AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 31st March 2022
Time 9.30 to 12.15
Venue Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/20-21/112	1.	Welcome, Introductions & Apologies		Verbal	Chair	9.30
TB/20-21/113	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/20-21/114	3.	Personal Story – Veterans		Verbal		9.35
TB/20-21/115	4.	Quality Improvement: Minimising violence and aggression in acute inpatient units		Verbal		9.45
STANDING ITEMS						
TB/20-21/116	5.	Minutes of the previous meeting – 27/01/2022	FA	Paper	Chair	9.55
TB/20-21/117	6.	Action Log & Matters Arising	FN	Paper	Chair	10.00
TB/20-21/118	7.	Chair's Report	FN	Paper	JC	10.05
TB/20-21/119	8.	Chief Executive's Report	FN	Paper	HG	10.10
TB/20-21/120	9.	Board Assurance Framework	FA	Paper	SS	10.20
QUALITY IMPROVEMENT AND SAFETY						
TB/20-21/121	10.	CQC Well-Led Inspection Update	FD	Paper	HG	10.30
TB/20-21/122	11.	Workforce Deep Dive – Agency staff strategy	FD	Paper	SG	10.35
TB/20-21/123	12.	Strategic Delivery Plan Priorities for 2022/23	FA	Paper	HG	10.45
SYSTEM UPDATE						
TB/20-21/124	13.	Mental Health, Learning Disability and Autism Improvement Board update	FD	Paper	HG	10.55
OPERATIONAL ASSURANCE						
TB/20-21/125	14.	Integrated Quality and Performance Report – Month 11	FD	Paper	HG	11.05
TB/20-21/126	15.	Finance Report: Month 11	FD	Paper	SS	11.25
TB/20-21/127	16.	'The Year of the Community Team' update	FD	Paper	KLa/ EE	11.35
GOVERNANCE						
TB/20-21/128	17.	Register of Interests	FN	Paper	TS	11.45
TB/20-21/129	18.	Managing Conflicts – gifts and hospitality policy	FA	Paper	TS	11.50
TB/20-21/130	19.	Standing Financial Instructions	FA	Paper	SS	11.55
TB/20-21/131	20.	Quality Committee Terms of Reference	FA	Paper	TS	12.00
CONSENT ITEMS						
TB/20-21/132	21.	Quality Committee Chair Report	FN	Paper	FC	12.05
TB/20-21/133	22.	Workforce and Organisational Development Committee Chair Report	FN	Paper	VB	
TB/20-21/134	23.	Audit and Risk Committee Chair Report	FN	Paper	PC	

TB/20-21/135	24.	Finance and Performance Committee Chair Report	FN	Paper	MW	
CLOSING ITEMS						
TB/20-21/136	25.	Any Other Business			Chair	12.10
TB/20-21/137	26.	Questions from Public			Chair	
	Date of Next Meeting: 25th May 2022					

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

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
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Martin Carpenter	MC	NExT Director Scheme
Helen Greatorex	CE	Chief Executive
Vincent Badu	VB2	Executive Director of Partnership and Strategy/(Deputy CEO)
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer
Sheila Stenson	SS	Executive Director of Finance & Performance
Sandra Goatley	SG	Director of Workforce & Organisational Development
In attendance:		
Tony Saroy	TS	Trust Secretary (Minutes)
Hannah Puttock	HP	Deputy Trust Secretary
Kindra Hyttner	KH	Director of Communications
Kirsten Lawson	KL	Deputy Medical Director/Clinical Director - CMHTs
Dr Efiong Ephraim	EE	Consultant Older Adult Psychiatrist/Clinical Director– Older Adult Care Group
Apologies:		
Sean Bone-Knell	SB-K	Non-Executive Director

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 27th January 2022
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	Non-Executive Director
	Fiona Carragher	FC	Non-Executive Director
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Martin Carpenter	MC	NExT Director Scheme
	Helen Greatorex	HG	Chief Executive
	Vincent Badu	VB2	Executive Director Partnerships & Strategy/Deputy CE
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Jacquie Mowbray-Gould	JMG	Chief Operating Officer
	Sandra Goatley	SG	Director of Workforce and Organisational Development
	Sheila Stenson	SS	Executive Director of Finance and Performance
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
	Kindra Hyttner	KH	Director of Communications
	Daniel Lagadu	DL	Head of Quality Improvement – item TB/21-22/92 only
	Mudasir Firdosi	MF	Clinical Director of Quality Improvement – item TB/21-22/92 only
Observers:			
	Emily Musara	EM	Service Manager
	Lauren Cane	LC	Urgent Access Lead

Item	Subject	Action
TB/21-22/91	**Welcome, Introduction and Apologies** The Chair welcomed members to the first Board meeting of 2022, as well as the members of the public, attendees and observers.	
TB/21-22/92	**Declarations of Interest** There were no declarations of interest.	
TB/21-22/93	**Personal Story: Quality Improvement** AQ introduced Daniel Lagadu and Dr Firdosi. DL gave an update on how quality improvement (QI) has helped KMPT to achieve a significantly improved position on mental capacity assessments and best interest discussions. The issue was first noted through the trust's CLiQ check audit system, which showed that the trust was either not having or recording relevant mental capacity and best interest conversations that were taking place with patients. The QI project team looked at the barriers and opportunities and where changes had been successful in other areas of the organisation. It was agreed	

Item	Subject	Action
	that a new mandatory training should be launched for staff, delivered through workshops and engagement exercises. The administration teams were trained on the effective recording of conversations. Once implemented, there was a significant positive change in the audit data which showed a stepped improvement in the recording of mental capacity assessments and best interest discussions. The project is currently at its 6-month check point and work is being carried out to ensure the changes have been sustained. It was confirmed that on a number of current projects service users are involved to ensure the patient's voice is heard. Work in on-going with the patient engagement team to co-produce other QI projects. Engagement with staff was discussed and it was noted that further QI training will be available, including one-hour bite size modules. The Board reflected on the Personal Story and recognised the positive impact this has had.	
TB/21-22/94	**Minutes of the previous meeting – 25/11/2021** The Board **approved** the previous minutes save for the following changes: • Item TB/21-22/72 – Chief Executive's Report: the words 'increasing staffing, streamlining processes and develop specialities' to be amended to say 'increasing staffing, streamlining processes and developing the service as a speciality' • Item TB/21-22/80 – Workforce Report: Fourth bullet point to be amended to state 'just below the top performing mental health trust'. • The term 'COVID-19' to be capitalised throughout the minutes.	
TB/21-22/95	**Action Log & Matters Arising** Action TB/21-22/73 – Board Assurance Framework was discussed and it was noted that the estates prioritisation plan is due to be discussed shortly and it was agreed this should come back to the March board meeting. **ACTION: By March 2022, TS to arrange for the estates prioritisation plan to be discussed at the next Board meeting.** Regarding action TB/21-22/80 – Workforce Report, the Board seminar scheduled for March 2022 to be renamed 'Hybrid working', which will focus on a combination of clinical and corporate services. The Board **approved** the Action Log.	
TB/21-22/96	**Chair's Report** The Board received the Chair's Report, with the Board approve the name change of the 'Executive Assurance Committee' to the 'Executive Assurance Group'. Noting this was JMG's final Board meeting, the Board gave its formal thanks for her service to the Trust and the difference she has made as Chief Operating Officer.	

