management Group
- Summary assurance report from Patient Experience and Learning Group
- Summary assurance report from Population Health Group
- Committee reports for assurance including but not exclusively: Quality Report, items from We Care visits, clinical audit, compliance with NICE, end of life care and research and development, quality improvement
- Areas of concern highlighted in the Integrated Performance Report
- Published external reviews relating to the Trust's services within the scope of the Committee
- Non-Executive Director led deep dives
- Updates from service visits including We Care visits if relevant to agenda items
- Feedback and actions from other committees/to other committees
- Ratification of policies
- Any other business
- Date of next meeting

Notice of Meetings:
Meetings of the Quality Committee, other than those regularly scheduled as above, shall be summoned by the Director of Governance at the request of the Committee Chair.

Conduct of Business:
The agenda for each meeting will be circulated seven working days in advance, together with any supporting papers and will be distributed by the Director of Governance or their nominated member of staff.

Declarations of Interest:
The Committee Chair will ensure that all interests are formally declared by committee members prior to the commencement of the proceedings. In particular the declarations will include details of all relationships and other relevant and material interests (pecuniary and non-pecuniary) specifically related to the business to be transacted as per the agenda.

Minutes of Meetings:

The Assistant Trust Secretary will record the minutes of the Quality Committee meetings, including the recording of names of those present and in attendance.

Minutes of the Quality Committee shall be circulated promptly to all members by the Assistant Trust Secretary. All meetings will receive an action log (detailing progress against actions agreed at the previous meeting) for the purposes of review and follow-up.

MONITORING EFFECTIVENESS AND COMPLIANCE WITH TERMS OF REFERENCE

The Quality Committee will review its Terms of Reference on an annual basis as part of a self- assessment of its own effectiveness in discharging its responsibilities, delivering its duties and objectives, and complying with its terms of reference. Any recommended changes brought about as a result of the yearly review, including changes to the Terms of Reference, will require Board of Directors' approval.

MONITORING COMPLIANCE WITH THESE TERMS OF REFERENCE

What will be monitored	How will it be monitored?	Who will monitor?	Frequency
Achievement of objectives	Chair provides a written assurance report to the Board	Committee Chair Trust Board	Quarterly to public Board
Frequency of attendance	Attendance register of each meeting	Assistant Trust Secretary will report to the Committee Chair	Annually

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 14
Report title:	Patient Story
Executive sponsor(s):	Dr Mercia Philips – Spare, Chief Nursing Officer
Report author(s):	Marcella Capper, Head of Medical Equipment Management / Interim Head of Complaints, PALS and Patient Experience
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☐ Assurance ☑ Information
Public/non-public	Public

Executive summary

92-year-old Anthony Sinden (Tony) was one of the first patients at our specialist stroke rehabilitation unit at Westbrook House in Margate.

Tony and his son Andrew have been invited to talk the Board about this journey and the factors that made his stay at Westbrook House so positive and how he was assisted in his recovery.

Tony is now back to helping on the farm that has been in his family since 1897.

This is a positive and motivational story which will demonstrate what went well, what went not so well and what 'good care looked like' for Tony and his son.

Vicki Pout AHP Stroke Lead at Westbrook House has also been invited to update the Board about the work being undertaken within the service and to take any questions.

Report history / meetings this item has been considered at and outcome

None

Recommendation(s)

The Board is asked to:

- **Receive and Note** the patient story

Link to CQC domain				
☑Safe	☑Effective	☑Caring	☑Responsive	☑Well-led

Strategic ambition this report supports	Please tick
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications			
Risk and assurance	Yes/No (If yes, provide brief one sentence description of issue)		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐BAF	☐CRR	☑DRR
Equality, diversity and inclusion	Yes/No		
Patients / carers health inequalities	Yes		
Legal and regulatory	No		
Quality	Yes		
Financial	No		

Executive lead sign off	
Name and post title:	Dr Mercia Philips Spare, Chief Nurse
Date:	11/10/2023

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 15
Report title:	Equity Diversity & Inclusion –WRES, WDES action plans
Executive sponsor(s):	Victoria Robinson-Collins, Chief People Officer
Report author(s):	Victoria Robinson-Collins, Chief People Officer
Action this paper is for:	☐ Decision/approval ☐ Discussion and input ☐ Assurance ☑ Information
Public/non-public	Public

Executive summary

The final action plans for the WRES and WDES 2023 are included for executives to consider prior to inclusion for October Board. Executives have seen several iterations of the action plans in draft form as part of the NLB updates and therefore they are shared for information and awareness.

The WRES and WDES reports and action plans are required to be published on Trust websites by end of October 2023.

Report history / meetings this item has been considered at and outcome

- NLB Ambassador Group – endorse findings and subsequent plans
- Executive Team Meeting – assured by direction of travel, significant number of actions, requiring prioritisation
- People Committee – significant assurance from engagement work and report
- Workforce Equality Group – endorse findings and subsequent plans
- Staff Partnership Forum – endorse findings and subsequent plans

Recommendation(s)

The Board is asked to

- **RECEIVE** and **NOTE** the report for **INFORMATION.**

Link to CQC domain

☐**Safe**	☐**Effective**	☐**Caring**	☐**Responsive**	☑**Well-led**

Strategic ambition this report supports	**Please tick**

Putting communities first	☐
Better patient experience	☐
A great place to work	☑
Sustainable care	☐

Implications			
Risk and assurance	Yes – BAF risk relating to EDI		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☑BAF**	**☑CRR**	**☐DRR**
Equality, diversity and inclusion	Yes – this work supports the creation of the EDI action plan to improve colleague inclusion and experience within the organisation as well as to increase levels of diversity		
Patients / carers / public / staff / health inequalities	No		
Legal and regulatory	Yes – this work supports the creation of the EDI action plan of which a number of actions will relate to the regulatory WRES and WDES reports		
Quality	No		
Financial	No		

Executive lead sign off	
Name and post title:	Victoria Robinson-Collins, Chief People Officer
Date:	6 October 2023

Workforce Race Equality Standard Action Plan 2023

Year 1

#	Objective	Task	Can this be measured? And how?	Metric and target	Communication	Senior Lead	Operational Lead
	The specific goal or outcome that we want to achieve	The specific activities or task that need to be completed in order to achieve the objective		The measures that will be used to evaluate the success of the action plan, quality or improvement and determine whether the objective has been achieved	The communication plan for keeping all stakeholders informed about the progress of the action plan and improvements	Accountability for delivery of this action will be with the Senior Lead	Responsibility for the practical implementation of this action will be with the operational lead
	1. Distribution of Band 1-9 and VSM **WRES 2022 Data: 13.9% Trust overall (BME well represented), 13.1% 8a+ trust (BME well represented), 17.3% clinical 8a+ (BME well represented), 6.4% non-clinical 8a+ (BME under represented)**						
1.1	Increase BME staff in non-clinical roles from 6.4% to 10.0%	**Project:** Non-Clinical Band 8a and above BME staff to be encouraged to mentor and coach BME staff at lower grades, given training opportunities to do so	Yes, count of Non-Clinical Band 8a staff who are involved in the project, and then the number of Band 1-7B BME staff who are being mentored/coached. Need to set a target of how many need to go through this programme.	Number of non-clinical staff being mentored. Increase in proportion of BME staff in 8a+ non-clinical roles from 6.4% to 10.0%	Reported back at quarterly WEG, annual WRES	Margaret Daly (Director of People Development)	Kim Sargent (Leadership and Talent Lead)
1.2	Increase BME staff in non-clinical roles from 6.4% to 10.0%	**Appraisals audit:** output of the appraisal career questions to be tracked over the next year to	Yes, track list of individuals who specified they would like to be progress in their career over the next 12 months	Quarterly presentation of the numbers of BME and White staff who have specified they would like to progress their career, % who had career conversation, % who have been promoted, % who have left. Comparison of BME and White to ensure fairness	Reported back at quarterly WEG, annual WRES	Victoria Robinson-Collins (Chief People Officer)	Jill Day (EDI Data Analyst)
	2. Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants **WRES 2022 Data: White staff are 1.52 times more likely to be appointed than BME staff (1.82 when international recruitment is removed)**						
2.1	Reduce the ratio from 1.82 (without international recruitment) to 1.5	Interview outcomes to be audited by EDI Team to monitor White appointments:BME appointments.	Yes, measure the relative likelihood on a quarterly basis. Reviewed at WEG	Flag any areas with a ratio greater than 2. Passed to P&ODBPs to follow up (understand from services underlying reasons, explore remedies) P&ODBPs would be asked to explore the root causes and engage the EDI team as appropriate in remedial action/support to the team/service. For example, P&ODBPs may recognise a need for fairer recruitment themed training which can be arranged with the EDI team.	Reviewed on a quarterly basis at WEG and via P&ODBPs meetings with Victoria Robinson-Collins (Chief People Officer)	Victoria Robinson-Collins (Chief People Officer)	P&ODBPs
2.2	Reduce the ratio from 1.82 (without international recruitment) to 1.5	Include intendent panel members in the form of Inclusion Ambassadors (IAs) in recruitment within pilot services identified as having a >2.0 disparity in appointing White applications compared with BME	Yes, through Trac and our internal list of Inclusion Ambassadors	Reduction in disparity of White to BME shortlisting-appointing in pilot teams/services (from 1.82 to 1.5)	Reviewed on a quarterly basis at WEG, reported annually via WRES	Nicola Rutter (Assistant Director of People)	Ryan Harris (Recruitment Manager) & Hasan Reza (Head of Workforce EDI)
	3. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff **WRES 2023 Data: BME staff are 1.18 times more likely to enter formal disciplinary**						
3.1	Review the formal disciplinary process (in year 1) with a view to reducing likelihood of BME staff entering the formal disciplinary process when compared with white colleagues (in year 2)	Audit a sample of disciplinary cases to provide assurance that all staff who enter into formal processes are treated with compassion, equity and fairness, irrespective of any protected characteristics.	Measure will be the outcome of the audit	Review 50% of disciplinary cases from 2022/23	Audit outcome reported to WEG	Nicola Rutter (Assistant Director of People)	MDT
	4. Relative likelihood of white staff accessing non-mandatory training and CPD compared to BME Staff **WRES 2023. BME staff are more likely to access non-mandatory training than white staff**						
4.1	To ensure equal opportunity of progression for all staff	Define what we mean by non-mandatory training. This may be internal or external training, apprenticeships etc and may need to be monitored separately once set up	Yes, once definitions have been in place. May want to break down in to specific groups e.g. Leadership academy, apprenticeship, paid course etc	% of BME/White staff accessing each of the types of non-mandatory training	Final definition to be shared with WEG members & Education and Development Team	Margaret Daly (Director of People Development)	Verity Barton (Career & Development Lead)
4.2	To ensure equal opportunity of progression for all staff	Monitor % of staff who are accessing non-mandatory training, once the definition of what non-mandatory training is has been agreed upon.	Yes, once definitions have been in place. May want to break down in to specific groups e.g. Leadership academy, apprenticeship, paid course etc	% of BME/White staff accessing each of the types of non-mandatory training	Reporting to WEG quarterly	Hasan Reza (Head of Workforce EDI)	Jill Day (EDI Data Analyst)
	5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months **Staff Survey 2022: 19.7% BME and 18.0% white**						
	6. Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months **Staff Survey 2022: 18.5% BME and 14.6 White**						
	8. In the last 12 months have you personally experience discrimination at work from a manager, team leader or other colleague? **Staff Survey 2022: 11.7% BME and 4.3% white**						
5.1	Reduce the amount of bullying, harassment and abuse received by employees	Promote the use of Freedom to speak-up and Resolution and accountability champions to de-escalate conflict	Make use of existing systems measuring uptake of freedom to speak-up champion/resolution and accountability champions	An increase in the % of individuals who are contacting Freedom to speak up and Resolution and accountability champions, by ethnicity	Updates provided at NLB Ambassador meetings and as appropriate to WEG	Joy Fuller (Governor Lead / Freedom to Speak Up Guardian)	NLB Ambassadors
5.2	Reduce the amount of bullying, harassment and abuse received by employees	All incidents of bullying and harassment reported in Datix are reviewed. Hot spots are identified and appropriate interventions are identified to reduce further incidents occurring	Yes, through Datix. EDI Team will support in analysis and reporting with P&ODBPs being asked to target interventions within teams/services where hot spots are recognised.	Number of % and incidences logged in Datix, by ethnicity	Reviewed on a quarterly basis at WEG and via P&ODBPs meetings with Victoria Robinson-Collins (Chief People Officer)	Hasan Reza (Head of Workforce EDI)	P&ODBPs
5.3	Reduce the amount of bullying, harassment and abuse received by employees	Bullying, harassment and violence reduction: establish whether there is benefit to enhancing the processes that KCHFT already has in place around violence and aggression	Evidenced through the development of KCHFT's existing violence reduction guidance	Evidence that guidance related to staff is available on flo, an increase in the uptake of F2SUP linked to action 5.1	Outcomes of task reported to WEG on completion via a summary paper	Nicola Rutter (Assistant Director of People)	Hasan Reza (Head of Workforce EDI)
5.4	Reduce the amount of bullying, harassment and abuse received by employees	Communication: Stories from BME staff about how they managed and addressed bullying/harassment that they faced (e.g. accessing speaking up services), how they built resilience, etc.	Count of numbers of stories that have been published on flo	Engagement insights from comms (no. of clicks, read time, etc.), an increase in the access of the KCHFT resolution framework and F2SUP in line with action 5.1	Quarterly updates to WEG with engagement report from the communications but also updates from ER with re: any increase in colleagues reaching out related to BH&D.	Chloe Crouch (Head of Communications and Engagement)	Trust Communications Team

5.5	Reduce the amount of bullying, harassment and abuse received by employees	Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities. (high impact action 5)	Measure the non-mandatory training accessed by international recruits separately to the Trust as a whole and compare uptake in the two groups	% of international recruits who have accesses non-mandatory training, compared to the Trust as a whole (non-mandatory training to be meaningfully disaggregated)	6 monthly updates to WEG	Margaret Daly (Director of People Development)	Terri Wood (Business Support Manager)
	7. Percentage of staff believing that their trust provides equal opportunity for career progression or promotion						
	52.0% BME and 69.5% White						
7.1	Increase the percentage of BME staff who believe the trust acts fairly around progression or promotion	Audit: Breakdown of career progression by month/year, to be reported to WEG on a quarterly basis. Jill Day will send this to P&ODBPs for them to follow up - if an disparity has been identified an explicit action should be raised in the workforce plan	Yes, ESR data	% of staff who have been promoted in last year. Disaggregated by Ethnicity. Target is zero disparity. P&ODBPs would be asked to explore the root causes and engage the EDI team as appropriate in remedial action/support to the team/service. For example, P&ODBPs may recognise opportunities not being advertised in line with action 7.2 - the Recruitment and EDI team can support in remedying this.	Reported to WEG quarterly, shared with key stake holders (names TBC)	Claire Poole (Director of Operations, Children & Young People)	P&ODBPs
7.2	Increase the percentage of BME staff who believe the trust acts fairly around progression or promotion	Ensure all acting up and secondment contracts are advertised internally for a minimum of 1 working week	All acting up, internal secondment and fixed term contracts in ESR will be reported on a quarterly basis. These will be linked back to the TRAC system, and if this recruitment activity is not there.	Count of individuals who are acting up, internal secondment and fixed term contract, disaggregated by Ethnicity. Further flag identifies if role was advertised through TRAC	WEG quarterly	Victoria Robinson-Collins (Chief People Officer)	Pay and Expenditure Control Panel
7.3	Increase the percentage of BME staff who believe the trust acts fairly around progression or promotion	Raise awareness of career progression and promotion with case studies and staff stories online. Invite BME senior staff from internal and external NHS organisation to speak about their journey	Yes. Number of BME staff from external organisation who has come to talk at the Trust	3% increase y/y of staff survey respondents feeling the Trust provides equal opportunities (52% now, 55% in 2023/24 WRES)	Speakers to meet with CC/HR prior to delivering keynote, explore key milestones in being able to progress and link it into the opportunities that exist within KCHFT (e.g. Mentoring being key, KCHFT offers mentoring)	Chloe Crouch (Head of Communications and Engagement) & Hasan Reza (Head of Workforce EDI)	Trust Communications Team & EDI Team
7.4	Reduction in disparity between BME and White leavers reporting voluntary reasons as the basis for their departure from 2.3% to 1.8%	Managers and HRD to raise the profile of exit questionnaires. P&ODBPs assess the questionnaire and asses why BME staff leave.	Currently turnover for BME staff is higher than for White staff. Measure number of staff leaving trust, % which have had an exit questionnaire	Reduction in the disparity between BME leavers and white leavers (from x% to x% to be agreed following data review). The focus would be on voluntary turnover where we continue to see a large disparity between BME leavers and White leavers. Where P&ODBPs are observing trends or themes arising these would be raised with the EDI team and appropriate support plans would be put in place.	Reviewed on a quarterly basis at WEG	Nicola Rutter (Assistant Director of People)	P&ODBPs
	9. BME Board Representation						
	6.7% BME, 92.3% White						
9.1	Increase BME Board Representation	Target BME organisations, recruiters and community groups to publicise NED roles	Yes, evidence through communications with/agreements with recruiters/appropriate organisations & eventual board level diversity increase	Board/NED roles being advertised/No of BME Applicants Shortlisted	Reported to WEG quarterly, shared with key stake holders (names TBC)	Ryan Harris (Recruitment Manager)	Trust Recruitment Team
9.2	Increase BME Board Representation	Offer shadowing opportunities for BME staff to be NEDs. BME staff network to help select candidates	Yes, through both the no. of opportunities being offered and the uptake	Increase in Indicator 7 (perception of equal opportunities at KCHFT) from 52% to 55%. While this task is aligned to the board indicator, the most immediate and direct measurable change should be seen in indicator 7.	Reported to WEG quarterly in the form of case studies. If appropriate these can be shared by the network when invited to Board.	Victoria Robinson-Collins (Chief People Officer)	EDI Team/BAME Network
9.3	Increase BME Board Representation	Communication: All Board members to write opinion pieces through the year on race equality and general inclusion. To be publicised internally and externally	Yes, through the no. of pieces produced	A decrease in experiencing discrimination (Indicator 8) from 11.7% to 10.5%		Chloe Crouch (Head of Communications and Engagement)	Trust Communications Team
	Other High Impact Actions						
10	High impact action 1	Every board and executive team member must have EDI objectives that are SMART and be assessed against these as part of their annual appraisal process	Yes, through individual objectives and annual appraisals	Agreed EDI objective present on PDP, reviewed by Remuneration Committee for CEO & Executives and the Nominations Committee for Chair and Non-Executive Directors	Half yearly review to Board of Directors and Council of Governors (part 1 meetings)	Mairead McCormick (Chief Executive Officer) & John Goulston (Chair)	Mercy Kusotera [Director of Governance]
11	High impact action 1	Board members should demonstrate how organisational data and lived experience have been used to improve culture	Yes, through discussions at Board and its Committees, the Staff Council and by visiting services and meeting staff networks	EDI data, lived experience and feedback on visits and Staff Council and staff networks being presented and discussed at Board and Committee meetings, evidenced through agenda and minutes	Quarterly updates to People Committee, half year review at the Board of Directors (part 1 meetings)	Mairead McCormick (Chief Executive Officer) & John Goulston (Chair)	Victoria Robinson-Collins (Chief People Officer)
12	High impact action 1	NHS boards must review relevant data and receive feedback / lived experience from staff to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board assurance framework	Yes but the specific data plus feedback process/route for lived experience / staff concerns needs to be agreed - potentially the metrics being included on the planned EDI dashboard	An EDI Dashboard is underdevelopment, this will offer the potential metrics. These metrics will need to include quadrants on staff feedback/ lived experience as well as cover key ESR metrics, feedback loops from the Staff Voice forums and Networks, information related to career progression and development and training up take. This will enable us to have a more live view into the culture and practices at the Trust which can act as the basis of programmes of work we plan in place of reliance on the annual WRES.	Quarterly updates to People Committee and half yearly report to Board of Directors (part 1)	Mairead McCormick (Chief Executive Officer) & John Goulston (Chair)	Victoria Robinson-Collins (Chief People Officer)
	Improve data monitoring						
13	To monitor progress against the WRES action plan	Build a framework for the monitoring of EDI data. This will involve the definition of the metrics that are required to monitor the EDI action plan, how these metrics will be RAG rated, the owner of the metric who will be responsible for intervention in the metric is not progressing towards the objective. Framework for the escalation of metrics which are RAG rated as red.	N/A	N/A	Links will need to be developed with the Business Intelligence Team and IT as appropriate to understand existing metric frameworks and management processes	Hasan Reza (Head of Workforce EDI)	Jill Day (EDI Data Analyst)

Workforce Disability Equality Standard Action Plan 2023

Year 1

#	Objective	Task	Can this be measured? And how?	Metric and target	Communication	Senior Lead	Operational Lead
	The specific goal or outcome that we want to achieve	The specific activities or task that need to be completed in order to achieve the objective		The measures that will be used to evaluate the success of the action plan, quality or improvement and determine whether the objective has been achieved	The communication plan for keeping all stakeholders informed about the progress of the action plan and improvements	Accountability for delivery of this action will be with the Senior Lead	Responsibility for the practical implementation of this action will be with the operational lead
	1. Distribution of Band 1-9 and VSM **WDES 2023: 7.3% trust overall, 5.9% 8a+ trust, 6.9% clinical, 8.1% non-clinical**						
1.1	Increase declaration rates to 8.3% Trustwide and Increase awareness of disability, including hidden disabilities within the Trust	**Communication:** Stories from staff who have declared their disability about how they have found it beneficial and how it has allowed them to both access support as well as better manage their health/personal needs.	Target of 8.3% declaration achieved | Count of numbers of stories that have been published on flo	Engagement insights from comms (no. of clicks, read time, etc.) | Overall increase in Trust declaration rates/diversity from 7.3% to 8.3 declaration rates	Report engagement figures to WEG, review declaration rates via WDES	Chloe Crouch (Head of Communications and Engagement) & Hasan Reza (Head of Workforce EDI)	Communications Team
1.2	Increase declaration rates to 8.3% Trustwide	**Communication:** myth busting campaign regarding what is done with the disability data in ESR, who sees it, what is it used for (e.g. ESR visibility for managers/recruiters/etc.)	Target of 8.3% declaration achieved | Count of numbers of stories that have been published on flo	Engagement insights from comms (no. of clicks, read time, etc.) | Overall increase in Trust declaration rates/diversity from 7.3% to 8.3 declaration rates	Report engagement figures to WEG, review declaration rates via WDES	Chloe Crouch (Head of Communications and Engagement) & Hasan Reza (Head of Workforce EDI)	Communications Team
1.4	Promote the visibility of leaders with a disability through effective communication campaigns	**Communication:** build an effective campaign to increase visibility of disability in senior managers	Count of numbers of stories that have been published on flo	Engagement insights from comms (no. of clicks, read time, etc.) | Overall increase in Trust declaration rates/diversity from 7.3% to 8.3 declaration rates	Report engagement figures to WEG, review declaration rates via WDES	Victoria Robinson-Collins (Chief People Officer) & Hasan Reza (Head of Workforce EDI)	Communications Team
	2. Relative likelihood of applicants declaring a disability being appointed from shortlisting compared to those not declaring a disability **WDES 2022 Data: Non-disabled staff are 1.04 times more likely to be appointed than disabled staff**						
2.1	Take positive action on recruitment of disabled people	Include intendent panel members in the form of Inclusion Ambassadors (IAs) in recruitment within pilot services identified as having a >2.0 disparity in appointing applications without disabilities compared with applicants declaring disabilities	Yes, through Trac and our internal list of Inclusion Ambassadors	Reduction in disparity of applicants with disabilities to those without in shortlisting-appointing (from 1.04 to 1.02)	Reviewed on a quarterly basis at WEG, reported annually via WRES	Nicola Rutter (Assistant Director of People)	Ryan Harris (Recruitment Manager) & Hasan Reza (Head of Workforce EDI)
2.2	Review the recruitment process to ensure each stage is accessible, does not discriminate and encourages people with disability to apply	Audit of recruitment process, advertisement templates, generic application page and associated elements a candidate has to interact with to make an application at KCHFT	Summary findings of audit with recommendations	Audit outcomes, areas within the process or e-interface that need improving are recognised and addressed by the appropriate Trust team (e.g. recruitment team)	Audit outcomes reported to WEG, actions followed thereafter every quarter at WEG	Nicola Rutter (Assistant Director of People)	Ryan Harris (Recruitment Manager)
	3. Relative likelihood of staff declaring a disability entering the formal capability process compared to non-disabled staff **So few staff enter the formal capability process that this could not be meaningfully measure in 2022/23**						
3.1	Ensure that all ER processes are fair. The WRES & WDES data only looks at a small proportion of ER cases and disparity might be further hidden in ER cases that do not become formal disciplinary	**Audit**: Breakdown of all ER figures e.g. disciplinary, grievances, bullying, capability, tribunals, dismissals by race to be reviewed on a quarterly basis. Also those that access the resolution and accountability framework. Check that all individuals who are dismissed are recorded on Datix	Yes, provided that all ER cases are correctly put onto the Datix system. Link in with current ER reporting processes	No of ER cases overall broken down by protected characteristic | Audit outcomes show that 100% of ER cases reviewed were deemed to be fair by the MDT	Audit outcomes reported to WEG followed by quarterly reporting to WEG and ODBPs of services/teams where ER cases are disproportionally impacting any one protected group	Nicola Rutter (Assistant Director of People)	MDT
	4a. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months 22.2% v 16.6% **4b. Percentage of staff experiencing harassment, bullying or abuse from line manager 9.8% v 5.7%**						
	4c. Percentage of staff experiencing harassment, bullying or abuse from colleagues 16.5% v 9.6% **4d. Percentage of staff who reported harassment, bullying or abuse the latest time it happened 60.9% v 60.0%**						
4.1	Reduce the amount of bullying, harassment and abuse received by employees	Embed 'fair and just' principles in all policies specifically focused on challenges for colleagues with a long-term condition or disability. Ensure all policies acknowledge that the needs of an individual with long term conditions may change over time	List of policies and signed off assurance that these have been reviewed with these principles in mind in line with existing policy review timelines - multi year action	All EqIAs within HR policies have been reviewed to ensure that they have appropriately assessed potential impacts on protected groups (specifically long term conditions/disabilities)	Quarterly updates provided to WEG	Victoria Robinson-Collins (Chief People Officer)	MDT
4.2	Reduce the amount of bullying, harassment and abuse received by employees	Promote the use of Freedom to speak-up and Resolution and accountability champions to de-escalate conflict	Through existing reports provided by freedom to speak up guardian re: service utilisation & themes	An increase in the % of individuals who are contacting Freedom to speak up and Resolution and countability champions, by long term condition/disability	Updates provided at NLB Ambassador meetings and as appropriate to WEG	Joy Fuller (Governor Lead / Freedom to Speak Up Guardian)	NLB Ambassadors

