AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 30th September 2021
Time 10am to 12pm
Venue The Orchards Event Centre, East Malling
Members of the public join via link published at
https://www.kmpt.nhs.uk/about-us/trust-board/board-meetings/

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/20-21/47	1.	Welcome, Introductions & Apologies		Verbal	Chair	10.00
TB/20-21/48	2.	Declaration of Interest		Verbal	Chair	
PERSONAL STORY						
TB/20-21/49	3.	Engagement from a Service User Perspective		Verbal	CS	10.05
STANDING ITEMS						
TB/20-21/50	4.	Minutes of the previous meeting – 29/07/2021	FA	Paper	Chair	10.15
TB/20-21/51	5.	Action Log & Matters Arising	FN	Paper	Chair	
TB/20-21/52	6.	Chair's Report	FN	Paper	JC	10.25
TB/20-21/53	7.	Chief Executive's Report	FN	Paper	HG	
STRATEGY AND DEVELOPMENT						
TB/20-21/54	8.	KMPT Engagement Council	FD	Paper	VB2	10.45
OPERATIONAL ASSURANCE						
TB/20-21/55	9.	Integrated Quality and Performance Report – Month 5	FD	Paper	HG	10.55
TB/20-21/56	10.	Board Assurance Framework	FA	Paper	MM	11.05
TB/20-21/57	11.	Finance Report: Month 5	FD	Paper	SS	11.15
TB/20-21/58	12.	Medical Revalidation Report	FD	Paper	AQ	11.30
TB/20-21/59	13.	Managing Conflicts Policy	FA	Verbal	TS	11.35
TB/20-21/60	14.	Committee Terms of Reference	FA	Paper	TS	
CONSENT ITEMS						
TB/20-21/61	15.	Quality Committee Chair Report • Director of Infection Prevention and Control Annual Report	FN	Paper	FC	11.40
TB/20-21/62	16.	Workforce and Organisational Development Committee Chair Report • Annual Equality and Diversity Report	FN	Paper	VB	
TB/20-21/63	17.	Audit and Risk Committee Chair Report	FN	Paper	PC	
CLOSING ITEMS						
TB/20-21/64	18.	Any Other Business			Chair	11.50
TB/20-21/65	19.	Questions from Public			Chair	11.55
	Date of Next Meeting: 25th November 2021					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Fiona Carragher	FC	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Anne-Marie Dean	A-MD	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Sean Bone-Knell	SB-K	Associate Non-Executive Director
Mickola Wilson	MW	Non-Executive Director
Helen Greatorex	HG	Chief Executive
Vincent Badu	VB2	Executive Director of Partnership and Strategy/(Deputy CEO)
Dr Afifa Qazi	AQ	Executive Medical Director
Jacquie Mowbray-Gould	JMG	Chief Operating Officer (COO)
Mary Mumvuri	MM	Executive Director of Nursing & Quality
Sheila Stenson	SS	Executive Director of Finance & Performance
Sandra Goatley	SG	Director of Workforce & Communication
In attendance:		
Tony Saroy	TS	Trust Secretary (Minutes)
Hannah Puttock	HP	Deputy Trust Secretary
Cinzia Shaw	CS	Service User Participant
Apologies:		

Key: DL: Diligent Reference FA- For Approval, FD - For Discussion, FN – For Noting, FI – For Information

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Board Meeting held at 0930 to 1130hrs on Thursday 29th July 2021
Via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Sean Bone-Knell	SB-K	Associate Non-Executive Director
	Fiona Carragher	FC	Non-Executive Director
	Peter Conway	PC	Non-Executive Director
	Helen Greatorex	HG	Chief Executive (CE)
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
	Mary Mumvuri	MM	Executive Director of Nursing and Quality
	Dr Afifa Qazi	AQ	Executive Medical Director
	Jacquie Mowbray-Gould	JMG	Chief Operating Officer (COO)
	Sandra Goatley	SG	Director of Workforce and Communications
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
Observers:			
Apologies			
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Associate Non-Executive Director
	Anne-Marie Dean	A-MD	Non-Executive Director

Item	Subject	Action
TB/21-22/24	**Welcome, Introduction and Apologies** The Chair welcomed all to the Board meeting. The Board meeting was livestreamed to allow members of the public to join. Several senior members of staff attended as did the five newly-appointed clinical directors. Apologies were received from AMD, KL and MW. However, MW joined the meeting later in the agenda.	
TB/21-22/25	**Declarations of Interest** There were no declarations of interest.	

Item	Subject	Action
TB/21-22/26	**Personal Story: Community Mental Health Services for Older People: Patient and family member stories** Prior to the Board meeting, the Board had the benefit of viewing two videos that had been produced by Mr Deadman, and Mr and Mrs Stroud. Both videos set out their respective experiences of the Community Mental Health Services for Older People (CMHSOP). At the meeting itself, the Board welcomed Mr & Mrs Stroud, Mr Deadman, Dr Ephraim, Clinical Director for Older Persons Care Group and Clare Lux, Locality Manager within the Older Persons Care Group. The discussions focussed on the less satisfactory aspects of the patient and carer experience – the initial stages of the Dementia pathway – with discussion of the support needed by service users. It was agreed that within the system, there are very few Admiral Nurses (Specialist Dementia nurses) and the Trust can see the benefit of working with its partners, particularly Kent Community Health Foundation Trust (KCHFT) in building up the number of Admiral Nurses within the system. Dr Ephraim is driving the work to transform the Memory Assessment Service, and the development of the pathway that delivers care from the point of the GP referral, rather than waiting for a formal diagnosis. The Board heard that key to positive service user and carer experience is the relationship built with the CMHSOP over time rather than any single intervention. This facilitated access to support that was flexible and responsive. The Board thanked Mr & Mrs Stroud and Mr Deadman for their willingness to come and talk to the Board so openly about their experiences.	
TB/21-22/27	**Minutes of the previous meeting – 27/05/2021** The Board **approved** the previous minutes save for the following changes: • For item TB/21-22/08 – IQPR – Workforce – the words “Most staff leave within the first year of qualifying and the Trust…” is to be replaced with “Most staff leave within the first year of employment and the Trust…” • For item TB/21-22/09 – Finance Report: Month 1 – the words “Agency spend cap is set at £2million” is to be replaced with “Agency CIP target is set at £2million”.	
TB/21-22/28	**Minutes of the previous meeting – 24/06/2021** The Board **approved** the minutes of the meeting. Actions that have been delegated to a sub-board committee can be removed from the action log.	
TB/21-22/29	**Action Log & Matters Arising** The Board **approved** the Action Log.	
TB/21-22/30	**Chair’s Report** The Board received the Chair’s Report.	

Item	Subject	Action
	In response to the Chair's comment about problematic transitions between services, JMG advised the Board that both the Deputy Chief Operating Officer and the newly appointed Clinical Directors are leading a number of workstreams to assist with the transition plan for both internal and external services. Teams are piloting a co-working arrangement with a third sector organisation to carry out joint assessments in order to reduce inefficiencies and reliance on signposting; and recently a joint transition role has been recruited to between the Children and Adolescent Mental Health Services Team and the Community Mental Health Teams. The Chair highlighted the new congratulations section of the report and advised this would be regularly included going forward. The Board **noted** the Chair's Report.	
TB/21-22/31	**Chief Executive's Report** The Chief Executive's Report was received by the Board, which as was taken as read. The Chief Executive highlighted: • Amanda Pritchard has been appointed as the new Chief Executive of NHS England and Sajid Javid has been appointed at the new Health Secretary. • KMPT'S first five Care Group Clinical Directors have been appointed too and congratulations was passed onto to the successful individuals. • As previously suggested by the Trust Board, an innovation fund of £50k has been introduced for staff. The Deputy Directors will lead on this project, with the support of a non-executive director. • HG recently chaired the Mental Health, Learning Disabilities and Autism Improvement Board. Attendees of the meeting were not afraid to have challenging conversations and tackle the issues head on. The Chief Executive also highlighted positive feedback from Jackie Huddleston, Locality Director for Kent & Medway, NHS England & NHS Improvement in regards to the Mental Health, Learning Disabilities and Autism Improvement Board. That feedback stated: "Whilst there remain areas for improvement there is strong evidence of significant grip and traction on the key actions. The ambitions, trajectories and plans for these areas have been approved by the Mental Health, Learning Disabilities and Autism Improvement Board which will also provide oversight going forward." The Board **noted** the Chief Executive's Report.	

Item	Subject	Action
TB/21-22/32	**Integrated Quality and Performance Report (IQPR) – Month 3** The Board received the IQPR for Month 3 and complimented the Executive Management Team for the new format. The Board considered it to be concise and easy to read. The paper was taken as read, with questions focussed on each of the CQC domains. <u>Safe</u> The Board reflected on the fall in the number incidents being reported and the need to drive reporting up, particularly in terms of low harm incidents. By streamlining the process of incident reporting, staff may begin to report incidents more frequently. <u>Effective</u> The Board noted that this part of the IQPR was overly focussed on performance matters and there is a need to include details of clinical outcomes and pathways in future iterations. The Board reflected on the 'CPA patients receiving follow-up within 72 hours of discharge' and 'Percentage of patients with a CPA Care Plan' datasets as both had fallen over the last 6 months. This is a priority over the next few months and there is an action plan in place. In the interim, the Trust has a Red Board Process to ensure that service users are being appropriately followed up. The Board considered the issue of patient acuity and the impact this is having on the use of Out of Area Beds. The Trust's Finance and Performance Committee (FPC) had received in-month a paper on Bed Capacity, which set out the three potential scenarios. It is unlikely that the worst-case scenario would occur but it may be that additional female Psychiatric Intensive Care Unit (PICU) beds will be needed. The Board requested that any bed capacity review should start from the position of considering the extent to which enhancing community provision might reduce demand on beds. The Board expressed its disappointment in the number of Personal Support Plans' dataset as this has consistently been below the Trust's target of 95%, and it has only moved from 70.2% in March 2021 to 74.4% in June 2021. Dr Kirsten Lawson, Clinical Director for Adult Community Mental Health Teams (CMHTs), confirmed that improvement in this dataset is hindered by the complex set of interventions currently offered by CMHTs. A workshop will be held on 9th August which will look at resolving the issue by the end of 2021. The Board requested that action on this matter be expedited. <u>Well-led</u> The Board queried whether the plateau in staff uptake of Covid-19 vaccinations is likely to continue. It was confirmed that there is likely to be an improvement in the rate, with pregnancy- and maternity-related issues preventing people taking up the offer of a vaccine. New risk assessments regarding unvaccinated front-line staff are taking place.	

Item	Subject	Action
	The Board formally noted that the staff turnover rate target is 9% and not 4% as recorded in the dataset. Finance To be dealt with in the Finance item. Caring The Board was pleased to see the partnership working that is occurring in terms of music therapy and the work with Citizens Advice Bureau (CAB). The Board is keen to continue the partnership working and it was confirmed that the Trust is engaging with local partners through the Integrated Care Partnerships (ICPs) to improve health inequalities and tackle issues such as substance misuse & homelessness. Responsive The Board noted this domain and requested the Trust to consider if standards should be set regarding cancellation rates and Did Not Attends.	
TB/21-22/33	**Finance Report: Month 3** The Board received the Finance Report (Month 3), with the following matters highlighted: • **Income and Expenditure:** Within the breakeven position reported, there are several key drivers. There is continued pressures in temporary staffing and private placements above budget. Agency spend at the end of Q1 was £1.9m, only £77k lower than this time last year, however spend in June was lower than previous months. This is being mitigated currently by vacancies due to challenges recruiting into substantive roles. • **Cost Improvement Plan:** The Long-term Sustainability Programme is on plan for the first quarter with savings targets phased more towards H2 in line with national expectations. So far of the £7m target, £3.1m has been developed, leaving a gap of £3.9m to be found. There are ideas coming forward via the pillars to be costed over the coming months to close this gap. • **Capital Programme:** The YTD position is underspent by £2m. The main reasons for the underspend are delays on the Closed Protocol schemes, more detailed specifications required for Emmetts and Walmer heating, VAT reclaims and retention adjustments, and Strategic IT schemes not yet proceeding. • **Cash:** The cash balance at the end of June was £15.1m. No cash plan was required for the national plan submission, but the Finance team continue to monitor internally. This cash balance has increased in month	

Item	Subject	Action
	with receipts for the Provider Collaborative and block contract income for Q1 from the CCG. There are four areas of concern which could adversely affect the delivery of a breakeven position by year-end. These are Temporary Staffing Spend: Agency, Private Placement Spend, Planned and Reactive maintenance, and Patient Travel spend. The Trust is mitigating these issues by: 1. Temporary staffing – deep dive on agency spend has been completed and included in this month's Board report 2. Private Placement Spend – a bed paper has been taken to FPC this month which presents three scenarios in regards to bed capacity 3. Planned and Reactive maintenance – TIAA Trust internal auditors are currently undertaking a review of the Trust processes 4. Patient Travel Spend – relates to the use of patient transport. A task and finish group are being set up to review our processes. The Board **noted** the Finance Report: Month 3.	
TB/21-22/34	**Finance Exception Report – Agency** The Board received the Finance Exception Report regarding Agency. To reduce its dependency on Agency staff, the Trust is making a number of changes with regards to recruitment, and the Board noted the following: • The development of a recruitment strategy to ensure roles are advertised earlier so as to close the time between someone leaving a role and the new person filling that role. • Work is also taking place at the Integrated Care System level (by increasing the advertising channels) and pursuing international recruitment. • Recruitment within the Trust's CMHTs has improved with the expectation of seeing a fall in agency use by October/November • The higher rate paid by neighbouring Trusts for agency doctors means that KMPT also needs to pay equivalent rates so as to remain competitive. The Board asked whether the design of a hypothetical model CMHT, that maximised the potential for new ways of working, could be presented. Dr Kirsten Lawson, Clinical Director for Adult CMHTs, confirmed that the re-design of the Model CMHT is taking place. The Board **noted** the Finance Exception Report regarding Agency.	
TB/21-22/35	**CQC Quality Improvement Plan** The Board received the CQC Quality Improvement Plan paper, with the Board's discussion focussing on:	

Item	Subject	Action
	• The improvements related to the 'Out of sight, who cares?' report by the CQC, • CLiQ checks, and • Waiting times for psychology. <u>The improvements related to the 'Out of Sight, Who Cares?' report by the CQC</u> The Board noted that the 'Out of Sight, Who Cares?' report was a review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition. As result of that report, the Trust audited its services to identify if there were any gaps in the service delivered in line with the CQC recommendations. There were three main gaps related to Human Rights, training needs for staff related to autism and learning disability, and Care Pathways. The Board received assurance, with the Board noting: • Welcome Packs for service users were being adapted and posters for the wards were being created so as to ensure service users were aware of their human rights, • Staff will be receiving training in regards to tier 1 of autism and Learning Disability competency framework, and • The creation of a new Standard Operating Procedure is in development which will focus on LD and autism pathways. <u>CLiQ checks</u> The Trust is currently evaluating the CLiQ checklists to ensure that they continue to add value to the Trust. CliQ checks now include a review of service user nutritional requirements in order for the associated care plan and information transfer during handover to be checked. <u>Waiting times for psychology</u> Dr Ben Smith, Director of Psychological Therapies, is leading the work on waiting times for psychology so as to reduce the length of time that service users need to wait. Whilst service users wait, the Trust works with them to ensure that they remain safe. The Board **noted** the CQC Quality Improvement Plan Paper.	
TB/21-22/36	**Progress on Turning the Tide; Tackling Racism** The Board received the Progress on Turning the Tide; Tackling Racism paper, with a request that the Board restates its commitment to tackling racism in the Trust. The Board considered the paper and the work that the Trust had undertaken since receipt of the letter from Simon Cook, Chair of the KMPT Black Asian and Minority Ethnic Staff Network in June 2020. The Board noted the progress and commended the tangible objectives set out in the future work of tackling racism.	

Item	Subject	Action
	The Board was pleased to note the results of Operation Cavell to date. Discussions also focussed on how the work on tackling racism feeds into the Trust's ambition being an anti-discrimination organisation and the lessons that can be learned not only from other NHS Trusts, but also organisations outside of the health sector. In September 2021, the Trust's Workforce and Organisational Development Committee will receive a report regarding Operation Cavell and a report on how the Trust will become an anti-discrimination organisation. **Action: CEO to produce an update paper regarding progress against the Tackling Racism workplan. Paper to be received by the Board in January 2021.** The Board **noted** the Progress on Turning the Tide; Tackling Racism paper and restated its commitment to tackling discrimination within KMPT.	
TB/21-22/37	**Eradicating dormitory wards in mental health facilities in Kent and Medway** The Board received a paper regarding the eradication of dormitory wards in mental health facilities in Kent and Medway, with VB2 setting out the background to the matter and the work that has occurred to date regarding the re-location of in-patient Older Mental Health Services. The Board received assurance that the Trust has worked with local partners and the local authorities to explore relocation options, but despite that due diligence, no appropriate site was found within the Medway area. With the relocation deemed a significant change of provision by Medway Council, the Kent and Medway Clinical Commissioning Group (KMCCG) is now required to undertake a public consultation. Further assurance was received that a detailed Equality Impact Assessment had been appropriately completed. The Board **noted** that: • the development of a single preferred option for the proposed relocation of Ruby Ward from Medway Maritime Hospital in Gillingham to a new purpose-built facility at KMPT's Hermitage Lane site in Maidstone • this proposal aligns with KMPT's wider plans for the redevelopment of the Maidstone site • KMCCG's Governing Body is being asked to approve the pre-consultation business case for a single preferred option for the future provision of Ruby Ward services as the basis for a public consultation, and that following consultation a final decision will be made by the CCG in November 2021 • if approved, this will mean that a formal public consultation with the public will start on 3 August 2021 and finish at midnight on 21 September 2021, and that the CCG will also directly consult with HASC as per its legal duties The Board **agreed** to: • support and endorse the single preferred option as set out in the business case	

Item	Subject	Action
	• support a decision for the CCG to consult, and for KMPT to engage with the consultation process as appropriate.	
TB/21-22/38	**NHSI Self-Certification Declaration** The Board received and **approved** the NHSI Self-Certification Declaration.	
TB/21-22/39	**Audit and Risk Committee Chair Report** The Board **received** and **noted** the Audit and Risk Committee Chair Report.	
TB/21-22/40	**Quality Committee Chair Report** The Board **received** and **noted** the Quality Committee Chair Report as well as: • Infection, Prevention and Control Board Assurance Framework • Annual Safeguarding Report • Mortality Report The Board noted that there was an environment risk identified in the Quality Committee Chair's report, with the cost of refurbishing the Trevor Gibbens Unit being likely to be higher than the cost of a full re-build. **Action: CEO and Trust Chair to discuss the issue of the Trust's underspending on capital projects and the overspending on reactive maintenance and ensure a focus on this area in a future Board meeting. Meeting to occur by end of September 2021.**	
TB/21-22/41	**Workforce and Organisational Development Committee Chair Report** The Board **received** and **noted** the Workforce and Organisational Development Committee Chair Report. The Board noted that there is realistic prospect that the Trust will never close the vacancy gap and the Board will consider this matter when receiving the new-look Board Assurance Framework in September 2021.	
TB/21-22/42	**Finance and Performance Committee Chair Report** The Board **received** and **noted** the Finance and Performance Committee Chair Report.	
TB/21-22/43	**Mental Health Act Committee Chair Report** The Board **received** and **noted** the Mental Health Act Committee Chair Report. The Mental Health Act Committee had noted at its meeting that there were 45 outstanding renewal appeals and the Trust should consider if additional finance could be provided to recruit a member of staff to deal with this backlog.	

Item	Subject	Action
	Action: CEO and AQ to consider if additional finance could be provided to recruit a member of staff to deal with this backlog and revert to KL by the end of September 2021.	
TB/21-22/44	**Use of the Trust Seal** The Board **received** and **noted** the Use of Trust Seal Report.	
TB/21-22/45	**Any Other Business** There was no other business.	
TB/21-22/46	**Questions from Public** There were no questions received from the Public.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 30th September 2021.	

Signed …….. (Chair)

Date ……..

DRAFT

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 23/09/2021

NHS Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN SEPTEMBER 2021								
27.05.2021	TB/21-22/08	Integrated Quality and Performance Report (IQPR) – Month 1	JMG to produce a paper setting out the Trust's plans for the Memory Assessment Service for the short term. Paper to be presented to the Board by September 2021.	JMG	September 2021		This item is to be taken to the Quality Committee in November 2021	CLOSED
29.07.2021	TB/21-22/40	Quality Committee Chair Report	CEO and Trust Chair to discuss the issue of the Trust's underspending on capital projects and the overspending on reactive maintenance and ensure a focus on this area in a future Board meeting. Meeting to occur by end of September 2021.	CEO	September 2021		Board seminar on Capital Projects to be scheduled for February 2022	CLOSED
29.07.2021	TB/21-22/43	Mental Health Act Committee Chair Report	CEO and AQ to consider if additional finance could be provided to recruit a member of staff to deal with this backlog and revert to KL by the end of September 2021	CEO	September 2021		AQ to provide a verbal update at Board	In Progress
ACTIONS NOT DUE OR IN PROGRESS								
29.07.2021	TB/21-22/36	Progress on Turning the Tide; Tackling Racism	CEO to produce an update paper regarding progress against the Tackling Racism workplan. Paper to be received by the Board in January 2021.	CEO	January 2021			Not due
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
27.05.2021	TB/21-22/05	Action Log and Matters Arising	By June 2021, VB2 to send TS a copy of the accessible three-page summary of the Organisational Strategy for circulation to the Non-Executive Directors (NEDs).	TS	June 2021			Complete
27.05.2021	TB/21-22/09	Finance Report: Month 1	For July's Board meeting, SS to produce a finance report detailing Finance and Performance Committee risks including details of capital control targets and agency spend.	SS	July 2021			Complete
27.05.2021	TB/21-22/09	Finance Report: Month 1	TS to invite clinical directors to July's Board.	TS	July 2021			Complete

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 23/09/2021

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
27.05.2021	TB/21-22/10	MHLDA Improvement Board	HG & AQ to provide a copy of MHLD&A Improvement Board's dementia plan to FC for feedback by July 2021.	HG	July 2021		Sent on 22.07.2021 to FC	Complete

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 30th September 2021**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Introduction

In my role as Trust Chair, I present this report focusing on 5 matters:

- Board Self-Assessment
- System-wide meetings
- NED visits
- Congratulations

2. Board Self-Assessment

All NHS Trusts Boards should self-assess their performance against the CQC Well Led framework. As a Board, each member recently undertook a self-assessment survey of the Board's current performance and governance processes. This is so important to us as a Board, as it helps us to identify where we feel can improve and any development work may be needed. It also allows us to celebrate and learn from what we are doing well in order to embed it going forward.

Since the last public meeting, the results of the surveys have been gathered and I have received a report of the data. As the Chair, I will be developing an action plan, consulting with Board members before finalising it. I intend for the finalised action plan to come to the public Board meeting in November.

3. System-wide meetings

This has been a busy two months for the Integrated Care System in Kent & Medway. I joined a stakeholder event to meet with the shortlisted candidates for the role of Chair of the ICS, and we expect to hear confirmation of the successful candidate by the end of this month. We also met in person as an ICS Partnership Board for the first, and this was a delightful opportunity to network and build relationships with leaders across the county.

I have also attended my second Mental Health, Learning Disability and Autism Board, and it was hugely encouraging to see how real changes are beginning to take place in terms of the mental health pathway for the people of Kent as a result of this collaboration.

4. Trust Chair and NED visits

My NED colleagues and I were able to carry out some virtual and in person visits over the months of May, August and September 2021. These are listed within the table, with further details of the visits below the table.

Where	Who
May 2021	
Sevenscore & Woodchurch Wards	Sean Bone-Knell
August 2021	
Highlands House	Catherine Walker
Trevor Gibbens	Trust Chair
September 2021	
Dartford LPS & Jasmine Ward	Kim Lowe
Cherrywood	Trust Chair

Chair visits

It was delightful to meet individually with each of our new Clinical Directors in August, and I anticipate inviting them to join us at a Board seminar in the new year. I also met with Rachel Farrow-Gent, our new Head of Digital Transformation; it is a pleasure to welcome her to KMPT, and I know the board will be supportive of our ambition in this area.

The Chief Executive and I met virtually with Kent & Medway Healthwatch in September; they organised a really impressive and informative series of meetings with their team. Healthwatch play a crucial role in ensuring we receive timely independent feedback from carers and service users regarding our services. However, we think there are also opportunities to work collaboratively in the future as part of our innovative partnership working within the ICS.

In terms of my clinical site visits, I was made to feel extremely welcome as always; thank you to the staff who took time from busy working lives to provide an informative experience. I think the dominant theme was that of estates; ensuring that we have timely maintenance and clinical areas that are really fit for purpose.

Sean Bone-Knell's visit to Sevenscore & Woodchurch Wards

I was really impressed with the staff on both wards and the managers who were professional, dedicated and passionate about their work and patients. I was pleased to see patients at both sites engaged in activities and that staff joined in.

I also took time to speak with Dr Birdi who again was excellent, and all wanted to do all they could to reduce the time taken to undertake the memory assessments.

Staff members were also very positive about the use of Lifesize and could see the business requirement to keep using this as we go forward as it saved many hours in the car in a number of instances.

Catherine Walker's visit to SWK CMHT at Highlands House

I spent the morning with the SWK CMHT at Highlands House on 17th August. Thanks to the team for being so open and welcoming. I was pleased to note that physical health checks via the well-being service are a met target and that the active review team are working at pace to cover our case load.

Kim Lowe's visit to Dartford LPS & Jasmine Ward

Dartford LPS

The Team were really welcoming on arrival. I was shown the main hospital A&E admissions area and they went through the admissions board and their operating procedures with me. Staffing was good and on the whole, they were able to meet their targets of seeing A&E admissions within an hour. I would sum up that it seemed a happy team, good leadership and they spoke of feeling connected to KMPT, other liaison units and the wider organisation. The team raised space as an issue and the duplication of paperwork due to IT.

Jasmine Ward

I was greeted with a warm welcome on arrival and the team gave a very honest and balanced account of how they felt. The team commented on the trust they have in Helen's leadership. When asked what gets in their way of doing their job I received a passionate and heartfelt account of how hard it was for nurses. Staff felt that the process and paperwork was overwhelming at times.

5 Congratulations

On behalf of the Board, I congratulate Shelley Butler, RMN on Boughton ward for her role in helping to save the life of a cyclist in July 2021. Shelley supported an off-duty

Fire officer to give CPR to the cyclist who was suffering a heart attack. I was relieved to be informed that the cyclist has recovered from the heart attack. In recognition of her help, Shelley is being awarded a CE Certificate of Commendation from the Kent Fire and Rescue Service's Honours and Awards Board on 1 October 2021.

The Board also wishes to congratulate Zoli Figusch, Principal Psychotherapist at The Brenchley Unit, who has been awarded a Lifetime achievement award from the British Psychodrama Association.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Chief Executive Board Report

Date of Meeting: 30 September 2021

Introduction

As always, today's board papers include significant items. In addition to our standing Integrated Quality Performance Report, the board will consider the Trust's first Commercial Strategy. Building on our board development work over the last two years, the strategy sets out a way forward that will enable us to operate in a more effective way to the benefit of those we serve.

Covid-19

We continue to operate to strictly observed infection, prevention and control measures, protecting our service users, their loved ones and ourselves. In the meantime, in common with other specialist trusts across the country, we are experiencing significant pressure on both our inpatient and community services. Our clinical teams are noting high demand for services as well as an increase in the acuity of those seeking help. Strong leadership from our Clinical Directors in partnership with Heads of Service is in evidence, ensuring that we manage this pressure in a safe way keeping our patients at the heart of what we do.

Staff Survey

As we approach the date that the staff survey opens this year, we have been talking with colleagues about the importance of completing and returning this annual, independently managed survey.

KMPT's overall response rate over the last five years has improved year on year from 41.07% in 2015 to 61.00% in 2020. This year we have set ourselves the target of an overall response rate of 68%. Making sure that we hear all three and a half thousand voices from across the organisation is vital if we are to achieve our aim of delivering Brilliant Care through Brilliant people.

Executive Management Team and Deputies

Over the last eighteen months, a programme of facilitated development has been running for the deputy executive directors. It has included individual and team coaching, a new series of executive and deputy meetings and opportunities for deputies to lead pieces of board level work (the most recent example being the creation and launch of the Innovation Fund).

Aimed at strengthening succession planning, the programme has been positively received and the model is now being applied to other groups including the Clinical Directors, Heads of Psychiatry and aspiring Clinical Directors.

Integrated Care System Workshop and Recruitment to Accountable Officer and Chair

On Tuesday 14th September over a hundred representatives from health and social care organisations were brought together at Detling Showground for an Integrated Care System (ICS) workshop. KMPT were pleased that our Chair was asked to act as facilitator to one of the table discussion groups. Outputs from the day will be shared with the board once available.

The recruitment process for both the ICS Chair and Accountable Officer are underway with an expectation that appointments will be confirmed in November.

Chief Nurse Recruitment

Since the last Board meeting, Executive Director of Nursing Mary Mumvuri has been appointed to a new role in Coventry and Warwickshire Partnership Trust. Mary will have been with KMPT for five and a half years when she leaves us in December. Recruitment to the post of Chief Nurse is underway with interviews scheduled for November 5th.

Director of Communications and Engagement

We were delighted to appoint Kindra Hyttner to this newly created role. Currently Director of Communications with the Audit Office, Kindra brings with her significant experience. Kindra's induction in November will include time with people who use our services, staff across the organisation and meetings with both executive and non-executive members of the board.

Dr Rosarii Harte's Retirement

Finally, we said goodbye in September to Deputy Medical Director Doctor Rosarii Harte. Dr Harte joined the organisation in 2000 and was a key player in developing a range of trust services including our Crisis Response Home Treatment Teams. Most recently, she has worked in our Patient Flow Team, ensuring that we keep our patients as close to their homes as possible and avoiding out of area admissions.

Members of the Board will recall that Rosarii took the role of Executive Medical Director for six months prior to Dr Afifa Qazi joining us. Her contribution to the organisation has been enormous and we are very glad to say that she will return to KMPT in a clinical role on a part time basis later this year.

Big Conversation and Leaders Events

September saw both a Big Conversation (open to anyone in any role anywhere in the Trust) and Leaders Event (open to our 150 most senior staff) held. Using the Trust's virtual platform LifeSize, both events were positively evaluated with participants commenting that being able to join virtually is enabling a better use of time, improved access and ability to share with their teams because the events are recorded. As the restrictions of the pandemic ease, we anticipate operating a mixed model of mainly virtual, and some in person events.

Chelsea Flower Show – Garden of Hope

In 2019, KMPT entered and won a national NHS competition to win a Chelsea Flower Show garden. The prize, designed by Arit Anderson was originally to be presented at the Flower Show in 2020. The show was cancelled because of Covid but on Monday September 20th Chelsea Flower Show opened once again and a number of colleagues from KMPT went to see it and meet the designer. The garden will be installed later this year, in Rosewood, our Mother and Baby Unit.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th September 2021
Title of Paper:	KMPT Participation and Involvement
Author:	Catronia Toms - Assistant Director of ICP Development Kamila Lobuzinska – Patient Engagement Coordinator
Executive Director:	Vincent Badu - Deputy Chief Executive/ Executive Director Partnerships & Strategy

Purpose of Paper

Purpose:	Approval
Submission to Board:	Board requested

Overview of Paper

The paper focusses on implementation of the Participation and Involvement Strategy 2020-2025 to facilitate the Trust's vision to make a valuable difference to its services by empowering and supporting service users and carers to bring a lived understanding of mental and physical wellbeing to the work of the Trust. It provides a short overview of the KMPT Engagement and the new processes and structures developed - the establishment of the Engagement Council and the activity of the Engagement Pool.

Issues to bring to the Board's attention

This paper presents the significant improvement in KMPT Engagement work, the growth of service user and carers involvement and the diversification of engagement.

Since the establishment of the new structures in Autumn 2020, 79% existing participants accompanied us on the journey. The Engagement pool currently consists of 102 service users, carers, members of the public and our aspiration is to increase this number to 200 across the next 12 months.

The implementation of the Engagement Council including the strategic interface and work plan which require Board agreement.

Governance

Implications/Impact:	Risks are recorded and managed on the Participation and Involvement Strategy Working Group Risk Register
Assurance:	Reasonable
Oversight:	Oversight is provided by the Trust Wide Patient and Carer Experience Group and the Participation and Involvement working group currently reporting into the Quality Committee.

INTRODUCTION

In April 2020 the Trust approved the new Participation and Involvement Strategy 2020-2025, which describes its commitment to work in partnership with our service users, volunteers, carers and their family members to improve the quality and capacity of our involvement and engagement. Involving them in the development and planning of services, as well as the governance of the rust, are the Trust's key commitments.

Engagement activities in 2020/21 and 2021/22 have focused on implementation of the Participation and Involvement strategy and alignment with the external review completed summer 2020.

1. Measures of success in implementation to date

These include:

- Co-production new processes and procedures
- Transition of existing participants to the new way of working (79% to date)
- Expansion and diversification of the engagement group – now 103 with 50 new participants since August 2020
- Engagement with external partners for projects including universities and other trusts
- Improved knowledge of where and how to add an engagement element to projects within transformation team and other staff groups
- Diversification of the mechanisms for engagement
- Improvements in matching engagement opportunities to skills, experience and aspirations of participants
- Development in coproduction of a training and support offer for all participants
- Standardisation of information sharing
- Recognition Policy reviewed and ratified

2. Work-streams to support Strategy implementation

Three work-streams comprising staff, service users and carers were developed to address the key themes outlined in the strategy and ensure that the pledges set out were achieved:

Workstream 1: Communication, Marketing and Recruitment

- A new communication plan has been developed
- New recruitment mechanisms for both engagement and volunteers have been introduced

  In development: Service user and carer e-bulletin

Workstream 2: Training and Support

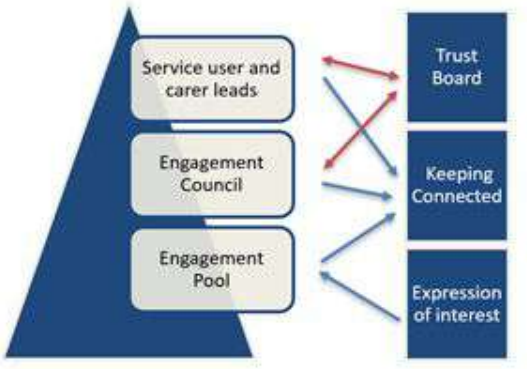
- Volunteering, participation and involvement in research and innovation - A guide for staff developed
- Welcome and induction booklet for service users, carers and volunteers developed
- In development: induction videos for service users and carers and joint training for staff and engagement participants on co-production

Workstream 3: Process and Practical issues

- Standard Operating Procedure 1 - Initial engagement process
- Standard Operating Procedure 2 – Level of engagement, training and support
- Standard Operating Procedure 3 - Evaluation and moving on:
- The Engagement Council processes development
    - Terms of Reference *(it will be reviewed initially in three months of the constitution of the first council and thereafter annually)*
    - Member role
    - Self-nomination form
    - Standard Operating Procedure – The Engagement Council work cycle

3. KMPT Engagement

Following the recommendations from the external review of the previous engagement structures (i.e. consultative committees, co-production network etc.) held in Summer 2020, a number of new ways to work in partnership with our patients and carers were identified and developed.



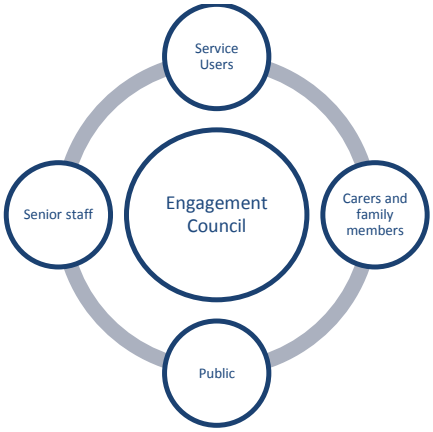
3.1 The Engagement Council

The Engagement Council will provide the strategic level of interface for engagement across KMPT. It will be supported by the Partnerships and Engagement Team and work strategically with the Board and operationally with the Engagement Pool and care group services.

The membership of the Council will reflect the Trust's care groups, patient demographics and the geography of Kent and Medway. A process of selection for the Engagement Council members has been developed to ensure that individuals are clear about the role and expectations / accountabilities of the Council prior to self-nominating.

The initial set up and Terms of Reference were drafted in co-production with engagement representatives. It is expected that people who apply for the Engagement Council as patient / carer representatives will join the Engagement pool first.

Members for the Council will be drawn from 4 constituency groups:



A self-nomination form has been developed in co-production and focusses on reasons for joining the Council, identifies any reasonable adjustments required to participate and alignment with KMPT values of members.

The Engagement Council will have accountability in the following activities to achieve their objectives:

- To meet with Trust Board and the wider Engagement Pool (in-patients and community) on a bi-annual basis to agree a series of priorities (February) and provide an update report (October)
- To be responsible for oversight and monitoring of agreed priorities.
- To provide formal assurance to the Trust Board through providing reports to KMPT Quality Committee and governance meetings (Trust-wide Patient and Carer Experience Group and Partnerships and Strategy).
- To provide assurance to the wider Engagement Pool by attending the Keeping Connected events and providing feedback on the work of the Council.
- To encourage innovative practice and learning from priorities.
- To make recommendations for service development and improvement from a lived experience perspective.
- To provide assurance that those who experience health inequalities and people with protected characteristics (including carers and those that are socially and economically deprived) are engaged in KMPT service development and improvement.
- To support recruitment and induction of new members to the Council.

Recruitment to the Engagement Council commenced in September 2021 via advertising at the Keeping Connected event on the 2nd September, communication to the Engagement Pool members, highlighting at the Annual General Meeting 30th September and communications on the internal and external website. The aim is to have the initial Engagement Council meeting in November 2021.

3.2 Engagement pool

This is a register of service users, carers and their family members who have completed the Lived-experience expression of interest form and currently engage with KMPT to drive improving and/or developing our services. The impact of the Engagement Pool is improvement to the quality services that understand and reflect the needs of those who use them. Our ambition is to double the number of participants in the next 12 months.

August 2021 data:

- 102 participants (72 service users, 26 Carers, 4 public).
- Care Group representation: 35% Community Recovery Care Group; 13% Forensic and Specialist Services; 11%Acute Care Group; 9% Older Adults Care Group; 4% Public and 28% not currently recorded.
- 58 engagement requests for service user and carers involvement in the project / programmes were received. (Acute – 5; Community Recovery – 12; External – 3; Older Adult – 2; Support Services – 33 (cross care group's projects); Forensic and Specialist Services – 3)

3.3 Client Management System project

This project is to systemise the Trust's processes and provide improved delivery and reporting functionality has continued to progress with a business plan to be presented.

The project is aimed at investigating a suitable, cost-effective, functionality and efficiency, client management system for the Trust, covering Partnerships and Engagement (Partnerships and Strategy Directorate), the Communication Team (Workforce Organisational Development and Communications Directorate) and the Executive Management Team (Trust Board). This will allow movement away from stand-alone spreadsheets and increase security and reporting capability.

This project is aligned with the Trust Digital Transformation Board processes.

RECOMMENDATIONS

For the Board to agree the following interactions with the Engagement Council:

- Engagement Council to meet twice per annum with the Trust Board to support priority setting and to provide evaluation of what has been achieved each year against agreed priorities – it is recommended that the first meeting occurs in February 2022 – following this a schedule of twice per annum can be established.
- Consideration for the KMPT Governance structure required to support the Engagement Council work and monitoring; i.e. identification of where the Councils fits within the organisational governance structure – this may be via the existing Trust wide Patient and Carer Experience Group (TWPCEG) which reports to the Quality Committee or via a new structure to be established within the Partnerships and Strategy Directorate. Summary reporting to TWPCEG, Triangle of Care (TOC) and Keeping Connected Events on the work of the Engagement Council will required.
- The Trust Board to support selection and development of the Engagement Council as part of the recruitment and induction process.

CONCLUSION

The Engagement Council is a new strategic structure that aims to influence the culture of the organisation from a strategic perspective and make a real difference for people with lived-experience and for the Trust.

The aspiration is that the Engagement Council would provide checks and balances on the strategic direction of the Trust, influence planning and annual objectives from lived experience perspective. It will also provide considerations for the Executive Management Team to change their ways of working to have a more co-productive approach.

Once established it is planned that the Engagement Council will nominate a service user and carer lead who will take accountability for the work of the Council and build a close working relationship with the Executive Management Team and report to agreed governance structures.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th September 2021
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

A paper setting out the Trust's performance across the Care Quality Commission (CQC)'s five domains.

Issues to bring to the Board's attention

The Trust's Business Intelligence System allows it to capture against a range of national and/or local targets that fall within the CQC's five domains. In August 2021 (the period covered by this report) there was an upturn in the 'unplanned readmissions in 30 days' metric to 11.0% against an 8% target. The Chief Operating Officer is reviewing the cause of this upturn with the Trust's Patient Flow Team.

The bed pressures that were identified in the July IQPR paper continue to increase. There is a high demand for acute beds, which is affected by the delay in completing the Orchards Ward refurbishment and also the acuity level of patients being treated.

For the Older Adult Care Group, the 4-week wait for assessment metric stood at 48.5% combined, that is, for both functional and Memory Assessment patients. The care group has seen significant increase in referrals overall with the data indicating referrals have increased month-on-month and at the highest level for 2.5 years.

In terms of the Urgent referrals seen within 72 Hours metric, the Trust instigated an audit because of the number of cases that had breached the 72-hour deadline. The Clinical Directors of both care groups affected, CRCG and Older Adults, alongside the two Deputy Chief Operating Officers, are addressing the findings of the audit and are reviewing the patient pathway. The safety of any patient waiting is

paramount and the availability of team duty and multi-disciplinary triage mitigates the risk to patient where clinically it is indicated that a patient needs an urgent response; CQC reported in their last report on community services the response to urgent referrals was appropriate and effective.

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The Executive Management Team continue to monitor performance and react accordingly to performance issues through the effective use of resources. Where performance is reasonably estimated to be improved only in the medium to long term, the Board is sighted on the Trust's plans through its committee structure.

Governance

Implications/Impact:	Regulatory oversight by CQC and NHSE/I
Assurance:	Reasonable
Oversight:	Oversight by Trust Board and all Committees

CQC Domain	Safe
Trust Strategic Objective & Board Assurance Framework	• **Achieving our Quality Account Priorities** • **Developing and delivering a new KMPT Clinical Strategy**

Executive Lead(s): Executive Director of Nursing & Quality
Lead Board Committee: Quality Committee

Issues of Concern
CPA patients receiving a formal review This is the fourth month we have seen a month on month decline. This will be discussed with the Care Groups at the Quality Performance Reviews this month and an action plan to be agreed focussing on how we improve performance.

Executive Commentary

CPA patients receiving a formal review – see issues of concern above.