Item	Subject	Action
	The Board **noted** the Chair's Report and **approved** the new name of Executive Assurance Group.	
TB/21-22/97	**Chief Executive's Report** The Chief Executive's Report was received by the Board. The Chief Executive highlighted: • Since the board's last meeting in November, the Omicron variant of COVID-19 has become a significant national concern. KMPT has continued to keep service users and staff safe. • AQ is now the lead for improving memory assessments waiting times. • KMPT is working in partnership with Alzheimer's Society that will bring to the county and deploy national best practice, setting an ambition and pace across the system. • The Trust received its highest ever response rate for the staff survey at 68%. • The Trust will open the first of three new high-quality staff rest spaces at Dartford in July, with all rest spaces to be ready by October. The Board expressed its disappointment that the staff rest areas had been delayed again. The Board **noted** the Chief Executive's report.	
TB/21-22/98	**Board Assurance Framework** The Board received the Board Assurance Framework (BAF), with SS highlighting that since the last iteration: • Two new risks have been added to the BAF – one regarding mandatory COVID-19 vaccinations, and the other one being unable to meet memory assessment demand. • No risks have increased in risk score. • Two risks have reduced in score. • It is recommended for the removal of Risk ID 6626 – Development of a Crisis Line. • Estates risks have now been added to the BAF following discussions at the last Board meeting. The Board raised concerns around removing the risk of the development of the crisis line given that the new phone system has only been in place a few weeks. It was agreed that the Board should retain oversight and the risk should remain on the BAF for the moment. The Board **noted** the Board Assurance Framework.	
TB/21-22/99	**Progress on Turning the Ride; Tackling Racism** The Board received the Progress on Turning the Tide; Tackling Racism report, which was noted. In June 2020, Simon Cook as Chair of the Trust's Black, Asian and Minority Ethnic (BAME) Staff Network raised seven challenges in tackling racism. The Board had accepted those seven challenges as focus areas of work,	

Item	Subject	Action
	HG confirmed that progress has been made against each of the challenges, with highlights including • the launch with Kent Police of Operation Cavell – tackling hate crime in February 2021, • creation of a dedicated Diversity and Inclusion Lead post in the Integrated Care System, • a programme of training and development for mentees and mentors through the first BAME reverse mentoring programme and • the appointment of 160 BAME allies. The Board reflected on the seven challenges and whether there are other criteria that the Trust should be benchmarking itself against in tackling racism, for example the national BAME standards. The Board recognised the importance of the emotional impact of the seven challenges but recognised that work may need to be done to ensure these align with wider considerations including any national reporting standards, resulting in an integrated approach to board oversight on this issue. The Board discussed the issue of BAME staff and disciplinary matters, noting that BAME staff are over represented. The Trust is not only addressing this issue, but also implementing alternative methods of dealing with issues without having to use disciplinary proceedings. Currently 12 workplace mediators are being trained across the trust to assist with this, and next year a further 24 workplace mediators will be trained. It was agreed that JC, HG, SG and VB should meet to discuss how the tackling racism updates are reported up to the Board to ensure that a range of standards and requirements are integrated into a single report. **ACTION: By March 2022, JC, HG, SG and VB are to meet to discuss how the tackling racism updates are reported up to Board to ensure that all statutory requirements are met as well as avoiding a duplication in reporting.** The Board **noted** the Progress on Turning the Ride; Tackling Racism update.	
TB/21-22/100	**KMPT'S Green Plan** The Board received the paper on KMPT's 'Green Plan'. In accordance with the NHS pledge to a commit to sustainable development and long-term carbon dioxide emission reductions, the trust has developed a Green Plan which will deliver and provide sustainable healthcare and mental health services. The green plan focuses on 10 main areas split across 4 themes of embedding sustainability, direct emissions, partnership working and travel. The Board praised the green plan, recognising how clear and concise it is. The Board discussed the targets included within the plan, noting that these are ambitious but would also be cost heavy and recognised that the trust should only set itself targets that it knows are possible to meet. The Board recommended that a significant goal should be set for the Trust within the first year of the introduction of the strategy to demonstrate the trust's commitment. It	

Item	Subject	Action
	was further suggested that individual teams should also be set targets so staff feel involved with the strategy. It was recognised that the Green Plan creates a great opportunity for the trust to work with third sector partners to ensure delivery of the plan. Regarding the new build due to begin shortly on the Maidstone site, it was confirmed that this is being completed in the most environmentally sound way possible, and will have a charging points available for electric cars. The Board recognised, in addition, that the trust needs to think about what its workforce will need in 20 years' time and what will be expected of patients, to avoid further costs and changes needing to be made later down the line. The Board **noted** KMPT'S Green Plan.	
TB/21-22/101	**Integrated Quality and Performance Report (IQPR) – Month 9** The Board received the IQPR, and noted the three main areas of focus: staffing, memory assessment and agency spend. <u>Staffing</u> Regarding staffing, the trust continues to struggle to deliver its key performance indicators for workforce; however when benchmarking, the trust is not an outlier compared to its peers. Sickness continues to above its target of 4%, currently standing at 4.78% including COVID-19 sickness. Deep dives into long term sickness are taking place within each of the care groups. Staff turnover remains high; although the number of staff joining the Trust continues to increase, it is being outpaced by the number of staff leaving. A new centralised process for exit interviews was put into place in December 2021; a paper will be taken to the Workforce and Organisational Development Committee with an update. An update was given on mandatory COVID-19 vaccinations for KMPT staff, noting there are currently 90 people have declined the vaccination despite ongoing conversations. Re-deployment and adaption of job roles will be considered for unvaccinated staff where possible however, this will not be possible across the whole organisation. A recruitment plan is being discussed to recruit to the roles that are likely to become vacant. Going forward, subject to an equality impact assessment, the organisation is taking the view that all new staff, bank staff and agency staff will have to be fully vaccinated irrespective of the role. <u>Memory Assessment Service</u> The Board discussed memory assessments, recognising that these continue to be a challenge due to the high numbers of referrals and the current backlog. The Trust has a capacity of 700 memory assessments per month, but is receiving 1000 referrals per month. The Trust has a trajectory of 66% by 2023 and was on track to meet this trajectory however, in month 9 memory assessments fell short of their trajectory by 0.45%. A task and finish group has identified 3 areas for improvement: a streamlined referral pathway (with a new triage tool), a fast track memory assessment service starting in Dartford and being rolled out across the county by May and accreditations for GPs so they can start carrying out memory assessments once they have completed their	

Item	Subject	Action
	one-year training. The Board recognised the importance of any solutions being sustainable and not short-term. It was agreed going forward, the Board should receive key actions and benchmarking on memory assessments within the IQPR. **ACTION: By March 2022, the IQPR to be adjusted so as to include a regular update on actions and benchmarking for memory assessments.** <u>Agency spend</u> There was a significant increase in agency use in December, with a further increase expected for January. There is an upward trend in medical agency spend and it has been identified that some agency doctors are being paid higher than the agency cap. Weekly medical agency spend meetings have now commenced with care groups to understand why agency is being used and how this can be reduced. It was noted that control targets had been put in place for each care group in November 2021 however, this has been breached across all care groups. Addressing agency spend is again a priority for the trust, with a focus on developing a sustainable approach to care group control targets in parallel with accelerating the work on new roles and improved retention. The **Board** noted the IQPR.	
TB/21-22/102	**Finance Report: Month 9** The Board received the Finance Report (Month 9), with the following matters highlighted: • **Income and Expenditure:** Within the breakeven position reported, there are several key factors. There are continued pressures in temporary staffing due to vacancies and staff absence. Year to date agency spend at the end of December was £5.7m, £1.0m lower than the same period last financial year. Agency spend remains at high levels with increases within medical agency in month. There are also rising costs in Estates maintenance as we address backlog issues across the Trust. • **Capital Programme:** The year to date position is underspent by £6.1m, £0.15m on IM&T, £3.8m on estates and £2.2m on strategic schemes and the Improving Mental Health Services programme. The year-end forecast of £10.9m has increased by £0.25m due to funding received for Cyber Security. The forecast will be updated in the coming weeks to reflect the rephasing of the Improving Mental Health Services Programme and 21/22 planned estates schemes. Any reduction in spend in the current year will put pressure on the capital budget for 22/23 and will need to be managed with the system. • **Cash:** The cash position increased by £0.7m in month to £19.6m, £6.3m higher than the original plan. Payments are £7.2m lower than plan due to slippage on the capital programme and reduced creditor payments, partially offset by the pay award. The forecast for year-end has been increased by £1.9m to £16.5m reflecting movements in the working capital position based on recent trends. Regarding financial planning for 2022-23, guidance has now been released and the draft financial plan is due to be submitted on 17th March, and the final plan to be submitted on 29th April. The next financial year will move away from the	