4.3	Reduce the amount of bullying, harassment and abuse received by employees	All incidents of bullying and harassment reported in Datix are reviewed. Hot spots are identified and appropriate interventions are identified to reduce further incidents occurring	Yes, through Datix. EDI Team will support in analysis and reporting with ODBPs being asked to target interventions within teams/services where hot spots are recognised.	Number of % and incidences logged in Datix, by long term condition/disability	Claire Hayler | Reviewed on a quarterly basis at WEG and via ODBP meetings with VRC	Hasan Reza (Head of Workforce EDI)	P&ODBPs
4.4	Reduce the amount of bullying, harassment and abuse received by employees	Bullying, harassment and violence reduction: establish whether there is benefit to enhancing the processes that KCHFT already has in place around violence and aggression	Evidenced through the development of KCHFT's existing violence reduction guidance	Evidence that guidance related to staff is available on flo, an increase in the uptake of F2SUP linked to action 5.1	Outcomes of task reported to WEG on completion via a summary paper	Nicola Rutter (Assistant Director of People)	Hasan Reza (Head of Workforce EDI)
4.5	Reduce the amount of bullying, harassment and abuse received by employees	Communication: Stories from staff about how discrimination made them feel, how they see themselves in the organisation, how they built resilience	Count of numbers of stories that have been published on flo	Engagement insights from comms (no. of clicks, read time, etc.), an increase in the access of the KCHFT resolution framework and F2SUP in line with action 5.1	Quarterly updates to WEG with engagement report from the communications but also updates from ER with re: any increase in colleagues reaching out related to BH&D.	Chloe Crouch (Head of Communications and Engagement)	Communications Team
	5. Percentage of staff believing that their trust provides equal opportunity for career progression or promotion						
	63.5.0% Disabled and 68.8% Non Disabled						
5.1	Increase the percentage of Disabled staff who believe the trust acts fairly around progression or promotion	Promotion of existing development opportunities, non-mandatory TAPs training suite (in line with the definition agreed via WRES action 4.1) and development opportunities offered externally	Up take of opportunities and utilisation of TAPs resources, broken down by long term health condition/disability	Increase in the percentage of disabled staff believing that there are equal opportunities in career progression from 63.5% to 65%	Quarterly reports to WEG outlining uptake as per task 5.1 broken down by disability and/or health condition where the Trust has the necessary data (e.g. excluding external programmes) with division level detail for P&ODBPs	Margaret Daly (Director of People Development)	P&ODBPs
	6. Percentage of disabled colleagues compared to non-disabled colleagues saying that they have felt pressure from their manager to come to work, despite not feeling well						
	17.7% Disabled, 10.8% non-Disabled						
6.1	Raise awareness of Disability Leave Guidance	Include information about disability and carers leave in Trust induction and new managers induction. Ensure that it is clear that needs of disabled staff change with time	Evidence of Disability and Carers leave guidance in Trust induction and new managers training	Reduction in disabled colleagues feeling pressured into attending work from 17.7% to 15%	Quality reporting of disability and carers leave utilisation to WEG and associated appropriate committees	Margaret Daly (Director of People Development)	Sam Clark (Head of Talent and Development)
6.2	Raise awareness of Disability Leave Guidance	Communication: Article of flo around disability leave, maybe with a personal story from someone who has had to access this?	Count of numbers of stories that have been published on flo	Reduction in disabled colleagues feeling pressured into attending work from 17.7% to 15%	Quality reporting of disability and carers leave utilisation to WEG and associated appropriate committees	Chloe Crouch (Head of Communications and Engagement)	Communications Team
6.3	Raise awareness of Disability Leave Guidance	Updated existing Disability & Carers leave guidance to highlight use in allowing staff to attend appointments to manage their conditions	Guidance hosted on Flo	Reduction in disabled colleagues feeling pressured into attending work from 17.7% to 15%	Quality reporting of disability and carers leave utilisation to WEG and associated appropriate committees	Chloe Crouch (Head of Communications and Engagement)	Communications Team
	7. Feeling valued Percentage of disabled colleagues compared to non-disabled colleagues saying that they are satisfied with the extent to which their organisation values their						
	49.1% Disabled, 55.9% non-Disabled						
	8. Workplace adjustments Percentage of disabled colleagues saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.						
	86.9% of Disabled staff feel that reasonable adjustments have been made to enable them to work						
8.1	Relaunch the Wellbeing passport to improve staff experience and management support within current role as well as facilitate easier transition within (or outside) the organisation	Relaunch the Wellness passport within the Trust. Review the current Wellness passport with the Disability and Carers Network. Comms campaign to be launched to make sure everyone is aware of Wellness passport. Mention in new starters induction and also include in new managers training	Evidence that this is included in the Trust induction and new managers training.	Increase of colleagues reporting the Trust has made reasonable adjustments to enable them to carry out their work from 86.9% to 88%	Updates provided to WEG quarterly	Nicola Rutter (Assistant Director of People) & Margaret Daly (Director of People Development)	Hasan Reza (Head of Workforce EDI) & John Stone (Wellbeing Manager)
8.2	Increase the % of staff who feel reasonable adjustments have been made at work from 86.9% to 88%	Review the reasonable adjustment guidance to make it more accessible and easy to navigate. E.g. one page flow chart to show where to go. Sign posting to different types of reasonable adjustments that are available. Note that reasonable adjustments may change over time	New reasonable adjustment guidance signed off by the EDI ambassadors	Increase of colleagues reporting the Trust has made reasonable adjustments to enable them to carry out their work from 86.9% to 88%	Outcomes of review reported to WEG as appropriate	Nicola Rutter (Assistant Director of People)	Hasan Reza (Head of Workforce EDI)
8.3	Increase awareness of the reasonable adjustment guidance	Guidance to be sign posted in trust induction, new managers induction	Evidence of sign posting in trust induction and new managers induction	Increase of colleagues reporting the Trust has made reasonable adjustments to enable them to carry out their work from 86.9% to 88%	Quality reporting of measurable examples of reasonable adjustments such as disability and carers leave utilisation to WEG and associated appropriate committees	Margaret Daly (Director of People Development)	Sam Clark (Head of Talent and Development)
8.4	Increase the percentage of Disabled staff who believe the trust acts fairly around progression or promotion	Ensure that all meetings, both online and in person are accessible for all individuals within the Trust. Disability Carers Network is making a guide for this, to be added to New Staff Induction, new manager induction, sign posted through flo.	Accessibility guide to be included in Staff Induction, New Manager Induction, Sign posted through flo, all corporate arranged events to demonstrate they have considered accessibility.	Increase of colleagues reporting the Trust has made reasonable adjustments to enable them to carry out their work from 86.9% to 88%	Updates provided to WEG as per the progress of this action - potentially through the Disability & Carers network	Senior Lead needs agreeing	Communications Team

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 16
Report title:	Approach to 2023/24 Winter Planning
Executive sponsor(s):	Pauline Butterworth, Deputy Chief Executive and Chief Operating Officer
Report author(s):	Clare Thomas, Community Services Director, Adults
Action this paper is for:	☐ Decision/approval ☑ Discussion and input ☑ Assurance ☑ Information
Public/non-public	Public

Executive summary
This paper summarises the approach that KCHFT are taking to winter planning as a partner within the east and west Kent Health and Care Partnerships.

Report history / meetings this item has been considered at and outcome
A previous paper was based on the High Impact Actions and the Universal Offer was presented to Executive Team Meeting (ETM) in July. This paper was presented to ETM in October.

Recommendation(s)
The Board are asked to: • Agree the principles and approach to winter planning • Note the risks identified

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☐Responsive**	**☐Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications			
Risk and assurance	Yes / **No** (If yes, provide brief one sentence description of issue)		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐**BAF**	☐**CRR**	☐**DRR**
Equality, diversity and inclusion	Yes / **No** (If yes, provide brief one sentence description of issue)		
Patients / carers / public / staff / health inequalities	Yes / **No** (If yes, provide brief one sentence description of issue)		
Legal and regulatory	Yes / **No** (If yes, provide brief one sentence description of issue)		
Quality	Yes / No (If yes, provide brief one sentence description of issue)		
Financial	**Yes** / No (If yes, provide brief one sentence description of issue) Non-recurrent funding as described.		

Executive lead sign off	
Name and post title:	Pauline Butterworth
Date:	10 October 2023

Date: 5th October 2023

Kent Community Health NHS Foundation Trust

Report: KCHFT approach to winter planning 2023/24

Situation:

This paper summarises the approach that KCHFT are taking to winter planning as a partner within the east and west Kent Health and Care Partnerships (HCPs).

Background:

KCHFT are a provider partner in both the east and west Kent HCPs and are therefore supporting the HCP level Urgent and Emergency Care Recovery Plans. As part of these plans, NHS England (NHSE) are focussing on the 10 High Impact Actions that are evidenced to support system improvement in preparation for winter. The NHSE letter published on 27th July 2023 (Delivering operational resilience across the NHS this winter) sets out the expectation for systems to use the High Impact actions to underpin the winter plans (see appendix 1). There is also a universal offer of support from NHS England (initially focussed on east Kent as part of the tier 1 system support).

Assessment:

KCHFT are in the process of finalising the winter plan for 23/24.

Principles:

The document is based on the following principles and reflects the plans in place for east and west Kent HCPs.

- ***Data driven modelling of the winter demand and planned interventions***:

Kent and Medway Integrated Care Board (ICB) have supported an approach to modelling the beds that will be required in each HCP over the winter period based on historical patterns and known risks for this winter (e.g. Covid and respiratory illness). This modelling approach has also been used to demonstrate how the existing interventions in place will mitigate any anticipated bed gap. These existing interventions were agreed as part of the System Discharge Funding (SDF) and Better Care Fund (BCF) (detailed in table 1 below).

KCHFT have been working with system partners to identify additional schemes based on this data and funding has been sought via the Urgent and Emergency Care (UEC) Fund with the local authority to increase provision against interventions in east and west Kent (detailed in table 1 below).

Modelling of acute length of stay has also been used to identify further opportunities to target the resource in the Community Hospitals and Virtual wards over winter.

- ***Focus on the 10 High Impact Actions:***

The ten high impact actions describe the areas that have been evidenced to support systems to improve flow; the east and west Kent interventions in the 2023/24 winter plans have been mapped against these. The High Impact actions are detailed below and the alignment with the local interventions is shown in table 1.

1. **Same Day Emergency Care (SDEC)**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week
2. **Frailty:** Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay (acute):** Reducing variation in inpatient care and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4. **Community bed productivity and flow:** Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
5. **Care Transfer Hubs:** Implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6. **Intermediate care demand and capacity:** Supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7. **Virtual wards:** Standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and improve discharge.
8. **Urgent Community Response:** Increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid unnecessary admission.
9. **Single point of access (SPOA):** Driving standardisation of urgent integrated care coordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time.
10. **Acute Respiratory Infection Hubs:** Support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures

- ***Support from the Universal Offer and Getting it Right First Time (GIRFT) Team***:

The universal offer has 4 components which are self-assessment against a maturity matrix, online resource to support system improvement, NHS Impact website and development support for recovery champions to build capability.

In east Kent the support is being used to focus specifically on the development of a SPOA, this is based on the maturity assessment and the need identified to simplify the out of hospital referral routes.

In west Kent, recovery champions have been nominated but as yet the formal support has not commenced.

In addition, the GIRFT team have been supporting the east Kent system and have made a set of recommendations that very much reflect the priorities in the High Impact actions. For the out of hospital model, the key recommendations are:

1. Improve capacity and elasticity of the virtual ward
2. Introduce direct community access to diagnostics (also via the virtual ward)
3. Improve speed and simplicity of transfer to community hospital beds

Whilst these recommendations were made for east Kent, review of the data demonstrates that they also apply to the pathways in west Kent and therefore they have been incorporated into the KCHFT plan for both HCPs.

- ***Provider Collaboration***

Development of formal provider collaboratives is a national mandate and these are being developed in Kent and Medway. In both east and west Kent systems, KCHFT is working on winter interventions in close collaboration with partners and wherever possible interventions are being delivered in an integrated model.

In east Kent it is the intention to develop this as a formal collaborative with Kent County Council (KCC) and East Kent Hospitals NHS Foundation Trust (EKHUFT) prior to this winter to support development of the short-term pathways. In west Kent there is no formal collaborative planned for this winter but KCHFT are delivering a number of interventions such as the Virtual Ward and Transfer of Care Hubs by working in close collaboration with partners from KCC, Maidstone and Tunbridge Wells NHS Foundation Trust (MTW) and primary care. This will provide a foundation for more formal collaboration following the learning from east Kent.

Interventions:

The KCHFT interventions for east and west Kent are as follows:

HCP	Interventions (High Impact alignment)	Description	Funding/ Issues or risks
Both	Virtual Ward Expansion (HI 7 with links to HI 1 & 2)	KCHFT and EKHUFT joint delivery in east and KCHFT and MTW joint delivery in west. Currently not meeting trajectory but improvement plan in place with significant increase in activity in September. Agreed transfer of some resource from MTW to Hospital @ Home team in west Kent to increase capacity.	Funded via the SDF with application for recurrent funding in process.
Both	Increase in pathway 2 flow (HI 4)	Bed management improvement to reduce time from referral to admission and increase bed occupancy, on track.	Within existing resource
Both	SPOA (HI 9)	Clinical Navigation Hub established via a pilot in west Kent in September. Now planned to continue to March 2024 in west Kent and pilot based on William Harvey Hospital geography agreed to start (November TBC) in east Kent	West Kent pilot funded via SDF and ongoing funding to March 2024 agreed via Virtual Ward slippage and SDF funding. East Kent funding not yet identified.

Both	UCR/ Stack project (HI 8)	UCR teams in east and west Kent attending daily meeting to review the stack of category 3 and 4 ambulance calls and identify those that can be diverted to UCR. Currently aiming to expand with direct web access.	Within current resource
Both	Transfer of Care (TOC) hub (HI 5)	East Kent has hubs in place at all 3 acute sites with phased changes to ward processes being implemented. West Kent have developed a draft model with a planned pilot start in November.	Funding for administrative support via the BCF
EK	Pathway 1 Home First support workers (HI 6)	Joint recruitment by KCHFT and KCC of a team of Home First support workers- recruitment partially complete	Funded via BCF. Planned paper to the BCF committee from all Kent areas in November regarding recurrent funding. Additional capacity also applied for via UEC funding, awaiting response.
EK	Stroke Beds (HI 4)	Current new capacity at Westbrook of 10 beds with trajectory to reach 15 by 31st October.	Funded via BCF. Planned paper to the BCF committee from all Kent areas in November regarding recurrent funding.
EK	Westview and Westbrook (HI 4 and 6)	Proposed phase 1 of the east Kent provider collaborative to include mobilisation of 15 beds per site with an integrated model delivered via KCHFT, KCC and EKHUFT.	Funding applied for via the UEC process, awaiting decision.
WK	Intermediate flow improvement (HI 4)	KCHFT oversight of additional capacity in pathways 1 and 2 via third party providers.	Capacity funded via SDF.

Oversight:
In both HCPs the UEC Recovery Plan is reported to the Urgent and Emergency Care Board. In east Kent this is supported by a weekly delivery group.

Risks and issues:
The key risks to delivery for KCHFT in the two systems are as follows:

- Community bed productivity and flow: There are a number of co-dependencies to enable improved flow in the community beds which include internal factors such as review of estates and external factors such as access to domiciliary care. There is internal work underway to implement the principles of SAFER (practical tool to reduce delays in discharges in hospital environments). This has seen a recent improvement in the percentage of patients who are no longer fit to reside and a set of monitoring metrics have been agreed.

- Virtual Wards: The VW programme is not meeting the bed trajectory set in east or west Kent. This applies to the pathways led by KCHFT and the acute Trusts. In both systems clinical engagement, jointly agreed pathways, maximising use of existing community services and maximising potential for admission avoidance have been identified as levers to improve performance. However, the virtual bed trajectories remain very challenging.
- Single Point of Access: In both systems there are multiple access points used to access the out of hospital admission avoidance services, this is particularly the case in east Kent where there are two separate models of frailty virtual ward delivery. The west Kent pilot of a clinical navigation hub has informed development of a SPOA that meets the guidance definitions.
- Funding: Most of interventions detailed have funding agreed non-recurrently and there is an ongoing process to apply for recurrent funding. Funding decision is awaited on 2 schemes as described above.

Recommendation:

The Board are asked to:

- Agree the principles and approach to winter planning
- Note the risks identified

Name: Clare Thomas, Community Services Director - Adults.

Appendix 1: Delivering operational resilience across the NHS this winter

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Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 17
Report title:	Learning from Deaths Report Quarter One
Executive sponsor(s):	Dr Sarah Phillips, Chief Medical Officer
Report author(s):	Tatum Mallard, Mortality Review Programme Lead Amy Radford, Senior LeDeR Reviewer
Action this paper is for:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	

Executive summary

Overview of paper:

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.

Items of concern to be brought to the committee's attention:

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

Significant improvements in matters that were previously an area of concern and items of excellence are detailed in the report, and the action taken to improve patient care, safety and or staff wellbeing.

Report history / meetings this item has been considered at and outcome

Recommendation(s)

The Board is asked to

- **RECEIVE** the report.

Link to CQC domain				
☑Safe	☑Effective	☑Caring	☑Responsive	☐Well-led

Strategic ambition this report supports	Please tick
Putting communities first	☑
Better patient experience	☑
A great place to work	☐
Sustainable care	☑

Implications			
Risk and assurance	No		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐BAF	☐CRR	☐DRR
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	No		
Legal and regulatory	No		
Quality	Yes. Review process supports quality of care, report provided for quality assurance		
Financial	No		

Executive lead sign off	
Name and post title:	Dr Sarah Phillips, Chief Medical Officer
Date:	09 October 2023

Kent Community Health
NHS Foundation Trust

Learning from Deaths Report 2023-2024 Quarter 1 (April - June 2023)

1. Introduction

The Trust Mortality Review and Learning from Deaths process adheres to the National Learning from Deaths Guidance (2017). All inpatient deaths in East Kent have been scrutinised by the Medical Examiner since Q1 2021-22 and scrutiny for inpatient deaths in West Kent is in place for deaths occurring after Q2 2022-23. Where internal review is indicated in accordance with the learning from deaths and mortality review policy, this is conducted using a structured judgement review (SJR) method.
In line with the national guidance, 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 review. Of those deaths reviewed, the Trust reports 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 2023-2024:

Community Hospital Inpatient Deaths Dashboard – (Including Deaths Occuring >28 days post Transfer of Care (ToC))								
Number of Inpatient Community Hosptials Deaths			Number of Completed Reviews			Number of deaths considered more likely than not due to problems in care		
June	May	April	June	May	April	June	May	April
2	**1**	**5**	**1**	**5**	**2**	**0**	**0**	**0**
Quarter 1	Prev. Q4		Quarter 1	Prev. Q4		Quarter 1	Prev. Q4	
8	**14**		**8**	**4**		**0**	**0**	
Year 2023-24	Prev. Year 2022-23		Year 2023-24	Prev. Year 2022-23		Year 2023-24	Prev. Year 2022-23	
9	**55**		**9**	**63**		**0**	**0**	

Community Hospital Inpatient Mortality Data Q1	
Deaths selected for review by Structured Judgement Review (SJR) %	50
Gender (%) Female Male	75 25
Age range (years)	85 - 101
Mean Age (years)	89
Ethnicity (%) White British White Other Not Stated	37.5 12.5 50
Length of stay range (days)	10 - 31
Length of stay mean (days)	22.9

Community Hospital Inpatient Mortality Data Q1	
Number of cases where resuscitation documentation not in place at time of death	0
COVID-19 deaths recorded	2
Nosocomial deaths Recorded	1
Cause of Deaths including Frailty and Advanced Frailty	8
Referred to coroner	0
Referred for SJR by Medical Examiner	1

3. Learning identified from Community Inpatient Deaths

During Q1 The West Kent Medical Examiners did not make any recommendations for a structured judgement review. The East Kent Medical Examiners made one recommendation for an SJR to review the EoL care in Community Hospital as the patient's notes recorded restless and agitated prior to death.

Three other inpatient deaths were selected for review by SJR process in accordance with Trust policy. One as nosocomial case, and two others selected at random for learning and quality review. There was no evidence that any patient death was contributed to by unsafe practice arising from mismanagement or misuse of controlled drugs.

Primary causes of death included; Covid pneumonia, Upper Gastrointestinal tract haemorrhage and Aspiration pneumonia, Biological frailty, Ischaemic Heart Disease, Urosepsis, Upper Respiratory Tract Infection.

Eight inpatient deaths were reviewed by SJR during Q1 in accordance with Trust policy, some of these deaths occurred in the previous quarter.

There is one review from a death in June which will feature in the next report.

4. Evidence of Good Practice recognised in Community Hospital reviews

Spread of Scores Awarded for the Phases of Care for the Deaths selected for SJR					
Phase of care	Grading				
	Very Poor	Poor	Adequate	Good	Excellent
Admission and Initial			1	2	
Ongoing				3	
End of Life (EoL)			1	2	
Overall				3	
Patient record quality				3	

22 elements of good practice have been recorded from the 3 mortality reviews in Q1, with the comments spread between the three phases of care; Admission and Initial Assessment – 9 comments, Ongoing – 5 comments and 8 comments relating to End of Life Care.

Admission: Rehab and assessment completed. Discussion about TEP and put into place on admission. Discharge planning and possible fast track trying to identify

patients' priorities. Good documentation. TEP reviewed by doctor when completing admission clerking.

Ongoing: Good solid plans in plan making it clear for staff to follow. Anticipatory meds prescribed and ready for Covid bundle if needed, NOK made aware. Staff where mindful of patient wishes throughout. Ward escalated immediately to HTS when noticed patient was deteriorating. Good communication from team to family regarding changes in patient's condition.

EOL: Honest reassuring conversation with the patient. TEP reviewed with discussions with patient and NOK. What matters most to patient and family also discussed discharge planning started. Good communication with the patient and their family in 2 cases. Good documentation on progress notes. All EoLC aspects and RiO windows completed & documented

Feedback from next of Kin received via MEO:

- The care was marvellous. Everyone was so kind, considerate and thoughtful. The Family were so impressed and so thankful to you all for making a difficult time, a lot easier.
- Son was extremely complimentary of the care his mum received. He said the care was superb and the team did everything they could to help his mum.
- Care at Victoria Hospital had been outstanding.

5. Themes of Areas for Improvement Identified for Learning from Deaths

Areas of Improvement Categories	Apr-23	May-23	Jun-23	Total 23-24
Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls				**2**
Ineffective recognition of end of life	0	0	0	**0**
Issues relating to physical needs	2	0	0	**2**
Problems with medication including administration of oxygen				**3**
Issues relating to medications and/or symptom control	3	0	0	**3**
Problems related to treatment and management plan				**3**
Lack of involvement in care decisions	0	0	0	**0**
Lack of respect of patient and family wishes in decision making	0	0	0	**0**
Lack of documentation around capacity and best interests	0	0	0	**0**
Issues relating to Personalised Care Plans and other documentation	3	0	0	**3**
Issues relating to Fast Track and palliative care support	0	0	0	**0**
Problems with infection management	0	0	0	**0**
Problems related to invasive procedures	0	0	0	**0**
Problems related to clinical monitoring				**2**
Reversible causes of deterioration not considered/excluded and/or documented	2	0	0	**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				**1**
Issues relating to emotional, psychological, social, spiritual, cultural and religious needs	0	0	0	**0**

Areas of Improvement Categories	Apr-23	May-23	Jun-23	Total 23-24
Issues relating to support of families and those important to the dying person	0	0	0	**0**
Patient related communication issues	1	0	0	**1**
Team related communication issues	0	0	0	**0**
Total number of issues arising by month	11	0	0	**11**
No. deaths with completed SJRs	**3**	**0**	**0**	**3**

Areas for Improvement Identified for Learning from Deaths Reviewed in Q1
1. Problems in assessment, investigation of diagnosis Including assessment of pressure ulcer risk, Ventricular Tachycardia (VT) risk, history of falls
• No documentation noted from ACP to have reviewed patient when it was documented that there was a lump on her neck. • Dentures could have been removed earlier when patient wasn't taking solid food. Notes stated mouthcare given which should have prevented accumulation of waste under the dentures.
2. Problems with medication including administration of oxygen
• Patient had vomiting episodes which could have been better managed with non – oral antiemetics via regular injections or syringe pump. • A missed opportunity to manage agitation and restlessness an hour before death. Delay in processing patient's pain and agitation should be looking at time window and planning ahead of next medicine to assess and control symptoms. • Mouthcare –oral thrush recorded, however no documentation by doctor/ACP, it appears not escalated.
3. Problems related to treatment and management plan
• Last days of life need completing per shift. • Risk assessment should have been completed for stay in the side room especially as patient was noted to be confused. • More detailed care plans exploring different model of care/intervention for patient. (i.e. mobility, infection/confusion and how this will be managed on the ward).
6. Problems in clinical monitoring
• NEWS2 score sometimes not properly calculated. Documented that she was sometimes drowsy but this doesn't reflect on NEWS2 chart especially as it was mostly showing she was alert. • NEWS 2 chart needs to be clearer with appropriate scores documented - Recorded patient was unarousable but this didn't show on the NEWS2 chart and only 1 completed vital sign was documented on the chart. Full set of observations should have been done. No documentation of escalation to doctor when she became unarousable.
8. Problems of any other type not fitting other categories
Patient related communication • Advanced care plan states that she wants to be cared in NHS ward if she deteriorates but documented that relatives where been contacted to discuss discharge plans.

6. Community Deaths Mortality Data

Community Deaths Dashboard Q1								
Number of Community Deaths Reported for Mortality Review			Number of Completed Reviews (SJR)			Number of deaths considered more likely than not due to problems in care		
June	May	April	June	May	April	June	May	April
9	**15**	**12**	**3**	**3**	**2**	**0**	**0**	**0**
Quarter 1	Prev. Q4		Quarter 1	Prev. Q4		Quarter 1	Prev. Q4	
36	**31**		**8**	**6**		**0**	**0**	
Year 2023-24	Prev. Year 2022-23		Year 2023-24	Prev. Year 2022-23		Year 2023-24	Prev. Year 2022-23	
36	**109**		**8**	**37**		**0**	**0**	

Community Mortality Data	Current Quarter Q1	Q1 Previous Year
Community Deaths notified	36	24
Community Deaths referred for full SJR	13	14
Number of Deaths reviewed by SJR that continued to undergo a Second Stage SJR	1	0
Number of complaints	4	4
Number reviewed via PSIRF	3	2
Number with Safeguarding investigations	0	0
Number referred for SJR by the Medical Examiner	2	0
Number reviewed and referred for SJR due to NoK comments collated by the Medical Examiner	11 Reviewed 6 referred for SJR	-

Mortality Community Pateint Data	
Kent Location (%) East	68.81
West	31.19
Gender (%) Female	47.71
Male	52.29
Ethnicity (%) White British	40.37
Not Stated	55.05
Other	2.75
White Other	0.92
White Irish	0.92

In September 2021 the Medical examiner (ME) process began its phased induction for all community deaths in East Kent. The ME process roll-out in the west began in April 2023. During this quarter, the East Kent ME made a recommendation for a further SJR review of community two patient deaths; one where the family had raised a complaint via the ME as concerns raised about the End of life care, and the second case as pain and agitation documented in Rio notes and appeared uncontrolled.

12 of the 13 cases selected for an SJR have been completed and closed. No cases reviewed found evidence that any patient death was contributed to by unsafe practice arising from mismanagement or misuse of controlled drugs.

7. Learning from Community Deaths

All deaths have been reviewed against the RCP problem categories. Five of the SJR cases of death occurring during Q1 have had problems identified. One case reviewed was judged to be potentially avoidable due to problems in care (the Royal College of Physicians scale of avoidability is yet to be finalised) and has been raised as a Patient Safety Incident Investigation (Case 5).

Case 1: Problems in assessment, investigation of diagnosis Inc. assessment of PU risk, VT risk, history of falls - (No Harm) Lack of assessments. Action: Assessment windows to be completed on RIO when patient has reduced mobility and palliative diagnosis**.** **Problems related to treatment and management plan -** (No Harm) **–** no advanced planning in place for palliative patient with advanced metastatic disease Action: Earlier identification of approaching end of life. To start advanced care planning for patients with palliative diagnosis. **Problems of any other type not fitting other categories -** (No Harm) Inappropriate prescribing for CMR Action: Previous history of opioid use not considered when requesting initial CMR for morphine to be added. **Problems of any other type not fitting other categories:** GP declining to prescribe all EOL medications for patient. Action: Case taken to the June EK LfD Workshop for cross-organisational learning.

Case 2: Problems with medication - (No Harm) - Prescribing and administering. Actions: Check all medicines are on chart and ensure prompt printing and delivering of CMR charts to patient's home. Check correct signed before issuing Medication. Update: Added to the Task & Finish group addressing incidents around prescribing documentation.

Case 3: Problems with medication - (Harm Caused) Under dosing and failure to escalate non-controlled pain. More confidence needed in managing EOL symptoms. To recognise pain management failures and escalate to appropriately.
Problems related to treatment and management plan (Harm Caused/ Probable Harm) –- discharged without review, Delay in catherization.

Due to the level of harm case 3 was referred to the patient safety team and has been included in a Local Patient Safety Cluster After Action Review.