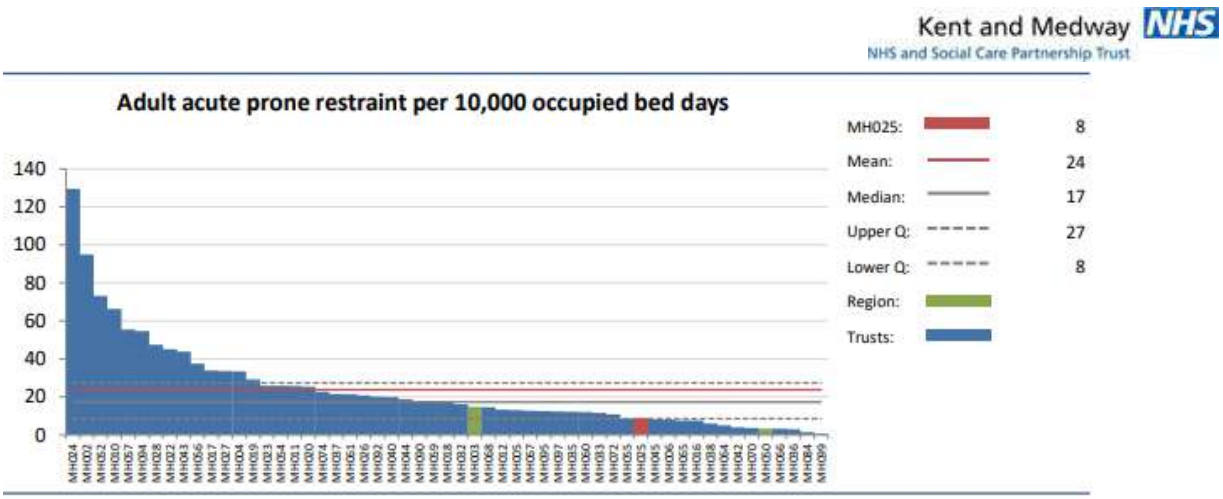
Restrictive interventions (011-013.S)

The Trust remains focused on reducing and where possible, avoiding the use of any type of restrictive interventions in order to protect people's Human Rights. The majority of incidents do occur in the most acute inpatient environments and the intensive care unit.

Physical restraints

In line with national guidance and best practise, the ambition is to have no prone restraints. Five prone restraints were used within the Acute wards during August., In all cases, the prone position lasted less than three minutes and there was no harm reported by the patients or staff involved.

Positively, when compared with other providers through the annual NHS National Benchmarking exercise, the Trust reported eight prone restraints per 10.000 bed days, which places us in the lower quartile of providers (graph 1 below).



Seclusion

There are five seclusion facilities across acute and forensic wards. 19 incidents of seclusion use were reported in August, with the majority lasting under two days. One incident of moderate harm was reported and appropriate support was given.

Restraint Reduction Network (RRN) accreditation standards

The Promoting Safe Services (PSS) team have been working towards attaining the new RRN training standards, which is a mandatory accreditation scheme for all mental health NHS Trusts. Evidence of compliance with the standards was submitted before the deadline for assessment. Accreditation status should provide assurance for compliance to both KMPT and the Care Quality Commission (CQC). The next six months will consist of multiple assessments for the PSS team and a final panel interview before an award of the accreditation status. Additionally, the recent release of the draft statutory guidance for the Mental Health Units (Use of Force Act) has allowed a benchmarking exercise to be completed. This shows that we are approximately 85% ready to comply and are on track to be 100% compliant when the final guidance and deadline is released later in the year.

Unplanned readmissions in 30 days

Whilst there has been an upturn in month to 11.0% against an 8% target, statistically it does not indicate if this is a one-off event or a cause for concern; for the previous 10 months the standard has been met. The Chief Operating Officer is reviewing with the Patient Flow team to assess if there has been a change.

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IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review		95%	N	95.6%	95.9%	97.1%	97.1%	96.4%	96.4%	95.5%	95.8%	94.7%	94.5%	94.2%	93.2%
003.S	% Inpatients With A Physical Health Check Within 72 Hours		90%	L	95.4%	97.5%	94.3%	95.2%	95.8%	92.9%	96.4%	96.2%	96.5%	98.8%	96.5%	95.8%
005.S	Number Of Unplanned Absences (AWOL and Absconds on MHA)		-	-	17	21	13	15	26	8	22	17	18	20	25	19
006.S	Serious Incidents Declared To STEIS		-	-	15	17	11	23	23	15	21	24	16	13	11	13
007.S	% Serious Incidents Declared To STEIS within 48 hours		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
008.S	Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days		0	L	17	12	20	14	5	0	5	2	4	5	4	1
010.S	All Deaths Reported On Datix And Suspected Suicide		-	-	140	134	232	225	275	178	155	150	77	146	75	123
011.S	Restrictive Practice - All Restraints		-	-	132	146	105	96	114	106	146	103	145	88	151	96
012.S	Restrictive Practice - No. Of Prone Incidents		0	L	13	11	6	3	10	3	6	4	8	4	6	5
013.S	Restrictive Practice - No. Of Seclusions		-	-	22	29	32	17	16	8	24	12	21	21	26	19
015.S	Ligature Incidents - Ligature With Fixed Points (moderate to severe harm)		0	L	0	0	0	0	0	0	1	0	0	0	0	0
016.S	Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm)		-	-	0	0	0	0	0	0	0	0	0	0	0	0
017.S	RIDDOR Incidents		-	-	4	4	1	1	2	0	3	2	6	0	2	2
018.Sa	Infection Control - MRSA bacteraemia		0	N	0	0	0	0	0	0	0	0	0	0	0	0
018.Sb	Infection Control - Clostridium difficile				0	0	0	0	0	0	0	0	0	0	0	0
019.S	Safer staffing fill rates		80%	L	111.9%	111.2%	109.4%	106.5%	106.0%	104.3%	108.8%	108.9%	110.1%	110.7%	110.5%	110.5%
020.S	Unplanned Readmissions within 30 days		8.8%	L	11.6%	8.2%	8.5%	6.3%	8.1%	7.7%	5.2%	6.3%	4.2%	3.8%	7.8%	11.0%

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CQC Domain	Effective
Trust Strategic Objective & Board Assurance Framework	• **Implementing programmes that improve Care Pathways** • **Strengthening our approach to Research and Development and delivering evidence-based care.** • **Testing and evaluating models for integrating care and systems with our partners**

Executive Lead(s): Executive Medical Director
Lead Board Committee: Finance and Performance Committee

Issues of Concern

High demand for acute beds (affected by the delay in completing Orchards ward refurbishment and the acuity level of patients being treated)

% of patients on CPA with a valid Care Plan & % Patients with Non CPA Care Plans or Personal Support Plans. Corrective action underway for both indicators, focussing on variation amongst teams to address low performance outlying teams.

Executive Commentary

	005.E: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			0.0	0.0	-38.7	95.5	28.4
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			103.0	0.0	18.9	323.1	171.0
4	**Trust Total**			103.0	0.0	16.9	375.5	196.2

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**

Narrative

August saw a saw a reduction of 49% to 103 bed days compared to July's usage of 201. This is the lowest number of external bed days used since September 2020. All bed days were PICU beds with no acute beds being used for the first time since October 2020. However, there continues to be high demand for beds and whilst the position for August is positive the trend is anticipated to remain upwards due to a delay in the reopening of Orchards ward, currently being refurbished, alongside ongoing challenges connected to the COVID pandemic and the acuity levels of patients.

Of note the current use of female PICU beds (contract in place due to the Trust not having female PICU beds within its bed stock), is operating within the current contracted bed base of 7 beds. This has been a steady state for the past 6 weeks.

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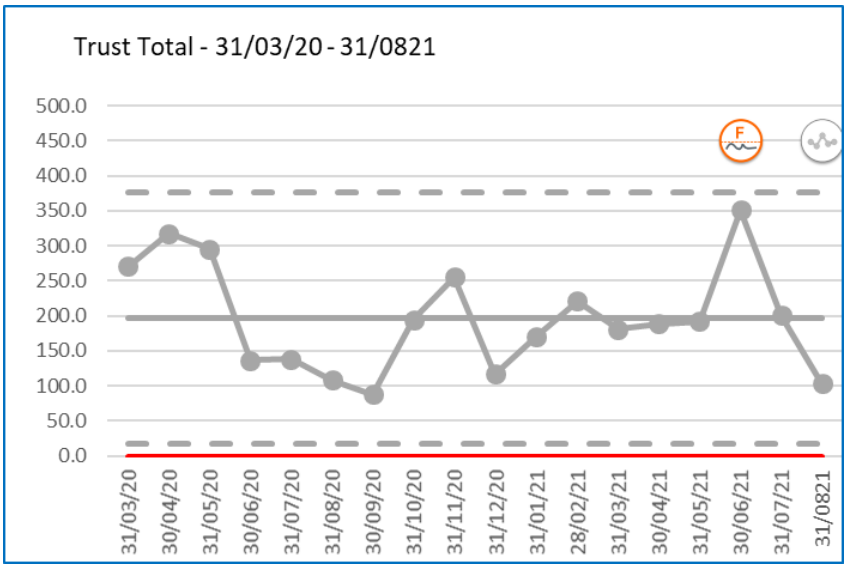
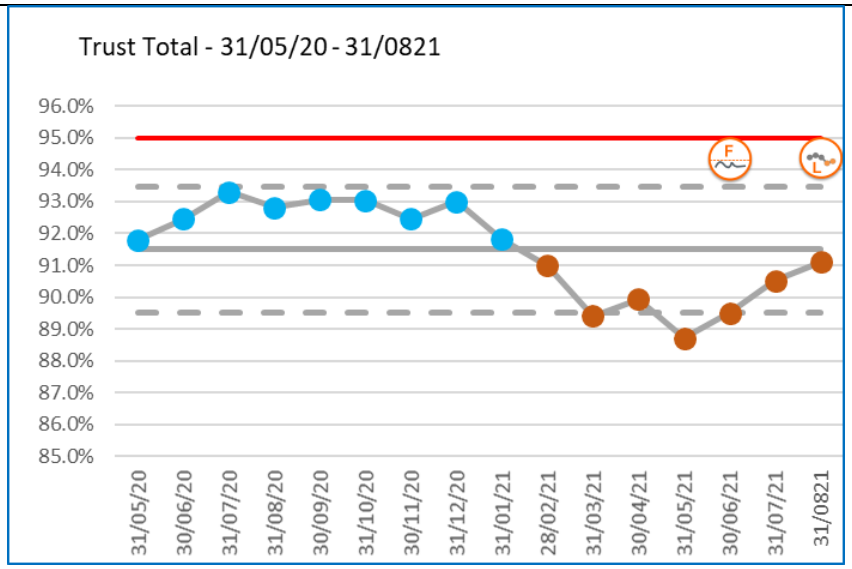
Financially there is an overspend against budget which will be fully reviewed at Finance Committee in October 2021 to understand what is driving this.



	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute		F	75.0%	95.0%	62.3%	92.8%	77.5%
2	CRCG	L	F	89.9%	95.0%	88.2%	92.5%	90.4%
3	FSS	L	?	94.1%	95.0%	92.4%	97.6%	95.0%
4	OPMH		?	97.0%	95.0%	94.7%	99.3%	97.0%
5	Trust Total	L	F	91.1%	95.0%	89.5%	93.5%	91.5%

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG	L	F	69.3%	95.0%	67.4%	73.4%	70.4%
2	FSS	H	F	81.3%	95.0%	60.1%	75.1%	67.6%
3	OPMH		F	66.1%	95.0%	63.9%	73.5%	68.7%
4	Trust Total	H	F	74.4%	95.0%	65.6%	72.1%	68.9%

Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Special cause of **Concerning** nature to **lower** values *Non CPA PSP & Care Plans:* Special cause of **Improving** nature to **higher** values
Assurance	Variation indicates consistently **failing short of target**
Narrative	
The % of patients on CPA with a valid Care Plan rose once again in month to 91.1%, however special cause variation is identified due to the metric being seven consecutive data points under the mean of the last 18 months. Further increases in September will hopefully see this indicator return to levels previous achieved last in January 2021 and start to move towards the target of 95%.	



People who are not subject to CPA and in receipt of a care plan or a Personal Support Plan (PSP) continues to show an improving position month on month overall although variation exists within care groups.

Community Recovery Care Group (CRCG) continue to have actions in place to support the 4 Community Mental Health Teams (CMHTs) where performance is below the standard expected, including ongoing performance monitoring. This is monitored weekly through the care group governance process. The team of most concern is SWK whose performance is at 30.9%. This team has capacity challenges to meet an increasing number of assessments, wider job planning analysis is underway to address total workload across all priorities. It is of note that Canterbury and Coastal CMHT and Maidstone CMHT have improved the PSP compliance by 12.5% in each team during the past 2 weeks. The other poor performing teams have also had an increase in compliance, albeit a smaller percentage.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHT			76.3%	95.0%	76.9%	85.9%	81.4%
2	Canterbury & Coastal CMHT			86.0%	95.0%	72.6%	84.2%	78.4%
3	DGS CMHT			61.1%	95.0%	55.1%	75.0%	65.0%
4	Dover & Deal CMHT			84.5%	95.0%	69.5%	85.3%	77.4%
5	Maidstone CMHT			53.7%	95.0%	47.3%	62.2%	54.7%
6	Medway CMHT			80.1%	95.0%	68.1%	82.4%	75.3%
7	Shepway CMHT			88.5%	95.0%	78.2%	91.3%	84.7%
8	Swale CMHT			62.2%	95.0%	60.6%	71.6%	66.1%
9	SWK CMHT			30.9%	95.0%	41.5%	65.8%	53.6%
10	Thanet CMHT			92.3%	95.0%	81.3%	94.1%	87.7%
11	**CMHT Total**			70.4%	95.0%	68.6%	74.1%	71.3%

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Of note over the coming year CPA will be replaced as a performance metric as part of the national Community Mental Health Framework (CMHF). The Trust Care Planning Group is reviewing options for a single care planning process for all patients requiring KMPT care. The Trust will continue to report on CPA until new metrics are agreed locally with the health system.

	012.E: Average Length Of Stay (Younger Adults)	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Amberwood Ward			36.2	25.0	-4.5	54.2	24.9
2	Bluebell Ward			41.5	25.0	0.6	71.0	35.8
3	Boughton Ward			20.6	25.0	-7.6	67.0	29.7
4	Chartwell Ward			28.5	25.0	-3.6	58.1	27.2
5	Cherrywood Ward			19.7	25.0	1.3	46.5	23.9
6	Fern Ward			26.8	25.0	-4.7	70.0	32.7
7	Foxglove Ward			35.7	25.0	-5.0	68.5	31.8
8	Pinewood Ward			24.7	25.0	-8.5	67.2	29.4
9	Upnor Ward			21.0	25.0	3.5	48.1	25.8
10	YA Acute			27.7	25.0	17.3	39.0	28.2

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates **inconsistently** hitting or failing short of target

Narrative

SPC analysis has not identified any significant variation in month within YA acute wards.

Whilst the Trust operates a needs led approach to in-patient admissions we continue to report against older and younger adult wards. The Older Adult Wards Length of Stay (LoS) in September was 56.9 days bringing the 12 months average to 69.4 days. This impacts positively on bed availability for older adults who need in-patient care. It should be noted the demand for OA beds remains on an upward trend, this is monitored daily and proactively managed. This is being reviewed to forecast forward and identify the potential need for the use of out of area beds.

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IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	98.2%	98.0%	97.8%	98.7%	96.5%	98.9%	98.3%	98.9%	97.3%	97.8%	97.8%	96.4%
001b.E	CPA patients receiving follow-up within 72hours of discharge				88.8%	90.3%	89.3%	87.5%	88.8%	90.9%	88.4%	86.7%	84.0%	82.7%	86.5%	86.6%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.2%	95.4%	95.4%	95.6%	95.6%	95.7%	95.8%	95.8%	96.0%	95.9%	95.7%	95.7%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	88	195	255	117	171	221	181	189	192	351	201	103
006.E	Delayed Transfers Of Care		7.5%	L	8.1%	10.7%	12.7%	11.9%	10.5%	9.2%	8.5%	8.7%	8.6%	8.4%	8.8%	9.0%
011.E	Number Of Home Treatment Episodes		224	L	225	248	234	192	189	220	250	241	270	291	246	242
012.E	Average Length Of Stay(Younger Adults)		25	L	26.25	25.29	33.11	35.75	36.25	31.78	27.75	25.94	26.42	33.92	28.23	27.68
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	66.31	64.35	64.90	92.21	69.97	76.09	70.97	101.79	61.63	65.75	53.24	56.90
015.E	%Patients with a CPA Care Plan		95%	L	93.1%	93.0%	92.5%	93.0%	91.8%	91.0%	89.4%	89.9%	88.7%	89.5%	90.5%	91.1%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	17.7%	19.6%	22.6%	24.3%	26.1%	29.9%	39.3%	50.9%	52.3%	53.8%	56.1%	57.2%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		95%	L	61.4%	64.2%	67.2%	67.8%	67.8%	71.2%	73.3%	73.1%	73.6%	74.4%	74.3%	74.4%

CQC Domain	Well led – Workforce
Trust Strategic Objective & Board Assurance Framework	• **Building a resilient, healthy and happy workforce** • **Evolving our culture and leadership**

Executive Lead(s): Director of Workforce and Communications
Lead Board Committee: Workforce Committee

Issues of Concern
Turnover for August 2021 is 11.3% for rolling 12 months, which is an increase of 0.4% since previous month. This is 2.3% above the target for 2021/22 (9%). The largest increase in month has been in the Forensics and Specialist Care Group.

Executive Commentary

Staff Sickness (001.W-W)

Sickness for the month is 4.2% for August. This is 0.2% above the target for 2021/22 (4%).

Sickness is 4.71% year to date – 0.48% of this relates to Covid and therefore is 4.2% year to date without Covid.

Short term sickness increased to 1.64% compared to 1.53% last month. Long term sickness is 2.55%, a decrease from 3.07% the previous month.

Activities in place to reduce sickness absence include:

- Successfully closed 38 long term sickness absence cases in August 2021.
    - 34 employees are returning to same post
    - 4 employees are no longer employed at KMPT
    - We are currently actively supporting managers with 71 cases of sickness absence.
- Deep dive into cases of stress/anxiety completed
- Wellbeing Guardian Board Principles Action Plan
- NHS Health and Wellbeing Framework Trailblazer Project
- Bringing Schwartz Rounds to KMPT
- Wellbeing Conversation Cafés - looking after our people
- Health and Wellbeing sessions and managers training
- Stop smoking practitioner training
- Healthy Workplace Allies eLearning programme
- Health and Wellbeing Conversations
- NatureWell Training for healthcare practitioners

Staff Turnover (004.W-W)

Turnover for August 2021 is 11.3% for the rolling 12 months, which is an increase of 0.4% since the previous month. This is 2.3% above the target for 2021/22 (9%). Turnover is 10.5% year to date.
The biggest increase is in the Forensics and Specialist Services Care Groups – 1.4%
All care group areas are developing their workforce plans. This is being supported further by the work we are doing supported by an external company to redesign the workforce planning model/template which will enable us to forecast forward based on national information and local initiatives. A KMPT recruitment and retention group is also supporting strategies to address turnover.

Activities to reduce turnover:

- Introduction of buddy schemes
- Attending best practice sharing national events and is joining an Integrated Care System task and finish group for retention across Kent and Medway.
- Health and Wellbeing initiatives and support
- Career pathways to improve staff retention
- Specific focus on leavers within first 2 years

Staff Retention (004.W-W)

The August 2021 data shows a retention rate of 88%, against a target set for 21/22 of 90%. We are now reporting against specific staff groups:

- Additional Clinical services from 86% to 90% - currently 84%
- Nursing from 88% to 91% - currently 82%
- Medical from 91% to 92% - currently 88%

We will report next month on the year to date position.

Activities to support retention are reflected in turnover:

- Introduction of buddy schemes
- Attending best practice sharing national events and is joining an Integrated Care System task and finish group for retention across Kent and Medway.
- Health and Wellbeing initiatives and support
- Career pathways to improve staff retention
- Specific focus on leavers within first 2 years

In addition, we are also implementing an approach to recognising and celebrating long service.

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IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
001.W-W	Staff Sickness - Overall	✓	4.00%	L	3.7%	4.4%	4.4%	5.1%	4.2%	3.8%	3.5%	3.7%	4.0%	4.6%	4.6%	4.2%
005.W-W	Appraisals And Personal Development Plans		99%	L		96.4%	98.0%	98.1%	98.1%	98.1%	98.1%	98.1%				
012.W-W	Essential Training For Role		90%	L	90.4%	90.0%	89.4%	89.5%	91.3%	90.4%	91.2%	91.8%	92.4%	92.4%	90.4%	90.5%
015.W-W	Staff Retention (overall)		90%											87.3%	82.7%	84.3%
016.W-W	Staff Retention (Additional Clinical Services)		90%											85.1%	82.3%	83.9%
017.W-W	Staff Retention (Nursing)		91%											87.0%	80.5%	82.1%
018.W-W	Staff Retention (Medical)		92%											89.2%	86.8%	88.4%
019.W-W	Staff Turnover (Overall)		9.00%		10.1%	9.6%	9.4%	9.4%	9.4%	9.6%	9.4%	10.1%	10.5%	9.5%	10.9%	11.3%
020.W-W	Staff Turnover (Additional Clinical Services)		10.00%											11.9%	13.1%	12.7%
021.W-W	Staff Turnover (Nursing)		9.00%											9.1%	10.8%	9.7%
022.W-W	Staff Turnover (Medical)		8.00%											8.1%	10.4%	12.2%

- *New indicators and targets were introduced June 2021; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

CQC Domain	Well led – Finance
Trust Strategic Objective & Board Assurance Framework	• **Partnering beyond Kent and Medway, where it benefits our population** • **Optimising the use of resources** • **Investing in system leadership.**

Executive Lead(s): Executive Director of Finance
Lead Board Committee: Finance and Performance Committee

Issues of Concern
Agency spend continues to be over budget. The finance report highlights four areas of exception this month. These include: 1. Agency spend 2. Private Placement spend 3. Planned and Reactive maintenance 4. Patient travel

Executive Commentary

Please see the financial performance report included as a separate agenda item for the detailed financial performance narrative.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
004.W-F	In Month Budget (£000)		0.0	N	0	0	(0)	(0)	(0)	0	0	0	0	(0)	(0)	(0)
005.W-F	In Month Actual (£000)		-	-	0	0	(0)	800	0	0	3	0	(0)	(0)	0	0
006.W-F	In Month Variance (£000)		-	-	0	0	0	800	0	0	3	(0)	(0)	0	0	0
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N								0.00%	0.00%	0.00%	0.00%	0.00%
007.W-F	Agency - In Month Budget (£000)		-	N	427	427	427	427	427	427	427	427	427	427	427	427
008.W-F	Agency - In Month Actual (£000)		-	-	804	825	824	761	638	596	767	699	661	520	664	658
009.W-F	Agency - In Month Variance from budget (£000)		-	-	377	398	397	334	211	169	340	272	234	93	237	231
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	68.95%	72.41%	74.97%	75.34%	72.74%	69.73%	75.78%	74.68%	73.02%	69.04%	60.85%	59.31%

- *Some targets are variable in year; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

Kent and Medway NHS
NHS and Social Care Partnership Trust

CQC Domain	Caring
Trust Strategic Objective & Board Assurance Framework	• **Embedding Quality Improvement in everything that we do** • **Build active partnerships with Kent and Medway health and care organisations** • **Strengthening partnerships with people who use our services and their loved ones**

Executive Lead(s): Executive Director of Nursing & Quality & Chief Operating Officer
Lead Board Committee: Quality Committee

Issues of Concern
Gradual decline in PREM scores for Community Recovery Care Group

Executive Commentary

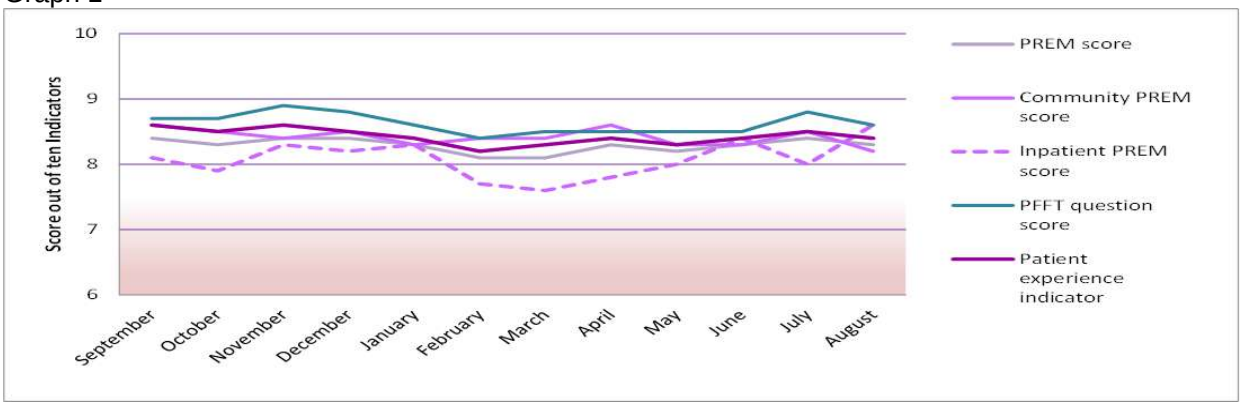
Patient Reported Experience Measures (PREM) (014-015.S)

The Trust has an ambitious target to receive 1400 PREM responses per month. The response rate is slowly increasing (n=541) since the re-start of PREMs in September 2020. Broken down by Care group, the responses were as follows:

- Older Adults = 111
- Forensic and Specialist Care Group = 83
- Acute Care Group = 165
- Community Recovery Care Group = 182

Results indicate a positive experience of above 8 out of 10, particularly for inpatients (graph 1). The goal is to have scores of above 6 out of 10 as this still indicates good experience of care. The Patients, Friends and Family (PFFT) test which asks about people's overall experience of services shows a favourable response rate above the regional and national average and a positive experience of 85%.

Graph 1

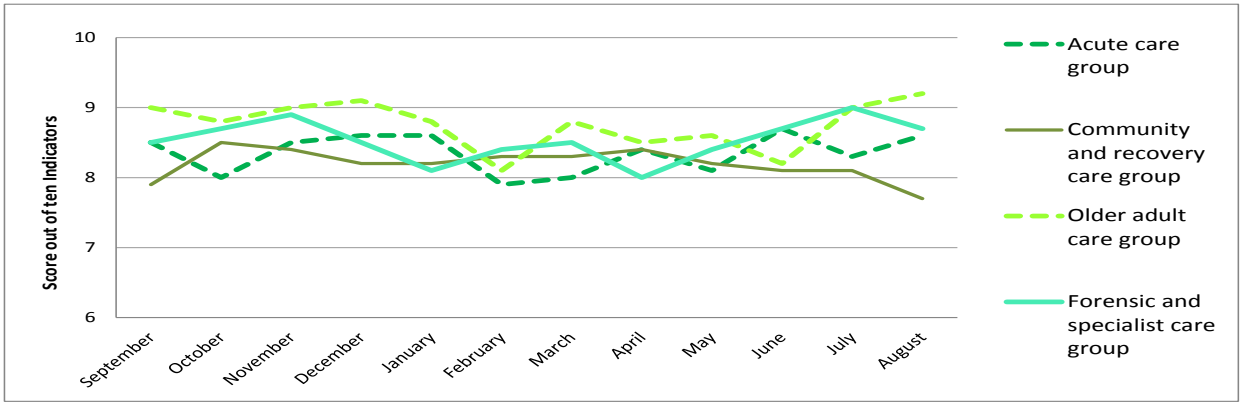


The acute care group continues to exceed the response rate, with improved experience reported in August (graph 2 below). All eight questions on the inpatient survey reported an improved experience. Of note, food experience increased from an average of 7.2 to 8 out of 10, the highest score year to date.

In contrast, the Community PREM is showing a downward trajectory. This is attributable to the community recovery care group where the average scores decreased to 7.5 out 10 which is however, still in the range where patients 'agree' that they are satisfied with their care. The survey questions contributing mostly to the lower score were related to being seen often enough for care needs, help in crisis and advice or help with finances and benefits and this was reported by teams in East and West of the county.

Care group patient experience 'score out of ten' month on month tracking

Graph 2



NHS
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IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N					86.4%	81.8%	82.6%	84.4%	82.4%	84.4%	87.2%	85.1%
003.C	Complaints - actuals		-	-	39	29	31	23	33	29	29	36	48	45	28	47
004.C	Complaints - per 10,000 contacts		-	-	10.63	7.79	8.04	6.45	8.97	7.90	6.88	9.29	12.84	11.27	7.19	13.36
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	98.0%	98.0%	98.0%
007.C	Compliments - actuals		-	-	111	132	120	99	97	96	122	111	100	120	141	121
008.C	Compliments - per 10,000 contacts		-	-	30.26	35.46	31.14	27.76	26.36	26.15	28.93	28.65	26.74	30.06	36.20	34.39
010.C	PALS acknowledged within 3 days (or agreed timeframe)		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
011.C	PALS responded to within 25 days (or agreed timeframe)		-	-	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%	100%	100%
012.C	PALS - actuals		-	-	128	117	105	53	86	81	110	97	75	94	83	62
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	207	394	348	357	249	391	447	372	550	591	611	541
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-		2.6	2.1	2.3	1.6	2.6	2.8	2.4	3.5	3.7	3.8	3.6
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.4	8.3	8.4	8.4	8.3	8.1	8.1	8.3	8.2	8.3	8.4	8.3

CQC Domain	Responsive
Trust Strategic Objective & Board Assurance Framework	• **Partnering beyond Kent and Medway, where it benefits our population** • **Driving integration to become business as usual for the system and for KMPT.**

Executive Lead(s): Chief Operating Officer
Lead Board Committee: Finance and Performance Committee

Issues of Concern
Urgent referrals seen within 72 Hours (019.R) **4 Week Wait for Assessment of Routine Referrals in Older Adults** – additional pressure from increased referrals

Executive Commentary

Urgent referrals seen within 72 Hours (019.R)
An audit to review urgent referral cases that breach the 72 hours window has taken place. The audit highlighted key points for action

Urgent new referrals into a CMHT or CMHSOP come in via the Single Point of Access (SPOA); as a triage and signpost service SPOA does not undertake mental health assessments - the clinical decision as to if an urgent assessment is needed is made by the SPOA clinician taking the call using the relevant risk assessment. SPOA put the referral into an available “urgent” assessment slot in the community team. Each community team has an agreed number of these slots which SPOA has direct access to. At this point the 72 hour clock commences. The audit has highlighted the below points;

- not enough slots available in some teams to meet the 72-hour time frame
- appointments are generally booked into the next available slot which can sit outside the 72-hour window.
- The model (pathway) has not factored in that community teams do not work at weekends, therefore limiting capacity available and affecting the delivery against the 72-hour standard
- A need to ensure SPOA clinical staff use the available slots effectively as well as investigating the possibility of allowing community teams to downgrade and record change of referral urgency post MDT review
- Findings indicate 32% (CMHSOP) and approx. 50% (CMHT) of “urgent” referrals were downgraded to routine appointments on receipt by the community team but at this point in time cannot be changed on RIO.

The Clinical Directors of both care groups affected, CRCG and Older Adults, alongside the two Deputy Chief Operating Officers, are addressing these findings and are reviewing the patient pathway. The safety of any patient waiting is paramount and the availability of team duty and multi-disciplinary triage mitigates the risk to patient where clinically it is indicated that a patient needs an urgent response; CQC reported in their last report on community services the response to urgent referrals was appropriate and effective.

Single Point of Access: Indicator development continues for SPoA, these will be added to the IQPR once complete and fully tested to ensure an accurate reflection of clinical practice.

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			74.0%	95.0%	61.1%	94.8%	78.0%
2	OPMH			48.5%	95.0%	32.3%	70.4%	51.3%
3	Trust Total			57.3%	95.0%	46.4%	75.5%	60.9%

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change
Assurance	Variation indicates consistently **failing short of target**

Narrative

Analysis by SPC shows that no special cause variation has been identified at Trust or care group level. Ongoing work continues concerning waiting list management to understand variation within processes with a view to inform robust demand and capacity planning longer term. It is understood staffing gaps, vacancy and sickness absence are the general reasons for not delivering against the target.

Considerable variation does exist at team level as noted between the West Kent CMHTs and the other CMHTs across the county, with a range in month of 27.8% (with special cause variation) in Maidstone to 100% being achieved in Thanet as shown by the table below. The West Kent CMHT clinical and operational leadership team are addressing this variation in performance, supported by senior clinical and operational leadership, with a clear plan of quick wins to be implemented across October 2021. The quick wins sit alongside the medium-term work of moving the teams to operate a hub and spoke model similar to the Canterbury and Coastal teams; this will allow for a more efficient use of resource and effective patient flow across the two sites. The revised model and implementation plan will be monitored via the QPR process from October onwards.

Kent and Medway NHS
NHS and Social Care Partnership Trust

	Routine Referral to assessment in 4 weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHT			93.8%	95.0%	72.2%	110.3%	91.2%
2	Canterbury & Coastal CMHT			87.2%	95.0%	65.9%	102.0%	84.0%
3	DGS CMHT			80.4%	95.0%	74.5%	102.3%	88.4%
4	Dover & Deal CMHT			84.6%	95.0%	45.0%	114.1%	79.5%
5	Maidstone CMHT			27.8%	95.0%	33.6%	110.5%	72.1%
6	Medway CMHT			96.4%	95.0%	46.5%	106.7%	76.6%
7	Shepway CMHT			75.0%	95.0%	38.9%	116.1%	77.5%
8	Swale CMHT			83.8%	95.0%	30.4%	122.9%	76.7%
9	SWK CMHT			40.4%	95.0%	20.3%	105.0%	62.7%
10	Thanet CMHT			100.0%	95.0%	28.8%	125.6%	77.2%
11	CMHT Total			73.9%	95.0%	60.8%	95.1%	77.9%

Older Adult against the 4 week wait for assessment for August stood at 48.5% combined, that is, for both functional and Memory Assessment patients. The care group has seen significant increase in referrals overall with the data indicating referrals have increased month on month and at the highest level for 2.5 years. The data shows there has been a sustained period of above average referral numbers being received by the CMHSOPs, with the numbers received during June and July statistically significant with a marginal dip in August. The Care Group is monitoring this closely as the obvious impact of this increase in demand is further outstripping capacity. The increased referrals are not uniform across all teams, Dover and Deal CMHSOP and Tunbridge Wells CMHSOP show special cause variation in August due to ongoing pressures. Many other teams have seen an increase, although not statistically significant.
There are a number of actions in place including extra weekend and evening clinics in operation offering 50 additional assessment slots a month and some follow up work but it will not resolve the current referral rate which could lead to a decreasing performance in 4 week wait.

As noted at previous boards the system response to memory assessment is progressing; the care group has been asked to take a future view of the likely impact in the change of pathways that the system will be implementing and by when so the Trust can assess the impact it will have on its capacity.

Kent and Medway NHS
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		Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			93.8%	95.0%	45.2%	101.2%	73.2%
2	Canterbury CMHSOP			31.8%	95.0%	23.6%	91.7%	57.7%
3	DGS CMHSOP			49.4%	95.0%	-0.9%	105.2%	52.2%
4	Dover & Deal CMHSOP			42.9%	95.0%	-1.3%	80.4%	39.5%
5	Maidstone CMHSOP			47.1%	95.0%	5.7%	82.8%	44.3%
6	Medway CMHSOP			57.4%	95.0%	4.7%	88.5%	46.6%
7	Sevenoaks CMHSOP			50.0%	95.0%	3.7%	80.5%	42.1%
8	Shepway CMHSOP			73.5%	95.0%	39.2%	95.5%	67.4%
9	Swale CMHSOP			28.6%	95.0%	29.2%	110.8%	70.0%
10	Thanet CMHSOP			25.5%	95.0%	7.3%	78.8%	43.1%
11	Tunbridge Wells CMHSOP			20.6%	95.0%	1.6%	58.7%	30.1%
12	CMHSOP Total			48.5%	95.0%	32.3%	70.4%	51.3%

At a team level variation exists across the teams, Tunbridge Wells CMHSOP continues to show negative special cause variation and achieved 20.6% in month, this mainly relates to staffing challenges, compared to Ashford and Shepway CMHSOPs who are showing positive special cause variation demonstrating an improving position. The Tunbridge Wells team had 6 new starters commence in post in August and whilst all need induction the new starters will support the team to improve their performance over the final months of this year.

017.R: 18 Weeks Referral To Treatment		Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**CRCG**			93.1%	95.0%	87.3%	96.4%	91.9%
2	**OPMH**			86.0%	95.0%	49.2%	76.4%	62.8%
3	**Trust Total**			89.1%	95.0%	67.9%	83.9%	75.9%

Interpretation of results (Trust wide)	
Variation	Special cause of **Improving** nature or higher pressure due to **higher** values
Assurance	Variation indicates consistently **failing short of target**

Narrative

The CMHT performance for the 18 week wait standard from referral to commencement of treatment continues to perform well. Five out of ten CMHTs achieved in excess of 95% in month.

It is also positive to note special cause variation of an improving nature within CMHSOPs despite consistently falling short of the target. Improvements are being driven by six teams demonstrating special cause variation of an improving manor. The increased referrals observed in the summer has the potential to impact this indicator in future months as patients progress through assessment

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and into treatment. This will be subject to ongoing monitoring through existing weekly waiting list management processes.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			100.0%	95.0%	39.0%	99.9%	69.5%
2	Canterbury CMHSOP			94.3%	95.0%	47.6%	84.5%	66.1%
3	DGS CMHSOP			83.6%	95.0%	33.0%	98.5%	65.8%
4	Dover & Deal CMHSOP			84.6%	95.0%	32.7%	101.7%	67.2%
5	Maidstone CMHSOP			84.6%	95.0%	24.4%	85.6%	55.0%
6	Medway CMHSOP			94.6%	95.0%	36.3%	80.3%	58.3%
7	Sevenoaks CMHSOP			70.7%	95.0%	40.5%	82.2%	61.4%
8	Shepway CMHSOP			97.7%	95.0%	52.3%	96.3%	74.3%
9	Swale CMHSOP			85.3%	95.0%	37.8%	106.5%	72.1%
10	Thanet CMHSOP			90.7%	95.0%	43.5%	87.5%	65.5%
11	Tunbridge Wells CMHSOP			47.5%	95.0%	15.8%	79.5%	47.6%
12	**CMHSOP Total**			86.0%	95.0%	49.2%	76.4%	62.8%

	013.R - 0.15R: Referrals	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**Acute**			1,741		1,770.1	2,867.9	2,319.0
2	**CRCG**			5,230		3,512.6	6,503.7	5,008.2
3	**FSS**			1,886		1,546.2	2,302.9	1,924.6
4	**OPMH**			1,532		864.5	1,795.8	1,330.2
5	**Trust Total**			10,389		8,167.9	12,995.9	10,581.9

Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change in month
Assurance	N/A – not set target
Narrative	

Referrals into CMHTs and CMHSOPs have seen some variation in the last six months. August resulted in CGRG showing Special Cause variation due to sustained higher pressure compared to the mean of the last 18 months.

OPMH saw a reduction in August resulting in common cause variation having previously shown special cause due to pressures in recent months. The referrals received by team for the last six months are show below.

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Ashford CMHT	129	123	128	125	130	130
Canterbury & Coastal CMHT	217	207	222	204	215	191
DGS CMHT	252	229	251	265	253	242
Dover & Deal CMHT	135	128	116	124	127	131
Maidstone CMHT	237	175	222	240	234	189
Medway CMHT	425	383	351	367	401	337
Shepway CMHT	99	111	152	119	132	109
Swale CMHT	139	157	111	134	154	118
SWK CMHT	247	223	151	198	187	183
Thanet CMHT	192	185	169	183	205	176
CMHT Total	**2072**	**1921**	**1873**	**1959**	**2038**	**1806**

	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
Ashford CMHSOP	58	76	87	74	84	76
Canterbury CMHSOP	134	164	178	206	190	162
DGS CMHSOP	117	100	107	112	142	141
Dover & Deal CMHSOP	63	55	59	57	75	78
Maidstone CMHSOP	131	121	150	157	135	135
Medway CMHSOP	132	132	131	151	169	146
Sevenoaks CMHSOP	62	57	59	63	75	70
Shepway CMHSOP	75	60	71	82	106	60
Swale CMHSOP	47	51	58	73	58	41
Thanet CMHSOP	112	108	119	128	133	98
Tunbridge Wells CMHSOP	73	69	71	74	81	74
CMHSOP Total	**1004**	**993**	**1090**	**1177**	**1248**	**1081**

Within the Community Recovery Care Group (CRCG) all CMHTs showed common cause variation with the exception of Medway CMHT where a prolonged increase in referral numbers is evidenced. As previously highlight as part of the review of 4 Week Wait for Assessment there has been special cause variation due to an increase in referrals within two CMHSOPs (Dover and Deal & Tunbridge Wells).

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IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	81.3%	78.3%	78.3%	69.6%	78.9%	63.6%	80.0%	71.4%	69.2%	75.0%	87.5%	78.6%
005.R	% of Liaison (urgent) referrals seen within 1 hour		-	-	93.6%	87.1%	92.4%	90.9%	88.3%	83.2%	82.5%	93.1%	88.3%	87.5%	85.7%	85.6%
006.R	% of Liaison (urgent) referrals seen within 2 hours		-	-	96.0%	95.5%	94.9%	93.5%	94.4%	90.7%	90.7%	88.2%	93.9%	89.1%	90.2%	96.0%
007.R	DNAs - 1st Appointments		-	-	8.4%	11.7%	13.0%	13.5%	12.6%	12.9%	11.3%	8.3%	8.7%	9.8%	11.0%	11.2%
008.R	DNAs - Follow Up Appointments		-	-	7.7%	11.4%	11.3%	11.1%	11.0%	9.9%	9.4%	8.1%	8.2%	10.7%	12.4%	9.8%
009.R	Patient cancellations- 1st Appointments		-	-	1.1%	1.0%	1.1%	1.3%	0.9%	1.0%	0.8%	0.1%	0.0%	0.1%	0.1%	0.0%
010.R	Patient cancellations- Follow Up Appointments		-	-	3.1%	3.1%	2.8%	3.2%	2.9%	2.6%	2.6%	0.4%	0.3%	0.2%	0.2%	0.2%
011.R	Trust cancellations- 1st Appointments		-	-	17.7%	18.6%	11.6%	3.7%	4.4%	3.9%	3.4%	4.2%	4.8%	6.0%	6.1%	6.0%
012.R	Trust cancellations- Follow Up Appointments		-	-	10.9%	9.8%	9.5%	8.9%	9.2%	9.2%	9.0%	11.2%	12.6%	12.7%	12.7%	14.2%
013.R	Referrals Received (ave per calendar day)		-	-	377.2	382.3	359.4	331.4	342.5	363.4	399.0	360.0	361.6	372.0	359.5	335.1
014.R	Referrals Received (ave per working day)		-	-	436.1	449.2	426.0	400.1	419.1	433.8	459.6	427.4	458.7	434.8	427.0	405.9
015.R	Referrals Received (per 10,000 Kent and Medway Registered GP population))		-	-	715.7	718.9	667.1	622.1	625.6	628.0	744.2	642.6	632.5	694.2	698.2	630.6
016.R	Referral to Assessment with 4 weeks Care Spell		95%	-	44.3%	44.1%	52.8%	53.0%	52.2%	68.7%	70.4%	68.9%	67.7%	63.6%	62.1%	57.3%
017.R	Referral to Treatment within 18 weeks Care Spell		95%	-	67.8%	70.3%	71.8%	72.5%	72.7%	74.0%	78.6%	84.1%	87.7%	90.0%	88.8%	89.1%
018.R	% Patients waiting over 28 days from referral		-	-	54.9%	50.5%	44.9%	45.6%	39.0%	30.9%	23.1%	28.0%	30.4%	28.5%	33.7%	43.3%
019.R	Urgent referrals seen within 72 Hours		95%	-	52.6%	53.7%	55.6%	57.6%	54.2%	61.6%	63.1%	59.6%	62.3%	62.4%	59.2%	62.6%

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Appendix A: Single Oversight Framework

Overview

The Single Oversight Framework (SOF) sets out how NHS Improvement (NHSI) oversees NHS trusts and NHS foundation trusts, using one consistent approach. It helps to determine the type and level of support needed. The first version of the SOF was published in September 2016 with small amendments made in 2017. The Framework aims to help NHSI to identify NHS providers' support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

NHSI monitor providers' performance under each of these themes and consider whether they require support to meet the standards required in each area. Individual trusts are segmented into four categories according to the level of support each trust needs. KMPT's current segmentation is 1 as highlighted below

Segment/ category	Description of support needs
1 (Maximum autonomy)	No actual support needs identified across the five themes described in the provider annex. Maximum autonomy and lowest level of oversight appropriate. Expectation that provider supports providers in other segments.
2 (Targeted support)	Support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not considered needed.
3 (Mandated support)	The provider has significant support needs and is in actual or suspected breach of the licence (or equivalent for NHS trusts) but is not in special measures.
4 (Special measures for providers; legal directions for CCGs)	The provider is in actual or suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean it is in special measures.