Item	Subject	Action
	COVID-19 financial regime and contracts will need to be negotiated with the trust's commissioners. The Board **noted** the finance report for month 9.	
TB/21-22/103	**Remuneration and Terms of Service Committee's Terms of Reference** The Board **approved** the Remuneration and Terms of Service Committee's Terms of Reference.	
TB/21-22/104	**Mental Health Act Committee Chair Report** The Board **received** and **noted** the Mental Health Act Committee Chair Report.	
TB/21-22/105	**Audit and Risk Committee Chair Report** The Board **received** and **noted** the Audit and Risk Committee Chair Report.	
TB/21-22/106	**Workforce and Organisational Development Committee Chair Report** The Board **received** and **noted** the Workforce and Organisational Development Committee Chair Report.	
TB/21-22/107	**Quality Committee Chair Report** The Board **received** and **noted** the Quality Committee Chair Report.	
TB/21-22/108	**Finance and Performance Committee Chair Report** The Board **received** and **noted** the Finance and Performance Committee Chair Report.	
TB/21-22/109	**Any Other Business** It was confirmed that the whole of the board is vaccinated against COVID-19.	
TB/21-22/110	**Questions from Public** There were no questions received from the Public. Feedback was received from the senior leaders observing the meeting, who found attending the meeting a valuable experience and felt that what was being discussed was mirrored and discussed by front line staff.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 31st March 2022	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 24/03/2022

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 MARCH 2022								
25.11.2021	TB/21-22/72	Chief Executive's Report	By January 2022, Dr Kirsten Lawson to provide progress report on CMHT work concerning increasing staffing, streamlining processes and developing the service as a speciality.	Dr Kirsten Lawson	January 2022	March 2022	Item is on the Board agenda	**Complete**
27.01.2022	TB/21-22/95	Action Log & Matters Arising	By March 2022, TS to arrange for the estates prioritisation plan to be discussed at the next Board meeting.	TS	March 2022		Since the last Board meeting, the Chair of the Audit and Risk Committee and the Chair of Finance and Performance Committee have considered the Trust's estates prioritisation plan. On behalf of the Board, both have been assured regarding the Trust's estates prioritisation plan.	Complete
27.01.2022	TB/21-22/99	Progress on Turning the Ride; Tackling Racism	By March 2022, JC, HG, SG and VB are to meet to discuss how the tackling racism updates are reported up to Board to ensure that all statutory requirements are met as well as avoiding a duplication in reporting.	JC	March 2022		The Trust will arrange an externally facilitated board seminar on the subject of the board approach to diversity and racism. Seminar scheduled to take place in July 2022	Complete
27.01.2022	TB/21-22/101	Integrated Quality and Performance Report – Memory assessment service	By March 2022, the IQPR to be adjusted so as to include a regular update on actions and benchmarking for memory assessments.	HG/SS	March 2022		Work is ongoing to include the datasets and an updated IQPR to be presented in May 2022.	In progress
ACTIONS NOT DUE OR IN PROGRESS								
25.11.2021	TB/21-22/74	Mental Health, Learning Disability and Autism (MHLDA) Improvement Board Update	In May 2022, HG to produce a year-end MHLDA Improvement Board report detailing what the position was last year, what the position is now, what are the future trajectories and how is learning shared.	HG	May 2022			
25.11.2021	TB/21-22/75	Strategic Delivery Plan Priorities Update	HG to give a year-end progress report on Operation Cavell in May 2022.	HG	May 2022			
25.11.2021	TB/21-22/76	Kent, Surrey and Sussex Provider Collaborative Update	SS to provide further update on the Kent, Surrey and Sussex Provider Collaborative by May 2022.	SS	May 2022			

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 24/03/2022

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
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 2022.	CEO	January 2022		On January agenda	**Complete**
25.11.2021	TB/21-22/72	Chief Executive's Report	By January 2022, TS to circulate upcoming Leaders events and Big Conversation dates to Board members for their optional attendance.	TS	January 2022		List circulated to Board members	**Complete**
25.11.2021	TB/21-22/73	Board Assurance Framework	SS, in consultation with HG and MM, to produce a single prioritisation plan for estates and finance. The prioritisation plan is to be provided to MW and PC for comment and consideration by December 2021.	SS	Update to Board in January 2022		Item to be taken to the Finance and Performance Committee in January 2022	**Complete**
25.11.2021	TB/21-22/77	Eradicating dormitory wards in mental health facilities in Kent and Medway	On behalf of the Board, TS to inform Trust-wide Patient Experience Group (TWPEG) that the monitoring of travel impact on family and carers as a result of relocation of Ruby Ward has been formally delegated to that group. Action to be completed by December 2021.	TS	Update to Board in January 2022		E-mail sent to admin support to TWPEG on 9th December 2021	**Complete**
25.11.2021	TB/21-22/80	Workforce Report	By January 2022, TS to schedule a Board seminar on new staff model profile.	TS	January 2022		Scheduled for March seminar	**Complete**
25.11.2021	TB/21-22/83	Development, Approval and Management of Formal Trust Documents - Policy and Procedures	TS to amend the 'certificate of formal trust documents approval' (appendix D of the document) to include confirmation that an Equality Impact Assessment has been completed and reviewed.	TS	January 2022		Appendix D was amended and is now part of the published Development, Approval and Management of Formal Trust Documents - Policy and Procedures	**Complete**

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 31st March 2022**
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 four matters:

- Kent & Medway system
- Board Development Day
- Trust Chair and Non-Executive Director visits
- Congratulations

2. Kent & Medway system

Relationships continue to flourish across the Integrated Care System, including between the Chairs. There are two key events for noting. First, the Chairs have taken on the role of chairing the Health & Care Partnership boards (formerly known as 'Place') of which there are four in Kent & Medway; I will be chairing the Dartford, Gravesham & Swanley HCP going forwards. Second, following agreement at the Partnership Board, the Mental Health, Learning Disability & Autism Improvement Board will move to the next stage in its development. Working as a provider collaborative, this board will become more strategic in its remit, providing vision as well as assurance to the system. I will be chairing the new Board with my colleague, John Goulston, who is Chair of Kent Community Health Foundation Trust.

3. Patient Engagement Council

On the 24th February 2022, the Board met virtually for three Board seminars. One of the seminars included the first joint session between the Trust Board and the new Patient Engagement Council. The session included introductions and getting to know each other, discussions around our strategic priorities and hearing about the Engagement Council's priorities and plans, with an opportunity for questions. The Board welcomes this development, and were keen to ensure that the Engagement Council is enabled to work with the trust in ways that achieve a real impact.

It was agreed that the Trust Board should continue to meet with the Patient Engagement Council on a bi-annual basis and discussions should take place around how the Patient Engagement Council can work with the Trust Board to ensure it achieves its strategic priorities.