Case 4 has had smart actions agreed with the operations manager for the team and the action plans will be monitored through the Qi Project; Learning from Deaths to improve EOL Care.

Case 4: Problems with medication - (no Harm) – improvement in initial patient assessment Action: full holistic assessment to be completed for all new patients admitted to the caseload within two-week period for those who will require on going care. E.g. catheter care, insulin administration End of Life care, chronic wound management. Evidence: Audit of new patient documentation for those patients admitted to the caseload during September 2023. **Problems related to clinical**

monitoring – (No Harm) To document handover conversations Action: To complete handover conversations on patient's RiO record. Evidence: Rio Audit to evidence of clear robust handover. **Problems related to clinical monitoring –** (No Harm) Improved recognition of Dying patient Action: Band 5 & 6's to complete recommended training as a priority with band 4 & 3's by year end of 2023. Evidence: Completion of training via TAPs - compliance report.

Case 5: - Raised as a PSII; Problems related to treatment and management plan - (Probable Harm) Lack of assessments. Action: Assessment windows to be completed on RIO when patient has reduced mobility and palliative diagnosis. **Problems related to treatment and management plan -** (Probable Harm) **–** Missed opportunity for TEP. discussions Action: To complete TEP and discuss options for treatment at home. **Problems with infection management -** (Probable Harm) Lack of MCA (patient decline treatment), no consideration of patient centred care Action: Consideration to refer to Home Treatment Services for symptoms and infection management, MCA to be completed when patient declines treatment. **Problems related to clinical monitoring -** (Probable Harm) No plan made to repeat observations on subsequent visits or follow up with outcome for GP re previous recording of very low oxygen saturation levels Action: Observations to be repeated on the subsequent visits.

Areas for Improvement Identified from Community Mortality Reviews (including; SJRs, Datix, Complaints, Patient Safety Learning and Safeguarding Adult Reviews) Mapped to the RCoP problem categories
1. Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls
• Missed identification of approaching end of life and the need for a syringe driver earlier in 6 cases. • The full ART care needs assessment was to be completed on admission to case load by an RN. • Earlier consideration around ordering equipment. • Delay in urgent visit for EOL in 3 cases. Action: The LRU are taking the learning forward with the team regarding the referral process.
2. Problems with medication including administration of oxygen
• Previous history of opioid use not considered when requesting initial CMR for morphine to be added. • Medication chart documentation (unsigned charts) & delay in printing and taking to home. • Medication administration error. Action: Staff to undertake e learning on TAPs, on end of life symptom control, including diabetes management. • Lack of steroid treatment not identified for 1 week following overdose by carers. Resulting in possible Addison's crisis. • Staff to be aware of Diabetes management at end of life, in Symptom control and care of the dying patient. Action: The CNT have already been in liaison with the Community Diabetic Specialist Nurse. The Community Nurse Specialist in End of Life Care is working with the teams to ensure syringe drivers are set up as per clinical need and work is ongoing regarding EOL assessments and anticipatory care planning. • TEP found to be in place when referred to HTS but no record of this within previous encounters by other community teams. No exploration of advance care planning prior to an emergency situation. • Missed visit – driver ran out, resulting in lack of drug administration for several hours. No evidence of Datix completed.

Areas for Improvement Identified from Community Mortality Reviews (including; SJRs, Datix, Complaints, Patient Safety Learning and Safeguarding Adult Reviews) Mapped to the RCoP problem categories
2. Problems with medication including administration of oxygen
• More confidence required in managing EOL symptoms. • Due to the sudden deterioration of patient and the pain that he described this should have been followed up as planned and not discharged. • Hospice advised increasing patch strength if required. However, it did not appear that this was considered further, despite oramorph for breakthrough. Morphine dose continued to be reduced as per hospice recommendation. Unclear if this was escalated back to hospice.
3. Problems related to treatment and management plan
• No assessment windows completed on RIO despite reduced mobility and palliative diagnosis (MUST/Purpose T/SSKIN/adv care planning) in 3 cases. • No TEP in place. DNACPR status not evident on RIO (docs or window) in 6 cases. • Review all patient DNAR status during initial assessment, refer to relevant clinician to complete doc. • CNT missed opportunities for holistic assessment as care task orientated for wound rather than holistic and recognising dying in 3 cases. • Lack of advanced planning, as soon as patient is unable to swallow or pass urine a catheter and syringe pump should have been considered in 5 cases. • the lack of a DNAR form Action: Training for Band 6 nurses in UCS to have the capability to write DNARs especially during the night shift when other services are not open. In house training on importance of all teams checking the house for DNAR even if stated in EDN. • Full assessment needed on RIO for a new catheter patient, full PMH. • Care needs assessment or enquiry into social support. • More registered nurse visits from ART • Better organisation of CMR/mauve charts. • Escalation of TEP and completion moving forward.
8. Problems of any other type not fitting other categories
Issues relating to support of families and those important to the dying person • Communication with daughter after death given incorrect information, causing distress to daughter whilst grieving. **Team related communication issues** • Ensure clear and concise documentation is completed in patient notes to accurately reflect the care and conversations staff have had. • Staff to ensure involvement of community specialties in Diabetes and end of life, when planning end of life care with patients and families. • Staff to escalate to senior staff if patients are not eating prior to administering insulin. • Staff to ensure that Insulin window is always completed, when administering insulin. • Staff to ensure that documentation is clear and concise and accurately reflects care and conversations with patients and families. • Transitions between HTS and community nursing teams do not demonstrate evidence of handover between teams or reflection in the notes of recent treatment provided by other community teams. However, care home where in place to be able to coordinate teams needed which occurred. • To ensure staff are working in line with the VOD process. • Escalation/communication between services. • To improve communication between teams.

Areas for Improvement Identified from Community Mortality Reviews (including; SJRs, Datix, Complaints, Patient Safety Learning and Safeguarding Adult Reviews) Mapped to the RCoP problem categories
8. Problems of any other type not fitting other categories
Patient related communication issues • Ensure that written instructions are in place for families for the use of additional medications such as buccal midazolam. Action: Staff will be supported to work with patients and their families to ensure understanding and confidence in the use of buccal midazolam. • Ensure that written information including clear leaflets are given to families to better support what families can and need to do following a loved one's death. Action: Alert shared for staff to highlight the importance of informing patients and families about the patient/carer led pathway. • Clearer communication: To fully explain reasons for change in decision for providing visit(s), and to considered the impact of these changes on families. Action: learning/action points discussed at the EOL steering group meeting • Consider the value of face to face support for families, as well as patients in end of life care situations. Action: learning/action points discussed at the EOL steering group meeting. • Ensure that written information including clear leaflets are given to families to better support what families can and need to do following a loved one's death. Action: Alert shared for staff to highlight the importance of informing patients and families about the patient/carer led pathway. • Consider the value of face to face support for families, as well as patients in end of life care situations. Action: learning/action points discussed at the EOL steering group meeting • Importance of providing clear written information as well as discussions with families to explain. • Consider the value of face to face support for families, as well as patients in end of life care situations. Action: learning/action points discussed at the EOL steering group meeting • Importance of providing clear written information as well as discussions with families to explain.

Areas of Improvement Categories	Apr-23	May - 23	Jun-23	Total 23-24
Problems in assessment, investigation of diagnosis including assessment of PU risk, VT risk, history of falls				**8**
Ineffective recognition of end of life	1	3	0	**4**
Issues relating to physical needs	1	3	0	**4**
Problems with medication including administration of oxygen				**7**
Issues relating to medications and/or symptom control	3	0	4	**7**
Problems related to treatment and management plan				**16**
Lack of involvement in care decisions	0	0	0	**0**
Lack of respect of patient and family wishes in decision making	0	0	0	**0**
Lack of documentation around capacity and best interests	0	0	0	**0**
Issues relating to Personalised Care Plans and other documentation	5	9	2	**16**
Issues relating to Fast Track and palliative care support	0	0	0	**0**
Problems with infection management	0	0	0	**0**
Problems related to invasive procedures	0	0	0	**0**
Problems related to clinical monitoring				**0**
Reversible causes of deterioration not considered/excluded and/or documented	0	0	0	**0**
Issues relating to nutrition and hydration	0	0	0	**0**

Areas of Improvement Categories	Apr-23	May - 23	Jun-23	Total 23-24
Problems in resuscitation following cardiac or respiratory arrest	0	0	0	**0**
Problems of any other type not fitting other categories				**14**
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	3	1	1	**5**
Patient related communication issues	0	5	0	**5**
Team related communication issues	0	3	0	**4**
Total number of issues arising	**13**	**24**	**7**	**45**
Number of deaths with completed SJR reviews	**4**	**1**	**1**	**6**

8. Evidence of Good Practice recognised in Community Patient reviews

93 elements of good practice have been recorded from the SJRs completed in Q4, with the comments spread between the three phases of care; Admission and Initial Assessment – 28 comments, Ongoing – 32 comments and 33 comments relating to End of Life Care.

Initial: RIO notes indicate good multi agency working in 5 cases, provided good care for patient and gave full support to family in 7cases, Patient's clinical observations were regularly monitored in 3 cases, HCA's initially recognised the patient was a falls risk and put preventative measures in place and made referral to OT. Documenting patient's pain and escalating concerns, Good documentation in 3 cases, Use of SBAR structure of first assessment, Factors contributing to wound healing considered e.g. nutrition and infection, Assessment tools such as SSKIN, Purpose T. EOL assessment completed, DNACPR discussed and patient's wishes around preferred place of death discussed and documented. Plan for catheter follow up.

Ongoing: Timely and appropriate response from nursing team. Referred to ongoing support in 3 cases. Sacral Ulcer care plan was completed by CNT and left in the home for ART to follow if necessary (shared care). Discussions with family about future care clearly documented on RiO in 2 cases. CHC fast track documentation completed in 2 cases. RiO demonstrates interaction with all teams, clear communication and the joint future care plan in 4 cases. Daily visits for wound and pressure area care. Compassionate care and offering reassurance to patient when tearful. Good response to relatives/NOK concerns. Documentation also remains extensive; ReSPECT document uploaded to RIO. Focus on privacy and comfort on all visits from all teams involved. Revisiting assessments even when previous visits have raised no concerns, e.g. pressure area checks. Evidence of brave, candid conversations about transfer to hospital by exploring her mental capacity thoroughly. 2-hour urgent response provided and a parallel planning approach provided, i.e. consideration of assessment for reversible causes and also reflection that end of life medications may be needed: 'hope for the best and plan for the worst'. Personalised care planning by identifying family that should be liaised with and use of occupation to engage conversations. Personalised care planning, medication review, provision of urgent oxygen and use of bedside diagnostics allowed hospital level care in a care

home. Open conversations with family by HTS team and an honest explanation that the acute episode of illness meant that patient was sick enough to die. Visits are all very prompt. Nurses have checked that the DNACPR and anticipatory medication is in the house. The puncture wound is photographed for wound matrix. Timely review by HTS and plan in place to treat pneumonia. Frailty consultant had honest conversation with family. Excellent assessments by HCA written in notes**.**

EOL: Comprehensive EOL assessment following rapid decline in health. Good ongoing support and contact from teams, onward referrals made. Stat dose of morphine sulphate given with good effect. Benefits of a syringe pump discussed with family. Initially were reluctant but agreed that if pain continued to discuss further in 3 cases. Request made to the GP for syringe pump medication to be prescribed and some medication changed to liquid form in 6 cases. Clear discussion with the family to monitor the patient's swallowing when assisted with eating and drinking and the risks of aspiration. Pressure ulcer care and repositioning discussed with family. My care plan written for syringe pump management. Communication with family in 2 cases. Thorough documentation in 4 cases. Buscopan suggested for colic pain. Ensured patient & family safe and have contact details in case required overnight. Visited daily for support. Staff escalating concerns and adjusting driver doses in response to clinical condition. Very good My Plan completed including EOLC plans

9. Pilot Project with Kent Medical Examiners

Feedback that is collected by the Medical Examiner as part of their process to contact all patient's next of kin. We identify patients on a community caseload at time of death with ACP and/or VoD windows completed and ask the MEO to collate and share the comments they have gathered from the relatives from the list of patients we shared. (These comments received would normally go back to the GP as they refer the death to ME for the cause of death to be agreed.) This means the community teams miss out on valuable feedback.

	April	May	June
Number of patients matching the criteria	77	49	66
comments with reference to KCHFT care	33	17	29
No concerns with care	12	7	13
Content/Happy/Complimentary of care received Of those that wished to comment further	18 9/18	8 4/8	11 5/11
Negative comments	3	2	4
Selected for SJR Review	3	1	0

Sample of positive comments:

- Very happy with all care received x7
- Care was brilliant
- Wonderful care
- Fantastic care
- Exceptional Care
- Very happy - excellent care
- Everyone was brilliant
- Everybody went above and beyond
- Excellent care given x2

- Care has been excellent, especially since Palliative
- Care was amazing

West Kent Data:
May: 33 patients matching the criteria, 12 came through the Medical Examiner Service with no specific comments collated.
June: 25 patients matching the criteria, 4 came through the Medical Examiner Service with no specific comments collated.

10. Learning Disability (LD) Mortality Reviews Report

LeDeR Mortality Review Report q1.pdf

Tatum Mallard – Mortality Review Programme Lead
August 2023

Kent Community Health NHS Foundation Trust

Mortality Review Report (LeDeR) – Q1 23/24 April-June

1. Introduction

The LeDeR Review team was commissioned in April 2021 and hosted by the Learning Disability service to carry out all LeDeR reviews on behalf of Kent & Medway CCG (ICB). They are responsible for leading and reviewing all deaths of people with a learning disability (aged 18+) and or Autism (aged 18+) across Kent & Medway that have been reported onto the national NHS England LeDeR programme. All deaths that are notified to LeDeR receive an initial review. Those that meet the criteria receive a focussed review.

There is an expectation that reviews are completed within 6 months of notification.

The detail within this report focuses primarily on patient's whose death occurred at the time they were open to a KCHFT service. The activity of the LeDeR team is broader than this which is why the report may hold additional information relevant to the service and deaths reviewed.

2. LeDeR Mortality Data

Deaths reported to LeDeR during Quarter 1		
	23/24	22/23
Number of deaths reported to LeDeR in Q1 open to KCHFT at time of death	11	12
Reviews awaiting allocation in Q1 23/24 (all reviews on platform)	25	
Death reported in Q1 where it is unknown if open to KCHFT at time of death [1]	3	

All reviews have been completed within the 6-month period, with no breaches.

KCHFT LeDeR Reviews completed/ signed off in Quarter 1 23/24		
Number of LeDeR reviews signed off by the ICB		10
Focussed Reviews		1
Age range (years)		26-88
Mean age (years)		58.2
Ethnicity (%)	White British	90
	Preferred not to say	10
Place of Death	Hospital	6

[1] Unknown if the client was open to a KCHT service at time of death as information not yet available.

	Residential Home	4

Cause of Death	
Dementia	1
Disease of the Circulatory System	1
Sepsis	2
Diseases of the Respiratory System	6

3. **Learning from completed LeDeR reviews** (patients open to KCHFT at time of their death)

Themes Identified for learning in reviews completed April-June 2023

The key themes and trends for Q1 23/24, mirror those seen in Q4 22/23. The themes detailed below are those most commonly found in the 10 reviews completed in Q1 for patient's whose death occurred at the time they were open to a KCHFT service. There was no direct learning link to any KCHFT teams, however they did identify positive practice for KCHFT which is detailed in section 4. The learning identified for other services who were also caring for the patient should be shared widely as KCHFT services may be in a position to identify similarities with own patients and services.

1. Annual Health Checks
2. Cancer Screening/Treatment
3. DNACPR Documentation

1. **Annual Health Checks (AHC)**
• 5 of 10 reviews identified areas of learning with AHC. This included poor quality of AHC and the client had not been invited for the AHC. • Of the above 10, 5 reviews identified the absence of a health action plan and a further where the action plan had been completed but not shared with the patient
2. Cancer Screening/Treatment
• 5 of the 10 reviews identified areas of learning relating to the offer or completion of recommended screening • 3 showing that limited screening was offered or took place • 1 review identified that a patient had declined screening • 1 review showing other as a concern with detail provided of a disclaimer on GP records at an early age that had not bene reviewed
3. DNACPR Documentation
• 3 of the 10 reviews identified areas of learning relating to DNACPR documentation • 2 showing that the DNACPR paperwork could not be found in the patient record. • 1 review showing that the paperwork had been updated in 2021 but the ambulance service held a previous version from 2017

All of the above learning is taken to the ICB LeDeR operational meeting, jointly chaired by the senior LeDeR reviewer and the Local Area Contact (LAC).

4. **Good Practice by KCHFT services identified from completed LeDeR reviews**

- The Home Treatment Service were able to identify the emotional load of this person's deteriorating health upon the care providers. The clinician from the home treatment team acknowledged the care team's anxiety and safety-netted her actions by requesting follow up by the GP. The care team were well-supported by the GP, other healthcare providers such as the East Kent Home Treatment Service and by members of the learning disability team.
- The Community Learning Disability Nursing Team completed video calls for 12 weeks following a patient's move to Kent, providing guidance and advise to his new support team which was out of borough.
- Good evidence of multi-agency work ensuring that the patient received full escalation of care. This ensured that the patient accessed appropriate support from the Community learning disability teams and specialists' teams during her admissions into hospital

5. **LeDeR ongoing work**
    - The admin position for the LeDeR team has been filled and the person is now in post.

Amy Radford- Senior LeDeR Reviewer
July 2023

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 18
Report title:	Reading the signals: Update on the workstreams implemented in response to - Maternity and Neonatal Services in East Kent – The report of the independent investigation.
Executive sponsor(s):	Dr Mercia Spare
Report author(s):	Dr Mercia Spare
Action this paper is for:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	

Executive summary

Purpose of the paper
To update the Board of the progress of the workstreams implemented at KCHFT in response to the and key action areas identified in 'Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation'.

Background
On 13 February 2020 the Minister of State, Department of Health and Social Care, confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSE/I) had commissioned Dr Bill Kirkup, CBE to undertake an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. The independent report was published on 19 October 2022.

Following the publication of the report, NHS England wrote to all NHS provider organisations to draw the report to the attention of Boards. It expressed a clear expectation that, organisations will review the actions below at their public Board meeting:

- Review the findings of the report;
- Examine the organisation's culture, and how the Board listens and responds to staff;
- Take steps to assure itself as a Board, and the communities that the organisation serves, that leadership and culture across the organisation positively supports both care and patient experience that the Trust provides;
- Evaluate the effectiveness of the mechanisms which provide the Board with effective intelligence to act on ("reading the signals");

In October 2022 a paper was presented to the Board on the actions being taken against the four key areas and a further verbal update was given in April 2023 on the key

streams of work that had been implemented to support long-term culture to enable people to speak up, and overall organisational governance.

Key Workstreams Implemented

- Executive portfolio review
- Good Governance Institute developmental well-led framework review
- Board effectiveness and culture
- Equity, Diversity and Inclusion programme
- Governors inclusion
- Staff Voice (Council)

Status and Impact to Date

The workstreams implemented in response to the Kirkup findings are either complete or progressing in line with agreed plans. They provide a platform on which to identify, escalate and monitor both risk and feedback to the Board, while strengthening the visibility of hard and soft indicators.

Conclusion

Positive culture in any organisation is a conscious decision made and delivered by all colleagues including the Board, governors and volunteers. It can only exist where there is psychological safety to make errors and learn from them, without the fear of retribution. Without this, closed cultures can form and impact on both staff and patient safety.

The general learning relating to organisational culture identified in the Kirkup inquiry are sadly reflected in the investigation in to neonatal deaths at the Countess of Chester Hospital NHS Foundation Trust. The findings emphasise the importance of having an open and transparent listening culture where staff understand how to raise concerns and are openly encouraged to do so without fear of retribution.

The work being undertaken with staff voice (council) will further strengthen the Trust commitment to acting on feedback and enabling opportunities for escalation of concerns. In addition, the Freedom to Speak up Guardian will complete the gap analysis against the new national guidance in the next month and it will be presented to the People Committee. October is ‘Speak Up Month’ and there are a number of promotions being undertaken to raise awareness of the training modules with services.

Recommendations

The Board is asked to note the progress on the workstreams and next steps.

The Board is asked to receive a more substantial paper on the learning from the Countess of Chester Hospital NHS Foundation Trust, in the public Board meeting in January 2024.

Report history / meetings this item has been considered at and outcome

In October 2022 a paper was presented to the Board on the actions being taken against the four key areas and a further verbal update was given in April 2023 on the key streams of work that had been implemented to support long-term culture to enable people to speak up, and overall organisational governance.

Recommendation(s)
The Board is asked to • **RECEIVE** the report

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

Implications			
Risk and assurance	No		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☐BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	No		
Legal and regulatory	No		
Quality	No		
Financial	No		

Executive lead sign off	
Name and post title:	Dr Mercia Spare, Chief Nursing Officer
Date:	9 September 2023

Kent Community Health
NHS Foundation Trust

Reading the signals: Maternity and neonatal services in East Kent – the Report of the Independent Investigation. Update on the impact of workstreams implemented in response to the findings of the public enquiry.

1. Introduction

1.1 On 13 February 2020 the Minister of State, Department of Health and Social Care, confirmed in Parliament that, following concerns raised about the quality and outcomes of maternity and neonatal care, NHS England and NHS Improvement (NHSE/I) had commissioned Dr Bill Kirkup, CBE to undertake an independent investigation into maternity and neonatal services at East Kent Hospitals University NHS Foundation Trust. The independent report was published on 19 October 2022.

1.2 The primary reason for the report is to set out the truth of what happened, so that maternity services in East Kent can begin to meet the standards expected nationally. The report identified 4 areas for action. The NHS could be much better at:

- Key Action Area 1: Monitoring Safe Performance – find the signals amongst the noise
- Key Action Area 2: Standards of Clinical Behaviour – technical care is not enough
- Key Action Area 3: Flawed Teamworking – pulling in different directions
- Key action Area 4: Organisational behaviour – looking good while doing badly

1.3 Boards were asked to

- Review the findings of the report;
- Examine the organisation's culture, and how the Board listens and responds to staff;
- Take steps to assure itself as a Board, and the communities that the organisation serves, that leadership and culture across the organisation positively supports both care and patient experience that the Trust provides;
- Evaluate the effectiveness of the mechanisms which provide the Board with effective intelligence to act on ("reading the signals");
- Be clear about the actions that the Board will take as a result of the above.

1.4 In October 2022 a paper was presented to the Board on the actions being taken against the four key areas and a further verbal update was given in April 2023 on the key streams of work that had been implemented to support long-term culture to enable people to speak up, and overall organisational governance.

1.5 This paper aims to update the Board on the status and impact of those workstreams to date.

2. Key Workstreams implemented

- Executive portfolio review
- Good Governance Institute developmental well-led framework review
- Board effectiveness and culture
- Equity, Diversity and Inclusion programme
- Governors inclusion
- Staff Voice (Council)

3. Status and impact to date

3.1 Executive portfolio review

This work is now complete. Clinical governance, quality and safety are now clearly aligned in to the Chief Nursing Officers portfolio enabling better triangulation of risks. A triangulation report has been developed and is submitted to the Quality Committee which aims to look at risk themes from a range of clinical assurance groups including safeguarding, IP&C, serious incidents and complaints.

The implementation of the national Patient Safety Incidence Response Framework (PSIRF) in 2023 is providing opportunities for early learning from patient incidents. This enables different approaches to review and investigating any patient incident (as opposed to just serious incident measured on level of harm). The introduction of the After-Action Review has been recieved as a positive approach by staff, as it is led by the team where the incident occurred, facilitated by the patient safety team and undertaken within two weeks so the details are still fresh in colleagues' minds. This enables any learning and required improvement to be applied earlier.

In addition, the Trust has appointed a Director of Governance, reviewed and updated the risk management framework and will implement an Integrated Governance and Risk group in November 2023, which will have overview of all organisational risks and look at the interdependencies

between clinical and non-clinical risk. This will ensure mitigation is both robust and impactful. It will also consider risks that have remained static for three months or longer.

3.2 Good Governance Institute developmental well-led framework review

This work is now complete and the actions have been considered and approved by the Board independently of this update. A number of workstreams were implemented from this including a strategy review and the subsequent development and launch of the We Care strategy, underpinned by 4 ambitions for the next 5 years:

- Putting Communities First
- Better Patient Experience
- Great Place to Work
- Sustainable care

Each ambition has a number of breakthrough objectives beneath it which are relevant to the services and provide a golden thread from the ambition to individual personal objectives.

3.3 Board effectiveness and culture

As part of Board development, they have commissioned a facilitated programme of work to analyse and enhance both the effectiveness and openness of the Board to deliver its statutory duties. This has provided opportunities to examine constructive challenge and consider individuals ability to speak up.

3.4 Equity, Diversity and Inclusion programme

A comprehensive programme of external support to engage the organisation on the key actions needed to shift the dial in relation to EDI has been delivered by the Public Engagement Agency which focused on staff engagement, feedback and plans for improvement. This has been reported to the Board in detail, independent of this update. Actions are now being progressed in the organisation which are being monitored by the People Committee.

3.5 Governors inclusion

A programme of joint Board and Governor development has been running for several months 2023 with good attendance and positive engagement. The Executive have aligned themselves with individual Governors so that

there is a clear escalation route for Governors to raise issues and general questions.

Staff governors now attend both the executive and the Board once every three months. This provides an opportunity for them to raise any concerns, issues or questions from colleagues direct to the Board.

3.6 Staff Voice (Council)

Extensive engagement with colleagues from across the organisation has taken place to co-design a new staff voice model, which includes developing a staff council-type approach. A draft model, developed by staff governors, network leads, FTSU guardian, health and wellbeing champions and other colleagues, was tested at our 'We care' conference in June, attended by 250 staff.

The aim of the model is to improve two-way communication between colleagues and the executive team, ensuring feedback is heard and acted upon. This will provide more opportunities for staff to raise concerns or share ideas for improving services.

The model has our staff governors at its heart – supported by local forums, staff voice (led by staff governors) and a staff council. Our staff networks, health and wellbeing champions and freedom to speak up (FTSU) Guardian are embedded into the model, which will help to triangulate feedback.

3.7 Freedom to Speak Up

The F2SU function has been reviewed to ensure it is appropriate to the level of contacts. There are a number of workstreams in place to raise awareness of this vital function. This includes developing the role descriptions and increased support and training for our staff governors; the training modules are being reviewed and promoted to relevant leaders in the organisation, such a line-managers to increase uptake. This is a targeted approach where uptake is known to be lower. There is an ongoing comms campaign to increase awareness of the ways people can speak up, including through the FTSU guardian.

In addition, there is refresh of the gap-analysis against the national guidance underway which will be completed in the next month and presented to the People Committee.

Further to the agreed workstreams, a review of the updated Fit and Proper Persons test framework is underway and will be presented to Board meeting the time frames outlined by NHSE.

4. Conclusion

4.1 Positive culture in any organisation is a conscious decision made and delivered by all colleagues including the Board, governors and volunteers. It can only exist where there is psychological safety to make errors and learn from them, without the fear of retribution. Without this, closed cultures can form and impact on both staff and patient safety.

4.2 The workstreams implemented in response to the Kirkup findings are either complete or progressing in line with agreed plans. They provide a platform on which to identify, escalate and monitor both risk and feedback to the Board, while strengthening the visibility of hard and soft indicators.

4.3 The general learning relating to organisational culture identified in the Kirkup inquiry are sadly reflected in the investigation in to neonatal deaths at the Countess of Chester Hospital NHS Foundation Trust. The findings emphasise the importance of having an open and transparent listening culture where staff understand how to raise concerns and are openly encouraged to do so without fear of retribution.

4.4 The work being undertaken with staff voice (council) will further strengthen the Trust commitment to acting on feedback and enabling opportunities for escalation of concerns. In addition, the Freedom to Speak up Guardian will complete the gap analysis against the new national guidance in the next month and it will be presented to the People Committee. October is 'Speak Up Month' and there are a number of promotions being undertaken to raise awareness of the training modules with services.

4.5 A further paper on the findings from the Countess of Chester Hospital NHS Foundation Trust will be presented to the Board in due course.