NHSI segment providers based on information collected under the SOF, existing relationship knowledge, information from system partners (e.g. CQC, NHS England, clinical commissioning groups) and evidence from formal or informal investigations. The process is not one-off or annual. NHSI will monitor and engage with providers on an ongoing basis and, where in-year, annual or exceptional monitoring flags a potential support need a provider's situation will be reviewed.

A breakdown of measures reported against the Single Oversight Framework is shown below. This shows that currently the trusts biggest challenge is achievement of the agency cap against the national target. It also reports staff turnover as non compliant. This is against a target that is set by the Trust as no target has been set in the SoF.

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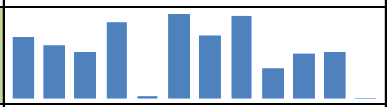
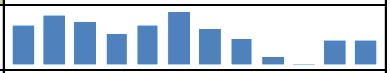
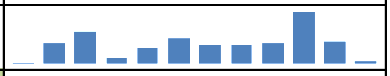
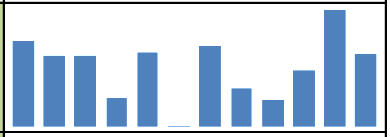
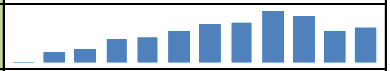
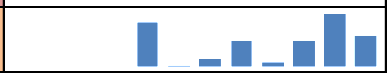
IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Jul-21	Aug-21	Trend *(Last 12 months where available, left to right)*
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	97.8%	96.4%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		86.5%	86.6%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		201	103	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	87.5%	78.6%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.7%	95.7%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	4.0%	4.6%	4.2%	
002.C	Mental Health Scores From Friends And Family Test – % Positive	93%	87.2%	85.1%	

**The above tables includes those SoF measures that are reportable and supported by clear national guidance but is not inclusive of all indicators within the SoF. Full details available*

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Appendix B: IQPR Overview and Guides

The Integrated Quality and Performance Report (IQPR) is a key document in ensuring that the Board is sighted on key areas of concern in relation to a range of internally and externally set Key Performance Indicators (KPIs).

Good examples of IQPRs from high performing organisations change and improve over time. KMPT's is no different, and continues to be adjusted and improved in the light of feedback from internal and external stakeholders. Any changes to indicators are clearly documented and the report will include the rationale for any change.

The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally embedded in executive led Care Group Quality Performance Meetings (QPR).

Each member of the Chief Executive's team provides the narrative to support the exceptions identified via SPC commentary along with wider commentary for the area for which they are the lead. This adds a further strengthening to the actions outlined, and ownership and accountability where improvements are required.

Because this report brings together in one place, all the key work streams that the Chief Executive's team lead, the overarching paper is presented to the Board by the Chief Executive.

Our Strategic Objectives (for 2020-23) are set out at the start of the report under our aim of Brilliant Care Through Brilliant People. The detail within these are mapped to the Care Quality Commission's five Domains (Safe, Caring, Effective, Responsive and Well Led) helping focus the report on both the national and local context.

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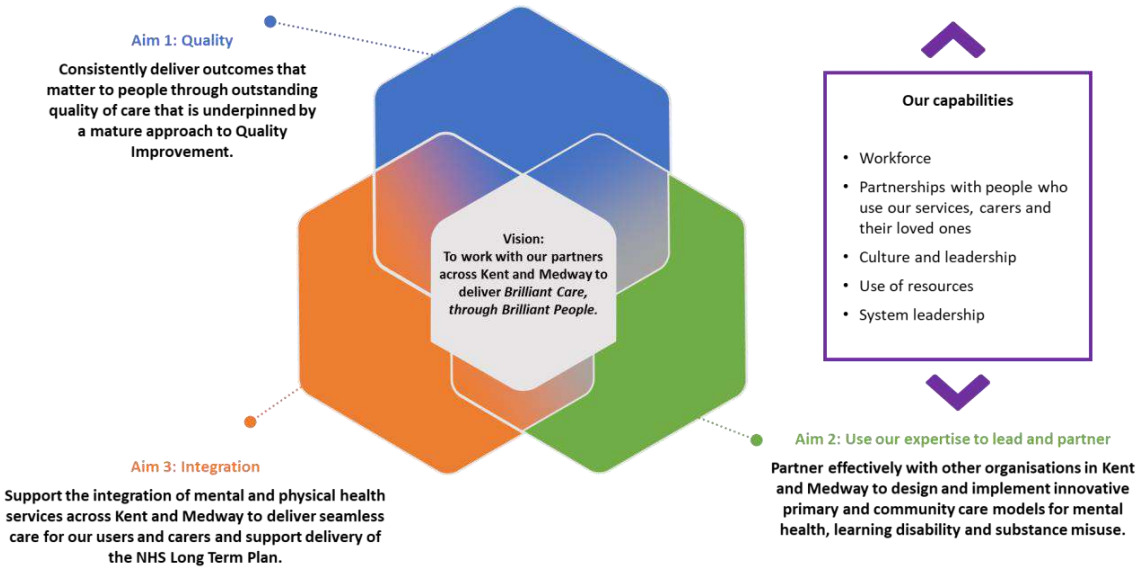

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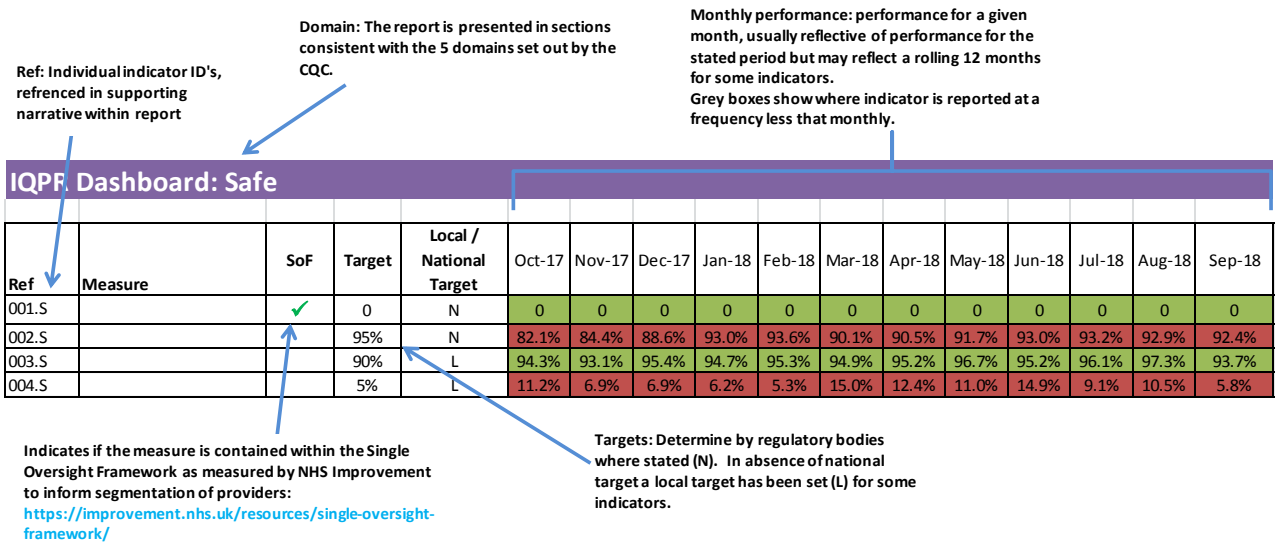
IQPR Dashboard Guide

The IQPR is structured by domains with executive commentary followed by the domains dashboard and a page in which up to three indicators are brought into focus with additional information on current actions in place.

The diagram below provides a guide for each of the columns with the domain dashboards; this is followed by further information on the application of Statistical Process Control charts which are applied within the 'Domain Indicators in Focus' sections.



Ref	Measure	SoF	Target	Local / National Target	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
001.S		✓	0	N	0	0	0	0	0	0	0	0	0	0	0	0
002.S			95%	N	82.1%	84.4%	88.6%	93.0%	93.6%	90.1%	90.5%	91.7%	93.0%	93.2%	92.9%	92.4%
003.S			90%	L	94.3%	93.1%	95.4%	94.7%	95.3%	94.9%	95.2%	96.7%	95.2%	96.1%	97.3%	93.7%
004.S			5%	L	11.2%	6.9%	6.9%	6.2%	5.3%	15.0%	12.4%	11.0%	14.9%	9.1%	10.5%	5.8%

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IQPR Exception Reporting

The report identifies exceptions against a selection of key trust measures using Statistical Process Control (SPC) Charts. SPC charts are used to study how a process changes over time. Data is plotted in time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. These lines are determined from historical data, usually over 12 months within this report. By comparing current data to these lines, you can draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation).

SPC Key:

Variation			Assurance		
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Full details on SPC charts can be found at: https://improvement.nhs.uk/resources/making-data-count/

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IQPR Change Tracker

Date	Change	Report Reference
January 2021	Statistical Process Control Charts implemented for exception report within a new section within the report. Previous areas of focus within individual domains removed.	
Februray 2021	Indicator removed: Freedom to speak up issues IQPR Overview and Guide moved to appendicles	013.W-W
May 2021	New/amended indicators for 2021/22: Unplanned Readmissions within 30 days (020.S) Replaces 28 day readmission indicator CPA patients receiving follow-up within 72hours of discharge (001b.E) New inclusion in IQPR Care Planning / Crisis Planning / Distribution Previous indicators retired, new measures introduced to include PSP reporting. (015.E – 017.E) Waited time measures Previous indicators retired, new measures introduced to include PSP reporting. (016.R – 018.R) Workforce metrics Vacancy metrics retired, replaced with retention measure (015.W-W) New absence and turnover targets	
July 2021	New indicator for urgent referrals	019.R

Changes made prior to January 2021 removed from table, these can be viewed in IQPR versions pre Dec 2020

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30 September 2021
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Mary Mumvuri, Executive Director of Nursing, Quality and Allied Health Professionals

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

The Board are asked to receive and review the Board Assurance Framework (BAF) and to ensure that any risks which may impact on achieving the strategic objectives have been identified and actions put in place to mitigate them. A summary of key controls and evidence is added as appendix 1.

The Board are also requested to approve the risks recommended for removal.

Issues to bring to the Board's attention

- No risks have been added to the BAF since the last report
- Five risks are recommended for removal.
  - Risk ID 3808 – Recruitment (Rating 12 – High)
  - Risk ID 5148 – Retention (Rating 6 – Moderate)
  - Risk ID 3738 - Staff engagement, acting on feedback and cultural change (Rating 9 – High)
  - Risk ID 6193 – Mobile Rio Approval and Funding (Rating 6 – Moderate)
  - Risk ID 6570 – New Finance Regime (Rating 16 – Extreme)
- One risk has increased in risk score
  - Risk ID 3164 – Capital Projects – Availability of Capital (Increased to 16 from 12)
- Two risks have reduced in risk score:
  - Risk ID 6626 – Development of a crisis line (Reduced to 12 from 16)
  - Risk ID 6485 – Clinical Engagement for the Strategy (Reduced to 2 from 4)

Governance

Implications/Impact:	Ability to deliver Trust Strategy.
Assurance:	Reasonable Assurance
Oversight:	Oversight by the Audit and Risk Committee and Board level risk Owners (EMT)

Version Control: 01

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The Board Assurance Framework

The BAF is presented in the new template format and was reviewed by the Audit and Risk Committee on 22 September.

The Top Risks are

- Risk ID 3164 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID 6570 New Finance Regime 2020/21 (Rating of 16 – Extreme)
- Risk ID 6573 Demand and Capacity for Adult and Older Adult CMHTs (Rating of 16 – Extreme)
- Risk ID 6628 Financial Sustainability (Rating of 16 - Extreme)

Supplementary assurance information has been provided with this paper relating to the key controls for each risk. The purpose is to demonstrate that evidence can be provided for each key control and that the control is being monitored and assessed for quality and impact.

Risk Movement

One risk has increased in risk score:

Risk ID 3164 – Capital Projects – Availability of Capital
The risk description has been updated to reflect the change in capital funding allocation this year compared to previous years. The risk score has been increased to reflect the impact this will have on the capital projects underway. A deep dive report into estates risk and associated mitigations was presented to Audit and Risk Committee on 22 September.

Two risks have reduced in risk score:

Risk ID 6626 – Development of a crisis line:
All actions are progressing positively. Initial quality and safety concerns are being managed appropriately. There is confidence that the risk will be mitigated to target level by September 2021 target date. Further Service development is required after October 2021. This may mean this risk needs to be refocussed.

Risk ID – Clinical Engagement for the Strategy:
Digital business partners are regularly attending the clinical meetings to improve engagement.

Risks Recommended for Removal

The following five risks are recommended for removal:

Risk ID 3808 – Recruitment:
It is recommended this risk is closed and new risk(s) are to be opened focussing on the current hard to recruit areas. A deep dive recruitment and retention paper was presented to WFOD Committee in September following which this recruitment risk will be amended.

Version Control: 01

Risk ID 5148 – Retention:
It is recommended this risk is closed and new risk(s) are to be opened focussing on the current retention workstream risk areas. As in Risk 3808 above, a deep dive recruitment and retention paper was taken to WFOD Committee in September following which this retention risk will be amended.

Risk ID 3738 - Staff engagement, acting on feedback and cultural change:
It is recommended this risk is closed and a new risk opened focussing on the current risk area around cultural change.

Risk ID 6193 – Mobile Rio Approval and Funding:
It is recommended this risk is closed as there is now a mobile Rio solution that is being rolled out across the Trust. A new risk may be opened to recognise any remaining risk from the implementation of the new system.

Risk ID 6570 – New Finance Regime:
It is recommended this risk is closed because the Trust baseline has been adjusted. H2 will be under the current Covid-19 regime and then for 2022/23 planning will return to the long-term plan trajectories agreed in October 2019.

New Risks

No new risks have been added

Recommendations

The Board is asked to receive and review the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.
The Board are requested to note that not all actions have been identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners. Some out of date actions are on risks identified and recommended for closure.

Version Control: 01

Updated: 06 September 2021

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Board Assurance Framework

Risks which may impact on delivery of a Trust Strategic Objective.

Definitions:

Initial Rating = The risk rating at the time of identification

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

Target Rating = Risk rating Month end by which all actions should be completed

Action status key:

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

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
1 - Consistently deliver an outstanding quality of care																			
17/11/2020 Risk Opened 04/06/2021 — The top 5 assurances need to be identified for this risk																			
6573	Nov 2020	Chief Operating Officer	**Demand and Capacity for Adult and Older Adult CMHTs as impacted by the covid-19 pandemic** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.	4	4	16	Digital working in place. Team level demand and capacity oversight in place. Care pathways programme streamlining clinical offer. MHIS funding invested. Standard Operating Procedures in place with a single operating model for assessment. Older Adult Care group awarded additional funding to improve memory assessment standards.	Reduction in referral to assessment and referral to treatment targets through IQPR. Recruitment and retention in line with Trust target moitored through IQPR. Improved Clinical outcomes	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Skill Mix of Workforce (CMHTs) / Head of Service / 30/09/2021 / G Increasing initial interventions capacity - CMHTs / Lead for Psychological Practice / 30/08/2021 / G Skill Mix of Workforce (CMHSOPs) / Head of Service / 9/30/2021 / A Dementia Strategy Development / Deputy COO / 31/03/2022 / A	Chief Operating Officer	To be confirmed	3	3	9	30/10/2021
14/12/2020 Risk Opened 04/06/2021 — Mitigating actions are progressing. Awaiting confirmation of national KPIs which has delayed completion of local action. — 06/09/2021 — All actions progressing positively. Initial quality and safety concerns are being managed appropriately. Confident the risk will be mitigated to target level by Sept target date. Further Service development required after October 2021.																			
6626	Dec 2020	Chief Operating Officer	**Development of a Crisis line** IF the SPoA is unable to respond to additional demand and requirements as it moves to become a Kent-wide Crisis Line as required by NHSE in response to the Covid pandemic in addition to its existing functions THEN there will be people who do not have their calls answered and/or clinical decision making may be compromised. Response to urgent referrals may also be compromised by an increase of crisis line calls RESULTING IN poor patient and referrer experience, patient safety issues, increased staff stress and reputational damage as a result of not delivering a nationally required service.	4	4	16	Urgent Access Lead role in place (1a) Oversight by COO and EMT (1a) MHIS funding invested in year and recruitment underway (1g) Delivery group in place with all relevant stakeholders - chaired by DCOO and supported by CCG (2a) Revision of Standard Operating Procedures (2e)	Development of a revised governance structure, including dedicated QPR (1b/1h) Governance Meetings / QPR (1a) CliQ Checks and local quality audits (1c) OAC Programme Board (2a)	3	4	12	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Revision of SOP, including development of local standards (no national KPI's for Mental health Crisis line) / Urgent access lead / 30/09/2021 / A Workforce Development based on new service requirements / Urgent access lead / 31/08/2021 / G Ongoing recruitment to vacancies to ensure safe operational staffing levels / Urgent access lead / 09/08/2021 / G	Chief Operating Officer	To be confirmed	3	3	9	30/09/2021
06/03/2019 Risk Opened 04/06/2021 — Actions to reduce risk need development — 06/09/2021 — There is a maintenance backlog and delays in progressing major ward refurbishments due to a reduction and unavailability of capital.																			
6052	Mar 2019	Executive Director of Nursing, AHPs and Quality	**Improving and sustaining quality and safety** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice.	3	4	12	CMHT 'day in the life of' guidance CQC Insight Report Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks Membership of quality networks and national accreditation schemes Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CQC Mental Health Act Reviews System wide Quality Surveillance Reports	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections	3	4	12	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Cliq checks and Deep dives / Executive Director of Nursing, AHPs and Quality / Ongoing / A Quality Summits / Executive Director of Nursing, AHPs and Quality / 30/09/2021 / A Learning from each other - Peer reviews / Executive Director of Nursing, AHPs and Quality / 31/12/2021 / A	Executive Director of Nursing, AHPs and Quality	To be confirmed	1	3	3	31/12/2021

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
	04/12/2014 Risk Opened 04/06/2021	Actions to reduce risk need development																	
4083	Dec 2014	Executive Director of Nursing, AHPs and Quality	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place	2	4	8	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Development of Ligature Reduction Programme, including new ligatures awareness training and refresher training, therapeutic observations competencies, and development of new ligature assessment tool. / Deputy Director of Nursing / 30/11/2021 / A	Executive Director of Nursing, AHPs and Quality	To be confirmed	1	4	4	31/03/2022
	28/04/2020 Risk Opened 04/06/2021	Performance Metric: Met Risk is well controlled but continues to be actively monitored and managed while we are in response to the Pandemic.	06/09/2021	Risk continues to be well controlled. It will remain actively monitored and managed while we are in response to the Pandemic.															
6420	Apr 2020	Executive Director of Nursing, AHPs and Quality	**COVID 19 Personal Protective Equipment** IF there are not adequate national stocks of COVID-19 PPE provided through the National Supply chain to NHS organisations THEN there is a risk that Trust Staff (including contractors, partners and volunteers on trust sites) will not have access to appropriate PPE RESULTING IN a failure of the Trust to comply with Health and Safety regulations which may lead to increased staff sickness and unions instructing staff to withdraw from the working environment which in turn will impact on the health and safety of patients.	3	4	12	National: National Stockpile of PPE National Daily Situation Reporting from Trusts to DoH National Exception reporting for PPE National/Regional Mutual Aid Agreement Regional: Kent and Medway Strategic Co-ordinating Group Kent and Medway Tactical Incident Control Centre Regional Distribution centre within Kent and Medway for COVID-19 PPE Mutual Aid between Partners in Kent and Medway Trust: Central Procurement strategy for COVID-19 related PPE, Managed by a Trust Director Link between Business intelligence and procurement to identify new suspected and confirmed cases by location Dedicated procurement contact email address Centralised stock and buffer store Trust tactical control meetings held three times a week (and assessment prior to any bank holiday period) Dedicated drivers for PPE logistics (department of Transport contact details should further logistical support be required) Policies, procedures, real time circulation of new/updated guidance via tactical control Product reviews prior to acceptance of product into the organisation. Dedicated tactical control contact details with ICC open 08:00-20:00 daily. Fit testing, Donning and Doffing and Hand Hygiene Training	Stock management system that is reported nationally. Local review of buffer stock annually from October 2021 with stock rotation as appropriate	1	4	4	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** No further actions identified	Executive Director of Nursing, AHPs and Quality	To be confirmed	1	4	4	23/05/2022
2 - Recruit, retain and develop the best staff making KMPT a great place to work																			
	12/05/2014 Risk Opened 04/06/2021	Actions to reduce risk require development	06/09/2021	This risk needs refocussing on current risk areas. It is proposed to close this risk and reopen a new risk for the next meeting.															
3808	May 2014	Director of Workforce and Communications	**Recruitment** IF we fail to recruit appropriate numbers of healthcare professionals THEN this will impact on the ability to meet safe staffing requirements RESULTING IN continued reliance on agency staff, increased cost and potentially lower quality service to patients	5	4	20	Escalation Policy. [2e] Medical Staffing programme board [2a] Recommend a Friend [1a] New Hire Bonus nurse and Consultant [1a] Consultant mentoring in place [1a] Improved Induction Process [1f] Open Days [O] Review of end to end recruitment process [1f] Career paths [2e]	Monitoring of recruitment and retention Report to WF&OD Committee Recruiting Manangers Training	4	3	12	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Tackling the Vacancy Challenge Task and Finish Group / Assistant Director of HR / 30/09/2021 / A ICS Group Recruitment and Retention work / Director of Workforce and Communications / 11/12/2021 / A International Nursing Recruitment / Director of Workforce and Communications / 31/01/2022 / A International Medical Recruitment / Assistant Director of HR / 31/012/2022 / A	Director of Workforce and Communications	To be confirmed	3	3	9	31/03/2024

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
			01/04/2014 Risk Opened 04/06/2021 — Actions to reduce risk require development — 06/09/2021: This risk needs refocussing on current risk areas. It is proposed to close this risk and reopen a new risk for the next meeting																
3738	Apr 2014	Director of Workforce and Communications	**Staff engagement, acting on feedback and cultural change** IF we do not have engaged employees THEN this would impact on staff morale, recruitment, retention, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	4	16	Quarterly People Pulse [1c] NHS Staff Survey [2e] Embedded Trust values as part of performance framework, new objectives [1b] Engagement with staff through Intranet, staff forum, local and KMPT wide leadership groups. [1h] Care Group and Staff Awards [1d] Freedom to Speak Up and Safe Working Guardians, with Green Button option [1g] Health & Wellbeing Group [2a] Supervision and Appraisal policies [2e] Big Conversation [1b] EMT Working With Days [2a] Report to Trust Board - Staff Survey and appraisals [3a] Culture change programme overseen by Programme Board [2a]	Green Button & FTSU activity reports to Workforce Committee and EMT [2b] Leadership and management development training is being delivered [2b] Culture Programme Board [2a] Annual Staff Survey [1c]	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Culture Programme in place with specific workstreams — Director of Workforce and Communications — 31/03/2022 — A Quarterly People Pulse — Director of Workforce and Communications — 31/03/2022 — A National Staff Survey — Director of Workforce and Communications — 31/12/2021 — A	Director of Workforce and Communications	To be confirmed	2	3	6	31/03/2022
			05/03/2017 Risk Opened 04/06/2021 — Actions to reduce risk require development — 06/09/2021: This risk needs refocussing on current risk areas. It is proposed to close this risk and reopen a new risk for the next meeting																
5148	Mar 2017	Director of Workforce and Communications	**Retention of Employees** IF we do not retain our employees THEN this would impact on staff morale, absence and productivity and have a potential impact on patient experience RESULTING IN impact on Turnover, Absence ETC	4	4	16	Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1e] Supervision and Appraisals [1a] Health & Wellbeing Group [2a] Engagement activities [1b] Buddy Approach [1f] Health and Wellbeing Conversations [1a] Career paths [2e] Talent Conversations [2e]	Monitoring of retention	2	3	6	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Work with Attain to review data quality and workforce plans for future — Director of Workforce and Communications — 31/03/2022 — A New roles development, with set targets in KMPT Strategic Delivery P — Director of Workforce and Communications — 31/03/2022 — A Develop career pathways — OD Specialist — 31/03/2022 — A Recruitment and Retention group have workstreams to support retention — HR Business Partners — 31/03/2022 — A	Director of Workforce and Communications	To be confirmed	2	3	6	31/03/2022
3 - Put continuous improvement at the heart of what we do																			
			25/01/2019 Risk Opened 04/06/2021 — This risk is required as part of the EPRR assurance process. Risk actions require development to evidence the ongoing monitoring and update of response plans and will reflect any learning from the covid-19 pandemic. Surge testing is in place to track spread in areas seeing increasing rate of infection — 06/09/2021: Rolling tactical control rota for the Trust is being maintained aligned to NHS command and control arrangements for monitoring and response functions.																
5989	Jan 2019	Executive Director of Nursing, AHPs and Quality	**Organisational Risk - Emerging Infectious Diseases (including response to Covid-19 and subsequent variants)** IF emerging infectious diseases (e.g. Zika virus or novel coronavirus) are discovered and managed via PHE containment phase in the UK and national command and control arrangements THEN this may have an impact on both staff and clients RESULTING IN the potential increase of sickness absence in staffing levels and additional workload concerning the physical and mental health of clients	3	4	12	Remote working availability for some staff [1f] Infection Prevention & Control Policy [2e] Infection Control Lead [1g] Business Continuity Plans [2e] Significant Incident Plan [2e] Working with external partners (e.g. NHS England, CCGs) [2f] Physical Health Nurses in post. [1g] Central Physical Health Nursing Team in place. [1g] Timely Trust adoption of new centrally provided guidance relating to the specific disease [3b] Engagement with Vaccination Programme Engagement with Surge testing requirements	Significant incident plan which provides Trust Command and Control linking into the system Command and Control, regional and national Physical Health Nurses in place Access to Cloud now widely available to staff Business Continuity Plans in place Risk Assessment reviewed by EPRR Team annually as part of EPRR Core Standards compliance	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Continued compliance with national IPC guidance — Infection prevention and control — ongoing — A Screening Programmes (lateral flow testing and PCR testing for both staff and patients) — Infection prevention and control — ongoing — A Fit testing and use of PPE — Infection prevention and control — ongoing — A Maintain a rolling tactical rota aligned to NHSE response — EPRR Lead — ongoing — A	Executive Director of Nursing, AHPs and Quality	To be confirmed	2	3	6	29/07/2023
			02/03/2021 Risk Opened 04/06/2021 — Actions to reduce risk and top 5 Assurances need development — 06/09/2021: The risk description has been updated to reflect where the government roadmap is with realtion to easing of lockdown. The Trust continues to have work from home direction in place and infection prevention and control measures in place on all trust sites.																
6623	Mar 2021	Executive Director of Finance	**Easing of Lockdown National Roadmap - Agile working** IF the national roadmap for easing of lockdown leads to staff returning to pre pandemic working practices THEN staff may conclude that they can return to work in Trust buildings RESULTING IN the Trust not maintaining the new ways of working (agile working) that have been developed during the national pandemic and not delivering on the Trust estates strategy to use our buildings more efficiently and effectively.	3	4	12	Agile working group Communications re continuation of work from home Covid secure SOP Restriction on number of staff in rooms against risk assessment Use of face masks on trust sites	Reporting through Agile Working Group EAC oversight	2	4	8	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop Agile Working Policy — Executive Director Partnerships and Strategy — 31/01/2022 — A	Executive Director of Finance	To be confirmed	2	2	4	27/02/2022
4 - Develop and extend our research and innovation work																			
			10/08/2017 Risk Opened 04/06/2021 — Recruitment to Research and Innovation Director post was successful. Candidate due to start in September. Further sources of assurance need to be identified. — 04/09/2021: Research and Innovation Director due to start mid October. Actions identified are currently on hold and will be picked up under their leadership. Some research activity/ participation in drug trials has been paused due to team capacity.																
5345	Aug 2017	Executive Medical Director	**Participation in international research & innovation** IF we don't increase research activity (including recruitment) that improves the profile of the Trust THEN this will impact on reputational gain and patient outcomes RESULTING IN diminished attractiveness of the Trust in terms of recruitment and tendering and patient choice.	3	2	6	R&D links across the organisation in line with the Research & Development Strategy [2e] Research & Development SoP [2e] Monitored by Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee [2b] Annual report to the Board [3a] Report CRN clinical research network [3e]	National Clinical Research governanace arrangements Clinical Effectiveness & Outcomes Group (CEOG) and Quality Committee minutes	3	2	6	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Recruitment to Research and Innovation Director post — Afifa Qazi — 29/10/2021 — G Increase in funding for research and innovation team — Sarah Dickens — 29/01/2022 — A Ratification of research and Innovation Strategy — Afifa Qazi — 19/03/2022 — A	Executive Medical Director	To be confirmed	1	1	1	17/10/2022

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5 - Maximise the use of digital technology																			
	19/09/2019 Risk Opened 04/06/2021		Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 Mobile Rio soultion is now in place. It is recommended that this risk is closed. Consideration will be given to whether a new risk needs opening to to recognise any residual risk from the solution deployed.																
6193	Sep 2019	Executive Director of Finance	**Mobile RiO Approval & Funding** IF we are unable to establish a Mobile RiO solution and get approval and funding THEN mobile staff would not realise the benefits to utilising mobile devices to access clinical records RESULTING IN the inability to improve services and realise improved productivity and improve patient experience.	3	4	12	Progress monitored via digital delivery board Engagement with vendors for hardware, software and mobile networks Engagement work with clinical teams Benchmarking with other NHS trusts Evaluation of potential solutions and suitability	None Identified	2	3	6	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Business case to be developed once solution identified / Head of ICT / 01/04/2021 / A Full evaluation of solutions / Head of ICT / 31/03/2020 / R Obtain Approval / Head of ICT / 31/03/2021 / R	Executive Director of Finance	To be confirmed	1	2	2	31/10/2021
	23/07/2020 Risk Opened 04/06/2021		Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 Digital Business partners are attedning clinical meetings to improve engagement. Action has completed ahead of planned date. Risk score reduced to reflect this.																
6485	Jul 2020	Executive Director of Finance	**Clinical Engagement for the Strategy** IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy	3	2	6	Trust board commitment and approval (3a) Digital business partners allocated (1g) reviewed at ICTSMT monthly (1a)	None Identified	2	1	2	↓	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Digital Business Partners to attend clinical meetings / Head of ICT / 29/03/2024 / G	Executive Director of Finance	To be confirmed	1	1	1	31/03/2023
6 - Meet or exceed requirements set out in the Five Year Forward View																			
			No Risks Identified against this Strategic Objective																
7 - Deliver financial balance and organisational sustainability																			
	03/04/2020 Risk Opened 04/06/2021		Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. 06/09/2021 This risk has been affected by a change in capital funding allocation and the risk score has been increased to refelct the impact this will have on the capital projects underway																
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned THEN the Estates Strategy will not be executed in the agreed timescales RESULTING IN clinical and workplace environments which may not be fully fit for purpose.	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	4	4	16	↑	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Ensure Capital Plan reflects backlog maintenance and services priorities, as well as implementing standing orders and SFI's for robust financial management / Joint Director of Estates and Facilities / To be Advised Provide comprehesive report to Trust Capital Group. / Joint Director of Estates and Facilities / To be Advised	Executive Director of Finance	To be confirmed	2	3	6	31/12/2021
	17/11/2020 Risk Opened 04/06/2021		Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 It is recommended that this risk be closed as the Trust baseline was adjusted. H2 will be under the current covid regime and then for 22/23, planning will return to the LTP trajectories agreed in October 2019.																
6570	Nov 2020	Executive Director of Finance	**New Finance Regime 2020/21** IF the national team do not acknowledge the financial pressure for KMPT created as a result of the calculation for control totals THEN KMPT will need to rely on expenditure controls and contingency to deliver its breakeven position RESULTING IN a higher chance of not achieving breakeven this financial year and will have an impact on future financial years if the funding regime remains the same.	5	4	20	Agency controls led by exec team Procurement meetings with agencies to review rates Monthly QPR meetings Budget Meetings Monthly reporting to FPC and Trust Board Financial forecasting Scenario modelling Monthly NHSE/I returns	Board and FPC Oversight	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status**	Executive Director of Finance	To be confirmed	4	3	12	31/03/2022
	10/03/2021 Risk Opened 06/09/2021		As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit.																
6628	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) (CIP delivery) has been launched in the organisation and is being led by the deputies. A 4 % efficiency target has ben set to start to tackle the underlying deficit.	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Deep dive into Acute Care Group Service line reporting. This has been discussed at the check challenge and support meetings with the DOF and COO. / Head of Service / 29/10/2021 / G Establish new CIP Programme. This is being embedded in the organisation / Deputy Director of Finance / 30/06/2021 / G Complete full budget setting / Deputy Director of Finance / 30/07/2021 / G Corporate benchmarking into Governanace and Risk. This will support a more up to date benchmarking in the Autumn / Deputy Director Quality and Safety / 30/07/2021 / G	Executive Director of Finance	To be confirmed	3	3	9	31/03/2022

				Initial rating					Current rating					Target rating				
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	L	C	Rating	Controls Description	Top Five Assurances	L	C	Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	L	C	Rating	Target Date (end)
8 - Develop our core business and enter new markets through increased partnership working																			
01/10/2017 — Risk Opened — 04/06/2021: Actions to reduce risk need development — 06/09/2021: The Trust continues to work with Sussex Partnership Trust to ensure that the five workstreams are effective and allow the provider collaborative to be sustainable on a long term basis.																			
5456	Oct 2017	Executive Director of Finance	**Provider Collaborative (New Care Models) - Secure Services** If we do not deliver on the objectives of the Provider Collaborative for KSS, for example achieving repatriation and reducing Length of Stay THEN the forensic services may not be able to sustain the investment in the community services and the overall provider collaborative may not be sustainable on a longer term basis. RESULTING in a risk to the sustainablity of the Provider Collaborative	3	5	**15**	Clear governance process established for the New Care Models (NCM) [1f] The DoF is the Executive Lead and attends the NCM Board and sub group [2f] The Trust are also part of the activity modelling group [2f] Financial governance (1g) Quality assurance processes (1f) Strategic Partnership with Surrey/Sussex Partnership (2f) Partnership working with 3rd party providers (2f) On-going service evaluation & audits (2d) Board oversight (3a) Peer network and other 3rd party assurance (3e)	Numerous quality audits are carried out within the service Regular inspections by CQC take place NHSE evaluation of performance	2	4	**8**	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Deliver care pathway within financial envelope and to required quality standards — Head of Forensic Psychological Services — R (empty) (empty) (empty)	Executive Director of Finance	To be confirmed	1	4	**4**	**31/03/2022**
9 - Ensure success of our system wide sustainability plans through active participation, partnership and leadership																			
10/03/2021 — Risk Opened — 04/06/2021: Actions to reduce risk need development and top 5 assurances need to be identified. — 06/09/2021: Robust reporting is in place to proide assurance and ensure that the strategy delivery plan priorities are taken forward. The MHLDA Improvement Board is in place and fuctioning effectively to ensure system wide suppport for the delivery of identified priorities.																			
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2024** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2024 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard.	3	3	**9**	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	Perfomance outlined in the delivery plan. EAC oversight through exception reporting	4	2	**8**	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Board Sub Committees to incorporate performance priorities from strategy delivery plan into Committee Workplans — Lead Executive Director and Trust Secretariate — End September — A Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021 — Executive Director Partnerships and Strategy — November 2021 — A Review of strategy delivery plan trajectories to final quarter 2021/22 — Executive Director Partnerships and Strategy — January 2022 — R (empty)	Executive Director Partnerships and Strategy	To be confirmed	2	2	**4**	**10/03/2022**

Kent and Medway NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th September 2021
Title of Paper:	Finance Report for month 5 (August 2021)
Author:	Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Executive Director of Finance

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 5 (August 2021). This is consistent with the position submitted to NHS Improvement in the Month 5 Financial Performance Return.

Items of focus

As at the end of August 2021, Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with forecast and plan.

There continues to be four areas of concern which could adversely affect the delivery of a breakeven position by year-end. These are Temporary Staffing Spend: Agency, Private Placement Spend, Planned and Reactive maintenance, and Patient Travel spend. The Trust is mitigating these issues by:

1. Temporary staffing – recruitment initiatives continue to be mobilised and developed further such as on-boarding a large cohort of newly-qualified nurses and mobilising the International Nurse recruitment programme.

2. Private Placement Spend – further focus has been spent on this internally to understand the position, the Trust are in discussions with the CCG regarding potential discharge funding being made available as part of the Spending Review funding which will continue investment in post-discharge support and potentially alleviate the pressure on placements spend.

3. Planned and Reactive maintenance – TIAA the Trust internal auditors have finalised their report, the Trust are currently drafting their action plan to be taken forward at pace in response to the audit findings. there is a review of the Maintenance schedule which will assist with managing spend and identifying further financial risks.

4. Patient Travel Spend – relates to the use of patient transport. A task and finish group has been set up to review our processes and standardise processes across the Trust. The first meeting has taken place and agreed the actions required.

The cash position remains strong at £15.3m at the end of August.

Governance

Implications/Impact:	Risk to capital programme due to restraints on capital funding in year. Further risk of non-delivery of efficiencies, impacting on financial sustainability.
Assurance:	Reasonable
Oversight:	Oversight by Finance and Performance Committee

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Finance Report

Trust Board

August 2021

Kent and Medway NHS and Social Care Partnership Trust

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Executive Summary

Key Messages for August 2021

As at the end of August, the Trust continues to report a breakeven position both in month and year to date. This is in line with the plan submitted for H1.

The Trust is awaiting confirmation of both guidance and timings for the H2 Planning Round but it expected that planning for H2 will be concluded by mid November. There have been indications it is likely to be similar to H1 with a higher efficiency target being required which is why focus remains within the Trust on the efficiency programme. Guidance is expected in late September.

The Trust is continuing to progress with the new approach to identify efficiencies, called the Long Term Sustainability Programme, which is being led by Deputy Directors. Of the £7m target set for the organisation, £3.1m has been identified.

Income and Expenditure

Within the breakeven position reported, there are several key drivers. There is continued pressures in temporary staffing and private placements above budget.Year to date agency spend at the end of August was £3.2m, £329k lower than the same period last financial year. Any overspend is being mitigated currently by vacancies due to challenges recruiting into substantive roles.

Year to Date

	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(92,237)	(89,984)	2,253
Employee Expenses	71,143	68,279	(2,864)
Operating Expenses	19,019	19,569	550
Operating (Surplus) / Deficit	**(2,075)**	**(2,136)**	**(61)**
Finance Costs	2,075	2,136	61
(Surplus) / Deficit	**0**	**0**	**0**

At a Glance - Year to Date

Income and Expenditure
Efficiency Programme
Agency Spend
Capital Programme
Cash

Key

On or above target
Below target, between 0 and 10%
More than 10% below target

Capital Programme

The YTD position is underspent by £3.9m. The main reasons for the underspend are delays on the Closed Protocol, Comms Room schemes and Orchards Ward, new year estates schemes in the planning stage, VAT reclaims, retention adjustments, and Strategic IT schemes not yet proceeding. The full programme is forecast to deliver £15.5m this financial year. A capital forecast is being compiled based on the estates planning information.

Cash

The cash position increased by £0.5m in month to £15.3m. The actual is £2.5m higher than the original plan,with receipts £1m below plan and payments £3.5m below plan. Whilst cash has been received from Health Education England quarterly rather than bi-annually, this has been offset by the August Provider Collaborative SLA not being paid until 1st Sept and the NHS England block payments to date being lower than planned. Payments have been lower largely due to slippage on the capital programme and reduced creditor payments.

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Income and Expenditure and Long Term Sustainability Programme

Statement of Comprehensive Income

	Current Month			Year to Date		
	Plan	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
	£000	£000	£000	£000	£000	£000
Income	(18,549)	(18,021)	528	(92,237)	(89,984)	2,253
Employee Expenses	14,238	13,739	(499)	71,143	68,279	(2,864)
Operating Expenses	3,896	3,842	(54)	19,019	19,569	550
Operating (Surplus) / Deficit	**(415)**	**(441)**	**(26)**	**(2,075)**	**(2,136)**	**(61)**
Finance Costs	415	441	26	2,075	2,136	61
(Surplus) / Deficit	**0**	**(0)**	**(0)**	**0**	**0**	**0**

Commentary

Pay continues to underspend and is underspent by £2.9m on a YTD basis.
Substantive pay is £5m underspent, this is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives. Some of which have significant underspend due to delay in mobilisation for which income has also been deferred. The underspend is partly been offset by bank and agency costs.

Operating expenses is overspent by £550k. The key area contributing to the overspend is Private Placements with a greater number of bed days being utilised than planned.

Long Term Sustainability Programme (Efficiency Programme)

	Annual	Current Month			Year to Date		
	Plan	*Plan*	*Actual*	*Variance*	*Plan*	*Actual*	*Variance*
Pillar	£000	£000	£000	£000	£000	£000	£000
Back Office	(2,000)	(167)	(101)	66	(833)	(557)	276
Workforce	(1,000)	(100)	(15)	85	(300)	(75)	225
Service Line Reporting	(1,000)	0	0	0	0	0	0
Patient Pathways	(1,500)	(163)	(80)	82	(363)	(401)	(39)
Procurement and Purchasing	(1,000)	(100)	(44)	56	(300)	(195)	105
Commercial Development	(500)	(56)	(15)	40	(111)	(76)	35
Total	**(7,000)**	**(585)**	**(255)**	**329**	**(1,907)**	**(1,304)**	**603**

Commentary

The majority of schemes are progressing as we move into Q2, though £3.9m remains unidentified. As sub-pillars and schemes are developing, it is expected that further savings will be identified as the year progresses.