4. Trust Chair and NED visits

Since the last Board meeting, the NEDs temporarily paused their site visits to KMPT services until March 2022. During this time period Trust staff remained focused on delivering services with a number of pressures however, some virtual visits did take place. Since March 2022, in-person visits have begun again with the following visits having taken place.

Where	Who
February 2022	
Volunteers Team	Jackie Craissati
Innovation Panel	Catherine Walker
LGBTQ+ staff network	Jackie Craissati
March 2022	
Newhaven Lodge	Jackie Craissati
Disablement Service	Jackie Craissati
Medway Crisis & Home Treatment Team	Jackie Craissati

Chair

I would like to thank all the staff on the Medway Hospital site who made my visit to the three KMPT services so enjoyable and informative. All the services had considerable strengths, and I was struck by the commitment of the hard-working staff who were providing great care. The issues raised were diverse, and included:

- The demands on the Crisis & Home Treatment team in terms of lone working, pressure of referrals not all of which were appropriate, and the crisis needs of those service users with emotionally complex presentations.
- The need for us to support the disablement service in resolving financial pressures and the requirement to move from the current premises.
- Delayed transfers experienced by residents in the rehabilitation unit, and the potential for new staffing models to assist with this.

In addition to my usual – and hugely enjoyable – participation in the Big Conversation and Leaders events, I was delighted to join the LGBTQ+ history month celebration in February. There were some great speakers and I felt it was a very moving event at times, as well as uplifting.

Catherine Walker - Innovation Fund Panel

I chaired the second session of the Innovation Fund Panel where colleagues from all over the Trust bring innovative ideas to help us deliver brilliant care by brilliant people. This time there were 27 wonderful and varied bids from across the Trust. 7 shortlisted finalists 'pitched' their ideas to the Panel for funding. Diverse ideas included tailored drug descriptions for learning disabled service users and a trial of 'smart' pill dispensers in the community which will send a message to a carer or health care professional when a drug dose is missed. I look forward to the next round to see what ideas our KMPT family come up with!
#KMPTveryproud

5. Congratulations

We are proud to be developing our Quality Improvement approach at KMPT and recently Dr Mudasir Firdosi was awarded first prize by the Faculty of Medical Leadership and Management, for the best presentation on doctor wellbeing which covered minimising violence and restrictive practices within acute inpatient units.

Chief Executive's Board Report

Date of Meeting: 31st March 2022

Introduction

On March 15th, demand for mental health services was noted in a press release shared by the Royal College of Psychiatrists to have increased to a record high (4.3m referrals in 2021) as a result of the pandemic. KMPT has like other similar mental health providers, witnessed significant increase in demand for some of our services and the board remains sighted on both the detail of the resulting pressure and the mitigation in place to manage the associated risk.

Against this backdrop of significant increasing demand, KMPT staff continue to work to the very best of their ability delivering our simple mission, Brilliant Care through Brilliant People. The board this month, will be sharing with every member of staff, a formal thank you and sincere best wishes for the outstanding work that they do every day.

It was pleasing to note that the Care Quality Commission in their Well Led inspection report, published since the last board meeting, formally noted the significant achievements of KMPT staff as well as the pride that colleagues shared with inspectors about the work that they do. The board will hear more about this during today's board meeting.

Mandatory Covid-19 Vaccinations of NHS Staff

When the board last met, in January, it was the government's position that NHS staff must be fully vaccinated against COVID-19 as a condition of employment. That position was revoked in mid-March. All staff have been informed and the opportunity to receive vaccination and booster injections remains open and easy to access for all.

Care Quality Commission (CQC) Well Led Inspection Report

In February, the CQC published their inspection report affirming KMPT's retention of our rating of Good overall, and adding to our Outstanding rating for Caring, a new overall rating of Outstanding for the Effective domain. Today's board will hear more about this important independent assessment of the organisation's performance across a range of areas and importantly, how we are creating a culture of continuous quality improvement.

Hybrid Working and the Closure of Trust Head Quarters

The board has been clear from the start of the pandemic that retaining new and more efficient ways of working that have become a necessity over the last two years is imperative. To that end, we have been working on our approach in KMPT to hybrid working. This month, after consultation with affected staff, we took the decision that we no longer need a central Trust HQ. The old HQ was scheduled for demolition in 2022 as part of a planned programme of building on the Maidstone site and a new HQ due to be built to replace it. The decision taken to close the existing HQ ahead of schedule will mean that the annual expenditure on running it will be recurrently saved. This equates to over seventy thousand pounds a year. The decision not to build a new HQ to replace it, but to work in a different and more effective way will mean a saving of circa £3m in new build costs.

The trust-wide work on more efficient ways of working is rolling out under the heading KMPT Hybrid Working. The Workforce and Organisational Development Committee will continue to receive detailed updates on progress with this trust-wide programme with regular overarching updates to other committees and the board.

New Executive Team Members

Today marks the first Board meeting of our two new executives, Chief Nurse Andy Cruickshank and Chief Operating Officer, Donna Hayward-Sussex. Joining us from East London Foundation Trust and South London and the Maudsley respectively Andy and Donna bring significant experience and expertise with them and are leading significant pieces of work across the organisation. We welcome them both.

Community Mental Health Transformation Model Fidelity Review

The investment of over £10m over three years in transforming our system's community mental health services is good news for the county as a whole. The transformation funds are held by the Clinical Commissioning Group and National Health Service England (NHSE) periodically review the county's approach to this work. In February they assessed our plans as a system and within that as KMPT, and confirmed that we were well positioned to deliver the required transformation. The board will receive a detailed update

Integrated Care System / Board

Executive appointments to the board, which will be formally established in July, are nearing completion. Members of KMPT's Executive Management Team have contributed to the selection process and it is anticipated that an announcement regarding the new team will made in the coming weeks.

KMPT's Big Conversation

This well-established quarterly event which is open to all KMPT staff, took place in March and was attended by over 150 delegates. Both the Chair and Chief Executive were present throughout.

A key question asked of delegates was 'What one thing would make working in KMPT even better?' An online survey (Slido) was used and the biggest response by far was 'Psychological safety'. For that reason, the board will see today, in the item on strategic priorities for the next twelve months, a dedicated target; creating psychological safety

Strategic Priorities

The board will consider today, the three overarching strategic priorities for the year 2022-23. They have been generated through board development work, reflection, discussion and testing across the organisation. Once agreed by the board, a detailed delivery plan will set quarterly milestones that will be reported to the board in public so that we can easily track our progress over the coming year.

Helen Greatorex
Chief Executive

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NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31 March 2022
Title of Paper:	Board Assurance Framework
Author:	Louisa Mace, Risk Manager
Executive Director:	Andy Cruickshank, Chief Nurse

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.

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in January 2022. It was then updated and presented to the Audit and Risk Committee at the beginning of March.

- 1 new risk has been added to the BAF since January
  - Risk ID 6966 – 2022/23 Financial Planning
- No risks have increased in risk score
- 2 risks have reduced in risk score
  - Risk ID 5345 – Participation in Research and Innovation (reduced to rating of 4 (moderate) from 6 (Moderate))
  - Risk ID 5456 – Provider Collaborative (New Care Models) – Secure Services (Reduced to rating of 4 (Moderate) from 8 (High))
- 3 risks are recommended for removal
  - Risk ID 6626 – Development of a Crisis Line
  - Risk ID 6880 – Impact of mandatory COVID vaccinations on staffing levels
  - Risk ID 6850 – H2 Planning

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)

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The Board Assurance Framework

The BAF was last presented to the Board on 31 January 2022. It was updated and presented to the Audit and Risk Committee on 1 March.