5. Recommendation

5.1 The Board is asked to note the progress on the workstreams and next steps.

5.2 The Board is asked to receive a more substantial paper on the learning from the Countess of Chester Hospital NHS Foundation Trust, in the public Board meeting in January 2024.

Dr Mercia Spare
Chief Nursing Officer
09 October 2023

Page numbering not necessary as automatic numbering is provided by the package we use to collate the papers

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 19
Report title:	IPC Board Assurance Framework
Executive sponsor(s):	Dr Mercia Spare
Report author(s):	Jacqui Griffin
Action this paper is for:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	

Executive summary

Legislative overview

The Health and Social Care Act 2008: code of practice on the prevention and control of infection is the legislative framework required to protect patients, service users, staff and others from avoidable harm in a healthcare setting.

The Health and Safety at Work Act 1974 and associated regulations, sets out the duty of care and responsibilities for employers and employees.
The Board Assurance Framework (BAF) is a comprehensive monitoring tool reviewed monthly and evidences repository in place aligning to these legislative frameworks.

Overview of paper

NHSE has changed the previous COVID-19 Board Assurance Framework (BAF) to include compliance against the Health and Social Care Act 2008: code of practice on the prevention and control of infections.

Evidence against the 10 criterions have been entered into the BAF; the template devised by NHSE provides a summary of compliance for each criterion and an overall compliance for the organisation. This is displayed as pie charts with a RAG rating.

- Red – not compliant
- Amber – Partially compliant
- Green – compliant.
- White – are areas that are not applicable to our organisation.

Within the 10 criterion there are a total of 150 key performance indicators of which the Trust is compliant with 125, and partially compliant with 21. Four key performance indicators are not applicable for the organisation. There are no indicators where the Trust is non-compliant.

Items of action to be brought to the Board's attention

Anti-microbial stewardship (AMS) requires strengthening in terms of closer monitoring and auditing of antimicrobial prescribing by Community prescribers.

Post infection reviews are being aligned to the Patient Safety Incident Response Framework (PSIRF) process. The IPC team are working closely with the patient safety lead and the IPC team in the ICB to complete this.

Significant improvements in matters that were previously an area of concern
During the COVID-19 pandemic there were delays in updating IPC policies that were out of date. These have now all been reviewed and updated to reflect national guidance.

Workstreams in place that positively support the strategic oversight and delivery of Infection Prevention and Control
NHSE published a National Infection Prevention and Control Manual that they mandated all organisations to implement. This has been successfully implemented into the Trust with teams transitioning well to living with COVID-19.
The IPC team actively contributes to the Kent & Medway system; guidance changes, epidemiological, and potential infection risks are promptly and appropriately acted upon for the organisation's needs.

How will this improve patient care, safety, or staff wellbeing.
Robust Antimicrobial Stewardship (AMS)- The increasing rates of Clostridioides difficile and multi-drug resistant organisms is a serious patient safety risk especially for the Trust's patients. Older frail patients and those with multiple co-morbidities are at an increase risk of developing adverse effects of antimicrobials including multi-resistant organisms and Clostridioides difficile infections. Working collaboratively with the Kent & Medway system can assist in supporting a co-ordinated approach to Antimicrobial Stewardship across the network.

PSIRF – Focuses on the learning from incidences to ensure changes in practice to promote patient safety. PSIRF is non-punitive and encourages a learning culture.

Report history / meetings this item has been considered at and outcome
Direct to board. Oversight and monitoring of key performance indicators reviewed by the Quality Committee.

Recommendation(s)
The Board is asked to • **RECEIVE** the report for assurance

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑

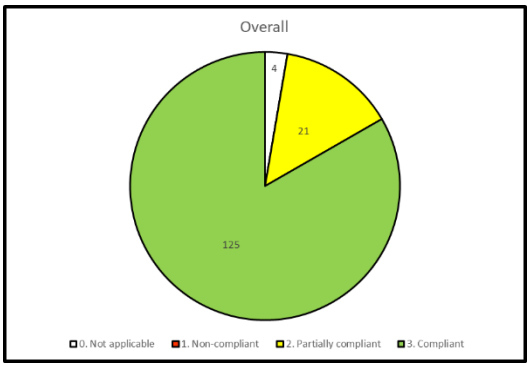
Better patient experience	☑
A great place to work	☑
Sustainable care	☑

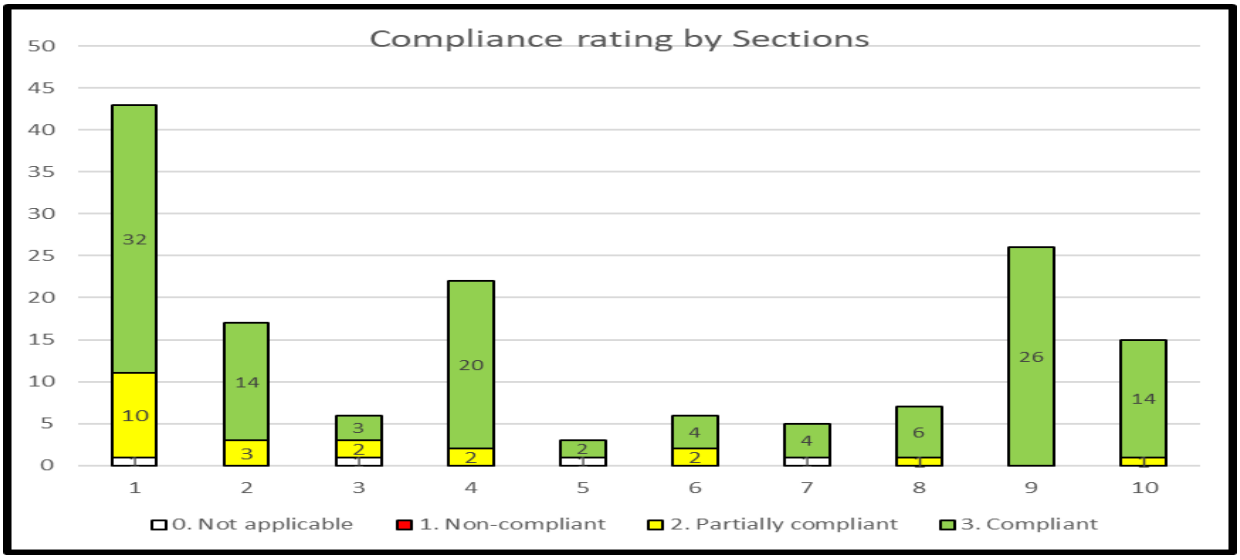
Implications			
Risk and assurance	No		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐**BAF**	☐**CRR**	☐**DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	No		
Legal and regulatory	Yes Requirement to comply with the Health and Social Care Act 2008: code of practice on the prevention and control of infections.		
Quality	No		
Financial	No		

Executive lead sign off	
Name and post title:	Dr Mercia Phillips-Spare. Chief Nurse and Director Infection Prevention and Control.
Date:	25/09/2023

Compliance wit he 10 criterion October 2023
(Health and Social Care Act, 2008)

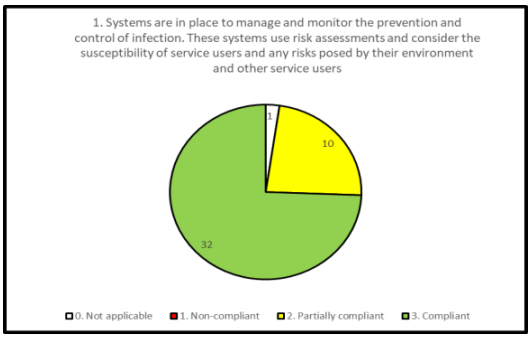
SUMMARY OVERVIEW





Breakdown of compliance to 10 Criterion

Areas of Partial Compliance and actions being taken



Target Date March 2024

Audit of compliance against IPC policies is being re-implemented in line with the NIPCM and organism specific SOP.

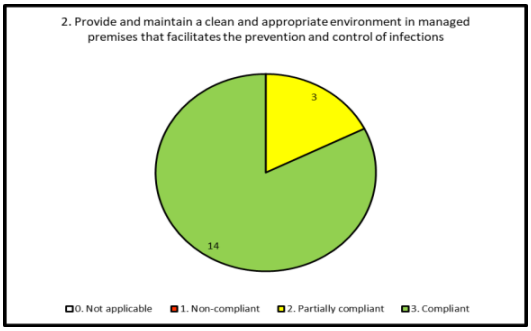
Work to Improve assurance that appropriate decontamination of medical devices in OPD and community teams is taking place.

Assurance of water testing from the external provider for the 2 PFI buildings is being carried out.

Closer monitoring and auditing of anti-microbials is being developed for dental, sexual health and community prescribing teams.

Improved and consistent facilities assurance reporting from NHS PS, external contractors including PFI buildings is being established.

PSIRF is being fully implemented in all post infection reviews.

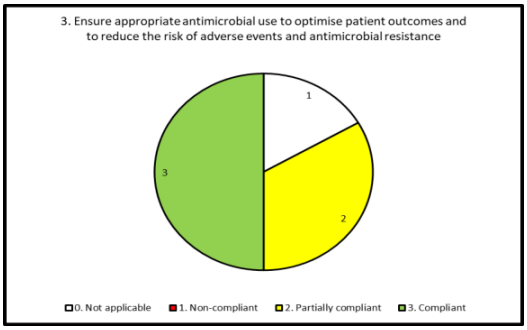


Target Date March 2024

Laundry KPIs re being confirmed and will be reported to the IPCAS sub-committee.

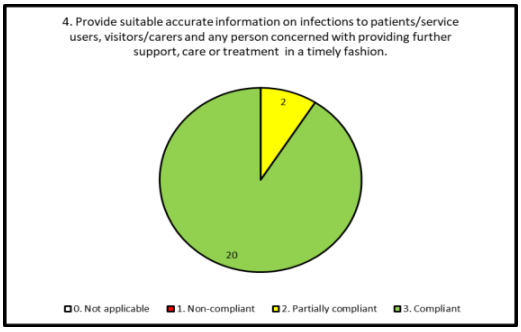
A more robust Dental procurement is being discussed to ensure that all devices procured can be appropriately processed by the Trust sterile services department.

Trust wide transition from infectious to offensive waste is in progress



Target Date March 2024

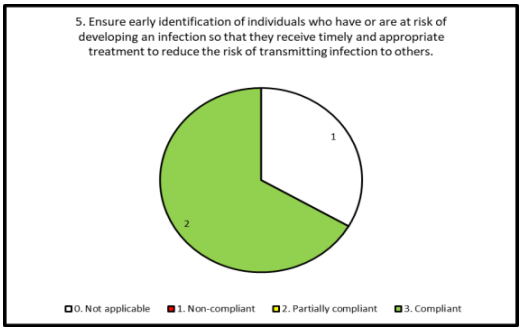
Audit and oversight on antimicrobial prescribing in community prescribers is being further developed.



Target Date March 2024

Standardised information about the use of antimicrobials for service users' needs to be developed and auditable.

Development of the referral paperwork into and out of KCHFT to include standardised IPC information recorded on it.



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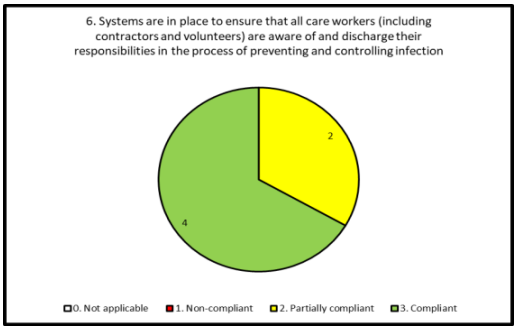
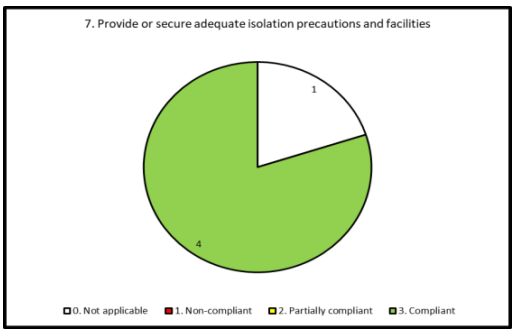


Areas of Partial compliance and actions being taken

Target Date March 2024
AMS training at induction and as part of the mandatory schedule is being developed.



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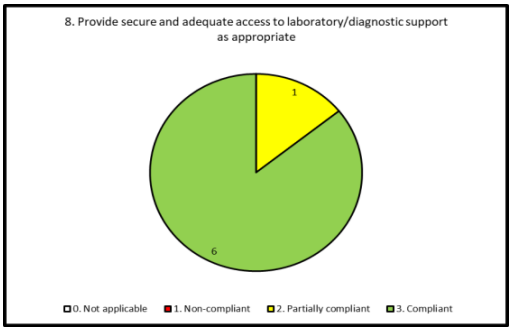
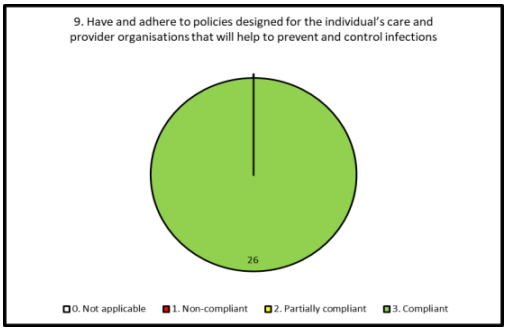


Target Date December 2023
Diarrhoea pathway for non-inpatients with diarrhoea is in development.



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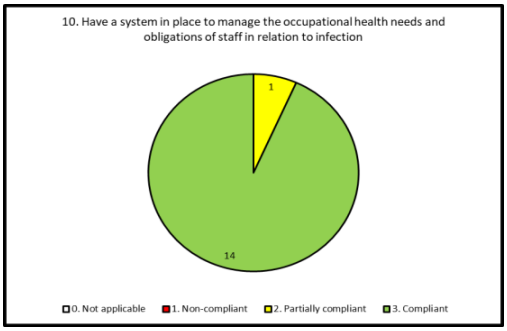

Target Date March 2024
IPC induction and mandatory training is being reviewed in line with the aims and outcomes of the Clinical Skills Framework, Skills for Health and Skills for Care.

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 20
Report title:	Director of Infection Prevention and Control (DIPC) Annual Report
Executive sponsor(s):	Dr Mercia Spare, Chief Nursing Officer and Director of Infection Prevention and Control (DIPC)
Report author(s):	Jacqui Griffin, Assistant Director of Infection Prevention and Control
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary

The Trust remained 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 during 2022/23.

Key performance over the year

- 207 patients tested positive to COVID-19 with KCHFT, 148 were nosocomial cases (identified after day eight and day 15 from admission).
- The Trust achieved its target of no cases of *Clostridioides difficile* infection (CDI) where level 3 lapses in care are identified by KCHFT staff. Three cases of *Clostridioides difficile* (CDI) were identified that were attributed to the ICB and where KCHFT had provided care. All of them were deemed unavoidable, but recurrent learning is the need for prompt stool sampling, and the need to have daily documentation of patients' bowel movements.
- There were no MRSA bacteraemia's; podiatry MRSA screening was 100%, In-patient units average is 84%. Patients were screened but not within the required timeframe.
- 1 Gram-negative bacteraemia identified in the acute following transfer from an in-patient unit. Learning identified included better documentation of catheter removal required. Catheter unlikely to be source of bacteraemia as urine culture on admission to the acute showed no growth.
- Both UTI and CAUTI breached the target for the year, with 144 UTI against a target of 137, and 39 CAUTI against a target of 36. Further analysis of the data has provided some themes for the IPC team to further work on.
- There have been 21 COVID-19 outbreaks, 3 Influenza outbreaks, and 1 Norovirus outbreak in 2022/23.
- 56.3% of eligible staff were vaccinated against COVID-19 and 58% of patient facing staff were vaccinated against Influenza.
- The National IPC manual has been implemented in the Trust resulting in 6 general policies no longer required. Nine organism specific policies have been

replaced with organism specific standard operating procedures with links to the National IPC manual. All IPC policies are in date.
- Bespoke training sessions have been delivered to clinical staff, and the link practitioner meetings have continued throughout the year. These have been re-invigorated with a new format which started 1st April 2023.
- The IPC team launched a Twitter page and actively promoted IPC week in October 2022 by undertaking a roadshow.

Report history / meetings this item has been considered at and outcome
This annual report has been considered at the Quality Committee in July 2023. Oversight of IP&C metrics and risks have been presented and discussed at Infection Prevention Anti-Microbial Stewardship sub-committee and the Patient Safety and Clinical Risk Group throughout the year.

Recommendation(s)
For the Board • To **RECIEVE** the annual report for assurance.

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☐
Sustainable care	☐

Implications			
Risk and assurance	No		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☐BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	~~Yes~~/No		
Patients / carers / public / staff / health inequalities	~~Yes~~/No		

Legal and regulatory	~~Yes~~/No
Quality	~~Yes~~/No
Financial	~~Yes~~/No

Executive lead sign-off	
Name and post title:	Dr Mercia Spare, Chief Nursing Officer
Date:	18 October 2023

Kent Community Health
NHS Foundation Trust

CCQ annual reports

Infection Prevention and Control

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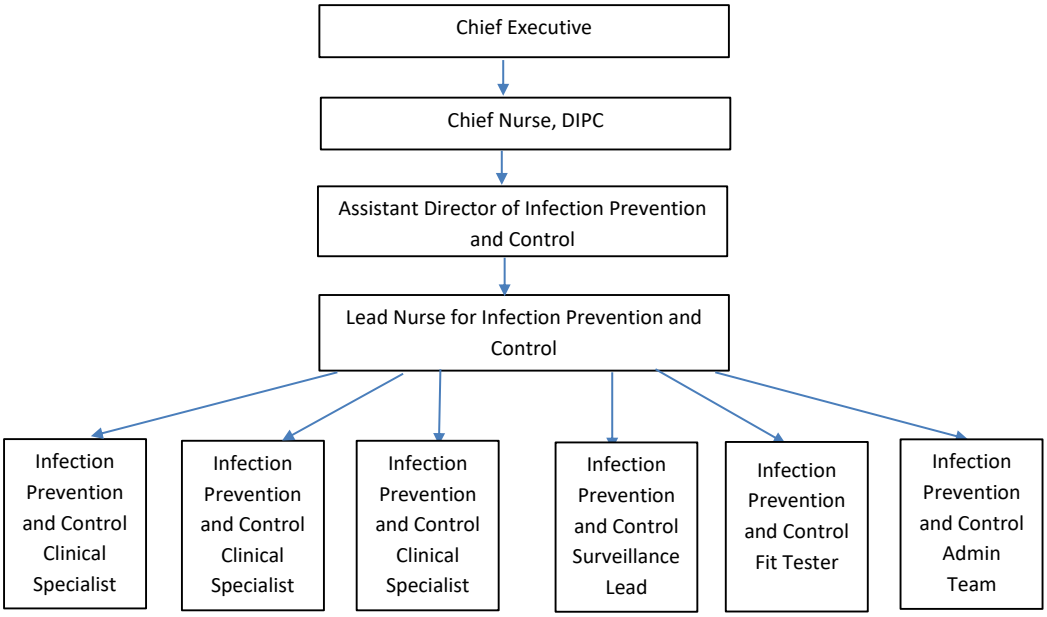
This is us

The Infection Prevention and Control Team consists of a Director of Infection Prevention and Control, an Assistant Director of Infection Prevention and Control, Lead Nurse ,3 IPC Clinical Specialists, 1 Surveillance Lead Administrator,1 team Administrator and a Fit Tester.



From December 2020 the Department of Health (DH) assigned a fit tester from the national team to assist with fit testing and this continued until April 1st 2023 when the national team withdrew the fit testers. Organisations now manage fit testing as part of business as usual.

In 2022-23 the Infection Prevention and control (IPC) specialists continued to support with the COVD -19 data collection at the weekends through their on-call service.

The IPC Team works closely with teams within the Trust and external organisations to ensure the organisation is compliant with the Health and Social care act 2008: Code of Practice on the prevention and control of infections (updated 2022). Working with the Estates team on new builds and refurbishments, water and ventilation safety. Joint efficacy audits with the facilities team checking areas are compliant with the National Cleaning Standards. The IPC team are a visible presence in clinical areas and on operational meetings, providing education, support and guidance on IPC policies and guidelines. They actively take part in system and regional meetings and attend IPC conferences and webinars to ensure they keep their specialist knowledge current with the latest research-based practice and evidence.

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This is what we do

This is what we do

The IPC Team is responsible for making sure KCHFT is compliant with all aspects of The Health and Social Care Act 2008; Code of Practice on the prevention and control of infections (updated 2022), and have action plans to address any gaps identified.

Compliance criterion:

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 that their environment and other users may pose to them.
2. The provision and maintenance of a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3. Appropriate antimicrobial use and stewardship to optimise outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4. The provision of suitable accurate information on infections to service users, their visitors and any person concerned with providing further social care support or nursing/medical care in a timely fashion.
5. That there is a policy for ensuring that people who have or are at risk of developing an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of transmission of infection to other people.
6. Systems are in place 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.
7. The provision or ability to secure adequate isolation facilities.
8. The ability to secure adequate access to laboratory support as appropriate.
9. Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10. Have a system or process in place to manage staff health and wellbeing, and organisational obligation to manage infection, prevention and control.

The team supports all services to make sure they are aware of their infection prevention and control responsibilities, write and implement all KCHFT infection prevention and control policies, and regularly collect data so the team can focus support where data suggests it's needed most. The Board Assurance Framework (BAF) went to Board and Quality Committee and we declared compliance as part of our annual IP&C statement.

This year, the focus has continued to be ensuring all guidance for COVID-19 was identified, evaluated and implemented, with an emphasis on living with COVID-19 as part of our normal business. We have worked collaboratively to ensure staff and patients were kept as safe as possible. Other operational IPC Team activities continued alongside this and in addition the team have been able to start working proactively around IPC promotions, education, and link

practitioner meetings.

The Facilities Team provides soft FM services to inpatient, outpatient and admin buildings across the county. This includes cleaning, catering, grounds and gardens, pest control, window cleaning, gritting.

The Estates Team makes sure all buildings are maintained to the highest level of service and responds effectively to emergencies and breakdowns for mechanical and electrical equipment, whilst maintaining compliance in our commercial and NHSPS estate. The Projects Team delivers capital funding schemes within the same building estate portfolio.

For KCHFT's commercial properties (non NHSPS, KCC etc) our mechanical and electrical (M&E) requirements are met using an outsourced third-party contractor.

Occupational health services (OH) are outsourced to a third party (Optima health) whose role is to provide an independent and confidential advisory service to the Trust and its employees. It advises on all matters relating to the effect of work on health and health on work.
The activities of the Occupational Health Department include:

- Pre-employment health screening,
- Immunisation of staff against Infectious Diseases,
- Providing advice and assistance in the management of Body Fluid Exposures,
- To advise both staff and management on the protection of employees against any physical or environmental hazard, which may arise from their work

Individual advice to staff on infectious illnesses they may have is not included in the contract with OH; staff advice is provided by the IPC team. During the pandemic the IPC and HR teams undertook COVID-19 contact tracing with staff; with the stepping down of COVID-19 precautions the test and trace system was phased out through the year. COVID-19 advice for staff is still provided by the IPC team and has now started to include advice to staff on other respiratory and non-respiratory viruses and infections.

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This is what we have done

Infectious Illnesses.

The IPC team have kept abreast of all the changes to the COVID-19 guidance promptly reviewing the changes and recommending the way forward for the organisation. During this reporting period Monkeypox (Mpox) was identified and the IPC team advised on the development of flow charts, the required PPE for staff, patient placement and isolation and cleaning after a suspected/ confirmed case. The team worked closely with the sexual health service and the MIU/UTC departments. Similar to COVID-19, Mpox guidance changed frequently in line with research findings; these were promptly communicated to staff with a number of changes to flow charts on the management of cases presenting with symptoms.

Winter viruses such as respiratory and gastrointestinal infections made a resurgence in the winter just gone, cases of RSV, Influenza, COVID-19 and Norovirus were all treated in our in-patient units. This caused significant bed pressures and at the height of it the risk averse approach of isolating patients who had been exposed to COVID-19 was stopped as was the routine asymptomatic testing of these patients. This was in line with the national guidance.

Patient screening for COVID-19

Routine screening (swabbing) of all patients was changed throughout the reporting period in line with national guidance. When the guidance for asymptomatic admission and discharge swabbing changed KCHFT moved to an LFT swab for their admission swab. This was to ensure patients were not positive on admission as they did not need to be screened prior to transfer to our inpatient units.
Day 3 and Day 5-7 screen were also discontinued and patients were only swabbed if they developed symptoms. KCHFT swab a patient 48 hours before discharge to another care facility.

Monitoring of compliance for admission day screening continued throughout the year as part of the inpatient wards KPIs.

COVID-19 isolation and outbreak management

All patients who have a COVID-19 positive result were isolated for 10 days until the last quarter when this was changed. Positive patients are de-isolated when they are 48 hours asymptomatic and meet the criteria for de-isolating.

COVID-19 outbreak management has been ongoing in this reporting period; a COVID-19 outbreak is declared if there are 2 or more nosocomial cases (Probable Health Care Onset & Definite Health Care Onset).

FFP3 mask fit testing

Updates to the national IPC manual state that staff should wear an FFP3 mask for all interventions with a patient who has a suspected or confirmed infection passed wholly or partially by the airborne route. or The IPC Team has a 1.0 WTE substantive fit tester who was supported with a fit tester provided by Ashfield Health funded by NHSE. The fit testing programme has been managed in a targeted approach for services that would require staff to be fit tested. Staff access fit testing through the TAPS system and the fit testers delivered bespoke fit testing sessions when this was more appropriate for teams.

Staff are fit tested using a Portacount machine. This fit testing method is a quantitative approach therefore does not rely on staff's ability to taste either a bitter or sweet solution. Fit testers can fit test up to 8 staff on 2 different masks as per the resilience principles in a day's session.
If staff cannot be fit tested successfully on FFP3 masks then a Powered Hood is provided.

IPC have frequently reviewed the staff groups whom require fit testing to be a mandatory training element. This will assist teams in ensuring they access the fit testing programme as this is on each staff members monthly training compliance record.
The staff groups identified as requiring mandatory fit testing are staff who are patient facing and cannot defer an appointment until the patient is out of their infectious phase. This includes facilities staff whom work in an inpatient area.

A PPE logistic team is established to monitor ordering and stock controls centrally within the organisation from national NHS supplies. Up until the end of March 2023 the Trust was receiving push stock but this is now being gradually phased out by NHSE with teams needing to order their own PPE supplies.

Staff support – COVID-19

The IPC team continued to support staff and managers with personal COVID-19 queries as this is not covered in the Occupational Health (OH) contract. During the reporting year there were a number of guidance changes specifically for healthcare workers which were cascaded out to all members of staff. Support and re-assurance were provided as required, referring to the research that had been undertaken by UKHSA and NHSE.

Staff flu vaccination programme/COVID-19 vaccination programme

In 2022-23 reporting period the administration of the Flu vaccination was in conjunction with the winter COVID-19 vaccination program. Eligible staff could have both vaccinations or opt for just

Flu or COVID-19.

Catheter associated urinary tract infections (CAUTIs) and urinary tract infections (UTIs)

The aim for 2022/23 was to reduce catheter-associated urinary tract infections (CAUTIs) and urinary tract infections (UTIs) compared to the previous year in our community hospitals and reduce community rates.

Urine samples were sent to both the laboratories in the acute EKHUFT for the East of Kent, MTW for the West of Kent. The KCHFT definition for both UTIs and CAUTIs requires a confirmatory microbiological report and sensitivity pattern for them to be counted as true infection. The inpatient units continue to submit the KCHFT UTI & CAUTI numbers each month and the IPC clinical visits incorporate this review.

The aim last year was for the IPC team to use existing systems such as RIO to review CAUTI / UTIs numbers in the wider KCHFT services. However, this was not possible due to how labour intensive it was. A QI project was also to be commenced to review the most effective ways of IPC delivering messages to teams for interventions such as effective hydration to manage the risk of UTIs and CAUTIs. Messages around interventions to prevent UTI/ CA-UTI were cascaded but the QI project was not able to start due to capacity issues in the team from vacancies.