The SLR pillar has been progressed during August with deep dive information being finalised for Older Adults, Acute and Forensics & Specialist Services.

The outputs have started to be shared in Care Groups during September to drive efficiencies at engagement meetings to discuss the range of metrics and opportunities and agree action plans and deadlines for delivery.

A detailed update will be provided to FPC in October on progress in closing the gap

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NHS and Social Care Partnership Trust

Exception Report

Top 4 Variances

	Plan £000	Actual £000	Variance £000	Proportionate Overspend	Reported Last month
Agency	2,379	3,201	822	**35%**	**47%**
Private Placements	1,389	2,033	644	**46%**	**50%**
Planned and reactive maintenance	1,027	1,300	274	**27%**	**37%**
Patient travel	242	459	217	**90%**	**127%**

1. Temporary Staffing Spend: Agency £822k

Although agency spend remains a high variance, the percentage overspend has reduced from 47% reported last month to 35% in August.

Mitigations continue to be explored with Care Groups and agency and bank spend is forecast to slow because of successful recruitment in CRCG and the Trustwide newly qualified nurse programme. International recruitment is expected to impact positively on agency use in the latter part of the financial year with recruitment plans currently being finalised.

	2017/18	2018/19	2019/20	2020/21	2021/22 YTD
Bank	11,131	11,390	13,560	16,968	7,066
Agency	***6,924***	***6,459***	***6,395***	***8,740***	***3,201***
Total	18,055	17,849	19,955	25,708	10,267

2. Private placement Spend £644k

As part of the Trust's block contract a level of private placement spend is commissioned due to KMPT not having female PICU capacity within existing bed base. However the year to date position continues to report a high level of external bed days which in month was an average of 17 placements per day. The overspend has reduced in month, but is still something that is being closely monitored.

The cost pressure is due to three main factors:

1. Refurbishment work on Willow Suite resulting in closed beds temporarily
2. An increase in acute bed days purchased to cope with acute inpatient pressures due to an increase in demand
3. Three "non core" placements which have now ended but were in the spend figures above plan for April - June

3. Planned and reactive maintenance £274k

The budget for Planned and Reactive maintenance charges is based on trend analysis from previous financial years with input from Estates in order to horizon scan what works are planned.

At the end of the month 5 spend is over and above these levels by £274k. The Executive Director of Finance and Estates Director are working with the supplier to
manage both spend and the overall maintenance schedule.

4. Patient Travel £217k

Between April and August the Trust has continued to see high levels of spend above budget, much of which aligns to the increase in private placements and associated travel costs.
To date the budgetary pressure for all of patient travel totals £217k. This is a deteriorating position and as a result a task and finish group is being led by the Deputy Director of Finance to review all patient travel and standardise booking processes accross the Trust.
The group will develop recommended workflows for future bookings. In the immediate term, all suppliers have been reviewed and contacted regarding rates and prices by the Procurement Team.

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Appendices

Kent and Medway
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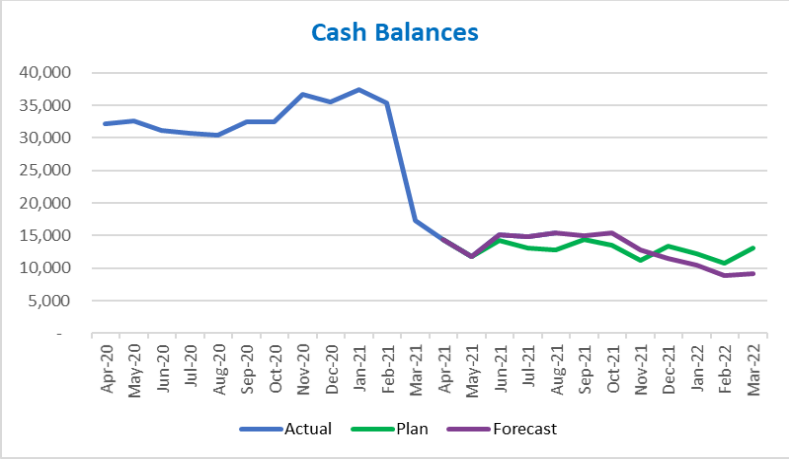
Statement of Financial Position Overview

Statement of Financial Position	Opening 31st March 2021 Actual £000	Prior Month 31st July 2021 Actual £000	Current Month 31st August 2021 Actual £000
Non-current assets	130,002	130,241	129,967
Current assets	22,682	21,662	22,783
Current liabilities	(24,777)	(24,374)	(25,305)
Non current liabilities	(11,976)	(11,597)	(11,514)
Net Assets Employed	**115,931**	**115,931**	**115,931**
Total Taxpayers Equity	**115,931**	**115,931**	**115,931**



Commentary

Non-current assets

Non current assets have decreased by £0.3m in month, reflecting depreciation exceeding the low YTD capital expenditure.

Current Assets

The cash position remains strong with an increase of £0.5m from the prior month.

Receivables have increased by £0.6m over the month, largely due to late receipt of £1.1m for the KSS Provider Collaborative SLA (1st Sept), partly offset by a decrease in VAT receivable of £0.5m due to June's reclaim being received in August.

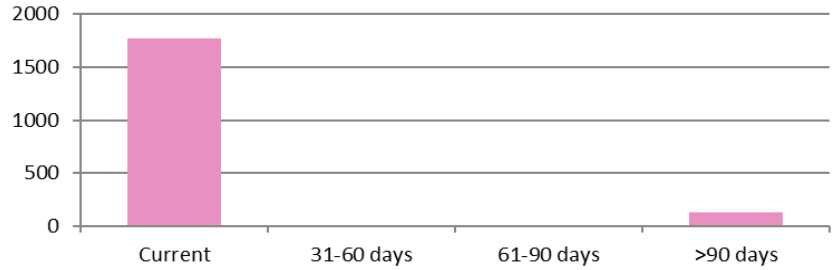
Current Liabilities

Trade and other payables have increased by £0.9m in month, mainly due to increase of £0.3m in general accruals (with increases in accruals for contingency, private beds and reactive maintenance) and £0.3m in PDC accruals. Trade creditors and capital creditors have also increased by £0.3m.

Aged Debt

Our total invoiced debt is £1.9m, of which £1.8m is within 30 days. Debt over 90 days has remained at £0.1m.

Aged Debt Analysis

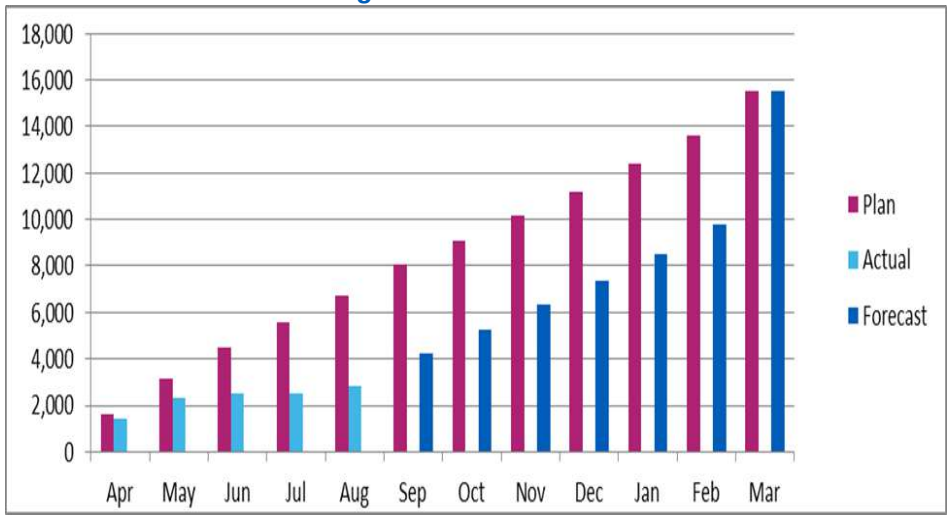


NHS Kent and Medway

Capital Expenditure

	Current Month			Year to Date			Full Year
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000	*Actual* £000	*Variance* £000	*Plan* £000
Information Management and Technology	217	126	(90)	1,102	552	(550)	2,856
Capital Maintenance & Minor Schemes 2021/22	358	0	(358)	993	0	(993)	2,142
Capital Maintenance & Minor Schemes from 2020/21	217	3	(215)	3,100	1,403	(1,697)	3,635
Capital Maintenance & Minor Schemes Prior Year Adj	0	20	20	0	(81)	(81)	0
Strategic Schemes - Orchards Ward	174	29	(145)	871	483	(387)	1,045
Improving Mental Health Services (Maidstone)	187	138	(49)	623	469	(155)	5,787
PFI 2020/21	3	3	0	17	17	0	40
Total Capital Expenditure	**1,156**	**319**	**(837)**	**6,705**	**2,843**	**(3,862)**	**15,505**

Cumulative Performance against Plan



Commentary

In August, the Trust has spent £0.3m against the initial plan of £1.1m, this is predominantly due to slippage on estates schemes, and recovery of VAT on Capital Schemes which were in the 2020/21 programme.

The year to date position is underspent by £3.9m, £0.6m on IM&T schemes, £2.8m on estates schemes and £0.5m on strategic schemes and the Improving Mental Health Services programme. The main reasons for the underspend are delays on the Closed Protocol, Comms Room schemes and Orchards Ward, new year estates schemes in the planning stage, an increased tendering requirement for Emmetts and Walmer heating, VAT reclaims, retention adjustments, and Strategic IT schemes proceeding differently to plan.

The forecast position for 2021/22 remains at £15.5m, this is being closely monitored by the Trust Capital Group. A capital forecast is being compiled based on the estates planning information.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th September 2021
Title of Paper:	Designated Body Annual Board Report and Statement of Compliance (2020/21)
Author:	Dr Rosarii Harte and Lynne Slater
Executive Director:	Dr Afifa Qazi, Executive Medical Director

Purpose of Paper

Purpose:	Approval for Submission to NHS England
Submission to Board:	Regulatory (Responsible Officer Regs 2010 (as amended 2013)

Overview of Paper

Annual Organisation Audit Report and Statement of Compliance to Board for approval prior to submission to NHS England (2020/21).

Report is submitted to Board to provide assurance on appraisal and revalidation of doctors employed by the organisation and following approval will be submitted to NHSE as a statutory requirement.

Issues to bring to the Board's attention

In line with national advice from NHS England, medical appraisals were halted during the peak periods of the COVID pandemic. We resumed appraisals in Spring 2021 and adopted the Appraisal 2020 Model in line with NHSE guidance, with a strong focus on health and wellbeing. The majority of KMPT doctors (93%) completed their appraisals within the appraisal year or within the first quarter of the next year.

Of the outstanding appraisals there are five doctors who are either on sabbaticals or long-term sick leave. All the remaining doctors have a timeline for completion within the next three months.

In line with GMC requirement and Responsible Officer Protocol, KMPT has a robust process in place to ensure recommendations to the GMC are timely and all our doctors have been revalidated in line with GMC requirements.

Governance

Implications/Impact:	Regulatory
Assurance:	Reasonable
Oversight:	Workforce and Organisational Development Committee

Version Control: 01

Kent and Medway
NHS and Social Care Partnership Trust

Briefing Note

Revalidation and appraisal is carried out in the NHS to ensure doctors are licensed to practice medicine and supported to develop, so care continuously improves. All Responsible Officers, who are the people responsible for helping doctors with revalidation, are required to complete the Annual Organisation Audit (AOA) on behalf of their organisations or 'designated bodies'. The collective results from the exercise provides a level of assurance about the consistency of the appraisal process supporting medical revalidation to patients and the public; and to doctors, Responsible Officers and the organisations in which they work; to higher level Responsible Officers in NHS England's regional teams, the General Medical Council and Ministers on the value that medical revalidation brings.

Our Annual Organisation Audit (AOA) for 2020/21 has concluded that as an organisation we have, fit for purpose processes, in place to ensure our doctors are appraised and revalidated in a timely manner in line with RO Regulation.

Version Control: 01

Classification: Official

Publications approval reference: B0614

A framework of quality assurance for responsible officers and revalidation

Annex D – annual board report and statement of compliance

Version 1, July 2021

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Introduction:

The Framework of Quality Assurance (FQA) for Responsible Officers and Revalidation was first published in April 2014 and comprised of the main FQA document and seven annexes A – G.

In 2019 a review of the Annual Organisational Audit (AOA), Board Report template and the Statement of Compliance concluded with a slimmed down version of the AOA (Annex C) and a revised Board Report template (Annex D), which was combined with the Statement of Compliance (previously listed as Annex E) for efficiency and simplicity.

Annual Organisational Audit (AOA):

At the end of April 2021, Professor Stephen Powis wrote to Responsible Officers and Medical Directors in England letting them know that although the 2020/2021 AOA exercise had been stood down, organisations will still be able to report on their appraisal data and the impact of adopting the Appraisal 2020 model, for those organisations who have, in their annual Board report and Statement of Compliance.

Board Report template:

Following the revision of the Board Report template in June 2019 to include the qualitative questions previously contained in the AOA, the template has been further updated this year to provide organisations with an opportunity to report on their appraisal data as described in the letter from Professor Stephen Powis.

A link to the letter is below:

https://www.england.nhs.uk/coronavirus/publication/covid-19-and-professional-standards-activities-letter-from-professor-stephen-powis/

The changes made to this year's template are as follows:

Section 2a – Effective Appraisal

Organisations can use this section to provide their appraisal information, including the challenges faced through either pausing or continuing appraisals throughout and the experience of using the Appraisal 2020 model if adopted as the default model.

Section 2b – Appraisal Data

Organisations can provide high level appraisal data for the period 1 April 2020 – 31 March 2021 in the table provided. Whilst a designated body with significant groups of doctors (e.g. consultants, SAS and locum doctors) will find it useful to maintain internal audit data of the appraisal rates in each group, the high-level overall rate requested is enough information to demonstrate compliance.

With these additional changes, the purpose of the Board Report template is to help the designated body review this area and demonstrate compliance with the responsible officer regulations. It simultaneously helps designated bodies assess their effectiveness in supporting medical governance in keeping with the General Medical Council (GMC) handbook on medical governance.[1] This publication describes a four-point checklist for organisations in respect of good medical governance, signed up to by the national UK systems regulators including the Care Quality Commission (CQC). The intention is therefore to help designated bodies meet the requirements of the system regulator as well as those of the professional regulator. Bringing these two quality strands together has the benefits of avoiding duplication of recording and harnessing them into one overall approach.

The over-riding intention is to create a Board Report template that guides organisations by setting out the key requirements for compliance with regulations and key national guidance, and provides a format to review these requirements, so that the designated body can demonstrate not only basic compliance but continued improvement over time. Completion of the template will therefore:

a) help the designated body in its pursuit of quality improvement,

b) provide the necessary assurance to the higher-level responsible officer, and

c) act as evidence for CQC inspections.

Statement of Compliance:

The Statement Compliance (in Section 8) has been combined with the Board Report for efficiency and simplicity.

[1] Effective clinical governance for the medical profession: a handbook for organisations employing, contracting or overseeing the practice of doctors GMC (2018) [https://www.gmc-uk.org/-/media/documents/governance-handbook-2018_pdf-76395284.pdf]

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team – [*delete as applicable*] of Kent and Medway NHS and Social Care Partnership Trust can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Yes - Dr Afifa Qazi Executive Medical Director Action for next year: In the process of appointing a new Deputy R.O.

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes there is adequate capacity and resources Action for next year: None

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

The trust has introduced a software system to support with ensuring accurate records are kept (SARD) Action for next year: Ongoing review of use of the system

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Policies were reviewed and updated prior to the implementation of SARD

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: A Quality Assurance Audit was undertaken in 2019.

Action for next year: A date is to be agreed for a further audit in 2022.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

All Locum/short term placement Drs have 1 PA (4hours) allocated in their weekly job plan to accommodate CPD activities .

Action for next year: To continue with the above

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

KMPT has adopted the Appraisal 2020 model and all doctors have been informed of this with emphasis in appraisal on verbal reflection, health and wellbeing.

Action for next year: Trust doctors have been advised to use the Appraisal 2020 model for the current round of appraisals

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

The trust is sighted on reasons for appraisals not completed. Action for next year: There are agreed plans/timelines for completion of outstanding appraisals for those doctors not on Sabbatical/Long term sick

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Medical appraisal policy is complaint and approved. Action for next year: There is a review process in place with aim to complete by Dec 21

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

KMPT has 39 Medical appraisers who have received appraiser training. Action for next year: Annual Refresher training for Appraisers and training of new appraisers.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

There is ongoing performance review including appraisee feedback, annual update training and regular peer appraiser meetings. Action for next year: To continue with above

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Annual Appraisal report is submitted to Trust board Action for next year – continue reporting to Board

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Kent and Medway NHS and Social Care Partnership Trust	
Total number of doctors with a prescribed connection as at 31 March 2021	145
Total number of appraisals undertaken between 1 April 2020 and 31 March 2021	102
Total number of appraisals not undertaken between 1 April 2020 and 31 March 2021	33
Total number of agreed exceptions	10

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

The trust has a process in place to ensure recommendations to the GMC are timely. The RO is supported by an Appraisal and Revalidation Manager to manage this process. Action for next year: Continue with this process

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the

recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Prior to the revalidation date there is regular discussion with doctors where deferral / non-engagement maybe an issue. The doctors are offered support with facilitating any outstanding actions. Correspondence is sent in line with GMC requirements to all relevant doctors when recommendations are submitted or deferred

Action for next year: To continue to ensure support mechanisms in place

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

The trust ensures that there are good systems and processes in place to ensure effective clinical governance of doctors. New Head of Psychiatry roles to ensure robust medical management structures have been created in the organisation. Also Clinical Director roles have been introduced to offer senior clinical leadership to all services in the organisation.

Action for next year: to continue to review effectiveness of the systems and processes

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Effective systems are in place and information is easily accessible to all doctors via the Revalidation manager and the Medical staffing team.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Trust policy in place which is in line with MHPS policy (Maintaining High Professional Standards) .

Action for next year: Policy is currently being reviewed

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

Monthly Decision Making Unit overseen by the Responsible Officer is established.

Quarterly Medical staffing report is submitted to the Workforce and OD committee which is a board subcommittee

Action for next year -review the reporting process and content of report to ensure analysis includes protected characteristics.

Action for next year: Further more detailed analysis to be undertaken.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

There is a process in place for timely R.O. to R.O. sharing of information

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

There is a regular review of processes at Decision Making Unit meetings . Discussion of individual cases with high level South East region RO and quarterly discussions with GMC liaison officer are in place.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Recruitment checks are carried out in line with GMC guidance.

Section 6 – Summary of comments, and overall conclusion

In line with National advice from NHSE/I medical appraisals were halted during peak periods of the COVID pandemic. When the appraisal process resumed doctors were advised to use the Appraisal 2020 model focusing on health and wellbeing. The majority of doctors (93%) completed their appraisals within the appraisal year or within the first quarter of the next year.

Of the outstanding appraisals 5 doctors are either on sabbaticals or long-term sick leave. The remaining 5 doctors and/or their appraisers have extenuating circumstances which have contributed to the delay in appraisals being completed. All these doctors have a timeline for completion within the next three months.

The plan for the current appraisal is to continue with the Appraisal 2020 model of appraisals. Due to last year's delays in completion dates have shifted for some doctors for the 2021/2022 cycle.

The aim for the 2022/2023 cycle is to return to previous timelines

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Kent and Medway NHS and Social Care Partnership Trust

Name: Helen Greatorex Signed: _ _

Role: Chief Executive

Date: _ 23 September 2021

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Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30 September 2021
Title of Paper:	Committee Terms of Reference (ToRs)
Author:	Tony Saroy, Trust Secretary
Executive Director:	n/a

Purpose of Paper

Purpose:	Approval
Submission to Board:	Standing Order/Regulatory Requirement

Overview of Paper

The Board is asked to approve the changes to Committee Terms of Reference proposed by the Committees.

Issues to bring to the Board's attention

The Board Committees have completed their annual reviews and as a result of these reviews are proposing some changes to their Terms of Reference for Board approval.

The Quality Committee (QC) and Finance and Performance Committee (FPC) are proposing changes to the wording of their purpose, aims and objectives to ensure they are clear and concise and accurately capture the work of the Committees.

The Mental Health Act Committee (MHAC) is proposing changes to its administration arrangements only.

The Audit and Risk Committee (ARC) and the Workforce and OD Committee (WFODC) have reviewed their Terms of Reference and are content that they continue to reflect the responsibilities delegated by the Trust Board and are not proposing any changes.

Governance

Implications/Impact:	Maintenance of sound governance systems
Assurance:	Significant
Oversight:	Oversight by ARC via assurance of the governance system

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Committee Terms of Reference (ToRs)

1 Context

In order to fulfil its statutory duties and responsibilities, the Trust Board has established Committees. The Board Committees are an essential part of the overall governance structure and provide the Board with assurance and scrutiny in the areas delegated to them by the Board. These responsibilities are defined in the Committees' Terms of Reference and only the Trust Board can approve any changes to these.

The Board Committees carry out an annual review of their effectiveness against their Terms of Reference. Changes as a result of these reviews are presented to the Board for approval. The Board Committees have completed their reviews for 2020-21 and the following changes are proposed.

Clean copies of the new Terms of References are attached. (Appendices 1 to 5)

2 Proposed Changes for Approval

1 Quality Committee

The Quality Committee is proposing seven changes as listed below

1 **Constitution** – sentence to be added to be consistent with other Committee ToRs -

"The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee."

2 **Purpose –** wording to be updated to read –

"The purpose of the Quality Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. It supports the Audit and Risk Committee on governance aspects of assurance associated with the adequacy and effectiveness of systems and controls."

Replacing

The Quality Committee carries out its duties as an assurance committee of the Board in reviewing systems of control and governance specifically in relation to clinical quality and safety. It is supported by the Audit Committee which provides the 'oversight' arm of the Board, reviewing the adequacy and effectiveness of controls.

3 **Aim** - wording to be updated to read –

"To assure the Board through consultation with the Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services.

To assure the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way."

Replacing

The main aim of the Quality Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients

4 **Objectives** - wording to be updated to read –

"To seek assurance that

- The content and effectiveness of the structures, policies, systems and processes for quality assurance, clinical, information and quality governance are in place.
- Effective processes are in place to achieve all areas of regulatory compliance including registration and recommendations of the CQC
- Current and future risks to quality and safety which may be included but not limited to the Quality Risk Register, reports from the Quality Impact Group (QIG) including Quality Impact Assessments (QIAs) are recognised, managed or mitigated.
- Locally-sensitive quality indicators and metrics are used to aid continual improvement in the quality of services and patient experience
- The meaning, significance and learning from trends in complaints, incidents and Serious Incidents is recognised.
- The learning from internal reports, local or national reviews and enquiries and other data and information that may be relevant for understanding quality and safety with the Trust is acted upon."

Replacing

To assure the Board through consultation with the Integrated Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services.

To assure the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.

5 Membership section updated to reflect members current job titles.
6 Methodology section updated to reflect Committee's expectation of exception reporting from the Chief Nurse and Chief Operating Officer's reports on the Quality Digest and scheduled reporting on the various annual programmes.
7 Accountability and Reporting section updated to include reference to the Policy Approvals Group and the receipt of regular exception reports from the groups reporting to the Quality Committee.

2 Finance and Performance Committee (FPC)

FPC is proposing 8 changes as listed below

1 Purpose – wording to be updated to –

"The purpose of the Finance and Performance Committee is to support the Trust's strategic direction by providing the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

The committee's role will also be to support the Executives with delivery of the overarching efficiency programme and also to take forward any funding opportunities that may exist to support capital and revenue projects. The committee will draw on the NEDs experience to support moving forward these agenda items.

Additionally, the Committee has delegated authority to: (a.) Approve the investment and borrowing strategy and associated policies; (b.) Approve Business Cases Project Initiation Documents for capital and revenue schemes above the de minimis amount; (c.) Approve capital investments and divestments above the de minimis amount2 ; (e.) Approve Business Cases with a capital cost or revenue cost greater than xx

Separation of duties
The roles and responsibilities of the Finance and Performance Committee is distinct from the Audit and Risk Committee who will maintain full oversight of the Annual Accounts process and also Treasury Management policy, as well as areas such as Standing Financial Instructions (SFIs) which are part of the Trust's system of control.

The Executive Management Team will remain responsible for operational delivery and management."

Replacing –

The purpose of the Finance and Performance Committee is to provide the Board with assurance concerning all aspects of finance and performance relating to the provision of care and services in support of getting the best value for money and use of resources. It is imperative that in arriving at final decisions that the committee have considered the impact on patients and quality of care prior to making a final decision with regard value for money.

To assure the Board, through consultation with the Integrated Audit and Risk Committee that structures, systems and processes are in place and functioning to support broad and long term Financial, Clinical, ICT and Estates Strategies and that it is managing its asset base efficiently and effectively.

To assure the Board that where there are risks and issues that may jeopardise the Trust's performance in respect of its key Financial Performance targets that these are being managed in a controlled and timely way.

To assure the Board that where there are risks and issues that may jeopardise the Trust's operational performance that these are being managed and controlled in a timely way.

2 Aims – wording to be updated to –

"The main aims of the Committee are:

To provide the Board with an independent and objective review of, and assurances, in relation to Financial and Operational Performance

To seek assurance that there is adequate organisational oversight of the financial, estates, Clinical Technology and informatics strategies to support the Trust's achievement its strategic plan

To seek assurance that the Trust's efficiency programme is aligned to strategic objectives and is adequately controlled

Monitor and seek assurance over the effective management of significant financial and operational risks which may impact upon the delivery of the strategy and the Trust's financial viability / sustainability. Reviewing the assigned Board Assurance Framework risks are key to undertaking this duty.

The Committee will support the Executive team with delivery of the efficiency programme and funding opportunities that may arise in year.

The Committee may be required to take on additional duties as directed by the Board."

Replacing –

The main aims of the Committee are:

To confirm a broad and long-term Financial Strategy is developed in support of the Trust Clinical Strategy and to review the overall financial performance of the Trust and the reporting practices related thereto.
To confirm the Trust manages its asset base efficiently and effectively and to confirm capital projects of significant value, whether related to property or other assets, are properly identified, managed and controlled. This definition relates equally to both the acquisition of assets and to their disposal.
To review the Trust's Estates Strategy, its formulation, development and implementation, its links to service and financial strategies and thus ensure that the Trust's capital assets are properly and effectively utilised.
To review the Trust's Clinical Technology Strategy, its formulation, development and implementation, its links to service and financial strategies.
To make recommendations to the Board and to the CEO as to appropriate actions required in respect of Finance, Operations, Estates and ICT to ensure the Trust is operating effectively, efficiently and economically.
To monitor the performance of the Trust in respect of its key Financial and Operational Performance targets.
To monitor the financial risks that the Trust face and ensure that robust mitigations are in place for managing these risks effectively.
Once established the Committee may be required to take on additional duties as directed by the Board.

3 Objectives – wording to be updated to –

"Agree and review those strategies relevant to its remit, ensuring their alignment with the Trust's vision and strategic direction and provide assurance to the Board on their ongoing development and delivery

These include but are not limited to: Financial Strategy; Commercial Development Strategy; Treasury Management; Estates Strategy; Procurement Strategy; Clinical Technology Strategy; Informatics Strategy

Ratify those underpinning policies and procedure, guidelines, protocols and plans to support delivery of agreed strategy. Monitor compliance with the policies – this may be undertaken through the sub-groups with assurance being provided to the Committee through the assurance and escalation reports.

Approve the Terms of Reference and membership of its supporting sub-groups and oversee the work of those groups, including work programmes to ensure these contribute to Trust objectives Major investments/divestments and business opportunities

Providing the Board with an objective review and assurances in relation to major investments/ divestments as classified by NHSI and business cases referred to it by the Board under delegated authority

Providing the Board with objective review and assurance in relation to the efficiency programme

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee holds delegated authority for Investment decisions as defined in the Trust Investment Policy."

Replacing

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.
The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.
The Committee holds delegated authority for Investment decisions as defined in the Trust Investment Policy.

4 Membership section has been updated to remove any old staff roles, and add relevant new roles.

5 Methodology has been streamlines to clearly show the Committee's duties and responsibilities and how these feed into the Committee's workplan.

6 Committee Rules and Administration Arrangements section has been amended to say that the Committee is expected to hold 6 meetings in a financial year rather than 10.

7 Accountability and Reporting Arrangements wording updated to be consistent with other Committees.

8 Review and monitoring wording updated to be consistent with other Committees.

3 Mental Health Act Committee

The Mental Health Act Committee is proposing changes to its administrative arrangements only. It is proposing the addition of a reference to virtual meetings being acceptable and noting the availability of Committee minutes to Board members.

4 Audit and Risk Committee and Workforce and OD Committee

Both ARC and WFODC have concluded their reviews against their Terms of Reference and concluded no changes are required to previously Board approved versions.

5 Remuneration and Terms of Service Committee

The Remuneration and Terms of Service Committee will continue to operate in line with the Terms of Reference approved by the Trust Board in June 2018 at this stage. The Committee reviewed a re-drafted version of its Terms of Reference at its meeting on 28 July 2021. The Committee approved the Terms of Reference, subject to a change in one section. That change dovetails the re-drafting of the Manging Conflicts Policy. Once the Committee has approved the finalised version, the Committee's Terms of Refence will be presented to Board for approval.

6 Conclusion and Recommendation

Board Committees have undertaken their annual reviews taking account of past operations and current priorities and objectives. The changes proposed are in line with the refreshed governance principles developed by the Trust Board at its Development Day in April 2021.

Committee Terms of Reference have been reviewed by ARC in their role of ensuring sound governance across the Trust.

It is recommended that the Board approve the changes proposed by the individual committees following their annual reviews.

Appendices

Appendix 1 – Audit and Risk Committee ToRs

Appendix 2 – Quality Committee ToRs

Appendix 3 – Finance and Performance Committee ToRs

Appendix 4 – Workforce and OD Committee ToRs

Appendix 5 – Mental Health Act Committee ToRs

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Terms of Reference

Name of Committee	**Audit and Risk Committee (ARC)**	
Date	**8 January 2021**	
Version	**V2.1**	
Approval	**ARC**	*Date 11th February 2021*
	Trust Board	*Date 25th February 2021*
Next review due	**XXXX 2021**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V1.0	Draft	29.07.11	Val Woodin	
V1.0	Draft	26.10.11	Trust Board	Approved at Trust Board meeting 26.10.11for implementation January 2012
V1.1	Draft	21.11.11	Simon Muir Internal Audit	Review requested by IAC re NHS Trust Audit Handbook requirements for incorporating Risk element
V1.2	Draft	15.03.12	Val Woodin	Minor amendments mainly related to the name of the Committee
V1.3	Approved	27.09.12	Val Woodin	Additional duty to oversee strategic objective
V1.4	Approved	04.09.14	Val Woodin	Minor amendments agreed by IARC
V1.5	Approved	03.03.16	Rosanna Roughley	Addition of role of Panel for Appointment of External Auditors
V1.6	Approved	18.04.17	Sheila Wilkinson	Annual review – no changes recommended
V1.7	Approved	08.03.18	Sue Manthorpe	Annual Review – Addition of EPRR
V1.7	Approved	28.06.18	Trust Board	Approved by the Trust Board 28.06.18
V1.8	Draft	05.09.19	IARC	Review and approve
V1.9	Draft	02.07.20	IARC	Addition of explicit reference to review of Board Assurance Framework twice a year
V1.9	Approved	30.07.20	Trust Board	Approved by Trust Board 30.07.20
V2.1	Draft	08.01.21	TS/PC	

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1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Audit and Risk Committee (ARC). The Committee is a Non-Executive Committee of the Board and has no executive powers nor decision making authority other than those specified in these Terms of Reference.

Any amendments to these Terms of Reference can only be approved by the Trust Board. The Terms of Reference will be reviewed annually.

2. Purpose

The Audit and Risk Committee provides assurance to the Board that governance, risk management, financial reporting and internal controls are effective across the Trust.

3. Responsibilities

The Audit and Risk Committee will provide assurance and advice to the Board on:

the strategic processes for risk, control and governance and the Annual Governance Statement

the accounting policies, the Accounts, and the Annual Report of the organisation, including the process for review of the Accounts prior to submission for audit, levels of error identified, and management's letter of representation to the External Auditors

the planned activity and results of both Internal (including Counter Fraud matters) and External Audit

adequacy of management response to issues identified by audit activity, including the External Auditor's management letter

assurances relating to the management of risk and corporate governance requirements for the organisation

proposals for tendering for either Internal or External Audit services or for purchase of non-audit services from contractors who provide audit services

anti-fraud policies, whistle-blowing processes, and arrangements for special investigations; and

its own effectiveness and report the results of that review annually to the Board.

The Audit and Risk Committee will review then advise the Board on:

- the operation of, and proposed changes to, the standing orders, standing financial instructions, schemes of delegation, codes of conduct and standards of business conduct and the maintenance of registers.
- Emergency Preparedness Response and Resilience and the Business Continuity Plan
- Health & Safety (including Fire)
- Risk Management Strategy and Risk Management Policy
- Freedom to Speak Up effectiveness (in time for the Annual Governance Statement)

- Information Governance (in time for the Annual Governance Statement)
- Single tender waivers compliance
- The adequacy of the policy process for ensuring compliance with relevant regulatory, legal and conduct requirements.

4. Membership

The Committee shall be appointed by the Board from amongst the Non-Executive directors of the Trust and shall consist of not less than three members, at least one of whom should have recent and relevant financial experience.

The members of the Audit and Risk Committee are Peter Conway (Chair), Fiona Carragher and Sean Bone-Knell. Tony Saroy, Trust Secretary, provides Secretariat support

The Audit and Risk Committee may:

- co-opt additional members for a period not exceeding a year to provide specialist skills, knowledge and experience
- procure specialist ad hoc advice at the expense of the organisation subject to spend approval by the Board

Committee members will be required to attend a minimum of 75% of all meetings.

5. Quorum

A quorum shall be two members.

6. Methodologies

Meetings

- The Audit and Risk Committee will meet at least four times a year. The Chair of the Audit and Risk Committee may convene additional meetings as deemed necessary. There will be a separate and private meeting between the Auditors and Committee members before every meeting.
- The Audit and Risk Committee meetings will normally be attended by the Executive Director of Finance and Performance, Executive Director of Nursing and Quality, the Emergency Preparedness and Resilience Lead, Risk Manager, Head of Internal Audit, and representatives of External Audit and Local Counter-Fraud.
- The Audit and Risk Committee may ask any other officials of the organisation to attend to assist it with its discussions on any particular matter
- The Audit and Risk Committee may ask any or all of those who normally attend but who are not members to withdraw to facilitate open and frank discussion of particular matters
- The Board or the Accounting Officer may ask the Audit and Risk Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.
- The Chair and Accounting Officer of the Trust will be invited to attend

meetings of the Audit and Risk Committee as required.

- The Audit and Risk Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

Reporting

- The minutes of Audit and Risk Committee meetings shall be formally recorded by the Trust Secretary and will be made available to the Board on request. The Chair of the Committee shall report to the Board after each meeting and draw attention to any issues that require action including details of any evidence of potentially ultra vires, otherwise unlawful or improper transactions, acts, omissions or similar practices. Reports may be presented to the Board at a time that members of the press and public have been excluded
- The Audit and Risk Committee will provide the Board and Accounting Officer with an Annual Report, timed to support finalisation of the accounts and the Annual Governance Statement, summarising its conclusions from the work it has done during the year

Miscellaneous

The Audit and Risk Committee will:

- examine any other matter referred to the Audit and Risk Committee by the Trust Board and to initiate investigation as determined by the Audit and Risk Committee.
- consider the outcomes of significant reviews carried out by other bodies which include but are not limited to regulators and inspectors within the health and social care sectors and professional bodies with responsibilities that relate to staff performance and functions.
- liaise with all Board committees in order to coordinate assurance activity efficiently and effectively
- Undertake risk management deep dives into any area the Committee deems appropriate
- undertake and evidence an annual review of its performance against the NHS Audit Committee Handbook, its annual work and training plans, in order to evaluate its effectiveness, the fulfilment of its functions in connection with these terms of reference and achievement of its duties.

7. Committee Administration

For each meeting the Audit and Risk Committee will be provided with:

- a report summarising any changes to the organisation's significant risks and a copy of the Board Assurance Framework/Risk Register
- a progress report from the each of the Auditors summarising:
  - work performed (and a comparison with work planned)
  - key issues emerging from the work
  - management response to audit recommendations
  - changes to the agreed plans; and
  - any resourcing issues affecting the delivery of the objectives
  - emerging findings
- management assurance reports
- reports on the management of major incidents, "near misses" and lessons learned.
- a risk deep-dive into an area as specified and requested by the Committee

When appropriate the Committee will be provided with:

- the Internal Audit charter
- the Internal Audit strategy and annual plan
- the local counter fraud strategy and annual plan
- the External Audit strategy and annual plan
- the Head of Internal Audit's Annual Opinion and Report
- Quality Assurance reports on the Internal Audit function
- the draft Annual Report and Accounts of KMPT
- the draft Annual Governance Statement
- a report on changes to accounting policies
- External Auditor's management letter
- a report on proposals to tender for audit functions
- a report on the co-operation between Internal and External audit; and
- the organisation's Risk Management Strategy and Policy
- updates on Emergency Preparedness, Business Continuity and Health & Safety (including Fire)

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Terms of Reference

Name of Committee	**Quality Committee (QC)**	
Date	**16 March 2021**	
Version	**V.12**	
Approval	**QC**	**Date: 16/03/2021**
	Trust Board	*Date: xx/xx/21 (pending)*
Next review due	**April 2022**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
v.01	Draft	23.09.11	Dr Karen White	New Board Committee
v.01	Final	29.03.12	Quality Committee	Approved by Trust Board
v.02	Draft	12/06/12	Quality Committee	Meeting frequency; title of Quality Risk Register
v.03	Final	27.09.12	Trust Board	Additional duty to oversee strategic objectives
v.04	Draft	17.12.13	Quality Committee	Non-Executive Director membership amended to 3 Non-Executive Directors
v.05	Final	30.01.14	Trust Board	Non-Executive Director membership amended to 3 Non-Executive Directors and Patient Safety Manager added as full member
v.06	Final	19.05.15	Quality Committee & Trust Board	Quorum change, section 9.2 bullet 4 removed (outmoded) and section 10.3 changed from may work with IARC to will work with IARC.
v.07	Final	15.03.16	Quality Committee	Reviewed by Quality Committee – no amendments required. Previous Trust Board approval stands.
v.08	Draft	21.03.17	Quality Committee	Reviewed by Quality Committee
v.09	Final	17.04.18	Quality Committee	Reviewed by Quality Committee
V09	Final	28.06.18	Trust Board	Approved by Trust Board
V10	Draft	16.04.19	Quality Committee	Reviewed by Quality Committee
V11	Draft	17.04.20	Quality Committee	Reviewed by Quality Committee
V11	Final	xx.xx.20	Trust Board	Approved by Trust Board
V12	Draft	16.03.21	Quality Committee	Review in line with Governance Refresh

NHS
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1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as Quality Committee. The Committee has no executive powers, other than those specifically delegated in these Terms of Reference.

The Terms of Reference can only be amended with the approval of the Trust Board.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any member of staff and all members of staff are directed to cooperate with any request made by the Committee.

2. Purpose

The purpose of the Quality Committee is to provide the Board with assurance concerning all aspects of quality and safety relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients. It supports the Audit and Risk Committee on governance aspects of assurance associated with the adequacy and effectiveness of systems and controls.

3. Aims

To assure the Board through consultation with the Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support an environment for the provision and delivery of excellent quality health and social care services.

To assure the Board that where there are risks and issues that may jeopardise the Trust's ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.

4. Objectives

To seek assurance that

- The content and effectiveness of the structures, policies, systems and processes for quality assurance, clinical, information and quality governance are in place.
- Effective processes are in place to achieve all areas of regulatory compliance including registration and recommendations of the CQC
- Current and future risks to quality and safety which may be included but not limited to the Quality Risk Register, reports from the Quality Impact Group (QIG) including Quality Impact Assessments (QIAs) are recognised, managed or mitigated.
- Locally-sensitive quality indicators and metrics are used to aid continual improvement in the quality of services and patient experience
- The meaning, significance and learning from trends in complaints, incidents and Serious Incidents is recognised.
- The learning from internal reports, local or national reviews and enquiries and

other data and information that may be relevant for understanding quality and safety with the Trust is acted upon.

5. Membership

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

- Three Non-Executive Board members, two of whom will be the Chair and Vice Chair of the Committee
- Executive Medical Director
- Executive Director of Nursing, AHPs and Quality
- Chief Operating Officer
- Director of Psychological Therapies Strategic Lead - Allied Health Professionals
- Chief Pharmacist
- Deputy Director of Quality and Safety

In Attendance and on request:

The Trust Risk Manager and H&S Lead and the Assistant Director of Transformation and Improvement may be in attendance.

Care Groups will be required to attend two Quality Workshops per year as part of Quality Account development and reporting

The Chief Executive and Heads of Service may attend any meeting unless requested to be in attendance when they must attend.

Other members of staff including directors, senior managers, and clinicians, will be invited to attend as appropriate by decision of the Committee or the Committee Chair.

Service users and Carers may be invited to attend as appropriate by decision of the Committee or the Committee Chair.

Meetings shall be held at least quarterly plus two Quality Workshops per year with additional meetings as necessary to fulfil the Committee Workplan.

6. Quorum

A quorum shall be four members, which must include one non-executive member and one executive member. The Executive member must include either the Medical Director or the Director of Nursing, AHPs and Quality

7. Methodology (Duties, Reporting, Annual Workplan,)

The Committee will seek assurance on all aspects of quality via:

Exception reports from:

- The Executive Directors which will highlight items to escalate to the Committee from the Quality Digest (QD) and key escalations from sub-groups

Scheduled reports from the various annual programmes including:

- Regulatory Compliance and CQC oversight
- Infection Prevention and Control
- Privacy and Dignity –Delivering Same Sex Accommodation standards
- Quarterly Mortality Reviews
- Patient Experience of Care, including community engagement and complaints and national patient surveys
- Research & Development including Clinical Audit & Effectiveness and Quality Improvement
- Learning from Deaths, SIs and Incidents
- Safeguarding
- Clinical Outcomes
- Annual Ligature audit
- Medicines Management
- Quality Account Priorities

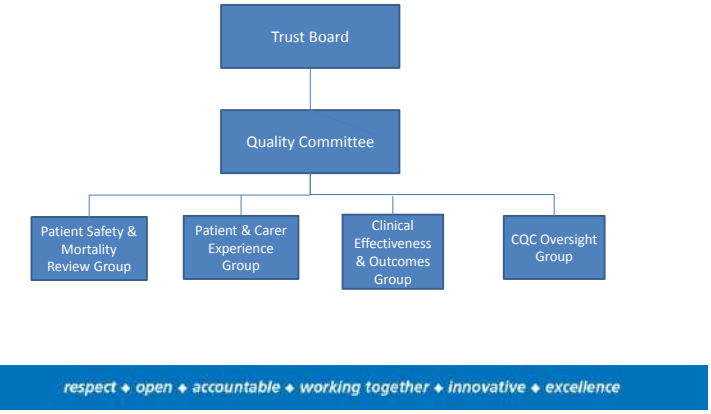
- The Trust's quality risk register will be scrutinised at alternate meetings.