The Top Risks are

- Risk ID 6848 – Staff Turnover (Rating of 20 – Extreme)
- Risk ID 6849 – Retention of Employees (Rating of 20 – Extreme)
- Risk ID 6857 – Maintenance Services Funding Availability (Rating of 20 – Extreme)
- Risk ID 3164 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID 6628 - Financial Sustainability (Rating of 16 - Extreme)
- Risk ID 6847 – Sickness (Rating of 16 – Extreme)
- Risk ID 6861 – Estates and Facilities Resources (Rating of 16 – Extreme)
- Risk ID 6880 - Impact of Mandatory COVID vaccinations on staffing levels (Rating of 16 – Extreme)
- Risk ID 6881 - Organisational inability to meet Memory Assessment Service Demand (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

Two risks have reduced in risk score.

- **Risk ID 5345 – Participation in Research and Innovation (reduced to rating of 4 (moderate) from 6 (Moderate))**
  This risk has reduced in score as there is now a Director of research and innovation in post. There has been progress on the other two actions with the Research and Innovation strategy due for ratification in May, and the increase in funding for the Research and Innovation Team being discussed.

- **Risk ID 5456 – Provider Collaborative (New Care Models) – Secure Services (Reduced to rating of 4 (Moderate) from 8 (High))**
  This risk has reduced in risk score as the Collaborative has successfully reduced the number of out of area patients. Additionally, the collaborative is anticipated to deliver a surplus this year which will add to the sustainability.

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Risks Recommended for Removal

Three risks are recommended for removal

- **Risk ID 6626 – Development of a Crisis Line**
  This risk is recommended for closure. The service has been through its development phase and is in place. The new telephony system has now gone live and is working well.

- **Risk ID 6880 – Impact of mandatory COVID vaccinations on staffing levels**
  This risk is recommended for closure. The government mandate for compulsory vaccinations has been withdrawn, so this is no lover a risk to staffing levels.

- **Risk ID 6850 – H2 Planning**
  This risk is recommended for closure. The Trust delivered the H2 plan and a breakeven position. A new risk for the 2022/23 financial plan is being developed and has been added to the BAF.

New Risks

One new risk has been added to the BAF.

- **Risk ID 6966 – 2022/23 Financial Planning**
  This risk has been added to reflect the risk of not delivering the 2022/23 Financial plan.

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 work continues to ensure that all actions are identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners.

Version Control: 01

Updated: 24 March 2022

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NHS and Social Care Partnership Trust

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

				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)
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. 15/11/2021 — Skill mix of CMHSOPs workforce continues, and a workforce plan is in place with immediate, mid and long term actions. Target date for this action has been extended to allow for all clinical care pathway interventions to be being offered. 14/01/2022 — Risk score has reduced slightly. Demand and capacity reamins an issue for the CMHTs, but this risk feels like it is at a steady state. Actions continue to reduce the risk, but there is good oversight at QPR and there does not seem to be any increase in S's or complaints. 22/02/2022 — A review is needed as this relates to Covid. MAS which was one of the highest areas of risk now has its own system risk in BAF and delivery of the CMHF is a 3 year programme due to fully deliver at the end of 2024. Therefore the risk for demand and capacity has mitigations for CMHTs and Older Adult CMHT which will take another two years																		
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	3	12	⟺	**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 / 28/02/2022 / A Dementia Strategy Development / Deputy COO / 31/03/2022 / A	Chief Operating Officer	To be confirmed	3	3	9	30/04/2022
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. 15/11/2021 — The new SPoA SOP has been agreed and approved by the Trust Wide Patient Safety Group. The service is working to locally defined KPIs which are giving good oversight of an agreed set of metrics. Nationally defined KPIs are still awaited, but there is no timescale for these to be received. There is a high level of confidence that this risk is well managed. 14/01/2022 — This risk is recommended for closure. The service has been developed and is in place, and has shown resilience over recent weeks. The new telephony system is in the process of going live and the workforce and recruitment actrions are completed. There will be further development of the service, but this can be considerd under business as usual processes. 22/02/2022 — This risk is recommended for closure. The new telephony system has gone live and is working well.																		
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) Open Access Crisis Programme Board (2a)	3	3	9	⟺	**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 / Completed / G Workforce Development based on new service requirements / Urgent access lead / Competed / G Ongoing recruitment to vacancies to ensure safe operational staffing levels / Urgent access lead / Completed / G Implement new telephony system / Urgent access lead / Completed / G	Chief Operating Officer		3	3	9	14/03/2022
12/01/2022 BAF Risk Opened — The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021. 10/03/2022 — The Dementia SIG have identified key actions for delivery by year end.																			
6881	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by October 2022. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery Programme, Dementia Care Navigators System Partners via MHLDA IB and KM Dementia SIG.	KPI/Targets - 6 week to diagnosis system metric with internal exception reports for 4 week and 18 week targets. NHSE Regional monitoring Kent and Medway system plans and achievement of Dementia Diagnosis Rate via MHLDA IB assurance sessions. NHSE National monitoring via quarterly returns .	4	4	16	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** KMPT providing increased MAS assessment appointments financed by NHSE for remainder of 21/22 financial year / Head of Service / 31/03/2022 / G MHLDA IB to escalate to ICB for addition to system risk register / Chief Execuitve / 18/03/2022 / A Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment / Chief Medical Officer / 31/12/2022 / A Dementia Strategy Development / Chair of K&M Dementia Service Improvement Group / 31/12/2022 / A	Chief Medical Officer	To be confirmed	3	3	9	27/03/2023

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)
	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. → 15/11/2021			Feedback from recent CQC inspections is that the quality and safety process in place are at as good standard. This gives confidence that this risk is well managed. → 10/01/2022					Risk to remain in current format awaiting receipt of CQC focused inspection report, expected February 2022. Thereafter this risk will be reviewed with a view to reframing.						
6052	Mar 2019	Chief Nurse	**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 Feedback from Healthwatch and Mental Health Action group Freedom to speak up process	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Learning from each other (mock 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 — Ongoing — A Learning from each other - Peer reviews — Executive Director of Nursing, AHPs and Quality — Ongoing — A	Chief Nurse		1	3	3	31/03/2022
	04/12/2014 → Risk Opened 04/06/2021		Actions to reduce risk need development → 15/11/2021	The Annual Ligature Audit Window will be undertaken thorugh November. There is a high level of confidence this risk is well manged as evidenced through the Quality Digest and IQPR data. → 15/11/2021			The Annual Ligature Audit was completed in November as planned. The results will be discussed at the January Ligature Monitoring group, and the actions to mitigate this risk will be updated following that.											
4083	Dec 2014	Chief Nurse	**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 Quality Digest reporting to Quality Committee.IQPR reporting to Board	2	4	8	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Refreshed 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 — 01/11/2022 — A Annual Ligature Audit (Undertaken in November) — Deputy Director of Nursing — 28/01/2022 — G	Chief Nurse		1	4	4	31/03/2023
	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. → 15/11/2021	Risk continues to be well controlled. It will remain actively monitored and managed while we are in response to the Pandemic. → 17/01/2022			There is a commitment to central funding for PPE for the 2022/23 financial year. In light of this the target date for this risk has been extended to cover any extended period of uncertainty in relation to the current pandemic response and allow for the learning outcomes from it to be identified.											
6420	Apr 2020	Chief Nurse	**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 weekly (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 to include assessment of any revised Fit testing required. Dedicated tactical control contact details with ICC open 08:00-20:00 daily. Fit testing, Donning and Doffing and Hand Hygiene Training Hybrid working arrangements support a reduction in demand for PPE.	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	Chief Nurse		1	4	4	29/07/2023