Surveillance

Throughout the waves of the pandemic, the team have continued full daily surveillance of COVID-19, and continued with monthly surveillance of other infectious illnesses, including *Clostridioides difficile* infection, MRSA bacteraemia / colonisation, and UTI/ CA-UTI.

Gram-negative bacteraemia surveillance

There is no specific objective for KCHFT in relation to Gram negative bacteraemia's, as currently cases are not attributed; however, there is a national focus to reduce healthcare associated cases by 50% by 2024.

This work is still on hold due to demands from the COVID-19 pandemic. However, the IPC Team investigates cases that have been identified within one of our community in-patient units or a request from one of the neighbouring acute Trusts for information to help with their investigation. The IPC team will re-look at this in the coming financial year.

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Facilities Team

Throughout the pandemic IPC and facilities teams have worked collaboratively to maintain the cleaning services for each site. The facilities team are an integral part of reducing the risk of patients developing Healthcare Associated Infections and management of outbreaks.

The National cleaning standards document has been implemented with all areas displaying their star rating. Joint efficacy audits will be undertaken in 2023-24 between IPC and the facilities team.

Estates Team

The IPC team work closely with the Estates team with both the operational and projects side. We are involved in the design, procurement and finalising of new builds and re-furbishes.

The Assistant Director for IPC is involved in the water safety group meeting. Estates monitor water safety by regular testing for legionella and any positive results are sent to the Assistant Director IPC. Pseudomonas testing is not required as the organisation does not have any augmented care areas.

The Trust successfully appointed an Authorised Engineer (ventilation) and the ventilation safety group commenced towards the end of this reporting period. The Assistant Director for IPC is involved in this group. KCHFT only has specialist ventilation systems in QVMH theatres.

The IPC team have continued to raise the awareness of adequate ventilation in our inpatient wards and offices to manage to risk of transmission of COVID-19.

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Policy updates

There were a number of policies that were out of date or due to go out of date in 2022 therefore when the team was fully established they focussed on reviewing all of those policies. This coincided with NHSE launching the National Infection Prevention and Control Manual, to be used by all organisations. The IPC team reviewed all their general IPC policies with the manual and found that 6 general IPC policies could be replaced by the manual. A subsequent 9 organism specific policies have been replaced with organism specific standard operating procedures with links to the National IPC manual. This means that all of the IPC policies are now in date.

Education and Promotions

During this reporting period mandatory training has remained mainly via e-learning, but the team have delivered bespoke education training for clinical staff. The IPC team identified a need for the International Educated Nurses (IEN) to have a broader IPC knowledge than what was available in the on-line training, and with agreement from the practice development team time in the induction period was allocated for an IPC session. The session was interactive covering legislation, the national IPC manual, personal protective equipment (PPE) station, hand hygiene stations, process and pathways, sharps and waste management, OH, RIO and alerts.

IPC standard precautions workshop was delivered in response to an action from an outbreak de-brief, and the team have attended huddles on the in-patient units to provide updates on national changes that are being implemented in the organisation. The IPC link practitioner meetings have continued through the year, with 2 meetings per month being facilitated by the IPC team. These

were service specific and for each service these worked out to be quarterly. The format included an update on national guidance changes, especially on COVID-19, updates on infectious diseases in the region, feedback from incidents and datix, information included in the Infection Prevention, Control and Anti-microbial Stewardship meeting (IPCAS) report. Link practitioners were encouraged to request subjects they were interested in learning more about.

The IPC team have continually developed themselves, with 2 members of staff undertaking Uni courses. 1 is undertaking an MA in infection prevention and control, the other has done an introduction to infection prevention and control as they are new to the speciality. The lead nurse has undertaken a Florence nightingale foundation leadership course specifically for senior IPC practitioners and the assistant director has attended and successfully passed the Decontamination lead role. The associate practitioner (who undertakes the fit testing) attended a virtual FNF course on Infection Prevention and Control. The surveillance lead is currently undertaking an NHS apprenticeship to progress her development and to enhance the presentation and reporting of the data that is being collected with the infection prevention surveillance.

Infection prevention week was celebrated in October with an IPC roadshow; the team visited all of the community hospitals including all teams working out of those buildings over the week promoting winter orientated IPC. Topics covered were keeping warm and well in winter, vaccinations, hand hygiene, anti-microbial stewardship, and the national IPC manual. There were fun activities like the bugs rogue's gallery, and showing contamination from doffing gloves with the use of red paint. Each member of the team wrote a blog to go with the topic of the day which was tweeted on the IPC twitter page.

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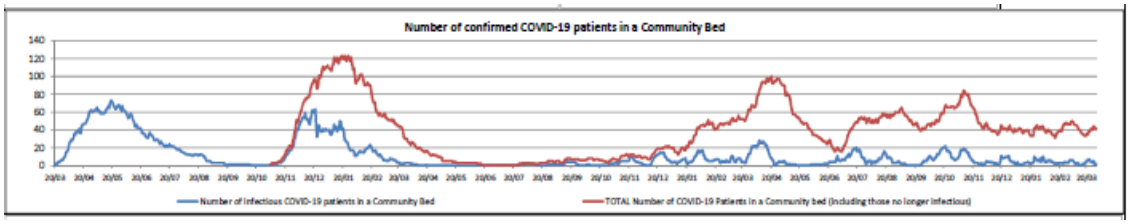
This is the impact we have had

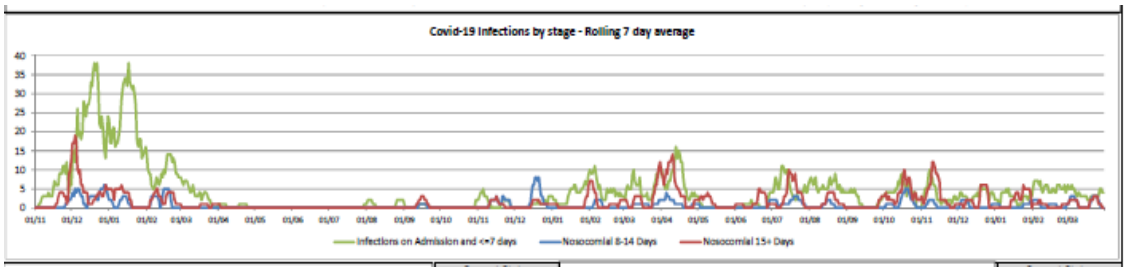
This is the impact we have had;

COVID-19: Incidents, outbreaks and surveillance



In this reporting period a total of 207 patients tested positive to COVID-19 with KCHFT, 148 were nosocomial cases (developed after day eight and day 15).

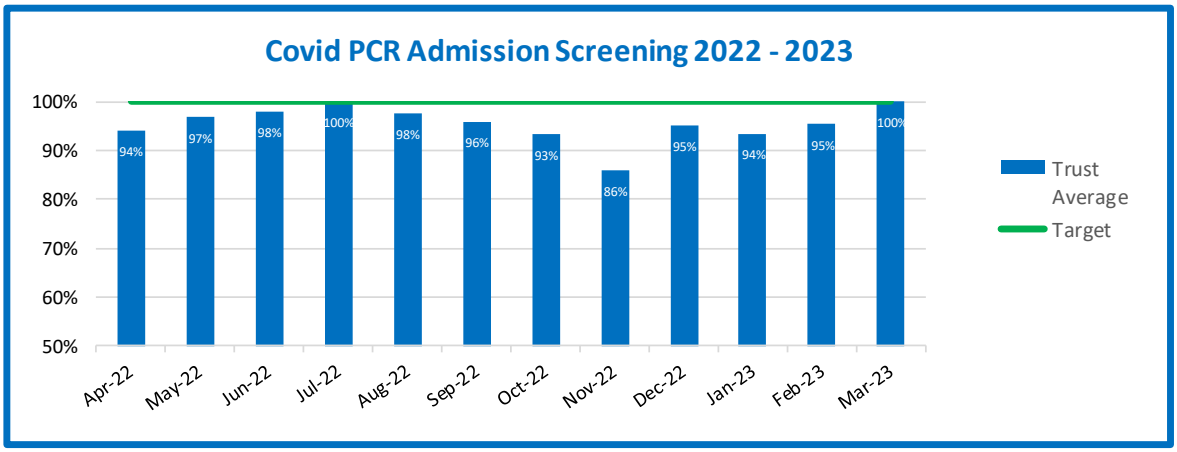
Nosocomial cases



Whilst national guidance was changed earlier in the reporting period so that patients exposed to COVID-19 did not need to be isolated or tested if they were asymptomatic. KCHFT took a more risk averse measure and continued with isolating patients who had an exposure to COVID-19 and regular testing throughout their 10 days of isolation. This was stopped in the final quarter due to “system extremis”.

COVID-19 Admission Screening compliance.

Admission screening for all patients admitted to inpatient units continued throughout the year.

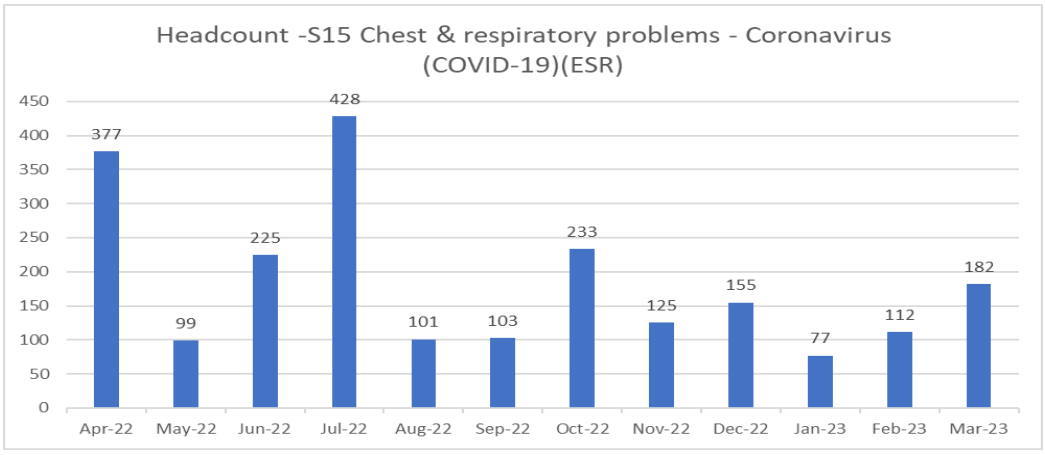


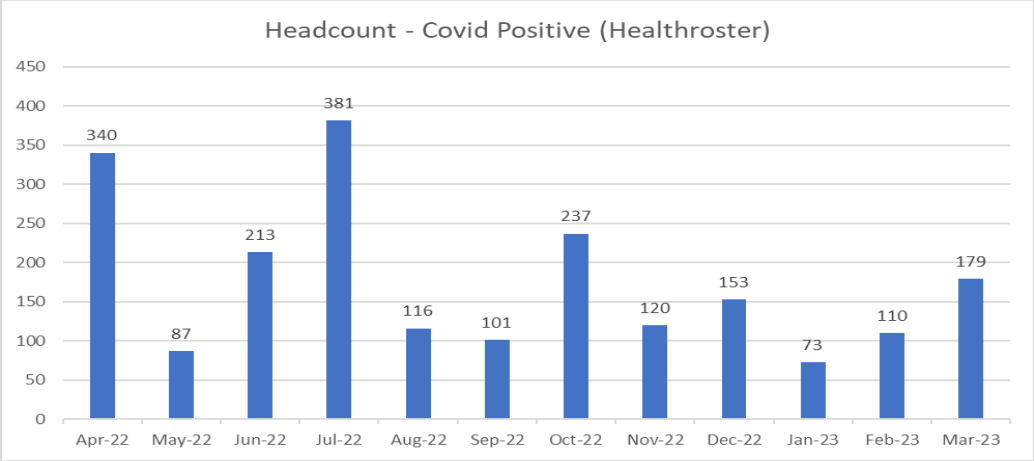
COVID-19: Staff

Throughout the year, sickness due to COVID-19 symptoms or COVID-19 positive result has continued; In September 2022 asymptomatic testing for COVID-19 was stopped for all staff except those caring for patients who were severely immunocompromised.

During the reporting time period the national guidance on self isolation for healthcare workers after a COVID-19 exposure was stopped, and this was implemented across the organisation.

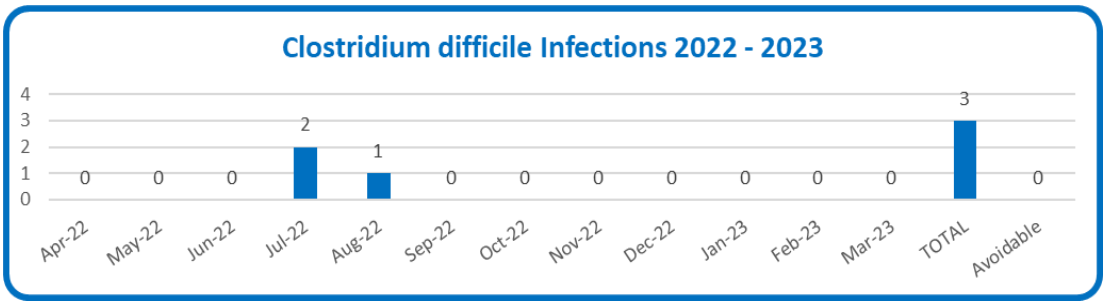
Absence reason:





Clostridioides difficile infection (CDI)

KCHFT does not report Healthcare associated CDI cases to UKHSA as the organisation does not have a laboratory. All samples are sent to the acute organisation laboratories. EKHUFT for samples in the East of Kent, MTW for the West of Kent. CDI attribution follows the national guidelines therefore the cases that are attributed to KCHFT are those that are attributed to the ICB and where KCHFT has provided input into their care. For this reporting period these were all in the in-patient units.

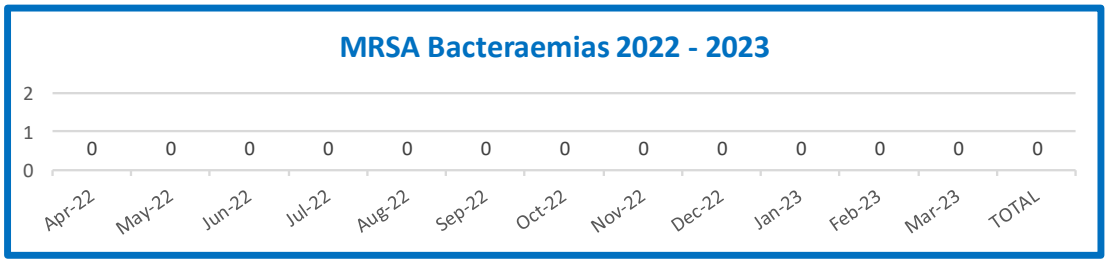


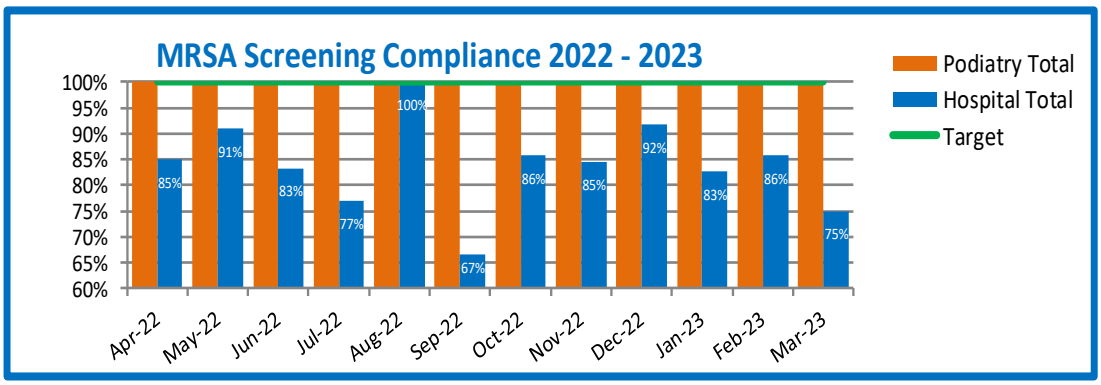
This year, 3 cases were identified that were attributed to the ICB and where KCHFT had provided care. This number is an increase of 3 cases on the previous year. Each case was investigated, and in 2/3 cases the route cause was deemed to be appropriate antimicrobial prescribing. The third case KCHFT had not prescribed any antibiotics but the patient had a history of CDI and had antibiotics in the acute. All these cases were deemed as UNAVOIDABLE, however recurrent learning is the need to send prompt stool samples, and the need to have daily documentation of patients' bowel movements.

There has been one case of CDI which was attributed to an acute organisation where KCHFT had prescribed some antibiotics whilst the patient was in our care and unfortunately these antibiotics were in-appropriate. Learning was fed back at the time to the prescriber.

MRSA

There have been no MRSA bacteraemias attributed to KCHFT for this year.





Podiatric surgery has been consistently fully compliant with MRSA screening. Within community hospitals average of 84% of patients were screened in line with policy, all were subsequently screened, and none were found to be MRSA positive. All wards were supported with reminding on the criteria for the requirement for MRSA screening when any non-compliances reported.

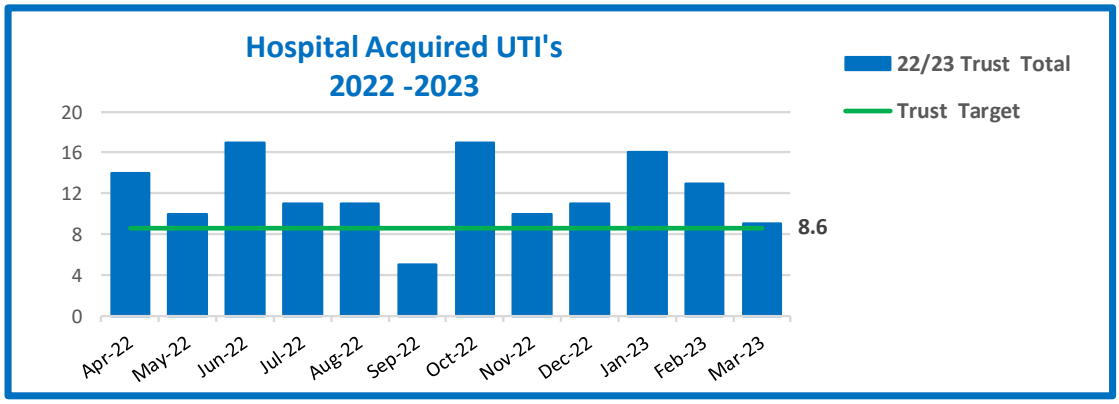
Gram-negative bacteraemia

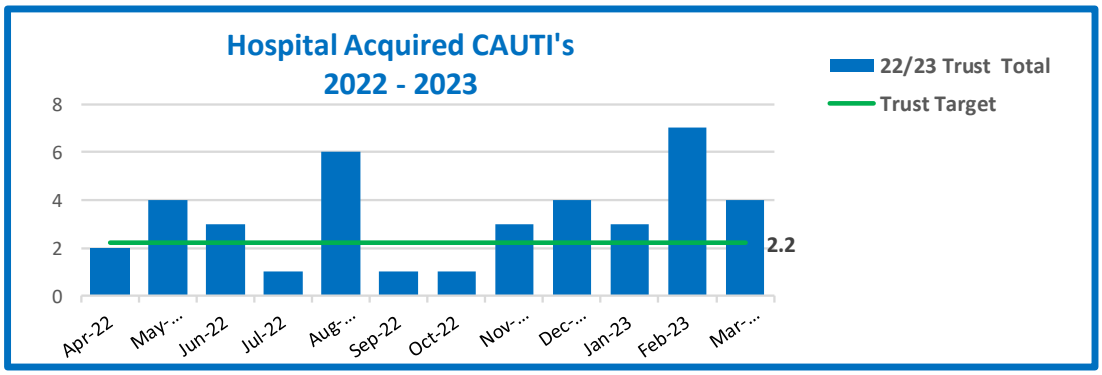
This work is still on hold due to demands from the COVID-19 pandemic. However, the IPC Team investigates cases that have been identified within one of our community in-patient units or a request from one of the neighbouring acute Trusts for information to help with their investigation.

There was 1 patient in this reporting year who developed their Gram-negative bacteraemia while in our wards. This was investigated, learning identified better documentation of catheter removal required. Catheter unlikely to be source of bacteraemia as urine culture on admission to the acute showed no growth.

Catheter associated urinary tract infections (CAUTIs) and urinary tract infections (UTIs)

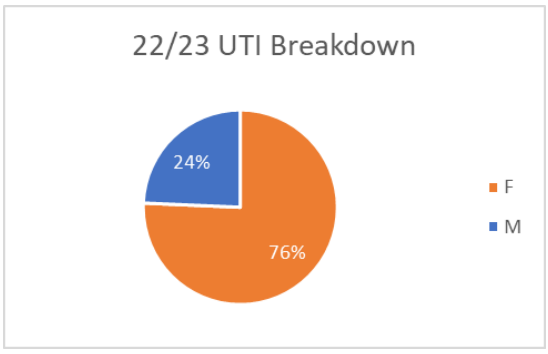
The aim for 2022/23 was to reduce both CAUTIs and UTIs compared to the previous year in our community hospitals and reduce community rates.

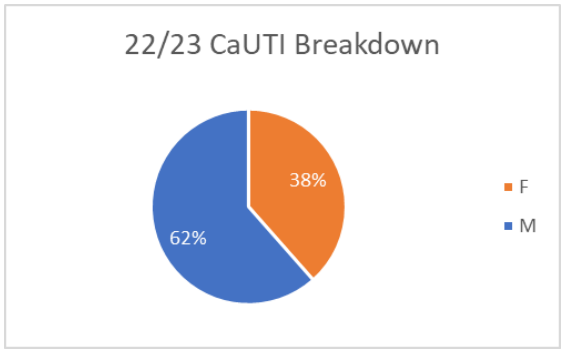




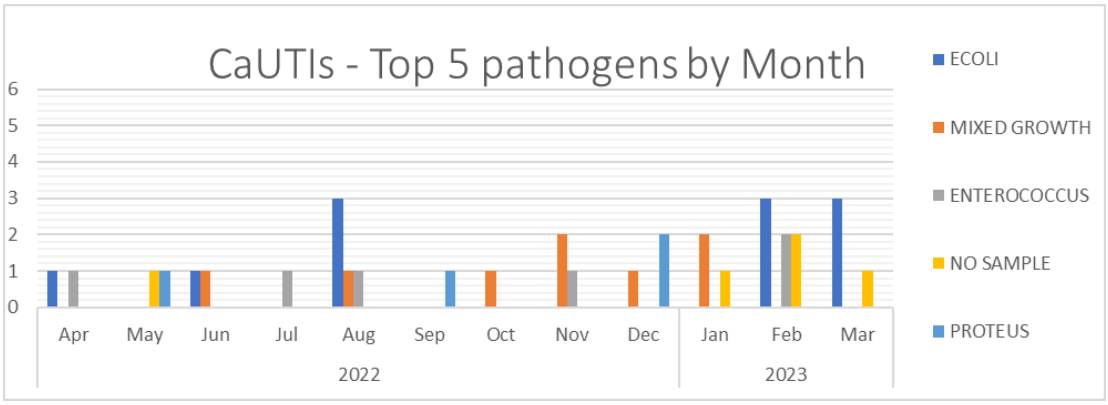
There were 144 UTIs and 39 CAUTIs reported in this year, this is an increase of 7 UTIs & 3 CAUTIs compared to last year. The KCHFT definition for both UTIs and CAUTIs is a confirmatory microbiological report and sensitivity pattern for the UTIs or CAUTIs to be counted as true infection. The data was looked at in relation to breakdown by sex, and the top 5 pathogens by month.

Male – female divide.



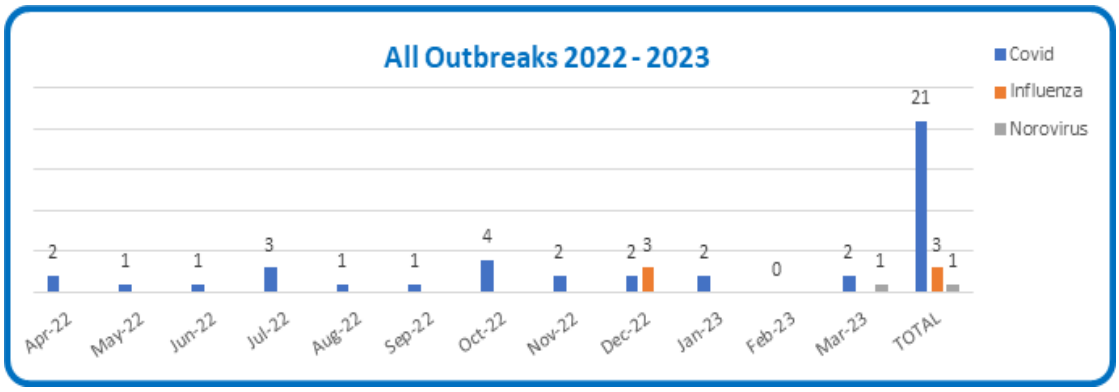


CAUTIs – top 5 pathogens by month



A QI project was proposed to ascertain the most effective way of IPC messaging to teams regarding interventions that can reduce the risk of UTIs and CAUTIs for the reporting year. The team struggled to get the QI project launched due to capacity issues from vacancies in the team, however they have continued with the CA-UTI steering group where meesages to help reduce CA-UTI have been cascaded.

Outbreaks.



In this timeframe, we declared 21 COVID-19 outbreaks 3 Influenza and 1 Norovirus outbreak. (Outbreak declared when there are two or more confirmed cases of the same organism on a ward).

Initial outbreak meetings were held for each specific site. Duration of outbreaks is dependent on the causative organism. COVID-19 outbreak is in place for 28 days, Norovirus and Influenza last until 48 hours after the last case and all positive, and exposed patients are asymptomatic for 48 hours. Actions were implemented quickly and all learning was shared across the organisation.

Staff flu vaccination programme/COVID-19 vaccination programme

In line with national guidance the staff flu and COVID-19 booster vaccination programmes were combined for winter 2022/23. The flu offer was to 100% of colleagues regardless of patient facing status, the COVID-19 offer was based on JCVI eligibility criteria and was prioritised as follows: place of work, age, health vulnerability of self or those cared for. As in previous years, colleagues who received either vaccination externally were asked to notify the trust using a link on Flo. The campaign ended in February 2023.

Cohort (covid criteria)	Number vaccinated (covid)	Number vaccinated (flu)	Total number of staff eligible
Patient facing / site**	2406	2,476	4,273*
Age	140		233*
Other (Health / caring)	124		Not known
Non-patient facing		340	592*
KCHFT trust total (inc externally vac)	2,671	2815	4861*
% patient-facing/ public-site staff vaccinated	56.3%	58%	

In the reporting period 58% of staff have been vaccinated for Flu and 56.3% for COVID-19. This is a continuing reduction from previous 2 year's reporting for Flu vaccination uptake.

Training compliance

		April 2022 - March 2023											
Compliance Category	Activities	Mar-23	Feb-23	Jan-23	Dec-22	Nov-22	Oct-22	Sep-22	Aug-22	Jul-22	Jun-22	May-22	Apr-22
Mandatory	Infection Control: Level 1	97.7%	97.1%	96.5%	98.5%	97.3%	97.3%	98.3%	98.4%	99.0%	99.0%	99.3%	98.9%
Mandatory	Infection Control: Level 2	96.0%	94.8%	94.7%	94.3%	95.3%	95.9%	96.0%	95.3%	95.7%	95.5%	94.3%	92.7%
Mandatory	Infection Control: Level 3	96.6%	96.2%	96.2%	95.4%	95.5%	94.6%	95.4%	96.3%	95.7%	95.7%	94.7%	92.6%
Mandatory	Hand Hygiene: Level 1	98.2%	97.6%	97.8%	98.4%	98.5%	98.1%	97.9%	97.6%	98.2%	96.5%	98.5%	98.3%
Mandatory	Hand Hygiene: Level 2	96.1%	94.3%	92.3%	93.1%	93.3%	93.7%	93.1%	93.6%	94.4%	93.3%	91.5%	87.1%
Mandatory	Hand Hygiene: Level 3	93.8%	92.7%	91.7%	91.8%	92.3%	92.1%	92.6%	91.8%	91.6%	91.1%	90.1%	87.5%
Essential to role	Mask Fit Training	58.4%	52.7%	47.8%	39.1%	36.8%	13.3%	5.9%	N/A	N/A	N/A	N/A	N/A

Mandatory IPC training and hand hygiene have remained above the 85% target thougout the year. FFP3 fit testing was added to the report from EWD in September and has been steadily increasing.