- Heads of Service will present their progress in achieving quality priorities to the Committee at twice yearly Quality Workshops.

The Committee may also receive, on alternate months when the Quality Digest is not presented, exception reports from:

- Trust Wide Patient Safety and Mortality Review Group
- Trust Wide Patient and Carer Experience Group
- Clinical Outcomes Group

8. Accountability and Reporting – Group Structure



Full Governance Structure can be found on iconnect

9. Committee rules and administration arrangements

The Committee will be supported administratively by a Secretary, whose duties in this respect will include:

- Agreement of agenda with Chairman and attendees, and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Advising the Committee on pertinent areas
- Ensuring the agenda, papers, and corresponding minutes reflect confidential items

The Secretary may delegate some or all of these duties as required.

The minutes of Committee meetings shall be formally recorded and stored by the Secretary.

10. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Chair of the Committee shall report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action including details of any matters in respect of which actions or improvements are needed.

The Committee will report to the Board annually on its work in support of the Annual Governance Statement and after each meeting highlighting areas of success in quality improvement and risks to the improvement of quality in any area of the Trust's services.

The Committee should work with the Audit and Risk Committee specifically when issues arise in relation to the Audit and Risk Committee role in maintaining effective systems of governance, risk management and internal control within the Trust.

The Chair of the Quality Committee would have authority to report to other organisations working in partnership any matter the Committee considers impacts on clinical quality.

11. Review and Monitoring

These Terms of Reference will be reviewed annually or sooner if required and recommendations made to the Trust Board for approval.

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Terms of Reference

Name of Committee	**Finance and Performance Committee (FPC)**	
Date	**March 2021**	
Version	**V15**	
Approval	**FPC**	**Date: 23/03/2021**
	Trust Board	*Date:*
Next review due	**April 2022**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V01	Draft	26.07.11	Val Woodin	Board Committee Structure review – replaces Finance and Estates Committee
V02	Approved	26.10.11	Trust Board	Approved at Trust Board meeting 26.10.11for implementation January 2012
V03		27.03.12	FRC	Bullet point added to section 9 to cover carbon reduction and sustainability
V04		22.10.12	FRC	Addition of Procurement Group to sections 9 & 11
V04		26.10.12	Trust Board	Approved addition of Procurement Group
V05		24.09.13	FRC	Approved addition of Transformation Board
V05		24.09.13	FRC	Approved addition of Performance Report
V06		27.03.14	Trust Board	Approved amendment of NED membership to 3 members and change of name to Finance and Performance Committee
V07		23.09.14	FPC	Approved subject to the transfer from paragraph 10 to IARC of:- • Oversee the Trust's insurance arrangements • Receive a quarterly report on ex gratia payments
V08		27.05.15	FPC	Reviewed and Approved

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V09	Draft	27.04.16	FPC	Reviewed
V10	Approved	June 2016	Trust Board	No changes so previous Board approval applies
V11	Draft	28.03.17	FPC	Reviewed
V12	Approved	24.04.18	FPC	Reviewed
V12	Approved	26.06.18	Trust Board	Approved by Trust Board 28.06.18
V13	Approved	23.04.19	FPC	Reviewed and Approved
V13	Approved	26.09.19	Trust Board	Approved by Trust Board 26.09.19
V14	Approved	26.05.20	FPC	Reviewed 28.04.20 and Approved 25.05.20
V14	*Approved*	*30.07.20*	*Trust Board*	*Approved by Trust Board 30.07.20*
V15		*23.03.21*	*FPC*	*Review in line with 2021 Governance Refresh*
V16		*20.07.21*	*FPC*	*Update to reflect FPC member comments*

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Finance and Performance Committee. The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

The Terms of Reference can only be amended with the approval of the Trust Board.

2. Purpose

The purpose of the Finance and Performance Committee is to support the Trust's strategic direction by providing the Board with assurance concerning all aspects of finance and operational performance relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients.

The committee's role will also be to support the Executives with delivery of the overarching efficiency programme and also to take forward any funding opportunities that may exist to support capital and revenue projects. The committee will draw on the NEDs experience to support moving forward these agenda items.

Additionally, the Committee has delegated authority to: (a.) Approve the investment and borrowing strategy and associated policies; (b.) Approve Business Cases Project

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Initiation Documents for capital and revenue schemes above the de minimis amount;
(c.) Approve capital investments and divestments above the de minimis amount2 ;
(e.) Approve Business Cases with a capital cost or revenue cost greater than xx

Separation of duties

The roles and responsibilities of the Finance and Performance Committee is distinct from the Audit and Risk Committee who will maintain full oversight of the Annual Accounts process and also Treasury Management policy, as well as areas such as Standing Financial Instructions (SFIs) which are part of the Trust's system of control.

The Executive Management Team will remain responsible for operational delivery and management.

3. Aims

The main aims of the Committee are:

To provide the Board with an independent and objective review of, and assurances, in relation to Financial and Operational Performance

To seek assurance that there is adequate organisational oversight of the financial, estates, Clinical Technology and informatics strategies to support the Trust's achievement its strategic plan

To seek assurance that the Trust's efficiency programme is aligned to strategic objectives and is adequately controlled

Monitor and seek assurance over the effective management of significant financial and operational risks which may impact upon the delivery of the strategy and the Trust's financial viability / sustainability. Reviewing the assigned Board Assurance Framework risks are key to undertaking this duty.

The Committee will support the Executive team with delivery of the efficiency programme and funding opportunities that may arise in year.

The Committee may be required to take on additional duties as directed by the Board.

4. Objectives

Agree and review those strategies relevant to its remit, ensuring their alignment with the Trust's vision and strategic direction and provide assurance to the Board on their ongoing development and delivery

These include but are not limited to: Financial Strategy ; Commercial Development Strategy; Treasury Management; Estates Strategy; Procurement Strategy; Clinical Technology Strategy; Informatics Strategy

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Ratify those underpinning policies and procedure, guidelines, protocols and plans to support delivery of agreed strategy. Monitor compliance with the policies – this may be undertaken through the sub-groups with assurance being provided to the Committee through the assurance and escalation reports.

Approve the Terms of Reference and membership of its supporting sub-groups and oversee the work of those groups, including work programmes to ensure these contribute to Trust objectives Major investments/divestments and business opportunities

Providing the Board with an objective review and assurances in relation to major investments/ divestments as classified by NHSI and business cases referred to it by the Board under delegated authority

Providing the Board with objective review and assurance in relation to the efficiency programme

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The Committee holds delegated authority for Investment decisions as defined in the Trust Investment Policy.

5. Membership

Membership
The Committee will be appointed by the Board and its membership shall consist of the following:
Two Non-Executive Directors, one of whom should be the Chair, one of whom should be the Vice Chair
Executive Director of Finance
Chief Operations Officer

Attendees – expected to attend all meetings
Deputy Director of Finance
Deputy Medical Director or a nominated AMD will be a regular attender to represent the clinical voice in Committee discussions

Attendees as required
Director of Contracting, IG and Business Development
Director of Capital Planning and Estates
Director of IT and Performance

Nominated deputies will be allowed for Executive Directors and outside appointments on an exceptions basis.

The Trust Chair and CEO and Deputy CEO (Director of Partnership and Strategy) may attend meetings but are not designated as members.

Frequency of Attendance
Committee members will be required to attend all meetings except in exceptional circumstances when notice is given to the Chair.

6. Quorum

A Quorum will be any two of the Executive and Non-Executive Directors including at least one Non-Executive and one Executive Director.

7. Methodology (Duties, Reporting, Annual Workplan,)

In order to fulfil its duties the Committee will undertake the following tasks:

Financial Strategy and Plans

- Reviewing on behalf of the Trust Board on an annual basis the Trust's Financial Strategy and Annual Plan
- Review the financial landscape of the wider ICS, with particular interest on how the other providers are performing financially as this is linked to the Financial Recovery Fund (FRF) achievement for the Trust

Performance Monitoring

Financial Performance

- Receive and review financial performance reports covering progress against plan, finance forecast and cost improvement programme.

- Receive analysis of significant variation from plan, with due explanation, and assure remedial actions are taken as necessary.

Operational Performance

- Receive and review reports on the Trust Integrated Quality and Performance Report, identifying progress against key targets and plans and provide regular reports to the Board.

- Receive analysis of significant variation from plan, with due explanation, and assure remedial actions are taken as necessary.

Capital Projects & Estates

- To seek assurance on behalf of the Board on the following:
  - That the Estates Strategy is linked to the Clinical and Financial

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Strategies.

- Assure major project proposals are robustly prepared and that the implementation plan is deliverable. Monitor the risk individually or collectively of such projects against the Trust's ability to manage its everyday activities
- That there is a robust disposal policy for redundant estate.

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- To oversee the Trust's Carbon Reduction and Sustainability Strategy, reporting as necessary to the Board.
- To seek assurance that the Trust's Environmental Strategy and policies are effectively implemented.

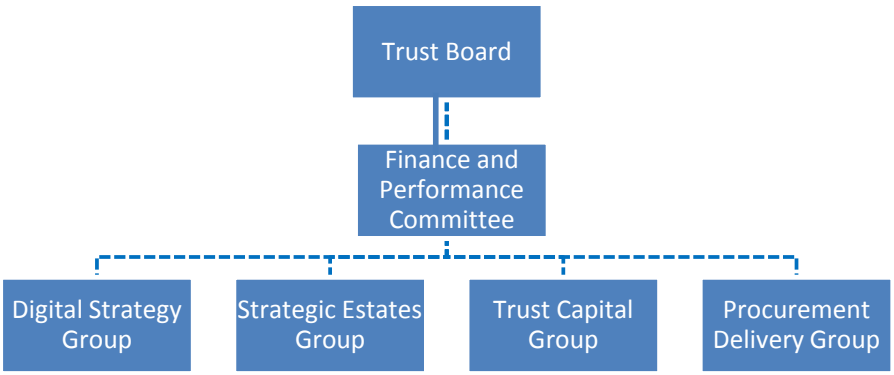
Clinical Technology and Informatics

- Receive and review assurance and exception reports from the Clinical Technology Board
- Receive and review assurance and exception reports from the Informatics Group

Procurement Delivery Group

Receive and review assurance and exception reports from the Procurement Delivery Group.

8. Accountability and Reporting – Group Structure



Full Governance Structure is available on iconnect

9. Committee rules and administration arrangements

The Committee is expected to hold 6 meetings in a financial year.

The Committee will be supported administratively by a Secretary, whose duties in this respect will include:

- Agreement of agenda with Chairman and attendees and collation of papers.
- Taking the minutes and keeping a record of matters arising and issues to be carried forward.

- Advising the Committee on pertinent areas of governance and procedure.
- Ensuring the agenda, papers and corresponding minutes reflect confidential items.
- Drafting a Board Report based on a review of the papers, as input to the Chair's Report to the Board

10. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Finance and Performance Committee will be accountable to the Trust Board.

The minutes of the Committee meetings shall be formally recorded by the Secretary and submitted to the Board.

The Committee will report to the Trust Board following each meeting.

The Committee will consider matters referred to it for action by the Integrated Audit and Risk Committee and report back in writing.

11. Review and Monitoring

The Committee will undertake and evidence an annual review of its performance against its annual work plans, in order to evaluate the achievement of its duties.

The Committee will undertake an annual review of its Terms of reference. Any proposed amendment must be reviewed approved by the Board.

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Terms of Reference

Name of Committee	**Workforce and Organisational Development (WFODC)**	
Date	**19 May 2020**	
Version	**V10**	
Approval	**Committee**	**Date 19 05 2020**
	Trust Board	*Date 30 07 2020*
Next review due	**April 2021**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V01	Draft	27.07.11	Val Woodin	
V01	Draft	26.10.11	Trust Board	Approved at Trust Board meeting 26.10.11 for implementation January 2012
V02	Draft	02.02.12	Workforce and OD Committee	Minor amendments
V03	Final	27.09.12	Trust Board	Additional duty to oversee strategic objective
V04	Final	06.06.13	Trust Board	Addition of two Service Line Directors under Technical Advisors
V05	Final	12.09.13		Addition of DME under technical advisor
V06	Final	20.05.15	WF&OD Committee	Quorum and attendance amended. Section 14: reference to IARC removed to be consistent with the Quality Committee terms of reference.
V07	Draft	22.03.17	WFODC	Minor amendments – addition of Deputy Director of Nursing as a member of the Committee
V08	Draft	20.03.18	WF&OD Committee	Minor Amendments
V09	Draft	~~21.05.19~~ 16.07.19	WFODC Committee	WFODC annual review
V10	Draft	19.05.20	WFODC	WFODC annual review – no changes
V10	Final	30.07.20	Trust Board	Approved at Trust Board
		16.03.21	WFODC	WFODC annual review – no changes

1. Constitution

The Board hereby resolves to establish a Committee of the Board to be known as the Workforce and Organisational Development Committee. The Committee is a **Non**

Executive Committee and has no executive powers, other than those specifically delegated in these Terms of Reference.

The Terms of Reference can only be amended with the approval of the Trust Board.

2. Purpose

The purpose of the Committee is to provide the Board with assurance concerning all aspects of workforce and organisational development relating to the provision of care and services in support of getting the best clinical outcomes and experience for patients and staff.

3. Aims

To assure the Board through consultation with the Integrated Audit and Risk Committee, that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of excellent quality health and social care services.

To assure the Board that where there are workforce or organisational development risks and issues that may jeopardise the Trust's ability to deliver its objectives that these are being managed in a controlled and timely way.

4. Objectives

To report on main Workforce key performance indicators, by the People Strategy areas and also by Care Group. Highlight reports of main areas of Workforce and OD, governance focussed reports and policies for ratification will also be on the agenda.

5. Membership

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

- Minimum of two Non-Executive Directors, one of whom should be the Chair and the Vice Chair
- Director of Workforce and Communications
- Chief Operating Officer
- Deputy Director of Nursing Practice

Or their nominated deputy.

Attendance by Other Directors and Staff

- One Care Group Director and the Care Group HR Business Partner on a rotational basis
- Deputy Director of Workforce and Organisational Development
- Organisational Development Consultant

Technical Advisors by invitation only

- Head of Employee Relations
- Director of Medical Education
- Staff Side representative
- Care Group Human Resources Business Partners
- Trust Lead for Equality and Diversity
- Medical Staffing Manager
- Recruitment Manager
- Business and Performance Manager
- Head of Workforce Information

Executive Director of Finance, Executive Director of Nursing and Quality and Executive Medical Director may be asked to attend meetings as required.

Representatives from Carers/Service Users may be invited when appropriate.

Other Directors, Deputy Directors or Heads of Service shall be invited to attend when the Committee is discussing areas of the operation that are the responsibility of that Director or Head of Service.

6. Quorum

A Quorum shall consist of one Non-Executive Director and either the Director of Workforce and Communications or the Chief Operating Officer.

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7. Methodology (Duties, Reporting, Annual Workplan,)

Meetings shall normally be bi-monthly and there should be no less than five meetings per year.

Committee members will be required to attend a minimum of 70% of all meetings.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

The duties of the Committee can be categorised as follows:

All areas within Workforce and Organisational Development

The Committee shall review areas under Workforce and Organisational Development to ensure adequate evaluation and monitoring within the Trust and to ensure local and national priorities are being addressed and that the Trust's ability to recruit, retain and develop its workforce is adequately supported.

The Committee shall review the establishment and maintenance of an effective system of Workforce and Organisational Development across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's strategic and operational objectives.

Workforce and Organisational Development Policies and Procedures

The Committee shall ratify Workforce and Organisational Development Policies and Procedures. The Committee may also virtually approve any policies which may require urgent ratification sooner than the next meeting of the Committee.

Risk Management

The Committee shall maintain a risk register related to the remit of the Committee which will feed into the Corporate Risk Register of the organisation.

Management

The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for Workforce and Organisational Development.

In particular, the Committee will take reports on the following:

- Learning and Development Group

- Health and Wellbeing Group
- Brilliant People Group
- Joint Negotiation Forum
- Local and National initiatives relating to the Workforce and Organisational Development agenda
- Workforce and Organisational Development key performance indicators
- Core Objectives in relation to Workforce and Organisational Development
- Equality and Diversity steering Group
- Other sub-groups as deemed necessary by the Committee

They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements.

The Committee shall oversee the strategic objective "Recruit retain and develop the best staff making KMPT a great place to work".

The Committee may consider other pertinent issues as required by the Board.

8. Accountability and Reporting – Group Structure

The Committee shall be accountable to the Trust Board.

The minutes of Workforce and Organisational Development Committee meetings shall be formally recorded by a Secretary and submitted to the Board. The Chair of the Committee shall report to the Board after each meeting and draw to the attention of the Board any issues that require disclosure to the full Board, or require executive action via a written report.

The Committee will report to the Board annually on its work in support of the Human Resources agenda and Trust objectives, specifically commenting on its relation to the Assurance Framework appropriateness of the self-assessment against the Care Quality Commission Essential Standards and Monitor Compliance Framework.

Relationship with Trust wide Groups

- Learning and Development Group
- Joint Negotiation Forum
- Health and Well Being Group

Equality and Diversity Steering Group

9. Committee rules and administration arrangements

The Committee will be supported administratively by a Secretary, whose duties in this respect will include:

Agreement of agenda with Chairman and attendees, and collation of papers
Taking the minutes and keeping a record of matters arising and issues to be carried forward
Advising the Committee on pertinent areas of governance and procedure
Ensuring the agenda, papers and corresponding minutes reflect confidential items

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10. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Committee will undertake and evidence, an annual review of its performance against its annual work and training plans, in order to evaluate its effectiveness, the fulfilment of its functions in connection with these terms of reference and achievement of its duties

11. Review and Monitoring

These Terms of Reference will be reviewed annually or sooner if required and recommendations made to the Trust Board for approval.

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Terms of Reference

Name of Committee	**Mental Health Act Committee (MHAC)**	
Date	**22 April 2020**	
Version	**V5**	
Approval	**MHAC**	**Date: 22/04/2020**
	Trust Board	*Date: xx/09/2020 (pending)*
Next review due	**April 2021**	

Review - Document Control

Version	Status	Date	Author	Summary of Changes
V1	Draft	8 02.17	K Learmond	First Draft for review
V1	Approved	28.06.18		Approved by the Trust Board 28.06.18
V2		Sept 18		MCA added explicit in remit and circulated for review
V3		Sept 18		Updated membership
V3	Reviewed by MHAC	08.04.19		Reviewed by MHAC, finalised with Director of Nursing and Quality Exec Lead now Executive Medical Director . 21/4/2020.
V4	Final	08.07.19	DoNandQ	Exec Lead now Executive Medical Director – 21/4/2020
V4	Approved	26/09/19		Approved by the Trust Board
V5	Final	22.04.20		Reviewed and Approved by MHAC
V5	*Approved*	*xx/09/20*		*Approved by the Trust Board*
V6	*Final*	*02/07/21*		*Reviewed and Approved by MHAC*
V6	*Approved*	*30/09/21*		*Approved by the Trust Board*

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1. Constitution

The Board hereby resolves to form a Committee of the Board to be known as the Mental Health Act Committee (MHAC). The Committee is a Non-Executive Committee of the Board and has no executive powers, other than those specifically delegated in these Terms of Reference.

The Terms of Reference can only be amended with the approval of the Trust Board

2. Purpose

The purpose of the Committee is to ensure that there are systems, structures and processes in place to support the operation of and to ensure compliance with the Mental Health Act 1983 (as amended 2007) and Mental Capacity Act and other related legislation within inpatient and community settings.

3. Aims

The aim of the Committee is to provide the Trust Board with assurance that Trust activities are compliant with current Mental Health legislation and best practice.

4. Objectives

The Committee will monitor that the Trust has in place and uses appropriate policies and procedures in relation to the aforementioned legislation and ensure effective oversight of the development of such protocols and procedures and facilitate the publication and guidance of the legislation to all relevant staff, services users, carers and managers.

To keep under review annually the Trusts “Delegation of Statutory Functions under the MHA 1983” policy including the Schedule of Delegation appended to that policy.

To receive and review the Mental Health Act Activity Report on a quarterly basis and bring to the Trust Board attention any areas of concern, risk or non compliance.

To receive assurance from the Mental Health Legislation Operational Group (MHLOG) via reports following each meeting

To ensure that the Trust is compliant with legislative frameworks and that there are robust processes in place to implement change as necessary in relation to the Mental Health legislation and report on ongoing and new training needs.

To receive the results in relation to the monitoring of policies linked to the Mental Health Act and Mental Capacity Act legislation and monitor any associated action plans.

To consider and recommend the annual audit plan in relation to Mental Health

Legislation.

The Committee will receive assurance that new law guidance and best practice is disseminated and actioned appropriately.

5. Membership

The Committee membership shall be appointed by the Board. One Non-Executive director of the Trust will be appointed Chair of the Committee by the Board.

The Committee membership will consist of :

Non-Executive Director (Chair)
Non-Executive Director (Vice Chair)
Executive Medical Director (Executive lead)
Executive Director of Nursing & Quality
Head of Legal Services (Co-chair of MHLOG)
Deputy Chief Operating Officer (Co-Chair of MHLOG)

All members require named deputies

Attendance will be expected by:

AMD/Medical Clinical Lead
Non-Medical Responsible Clinician (Psychology/Nursing)
Head of Safeguarding
Chair of Associate Hospital Managers or (Deputy)

Committee members will be required to attend a minimum of 75% of all meetings.

6. Quorum

A quorum shall be a minimum of 3 members including 1 Non Executive Director and 1 Executive Director

7. Methodology (Duties, Reporting, Annual Workplan,)

Specific duties of the Committee are:

Receiving and reviewing reports on the use of the Mental Health Act and Mental Capacity Act within the Trust and in respect of the administration and conduct of reviews by Associate Hospital Managers;

Receiving evidence of written decisions pertaining to detention and compulsory powers in the community;

Receiving and reviewing reports from CQC MHA visits;

Monitoring implementation of CQC Quality Improvement Plan actions in relation to

MHA

Directing and receiving result of MHA and MCA audits

Reviewing relevant policies and guidance for ensuring compliance with the Mental Health and Mental Capacity legislation;

Monitoring content and compliance training relevant to MHA and MCA policies and procedures;

Reviewing relevant policies and guidance for ensuring compliance with the Hospital Managers powers under section 23 of the Mental Health Act and its Code of Practice including policies for governance of Associate Hospital Mangers and diversity;

The committee will be responsible for reviewing and authorising both standing and time limited sub-groups, their Terms of Reference and workplans.

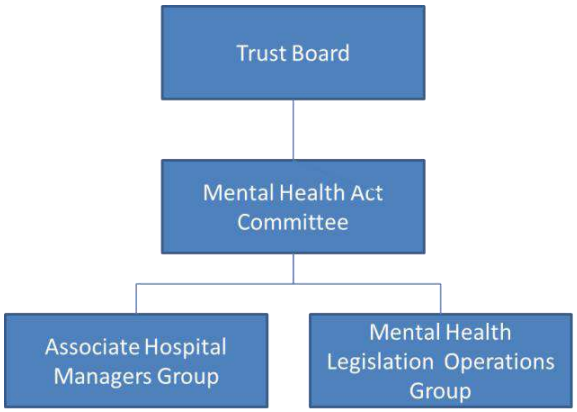
The following sub-groups will report into this committee:

- Mental Health Legislation Operational Group (MHLOG) (previously the Mental Health Good Practice Group) Any other task and finish sub-groups of either the Mental Health Act Committee or the Mental Health Legislation Operational Group (MHLOG) Safeguarding Board

8. Accountability and Reporting – Group Structure

Links into the following meetings and groups:

- Trust Board (report/minutes to Trust Board)
- Mental Health Legislation Operational Group (MHLOG)
- Associate Hospital Managers Group
- Integrated Audit and Risk Committee (IARC)
- Quality Committee



Full Governance Structure is available on iconnect

9. Committee rules and administration arrangements

The Committee will be supported administratively via Trust Secretariat Team in respect of:

- Agreement of agenda with Chairman and attendees, and collation of papers
- Taking the minutes and keeping a record of matters arising and issues to be carried forward
- Arrangements with additional attendees
- Communication and reporting on actions directed to the Mental Health Legislation Operational Group (MHLOG)
- Reporting relevant matters and response to and from the Quality Committee
- Drafting of report to Trust Board

Meetings shall be held quarterly. The Committee Chair may request additional meetings if they consider it necessary. Meetings can be face to face or via video conference as decided by the Chair

10. Accountability and Reporting Arrangements (Annual Effectiveness Report)

The Committee is directly accountable to the Trust Board.

The minutes of Committee meetings shall be formally recorded and made available to the Board.

The Chair of the Committee shall report to the Board after each meeting.

11. Review and Monitoring

The Committee will undertake and evidence a review of its performance against its purpose in order to evaluate its effectiveness, the fulfilment of its functions in connection with these terms of reference and achievement of its duties at the conclusion of the time line, at least annually.

These Terms of Reference will be reviewed annually or sooner if required and recommendations made to the Trust Board for approval.

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Title of Meeting	**Public Board Meeting**
Meeting Date	**30th September 2021**
Title	**Quality Committee (QC) Chair Report**
Author	**Fiona Carragher, Non-Executive Director**
Presenter	**Fiona Carragher, Non-Executive Director**
Executive Director Sponsor	**-**
Purpose	**Noting**

Matters to be brought to the Board's attention

- The Director of Infection Prevention and Control Annual Report was approved by the Quality Committee. Congratulations was provided to the Infection Control Team for their hard work over the last year and for producing the DPIC Annual Report.
- The Committee recognised the positive enhancements the Quality Improvement Team are making, particularly with Mental Capacity Act compliance.

Items referred to other Committees (incl. reasons why)

- It was agreed the growing risk of estates should be referred to the Audit and Risk Committee. The Committee recognised that the estates issues was a risk that was mentioned in a number of papers received by the Committee. It was noted that the Audit and Risk Committee would be receiving an Estates deep dive risk paper at their meeting on 21 September 2021.
- The Committee discussed the risk associated with the current Government consultation to mandate Covid 19 and flu vaccinations for NHS staff visiting care homes. It was agreed to refer the matter to the Workforce and Organisational Development Committee. QC noted the difficulty the Trust may face if KMPT staff are not vaccinated and the mitigations in place.

Summary of Committee Meeting:

The Quality Committee (QC) met on Tuesday 21st September and discussed the following agenda:

- CQC inspection – Littlebrook Hospital Report
- CQC Mock Inspections
- Quality Digest
- DPIC Annual Report
- Operational Hotspots Presentation
- Q3 & Q4 Suicide Thematic Report

- Safeguarding: Allegations against staff deep dive
- Mental Capacity Act – quality improvement
- QIA Terms of Reference

The Committee would like to bring the following items to the attention of the Board:

CQC Mock Inspections

The Trust undertook peer CQC mock inspections across 27 wards between July and August. The inspections were focused on the safety and well led-key lines of enquiry.

A number of positives were identified including patient information being easily accessible and informative. All staff were welcoming on arrival and fresh fruit and a good range of patient activities was available for patients. Staff were confident in demonstrating trust values, felt well supported by colleagues and managers and all staff could identify things they were proud of and liked about working on the ward.

As well as positives, areas of learning were also identified. This included ensuring consistency in involvement of patients, family and carers in care planning and risk assessment, disposing medication that is no longer required, improving knowledge on restrictive interventions and that of Independent Advocates for Mental Health and Mental Capacity. Actions have been put in place to work on all areas of learning.

Safeguarding allegation against staff deep dive – a review of safeguarding allegations identified the main locations as the most acute inpatient wards and a small proportion were not upheld following investigation. Learning was identified in relation to professional boundaries and additional training and supervision for unregistered staff..

DPIC Annual Report

The Committee received and approved the DPIC Annual Report. The report noted areas of good practice, challenges facing the Trust and the proposed work plan for the coming year for Infection Control. It was confirmed that KMPT are compliant with the Health and Social Care Act's (2012) Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance.

The Committee provided its thanks to the Infection Control Team for all their hard work throughout the last year and in producing this mandatory report.

Operational Hotspots Presentation

A useful presentation was discussed regarding the operational areas of concern regarding workforce, performance, incidents and complaints for each of the Care Groups. The presentation gave key updates and progress on each of these areas and it was agreed that this presentation should be added to the QC workplan and should be received at every meeting.

The Board is asked to note the content of this report.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th September 2021
Title of Paper:	Annual Infection Prevention and Control (IPC) report
Author:	Cheryl Cramer- Infection prevention and Control Matron
Executive Director:	Mary Mumvuri – Executive Director of Nursing & Quality Director of Infection Control and Prevention (DIPC)

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

The report was presented to the Quality Committee on 21 September 2021. It notes good practice, challenges and the proposed work plan for coming year. KMPT are compliant with the Health and Social Care Act's (2012) Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance

Issues to bring to the Board's attention

Highlights:

- Annual IPC audit highlighted good infection control practice with an overall score of 98% compliance for inpatient teams and 95% for community teams.
- All 24monthS Risk Assessments required under approved code of practice, "Legionnaires' disease: the control of legionella bacteria in water systems" L8 were completed and actions identified completed.
- Zero cases of clostridium difficile or MRSA bacteraemia reported.
- Increase in flu vaccinations from 62% 2019-2020 to 67% 2020-2021
- Robust management of Covid19

Priorities for the 2020/2021 are:

- Continue to monitor the rates of infections for both national and local reporting requirements.
- Conduct regular audits on infection prevention and control practices

- Continue to improve staff education and awareness of infection prevention and control practices and hand hygiene and use of Personal and Protective Equipment
- Work collaboratively with Care Groups to manage infection prevention and control issues

Governance

Implications/Impact:

Good IPC practice is significantly linked to patient safety

Poor IPC practice will lead to individual and group/herd risks in relation to the prevention and management of infection

Poor IPC practice has the potential to result in significant staffing shortages, which would result in a lack of workforce resource and therefore financial strain

This report is a mandated report. Good IPC practice is a requirement of the Health and Social Care Act

The DIPC report engages the Trust's Infection prevention and control matron in ensuring that the Annual report gives an accurate reflection of progress

Risk recorded on: BAF

Risk IDs:

- 5859 – Organisational risk – Emerging infectious diseases (including covid-19 and subsequent variants)
- 6420 – Covid-19 – low compliance to FFP3 Fit testing

Assurance/Oversight:

Substantial Assurance

Quality Committee

Trustwide Patient Safety and Mortality review group

Trustwide Infection control group

Infection, Prevention and Control Annual Report 2020-2021

1. Foreword

Kent and Medway NHS and Social Care Partnership Trust (KMPT) is committed to ensuring a robust infection control function that operates within the Trust, supporting the delivery of high quality healthcare and protecting the health of its patients and staff.

The Trust has a statutory responsibility to comply with the Health and Social Care Act: Code of Practice for the prevention and control of Healthcare-Associated Infection (2012). A requirement of this Act is for the Board of Directors to receive an annual report from the Director of Infection Prevention and Control. The annual report of the Infection, Prevention and Control Team (IP&C) provides an overview of the activities carried out in the Trust to progress the prevention, control and management of infection from April 2019 to March 2020.

During the period 2020-2021, the trend of low rates of alert organisms and conditions has continued. There were no outbreaks of confirmed micro-organisms of gastrointestinal disease (Norovirus), clostridium difficile or MRSA bacteraemia. We had 33 Covid 19 outbreaks across inpatient and community based services.

KMPT and The NHS as a whole began working with the additional challenges and pressures of Covid 19. It has highlighted some outstanding areas of patient care and staff dedication and resilience but has also highlighted some additional areas of improvement and consideration.

As the Director of Infection Prevention and Control (DIPC), both I and the Infection prevention control team (IP&C team) continue to be committed to ensuring that patient safety is at the forefront of everything we do.

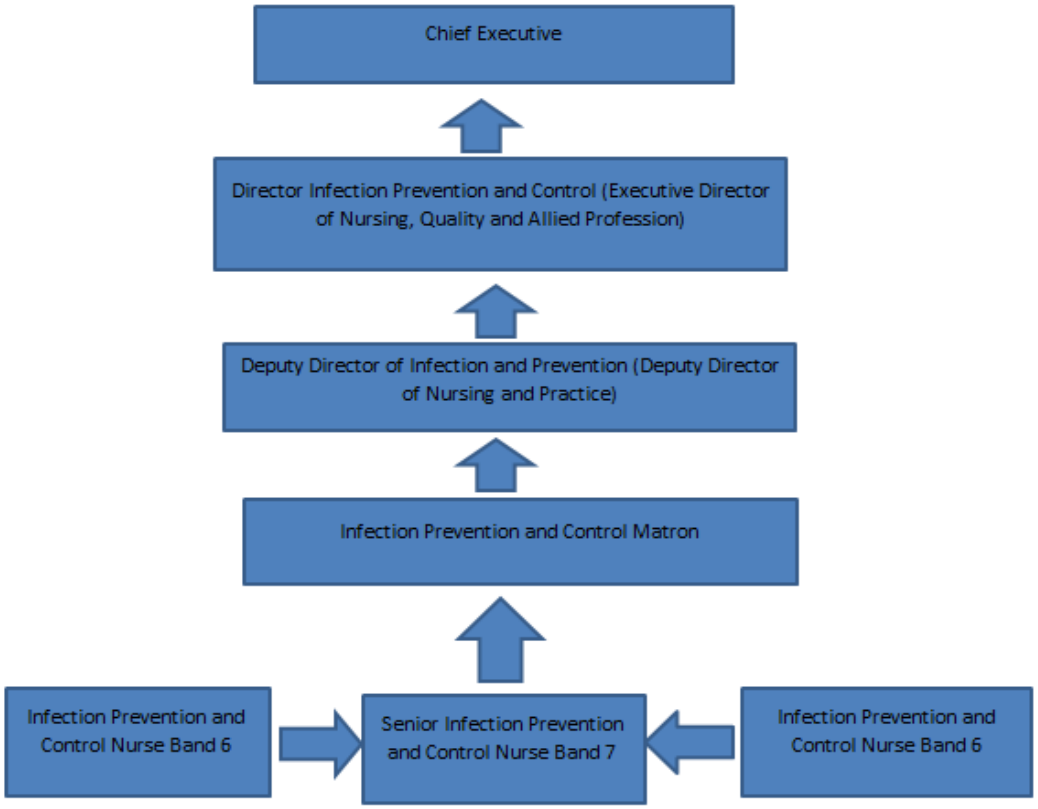
I commend this annual report to you and thank the infection control team for their excellent leadership of this agenda, and to the Trust for the continued focus they give to this important area.

Mary Mumvuri
Executive Director of Nursing, AHPs and Quality and DIPC

2. Executive summary

The annual report from the Director of Infection Prevention and Control (DIPC) is produced to provide information about our current progress in IPC practice and activities carried out in 2020-2021, reports on our challenges and outline our future plans.
Within 2020-2021, the IP&C team maintained and supported improvement in the standards of care for our patients in relation to infections, and in particular the additional pressures of Covid 19. A summary of the IPC work plan can be noted in Appendix A.

1. **Structure, accountability and assurance**
   The structure for the management of the infection, prevention and control service complies with the Hygiene Code 2008.



The Lead Nurse for Physical Health and Senior Physical Health Nurse were integral to the IPC team response to Covid 19; working a temporary 7 day working pattern to provide support to the organisation. Matrons, Heads of Nursing for each Care Group and Care Group Lead Nurses also have IPC in their portfolios. A business case for an increase in the provision of IPC in the organisation was agreed to include an Infection Prevention and Control Matron, Senior Infection Nurse, 2 Band 6 Infection Prevention and Control Practice development nurses. The structure commenced in February 2021 with completion scheduled by July 2021.

Microbiology Services The processing of clinical specimens is carried out via the microbiology departments within the 4 acute hospitals within Kent & Medway through Service Level Agreements (SLAs) with support from a Consultant Microbiologist at MTW.

The Trust wide Infection Control Group is chaired by the Deputy DIPC and meets bi-monthly with representation from all Care Groups and support services, including Estates and Facilities. In addition to this, the water group meets every 4 months. The group provides a forum for discussion, decision making and governance oversight on measures for the prevention and control of infection within the Trust. Members are expected to cascade information back to their relevant teams, ensuring that infection prevention and control is on the governance agenda for care groups.

Infection prevention and control continues to be essential in ensuring that people who use health and social care services receive safe, effective, well-led and responsive care. Effective prevention and control must be part of everyday practice and has to be applied consistently by everyone.

The key documents and legislation that the organisation adheres to includes:

- Health and Social Care Act 2012 (Regulated Activities).
- Care Quality Commission (Registration) Regulations 2009.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- CQC Fundamental Standards CQC (Registration) Regulations 2009 - Regulation 12 – Safe care and treatment
- All relevant NHSI/E / Department of Health and Social Care guidance.

4. Reporting mechanisms

The DIPC reports to the Trust Board via the IQPR and Quality Committee. Period reports are provided to the Trust wide Patient Safety and Mortality Meeting in accordance with the work plan.

Data surveillance of all suspected or confirmed infections are reported to the IP&C team from all Care Groups and this is monitored through the bi-monthly Trust wide IP&C group.

Infection control issues are supported by the Senior Infection Control Nurse with support from the Lead Nurse for Physical Health and Deputy DIPC. The members of the IP&C Team provide infection control expertise including results of surveillance, audit and alert organism reporting to a variety of groups across the organisation.

The Senior Infection Control Nurse has recently been promoted to Infection prevention and control Matron and continues to provide a named infection control link to senior staff within all care groups. Link champions from each ward/unit are nominated to provide 'on the floor' infection control advice.

5. Assurance framework

The IP&C team produces an assurance framework which ensures that all relevant actions are being taken in order to comply with the 10 criteria identified in The Health and Social Care Act's (2008) Code of Practice for health and adult social care on the prevention and control of infections and related guidance (also known as the Hygiene Code). This assurance framework provides the trust with a comprehensive method for the effective and focused management of the principal risks. It also provides a structure for the evidence to support the statement on internal control.

6. Policies

In 2020-2021 the following policies were reviewed and updated in line with current legislation and guidance.

- Exposure to and Prevention of Blood Borne Viruses Policy
- Mattress & Pillow Policy

In addition to business as usual policies, a number of standard operating procedures (SOPS) were developed in response to Covid 19. These were developed by a number of health professionals and agreed at a SOP approval group attended by 3 Executive directors, senior professional leads and subject matter experts. These were initially weekly, then changed to monthly then bi- monthly in line with need. These SOPs were continually version controlled, reviewed, updated or archived in response to rapidly changing guidance. See Appendix D.

7. Clinical audit and effectiveness

Trust wide Infection Prevention and Control Audit

KMPT produces an audit to monitor, develop and implement plans for reducing Health Care Acquired Infections (HCAIs), including Methicillin Resistant Staphylococcus Aureus (MRSA), Clostridium difficile *(C.diff)* and other significant infections.

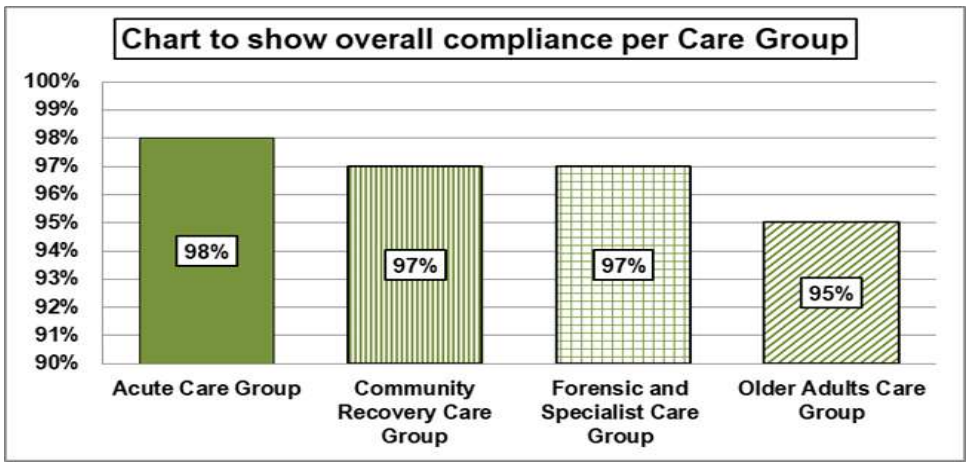
Once an audit is undertaken each ward/community team is provided with an action plan to complete and return to finalise the audit process.

Results

The results of the trust wide IP & C audit had identified that the organisation is performing well with 98% compliance for inpatient sites and 95% Community. This is an increase from last year with scores of 96% and 95% respectively

Areas for audit were chosen to ensure compliance for the aforementioned policies and national guidance

Table 1- Overall compliance per Care Group



Action plans for this audit, 2020/2021 were developed by the Quality improvement team and immediate remedial action taken.

The Trust wide IP&C audit proves to be beneficial in identifying actions required to ensure that all inpatient units and community teams comply with the trust's policies and procedures and to meet the 10 elements of the Health and Social Care Act 2012.
Where anomalies are identified and improvements required, an action plan is written in collaboration with the respective ward/unit managers, Matrons and Heads of Nursing to ensure that they are resolved quickly to reduce any potential risk to our service users, staff and visitors.

Hand hygiene audit

Older adult inpatient wards and Mother and Baby Unit complete monthly observational hand hygiene audits. The remaining care groups (Forensic and Specialist, Acute and working age adult community) complete the observational audit when a more regular need presents itself i.e. when a patient has a regular wound dressing. This is to ensure further assurance regarding

safe practice. The results of these audits are returned to the infection control team who compile the data and produce a certificate for wards to display.

Older Adults Care Group achieved 100% compliance with Community and Recovery, Forensic and Specialist and Acute Care group all scoring 96%.

Urinary tract infection audit

Urinary tract infections are one of the most common types of infections reported which can have a detrimental effect on physical health as well as mental health. Urine infections can affect a patient's personality and behaviour and go on to cause some acute and challenging conditions. They can result in prolonged hospital stays and increased costs for healthcare providers. Indwelling devices (catheters) are a particular risk.