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)
2 - Recruit, retain and develop the best staff making KMPT a great place to work																			
17/11/2021 Risk Opened 22/02/2022: Sickness rates have increased over the months of December and January due to the impact of Omicron variant of Covid-19. Consideration is being given to Health and wellbeing initiatives to support staff.													21/03/2022: Sickness levels remain consistent. A Health and Wellbeing Strategy has been drafted and will be presented to EMT for sign off. The current Key actions have been completed. New Actions will be aligned to key strategy deliverables for the coming year.						
6847	Nov 2021	Director of Workforce and Organisational Development	**Sickness** IF we fail to support the health and wellbeing of our staff THEN this will impact on the sickness absence rate RESULTING IN reliance on agency staff, increased cost and potentially lower quality service to patients	5	4	20	Health & Wellbeing Group [2a] Range of targeted support and leadership Musculosketal health and screening Mental wellbeing and stress support Tobacco control Physical activity and active travel Healthy eating and healthy weight Alcohol and substance misuse support Winter wellbeing messaging Health and Wellbeing Conversations [1a]	Monitoring locally, reporting to IQPR Report to WF&OD Committee	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Targeting communications — H&WB lead — 31/03/2022 — G Supporting managers through absence management cases — Deputy Director of Workforce and OD — 31/03/2022 — G Flu vaccination programme — Director of Workforce and OD — 28/02/2022 — G Covid vaccination programme — Deputy Director of Workforce and OD — 31/03/2022 — G	Director of Workforce and Organisational Development	To be confirmed	4	4	16	31/03/2023
17/11/2021 Risk Opened 22/02/2022: Turnover rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning.								21/03/2022: Granular detail from the National Staff Survey has been received and shared with EMT and the WFOD Committee. This detail is being used to inform the priorities for 2022/23											
6848	Nov 2021	Director of Workforce and Organisational Development	**Staff Turnover** IF we have high turnover in Additional Clinical Services and Allied Health Professionals 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	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] Exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1f] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop career pathways — OD Specialist — 31/03/2023 — A Quarterly People Pulse — Director of Workforce and OD — 31/03/2022 — G National Staff Survey — Director of Workforce and OD — 31/01/2022 — G Recruitment and Retention group to deliver on identified workstreams to support retention — HR Business Partners — 31/03/2023 — A	Director of Workforce and Organisational Development	To be confirmed	4	5	20	31/03/2023
17/11/2021 Risk Opened 22/02/2022: Retention rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning.								21/03/2022: Granular detail from the National Staff Survey has been received and shared with EMT and the WFOD Committee. This detail is being used to inform the priorities for 2022/23											
6849	Nov 2021	Director of Workforce and Organisational Development	**Retention of Employees** IF we do not retain our employees in additional professional scientific and technical group and allied health professionals group THEN this would impact on staff morale, recruitment, turnover, absence and productivity and have a potential impact on patient experience RESULTING IN loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Quarterly People Pulse [1c] NHS Staff Survey [2e] Health & Wellbeing Group [2a] Career paths [2e] 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] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e]	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c]	4	5	20	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop career pathways — OD Specialist — 31/03/2023 — A Quarterly People Pulse — Director of Workforce and OD — 31/03/2022 — G National Staff Survey — Director of Workforce and OD — 31/01/2022 — G Recruitment and Retention group to deliver on identified workstreams to support retention — HR Business Partners — 31/03/2023 — A	Director of Workforce and Organisational Development	To be confirmed	4	5	20	31/03/2023
10/01/2022 Risk Opened 22/02/2022: Whilst the proximity of this risk has changed due to the suspension of the requirement for mandatory vaccinations, this risk remains at a high level while a consultation is in place. This risk is being kept under review.								21/03/2022: It is recommended this risk is closed. The mandate has been withdrawn by central government so this is no longer a risk.											
6880	Jan 2022	Director of Workforce and Organisational Development	**Impact of Mandatory COVID vaccinations on staffing levels** IF we have a number of unvaccinated staff THEN we will need to redeploy or serve notice to staff RESULTING IN less available staff and potential impact on patient safety and experience	4	4	16	Project Plan for mandatory vaccinations including data collection of vaccination status	TiAA Audit QPR Reporting	4	4	16	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Set up a task and finish group regarding mandatory vaccines — Director of Workforce and OD — Completed — G Task and Finish Group workplan — Director of Workforce and OD — 01/04/2022 — A	Director of Workforce and Organisational Development	To be confirmed	3	3	9	01/04/2022

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)
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. 15/11/2021: NHS command and control arrangements continue, Trust monitoring and response functions continue to align. Staff encouraged to have their Covid booster vaccinations in addition to seasonal Flu vaccination, and uptake is monitored. 17/01/2022: There is a commitment to central funding for PPE for the 2022/23 financial year. In light of this the target date for this risk remains appropriate to cover any extended period of uncertainty in relation to the current pandemic response and allow for the learning outcomes from it to be identified. This risk remains stable and well controlled, but is being closely monitored to ensure any impact from a variance in the pandemic response (to new variants of concern) or an influx of displaced European Nationals is considered.																			
5989	Jan 2019	Chief Nurse	**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	Chief Nurse		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 relation 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. 17/01/2022: A draft policy for hybrid working is under development and is due to be presented at the next Agile working group meeting in February. The work from home where possible direction for Trust staff remains in place. 14/03/2022: Hybrid working will be launched in the Trust formally in April 2022. A Standard Operating Procedure (SOP) has been developed, with tool kits for staff and managers. This will allow the Trust to deliver on its Estates Strategy to use our buildings more efficiently and effectively.																		
6623	Mar 2021	Executive Director of Finance	**Easing of Lockdown National Roadmap - Hybrid working** IF the national removal of restrictions 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. Hybrid working will be launched in the Trust formally in April 2022. A Standard Operating Procedure (SOP) has been developed, with tool kits for staff and managers. This will allow the Trust to deliver on its 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 Hybrid Working Group EAC oversight	2	4	8	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Develop Hybrid Working Policy — Executive Director of Finance — 11/02/2022 — G Launch Hybrid Working Standard Operating Procedure — Executive Director of Finance — 30/04/2022 — A	Executive Director of Finance	To be confirmed	2	2	4	30/04/2022
23/11/2021 Risk Opened																			
6862	Nov 2021	Executive Director of Finance	**Contract Management of Outsourced Services** IF the outsourced services contracts are not robustly managed THEN services as required and contracted are at risk of not being delivered at all or compliantly RESULTING in complaints, accidents/incidents, statutory non-compliances, over-expenditure, poor value for money, KPIs not achieved, quality of care for patients and property compromised and adversely impacted	5	4	20	Estates and Facilities Review 1a Management controls are in place Management of Key Performance Indicators 1b Contract Management Procedures 1f Project Board Policies and procedures in place with robust Standing Orders / SFI's		4	3	12	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Management training on client side contract management — Acting Lead for Estates — 28/03/2022 — A Recruitment to interim resource — Acting Lead for Estates — 24/11/2021 — G High level Improvement plan in place — Acting Lead for Estates — 31/12/2021 — A	Executive Director of Finance	To be confirmed	2	3	6	01/04/2022
02/03/2021 Risk Opened																			
6861	Nov 2021	Executive Director of Finance	**Estates and Facilities Resources** IF adequate resources are not available to deliver the required services THEN non-delivery of all or some contracted services would occur RESULTING in backlogs, complaints, reputational damage, statutory non-compliances including CDM Regulations, potential harm to life and property, inability to respond to or avoid emergencies	5	4	20	Adequate staffing levels to carry out critical tasks to ensure compliance. Regular updates from Contractors regarding availability of staff / resources. Possible restructure of Estates and Facilities. Interim appointments of staff where required use of external specialist advisors	Project management support and reporting Interim recruitment to posts Vacancy reporting and recruitment	4	4	16	⟺	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Interim Appointmentsbeing made to support operations and the capital programme — Acting Lead for Estates — 20/06/2022 — G Monitor staff workloads — Acting Lead for Estates — 20/06/2022 — A New structure being drafted and approved at EMT w/c 21st March — Strategic Director of Estates and Facilities — 31/03/2022 — A Full review of JDs and Person Specifications underway to draft develoment programmes where required for staff — Strategic Director of Estates and Facilities — 20/06/2022 — A	Executive Director of Finance	To be confirmed	3	3	9	27/06/2022
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. 06/09/2021: 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. 15/11/2021: Research and Innovation Director is now in post. The research and innovation strategy is on track for ratification ahead of March 2022. 10/03/2022: This has reduced in current risk score due to the Research and Innovation Director being in post. There has been progress on the other two key actions with the R&I Strategy due for ratification in May 2022.																		
5345	Aug 2017	Chief Medical Officer	**Participation in 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	2	2	4	⇩	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Recruitment to Research and Innovation Director post — Chief Medical Officer — 29/10/2021 — G Increase in funding for research and innovation team — Research and Innovation Director — 29/06/2022 — A Ratification of research and Innovation Strategy — Chief Medical Officer — 31/05/2022 — A	Chief Medical Officer	To be confirmed	1	1	1	17/10/2022