FIT testing FFP3 masks

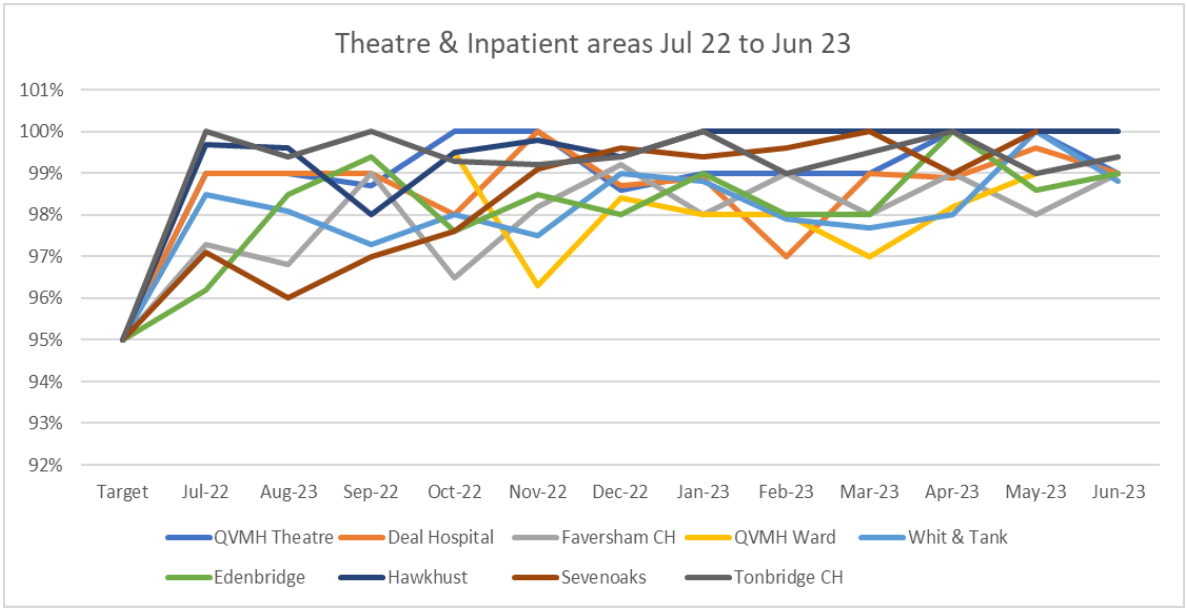
National guidance now requires all patient facing staff to be FFP3 fit tested on at least 2 different masks every 2 years. The wearing of an FFP3 mask is not just for when caring for COVID-19 positive patients, these masks are required for all infections transmitted via the airborne route. Staff in the target audience have the requirement identified on their TAPS training record. The fit testing compliance has been a regular agenda item on IMM with enhanced focus from the IPC team since September to ensure compliance improves.

Staff book FFP3 fit testing though the TAPS system. The pre reading for this involves watching a donning & doffing demonstration. If staff cannot be fit tested due to the shape of their face or facial hair they are recommended to have an air powered respirator. 1101 out of 1884 staff are fit tested on 2 or more masks as of the 30th March 2022 from EWD. This has increased from 480 staff at the same time in 2022.

Facilities

All KCHFT sites are monitored for cleanliness against the National standards of healthcare cleanliness 2021. This has been successfully rolled out through the organisation and the facilities are undertaking efficacy audits which the IPC team are involved in. All areas within the healthcare setting are assigned a Functional Risk (FR) category which determines the frequency of cleaning. This is based on the clinical activity within the clinical area: Inpatient sites are in the high-risk category with a compliance target for monitoring of 95 per cent. Performance reports are provided to IPC monthly.

The new cleaning standards started in July 2022 and the below graph shows cleanliness monitoring results for the inpatient sites according to the National cleaning standards, between July 2022 and June 2023.



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Kent and Medway IPC network and NHSE IPC network

The Kent and Medway Integrated Care Board (ICB) holds an IPC network call every 2 weeks where all organisations in the Kent and Medway system meet to share practice, learning, and discuss themes in the system.

Additionally, the ICB holds monthly leadership forums for the Directors and Deputy Directors of Infection prevention and control to share learning, good practice, training opportunities and contribution to the system IPC strategy and ways of working. The Assistant director and lead nurse infection prevention and control represented KCHFT at the K&M IPC strategy launch and presented how KCHFT would deliver the system strategy in their organisation.

The South East Infection Prevention and Control Network meetings are held every other week via MS Teams and discusses latest infectious disease rates, recommendations for organisations and guidance changes. Learning from incidences, and good practice is shared.

The ICB have held 2 IPC conferences for link practitioners which were widely promoted in the Trust and KCHFT link practitioners attended.

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Debbie Evans/ Kay Hare
IPC Team Administrator
07557 427468

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 21
Report title:	Safeguarding Annual Report
Executive sponsor(s):	Dr Mercia Spare, Chief Nursing Officer
Report author(s):	Andrea Svinurai, Safeguarding Assurance Lead Paul Hodson, Assistant Director for Safeguarding
Action this paper is for*:	☐ Decision/approval ☐ Discussion and input ☑ Assurance ☐ Information
Public/non-public	Public

Executive summary

The Trust remained compliant with its statutory and regulatory duties for safeguarding adults and children during 2022/23.

The purpose of this annual report is to:

- Provide an overview of the organisations safeguarding activity during 2022/23
- Provide assurance that the organisation is meeting its statutory safeguarding duties and responsibilities and is making a difference to patient outcomes.

Report includes and to note:

- An overview of the trust safeguarding statutory duty and how this is being met within KCHFT.
- The structure and mechanism of safeguarding delivery within KCHFT.
- Evidence of an increase in safeguarding consultations and activity for reporting period 2022–2023.
- Evidence of KCHFT staff receiving specialist safeguarding advice, support via mandatory supervision (planned and ad-hoc), training and consultation support.
- Evidence that KCHFT is an active member of local safeguarding boards, partnerships and sub groups. The voice of KCHFT is represented within these groups.
- Evidence of how the KCHFT Safeguarding Service supported safe patient care delivery including delivery of safeguarding training support complex case management and escalation.
- Training delivery program achieved its expected trajectory and full compliance of new training program has exceeded the 85% key performance indicator.
- The focus for the coming year to include:

- Learning and themes from safeguarding enquiries include use of professional curiosity, agency collaboration and information sharing, professional escalation, identification of carers, risk of suicide for victims of domestic abuse, engagement with fathers, adult mental health, understanding of; different cultures, forced marriages, and honour-based violence.
- Review of the safeguarding strategic plan to support and reflect the organisations 'We Care Strategy.'
- Preparation and readiness for the pending change in legislation for the deprivation of liberty of individuals. Report provides a summary of actions taken during this reporting period to ensure KCHFT is ready for the future introduction of Liberty Protection Safeguards (LPS). LPS will continue to be a focus for the team in the coming year.

Report history / meetings this item has been considered at and outcome
This annual report has been considered at the Quality Committee in July 2023. Oversight of data and evidence have been presented and discussed at KCHFT Safeguarding Assurance Group and Patient Safety and Clinical Risk Group throughout the year. Annual report was presented to the KCHFT Safeguarding Assurance Group on 14 July 2023.

Recommendation(s)
Safeguarding Service Annual Report 2022/23. The Board is asked to **RECEIVE** the report for assurance.

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☑
Better patient experience	☑
A great place to work	☐
Sustainable care	☐

Implications			
Risk and assurance	No		
Is the risk included on the Corporate Risk Register or Directorate risk register?	**☐BAF**	**☐CRR**	**☐DRR**
Equality, diversity and inclusion	No		

Patients / carers / public / staff / health inequalities	No
Legal and regulatory	This paper refers to the Liberty Protection Safeguards (LPS) which will be a change in legislation (implementation on hold until after the next general election). This is not a planning or delivery paper for the LPS introduction, therefore an equality assessment has not been completed.
Quality	No Assurance paper that the KCHFT is compliant with its statutory safeguarding duty and is supplying a quality safeguarding service to its service users.
Financial	No

Executive lead sign off	
Name and post title:	Dr Mercia Spare, Chief Nursing Officer
Date:	18 October 2023

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CCQ annual reports

Safeguarding Service 2022/2023

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This is us

Introduction

The Safeguarding (SG) Service works in partnership with key stakeholders to make sure children and adults at risk in our care are identified early and protected from harm using the 'Think Family' approach.

The purpose of this report is to:

- Provide an overview of the trust's safeguarding activity during 2022/2023
- Provide assurance that the organisation is meeting its statutory safeguarding duties and responsibilities and makes a difference to patient outcomes.

KCHFT Safeguarding Service works closely with local provider services throughout the Kent health and social care community to drive forward standards and quality of safeguarding. This includes providing safeguarding services to our services within Medway, East Sussex and London.

Safeguarding infrastructure

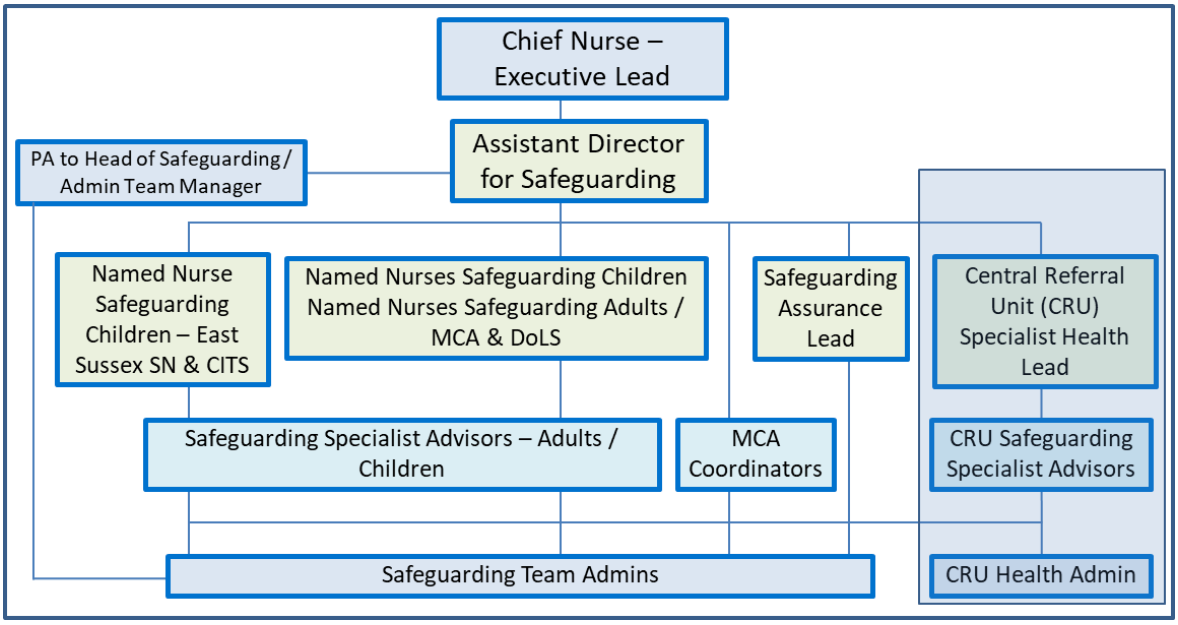
Statutory context

Kent Community Health Foundation Trust (KCHFT) Safeguarding Service is one team based across three sites providing support to north/west Kent/Medway, east Kent and east Sussex and parts of London. The service consists of children and adult named nurses and specialist safeguarding practitioners.

- The Children Act 1989 (Updated 2004) provides the core legislative framework for **safeguarding children**, which is supported by the statutory duty on agencies to co-operate in making arrangements to safeguard and promote the welfare of children. Working Together to Safeguard Children (2018) remains the key, statutory safeguarding children guidance that underpins local policy and procedure, in accordance with the Children Act.
- At local level, the Kent Safeguarding Children Multi-Agency Partnership (KSCMP) is the key statutory mechanism for agreeing how organisations/agencies within its geographical location will co-operate to safeguard and promote the welfare of children and for ensuring the effectiveness of

what they do. Lead officers within the trust were identified for each KSCMP sub-group, where the organisation had standing membership. KSCMP has system oversight for safeguarding children across Kent. Due to KCHFT also being commissioned to provide some services outside the Kent area – local partnership arrangements are followed if the children reside outside of Kent.

- The named nurses for safeguarding children have statutory responsibilities, as laid out in Working Together to Safeguard Children (2018), to support other professionals in their agency to recognise the needs of children, including responding to possible abuse or neglect. Their key roles and competencies are outlined in the Royal College of Paediatricians and Child Health intercollegiate document - Safeguarding Children and Young People: Roles and Competencies for Health Care Staff (2018).
- The named nurses for safeguarding children work closely with the trust's named doctors for safeguarding children. The safeguarding service routinely reviewed skill mix and locality in relation to provision as per the adult and children intercollegiate guidance documents.
- The Care Act 2014 provides the core legislative framework for **safeguarding adults**. There is also other legislation which supports the safeguarding of adults including the Duty Prevent, Modern Slavery Act and the Mental Capacity Act.
- The trust has standing membership on the Kent and Medway Safeguarding Adults Board (KMSAB), who have system oversight across Kent and Medway, and the trust is represented by the KCHFT Executive Lead for Safeguarding or Assistant Director of Safeguarding as deputy.
- Lead officers within the trust were identified for each KMSAB sub-group. Significant work continues within KMSAB with the service continuing to further develop and strengthen the local arrangements around safeguarding adults to meet the requirement of the Care Act 2014.
- The trust has a dedicated safeguarding page and workspace on the trust intranet site (flo) which enables colleagues to have access to up to date information on raising safeguarding concerns, support available and relevant guidance and policies for both adults and children. This workspace is updated regularly to ensure staff have accessible safeguarding information and guidance during their working hours to enable them to deliver care within legal frameworks.
- Kent Community Health NHS Foundation Trust's (KCHFT's) Safeguarding Operational Manual is available on the intranet and provides a link to the local safeguarding boards for adults and children multi-agency procedures and all relevant guidance and legislation to support staff in undertaking work that is associated with protecting the right for adults and children to stay safe, free from abuse and neglect. Together, these resources underpin the legislation to protect children and adults.


Chief Nurse – Executive Lead
Assistant Director for Safeguarding
PA to Head of Safeguarding / Admin Team Manager
Named Nurse Safeguarding Children – East Sussex SN & CITS
Named Nurses Safeguarding Children Named Nurses Safeguarding Adults / MCA & DoLS
Safeguarding Assurance Lead
Central Referral Unit (CRU) Specialist Health Lead
Safeguarding Specialist Advisors – Adults / Children
MCA Coordinators
CRU Safeguarding Specialist Advisors
Safeguarding Team Admins
CRU Health Admin

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This is what we do

This is what we do

We put the adult and child at the centre of all of our safeguarding support, ensuring safeguarding is personal and that we listen to the voice of the individual:

Policies and procedures

- We regularly review key legislation (including Prevent) to ensure our policies and processes reflect current guidance.
- We develop and update relevant trust safeguarding policies and guidance, as well as contributing to local multiagency policies.
- We work with the local safeguarding partnerships and boards to develop multiagency policies and guidance.

Case reviews and lessons learnt

- We work with local safeguarding partnerships and boards to fulfil our statutory safeguarding function to conduct safeguarding adults and children reviews when there has been significant harm or death to an adult or child. Throughout the review process, we identify lessons to learn and disseminate these across the health system. Improvements, where relevant, are imbedded into practice.
- We complete adults and children case reviews on behalf of the trust and respond to requests for SOIs (Summary of Involvement) / RRs (Rapid Reviews) /SARs (Safeguarding Adult Reviews) / DHRs (Domestic Homicide Reviews) / LCSPR (Local Child Safeguarding Practice Review), from local safeguarding adults board and children partnerships.
- We attend multi-agency meetings and complex case meetings as appropriate in order to support our staff with safeguarding cases and enquiries.

Specialist support

- We support our staff with access to a safeguarding duty consultation line, safeguarding supervision and training and also have an online safeguarding workspace to ensure all information is accessible to all KCHFT employees.
- We support our staff with complex safeguarding cases, professional escalation and referrals into social care.
- We ensure the whole family is considered when there are safeguarding concerns and ensure the child or the adult is the focus, their voice is heard and they are at the centre of the decision making and safeguarding intervention.

- We support staff and patients when there has been domestic violence and abuse incidents, to support identification, assessment and response to safeguard adults and children.
- We co-ordinate Section 42 Safeguarding Enquiries, by gathering information, supporting staff with chronologies and Service Provider Inquiry Reports (SPIR).
- We escalate concerns in cases when there is a lack of progress to minimise risks or when there is a professional disagreement.

Multi-agency working

- On behalf of the organisation we complete a Section 11 Audit (child safeguarding) and Adult Self-Assessment Framework (SAF) and themed audits ensuring that the trust does not work in isolation and continues to work collaboratively with partner agencies in Kent, driving forwards key safeguarding standards.
- We work with partners across the whole system in Kent, Medway and East Sussex as relevant, to support adults and children at risk of harm, through meetings, reviews, quality assurance and development/review of multiagency training, policies and procedures.
- We provide information and attend several local MARAC's (Multiagency Risk Assessment Conference) to provide health expertise and to support information sharing in cases of domestic abuse.

Training

- We deliver training across all areas of safeguarding to equip our staff with the right knowledge to enable them to support the people and families they care for.
- We have developed bespoke joint safeguarding children and adults training in line with new emerging threats and themes which include exploitation, domestic violence and abuse and self-neglect, with the end outcome of supporting staff to understand the indicators of these themes and how to support children, young people and adults. We raise awareness of new national and local themes and trends as they emerge. This year we have continued to support practitioners with knowledge of legal literacy, understanding self-neglect, changes in domestic abuse definition and inclusion of carers and fathers in assessments including how we imbed this learning in practice.

Supervision

- We facilitate ad-hoc adult safeguarding supervision sessions with staff to give them the opportunity to de-brief and reflect on their practices. In addition to that, we facilitate quarterly safeguarding supervision sessions to different staff groups; nursing, allied health professionals and support staff across Kent.

- The safeguarding children team continue to facilitate 1-1 mandatory supervision to Kent Health Visiting and School Health Service/East Sussex School Health in line with the KCHFT Supervision Policy. In addition to this we offer group supervision, ad-hoc supervision and debrief sessions for all KCHFT Services. The Safeguarding children team also provide regular group supervision for Band 5 public health nurses within Kent and children therapy staff in East Sussex services.
- The team have supported a number of band 6 and 7 professionals from children's services to develop safeguarding supervision skills. There were 10 who initially attended an In-Trac training session, which was delivered by an external trainer. Following this they have been supported by safeguarding specialist advisors by observing sessions and being observed. This is in order to facilitate safeguarding supervision to their own services to a unified standard. There are 8 staff who completed the shadowing requirement and are now facilitating safeguarding supervision to their services. There is 1 additional practitioner who arrived from another area and was delivering safeguarding supervision in the previous area. The safeguarding service will be available to these new supervision facilitators for support via the duty line, routine supervision and ad hoc sessions as needed.

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This is what we have done

- We have provided **2142 consultations** to staff through our duty line (1043 adult and 1099 children consultations and advice). This demonstrates good recognition of concerns and support provided to people at risk in the community. Adult related consultations increased by 12.5 % compared to 2021/22 and was 70% higher than 2020/21.
- We have delivered **515 supervision session (457 1:1 mandatory supervision sessions, ad hoc and 56 group supervision sessions** to Kent based staff. We have also provided **42 sessions of 1:1 mandatory, ad hoc and groups supervision** to KCHFT East Sussex School Nursing and Children Integrated Therapies and Equipment (CITES) Services.
- We facilitated ad-hoc adult safeguarding 1:1 and group supervisions with staff to give them the opportunity to de-brief and reflect on their practices as well as themed topics around application of the Mental Capacity Act, self-neglect, mental health and domestic abuse. We facilitated regular group supervision to primary care nurse leads of community nursing teams, community hospitals therapeutic workers, west Kent therapy staff, frequent services user's team and complex care nurses.
- We have processed **549 adult referrals** raised into the local safeguarding process, this is a 24% increase from the previous year. The main category of abuse raised was neglect, followed by the category of self-neglect and domestic abuse.
- Out of the **549 referrals** that were raised, we have completed **63 safeguarding enquiries that potentially implicated KCHFT**. However, the number of substantiated Kent Adult Safeguarding Concerns Forms (KASCF) was **four** following the completion of the safeguarding enquiry.
- We have supported operational staff in raising safeguarding referrals, completing chronologies and SPIR reports, professional challenge through multiagency escalation process and on occasions, incident reports. We have reviewed all reported significant incidents of a safeguarding nature and we were routinely involved in supporting patient safety investigations and After Action Reviews (AAR).
- Learning from incidents and safeguarding adult and children reviews remained a priority for the team. We worked closely with local safeguarding partnerships and boards to complete information requests for safeguarding adults and children review referrals within agreed timescales. We worked with services to develop action plans for all reviews where learning was identified and supported teams to make changes in processes and imbed learning in practice.
- We shared identified learning via monthly safeguarding news brief, patient safety and clinical risk group, link worker meetings and safeguarding assurance group meeting. Progress on action plans are monitored through the trust governance process and presented at safeguarding assurance group meeting attended by ICB (Integrated Care Board) colleagues. Safeguarding training was regularly updated with new learning, safeguarding supervision sessions were used to share updates and lesson

learned through discussion specific scenarios. Good practice and learning themes were triangulated from safeguarding, patient safety and mortality review incidents and shared with services through governance meetings.

- We have contributed to **26 Summaries of Involvements for cases referred to KMSAB** as potential Safeguarding Adult Reviews (SARs), **9 SARs** commissioned by KMSAB, **17 Rapid Reviews** requested by Kent and Medway Multiagency SG Children Partnership and **2 Rapid Reviews** by East Sussex Safeguarding Children Partnership, **5 Local Safeguarding Children Reviews** commissioned by Kent and Medway Multiagency Safeguarding Children Partnership and **1** by East Sussex Partnership, **1 Domestic Homicide Review** (DHR) commissioned by Community Safety Partnership and **5 cases that required DHR research.** The following table shows the number of competed reviews compared to previous years.

Safeguarding case reviews	2020/2021	2021/2022	2022/2023	
Summary of involvements	22	26	26	
Safeguarding Adult Reviews	8	6	9	↑↑
Rapid Reviews	8	24	19	↓↓
Local SG Children Practice Reviews	1	5	6	↑↑
Domestic Homicide Reviews	1	1	1	
Domestic Homicide Review enquiries/research	3	3	5	↑↑

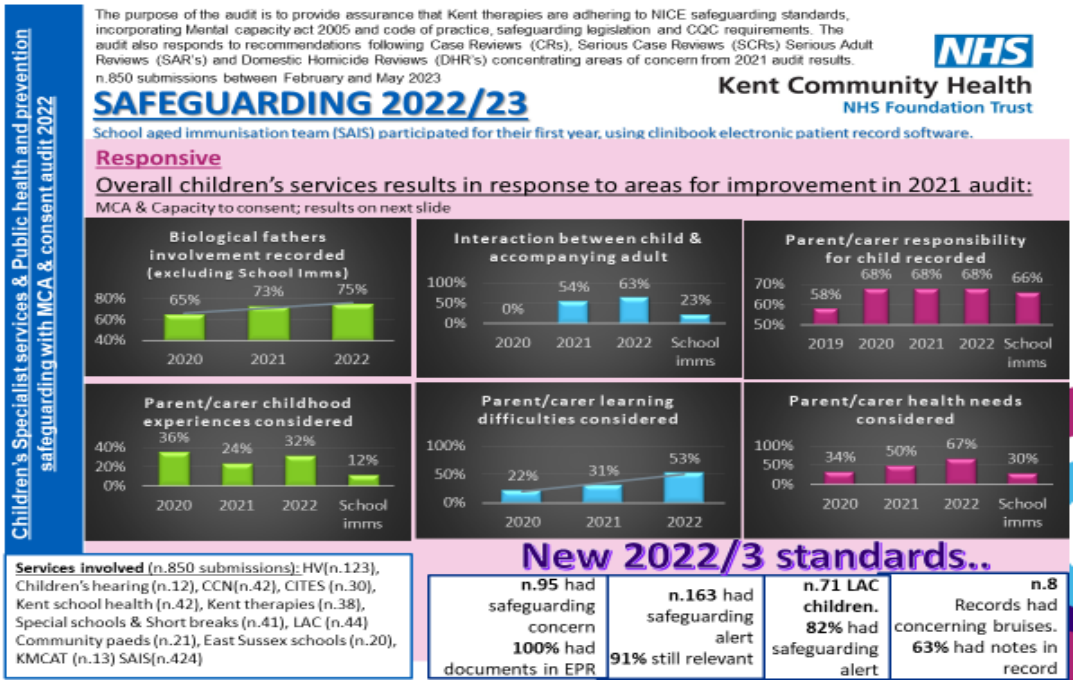
- We have reviewed our methods of delivery of information to meet the needs of staff and made changes to the electronic patient record systems to strengthen how safeguarding information is recorded and so safeguarding concerns can be easily identified and reported on.
- We have provided focussed support to Urgent Treatment Centres, Community Paediatric Service, Community Children's Nursing Team, Looked After Children and Children Therapy Services, Dental services in London who work with extremely vulnerable children, often with complex health needs. This support has been provided utilising ad hoc, 1:1 and group supervision sessions, support with professionals meetings, including escalation and professional disagreement processes. The safeguarding children team also attended team meetings to discuss safeguarding processes and procedures and the new ICON roll out. (ICON stands for I - Infant crying is normal, C - Comforting methods can help, O - It's OK to walk away, N - Never, ever shake a baby or hurt a baby). Additional support to health visiting services has been given to certain localities within Kent due to current complexities within their caseloads.
- We have provided information for **308 Multi Agency Risk Assessment Conference (MARAC) meetings** and **attended 275** of these across Kent and we ensure staff are aware of relevant information

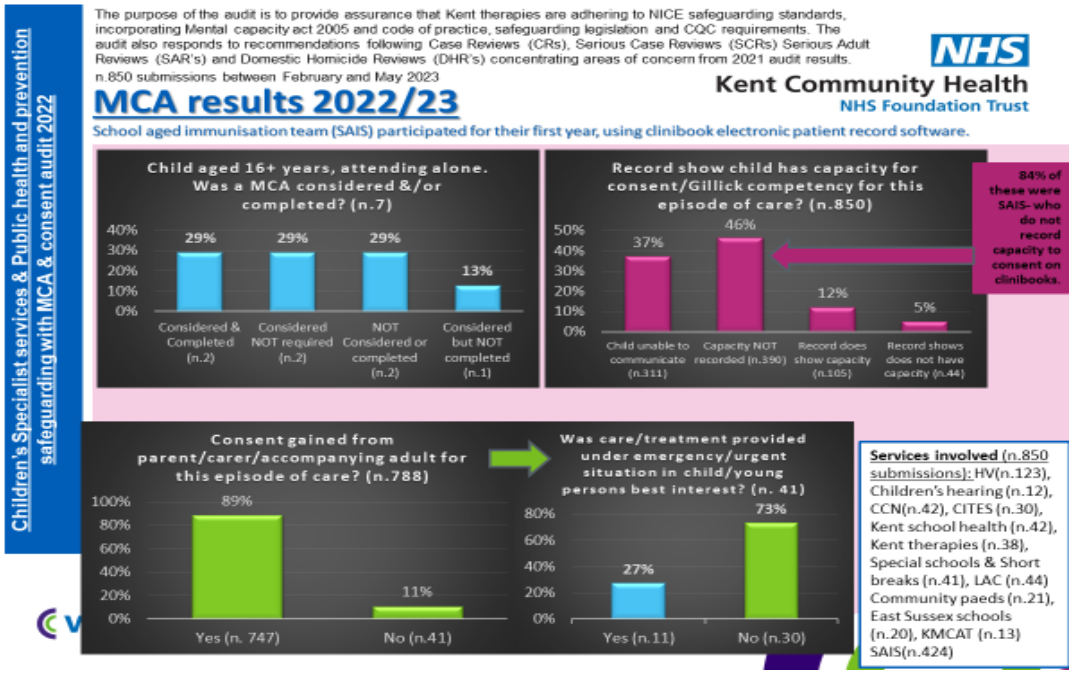
in order to protect staff and patients by adding an alert to the electronic patient record where risk was identified.