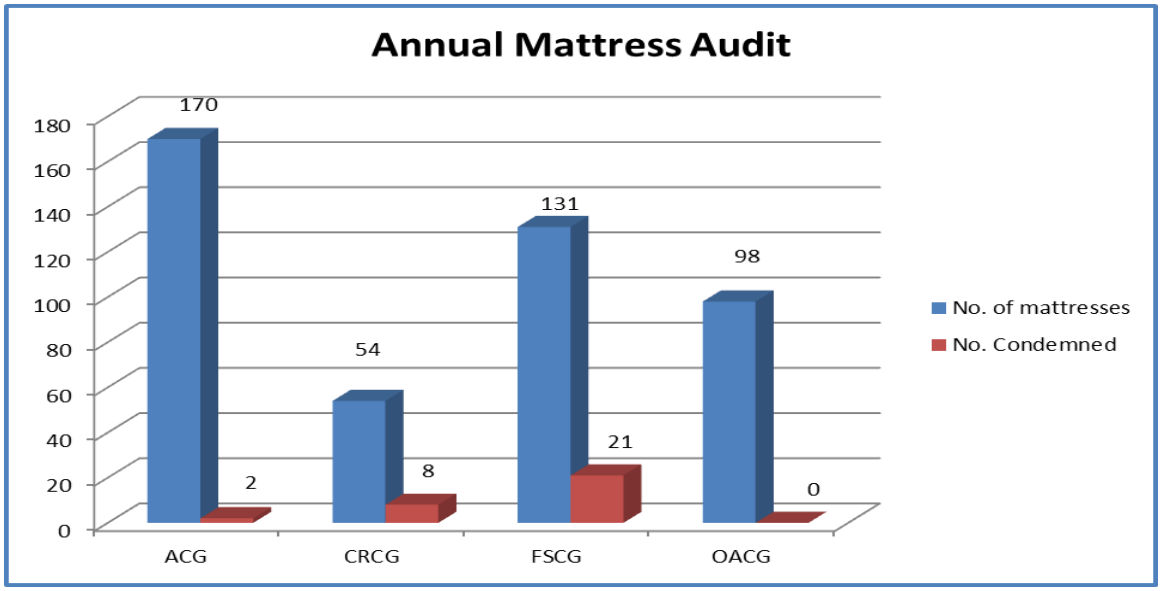
There were 95 suspected and laboratory confirmed urinary tract infections identified in 2020-2021, a reduction compared to (101) in 2019-2020 period.

All identified urinary tract infections across care groups were closely monitored by the infection control team and pharmacists to ensure that the treatment offered was appropriate and timely.

Trust wide Mattress Audit

Hospital mattresses can deteriorate quickly. Poor maintenance of mattresses and their covers may lead to contamination or inner surfaces.
All condemned mattresses are disposed of and replaced. It is believed Forensic and Specialist and rehab have more mattresses condemned due to the longer length of stay in these services, with patients responsible for the turning of mattresses and making of beds.

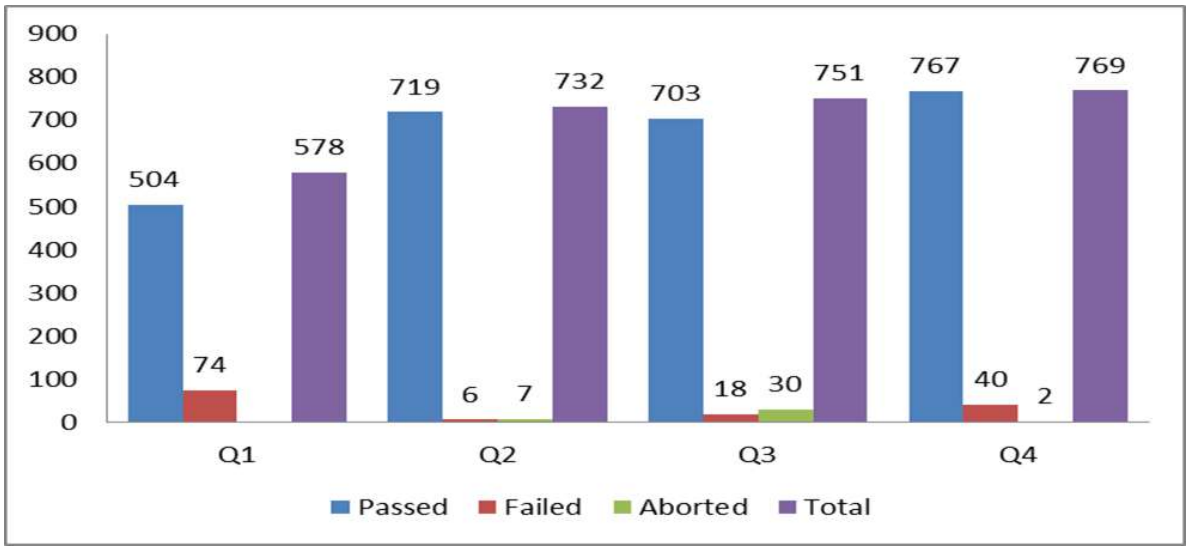
Table 5- Results of Annual Mattress audit



Annual water report

The organisation remains committed to reducing the risks associated with water borne pathogens by providing arrangements through planned preventative maintenance (PPMs) to ensure effective practice, training and audit required to ensure compliance. The PPM's are carried out to ensure KMPT are compliant with the Legionella regulations and they include flushing, monitoring temperatures, and boiler servicing and filter changes. The majority of tasks are completed by the maintenance contract services although some flushing is completed by the in-house housekeeping staff.
Of the 2830 tasks 4.88% failed (n138). 6 failed due to lack of contractor attendance and 132 failed as remedial works were needed. 1.38% of tasks were aborted (39) as the site or clients could not give access to areas. This gives a pass rate of 95.16% (2693). This is an improvement from 2019-2021 where 3168 tasks were completed with a 6% failure rate.

Table 6 below shows the breakdown per quarter:



They cover all aspects of L8 ALCOP, HTM 04-01 part 2, KMPT Water Safety Group (WSG) and Control of Legionellae Policy 2017 v4 for compliance as indicated as follows:

- Weekly flushing where required.
- Bi Weekly water softener inspection.
- Monthly tap, hot water calorifier, sentinel temperature checks for Legionella.
- 6 monthly water storage temperature checks.
- Yearly TMV maintenance and all other items mentioned above.

Additionally, all of the 24 month Risk Assessments required under ALCOP L8 in the year was completed and the actions identified in the Risk Assessments were also completed. The maintenance contract performance on water standards was within the requirements of the contract and regulations; no issues have been detected.

8. Antimicrobial prescribing and management

Effective antimicrobial stewardship within hospitals and community settings makes an

important contribution to the control and prevention of Clostridium difficile (C.*diff*), associated diarrhoea and other health care associated infections.

Monitoring compliance and effectiveness of KMPT Antimicrobial policy includes the need for inpatient units to submit antibiotic data to the IP&C email address when any antibiotic is prescribed. This information is collated onto a database and any concerns regarding antimicrobial prescribing is addressed between the IP&C Team, ward staff, the prescriber and pharmacy staff. In addition, broad spectrum antibiotics are not a stock item on the wards. All broad spectrum antibiotic requests made to Lloyd's pharmacy are highlighted to the KMPT pharmacists.

There have been discussions with a local Acute Trust for a microbial pharmacist to provide training for KMPT staff. A service level agreement for Consultant microbiologist support has been agreed with Maidstone and Tunbridge Wells NHS Trust.

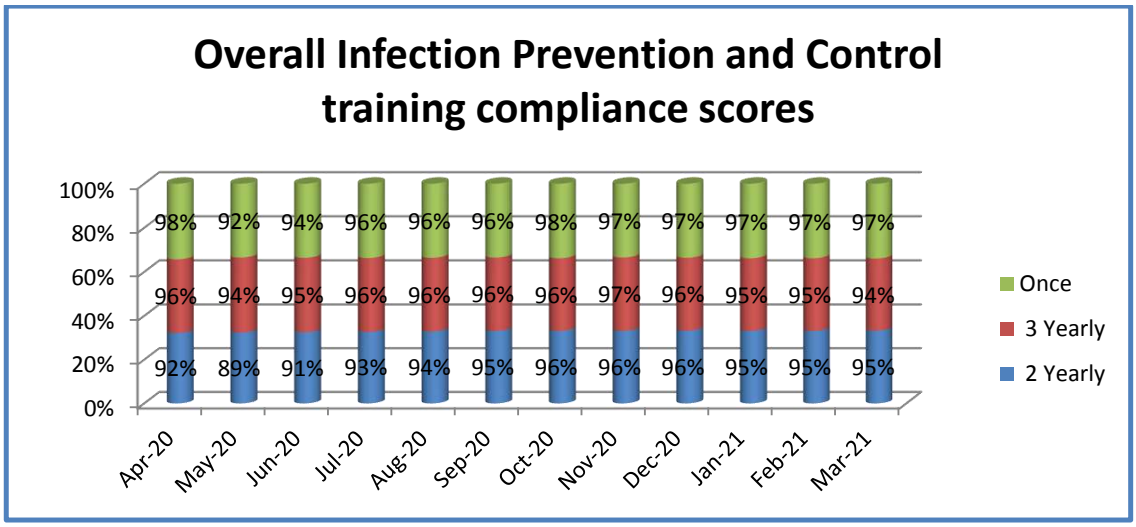
9. Training and education

Training remains high priority on the IP&C team's agenda, providing face to face training for staff or producing the training packages used for core training or e-learning. During the period from the 1 April 2020 to the 31 March 2021, staff were trained in infection prevention and control through a variety of training methods which include:

E-Learning packages	Student nurse infection control training
Ad-hoc drop in	Light box hand hygiene training for in-patient and community team
Face to face taught sessions	Link nurse three monthly updates
Link nurse training and development	Learning from RCA's

The following charts show compliance with mandatory training across the organisation.

Table 7- Trust Overall Infection Control training compliance



Learning and Development send monthly e-mail reminders to those who are out of date and those who are due to expire within the next four months.

The infection control team analyse these figures quarterly for the board report and any areas below target are contacted, either via ward managers or matrons, to inform them of this shortfall.

In addition to the Mandatory training and Link practitioner programme, the IPC team provided training for our Covid 19 cohort ward in the management of patients with Covid 19. They also provided training for the swabbing process for Covid 19, donning and doffing of PPE and Face Fit testing for FFP3 masks.

10. Link nurse practitioners

The majority of inpatient units and community teams have an identified Link Champion in place working in partnership with the senior infection control nurse to provide IP&C support to their clinical areas.

A link Champion training programme facilitated by the Senior Infection Control Nurse is undertaken which enables the link practitioner to train and support staff within their own clinical areas. These sessions provide the skills required to facilitate this role successfully. Link champion update meetings are held on a 3 monthly basis. They act as a communication tool to impart information from board to ward and also offer network opportunities for staff.

11. Needlestick/sharps injuries

Needlestick injuries occur when a needle or other sharp implement penetrates the skin. If the needle or sharp instrument is contaminated with blood or other bodily fluids, there is the potential risk of transmission of infection. Staff experiencing this type of injury risk acquiring Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV).

There were 11 reported cases of sharps injury this year which is slightly higher than the previous year where 8 cases were reported. In all these instances, safety devices were used and sharps injury policy followed.

A new Occupational Health provider, Optima began in June 2020 which provides management of sharps and splash injuries as part of their service provision.

12. Outbreaks / periods of increased incidence

Outbreaks

Nil outbreaks of notifiable diseases or gastro intestinal diseases. Covid outbreaks are discussed later in report.

13. MRSA screening

The Department of Health and Social Care (DHSC) requires all NHS trusts to record methicillin-resistant staphylococcus aureus (MRSA) screening data for elective and emergency admissions. Within mental health, there are no elective patients; therefore, the DHSC has identified incidents of greater clinical risk for admissions to Mental Health providers.

The screening criterion for new admissions within KMPT is as follows:

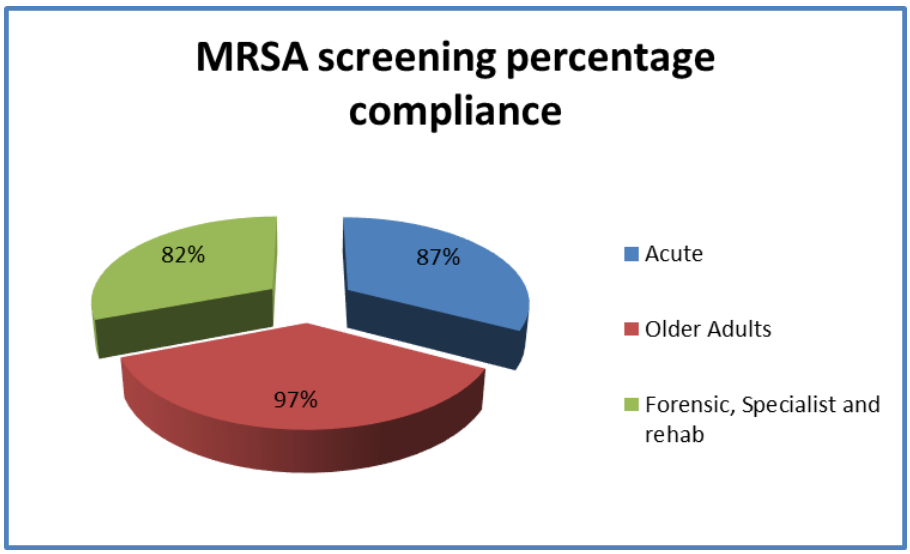
- service users who are admitted to mental health wards or units having had surgery or any surgical procedures
- any service user who was transferred from an acute trust
- service users who misuse drug intravenously
- service users who self-harm
- service users with chronic wounds, e.g. leg ulcers or have a catheter or any other indwelling device.

MRSA screening figures

MRSA screening figures are discussed at each Trust wide Infection Prevention Control Group meeting with actions to care group representatives in those areas that have reduced levels of screening.

The target for MRSA screening is 100 per cent, but due to the nature of our service users' mental health presentation, people may refuse the swabbing procedure at times. This is monitored via the Senior Infection Control Nurse.

Table 8- MRSA screening compliance



MRSA bacteraemia

There were no reported cases of MRSA bacteraemia (MRSA bloodstream infection) during this time period. The last case reported was October 2011.

14. Sepsis

Sepsis is a medical emergency with a high mortality rate. It is often under-recognised and frequently under-treated. The successful management of sepsis requires a high index of suspicion and early recognition. Patients cared for within their own home or within inpatient settings must be identified and treatment initiated quickly to improve outcomes.

Sepsis awareness is promoted in the organisation by annual training updates for clinical staff within Cardio Pulmonary Resuscitation (CPR) and Immediate life support (ILS) training in

conjunction with the Sepsis screening tool on our NEWS2 (National Early Warning Score) charts. There is also a sepsis policy available for reference on the Trust's intranet.

There were 9 reported incidences of suspected sepsis within the Trust for 2020-2021. This is an increase from 4 in the 2019-2020 period which indicates an increased in awareness. All patients were identified using NEWS 2 and transferred in a timely manner to the local Acute hospital for management.

15. Decontamination

The IP&C team work closely with the Medical Device Co-ordinator to ensure that sufficient guidance is available to staff on the safe methods of decontamination for medical devices. This is to protect all staff and service users from the transmission of micro-organisms from medical devices, associated consumables and materials used in the physical assessment, treatment, diagnosis and care of our service users.

Cleaning

The following report gives assurance that cleaning standards are reviewed and audited across the Trust in line with NHS cleaning standards.

Cleaning audits are carried out in compliance with NHS requirements:

- All mon-patient sites are audited on a twice-yearly basis.
- Outpatient sites to be audited on a quarterly basis
- In-patient Areas will be audited on a quarterly basis.
- Kings Renal Unit will be audited on a Monthly basis.

When a site falls below the proposed standard it must obtain one consistent pass mark at the higher level before it reverts back to the proposed schedule. This would be carried out the following month. The results are discussed at the trust infection prevention and control group meetings bi-monthly.

80 cleaning audits were completed in Outpatient sites from June 2020 to December 2020. April to May 2020 no audits were completed due to Covid. January 2021 to March 2021 no audits were completed due to Covid.
The highest scoring sites for consistent results were: Trevor Gibbins Unit Café 100%, Britton House at 99%, Beech House 98%, Twistleton Court 97%, Darent House 96%; between June – December 2020. The following sites also achieved good scores for cleanliness: Albion Place, Arndale House, Archery House Hydro Pool, Kings Road, Kings Renal Unit, Thanet Mental Health Unit sites. Some sites had a low overall score due to Estate issues, for example; Disablement Service Centre (DSC), Laurel House & Coleman House but the cleaning scores were high.
The lowest scoring site was 71% (Littlebrook Outpatients Admin). This included 2 revisits at Littlebrook Outpatients Admin for cleaning issues for the timeframe above.

16 of the cleaning audits were completed in Admin/hub sites. The highest score was Chris Ellis 98%, Magnitude 97%, Trevor Gibbins Unit Forensic Outreach and Liaison Service 97%. The lowest scoring site was Trinity Research Centre at 55%. This included 1 revisit for cleaning issues for the time frame above.

89 of the cleaning audits were completed in Inpatient sites. The highest score of 100% (St Martins Off ward Therapeutic area, The Grove, TGU Bedgebury. Ruby Ward, Priority House, TGU Walmer, so many of the sites have worked consistently hard at achieving the cleaning standards during the pandemic and should be proud of their accomplishments. For those that had a low cleaning score, they have rectified any issues at hand.

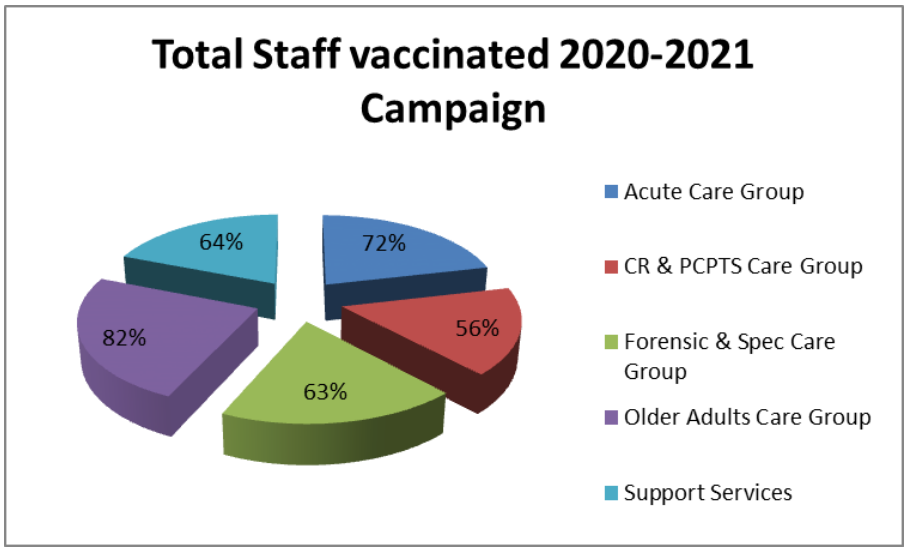
In addition to the usual cleaning, the hotel service team have undertaken extra duties in response to the Covid 19 pandemic. They have increased cleaning of high touch points making sure to maintain effective cleaning standards such as door handles, chairs, toilets, hand rails as well as additional deep cleans after an outbreak or when a covid positive patient is removed from isolation.

1727 deep cleans took place in January and February. All 4 sites were conducted by substantive staff and used minimal agency cover in cases of short-term absence related to Covid. All staff worked really hard to ensure the standards were maintained and this included changing the SOP so hotel services staff cleaned bedrooms when there was a covid case.

16. Seasonal influenza campaign

The 2020/2021 Flu Campaign was our most successful in the last few years. The CQUIN target for the 2020/2021 campaign was set at 90%. Despite being unable to hold large flu clinics this season due to Covid-19, KMPT InFLUencers have worked remarkably hard to achieve 67% which is an increase on 2019/2020 final total of 62%. The table below shows percentages of staff vaccinated per Care Group.

Table 9- Total staff vaccinated 2020-2021



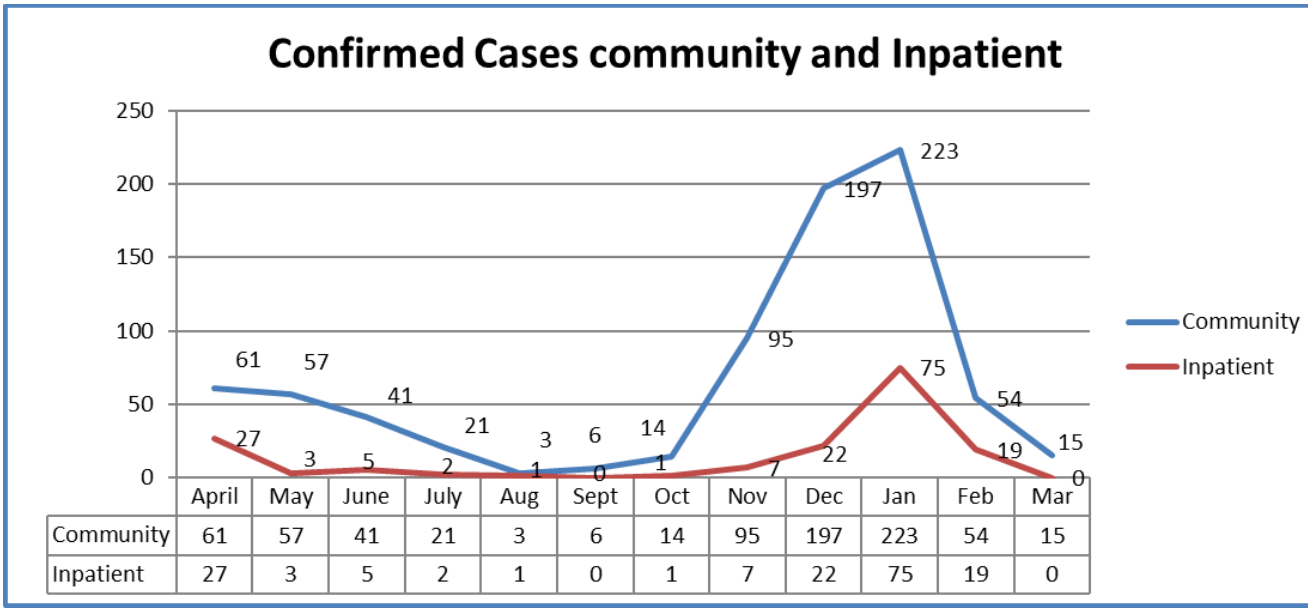
Covid19 Pandemic

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease was first identified in December 2019 in Wuhan, the capital of China's Hubei province, and has since spread globally, resulting in the ongoing 2019–20 coronavirus pandemic. Common symptoms include fever, cough, and shortness of breath. Other symptoms may include fatigue, muscle pain, diarrhoea, sore throat, loss of smell, and abdominal pain. The time from exposure to onset of symptoms is typically around five days but may range from two to fourteen days

The World Health Organisation declared Covid 19 a pandemic on 11th March 2020. KMPT reported their first suspected inpatient case on 13th March 2020.

In response to the pandemic, the IPC team began a 7 day working rota to fully support the organisation. They provided expert advice and guidance for the organisation, in conjunction with Department of health guidelines, and developed many standard operating procedures to provide guidance to the Trust. They liaised directly with colleagues across the Kent and Medway network and the UK as a whole.

Table 10- Confirmed Covid-19 cases



	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Community	61	57	41	21	3	6	14	95	197	223	54	15
Inpatient	27	3	5	2	1	0	1	7	22	75	19	0

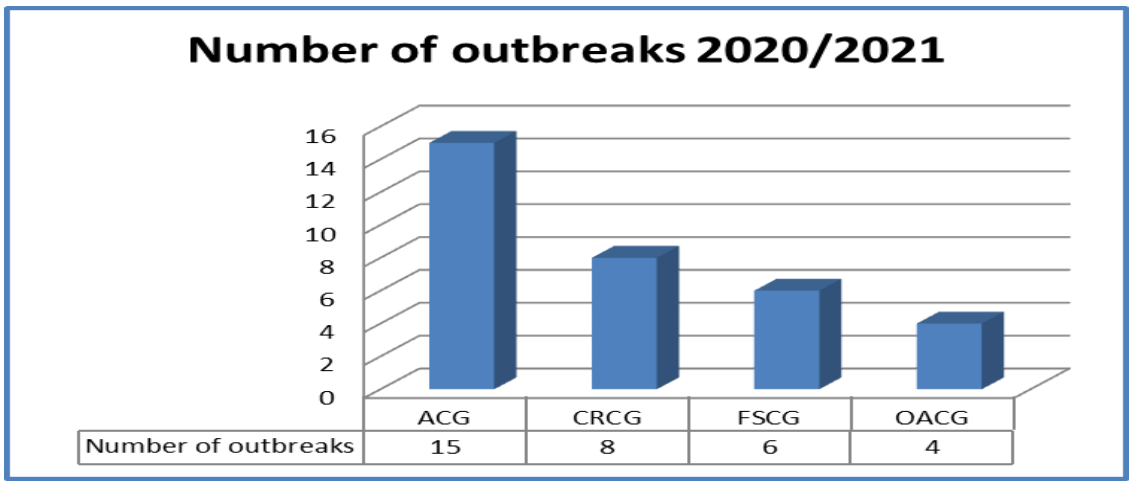
All patients are isolated following government recommended timeframes. A cohort ward was opened in North Kent for new positive admissions and those patients unable to successfully isolate due to the mental health condition.
PPE is being provided centrally by our procurement team, overseen by the infection control team. A number of Standard Operation Procedures were developed as previously listed to support staff across the organisation.

In response to the pandemic, KMPT developed a number of systems and processes to manage the Covid 19 pandemic. These were established in conjunction with the National Major incident level 4 response led my NHS England and Public Health England. Command and control was established across the entire NHS and guidance was received nationally, regionally and disseminated locally. Within the Trust a range of standard operating procedures were developed and approved. The IPC team worked collaboratively with the information and performance team to identify suspected and positive Covid 19 patients via RiO, KMPT's web-based clinical system and this information is reported daily for community and inpatient services back in to the National reporting system and identified personnel within KMPT. Command and control continues and the Trust is adapting procedures as new guidance is received.

Outbreaks are defined as two or more cases on a ward/unit of the same type related in time and place. KMPT saw only 2 outbreaks in Covid at the beginning of the Pandemic but saw an increase from November 2020 where we saw 31 outbreaks. These were monitored closely by the IP&C team who provided support and guidance to manage the outbreak with regards to ventilation, PPE use and increased testing for all staff and patients. IP&C also externally reported on these outbreaks daily to the CCG and the Outbreak portal. These outbreaks are treated as Serious Incidents and root cause analysis investigations are conducted for each

incident. Any actions identified were completed and lessons learned communicated back to the ward. The IPC team continued to work additional hours on demand.

Table 11-Covid 19 outbreaks



Fit testing

As of December 2021, KMPT had 864 staff fit tested on 3M FFP3 masks required for aerosol generating procedures. We were informed from the National PPE cell that the supply of 3M masks represented a fraction of demand for these masks and therefore there was a requirement for Trusts to move to a mask that had enduring supply and is UK made due to intermittent export bans of various masks. This required all staff fit tested on these masks to be re-fit tested. This was co-ordinated by the IPC team and carried out by Fit testers within teams across the Trust in additional to their usual workload.

17. Conclusion

Within 2020-2021, the IP&C team maintained and improved the standards of care for our patients in relation to infections.

Auditing current infection prevention and control systems, processes and practice ensures a continual progression of quality improvement. This results in change to clinical practice and makes certain that all staff are trained to a high standard. This has been achieved by working collaboratively with internal and external stakeholders across the whole system.
Covid-19 has had a large impact on KMPT and the NHS as a whole. It has had a positive effect on streamlining working practices and the use of technology. The infection control team quickly moved to prioritising Covid 19 support and guidance. Operational teams across the organisation are working collaboratively to provide and disseminate information and offer support to all staff in regards to infection control measures.
The infection control team continue to support monitoring for infections across the Trust, working additional hours on demand. KMPT staff are to be commended for their resilience and care for our clients.

Appendix A

Infection Prevention and control Team work Plan

2021-2022

Purpose

This programme sets out the Infection Prevention Control programme for the forthcoming year working closely with the Estates and Facilities Team while building up the Link nurse role.

- The overall key aim will to be to achieve compliance with requirements of the Health and Social Care Act 2012 – Code of Practice for health and adult social care on the prevention and control of Infections and related guidance and CQC Fundamental Standards CQC (Registration) Regulations 2009 - Regulation 12 – Safe care and treatment

The programme identifies the Infection Prevention Control (IPC) activities that the Team will focus on for the coming year. All areas are expected to follow existing IPC activities, policies, procedures and guidelines

The main focus for this year will be:

- To monitor the rates of infections for both national and local reporting requirements.
- The increased and ongoing education of staff in Infection Prevention and Control practices
- Monitoring practices and processes through audit
- The improving of staff awareness of hand hygiene and PPE use
- To proactively work with Care Groups to manage Infection prevention and control issues

Trust Board - Public-30/09/21

The method of achieving this will be as follows

	Area to address	Action Required	Timescale	By whom
1.	Demonstrate compliance with all IPC policies	Review all IPC policies in line with current evidence base ensuring it is user friendly Ensure that the IPC policy folder on i-connect is kept up to date Audit compliance with policies through Trust Wide infection control annual audit	Ongoing Ongoing Yearly	Infection Prevention and Control Team Infection Prevention and Control Team Ward managers/Matrons
2.	Surveillance of alert organisms and conditions	Provide quarterly information to the Trust Board on alert organisms and conditions via Trust Wide Patient safety group. Surveillance to be included in annual report Report any conditions /organisms as required to PHE and CCGs	Quarterly Yearly As required	Infection Prevention and Control Team Infection Prevention and Control Team Infection Prevention and Control Team

		Monitor clusters of cases of communicable diseases and make recommendations to stop ongoing transmission as required. Support ward managers with Learning Reviews for all outbreaks within the wards and report back to the Trust wide Patient safety Group and CCGs Provide advice and education to all staff with regards to sending clinical samples to confirm presence of infection Continue to monitor Covid 19 instances and provide expert advice to the Organisation	As required As Required As required Ongoing	Ward managers/ Infection Prevention and Control Team Infection Prevention and Control Team Infection Prevention and Control Team
3.	Outbreaks of infection	Ensure that the IPC database is kept up to date and reporting is accurate.	Ongoing	Infection Prevention and Control Team Infection Prevention and

		Attend debrief meeting after an outbreak and disseminate any lessons learned Continue to monitor Covid 19 instances and provide expert advice to the Organisation	As required Ongoing	Control Team Infection Prevention and Control Team
4.	Infection Control Champions	To continue to recruit new Link Champions from operational care groups and to maintain a database for every area To provide coaching to all Link champions To hold regular Link champions Study Days To provide regular communications and briefings to Link champions via email. To provide up to date training materials for Link	Ongoing Ongoing Quarterly Ongoing Ongoing	Infection Prevention and Control Team/ Heads Of Nursing for each Care Group Infection Prevention and Control Team Infection Prevention and Control Team Infection Prevention and Control Team Infection Prevention and Control Team

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		champions		
5.	Education and Training	Support staff that are using the IC 'e' learning program. Provide onsite Infection Control training as required. Develop new ways of delivering IC training in conjunction with the L+D department Ensure all relevant staff are aware the appropriate use of personal protective equipment. Face FIT testing for FFP3 masks	Ongoing As required Ongoing Ongoing Ongoing	Infection Prevention and Control Team Infection Prevention and Control Team Infection Control Link Staff/IC Champions Infection Prevention and Control Team Infection Prevention and Control Team
6.	Audits	Depending on need, IP&C Team will audit services when a critical issue has been identified and on an ad hoc basis. To disseminate audit tools for Trust wide infection control Annual audit to all	As required Yearly	Infection Prevention and Control Team Infection Prevention and Control Team

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		wards and CMHT's that have service users visiting. This will include the annual mattress audit.		Infection Prevention and Control Team
		To ensure that hand hygiene audits are completed and reported	Monthly	Infection Prevention and Control Team
		Ensure all antimicrobial prescribing is fully monitored by Pharmacy	Yearly	Infection Prevention and Control Team and Pharmacy
		Audit Results to be part of the annual report	Yearly	Infection Prevention and Control Team
7.	New builds and refurbishments	Estates and Facilities to ensure the Infection Control Team are informed of and involved in the development and planning to ensure all standards are met	As required	Infection Prevention and Control Team
8.	Staff Health and Safety	Continue to audit and review of sharps incidents and the subsequent actions taken by all Care Groups concerned.	Ongoing	Infection Prevention and Control Team /Matrons and ward managers
		This is to be reported to the Trustwide	Ongoing	Infection Prevention and Control Team

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		Infection Control group. Increase compliance of safety needles.	Ongoing	Infection Prevention and Control Team

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9.	Seasonal Influenza Campaign	To lead on the Flu campaign for the Trust To Procure the Flu vaccinations To ensure that communications are involved within the campaign To ensure that all flu vaccinations data is given to workforce in a timely manner To obtain "Flu Champions" across the Trust To support training staff in the giving of vaccinations To co-ordinate clinics/visits across the Trust	Sept 2021 – Mar 2022 March 2021 – Sept 2022 July 2010 – January 2022 Sept 2021– Feb 2022 August 2021 – January 2022 August 2021 – January 2022 July 2021 – January 2022	Lead Nurse, Physical Health /Infection Prevention and Control Team Communications Operational Care groups/Heads of Nursing and Clinical Directors
10.	Procurement	Make recommendations available for approved products used To keep preferred list of products up to date	Ongoing Ongoing	Infection Prevention and Control Team in collaboration with the Medical Devices Co-ordinator Infection Prevention and Control Team

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Appendix B **KMPT ASSURANCE FRAMEWORK COMPLIANCE 2021/2022**

Development Plan for Infection Prevention and Control to meet the Health and Social Care Act's (2012) Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance

Compliance Criterion 1 – Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and others may pose to them.					
1.1 Appropriate management and monitoring arrangements should ensure that:	**Self-assessment**	**Description for compliance**	**Actions**	**responsibility**	**Progress**
• A board level agreement outlining the boards collective responsibility for minimising the risk of infections and the general means by which it prevents and controls such risks	Infection Prevention and Control (IP & C) policy in place. Trust Wide infection Prevention and Control Group in place. Quarterly reports to through the Trust quality governance meetings	Demonstrates sign up by the board of directors. The report is submitted quarterly	Reports to Board Committees which incorporate minutes from the Trust IP & C Group	Executive Director of Nursing and Quality/DIPC	

• The designation of a DIPC who is accountable directly to the CEO and the board	Appointment of the Executive Director of Nursing and Quality/DIPC	DIPC in place job description reflects roles and responsibility.	None Required	CEO	
• The mechanism by which the board intends to ensure that sufficient resources are available to secure the effective prevention and control of infection.	IQPR report	Within the board IQPR IPC BAF	None Required	Executive Director of Nursing and Quality/DIPC	
• Ensuring that relevant staff, contractors and other persons receive suitable training and information and supervision in, measures required to prevent and control risks of infection	Face to face training is provided for staff, as is Corporate induction and e-learning for clinical and non-clinical staff. Record of staff attendance to training is kept by the L & D department. Training Policy identifies levels of training needed for staff. Link nurses meetings for the Trust	Training records All contractors have a letter. Visitors Ward closure signs when necessary	Learning and Development Department to monitor the number of staff undertaking the training Managers to ensure attendance of the link nurse meetings	Learning and Development Dept Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice/DDIPC Heads of Nursing Service Managers /Matrons. Head of Facilities	
• A programme of audit to ensure key policies and practice are being	IP & C Audits are carried out in all service areas annually.	Demonstrates annual audit of compliance on a site by site basis	Implement all audit recommendations	Executive Director of Nursing and Quality/DIPC,	

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implemented appropriately	Monthly Hand Hygiene Audits for Older Adults Annual Trust wide Mattress audits Annual audit of Transfer of Care Infection Control Documentation. PLACE visits		Implement PLACE action Plans Quarterly Cleaning audits Implement Hand hygiene Audit Action plans	Deputy Director of Nursing and Practice/deputy DIPC Infection Prevention and Control Team (IP&C) Heads of Nursing Service Managers/Matrons Hotel Services	
• A policy addressing where relevant the admission transfer discharge and movement of patients between depts. and between healthcare facilities	Trust wide Infection Prevention and control policy	Clearly outlines the process for checking HCAI's on transfer of care/admissions.	Ensure the Transfer check list is used Monitor the HCAI transferred into the Trust from the Acute Trusts	Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice/deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	
• Designation of a decontamination lead	The Deputy Director for Nursing/Deputy DIPC is the lead for decontamination	The Deputy DIPC works closely with the Medical Devices Manager	To be monitored through the medical devices meeting and infection prevention and control meeting minutes	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and	

				Practice/Deputy DIPC Medical Devices Manager	
1.2 Risk Assessment **A registered provider should ensure that it has:** • made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention and control of infection • identified the steps that need to be taken to reduce or control those risks • recorded findings in relation to the first two points; • implemented the steps identified and put appropriate methods in place to monitor the risks of infection to determine whether further steps are	Covered by the audit and service action plans. Quarterly board report Trustwide infection control annual audit MRSA management and Screening Policy Transfer of Care infection control documentation form All suspected/confirmed infections reported to the IP & C Team	Yearly Trustwide infection control audit to risk assess and ensure compliance with the Hygiene Code and to provide support to services		Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice/Deputy DIPC Heads of Nursing Service Managers/ Matrons IP & C Team	

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needed to reduce or control infection.					
1.3 The role of the DIPC in NHS provider organisations is to: • be accountable directly to the chief executive and to the board (but not necessarily a member of the board) • be responsible for the organisation's infection prevention and control team (IPT) or infection control team (ICT) • oversee local prevention and control of infection policies and their implementation; • be a full member of the IP&C Team and regularly attend its infection prevention	In DIPC job description Chairs Trust wide IP & C group Antimicrobial Prescribing and Management Policy	Demonstrates compliance to Hygiene Code Minutes of Patient Safety Group meetings Minutes of Trust wide Infection Control Meetings Minutes of CCG meetings	None required	Executive Director of Nursing and Quality/DIPC	

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and control meetings; • report directly to the NHS board and, in non-NHS care settings, the registered provider; • have the authority to challenge inappropriate practice and inappropriate antibiotic prescribing decisions; • assess the impact of all existing and new policies on infections and make recommendations for change; • be an integral member of the organisation's clinical governance and patient safety	Through trust wide audit Annual DIPC report produced	Minutes of Patient safety and Governance meetings			

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teams and structures; and • produce an annual report and release it publicly as outlined in *Winning ways: working together to reduce healthcare associated infection in England.*					
1.5 Assurance Framework • regular presentations from the DIPC and/or the IP&C team to the board. These should include a trend analysis for infections and compliance with audit programmes; • quarterly reporting to the NHS board or registered provider by clinical directors and matrons (including nurses who do not	Assurance Framework in place RCA's and audits performed Outbreak Management Team IP & C Team to support and advise ward on actions to take	Assurance Framework monitors compliance to the Hygiene Code. It is monitored by the IP & C Team and the Trust wide Infection Control group. Service Managers/ Matrons monitor and update this through the modern matron forums. The IP&C team provide quarterly reports to the board that is shared with the Matrons at the 6 weekly meetings providing a 2 way sharing of information process, demonstrating that	To be monitored through the board, IC meetings, Service Managers/Matrons Meetings Link nurse Meetings Service Managers to produce a quarterly report to the Board.	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons	

hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the patient or the patient's environment); • a review of statistics on incidence of alert organisms (for example, but not limited to, meticillin-resistant *Staphylococcus aureus* (MRSA) and *Clostridium difficile*) and conditions, outbreaks and serious untoward incidents • evidence of appropriate action taken to deal with occurrences of infection including, where applicable, root cause analysis; and	SI meetings / minutes of meetings IP&C investigate RCA and report findings to Trustwide Infection Group who cascade any learning throughout the Trust and the SI Risk Manager.	infection prevention and control are an integral part of quality assurance			

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• an audit programme to ensure that policies have been implemented;					
1.7 The infection prevention and control programme should: • set objectives that meet the needs of the organisation and ensure the safety of service users; • identify priorities for action; • provide evidence that relevant policies have been implemented to reduce infections; and • if appropriate, report progress against the objectives of the programme in the DIPC's annual report or the IPC Lead's annual statement.	Trust Wide Infection Prevention and Control group Infection Control Link Nurse Meeting minutes Matron Meetings Quarterly Board reports Data Surveillance Monthly Hand Hygiene observational audit for Older adults MRSA Screening data and Infection database Monthly training stats IP & C audits	Demonstrates compliance with Hygiene Code	Continue with IP & C programme	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team	
1.8 Infection control infrastructure An infection prevention and control infrastructure should encompass:	Trust Wide Infection Prevention and Control group Infection Control Link Nurse Meeting minutes	Demonstrates surveillance of HCAI's, monitoring of database, cleanliness standards and collaboration with the Health Protection Agency, Primary Care Trusts	Continue with IP & C infrastructure	CEO Executive Director of Nursing and Quality/DIPC	

• in acute healthcare settings, for example, an IP&C team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and control) and appropriate administrative and analytical support, including adequate information technology – the DIPC is a key member of the IP&C team; • in other settings, there will be an infection control nurse (ICN) or another designated person who is responsible for infection prevention and control matters and has access to specialist expertise as necessary; and • 24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/communicable disease control. The registered provider should know how to access this advice.	Matron Meetings Quarterly Quality Committee reports Data Surveillance Access to Consultant/expert at KHPU 24hours via local acute hospital switchboard out of office working hours. SLA with Consultant Microbiologist ay MTW Transfer of Care Audit	and Acute Trusts and trust staff The link nurse meetings Demonstrate a Trust wide management system for both dissemination, imparting & collection of information to clinical staff and provide support from senior Infection Control staff		Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team	

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1.9 Movement of patients There should be evidence of joint working between staff involved in the provision of advice relating to the prevention and control of infection; those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers, discharges and movements between departments; and within and between health and adult social care facilities. Where necessary, ambulance providers, hospitals and primary care trusts (PCTs) may need to be involved in such planning	Transfer check list Transfer of Care Infection Control documentation Audit	Transfer of patients from and to the Acute Trusts and nursing homes incorporated within the IP&C policy	To be monitored through the Service Managers/Matrons meetings and IP & C trust wide group	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads od Nursing IP & C Team Service Managers/ Matrons Ward Managers	
1.10 A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, or from a service user's home, so that any risks to the service user	Transfer check list and discharge letter Transfer of care infection Control documentation audit	Transfer of patients from and to the Acute Trusts and nursing homes incorporated within the IP&C policy	To be monitored through the Service Managers/Matrons meetings and IP & C trust wide group	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team	

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and others from infection may be minimised. If appropriate, providers of a service user's transport should be informed of any infection.				Service Managers/Matrons Ward Managers	

Compliance Criterion 2 – **Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections**					
2.1 With a view to minimising the risk of infection, a registered provider should normally ensure that:	**Self-assessment**	**Description for compliance**	**Actions**	**responsibility**	**Progress**
• it designates leads for environmental cleaning and decontamination of equipment used for diagnosis and treatment (a single individual may be designated for both areas)	Hotel Services responsible for cleaning Hotel Services managers in each directorate Service Managers/ Matrons responsible for ensuring that ward equipment is decontaminated Decontamination of medical devices	Ensures partnership working with hotel services in cleaning standards for all buildings Ensures decontamination issues for mental health addressed. Operational Cleaning Policy Board Reports Medical Devices Meetings	Hotel Services to monitor cleaning and contract cleaners Unannounced Visits Monitor/report to the IC committee Service Managers/Matrons to ensure that all medical devices e.g. commodes/beds/hoists are decontaminated in	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP&C Team Service Managers/Matrons	