				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)
5 - Maximise the use of digital technology																			
	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.	15/11/2021 Digital Transformation team now in place to support improved clinical engagement with the clinical technology strategy.											
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)	Current User Acceptance processes in place in the RAID log Digital Transformation Team Established Digital Transformation Group and Digital Strategy Board Minutes of meetings detailing attendance	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 Recruitment of Change Leads — Head of ICT — 31/01/2022 — A	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																			
	01/04/2020 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 reflect the impact this will have on the capital projects underway	17/01/2022 The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022.										
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned and we continue to see restricted capital allocations 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 and a potential for an increasing backlog.	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 — Director of Estates and Facilities — 31/03/2022 — A Provide comprehesive report to Trust Capital Group. — Director of Estates and Facilities — 31/03/2022 — A	Executive Director of Finance	To be confirmed	2	3	6	31/03/2024
	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** Review of underlying defecit — Deputy Director of Finance — 31/01/2022 — G Delivery of multiyear efficiency programme — Deputy Director of Finance — 31/06/2022 — A Deep dive of Acute and Forensics financial position — Deputy Director of Finance — 28/02/2022 — G Complete financial planning (Subject to national timetable being confirmed) — Deputy Director of Finance — 31/03/2022 — G	Executive Director of Finance	To be confirmed	3	3	9	31/03/2023
	17/112021 Risk Opened 14/03/2022		This risk is recommended for Closure and removal from the BAF. the Trust delivered the H2 plan and breakeven. A new risk is being drafted for the 22/23 planning																
6850	Nov 2021	Executive Director of Finance	**H2 Planning** IF the Trust fails to deliver on the H2 financial plan THEN the Trust could fail to deliver the Trust control total of a break even position in the current financial year. RESULTING IN an increased risk that the Trust doesn't break even. This will also have an impact on the Trust ability to deliver long term financial sustainability	4	3	12	CIP Process [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 Care group efficiency targets	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] QPR Meetings [2a]	3	2	6	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Introduction of new agency controls to reduce care group agency spend — Deputy Director of Finance — 06/12/2021 — G Agency use reporting via new weekly meeting — Executive Director of Finance — 21/01/2022 — A	Executive Director of Finance	To be confirmed	2	2	4	31/03/2022
	23/11/2021 Risk Opened																		
6858	Nov 2021	Executive Director of Finance	**External Market Forces** IF external market forces that have arisen from Brexit and the Coronavirus pandemic are not built into the Trust plans sufficiently this could lead to inadequate planning for building projects and contracts THEN additional expenditure and delays to projects might arise RESULTING in RESULTING in poorly set budgets and contract management.	4	4	16	Robust supply chain and procurement process in place. Clear Route to Market. Pre-Tender Estimates. Complete and comprehensive invitation to tender packages. Use of competent external project managers.	Sense checking against other providers	4	3	12	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Clear route to Market — Wilson, Craig — 25/07/2022 — A Pre tender estimates — Wilson, Craig — 25/07/2022 — A Complete and comprehensive Invitation to Tender packages — Wilson, Craig — 25/07/2022 — A Use of competent external project managers — Wilson, Craig — 25/07/2022 — A	Executive Director of Finance		2	3	6	29/08/2022

				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)
	17/11/2021 Risk Opened																		
6857	Nov 2021	Executive Director of Finance	**Maintenance Services Funding Availability** IF sufficient resources are not allocated for reactive, cyclical and planned maintenance of buildings, building services, grounds, gardens, trees in leased and owned properties THEN the ratio of planned to reactive maintenance spend would not be in accordance with industry best practice and in favour of reactive maintenance RESULTING in the planned maintenance backlog increasing year on year, maintenance overspends and in-patient facilities not fit for purpose for lengthy periods	5	4	20	Existing approved and in date contracts in place with external maintenance contractor Maintenance process in place for reporting required maintenance Maintenance KPIs in place Issue reactive maintenance Procedures to services.	Reporting to FPC TiAA Audit and follow up Audit due to limited Assurance	5	4	20	↔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Implement 5-year Planned Maintenance Programme / Acting Lead for Estates / 20/06/2022 / A Issue Reactive Maintenance Procedures to Services / Acting Lead for Estates / 20/06/2022 / A Invest in SFG 20 for statutory Planned Preventative Maintence / Acting Lead for Estates / 20/06/2022 / A	Executive Director of Finance	To be confirmed	3	4	12	26/09/2022
	22/03/2022 Risk Opened																		
6966	Mar 2022	Executive Director of Finance	**2022/23 Financial Planning** IF the Trust fails to deliver on the 2022/23 financial Plan THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance	3	4	12	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	Monthly Finance Report [1h] Finance position and CIP update [1h]	3	4	12	NEW	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Deliver efficiency programme - fully identified 29th April 2022 (as per CIP delivery plan led by the deputies) / Deputy Director of Finance / 31/03/2023 / A Ensure appropriate cost controls are in place, with particular focus on agency / Deputy Director of Finance / 22/06/2022 / A Full Review of Vacancies / Deputy Director of Finance / 22/09/2022 / A Signed Commissioner Contracts / Deputy Director of Finance / 30/04/2022 / A	Executive Director of Finance	To be confirmed	3	4	12	31/03/2023
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.; 17/01/2022 This risk and actions will be fully reviewed on completion of the planning round at the end of March 2022. it may be at this time this risk is reframed to reflect the development in the provider collaborative since this risk was opened. the objectives set via the planning round will inform the BAF risk actions.																		
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	1	4	4	↓	**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 / 31/03/2022 / A	Executive Director of Finance	To be confirmed	1	4	4	31/09/2022
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 fucttioning effectively to ensure system wide suppport for the delivery of identified priorities.; 17/01/2022 Quarter 3 review is currently underway to inform the Q4 delivery. A further review will be undertaken in March and this BAF risk will be reviewed.																		
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2023** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2023 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	3	2	6	↔	**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 / Completed / G Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021 / Executive Director Partnerships and Strategy / Completed / G Review of strategy delivery plan trajectories to final quarter 2021/22 / Executive Director Partnerships and Strategy / March 2022 / A	Executive Director Partnerships and Strategy	To be confirmed	2	2	4	25/04/2022

NHS
Kent and Medway
NHS and Social Care Partnership Trust

COMMITTEE MEETING

Meeting details

Committee:	Trust Board
Date of Meeting:	31 March 2022
Title of Paper:	CQC Well-led with Core Service Inspection
Author:	Rachel Town, Compliance and Assurance Manager
Executive Director:	Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Committee:	As per reporting schedule

Overview of Paper

This report provides an overview of the findings identified during the well-led with core service inspection undertaken by the CQC in November and December 2021. A total of 24 recommendations were made for improvement and of these 7 were must do actions (those that are linked to the regulations set out in the Health and Social Care Act) and 17 were should do actions.