- We have reviewed existing MARAC alerts that were on the individual patients RiO records for a year or longer and we **removed 5469 MARAC alerts from RiO** to ensure patient records were up to date with risks accurately reflected.
- Following a launch of **new safeguarding training programme**, we continued to deliver a safeguarding training in line with the adult, children and looked after children (LAC) safeguarding intercollegiate documents for all staff groups in level 1,2,3,4 and Board level target audience. We used a blended approach of both e-learning and instructor led topic specific workshops using virtual platforms. The themed bite size workshops included safeguarding processes and procedures, domestic abuse, self-neglect, learning from safeguarding adult reviews (SAR's), domestic homicide reviews (DHR's) and local safeguarding children practice reviews (LSCPRs), exploitation and mental capacity act practical application, all highlighting the importance of person-centred care. We trained 1464 staff, contributing to the 91% overall compliance with safeguarding training at the end of March 2023 and therefore successfully exceeding the expected 85% key performance indicator.
- We developed a safeguarding training workbook to ensure that the trust volunteers have the required safeguarding knowledge and skills.
- We have facilitated bespoke adult safeguarding sessions on recognition and escalation of concerns to community nursing teams and following learning from case reviews.
- In response to many non-accidental injuries in babies both nationally and locally we facilitated ICON training to the urgent treatment centre staff, the community paediatric staff and supported the health visiting services to roll out the ICON training to their staff. ICON stands for I - Infant crying is normal, C - Comforting methods can help, O - It's OK to walk away, N - Never, ever shake a baby or hurt a baby.
- We have attended partnership meetings to support processes and safeguarding systems across Kent and East Sussex and contributed to multiagency policy development.
- The Central Referral Unit Specialist Health Team have attended over **1712 strategy discussions,** shared over **10045 pieces of sensitive information and 10404 pieces of personal information** and given over **3300 individual areas of specialist health** advice in and outside of strategy discussions in order to support safeguarding children and adults within the Central Referral Unit.
- We have collaborated with the audit teams for children's services, adult services, sexual health services and the dental service to develop an internal single agency audit tool.
- The safeguarding peer review audit is the main annual audit conducted to meet the trusts contractual requirement incorporating our adult and children as well as learning from case reviews. The audit leads for each individual service in all adult, children/public health and specialist services were involved in order to adapt the tool for their specific service. We have also collaborated with the audit services to

develop infographics and support with specific areas of good practice that should be highlighted and areas that need improving.

- During the pandemic, 2020/2021 and 2021/2022 services completed the peer review audit and compiled service specific reports. Each service completed an action plan to provide the evidence of improvement in practice and documentation. This provided the necessary assurance and was shared with the relevant governance groups. The safeguarding audit lead for children provided an overarching report to the safeguarding assurance groups. In 2022 a decision was made to complete a Plan, Do, Study, Act (PDSA) audit in order to audit any individual area the service would like to measure, to identify if standards have improved, post the actions being completed The pilot audit tool for PDSA, was 18 questions and focussing on specific aspects. This audit also incorporated MCA and consent. The PDSA cycle was designed to identify whether recommendations had influenced changes in practice.
- The audit results are promising so far and when all the audit results are collated the final infographics and reports will be shared with the service audit leads and assurance groups.





- We have also participated in multiagency audits to ensure the trust has met its statutory requirements to have embedded organisational procedures and policies to safeguard and protect adults and children from harm, that learning has occurred and practice changed following case reviews. Some audits were themed, whilst others were to determine specific practice including how agencies worked together in a timely manner ensuring all aspects were considered to ensure the right impact for child/family.

Audits conducted	Type of audit
East Sussex Case Review Audits	Multiagency
East Sussex electively home educated children audit	Multiagency
East Sussex Safeguarding Children Partnership Section 11	Multiagency

Kent and Medway Safeguarding Children's Partnership Section 11	Multiagency
Kent and Medway Safeguarding Adults Board SAF	Multiagency
CRU Multiagency Audit	Multiagency
KCHFT Annual Safeguarding Peer Review Audit (Adults and Children)	Internal single agency

- We have enabled staff to **support patients who self-neglect,** supporting, role modelling and leading multiagency meetings in line with multiagency self-neglect procedures. This has meant that patients received the appropriate support and the risk to their wellbeing was reduced.
- We have continued to provide staff with safeguarding updates on key safeguarding topics, incorporating local safeguarding board and partnerships newsletters, access to available internal and external and multiagency training opportunities, learning from incidents and safeguarding adult and children reviews, mental capacity, deprivation of liberty updates and progress on liberty protection safeguards using a **monthly safeguarding brief**.
- We supported key national safeguarding awareness raising campaigns (national stalking awareness week, safeguarding adults awareness week (SAAW), 16 days of action against domestic abuse) through staff and public engagements using the following methods; sharing messages via staff intranet, blogs, question and answer sessions for staff on various topics during safeguarding awareness week, use of the trust social media platform (Facebook and Twitter), and safeguarding stalls at trust conferences and public facing shops like One You.
- As part of safeguarding awareness week, the safeguarding team joined up with the Integrated Care Board to set up a safeguarding stall at the One You shop in Ashford town centre. Many conversations were had with the One You staff and the members of public who dropped in. People took posters and information to display and share with their friends, church members and peers including how to support someone they were worried about. It was really positive how the public were embracing safeguarding, thinking about themselves, others and what safeguarding meant to them.
- We have continued to develop **the KCHFT Safeguarding and Mental Capacity Act Link Worker Role** across the trust whose role is to work at team/service level to make sure key safeguarding messages and person-centred safeguarding is imbedded in practice. We held quarterly link workers meeting to provide opportunities to share examples of good practice and challenges, and surveys were used to determine the impact of the link workers in practice. The link worker meetings have been well represented and attended by various services across the organisation which further improved networking with different services and developed the wider knowledge of staff to embed mental capacity act in their service areas.

- We continue to strengthen the application of the mental capacity act (MCA) in practice and held a MCA awareness week 24 – 28 October 2022 which included sharing of key MCA messaged with staff and patients to highlight lasting power of attorney, what a capacity is and awareness of deprivation of liberty safeguards (DoLS).
- We have supported staff with exploring any **Mental Capacity Assessment/Deprivation of Liberty Safeguards (MCA/DoLS)** concerns and provided practical support such as assisting with DoLS applications and completed CQC notifications. The weekly liaison by mental capacity coordinators with the community hospitals ensured that the DoLS process is being followed. This has improved the profile of DoLS within the workplace and ensured that patients human rights are protected appropriately. Close liaison with the Kent County Council (KCC) DoLS office enabled accurate reporting of DoLS to the Integrated Care Board and timely CQC notifications, identified any non-reported DoLS to the safeguarding service and provided status of the patients DoLS application. A total of **96 DoLS applications** were raised in 2022/22.
- The team provide a dedicated **MCA/DoLS** duty line via MS teams and telephone to ensure staff had access for support and advice for MCA/ DoLS concerns. This provided support following legal MCA framework for 71 patients who needed support to make decisions related to their care and treatment.
- MCA co-ordinators provided coaching and support for best interest meetings and multi-disciplinary team meetings. Face to Face and bespoke MCA/DoLS training have also been made available to staff. This has helped practitioners to gain knowledge in the process and identify their roles and responsibilities to enable them to manage complex cases independently in the future. This also has helped to achieve positive outcomes by promoting patient's views and wishes, improving patient's safety, mitigate risks and ensuring that the trust has met its legal responsibilities.
- We have used MCA/DoLS data collection tools to analyse information, trends and themes and work with teams and community hospitals on improvements.
- We created a resource pack that was shared with safeguarding and MCA link workers in practice areas and the trust community hospitals. Further support tools were created to support completion of MCA assessments and DoLS care plan.
- We updated MCA and DoLS forms on Rio and created a DoLS care plan to ensure the completion of necessary documentation is in line with legal framework.
- We have continued to work in collaboration with system partners in preparation for **the implementation of Liberty Protection safeguards (LPS).** The work of KCHFT LPS task and finish group continued to prepare and plan for changes within the trust and ensure readiness to meet the challenges to changes in legislation. LPS updates were provided to staff via the safeguarding monthly newsletter, Trust intranet, MCA work space, link worker meetings and training to maintain momentum. An LPS work plan is in place and monitored by the Safeguarding Assurance Committee and includes

time focused actions to achieve the changeover to LPS. The team representatives were present on external LPS planning / information groups with the Integrated Care Board and other health and social care partners. An LPS patient flow has been written following a table top exercise to test process flow in November 2022.

- We reviewed roles and responsibilities and training identified for the role of best interest assessor (to convert to approved mental capacity professionals). We have supported colleagues to access external best interest assessor (BIA) training; 3 colleagues are not BIA qualified.
- We have provided staff with Prevent updates as released, and published an annual Prevent briefing. We provided monthly update via safeguarding news brief and Prevent workspace. The trust raised two Prevent referral to the Channel Panel over the last year, both were not adopted by the panel, but as a result of the referral, safeguards were put in place for the individuals. KCHFT was commended for their engagement with Prevent.
- We have updated the Modern Slavery Statement and is available on both the organisation's public web page as well as its Intranet.

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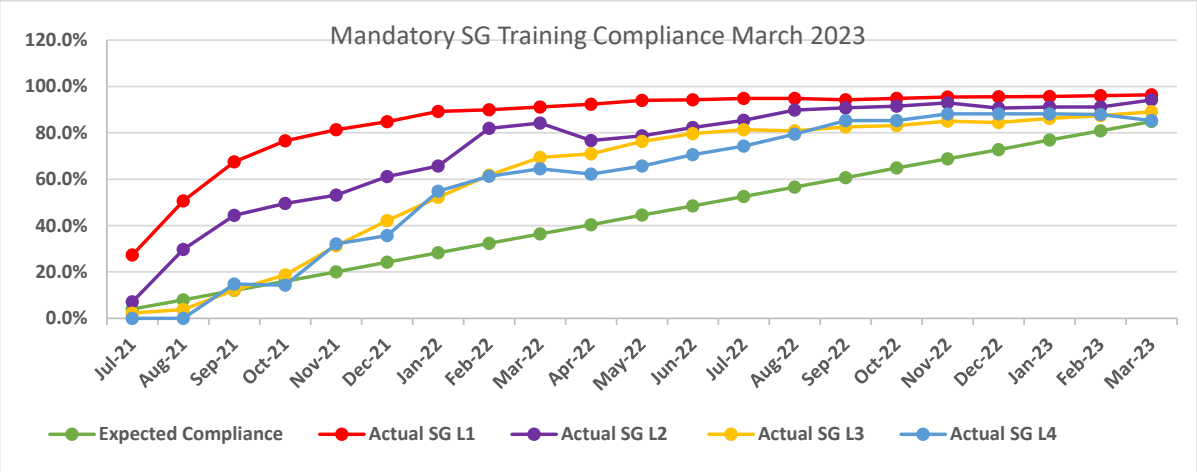
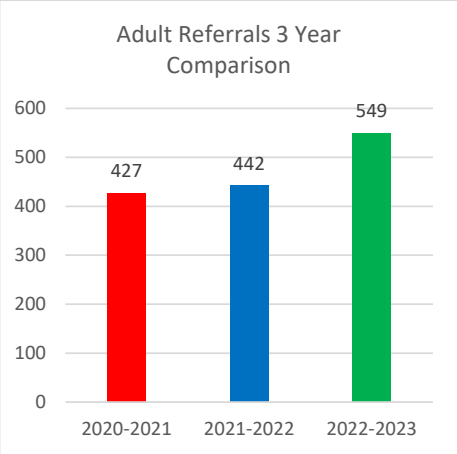
This is the impact we have had

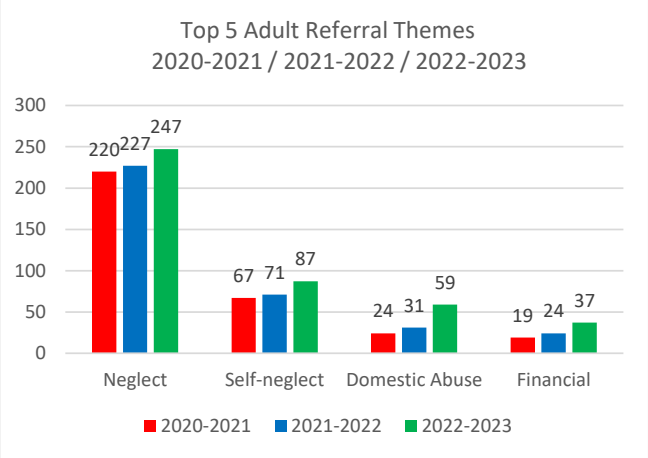
Specialist support and training

- As a result of delivering 613 children's supervision sessions to Kent and East Sussex based staff through 1:1, group and ad hoc supervision sessions to a wide range of staff groups across the trust, children and families at risk were supported and risk of harm was minimised and where identified concerns escalated to for greater support from agencies. The supervision sessions provide practitioners with protected time to reflect on and have an in-depth discussion about cases with specialist safeguarding support and objectivity. This process supports the development of effective and robust safeguarding practices as cases are risk assessed and measures identified to enhance outcomes. This ensures there is a clear focus on the child/young person/adult ensuring their voice has been heard and that clear action plans are put in place to support timely safeguarding actions/interventions.
- We have ensured staff have access to training using a blended approach of eLearning and practical workshops using virtual platform MS team. The method of delivery enabled staff easier access to good quality mandatory training and it raised awareness of different national and local themes and learning from case reviews. Staff were as a result more skilled to identify, assess and refer people as appropriate for safeguarding support, enabling staff to respond to concerns. The robust training programme delivered by the team demonstrated that statutory compliance with safeguarding mandatory training and exceeded the set 85% key performance indicator.

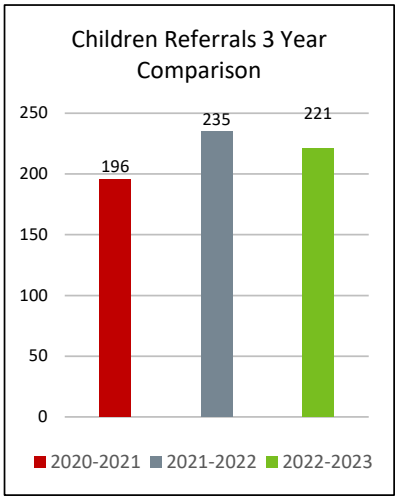


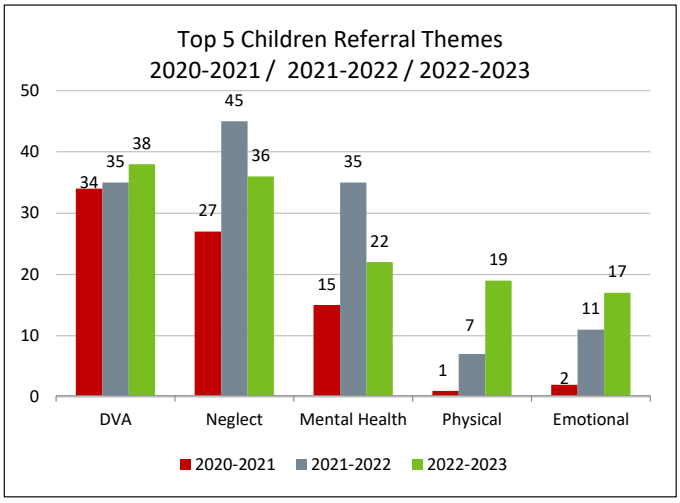
- The impact of training is evident through reviewing the safeguarding referrals, calls into KCHFT safeguarding consultation line, annual safeguarding audit, patient safety incidents and clinical practice. The activity comparison shows staff recognition of key safeguarding concerns and action taken. Increased activity is evidenced in a number of referrals raised to local authority and key themes.
- KCHFT staff have made 465 adults and 221 children's safeguarding referrals. The following tables provide comparison of adults and children referrals and the key themes compared to previous years. Compared to the previous year marked increase in adult referrals is noted in relation to self-neglect increased by 22%, domestic abuse increased by 90% and financial abuse increased by 50%, indicating the complexity of the support needed for people at risk.



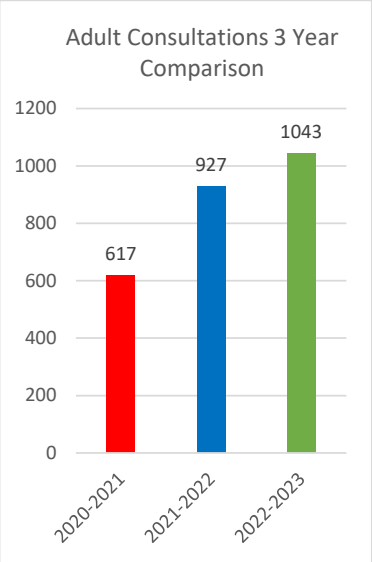


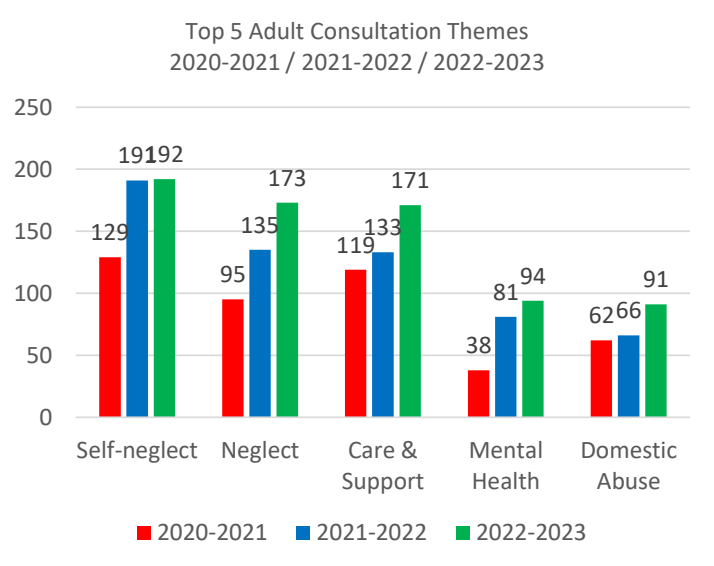
- In children referrals we have seen 20% reduction in referrals related to neglect and 37% reduction in referrals related to mental health however we noted 171% increase in concerns for physical and 55% increase in concerns for emotional abuse.

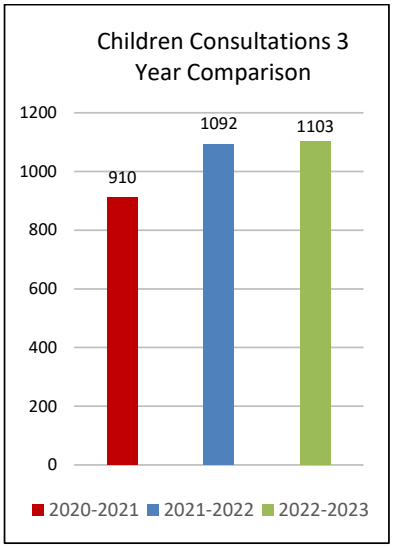


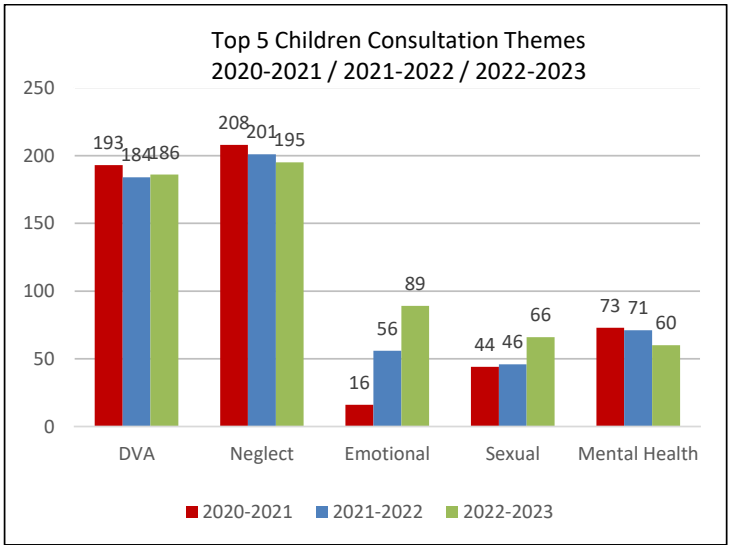


We have provided 1043 adults and 1103 children's consultations to staff through our duty line, enabling staff to provide safeguarding support to adults and children to prevent and reduce abuse to individuals and their families. The following table provides comparison of adults and children safeguarding duty line consultation and the key themes compared to previous years. In adult related consultations an increase has been seen in concerns about neglect (by 28%), people with care and support needs (by 29%), domestic abuse (by 38%), mental health by 16%) and domestic abuse (by 38%). In children consultation marked increased has been noted in emotional abuse (by 59%) and sexual abuse (by 20%). As demonstrated in the graphs below.


Adult Consultations 3 Year Comparison
1200
1000
800
600
400
200
0
617
927
1043
2020-2021
2021-2022
2022-2023


Top 5 Adult Consultation Themes
2020-2021 / 2021-2022 / 2022-2023
250
200
150
100
50
0
129
191
192
95
135
173
119
133
171
38
81
94
62
66
91
Self-neglect
Neglect
Care & Support
Mental Health
Domestic Abuse
2020-2021
2021-2022
2022-2023


Children Consultations 3 Year Comparison
1200
1000
800
600
400
200
0
910
1092
1103
2020-2021
2021-2022
2022-2023


Top 5 Children Consultation Themes
2020-2021 / 2021-2022 / 2022-2023
250
200
150
100
50
0
193
184
186
208
201
195
16
56
89
44
46
66
73
71
60
DVA
Neglect
Emotional
Sexual
Mental Health
2020-2021
2021-2022
2022-2023

- For all patients discussed at MARAC meetings we have added alerts to the electronic patient records (RiO) This enables all services using RiO to know the risk of domestic abuse and violence within the household, in order to take appropriate actions to safeguard patients and staff. In addition, the team reviewed and removed historic MARAC alerts on RiO therefore ensuring that all staff have access to accurate risk information to safely deliver patient care.
- By contributing to the MARAC multiagency forum, the KCHFT Safeguarding Service has ensured that swift decisions and actions put in place have been made to protect victims and their families from domestic violence and abuse.
- We have supported patient safety incident investigations ensuring safeguarding support was provided to the patient and safeguarding referrals were made where indicated, patients were involved in decision making and ensuing measures were put in place to reduce harm and abuse to adults and children.
- Learning from incidents and case reviews relating to self-neglect, need for early escalation and the importance of a multiagency approach to safeguarding people at risk has resulted in an increase in identification and support of people with complex needs who demonstrate signs of self-neglect, and identification of people potentially being exploited, enabling support to be given to staff and reduced harm to patients. The common themes running through the multiagency reviews can be summarised as: legal literacy, professional curiosity, agency collaboration and information sharing and shared risk assessments via multiagency meetings, professional escalation, identification of carers, risk of suicide for victims of domestic abuse, supporting please with alcohol and substance misuse, engagement with fathers, adult mental health. The team are working with the Adult Safeguarding Board and Children Partnerships to support learning across the system in relation to these themes. Training has been developed referring to these themes to support staff to recognise these harms and to take appropriate actions to safeguard adults and children.
- Delivery of Safeguarding training in workshops has led practitioners to become more aware of specific themes and trends within safeguarding and how they respond to cases of concerns within their caseloads. KCHFT Health Visiting Service has employed Community Public Health Nurses (CPHN) to support health visitors with packages of care and the safeguarding service has seen a rise in calls into our safeguarding duty line from CPHN's following attendance at these training workshops.

Support for complex situations

- Safeguarding adults and children practitioners have received feedback regarding complex cases they have supported, ensuring practitioners feel listened to and receive timely responses to cases of concern,

especially in relation to respectful challenge to multi agencies and escalation. This has ensured that KCHFT services working with adults and children/families are safeguarded and correct procedures are followed.

- Safeguarding adults and children practitioners work together to safeguard patients by utilising the 'Think Family' model – one recent example is a domestic violence case whereby a KCHFT children and young people practitioner rang the safeguarding adults team about the adult within the family. The team were able to give a collective response on the same day to ensure that the patient and her family received a timely response to a domestic abuse situation to safeguard the whole family. The team also supported the practitioner to respond to the safeguarding situation in a timely way.

Examples of learning, support and how this is embedded in practice

- **Professional curiosity** – an adult was referred to a pharmacy technician, due to no response to attempted contacts the pharmacy technician completed a cold call to the address. On attending, the practitioner identified that the adult was living with a teenager, the home was in poor living conditions and the adult care needs were high. The practitioner made referrals for both the adult and the young person to the relevant social care teams for support.
- **Neglect / multiagency working / mental capacity assessment (MCA) / escalation** - KCHFT staff raised a safeguarding referral for young adult living with parents whose needs were neglected at home, there were concerns about disengagement with carers and health colleagues, use of inappropriate restraints, repeat hospital admissions and deterioration in the adult's health. KCHFT staff initiated multi-agency meetings held around neglect, principles of mental capacity and best interests were applied and specific assessments and decisions were made about placement which led to risk reduction and additional support for the adult.
- **Escalation** – The learning disability team with support from the safeguarding team was instrumental in challenging continuing health care and ensuring that an adult with a learning disability was moved to into a place of safety.
- **Escalation utilising KSCMP escalation and professional challenge procedures** -KCHFT health visiting practitioner raised concerns regarding a family who had reported concerns about being victims of modern-day slavery and exploitation. Children's integrated services closed the case as they did not deem the child to be at risk. With support from KCHFT Safeguarding service and Modern Day slavery helpline the procedures were utilised to gain further professional support for the family which included housing and a social worker.
- **Multi Agency Working / information sharing/ Think Family –** Following receipt of a child death notification safeguarding practitioner reviewed the records to establish what

involvement KCHFT had with the family. It was established that there was a sibling and on reviewing their records determined that the sibling was known to a mental health trust for emotional health needs and suicidal thoughts. This information was shared with the child death team and the child death team then contacted the mental health trust to share the details of the sibling's death with them to ensure appropriate specialist support was given to the sibling.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)

- Regular updates were provided to staff on the changes the Liberty Protection Safeguards will bring and through practical support strengthening the MCA application in practice. Staff felt more confident to support patients and families ensuring that patients within the trust care are safeguarded and not deprived of their liberty unlawfully. This will support staff with knowledge and skills to deliver LPS when it comes into force.
- All applications received from community hospitals were assessed by MCA co-ordinators using the Association of Directors of Adults Social Services (ADASS) criteria of priority. The process gives clearer governance of reporting DoLS within the trust. It allows weekly comparison of the assessments received by the DoLS office and allows any challenge if required (none to date). This process supports the prioritisation of DoLS with referrals and earlier assessment for patients who are at a higher priority risk to have their Deprivation of Liberty authorised. Following changes in how DoLS authorisation are reported to CQC we developed a process and notified CQC of all DoLS applications and authorisations therefore ensuring CQC requirements compliance.
- We have prepared for the Liberty Protection Safeguards and ensured we have trained staff to fulfil new roles that will be introduced by LPS and have patient flow charts ready to put in practice.