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	identified in the Safe Management of Medical Devices policy and Decontamination policy		accordance with manufacturer's guidance.	Medical Devices Manager	
• The designated lead for cleaning involves directors of nursing, matrons and the ICT or persons of similar standing in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level. In other settings, the designated lead for cleaning will need to access appropriate advice on all aspects of cleaning services	All aspects of cleaning services are discussed in the Trust wide Infection Prevention & Control Group in which the Deputy Director of Nursing and Practice, the Infection Prevention & Control Team and Service Managers/Matrons attend.	Ensures partnership working with hotel services in cleaning standards for all buildings	Continue to involve Deputy Director of Nursing and Practice, Service Managers/Matrons and the IP & C Team in all aspects of cleaning services	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC IP & C Team Service Managers/ Matrons Hotel Services	
• It has policies for the environment that make provision for liaison between the members of the ICT and the	PLACE assessment undertaken by facilities, clinical staff and IC staff.	Hotel Services and Facilities as members of the I.C. committee	Continue with PLACE assessments Monitor attendance	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and	

persons with overall responsibility for facilities management;	Hotel Services attend all IP & C meetings at Trust and local level Attendance to IC Link meetings Overarching policy re link with IP & C team			Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons Hotel Services	
• in healthcare, matrons or persons of a similar standing have personal responsibility and accountability for delivering a safe and clean care environment	Service Managers/ Matrons are aware of responsibilities and accountabilities (Job Description's and IP & C policy) Nurse in charge of shift is aware of responsibility regarding cleanliness standards during their shift	This was included in the Service Manager's Job Description's during the Care Group restructuring.	To ensure that accountability and responsibility continues to be reflected in job descriptions	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons Hotel Services Nurse in Charge of Shift	

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				Human Resources Service line directors	
• The cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning frequencies is publicly available;	Cleaning schedules are openly displayed on public view on each ward/unit Trust wide	Demonstrates standards of cleanliness for each area Trust Wide	Monitored through PLACE inspection	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons Hotel Services	
• There is adequate provision of suitable hand-washing facilities and water based hand sanitisers	Individual water based hand sanitisers for staff available Hand hygiene notices above all clinical sinks	Hand Hygiene Audits are now carried out Trust wide annually to monitor compliance Hand Hygiene Link Nurses/ workers on each ward/unit promote good hand hygiene techniques and practices for all staff, patients and visitors	IP & C Training Hand hygiene Audit Mobile Sink Unit	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC	

		Trust Infection Prevention and Control training includes the importance of good hand hygiene techniques and practices. This is demonstrated by the use of UV light boxes.		Heads of Nursing IP & C Team Service Managers/Matrons Hotel Services	
• There are effective arrangements for the appropriate decontamination of instruments and other equipment – these should be incorporated within appropriate disinfection and decontamination policies;	Hotel Services responsible for cleaning Hotel Services managers in each directorate Service Managers/Matrons responsible for ensuring that ward equipment is decontaminated Board Reports	Decontamination of medical devices identified in the Safe Management of Medical Devices policy Service Managers/Matrons responsible for ensuring that ward equipment is decontaminated The IP & C Team promote the use of single patient items and single use items e.g. hoist slings, nail clippers, medicine pots	Hotel Services to monitor cleaning and contract cleaners for cleaning of beds/hoists/commodes Monitor/report to the IC committee Service Managers/ Matrons to ensure that commodes/beds/hoists are decontaminated in accordance with manufacturer's guidance.	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP&C Team Service Managers/ Matrons Medical Devices manager	

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2.2 All parts of the premises in which it provides healthcare are suitable for the purpose, kept clean and maintained in good physical repair and condition;	Cleanliness reports following quarterly cleaning audits and Trust wide monitoring. The report identifies PLACE assessment undertaken by facilities, clinical staff and IP & C staff. Infection Prevention and Control Annual Audit Hand Hygiene Audit	Demonstrates quarterly cleaning audits and trust wide monitoring. Also shows SHA deep cleaning returns	Continue to monitor standards of cleanliness and maintenance through the audit process	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP&C Team Service Managers/Matrons Hotel Services Estates & Facilities	
2.3 Premises and facilities should be provided in accordance with best practice guidance. The development of local policies should take account of infection prevention and control advice given by relevant expert or advisory bodies	Operational Cleaning Policy Food hygiene policy Control of Legionella bacteria in Trust Premises policy and procedure	Demonstrates compliance with the Hygiene Code	Update policies when required	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC	

or by the ICT, and this should include provision for liaison between the members of any ICT and the persons with overall responsibility for the management of the service user's environment	Policy for management of asbestos containing materials in trust Properties including asbestos management plan Uniform and work wear policy Standard (Universal) Precautions Policy IP & C policy (infected linen) And Service Level Agreements (SLA) with Acute Hospital Trusts Standard (Universal) Precautions Policy. Linen discussed in IP & C training Waste Management policy			Heads of Nursing IP&C Team Service Managers/ Matrons Hotel Services Estates & Facilities	

Compliance Criterion 3 – **Provides suitable accurate information on infections to service users and their visitors**					
	Self assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**

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3.1 Areas relevant to the provision of such information include: • general principles on the prevention and control of infection and key aspects of the registered provider's policy on infection prevention and control, which takes into account the communication needs of the service user; • the roles and responsibilities of particular individuals such as carers, relatives and advocates in the prevention and control of infection, to support them when visiting service users; • supporting service users' awareness and involvement in the safe provision of care; • the importance of compliance by visitors with hand hygiene; • the importance of compliance with the registered provider's policy on visiting;	KMPT IP & C website available to service users/relatives/carers on the following link http://www.kmpt.nhs.uk/infectioncontrol Infection Prevention and Control leaflets are available to patients, visitors and staff on the following subjects: C. diff, MRSA, Noro virus, IP & C Team, guide for patients and a guide for visitors about infection prevention. Admission, transfer, discharge and movement of service users is addressed in the Infection Prevention and control policy Signage Outbreak is defined in the Infection Prevention and Control Policy Management of a patient with a	Demonstrates full compliance with DH guidance	Ensure that the Admission ,transfer, discharge and movement of service users form is completed as per Trust policy Ensure that signs and information displayed is current To be monitored through the Service Managers/Matrons meetings and IC trust wide group	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of nursing IP&C Team Service Managers/Matrons Ward Managers Hotel Services	

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• reporting failures of hygiene and cleanliness; • explanations of incident/outbreak management.	transmissible infection policy Board minutes are available for patients, public and staff Patients and carers are encouraged to report concerns regarding infection prevention and control to staff. Concerns regarding hygiene and cleanliness can be reported to the Ward Manager, Matron and the Infection Prevention and Control Team. The IP & C Team can be contacted via email and/or phone by patients, visitors or staff. Whistle blowing policy can be used				
3.2 Information should be developed with local service user representative organisations, which could include Local Involvement Networks (LINks) and Patient Advice and Liaison Services (PALS).	Service user involvement requested through PALS managers for IP & C meetings Links involvement	Demonstrates full compliance with DH guidance	To be monitored through the Service Managers/ Matrons meetings and IP&C trust wide group	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and	

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				Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons	

Compliance Criterion 4 – Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**
4.1 A registered provider should ensure that: • accurate information is communicated in an appropriate manner; • this information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection; and	IP & C Transfer of care documentation check list Outbreaks are communicated to Public health England. and adjacent acute Trust's DIPC/IP & C Team	Transfer of patients from and to the Acute Trusts/our Trust and nursing homes incorporated within the IP&C policy Annual Trust wide Transfer of Care Infection Control Documentation audit	To be monitored through the Service Managers/ Matrons meetings and IC trust wide group	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team	

• where possible, information accompanies the service user.					
4.2 Provision of relevant information across organisational boundaries is covered by the regulation requirement 'Co-operating with other providers'. Due attention should be paid to service user confidentiality as outlined in national guidance and training material.	Care Programme Approach documentation Outbreaks are communicated to Public Health England and adjacent acute Trust's DIPC/IP & C Team	CPA documentation would record relevant Infection Control issues and enable this to be shared with relevant professionals.	Ward manager via internal records audits.	Ward Managers/clinical staff Heads of Nursing IP & C Team	

<u>Compliance Criterion 5</u> – Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**
5.1 Registered providers, excluding personal care providers, should ensure that advice is received from suitably informed practitioners and that, if advised, registered providers should inform	Outbreaks are communicated to Public Health England and adjacent acute Trust's DIPC/IP & C Team	Demonstrates Compliance as per national and local policy	Ensure that all IP & C policies, reflect any changes in legislation, standards and guidance. Ensure all staff attend IP & C training and the Learning and	Ward staff/Ward Managers Service Managers/Matrons	

their local health protection unit of any outbreaks or serious incidents relating to infection.	Reporting flow chart with contact details are provided to all teams IP & C policy, Hand Hygiene Policy, MRSA and Screening policy, Uniform and Work wear policy, antimicrobial prescribing and management policy, Management of a patient with a transmissible infection policy Policy compliance is monitored in the annual IP & C and Hand Hygiene audits. Board reports which includes infection data surveillance and training figures Infection prevention and control staff training programme Staff have access to IP & C Team and IC link nurses Trust wide.		Development Department to monitor the number of staff undertaking the training Monitoring of infection surveillance data and antibiotic prescribing data IP & C Team to update training programme as required	Heads of Nursing IP & C Team Deputy Director of Nursing and Practice / Deputy DIPC Executive Director of Nursing and Quality/DIPC	

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	Unannounced IP & C visits				
5.2 Arrangements to prevent and control infection should demonstrate that responsibility for infection prevention and control is effectively devolved to all groups in the organisation involved in delivering care.	Roles and responsibilities for all groups identified in the IP and C policy Responsibilities in JD's Infection prevention and control staff training programme IP & C policy, Hand Hygiene Policy, MRSA and Screening, Uniform and Work wear policy, antimicrobial prescribing and management policy, Management of a patient with a transmissible infection policy	Demonstrates Compliance as per national and local policy	Ensure that all IP & C policies, reflect any changes in legislation, standards and guidance. Ensure all staff attend IP & C training and the Learning and Development Department to monitor the number of staff undertaking the training Monitoring of infection surveillance data and antibiotic prescribing data IP & C Team to update training programme as required	Ward staff/Ward Managers Service Managers/Matrons Heads of Nursing IP & C Team Deputy Director of Nursing and Practice / Deputy DIPC Executive Director of Nursing and Quality/DIPC	

<u>Compliance Criterion 6</u> – Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**

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6.1 A registered provider should, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of care co-operate with it, and with each other, so far as is necessary to enable the registered provider to meet its obligations under the Code. 6.2 Infection prevention and control would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and control and obtain 'permission to work'. Confidentiality must be maintained. 6.3 Where staff undertake procedures, which require	Aseptic Non Touch Technique Policy IP & C responsibilities in all JD's via HR and AD's The Control of Legionellae Bacteria in Trust Premises policy MRSA and Screening policy Hand Hygiene Policy Uniform and Work wear policy Standard (universal) precautions policy IP & C information leaflets Competency framework kept by Learning and development department	Demonstrates Compliance as per national and local policy	For Facilities Department to continue to send IP & C information to contractors for them to sign up to Monitor adherence to policies	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons Facilities Department HR Service Line Directors	

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skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently.					

Compliance Criterion 7 – Provide or secure adequate isolation facilities					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**
7.1 A healthcare registered provider delivering in-patient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection. This may include facilities in a day care setting.	The majority of in-patient wards have single sex accommodation. Where there are still bays single rooms are available for isolation purposes Management of a patient with a transmissible infection policy MRSA Management and screening Policy	Demonstrates Compliance as per national and local policy	Continue to monitor compliance through the audit process	Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	

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				Ward Managers	
7.2 Policies should be in place concerning the allocation of patients to isolation facilities, based on local risk assessment. The risk assessment should include consideration of the need for special ventilated isolation facilities. Sufficient staff should be available to care for patients safely.	Management of a patient with a transmissible infection policy MRSA Management and screening Policy Policies are available and accessible to staff, patients and the public as they are placed in each ward/unit or community team setting throughout the Trust	Demonstrates Compliance as per national and local policy	Continue to monitor compliance through the audit process	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons Ward Managers	

Compliance Criterion 8 – **Secure adequate access to laboratory support as appropriate**					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**
A provider should ensure that laboratories used to provide microbiology services in connection with arrangements for infection prevention and control have in place appropriate protocols and that they operate according to the standards required for accreditation by Clinical Pathology Accreditation (UK) Ltd. Protocols should include: ▪ a microbiology laboratory policy for investigation and surveillance of HCAI; and ▪ standard operating procedures for the	SLA with Acute Trust's Microbiology Services	Demonstrates Compliance as per national and local policy	Non required	Finance department	

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examination of specimens.					

Compliance Criterion 9 – Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**

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9a. Standard (universal) infection control precautions • The policy should be based on evidence-based guidelines, including those on hand hygiene and the use of personal protective equipment. • The policy should be easily accessible to all groups of staff, patients and the public. • Compliance with the policy should be audited. • Information on the policy should be included in induction programmes for all staff groups	Infection Prevention and Control Policy Hand Hygiene policy includes 5 moments for hand hygiene at the point of care Standard (Universal) Precautions Policy Policies are available and accessible to staff, patients and the public as they are placed in each ward/unit or community team setting throughout the Trust. Trust wide compliance to IP & C and Hand Hygiene policy is audited monthly in Older adults and a Trust wide Audit report is produced annual. IP & C corporate induction training includes standard precautions and covers epic 2 guidelines for all staff groups	Demonstrates Compliance as per national and local policy	Review of policies to reflect any changes to guidance relating to standard (universal) infection control precautions (should they occur) is ongoing Audit to evaluate Trust wide compliance to policies to continue For IP & C training programme to continue	Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team, Service Managers/ Matrons	

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9b. Aseptic technique • Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis. • Education, training and assessment in the aseptic technique should be provided to all persons undertaking such procedures. • The technique should be standardised across the organisation. • Audit should be undertaken to	Identified in the Trust Infection Prevention and Control policy Staff are trained and evaluated locally Aseptic Non Touch Technique Policy	Demonstrates Compliance as per national and local policy	Review of policies to reflect any changes to guidance relating to aseptic technique (should they occur) will be ongoing	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons	

monitor compliance with the technique.					
9c. Outbreaks of communicable infection ▪ The degree of detail in the policy should reflect local circumstances to take into account at-risk patients and clinical specialties. ▪ Policies for major outbreaks of communicable infection should include initial assessment, communication, management and organisation, and investigation and control. ▪ The contact details of those likely to be involved in outbreak management should be reviewed at least annually. ▪ Significant outbreaks should be reported as serious untoward incidents. ▪ Formal arrangements should be in place to fund the cost of dealing with outbreaks	Identified in the Infection Prevention and Control policy Management of a patient with a transmissible infection policy Pandemic Flu Policy Policies are available and accessible to staff, patients and the public as they are placed in each ward/unit or community team setting throughout the Trust Significant outbreaks of infection are also reported following the SUI process and are followed by root cause analysis (RCA) using the National Patient Safety Agency's RCA tool	Demonstrates Compliance as per national and local policy		Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	

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9d. Isolation of patients ▪ The isolation policy should be evidence-based and reflect local risk assessment of in-patients. ▪ Indications for isolation should be included in the policy, as should procedures for the infection control management of patients in isolation. ▪ Information on isolation should be easily accessible to all groups of staff, patients and the public	Management of a patient with a transmissible infection policy Policies are available and accessible to staff, patients and the public as they are placed in each ward/unit or community team setting throughout the Trust Single Bedrooms available in most wards/units	Demonstrates Compliance as per national and local policy	Continue to monitor compliance through the audit process and IP & C unannounced visits	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	
9e. Safe handling and disposal of sharps Relevant considerations include: ▪ risk management and training in prevention and management of needlestick injuries; ▪ provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe	Waste Management policy Standard (Universal) Precautions policy Taking Specimens for Microbiological Investigations policy Venepuncture Policy Management of Sharps injury/splash incidents Policy The use of safety needles by clinical staff	Demonstrates Compliance as per national and local policy		Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice/ Deputy DIPC Heads of Nursing IP & C Team	

systems of working for healthcare workers; ▪ policy that is easily accessible to all groups of staff; ▪ auditing of policy compliance; and inclusion of information on the policy in induction programmes for all staff groups.	are being used Trust wide. Policies are available and accessible to staff, patients and the public as they are placed in each ward/unit or community team setting throughout the Trust All IP & C staff training programmes, including corporate induction include the safe management of sharps and needlestick injuries Waste Management training includes safe disposal of sharps			Service Managers/ Matrons	
9f. Prevention of occupational exposure to blood-borne viruses, including prevention of sharps injuries Measures to avoid exposure to blood-borne viruses should include: ▪ immunisation against hepatitis B; ▪ the wearing of gloves and other protective clothing;	Standard (Universal) Precautions Policy Occupational Health Policy - Management of Sharps Injury/Splash Incident The use of safety needles by clinical staff are in use Trust wide. PPE is available for all clinical staff	Demonstrates Compliance as per national and local policy	IP & C Team and Occupational Health to raise awareness for the prevention of needle sticks injuries through training programme Attendance to be monitored by the Learning and Development Department Audit process	Occupational Health Department Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC	

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▪ the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for healthcare workers; and ▪ measures to reduce risks during surgical procedures.	Blood and body fluid spillage kits on every ward/unit All IP & C staff training programmes, including corporate induction include the safe management of sharps and BBV awareness Surgical procedures are not performed within a Mental Health environment			Heads of Nursing IP & C Team Service Managers/Matrons Learning & Development Department	
9g. Management of occupational exposure to blood-borne viruses and post-exposure prophylaxis Management should include: ▪ designation of one or more doctors to whom healthcare staff and others may be referred immediately for advice following occupational blood exposure; ▪ provision of clear information to healthcare staff about	Occupational Health Policy - Management of Sharps Injury/Splash Incident identifying actions required post occupational exposure All IP & C staff training programmes, including corporate induction include the safe management of sharps, BBV awareness and safe management of blood and body fluid spillages and actions	Demonstrates Compliance as per national and local policy	IP & C Team and Occupational Health to raise awareness for the prevention of needle sticks injuries through training programme Attendance to be monitored by the Learning and Development Department Clinical audit process	Occupational Health Department Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team	

reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to human immunodeficiency virus (HIV) or hepatitis B; and ▪ arrangements for post-exposure prophylaxis for blood-borne viruses.	required post occupational exposure			Service Managers/ Matrons Learning and Development Department	
9h. Closure of wards, departments and premises to new admissions ▪ A system should be in place for the provision of advice by the DIPC/ICT to the chief executive and medical director. ▪ There should be clear criteria in relation to closures. ▪ Management arrangements for redirecting admissions should be drawn up with ICT input.	Identified in the Trust Infection Prevention and Control policy Trust wide IP & C Group Board reports Environmental decontamination/deep cleaning is identified in the Trust Infection Prevention and Control policy Ward Closure (outbreak) policy Norovirus Management Policy	Demonstrates Compliance as per national and local policy		Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	

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▪ The policy should address the need for environmental decontamination prior to reopening.	Clostridium difficile Policy Isolation (Nursing) Policy Public notice to display on ward/unit door Data Surveillance			Hotel Services	
9i. Environmental disinfection policy ▪ The use of disinfectants is a local decision, and there should be local policies on disinfectant use which focus on specific infection risks. ▪ If appropriate, the role of high-level disinfectants to kill bacteria, viruses and spores should be considered	Strategic and operation cleaning policies in place	Demonstrates Compliance as per national and local policy	To be monitored through the PLACE process, IP & C Team	Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons Hotel Services	
9j. Decontamination of reusable medical devices ▪ Effective decontamination of	Safe Management of Medical Devices Policy	Demonstrates Compliance as per national and local policy	Monitor in Trust wide IP & C Group and the Medical Devices Management Meeting	Executive Director of Nursing and Quality/DIPC,	

reusable medical devices is essential. There should be a system to protect patients and staff that minimises the risk of transmission of infection from medical devices and other equipment that comes into contact with patients or their body fluids. ▪ Decontamination is the combination of processes, including cleaning, disinfection and sterilisation, used to render a reusable item safe for further use on patients and handling by staff. ▪ Reusable medical devices and other devices should be decontaminated in accordance with manufacturers' instructions and current guidelines. ▪ Systems should ensure adequate supplies of reusable medical devices and should allow reusable medical	Agenda item on the Medical Devices Management Meeting IP & C Team promotes the use of single patient/single use items.			Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing Medical Devices Manager IP & C Team Service Managers/ Matrons	

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devices to be tracked through decontamination processes in order to ensure that the processes have been carried out effectively. ▪ Systems should also be implemented to enable the identification of patients on whom the medical devices have been used.					
9k. Antimicrobial prescribing ▪ Local prescribing should, where appropriate, be harmonised with that in the *British National Formulary* (BNF). ▪ All local guidelines should include information on the regimen and duration of particular drugs. ▪ Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship.	Antimicrobial Prescribing and Management Policy MRSA Management and Screening policy Surveillance by IP&C Team using infection reporting structure includes pharmacy input	Demonstrates Compliance as per national and local policy	None required	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of nursing Pharmacists IP & C Team Service Managers/Matrons	

9L. Reporting HCAI to Public Health England as directed by the Department of Health This includes a mandatory requirement for NHS trust chief executives to report all cases of MRSA bacteraemia and all cases of *C. difficile* infection in patients aged two years or older. Reporting should include procedures for dealing with serious untoward incidents.	Reporting structure is in place and is identified in the IP & C policy. Reporting procedure flow chart in nursing offices identifying contact details of IP&C team Staff to inform Public Health England of all suspected/confirmed outbreaks, which includes MRSA bacteraemia and C.difficile. IP & C training programme identifies reporting structure/procedure.	Demonstrates Compliance as per national and local policy		Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons Ward Managers Nurse in charge of shift.	
9m. Control of outbreaks and infections associated with specific alert organisms This should take account of local epidemiology and risk assessment. These infections must include, as	❑ Management of a patient with a transmissible infection policy ❑ Management of a patient with a multidrug resistant organism.	Demonstrates Compliance as per national and local policy	To be monitored through the infection control reporting forms, Data surveillance IP&C groups	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and	

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a minimum, MRSA, *C. difficile* infection and transmissible spongiform encephalopathies	❑ Human infestation (including Scabies, Head lice and body lice infestation) Policy ❑			Practice /Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons	
MRSA The policy should make provision for: ▪ screening of patients on admission, which should include screening of all elective admissions by March 2009 and provision for screening of emergency admissions at presentation as soon as is practical; ▪ decontamination procedures for colonised patients, as appropriate; ▪ isolation of infected or colonised patients; ▪ transfer of infected or colonised patients within NHS bodies or to	MRSA screening policy identifies reasons for screening mental health service users (elective and emergency admissions). They may have other clinical conditions that may put them at risk of MRSA infection and should be screened for that reason. ❑ Management of a patient with a transmissible infection policy	Demonstrates Compliance as per national and local policy	To be monitored through the infection control reporting forms, Data surveillance IP & C groups	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	

other healthcare facilities; and ▪ antibiotic prophylaxis for surgery.					
***C.* difficile** The policy should make provision for: ▪ surveillance of *C.* difficile infection; diagnostic criteria; ▪ isolation of infected patients and cohort nursing; ▪ environmental decontamination; ▪ antibiotic prescribing policies; and a statement concerning contraindication of antimotility agents in symptomatic antimicrobial-associated diarrhoea	□ Management of a patient with a transmissible infection policy	Demonstrates Compliance as per national and local policy	To be monitored through infection control reporting forms, Data surveillance IP & C groups	Drug & Therapeutic Committee Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team	
Transmissible spongiform encephalopathies The policy should make provision for the management of known or high-risk patients.	□ Management of a patient with a transmissible infection policy	Demonstrates Compliance as per national and local policy	To be monitored through infection control reporting forms, Data surveillance IP & C Team	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice /Deputy DIPC	

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				Heads of Nursing IP & C Team Service Managers/ Matrons	
Relevant policies for other specific alert organisms The specific alert organisms and matters that follow are relevant to any acute trust. They may also be relevant to certain other NHS bodies to which criterion 8 applies, depending on their spectrum of activity. *Glycopeptide-resistant enterococci:* ▪ screening of high-risk groups; ▪ isolation and prevention of cross-infection; and ▪ prophylaxis for surgical procedures.	❑ Management of a patient with a transmissible infection policy ❑ The Infection Prevention and Control policy identifies cleaning/disinfection following outbreaks ❑ Management of a patient with a multidrug resistant organism.	Demonstrates Compliance as per national and local policy	To be monitored through infection control reporting forms, Data surveillance IP & C Team	Executive Director of Nursing and Quality/DIPC, Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/Matrons	

Acinetobacter and other antibiotic-resistant bacteria: ▪ surveillance of identified patients at risk and of high-risk environments; and ▪ procedures for managing infected patients to prevent spread of infection. *Control of tuberculosis, including multi-drug-resistant tuberculosis:* ▪ isolation of infectious patients; ▪ transfer of infectious patients within NHS bodies or to other healthcare facilities; and ▪ treatment compliance. *Respiratory viruses:* ▪ alert system for suspect cases; ▪ isolation criteria; ▪ infection control measures; and ▪ terminal disinfection and discharge. *Diarrhoeal infections:* ▪ isolation criteria;	❑ The Control of Legionellae Bacteria in Trust Premises policy				

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▪ infection control measures; and cleaning and disinfection policy. *Viral haemorrhagic fevers (VHF):* ▪ patient risk assessment and categorisation; ▪ appropriate staff to be aware of the special measures to be taken for nursing VHF patients, and to be properly trained in the application of full isolation procedures; ▪ confirmed cases to be handled under full isolation measures in a high-security infectious diseases unit or equivalent; ▪ handling of patient specimens at the appropriate containment level; ▪ follow-up of all staff in contact with the patient at every stage of care; and ▪ special measures for the handling of all healthcare waste.					

Legionella: ▪ premises should be regularly reviewed for potential sources of infection, and a programme should be prepared to minimise any risks. Priority should be given to patient areas, although the exact priority will depend on local circumstances. Any provider that should have in place any of the core policies mentioned above should, having regard in particular to the healthcare it provides, also consider whether it would be appropriate for it to have in place any of the additional policies or to take any of the measures mentioned in Part 5 of this					

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Code with a view to minimising the risk of HCAI. If such a provider considers that it is appropriate for it to have in place any of those policies or take any of those measures, it should take into account the content of Part 5 insofar as it is relevant to making those arrangements, including the content of guidance and other publications referred to in any relevant citation. The sufficiency and suitability of any policy implemented in accordance with this provision of the Code should be monitored via the clinical governance system, and there should be evidence of a rolling programme of audit, revision and update. All policies should be clearly marked with a review date.					

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Compliance Criterion 10 – Ensures, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of health and social care.					
	Self-assessment	**Description for compliance**	**Actions**	**responsibility**	**Progress**
All staff can access relevant occupational health services	In Place	Demonstrates Compliance as per national and local policy	Update as new guidance is issued	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice / Deputy DIPC Heads of Nursing IP & C Team Service Managers/ Matrons	
Occupational health policies on the prevention and management of communicable diseases in healthcare workers, including immunisation, are in place	In Place				
Prevention and control of infection is included in induction programmes for new staff, and in training programmes for all staff	In Place Training and development department records		Review and develop training sessions across all services as required.	Learning & Development Department Occupational Health Dept	
There is a programme of ongoing education for	In Place		Learning and Development Department to monitor attendance		

existing staff (including support staff, agency/locum staff and staff employed by contractors);	Training and development department records				
There is a record of relevant immunisations;	In Place				
There is a record of training and updates for all staff	In Place Training and development department records				
The responsibilities of each member of staff for the prevention and control of infection is reflected in their job description and in any personal development plan or appraisal.	In place - Job descriptions		Completed by IP & C team, HR and AD's working together.	Executive Director of Nursing and Quality/DIPC Deputy Director of Nursing and Practice/ Deputy DIPC Heads of Nursing Service Managers/ Matrons	

Appendix C- Cleaning audit tables

Table 1-Mental health Inpatient audit results

Mental Health - Inpatient										
	Apr-Jun Overall	Apr-Jun Cleaning Only	Jul-Sept Overall	Jul-Sept Cleaning Only	Oct-Dec Overall	Oct-Dec Cleaning Only	Jan-Mar Overall	Jan-Mar Cleaning Only	Yearly Average Overall Score	Cleaning Only Average Score
11 Ethelbert Road			96%	98%	92%	98%			94%	98%
111 Tonbridge Road			90%	95%	93%	96%			92%	96%
Allington Centre			97%	98%	96%	98%			97%	98%
Archery House Kitchen			78%	92%	82%	100%			80%	96%
Bridge House at Fant Oast			98%	100%	89%	100%			94%	100%
Brookfield Centre			96%	100%	94%	99%			95%	100%
Jasmine Assessment Centre			92%	98%	85%	97%			89%	98%
Kings Renal Unit	94%	100%	89%	100%	95%	100%			93%	100%
Littlebrook - Amberwood	91%	98%	86%	97%	89%	100%			89%	98%
Littlebrook - Cherrywood	98%	100%	86%	95%	93%	100%			92%	98%
Littlebrook - Pinewood			87%	99%	89%	97%			88%	98%
Littlebrook - Willow	98%	100%	91%	98%	97%	98%			95%	99%
Medway A Block - Ruby Ward	97%	98%	99%	100%					98%	99%
New Haven Lodge			96%	100%	94%	98%			95%	99%
Priority House - Adult Acute Shared			94%	100%	89%	95%			92%	98%
Priority House - Boughton			84%	97%	88%	99%			86%	98%
Priority House - Chartwell			94%	97%					94%	97%
Priority House - Orchards			93%	97%	92%	99%			93%	98%
Priority House - Upnor			92%	100%	86%	98%			89%	99%
Rivendell			94%	98%					94%	98%
Rosebud Ward (Birling Centre)			85%	97%	89%	99%			87%	98%
Rosewood M&BU	99%	100%	98%	100%	96%	99%			98%	100%
St Martins - Bluebell / Foxglove Entrance Areas			97%	100%	89%	97%			93%	99%
St Martins - Bluebell			80%	97%	80%	98%			80%	98%
St Martins - Foxglove			71%	96%	86%	100%			79%	98%
St Martins - Fern Ward	86%	98%	72%	96%	88%	98%			82%	97%
St Martins - Heather	97%	99%	97%	98%					97%	99%
St Martins - Kitchen			89%	92%	74%	96%			82%	94%
St Martins - Off War Theraputic Area			100%	100%	100%	100%			100%	100%
Tarentfort - Entrance Area			92%	100%					92%	100%
Tarentfort - Marle			91%	98%					91%	98%
Tarentfort - Riverhill			90%	100%					90%	100%
TGU Bedgebury Building			100%	100%	100%	100%			100%	100%
TGU Emmetts			97%	100%	95%	100%			96%	100%
TGU Groombridge / Penshust Entrance Area			100%	100%	89%	100%			95%	100%
TGU Groombridge			95%	99%	88%	97%			92%	98%
TGU Penshurst			94%	99%	88%	97%			91%	98%
TGU Sports Hall			72%	100%	100%	100%			86%	100%
TGU Walmer			98%	100%	98%	100%			98%	100%
Thanet MHU Sevenscore	96%	99%	93%	100%	97%	100%			95%	100%
Thanet MHU Woodchurch	98%	99%	96%	100%					97%	100%
The Grove			100%	100%					100%	100%

Table 2- Administration Directorate audit results

Administration Directorate										
	Apr-Jun Overall	Apr-Jun Cleaning Only	Jul-Sept Overall	Jul-Sept Cleaning Only	Oct-Dec Overall	Oct-Dec Cleaning Only	Jan-Mar Overall	Jan-Mar Cleaning Only	Yearly Average Overall Score	Cleaning Only Average Score
Chris Ellis Centre			92%	100%	98%	100%			95%	100%
Facilities (Greenacres)			93%	100%					93%	100%
Farm Villa			87%	96%					87%	96%
Magnitude			97%	100%					97%	100%
St Martins - Eastern & Coastal Offices			84%	97%					84%	97%
St Martins - The Cube			95%	100%					95%	100%
TGU Bedgebury Admin			94%	100%					94%	100%
TGU FOLS			95%	97%	97%	100%			96%	99%
TGU Forensic Management			92%	98%					92%	98%
TGU TAT Team			91%	97%					91%	97%
Trinity Church	96%	100%	55%	72%	90%	95%			80%	89%

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Table 3- Mental Health Outpatient audit results

Mental Health - Outpatient										
Sites	Apr-Jun Overall	Apr-Jun Cleaning Only	Jul-Sept Overall	Jul-Sept Cleaning Only	Oct-Dec Overall	Oct-Dec Cleaning Only	Jan-Mar Overall	Jan-Mar Cleaning Only	Yearly Average Overall Score	Cleaning Only Average Score
2 Cossington Road	78%	94%	87%	97%	84%	93%			83%	95%
Albion Place			93%	99%	95%	99%			94%	99%
Archery House	90%	97%	79%	83%	86%	89%			85%	90%
Archery House-Hydro Pool			80%	100%	91%	100%			86%	100%
Arndale House			92%	99%	92%	96%			92%	98%
Ash Eaton			88%	98%	95%	100%			92%	99%
Bay Tree House			95%	100%	94%	100%			95%	100%
Beech House			98%	98%	98%	100%			98%	99%
Britton House			99%	100%	99%	99%			99%	100%
Coleman House			85%	97%	87%	97%			86%	97%
Darent House			96%	100%	86%	100%			91%	100%
Deal Mental Health at Royal Victoria Hospital			81%	94%					81%	94%
Disablement Services Centre	87%	98%	89%	99%	92%	100%			89%	99%
Elizabeth Reybould Centre			89%	96%	92%	99%			91%	98%
Eureka Park			93%	99%	91%	96%			92%	98%
George Turle			89%	98%					89%	98%
Heathside - Avalon House			92%	98%	97%	100%			95%	99%
Highlands House			94%	98%	93%	97%			94%	98%
Kings Road Clinic			97%	100%	93%	100%			95%	100%
Laurel House	81%	92%	77%	96%	82%	88%			80%	92%
Littlebrook - Outpatients / Admin	93%	97%	71%	73%	85%	90%			83%	87%
Orchard House			91%	98%	78%	93%			85%	96%
Poppy House			91%	95%	91%	96%			91%	96%
Priority House - Outpatient/Admin			86%	99%	84%	95%			85%	97%
Priority House - Support & Signposting			85%	100%	96%	100%			91%	100%
Priority House 1st Floor			87%	93%					87%	93%
Red House			89%	96%	98%	100%			94%	98%
St Martins - Eastern & Coastal Outpatient			88%	100%	95%	100%			92%	100%
St Martins - Gregory House			85%	95%	94%	100%			90%	98%
St Michaels House			87%	98%					87%	98%
Tarentfort - Broadview	93%	94%	86%	93%	90%	96%			90%	94%
TGU Lakeside Café			100%	100%	100%	100%			100%	100%
Thanet MHU Lydden			98%	100%	96%	96%			97%	98%
Thanet MHU Elmstone Admin			100%	100%	97%	100%			99%	100%
Thanet MHU Elmstone Day Centre (Sarre)			94%	100%	98%	100%			96%	100%
The Beacon			90%	99%	85%	99%			88%	99%
The Brenchley Unit, 22 Oakapple Lane			92%	93%	100%	100%			96%	97%
Twiseldon Court	96%	99%	97%	98%	97%	100%			97%	99%

*Please note some sites may be missing due to having no Year on Year data, the sites may have been shut for refurbishment or new to the trust

Appendix D- COVID-19 Standard Operating Procedures

Access Visits and Home Visits from Inpatient Settings SOP

Bed Management SOP on Outbreak Wards

Cancellation or DNA Process for Community Teams SOP

Clozapine Guidance - Guidance for managing community clozapine patients during COVID19

Community Adult Cardiac Arrest Guidance SOP

Consent to informal admission agreement form to be used during Covid-19 pandemic

Covid-19 Outbreak Plan

Death in Service Guidance - Covid-19

Death of Patient due to Covid-19 or Suspected Covid-19

Decontamination Plan - Covid-19 SOP - read with the following documents:

Bedroom cleaning flow chart

Office cleaning flow chart

End of Life Care on Inpatient Units (COVID-19) SOP

Emergency Business Continuity Planning COVID-19 - Standard Operational Delivery Plan (SOP) April 2020

Eye Protection SOP

Guidance for Isolation and Ending Isolation of a Patient on an Inpatient Ward SOP

Guidance for management of patients that use CPAP and BiPAP SOP

Guidance for prescribing medication in acute disturbance in COVID-19 patients

Home Visit and Patient Review Process SOP

Home Working SOP - read with the following documents:

Guidance for managers completing risk assessment for BAME staff for mitigating Covid-19 risks

Inpatient Cardiac Arrest Management During COVID-19 Pandemic - read with the following document:

Adult Advanced Life Support for COVID 19 patients

Inpatient Contact with Friends, Family and Carers SOP

Keeping Everyone Safe SOP - Working Safely During Covid-19 Including Social Distancing

Linen Guidance SOP

Management of Tobacco Smoking during Covid-19 Response SOP

Managing Acutely Disturbed /Challenging Behaviour during COVID-19 Pandemic - Protocol and Guidance

Medical Devices Acceptance Testing/ Re-Calibration/ Service/ Repairs Procedure during the Covid-19 Crisis

NMP Guidance - Guidance for non-medical prescribers (NMP) on writing a prescription for a patient that they have not assessed

Procedure for nursing patients whilst awaiting swab results or refusing to isolate

Protocol for returning to deliver clinical work in community clinical settings

Protocol for Vitamin D Treatment for Inpatients during Covid-19 Pandemic at KMPT

Re-establishment of Individual Volunteers SOP

Resumption of Inpatient Visits and Section 17 Leave SOP

Safe Oxygen Delivery Guidance SOP

Single Point of Access Standard Operating Procedure

Social Distancing Inpatient Settings SOP

Specialist Personality Disorder Services SOP

Standard Operating Procedure for ICOM during COVID Pandemic

Summer Resilience Plan

Swabbing SOP - Dartford

Swabbing SOP - East Kent

Swabbing SOP - Maidstone

Swabbing SOP - Ruby Ward

Test and Trace SOP

Transfer from Inpatients to Rehab Services SOP

Uniform Guidance SOP

Waste Management Guidance KMPT SOP

Waste Management Guidance from NHS England

Video or Telephone Conferencing for Clinical and Therapeutic Consultations SOP

Title of Meeting	**Public Board Meeting**
Meeting Date	**30th September 2021**
Title	**Workforce and Organisational Development Committee Chair Report**
Author	**Kim Lowe, Non-Executive Director**
Presenter	**Kim Lowe, Non-Executive Director**
Executive Director Sponsor	**-**
Purpose	**Noting**

Matters to be brought to the Board's attention
• Violence and Aggression suffered by staff – WFODC noted with concern the number of assaults suffered by staff and the impact it had on those staff in terms of wellbeing, sickness and retention. • Winter Planning for Health and Well-being – the Committee recommended to the Trust that an action plan be formed quickly with clear deliverables so that KMPT's staff health and well-being is protected • Deep Dive regarding Recruitment – Although the Board will receive an update on recruitment issues through the Strategic Priorities Delivery Plan updates, WFODC recommends to the Board that a bespoke Board Seminar is created to allow the Board to reflect on recruitment and retention issues and their wider impact on the Trust. • Annual Equality Report 2021 – WFODC receive the Annual Equality Report and recommends it to the Board. A copy of the Annual Equality Report is attached for the purposes of publication.

Items referred to other Committees (incl. reasons why)
• Referral to Quality Committee – request that, on behalf of the Board, Quality Committee seeks assurance regarding the low training compliance rate in respect of the "See, Think, Act" course and its potential impact on Serious Incidents.

Summary of Committee Meeting:

The Workforce & Organisational Development Committee (WFODC) met on Tuesday 21st September and discussed the following agenda:

- Workforce, OD and Communications Overview Report
- Health & Wellbeing Programme Update
- Staff Assaults update
- Community Recovery Care Group – Psychology
- Deep Dive Recruitment, Retention and Absence Paper

- Annual Equality Report
- Safer Staffing Paper
- HR Risk Register; and
- HR Policies.

Workforce, OD and Communications Overview Report

The Committee received a comprehensive presentation setting out a range of datasets. Discussions focussed on the staff sickness rate (standing at 4.2% year to date against a target of 4%) and staff turnover (standing at 10.5% year to date against a target of 9%). In terms of staff turnover, the Committee reflected on the Retention of Employees Risk score as recorded on the HR Risk Register. The Committee recommended that the Retention of Employees Risk (rated at 6) was too holistic and needed to be more granular in order to more accurately reflective of the various professional areas where retention of staff is more problematic.

The Committee noted with concern some of the low training compliance rates and in particular noted the low training compliance rate regarding the “See, Think, Act” training programme. The Committee considered there may be a correlation between the low training compliance and serious incidents and therefore considered that Quality Committee seeks assurance regarding the low training compliance rate in respect of the “See, Think, Act” course and its potential impact on Serious Incidents.

The Trust is working on embedding proactive support to staff as well as reactive support. Whilst the Trust’s Compassionate Leadership work is a mid-to-long term matter, the Committee recommended that the Trust brings in a Winter Health and Wellbeing action plan in order to ensure that staff health and wellbeing is protected.

Staff Assaults Update

The Committee received a report setting out a thematic review of the staff assaults dataset. The Trust is rightly concerned regarding violence and aggression, with several workstreams currently in play to tackle the issue from a patient safety perspective and a staff perspective. Discussions were had regarding staff usage of Skyguard, with uptake not where the Trust wishes it to be, with the Committee receiving assurance that the Trust is engaged with staff with risks being mitigated so far as possible.

Community Recovery Care Group – Psychology

The Committee received a paper regarding the workforce model of Psychological services within the Community Recovery Care Group. The Committee noted the paper and received assurance that the Trust is adapting its recruitment model and staffing model in order to support the delivery of psychology to service users in a timely way.

Deep Dive Recruitment Paper

The Committee received a deep dive paper into the Trust’s recruitment, retention and absence issues. The paper was taken as read, with the Committee using the time to reflect on how these issues can be addressed.

Discussions focussed on the use of different staffing models and the need to receive buy-in from various external organisations, which will allow the Trust’s new staffing model to have

the support of the medical and nursing organisations. Adaptation to a new staffing model over a short-term period may result in a boost in staff morale as they consider that the shift they are on is operating at a full level.

The Committee also reflected on the bureaucratic burden on Trust staff and the impact it has on the delivery of services and staff morale. As part of the horizon scanning, the Trust's partnership work may also reduce the bureaucratic burden and work pressures on staff. The Committee was assured that work is already ongoing to reduce the bureaucratic burden on staff.

Annual Equality Report

The Annual Equality Report was received by the Committee and taken as read. The Report set out the Trust's progress against a number of metrics/indicators of workforce equality. The Committee was assured that the Trust is making progress on its action plan in terms of Workplace Race and Disability Equality Standards.

A copy of the Annual Equality Report is attached to this Committee Chair's Report.

The Board is asked to note the content of this report.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Annual equality report 2020/2021

Brilliant care through brilliant people

RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

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FOREWORD

Welcome. This document reports progress against inclusion and where we need to continue progressing towards equality in our mission of brilliant care through brilliant people at Kent and Medway NHS Social Care Partnership Trust (KMPT) across 2020-21.

1) PROTECTING OUR STAFF

We aim to have zero tolerance against abuse at KMPT to ensure that all our staff have a right to care for others without fear of being abused.

2) INCREASING REPRESENTATION

Over the next five years it is important that we increasingly become an employer of choice for people from minority backgrounds.

We are changing attitudes and removing barriers to participation by involving people from minority groups in targeted opportunities: staff networking, coaching, training, reverse mentoring and recognising talent within KMPT.