Central Referral Unit

- CRU Health identify risk within current safeguarding cases and apply their specialist health and safeguarding knowledge to advise partners on possible transferable risk to persons working in a position of trust. CRU health alert the acute trusts of any safeguards required for pregnant adults and children in case they present to the acute service in Kent and require assessment through the Front door.
- Due to access to Kent and Medway health records (KMCR) alongside systems available such as RIO, CRU health are able to quickly analyse pertinent health information, exploring risks and considerations for social care and police in the immediate safeguarding planning for children, examples are parents with long standing physical and mental health issues,

drug use/ prescription medicines/ impact with non- attendance to health appointments / neglectful home conditions, confirmation of pregnancy & relate this to the lived experience for the child. This specialist health information is shared as appropriate with Police and Social Service partners to safeguard children and families and ensure support is timely and relevant

Audits

- To seek assurance on how person-centred approach is imbedded in the Trust, we conducted a short audit of all safeguarding adult referrals made by KCHFT staff between July and August 2022. The aim was to review if Making Safeguarding Personal (MSP) is evidenced within safeguarding referrals made, including consent to referral and the service users views and wishes (linked to KMSAB Strategic plan 2022-2025). There was a total of 56 records reviewed for this audit. The audit evidenced that the consent for referral was sought in 87.5% and rationale was provided if staff were unable to gain consent, 75% of referrals included MSP. Following the audit further awareness was raised about MSP and that all questions are answered via monthly safeguarding news brief and processes and procedure safeguarding workshops.
- The safeguarding peer review audit was developed with support of leads in children and adult and audit services in order to adapt the audit tool for their specific service. During the pandemic, 2020/2021 and 2021/2022 services completed the peer review audit and compiled service specific reports. Each service completed an action plan and to provide the evidence of improvement in practice and documentation. This provided the necessary assurance and was shared with the relevant governance groups. The safeguarding audit lead for children provided an overarching report to the safeguarding assurance groups. In 2022 a decision was made to complete a Plan, Do, Study, Act (PDSA) audit in order to audit any individual area the service would like to measure, to identify if standards have improved, post the actions being completed The Pilot audit tool for PDSA, was 18 questions and focussing on specific aspects. This audit also incorporated MCA and consent. The PDSA cycle was designed to identify whether recommendations had influenced changes in practice.
- The safeguarding peer review audit results for children and young people's services are promising so far and have highlighted many areas of good and improved practice. For example, records show 100% for consent to refer to another service, 100% for follow up of referrals, 100% response to non-engagement and actions taken where there were safeguarding concerns and 100% where action was taken if there was a professional disagreement.
- The importance of asking who adults are and their relationship to the child has been an issue raised in several serious case reviews. All staff have been reminded that they must record who has parental responsibility for children and young people. This supports staff to understand who has parental

responsibility and who is able to make decisions on care for the child. The audit has evidenced an increased awareness of the importance to ask and document who is present, and who has parental responsibility from 58% in 2019 to 68% in 2022. In addition, asking the accompanying adult's name has improved to 82% and relationship to child 94% in 2022.

- The question regarding if biological father is involved with the child/ren has increased from 73% in 2021 to 75% in 2022. Consideration of parental health needs has improved from 34% in 2020 to 67% in 2022 and consideration of parental learning difficulties has increased from 22% in 2020 to 54% in 2022. The reports from services that have been seen reflect that services recognise areas that need improvement and are putting into place clear actions to meet the practice requirements.

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This is how we have contributed to the health and social care system

Policies and procedures

- The safeguarding service representatives has attended multiagency meetings, case review meetings across Kent, Medway and East Sussex supporting decision making and policy development across the system.
- The safeguarding Team has contributed to the development of policies and processes with partner agencies including: Kent Father Inclusive Practice Guidance, Multi-Agency Pre-Birth Procedures, Nude and Semi Nude Image Sharing Guidance, Safer Professional Practice with Technology Guidance, Protocol on Bruising in Non Mobile Babies and Children, Working with Sexually Active Young People, Kent Escalation Policy and Medway Contextual Safeguarding Policy, Kent and Medway Multi Agency Resolving Practitioner Differences; Escalation Policy for Referrals and Adult Safeguarding, Policy and Procedures to support people that self-neglect or demonstrate hoarding behaviour, Multi-Agency Safeguarding Adults Policy, Procedures and Practitioner Guidance for Kent and Medway, Policy, Procedures and Practitioner Guidance for Safeguarding Adults Reviews and Managing Concerns around People in Positions of Trust (PiPoT).
- The KCHFT safeguarding training, Prevent and Domestic abuse policy was reviewed and updated in line with National changes and to ensure that KCHFT has fulfilled its commitment and statutory responsibilities as a safeguarding organisation. We contributed to KCHFT Transitional policy.

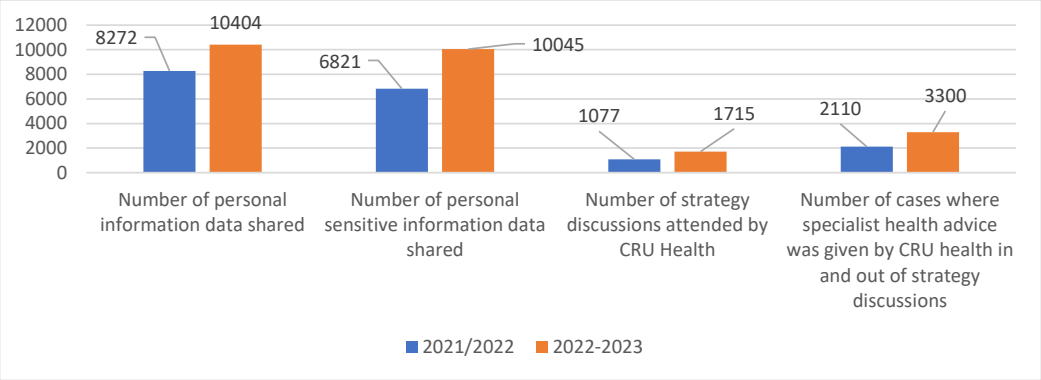
Specialist support

- Through training, the duty line, supervision and information being accessible to KCHFT staff via flo and the safeguarding workspace, we are contributing to the disruption of current themes such as extrafamilial harms and the protection of children, young people and adults across Kent.
- KCHFT's domestic abuse work, through contribution to MARAC, has been highlighted as positive and of high value to the multi-agency group enabling the continuation of risk assessment being able to be put in place swiftly to protect victims and their children.
- The safeguarding children team have provided extra support to Swale Health Visiting Service due to the complexity of cases within their caseloads.
- We have updated and distributed the safeguarding adult and children flowchart for the urgent treatment centres to use an aide memoire and a prompt for practitioners to consider different elements of safeguarding at every step of the contact.

- **Training**
- KCHFT safeguarding team contributed to development of multi-agency training and learning form reviews sessions, supported the facilitation of specific learning identified from SARs and become regular multiagency training facilitators for local partnership. This means that staff have access to training at multi-agency level that will support their knowledge and skills in specific safeguarding topics that will provide them with an understanding how to support and safeguard patients in their care. The workshops have been facilitated via virtual platforms and KCHFT staff who attend provide positive feedback following attendance.

Central Referral Unit

- Multi-agency working by the specialist Central Referral Unit Health Team (CRU HT) has ensured relevant and appropriate information is shared across all partners supporting safeguarding concerns for children and families experiencing abuse and harm. The main themes of abuse suffered by children and families in strategy meetings attended by CRU Health are emotional abuse, mental health, neglect, physical, domestic violence, drugs and alcohol misuse and contextual safeguarding access to health systems has widened (KMCR) and this provides additional health information often in relation to safeguarding themes (e.g. historic/current mental health, medications, ED attendances) that would not be accessed by any other agency in a timely manner.
- In 2022/2023 the support given to social services partners from the CRU health team in relation to the number of personal information shared increased by over 26%, in relation to sensitive information shared increased by 47%, the number of strategy discussions attended increased by 59% and the amount of specialist advice given by the specialist nurses increased by 56% from 2021/2022.



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Contact us

Safeguarding Service
Phone: 0300 790 6827
Duty consultation line is available on Monday to Friday, 9am to 5pm.

Email
SG adults: kcht.SGA@nhs.net
SG children: kcht.SGC@nhs.net
Central Referral Unit Specialist Health Team: kcht.CRU@nhs.net

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Version 1 – 20/06/2023

Kent Community Health
NHS Foundation Trust

Meeting:	Board Meeting - Part 1 (Public)
Date of Meeting:	18 October 2023
Agenda item:	Item 22
Report title:	Fit and Proper Person Test (FPPT) Framework
Executive sponsor(s):	Victoria Robinson-Collins, Chief People Officer Mercy Kusotera, Director of Governance
Report author(s):	Victoria Robinson-Collins, Chief People Officer Mercy Kusotera, Director of Governance
Action this paper is for:	☐ Decision/approval ☐ Discussion and input ☐ Assurance ☑ Information
Public/non-public	Public

Executive summary
The accompanying paper summarises the changes to the requirement to undertake the Fit and Proper Person Test (FPPT) for Executive Directors and Board Members. Providers, including KCHFT and predecessor organisations, have undertaken a FPPT since its inception in 2014. However, the new FPPT Framework, effective from 30 September 2023 includes a board member reference check at appointment and as part of annual appraisal, and includes a requirement to hold the FPPT data in ESR as well as in local records.

Report history / meetings this item has been considered at and outcome
The FPPT Framework was presented to Part 2 Board in September 2023.

Recommendation(s)
The Board is asked to • **NOTE** the report.

Link to CQC domain				
☑Safe	**☑Effective**	**☑Caring**	**☑Responsive**	**☑Well-led**

Strategic ambition this report supports	**Please tick**
Putting communities first	☐
Better patient experience	☑
A great place to work	☑

Sustainable care	☐

Implications			
Risk and assurance	No		
Is the risk included on the Corporate Risk Register or Directorate risk register?	☐**BAF**	☐**CRR**	☐**DRR**
Equality, diversity and inclusion	No		
Patients / carers / public / staff / health inequalities	Yes – regulatory changes to the FPPT checks for Board members.		
Legal and regulatory	Yes – regulatory changes to the FPPT checks for Board members.		
Quality	Yes – regulatory changes to the FPPT checks for Board members.		
Financial	No		

Executive lead sign off	
Name and post title:	Victoria Robinson-Collins, Chief People Officer Mercy Kusotera, Director of Governance
Date:	10 October 2023

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NHS Foundation Trust

FIT AND PROPER PERSON TEST (FPPT) FRAMEWORK

Introduction

NHS England has developed a Fit and Proper Person Test (FPPT) Framework in response to recommendations made by Tom Kark KC in his 2019 review of the FPPT (the Kark Review). This also considers the requirements of the Care Quality Commission (CQC) in relation to directors being fit and proper for their roles.

The recommendations aim to prioritise patient safety and good leadership in NHS organisations, as well as to allow board members to build a portfolio to support and offer assurance they are fit and proper. Demonstrably unfit board members will be prevented from moving between NHS organisations.

The framework introduces a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the applicability to some other organisations, including NHS England and the CQC.

The framework is effective from 30 September 2023 and Boards are expected to implement by this date. NHS organisations are not expected to collect historic information to populate the ESR system or local records but should use the framework for new board appointments or promotions and for annual assessments going forward.

The framework applies to executive and non-executive directors irrespective of voting rights, and interim (all contractual forms) and permanent appointments. It also incorporates all individuals called ‘directors’ within Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. It also requires those board members who by virtue of their profession are members of other professional registers to be assessed.

The framework should springboard an ongoing dialogue between board members about values, probity and be seen as part of a program of board development, appraisals and values-based appointments.

Process

Regulation 5 of the Health & Social Care Act requirements are that:

An individual is of good character

- An individual has the qualifications, competence, skills and experience necessary for the relevant office or position of the work for which they are employed
- The individual is able by reason of their health, after reasonable adjustments are made, of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed
- The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) whilst carrying out a regulated activity or providing a service elsewhere, which if in England would be a regulated activity
- None of the grounds of unfitness specified in part 1 of Schedule 4 apply to the individual:
    - The person is an undischarged bankrupt or a person whose estate has had sequestration awarded in respect of it and who has not been discharged
    - The person is the subject of a bankruptcy restrictions order or an interim bankruptcy restrictions order or an order to like effect made in Scotland or Northern Ireland
    - The person is a person to whom a moratorium period under a debt relief order applies under Part VIIA (debt relief orders) of the Insolvency Act 1986
    - The person has made a composition or arrangement with, or granted a trust deed for, creditors and not been discharged in respect of it
    - The person is included in the children's barred list or the adults' barred list maintained under section 2 of the Safeguarding Vulnerable Groups Act 2006, or in any corresponding list maintained under an equivalent enactment in force in Scotland or Northern Ireland
    - The person is prohibited from holding the relevant office or position, or in the case of an individual from carrying on the regulated activity, by or under any enactment.

The good character requirements referred to above in Regulation 5 are specified in Part 2 of Schedule 4 to the Regulated Activities Regulations, and relate to:

- whether the person has been convicted in the United Kingdom of any offence or been convicted elsewhere of any offence which, if committed in any part of the United Kingdom, would constitute an offence
- whether the person has been erased, removed or struck off a register of professionals maintained by a regulator of health care or social work professionals.

These requirements underpin the NHS constitution, guiding principles and values, as well as the Nolan Principles of Standards in Public Life.

Personal data of board members relating to FPPT will be retained in local records and specific fields of the ESR system. This data will routinely not be accessible

externally to the individual's organisation/ employer, and NHSE have established the relevant lawful basis for collection and storage of the data under the GDPR regulations.

Assessment

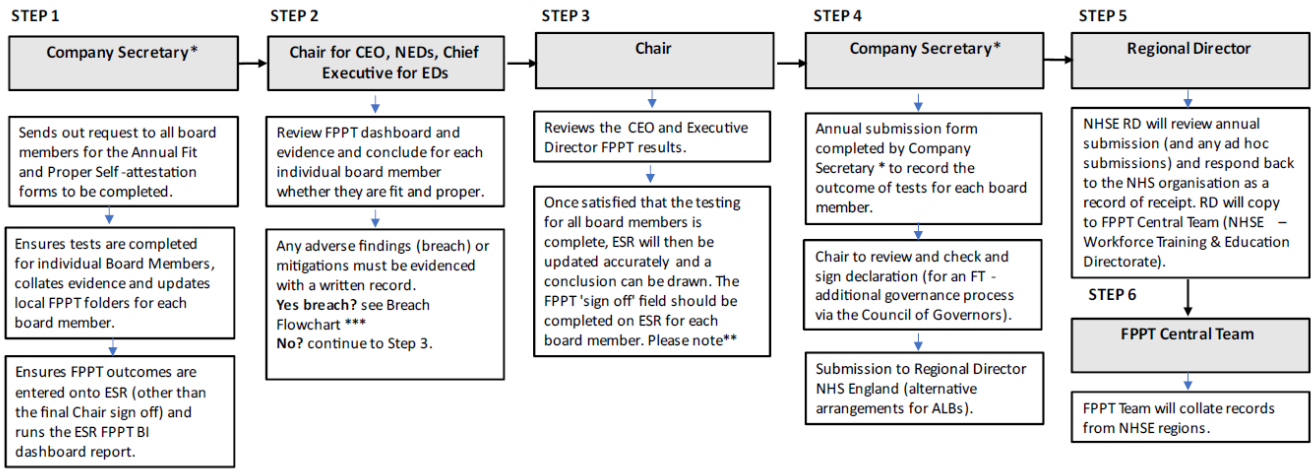
The Chair is responsible for ensuring the organisation conducts and keeps under review a FPPT to ensure board members are, and remain, suitable for their role. A FPPT check has been in place for providers, including KCHFT and any predecessor organisations where TUPE would have applied for board members, since its inception in 2014. The key additions under the framework include a requirement to hold information in ESR as well as local records, and to complete the board member reference check.

The FPPT process is needed for:

- New appointments in board members roles, whether permanent or temporary, where greater than six weeks duration. Covering:
  a) new appointments that have been promoted within an NHS organisation
  b) temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis
  c) existing board members at one NHS organisation who move to another NHS organisation in the role of a board member
  d) individuals who join an NHS organisation in the role of board member for the first time from an organisation that is outside the NHS.
- Where a board member changes to a new board role within their current NHS organisation
- Annually, i.e. within 12 months of the date of the previous FPPT

For 1a, b and c the full FPPT will include a board member reference check. For the others, this is not required.

The suggested approach to the FPPT assessment is:



Self-Attestation

Each board member will be required to complete an annual self-attestation, to confirm they comply with the FPPT requirements. This is also a necessary step forming the full FPPT requirement, for example at appointment for new starters.

The Board Member Reference Process

A standard reference is being introduced to ensure greater transparency, robustness and consistency of approach when appointing board members in the NHS. This aims to ensure no recycling of unfit individuals within the NHS and is informed by the NHS Leadership Competency Framework. The expectation is that the competency domains are considered when writing a board member reference.

Board level leaders will be asked to attest they have the requisite experience and skills to fulfil minimum standards against the six competency domains. This will be reviewed by the board director's line manager and overseen by the organisation's chair, and will be captured on ESR.

The annual attestation is expected to be undertaken at the same time as the annual appraisal process and assessment of competence against the six competency domains will also be used to guide the board member's development plan for the coming year. The line manager will also capture stakeholder feedback as part of the appraisal process and summarise competence against each of the six competency domains. A board member appraisal framework is expected to be published ahead of the 2023/2024 appraisal process to support this process. The annual appraisals of the past three years will be used to guide the board member's reference.

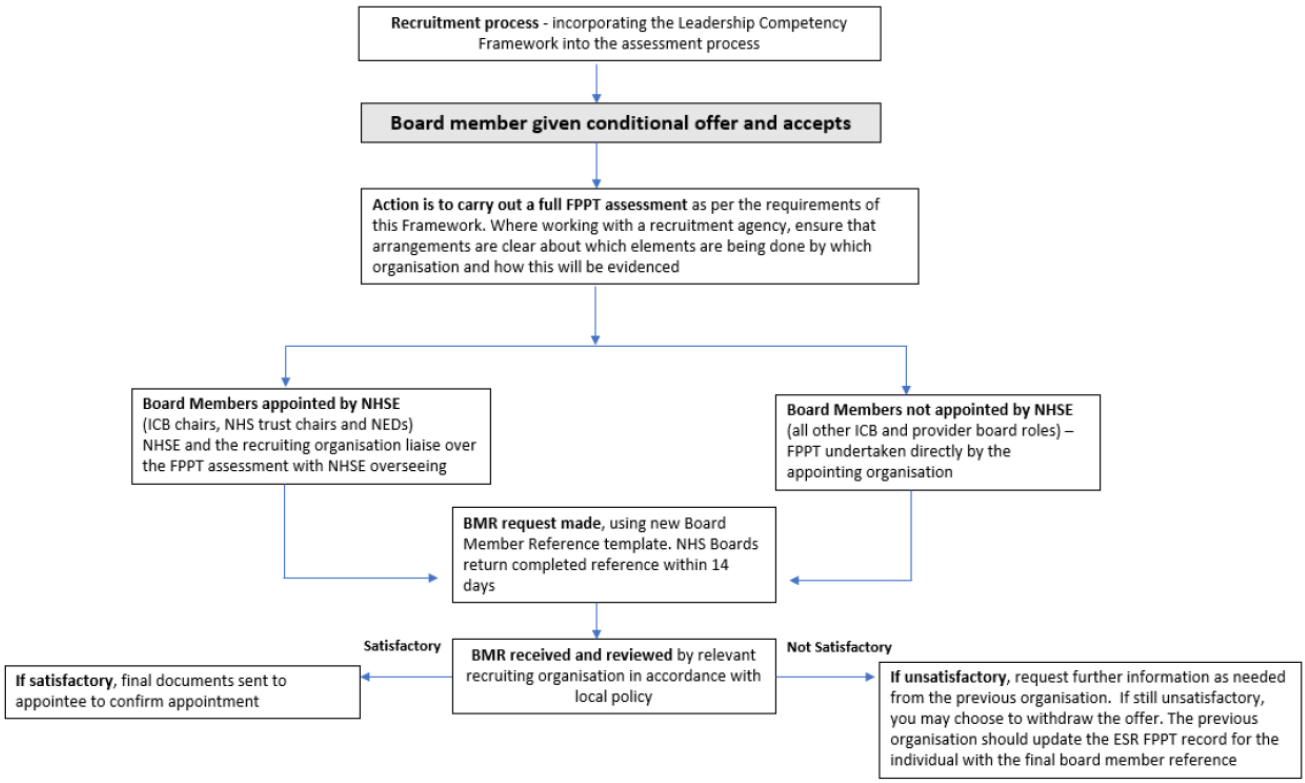
NHS organisations will need to request board member references, and store information relating to these references so they are available for future checks; and use this to support the full FPPT assessment on initial appointment.

Dependent on NHS background and external versus internal movement/ promotion, a minimum of one reference should be obtained as stipulated by the framework guidance, and in the case of joiners from another NHS organisation, comprising up to six years employment history.

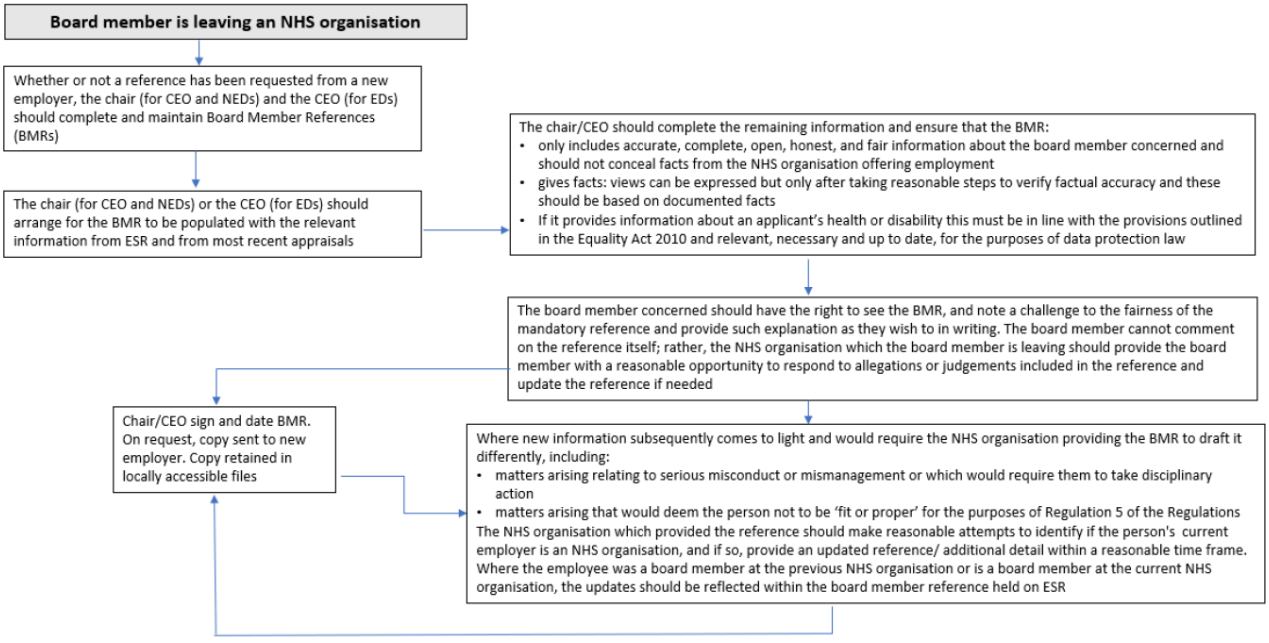
NHS organisations should maintain complete and accurate board member references at the point where the board member departs, irrespective of any request from another NHS employer and including on retirement. Both the initial and board member references should be retained locally.

Requests for references from other NHS organisations should aim to be returned within 14 days. In the event a reference has been provided and subsequently becomes aware of matters that would cause them to write the reference differently, including maters of serious misconduct or mismanagement, they should make the effort to identify if the new employer is an NHS organisation and is so, provide an updated reference.

Board Member Reference (BMR) – for appointments



Board Member Reference (BMR) – for leavers



Capsticks have indicated a national offer to provide wording to insert into contract of employment templates, the board member reference and right of reply process. This will be included in local processes when provided.

Settlement Agreements and the board member reference check

Board member references will not ask specifically whether there is a settlement agreement or non-disclosure agreement in place but will instead ask for any further information and concerns about an applicant's fitness and propriety, relevant to the FPPT, to fulfil the role as a board member.

Trusts are expected to retain information on settlement agreements locally (where applicable) and included in the overall consideration of the fit and proper status of the individual in question.

If there is a historical settlement agreement or non-disclosure agreement already in place which includes a confidentiality clause, NHS organisations are expected to seek permission from all parties prior to including any such information in a board member reference.

Going forward, NHS organisations are asked to consider inclusion of a term in any proposed settlement agreement to state that information about the settlement agreement can be included in ESR, and in doing so will not be a breach of confidence.

The existence of a settlement agreement does not, in and of itself determine that a person is not fit or proper to be a board member.

Investigations

The board member reference is based on the standard NHS reference and includes additional requests for information as follows (relevant to the FPPT):

- Any discontinued, outstanding, or upheld complaint(s) considered as gross misconduct, serious misconduct or mismanagement including grievances or complaint(s) under any of the organisation's policies and procedures (for example, under the trust's equal opportunities policy).
- Confirmation of any discontinued, outstanding or upheld disciplinary actions under the trust's disciplinary procedures including the issue of a formal written warning, disciplinary suspension, or dismissal for gross or serious misconduct.
- Any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the FPPT to fulfil the role as a director, be it executive or non-executive.

Discontinued investigations are included in the reference request to identify issues around serious misconduct and mismanagement and to deliberately separate them from issues around qualifications, competence, skills, and experience (which it is believed can be remedied) and health (which it is believed can improve), unless such competence and/or health issues could potentially lead to an individual not meeting the requirements of the FPPT.

Investigations should be limited to those which are applicable and potentially relevant to the FPPT, and examples are:

- Relating to serious misconduct, behaviour and not being of good character (as described in the FPPT Framework)
- Reckless mismanagement which endangers patients
- Deliberate or reckless behaviour
- Dishonesty
- Suppression of the ability of people to speak up about serious issues in the NHS, e.g. whether by allowing bullying or victimisation of those who speak up or blow the whistle, or any harassment of individuals
- Any behaviour contrary to the professional Duty of Candour which applies to health and care professionals, e.g. falsification of records or relevant information.

The reason for discontinuing or not commending an investigation should be recorded, including whether an investigation was not started or stopped because a compromise, confidentiality or settlement agreement was then put in place.

Right of Reply

It is important as a matter of fairness that an individual has the opportunity to comment on information likely to be disclosed as part of a reference request. A local policy will be developed to confirm who provides references, when they are provided, what will be included and a formal right to reply.

Access in ESR

Access to the FPPT fields in ESR will be limited to the Chair, CEO, Senior Independent Director (SID), Deputy Chair, Company Secretary (Director of Governance) and Chief People Officer (CPO). Access will be provided to appropriate individuals in the CQC at a local level as required for their roles.

The relevant data fields in ESR will require maintenance to ensure the information held is current. As a minimum it is expected that this data is reviewed and updated annually and the chair will be accountable for ensuring this is in place.

It is anticipated that a small number of senior HR professionals with appropriate granted access rights will undertake any maintenance required or run reports on behalf of the Chair, overseen by the Chief People Officer. The specifics in relation to the standard operating protocols for the ESR system have not yet been published nationally in response to the FPPT framework.

The FPPT assessment on initial appointment of a board member will cover all points mentioned below:

- First name
- Second name/surname
- Organisation
- Staff group
- Job title
- Occupation code
- Position title

- Employment history
- Training and development
- References
- Last appraisal and date
- Disciplinary findings
- Any ongoing and discontinued investigations relating to Disciplinary/ Grievance/Whistleblowing/Employee behaviour should also be recorded.
- Type of DBS disclosed
- Date DBS received
- Disqualified directors register check
- Date of medical clearance
- Date of professional register check
- Insolvency check
- Self-attestation form signed
- Social media check
- Employment tribunal judgement check
- Disqualification from being a charity trustee check
- Board member reference
- Sign-off by chair/CEO.

It should also be noted that the national insurance number is an additional check where there may have been a change of name highlighted in the initial or annual assessment.

Victoria Robinson-Collins, Chief People Officer

Mercy Kusotera, Director of Governance

October 2023