3) BUILDING AN INCLUSIVE CULTURE

We are providing opportunities for allies and for role models to develop cultural competence through our Culture programme.

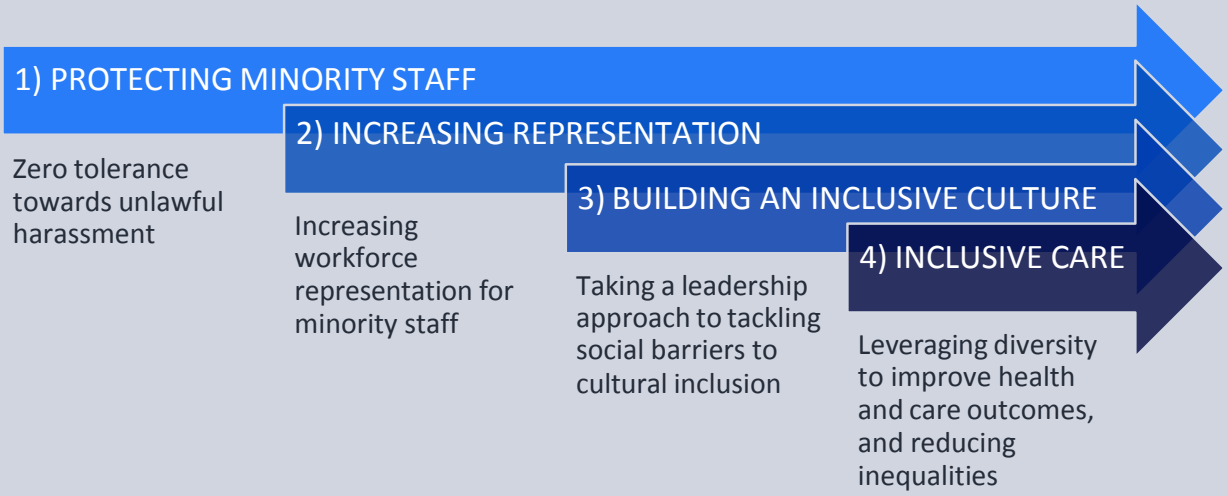
We are aiming for a psychologically safe environment with a just and learning culture.

4) INCLUSIVE CARE

We are taking steps to begin the promotion of culturally competent care by supporting staff to sensitively identify, record and meet patients' cultural, social and spiritual needs.

We will continue to take every opportunity to advance equality, diversity and inclusion in the design, delivery and review of all our functions, policies and practices.

FIG. 1 KMPT Inclusion



SUMMARY

Below is a summary of the key findings against each area of the KMPT's equality,diversity and inclusion programme:

RACE (page 5)

i. The proportion of BAME (Black, Asian and Minority Ethnic) staff is 24.7% across KMPT, an increase of 5% over the last three years. There has been an improvement in BAME representation at Board level of 6% since 2019.

ii. There has been a small improvement in the likelihood that a BAME person will be appointed compared to a white person over the past five years; this key national workforce race equality standard (WRES) measure is a priority in our action plan.

iii. Across three years there was a four-point decrease in BAME staff reporting the Trust provides equal opportunities.

iv. There was a four-point decrease in BAME staff experiencing harassment, bullying or abuse from other colleagues in 2020,with BAME ally training set-up to support BAME staff members. This coincides with the growth of the BAME Network to include at present over 140 members (4% of the workforce).

v. Covid-19 had a larger impact on our BAME staff and we focused work on ensuring all BAME staff received a risk assessment. KMPT also offered additional support to BAME colleagues through the BAME Staff Network and EDI Team 'Drop In' Sessions for staff and managers.

RELIGION AND BELIEF (page 7)

vi. The proportion of staff (76.64%) sharing their beliefs grew by 2% over the past five years.

vii. The Chaplaincy Team continue to promote the Faith Network to encourage wider awareness and understanding of faith related issues.

viii. The Network's purpose is to benefit service users, patients and employees, offering a platform for identifying, promoting and addressing issues, as well as link in with the other Networks to promote intersectionality.

GENDER (page 9)

ix. 75% of the workforce is female with 25% male representation. We cannot evidence representation for Trans or non-binary people.

x. Women were just under one and a-half times as likely as men to experience bullying and harassment from other staff.

xi. Men were more likely than women to experience discrimination from patients, relatives or members of the public.

xii. Women occupied 71% of the highest paid jobs (Across Band 8 and 9).

SEXUAL ORIENTATION (page 11)

xiii. Just under 3% of the workforce shared with us that they identify as lesbian, gay or bisexual (LGB).

xiv. The Trust became Stonewall Diversity Champions in 2020.

xv. Bisexual people (8.5) and those Preferring not to say (8.5) scored lower than Trust average (8.9) for their perceptions of equality

xvi. Only those identifying as Heterosexual/Straight (8.2) scored above the Trust average (8) of safety regarding bullying and harassment.

DISABILITY (page 13)

xvii. 6.77% of the workforce shared they identify as disabled on their staff record, with 11.91% of the workforce choosing not to share their disability status.

xviii. People who were disabled were just as likely to be appointed from shortlisting than non-disabled people against this key national workplace disability equality standard (WDES) measure.

xix. There was a seven-point gap between disabled (81%) and non- disabled (88%) staff who feel KMPTprovides equal opportunities in career development.

xx. 84% of disabled staff felt KMPT made adequate adjustments to enable them to work; an increase of nine percent over four years.

xxi. Covid-19 meant that many staff with a disability were shielding and KMPT ensured they received risk assessments and the EDI Team offered 'drop in' sessions to support both staff and their managers.

AGE (page 15)

xxii. The majority of the workforce is aged 46-55 years old, which is comparable with the national data. This data shows that KMPT has an ageing workforce.

ORGANISATIONAL INCLUSION (page 17)

xxiii. Operation Cavell – launched on 15th February 2021 and is a joint initiative with Kent Police to tackle hate crime and violence against KMPT staff.

xxiv. This aim of this work is to make every effort that KMPT staff remain safe during the course of their role and if subjected to unacceptable behaviours (violence and anti-social) from service users, they have a clear way to report such crimes and be supported**.** This is in recognition of the increase of incidents of this kind and can be from service users and or their loved ones but in either case should not go unreported.

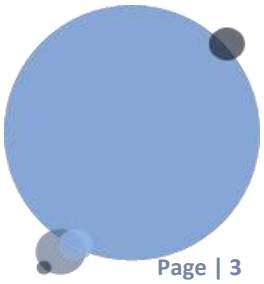
Conclusion

xxv. The findings indicate areas of progress, particularly increasing representation through minority staff and community engagement, with some barriers to inclusion still requiring action. The findings also indicate pockets of negative experiences for some staff; a focus for the 12 months ahead.

xxvi. Covid-19 had implications on the delivery of some of the work to support inclusion during 2020-2021 but efforts were focused on ensuring staff safety.

xxvii. Across 2021-22 we will increase support for staff to promote inclusive leadership to highlight and remove cultural barriers to inclusion.

xxviii. The end goal remains thriving and culturally competent staff providing inclusive care to promote positive health outcomes and tackle health inequalities.



INTRODUCTION

Welcome to our annual equality report 2020-21

This report demonstrates what we have achieved and where we need to continue progressing towards equality in our mission of brilliant care through brilliant people.

Our equality, diversity and inclusion (EDI) programme delivers our workforce strategy commitment for thriving staff to be inclusive, diverse and fair, and supports our other strategies, particularly on patient and carer experience and involvement.

The report is made up of seven sections that reflect our aspirations across:race, religion and belief, gender, sexual orientation, disability, age, and organisational inclusion.

- Each section begins with our key achievements to advance equality, including fostering good relations
- There are then key findings including measures of workforce equality, in particular representation and recruitment rates
- There are measures of our work to eliminate discrimination, including harassment
- Each section then ends with next steps to address the findings that underpin the 2021/22 equality, diversity and inclusion action plans.

Key measures include a traffic light system of progress, illustrated by either a red (**R**), an amber (**A**) or a green (**G**) point.

Green indicates any gaps between groups which are within accepted thresholds, and do not indicate concerns. Amber indicates work in progress and red indicates a decline beyond acceptable thresholds.

The data is taken from electronic staff records, employee relations case-trackers, staff surveys, gender pay gap and our WRES and WDES findings.

Patient data has not been included in this report due to quality. We are focusing on barriers to recording demographic details and accessible information, with thesupport of IT and our clinical services.

This report evidences compliance with our specific equality duty (Equality Act 2010), our duty to publish gender pay gap information (on page 10) and our obligations to publish information relating to the workforce race equality standard (WRES; on page 5) and the workforce disability equality standard (WDES; on page 13).
It also provides the progress on our Equality, Diversity and Inclusion Strategy 2020-2024.

RACE

The proportion of BAME (Black, Asian and Minority Ethnic) staff grew by 5% over three years across KMPT. There has been an improvement in BAME representation at Board level of 6% since 2019.

Across five years there was a seven-point increase in BAME staff reporting the Trust provides equal opportunities, coinciding with the creation and growth of the BAME Network to include at present 140 members (4% of the workforce). There was a two-point decrease in BAME staff experiencing harassment, bullying or abuse from other colleagues in 2020, with BAME ally training delivered to support BAME staff members.

1.1. Across 2020-21 KMPT's BAME Network brought people together from different ethnic backgrounds committed to valuing individuality, supporting inclusion and promoting diversity. Key achievements include:

- Over 140 BAME allies were trained over four courses.
- A month of staff events held to promote intercultural learning, culminating in the first virtual Black History Month Celebration
- The BAME staff network membership grew to 140 (approximately 4% of the total Trust workforce)
- The staff survey engagement score was higher for our BAME staff (7.4) than for our white staff (7.0).

KEY FINDINGS: RACE

Workforce ethnicity representation (WRES 1) A

1.2. The number of BAME people in the workforce at 31 March 2021 was 908, or 24.7% of the workforce overall. The Trust's BAME workforce has grown by 5% over the past three years.

1.3. Medical and dental staff was 58.5% (n.188) BAME. Clinical staff was 28.1% BAME (n. 691). Agenda for Change (AfC) pay band 2 had the largest proportion of any AfC pay band at 55% (n. 180), followed by band 9 at 30% (n.10),then band 5 at 29% (n.102).

1.4. By comparison the average workforce was 20.1% BAME in the whole NHS South Region.

1.5. AfC 8d-9 and very senior managers (VSMs) is 46 %White British and 54% BAME.

Fig. 2 Workforce by ethnic group

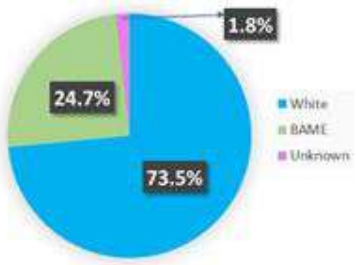
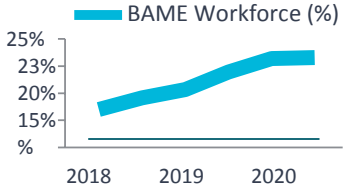


Fig. 3 Trust BAME workforce % over time



Ethnicity shortlisting-to-appointment likelihood (WRES 2) A

1.6. 156 BAME people and 448 white people were appointed in 2020-21.White people were 1.19 times more likely to be appointed from shortlisting than BAME people, the same as the regional and the sector averages. This is a reduction from white people being 1.5 times more likely to be appointed in 2019. If the Trust had employed 28 more BAME people it would have achieved racial equality in appointments.

Fig. 4 Likelihood BAME staff disciplinary

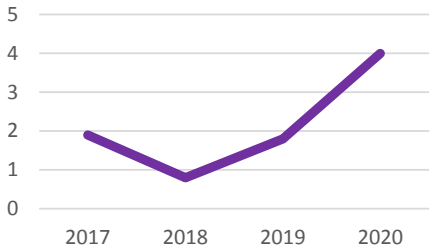


Fig. 5 Patient-on-staff harassment by ethnicity

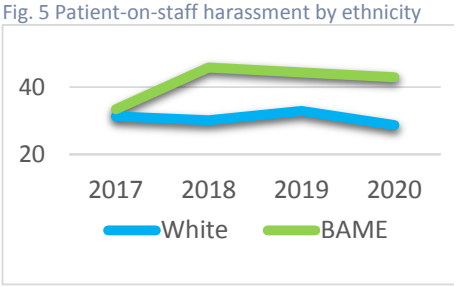


Fig. 6 Staff-on-staff harassment ethnic group

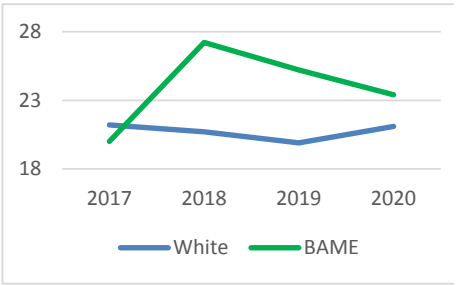
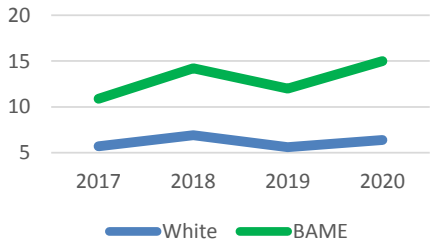


Fig.7 Staff experiencing discrimination



Formal disciplinary likelihood by ethnicity (WRES 3) R

1.7. BAME people were over 4 times more likely than white people to enter formal disciplinary, including 8 BAME people and 12 white people. Although based on small numbers this is an increase year on year since 2018.

Non-mandatory training (WRES 4) A

1.8. White people (n. 1041) were 1.26 times as likely to access non-mandatory training and development as BAME people (n. 279).

Harassment, bullying or abuse by ethnicity (WRES 5-6) R

1.9. 42.9% of BAME staff experienced harassment, bullying or abuse from patients, relatives or the public in the prior 12 months, although a decrease of 1.4 points than 2019 it is 7.3 points greater than the 35.6% BAME staff in 2017. This figure is just over 10% more than the 32.1% BAME staff mental health trust providers benchmark. KMPT have committed to reducing this percentage to 34.3% over two years.

1.10. 23.4% of BAME staff experienced harassment, bullying or abuse from other colleagues in the prior 12 months, 1.6 points less than the national average and 2.1% points from the 25.5 % BAME staff in 2019. KMPT has committed to reducing this 17.5% over two years. R

Racial equality of opportunity for promotions (WRES 7) A

1.11. 74.3% of BAME staff reported the Trust provided equal opportunities for promotion. The Trust is 1.6 points greater than the 72.7% BAME staff mental health provider benchmark and 9.3 points less than the national average (83.6) but with the Trust's white staff reporting of 89.3%, hence the rating is amber.

Staff work discrimination by ethnicity (WRES 8) R

1.12. 15% of BAME staff (n.54) experienced discrimination at work from their manager or colleagues, an 8.6-point difference to the 6.4% of white staff experiencing it and a 0.1-point difference from the 15.1% BAME staff mental health provider benchmark.

Board ethnicity membership (WRES 9) G

1.13. The Board, including voting and executive, was 80% white and 20% BAME. This is thirteen points greater than the 7.5% Board mental health provider benchmark

NEXT STEPS FOR RACE EQUALITY 2021-22

- Set an inclusive leadership masterclass for equality, diversity and inclusion
- Introduction of the Early Resolution Policy to decrease numbers of staff going through the disciplinary process
- Develop and deliver positive action workshops to support job applications
- Trust-wide discussion on what being an anti-racist organisation means
- Develop our actions on reducing our race disparity ratio for implementation and incorporate into our WRES action plan next year.

RELIGION AND BELIEF

The proportion of staff (77%) sharing their beliefs remained static over the past five years, however those stating non-religious grew by over 6%.

Buddhist staff scored their safety (6.3 out of 10) in relation to bullying and harassment).

Discrimination rates from patients or the public towards our staff are higher towards our Muslim, Hindu staff and staff identifying as Any other religion.

2.1. Across 2020-21 the Trust's Religion and Belief Network explored and developed the expression of spirituality at work. Key achievements include:

- Holding virtual Diwali and Christmas celebrations
- Supporting patients with spiritual needs during the pandemic

KEY FINDINGS: RELIGION AND BELIEF

Workforce religion and belief representation A

2.2. The number of people sharing their religion or belief with the Trust at 31 March 2021 was 2,689, or 77% of the workforce. Staff in agenda for change (AfC) pay band 8a had the largest proportion identifying as religious at 81.4% (n.114).

2.3. Staff sharing, they were Christian was the largest belief group at 48.7% (n. 1,696), followed by the non-religious group at 15% (n. 540) and then followed by the group of staff sharing that they described their religion or belief as 'Other' at 9% (n. 307).

2.4. The proportion of all staff sharing that they identify as religious remained relatively static over five years.

2.5. The proportion sharing that they identify as non-religious increased by 6.3% overall, over five years. The score is rated amber because of the 22% of staff not wishing to share with us.

Fig. 8 Workforce by belief group

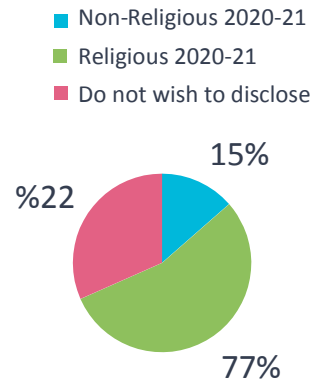


Fig. 9 Belief group workforce % over time

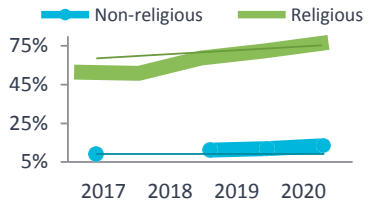
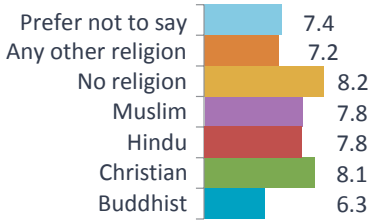


Fig. 10 Bullying & harassment score (religion and belief group)

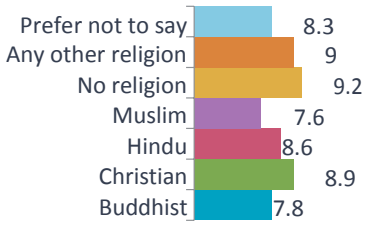


Safe environment (bullying and harassment) by religion and belief

2.6. The safety (bullying and harassment) score is aggregated from responses to three questions from the staff survey 2020 relating to personal experience of harassment, bullying or abuse from patients, relatives, members of the public, managers and / or colleagues.

2.7. The Trust average score for all staff was 8 out of 10. The group with the lowest score was Buddhist at 6.3 (n.16), 0.5% less than the 8.8 average staff score nationally. The next Trust lowest was Any other religion at 7.2 (n. 33).

Fig. 11 Equality, diversity & inclusion score (religion and belief group)

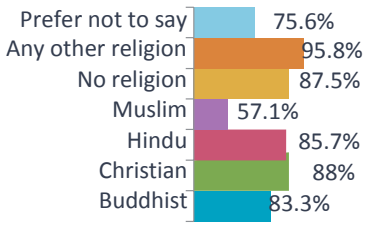


Religion and belief equality, diversity & inclusion score

2.8. The equality, diversity and inclusion score is aggregated from responses to four questions taken from the staff survey 2020 relating to equal opportunities in career progression, discrimination at work and the adequacy of adjustments made to enable individuals to work.

2.9. The Trust average score for all staff was 8.9 out of 10. The group with the lowest score was Muslim at 7.6 followed by Buddhist at 7.8 and prefer not to say at 8.3 out of 10.

Fig. 12 Equality of opportunity for promotions (religion and belief group)



Religion and belief equality of opportunity for promotions

2.10. On average, 86% of staff reported the Trust acts fairly with promotions. The group with the lowest proportion was Muslim at 57.1% (n. 14); nearly 19 points behind the 75.5% Muslim staff mental health provider benchmark. The next lowest in the Trust was Prefer not to say at 75.6% (n. 15) more than the 70.3% (n. 72) nationally in the Prefer not to say mental health provider benchmark.

Staff experiencing discrimination from patients, relatives or members of the public by religion and belief

2.11. On average, 11.9% of staff experienced discrimination from patients, relatives or the public in the prior 12 months. The top three groups were: Muslim at 32%, Hindu at 22.4% and Any other religion at 14.7% – score for Muslims is about double the national averages in their groups' mental health provider benchmarks.

NEXT STEPS FOR RELIGION AND BELIEF EQUALITY 2021-22

- Increase membership of the Faith staff network
- A new action plan for the Faith staff network
- Delivery of active ally training to support those of different beliefs

GENDER

The proportion of the male workforce has grown by 9% over five years, with an overall split currently of 75% female and 25% male. We are unable to evidence representation for Trans or non-binary people. Women were just under one-and-a-half times as likely as men to experience bullying from other staff. Men were more likely than women to experience discrimination from patients.

For every £1 earned by men, women earned £1. Women occupied 71% of the highest paid jobs (8a-9).

3.1. Across 2020-21 the Trust continued its work to promote gender equality between men, women and non-binary people, including trans people. Key achievements include:

- Actively promoting the preferred pronoun campaign in LGBT History Month
- Delivering gender identity awareness training to our Consultant Psychiatrists and offering courses to all our staff

KEY FINDINGS: GENDER

Workforce gender representation

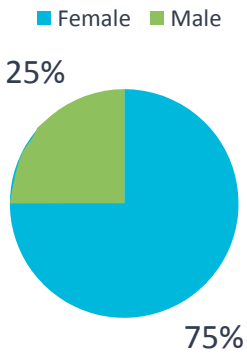
3.2. Out of 3,484 staff, 75% (n. 2,607) were recorded as female and 25% (n. 877) as male on their staff record. The proportion of the male workforce grew over five years.

3.3. The female workforce in Agenda for Change pay bands was 76.2%(n. 2,490) compared to 53.9% (n. 117) females with medical and dental contracts.

3.4. The voting board was comprised of 3 men and 13 women, inclusive of both executive directors and non-executive directors.

3.5. At present the national Electronic Staff Records (ESR) system is unable to record staff members who do not identify with a specificbinary sex or who identify as Trans, hence this measure is rated amber.

Fig. 13 Workforce by sex



Harassment, bullying or abuse from staff by gender

3.6. There was a 4.7-point difference between the proportion of females (16.5%) who reported experiencing harassment, bullying or abuse from colleagues and the proportion of males (11.8%) reporting this in the last twelve months.

Fig. 14 Staff-on-staff harassment (% gender)

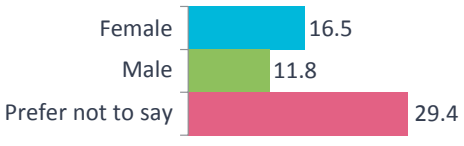
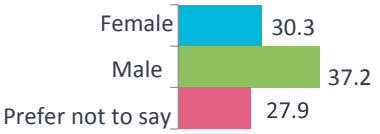


Fig. 15 Discrimination from patients towards staff by gender (%)



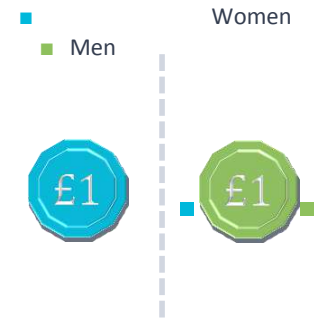
Discrimination from patients, relatives or members of the public by gender

3.7. There was nearly a seven-point difference between the proportion of males (37.2%) who reported discrimination from patients, relatives or members of the public and the proportion of females (30.3%) reporting this in the last twelve months.

Gender pay gap

Hourly wages pay gap

Fig. 16 Hourly wages pay gap by gender



3.8. In the Trust, women earned £1 for every £1 that men earned when comparing median hourly wages.

Proportion of women in each pay quarter

3.9. In the Trust, women occupy 71% of the highest paid jobs and 77% of the lowest paid jobs.

Gender bonus gap

3.10. In the Trust there is no bonus pay and therefore no gender pay discrepancy.

NEXT STEPS FOR GENDER EQUALITY 2021-22

- Deliver staff engagement workshops / surveys aimed at understanding better the experiences of staff harassment towards women and discrimination from patients and the public towards men
- Encourage staff participation in Kent and Medway system wide activities e.g. understanding menopause
- Support the Perinatal Mental Health Community Service to develop culture awareness information for staff to support new and expectant mothers.

SEXUAL ORIENTATION

Nearly three percent of the workforce shared with us that they identify as lesbian, gay or bisexual (LGB). This is static for over the past three years. On average higher paid staff were less likely to share they were LGB. The Trust became Stonewall Diversity Champions in 2020.

Staff identifying as gay or lesbian score the same as Trust average for their perceptions of equality, diversity and inclusion. There are 42 registered members of the LGBTQ++ network.

4.1. Across 2020-21 the Trust continued its work to promote equality between people of all sexual orientations, including lesbian, gay, bisexual (LGB) and straight people. Key achievements include:

- Rolling out Sexual Orientation and Gender Identity Training
- Becoming Stonewall Diversity Champions
- Producing a Pride magazine and sending out Pride cupcakes to all inpatient services

KEY FINDINGS: SEXUAL ORIENTATION

Workforce sexual orientation representation A

4.2. The number of people sharing their sexual orientation with the Trust at 31 March 2021 was 2,884 or 82.5% of the workforce.

4.3. Staff sharing that they were Heterosexual was the largest group at 79.6% (n. 2,782), followed by the group of staff sharing that they do not wish to disclose at 17.4% (n. 608), then by staff who shared they identified as either lesbian or gay at 1.8% (n. 64) staff who shared they were bisexual at 0.94% (n. 33) and lastly was 0.11% (n.4) of staff who selected their sexual orientation as “other”.

4.4. Staff in Agenda for Change (AfC) pay group 1-4 had the largest proportion identifying as LGB on their staff record at 3.3% (n.52), compared to 2.7% in the workforce overall.

4.5. Correspondingly the lowest proportion of LGB on staff records was in Agenda for Change pay bands 5-7 at 1.7% (n.5), hence the amber rating for this measure.

Fig. 18 Workforce by sexual orientation

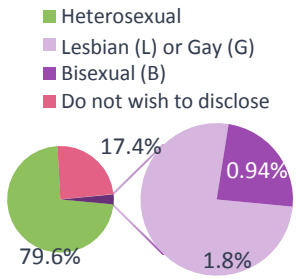


Fig. 19 LGB workforce by AfC pay group

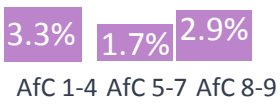


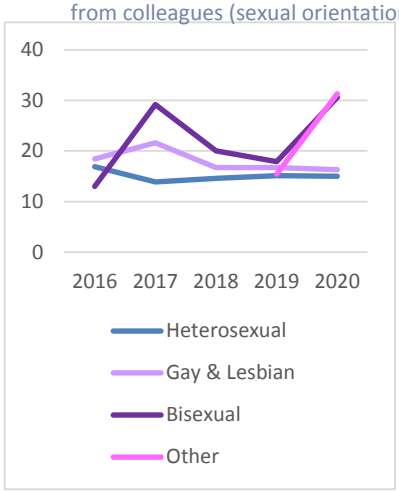
Fig. 20 Bullying & harassment score (sexual orientation)

Safe environment (bullying and harassment) by sexual orientation

4.6. The Trust average score was 8.0 out of 10 from 1,934 staff. The group with the lowest score was those staff describing themselves as other at 6.3; 1.4 less than the 7.7 average other score in the mental health provider benchmark. Staff who preferred not to say were next lowest at 7.4; 0.2 difference to their mental health provider benchmark, followed by bisexual staff at 7.5, 0.2 less than the bisexual staff mental health provider benchmark.

Staff experiencing harassment from colleagues by sexual orientation

Fig. 21 Bullying & harassment score from colleagues (sexual orientation)

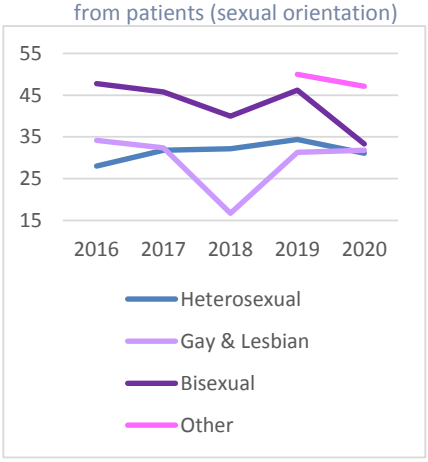


4.7. 31.3% (n.5) of those staff declaring as other experienced at least one incident of bullying, harassment or abuse from their colleagues. There were decreases for staff of all sexual orientations, except an increase of thirteen percent (30.6%) for bisexual staff (n.12).

Staff experiencing harassment from patients by sexual orientation

4.8. All groups experienced harassment from patients with those identifying as other at the highest with 47% (n.8) and those identifying as heterosexual or straight the lowest at 31.3% (n.517). Every group experiencing harassment from patients decreased except for a 0.5% increase for those identifying as gay or lesbian.

Fig. 22 Bullying & harassment score from patients (sexual orientation)



Sexual orientation equality, diversity & inclusion score

4.9. The Trust average score was 8.9 out of 10 for all 2,015 staff. The group with the lowest scores were bisexual and other at 8.5, 0.2 less than the mental health provider bisexual benchmark, followed by other at 8.9, which was very slightly better than the mental provider gay staff benchmark.

Stonewall Diversity Champions

4.10. The Trust became Stonewall Diversity Champions in 2020 allowing the Trust use of the Diversity Champion logo to use on promotional materials, listing KMPT on the Proud Employers careers site and setting the Trust out as an inclusive employer of choice. There was also access to an annual series of seminars and webinars which the Trust were unable to take full advantage of due to Covid-19.

Stonew

NEXT STEPS FOR SEXUAL ORIENTATION EQUALITY 2021-22

- Redesigning logo of LGBTQ++ network to use the inclusive progress flag
- Develop a WRES/WDES style report for sexual orientation

DISABILITY

7% of the workforce shared that they identify as disabled on their staff record, with 12% choosing not to share their disability status. People who were disabled were just as likely to be appointed from shortlisting than non-disabled people against this key national workplace disability equality standard (WDES) measure.

84% of disabled staff felt the Trust made adequate adjustments to enable them to work; an increase of 7.9% on the previous twelve months. The disability staff network has 53 registered members.

5.1. Across 2020-21 the Trust continued to advance disability equality and make reasonable adjustments for disabled people in our workplaces and to facilitate that their voices be heard (WDES 9):

- Introduced the Staff Wellness Passport, which was designed by the Trust's disAbility Staff Network
- Rolled out Disability Awareness Training delivered by Disability Rights UK

5.2. Disabled staff scored on average 6.8 out of 10 for how engaged they felt; 5% different from the 7.2 out of 10 score of non-disabled staff.

KEY FINDINGS: DISABILITY

Workforce disability representation (WDES 1) A

5.3. The number of people sharing their disability with the Trust at 31 March 2021 on their staff record was 236, or 6.8% of the workforce. The group not wishing to share their disability status is at 11.9%, hence the amber rating. There were 22.3% (n.450) of 2,015 who answered the staff survey 2020 and selected they were disabled.

5.4. Staff in agenda for change (AfC) pay band 6 had the largest proportion of disabled staff at 25% (n. 59), with 1.7% sharing a disability in the AfC 8c-9 cluster.

5.5. Over the last year the amount of staff sharing their disability status grew by 0.8% overall.

Fig. 23 Workforce by disability status

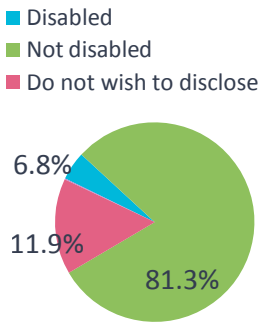
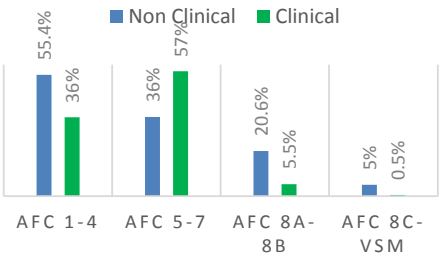


Fig. 24 Disability (%) by staff cluster



Shortlisting-to-appointment by disability (WDES 2) A

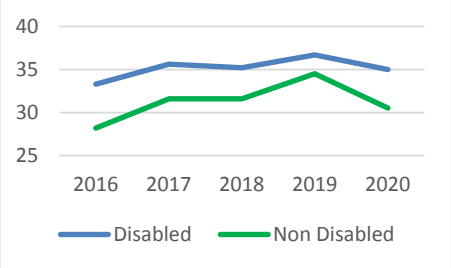
5.6. There were 45 disabled people and 547 non-disabled people appointed in 2020-21. Non-disabled people were 1.2 times more likely to be appointed from shortlisting as disabled people. If the Trust had employed 9 more disabled people it would have achieved equality in appointments.

Formal capability likelihood by disability (WDES 3) G

5.7. No people who had shared they were disabled on their staff record entered a formal capability process in 2020-21. There were 6 non-disabled people who entered a formal capability process.

Harassment, bullying or abuse by disability (WDES 4) A

Fig. 25 Patient-on-staff harassment by Disability

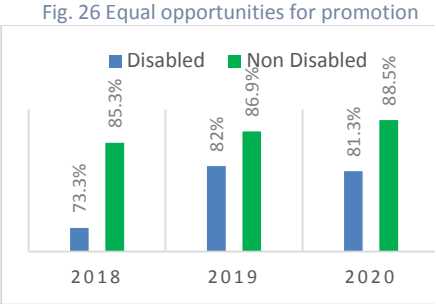


5.8. 35% of disabled staff in the 2020 staff survey experienced harassment, bullying or abuse from patients, relatives or the public in the prior 12 months, a 5% difference from the 30% of non-disabled staff, and a 4% difference from the disabled staff mental health provider benchmark (31%).

5.9. 16.2% of disabled staff experienced harassment, bullying or abuse from managers, nearly double that of the 8.6% of non-disabled staff, and a decreasing three-year trend for non-disabled staff.

5.10. 24.5% of disabled staff experienced harassment, bullying or abuse from other colleagues, a 11-point difference from the 13.6% of non-disabled staff, and an increasing three-year trend for disabled staff.

Fig. 26 Equal opportunities for promotion



Disability equal opportunities for promotion (WDES 5) A

5.11. 81.3% of disabled staff felt the Trust provided equal opportunitiesfor promotion, with a positive (more desirable) trend over three years, a 6.7-point difference from the 88.5% of non-disabled staff, hence the amber rating. The Trust disabled staff figure is similar to the disabled staff mental health provider benchmark (82%).

Pressure to work when unwell by disability (WDES 6) A

5.12. 25.6% of disabled staff felt management pressure to come to work when not feeling well enough, nearly a 6-point difference from the 19.2% of non-disabled staff.

Trust values their work by disability (WDES 7) A

5.13. 44.3% of disabled staff felt the Trust valued their work, a 11-point difference from the 55.3% of non-disabled staff but similar to that of the disabled staff mental health provider benchmark of 44.6%.

Adequate adjustments for disabled people (WDES 8) A

5.14. 84.8% of disabled staff felt the Trust made adequate adjustment(s)to enable them to carry out their work. A 7.9% increase on those disabled staff completing the staff survey in the previous twelve months.

Board disability membership (WDES 10) R

5.15. The Board, including voting and executive, was 100% non-disabled.

NEXT STEPS FOR DISABILITY EQUALITY 2019-20

- Collect disabled staff life stories 'Hidden Talents' to raise staff awareness
- Produce a handbook for managers in accessing the right information to support their staff who have disabilities

- Review and produce a new WDES action plan developed with our disAbility network

AGE

Staff in the 16-20 years age group have 'average' perceptions of equality of opportunity, higher than the mental health sector benchmark.

Staff in the 41-50 years age group report on average lower perceptions of equality of opportunity than all other age groups, and the mental health sector benchmark, with a decreasing trend over time.

6.1. Across 2020-21 the Trust continued its work to promote age equality between people of different ages. Key achievements include:

- Working with Finance to ensure Older Adults Care Group is consistently considered for funding opportunities
- Raising age discrimination to the Trust wide Equality and Diversity Steering Group

KEY FINDINGS: AGE

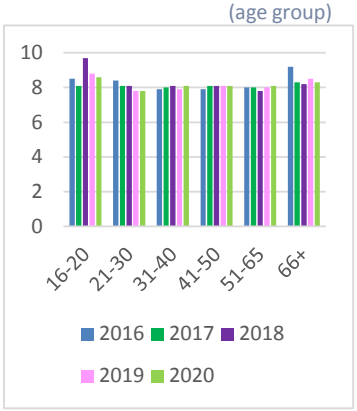
Workforce age representation

6.2. The Trust staff in FTE posts grew by 8.4% over three years from 2836 to 3077 in 2020.

6.3. The largest absolute percentage increase in any age group in the workforce over the last three years was the extra 45 people in the 61-65 years' group.

6.4. The smallest absolute percentage increase in any age group over the last three years was the extra 7 people in the 66-70 years' group.

Fig. 28 Bullying & harassment score (age group)



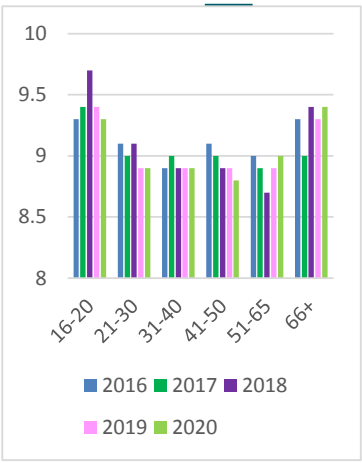
Safe environment (bullying and harassment) by age

6.6. The 16-20 years group gave the highest safe environment score at 8.3 out of 10 of any age group in 2020, and just below the mental health provider benchmark for staff in that age group (8.6).

6.7. Scores decreased in 2020 (8.3) for the 66 and over age groups from 2019 (8.5), and either increased slightly or remained the same for all other age groups, the national trend increased (8.7) in the mental health benchmark for that particular age group (66+).

6.8. The 21-30 years group gave the lowest safe environment score at 7.8 out of 10 of any age group in 2020, lower than the mental health provider benchmark for staff in that age group (8.3)and just lower than the Trust average score (8.0).

Fig. 29 Equality, diversity & inclusion score (age group)



Age equality, diversity and inclusion score

6.9. The 66 years' + group gave the highest equality, diversity and inclusion score at 9.4 out of 10 of any age group in 2020, higher than the mental health provider benchmark for staff in that age group (9.2) and higher than the Trust average score (8.9).

6.10. The 41-50 years group gave the lowest equality, diversity and inclusion score at 8.8 out of 10 of any age group in 2020, lower than the community provider benchmark for staff in that age group (9.0), with a decreasing trend within the Trust over the past five-years.

NEXT STEPS FOR AGE EQUALITY 2019-20

- Deliver a staff engagement programme aimed at identifying the experiences and needs of the growing number of staff aged 51+ years working at the Trust
- Increase the awareness of age discrimination across the Trust

ORGANISATIONAL INCLUSION

Operation Cavell launched on 15th February 2021 and is a joint initiative with Kent Police to tackle hate crime and violence against KMPT staff.

A new equality impact assessment process was rolled out across the organisation and work has begun on improving collection of demographic data of patients.

7.1. In addition to the progress made highlighted in each section, across 2020-21 the Trust continued certain trust-wide initiatives toadvance equality of opportunity eliminate discrimination and foster good relations. Key achievements include:

- Rolling out a new equality impact assessment process
- Developing and piloting a reverse mentoring programme
- Rolled out the accessibility information standard training for all front-line staff
- Set up a working group to ensure better capture of demographic information about patients

KEY FINDINGS: INCLUSION

Equality, diversity and inclusion (EDI) score

7.2. The Trust average score for equality, diversity and inclusion was 8.9 out of 10, similar to the mental health provider benchmark.

Safe environment (bullying and harassment)

7.3. The Trust average score for a safe environment relating to bullying and harassment was 8.0 out of 10, this is 0.3 lower than the mental health provider benchmark

NEXT STEPS FOR CULTURAL INCLUSION 2021-22

INCLUSIVE LEADERSHIP& CULTURE

We will provide opportunities for allies and for role models to develop cultural competence by increasing support for leaders to identify bias, to reduce prejudice and to eliminate systemic barriers.

We will align systems to strengthen the conditions for change; embedding inclusion within talent management, and tying recognition for inclusive behaviours within staff appraisals.

We will be producing new action plans for our WRES and WDES and incorporate the 6 national actions for the overhaul of recruitment to decrease our race disparity ratio into our WRES reporting.

We will work with our staff networks to improve our understanding of the impact of intersectionality to overcome the barriers faced by our staff and our patients.

	Title of Meeting	**Public Board Meeting**
	Meeting Date	**30 September 2021**
	Title	**Audit and Risk Committee (ARC) Report**
	Author	**Peter Conway, Chair of ARC**
	Presenter	**Peter Conway, Chair of ARC**
	Executive Director Sponsor	**N/A**
	Purpose	**Assurance**

ARC met on 22 September 2021 to consider:

- Risk Registers, Risk Management, Estates deep-dive
- Auditors' Progress Reports
- Finance Matters
- Health & Safety, Fire Safety, Emergency Planning Resilience and Response, Policies
- Information Governance, Cyber Security

Area	**Assurance**	**Items for Board's Consideration and/or Next Steps**
Risk Management	BAF, Trust Risk Register, Estates - *Partial Assurance*	(1)The enhancement of processes and formats remain work-in-progress. (2)BAF and Trust Risk Registers are incomplete in terms of totality and severity of risks. Retention, recruitment, staff engagement to be restated and several Estates risks need to be included (see below) (3)Estates - 6 significant risks which will require time, money and resource to mitigate (statutory compliance, capital funding, contract management, capability and capacity of the team, Orchards House, ongoing maintenance). All impact on patient and staff experience/safety and referred to ARC as a concern by QC
External Audit	Auditor's Annual Report - *Reasonable Assurance*	
Internal Audit	Progress Report - *Reasonable Assurance*	3x reasonable assurance reports (data quality of KPIs, site visits and safeguarding, 1x limited (E-Roster) and 1 follow up (IT facilities). E-Roster remediation planned by end November. Too many remedations of recommendations now overdue so ARC to have a deep-dive on this at next meeting in December
Counter Fraud	Progress Report - *Reasonable Assurance*	
Finance Matters	Single Tender Waivers, Cyber Security, Staff	(1)STWs - 1 ST rejected but it still went ahead (training contract) (2)Cyber - benchmarks well to peers

	Overpayments - *Reasonable Assurance*	(3)Staff overpayments - 145 overpayments with value £176k in 15 month period. Actions in train to improve
Governance	Health & Safety, Fire Safety, Emergency Planning Resilience and Response, Policies - *Reasonable Assurance*	1)Gifts/Hospitality Policy rejected as too long and not reader friendly
Information Governance	WTE reporting, IG Progress Report, Data Incident - *Partial Assurance*	(1)WTE reporting - reconciliation of ESR/Finance data being scoped with support of Attain (2)Data Incident re loss of paper files archiving - poor performance from outsourced supplier of paper files archiving. Remediation in train including review of supplier, financials and electronic options