Issues to bring to the Committee's attention

- A total of 24 recommendations were made for improvement and of these 7 were must do actions (those that are linked to the regulations set out in the Health and Social Care Act) and 17 were should do actions.
- Quality improvement plans (QIPs) have been put in place to ensure that improvements are made in a timely manner. Work is already underway on a number of the actions.
- Both outstanding practice was identified and positive feedback was received from patients that were using the services at the time of the inspection.

Governance

Implications/Impact:	Failure to comply with the regulatory standards could result in an enforcement action being taken against the trust which may have financial and resource implications.
Risk recorded on:	Trust Risk Register
Risk IDs:	Strategic risk 3756
Assurance/Oversight:	CQC Oversight Group meets monthly and has a workplan in place for assurance and monitoring purposes.

1. Overview of the inspection

KMPT received a well-led review in December 2021 which followed on from the inspection of three core services which took place in November 2021. The core services/wards visited included:

- Acute wards and PICU wards – The wards on the St Martins Hospital site; Bluebell, Fern, Foxglove, the wards at Priority House; Boughton, Chartwell and Upnor and Willow suite (PICU) at Little brook Hospital were inspected.
- Forensic secure wards – This included the 4 wards at the TGU; Penshurst, Groombridge, Emmetts and Walmer and the Allington Centre in Dartford.
- Wards for older people with mental health problems – All 6 older adult wards wee visited as follows; Ruby, Jasmine, The Orchards, Heather, Sevenscore and Woodchurch.

Following the core service review, an announced well-led review took place at Farm Villa over 2 days. This involved conducting a number of interviews and focus groups either in person or via Lifesize, reviewing some key documentation such as the fit and proper person information and a sample of SIs and complaints and observation of a Trust Board Meeting (they attended the November Board meeting). The feedback received following this was that it was well-organised, that they could see functioning governance in place although this could be strengthened as there were still some areas in development and they found that the majority of staff were confident that they are able to speak up and highlight when things aren't right.

In addition to identifying areas for improvement (see section 2 below), the CQC noted some positive practice around MDT working, the interaction between patients and staff was viewed as caring (see also section 4 below), medicines management was of a good standard for both prescribing and administering and there were good quality risk assessments and care plans in place for patients. Patients were also observed to be relaxed within the environments despite there being some estates issues in place.

The trust maintained is 'good' overall rating with the effective domain moving from a good to outstanding and the safe domain moving from a good to a requires improvement. The core services inspected also received the following ratings:

- Acute and PICU wards – the rating for this core service moved from a requires improvement to a good overall. For this core service, improvements were made in the effective and well-led domains with both of this moving from a requires improvement to a good.
- Forensic secure wards – the rating for this core service moved from an outstanding to a good overall. For this core service, the caring and well-led domains moved from an outstanding to a good. This was due to ongoing estates and maintenance issues and how these were monitored and escalated. There was also an issue identified in relation to ligature risks with the admission criteria for one ward needing to be reviewed and updated.
- Wards for older people with mental health problems – the rating for this core service stayed the same, remaining as good overall. The safe domain moved from a good to a requires improvement as there were issues identified on Jasmine Ward relating to the adherence of the therapeutic observations policy and issues identified with the flooring and ward environment.

The final inspection report was published on 24 February and quality improvement plans (QIPs) have been developed for the must and should do actions identified. These were submitted to the CQC on 18 March.

2. Actions identified as areas for improvement

A total of 24 recommendations were made for improvement and of these 7 were must do actions (those that are linked to the regulations set out in the Health and Social Care Act) and 17 were should do actions. These are as follows:

Applicable to	Must do actions	Should do actions
Trustwide	1. The trust must have an effective estates and facilities response to repairs and maintenance concerns in patient areas, and must ensure that these are addressed in a timely way once identified by staff or patients in these areas.	1. The trust should ensure there is sufficient management oversight and project management resources available to deliver its capital projects. This includes financial and senior leadership oversight to ensure that slippage in planned costs is kept to a minimum. 2. The trust should ensure that there is sufficient monitoring of outsourced functions, such as maintenance and food provision, and review contract performance informed by the feedback from patients and frontline staff. 3. The trust should actively encourage staff to speak up, and have appropriate means to support this, including the implementation of the new Freedom to Speak UP provision for staff in 2022. This includes ensuing there is an open and transparent culture in which staff can raise their concerns to senior leaders without fear of retribution and reprisal. 4. The trust should consider a more ambitious target and more concentrated focus to improve WRES outcomes and reduce the frequency of BAME staff experiencing bullying and harassment from patients, carers and the public.
Acute and PICU wards	1. The trust must ensure that the outstanding maintenance issues on Fern ward, such as the overflowing drain and	1. The trust should ensure that the patient monies protocol is being followed on Fern ward. 2. The trust should consider how maintenance issues are recorded and monitored on the

Applicable to	Must do actions	Should do actions
	communal showers, are rectified in a timely way. 2. The trust must ensure that all patients on Fern ward are able to lock their bedroom doors in order to keep their belongings safe.	wards at St Martin's, to ensure outstanding actions are completed. 3. The Trust should ensure that patients receive updated copies of their care plans. 4. The trust should ensure that all outstanding face to face training such as CPR and AED Practical, immediate life support, moving and handling patient and physical interventions are completed in line with trust policy.
Forensic secure wards	None identified.	1. The trust should ensure that the programme for the replacement of vision panels in doors is accelerated. 2. The trust should ensure that it makes explicit in its admission criteria for Emmetts ward that the ligature risks on the ward are managed by the individual risks of the patient group and that the ward is suitable to have high levels of managed ligature risk. 3. The trust should consider how it improves its response times for localised maintenance works. 4. The trust should resolve the issue with the quality of patient food and the impact the regeneration of food on the ward has on clinical staff's time.
Wards for older people with mental health problems	1. The trust must ensure intermittent observations are being carried out in accordance with trust policy on Jasmine ward. 2. The trust must move forward urgently to implement its plan to replace the flooring on Jasmine ward to ensure patients are safe.	5. The trust should ensure improvements are made to the general ward environments on Sevenscore, Jasmine, Woodchurch wards to ensure they are decorated to a good standard and fit for purpose. 6. The trust should ensure the ramps in the outdoor spaces on Heather ward and Woodchurch ward are repaired and have appropriate safety markings.

Applicable to	Must do actions	Should do actions
	3. The trust must ensure all patients have routine access to hot water to make hot drinks on all wards, who are risk assessed as safe to do so. 4. The trust must have a plan to address all the issues identified on Jasmine ward, including ward environment, activities and involvement of patients and carers in care plans, with appropriate oversight and leadership at ward level.	7. The trust should ensure patients on Ruby ward can routinely access fresh air and healthy snacks. 8. The trust should ensure they review the blanket restrictions in place on several wards regarding patients holding keys to their bedroom doors. 9. The trust should ensure that all patients who require physiotherapy and individual psychological therapies receive these in a timely way.

3. Outstanding practice identified

The CQC identified the following as areas of outstanding practice:

- **Trust** - As part of its participation and involvement strategy, the trust was implementing a new engagement panel and engagement council for the users of the trust services to be more fully engaged and broaden the scope of patients' representation.
- **Acute and PICU wards** - The service was part of the armed forces network and had recently completed a piece of work around the things to consider if a veteran was in mental health settings.
- **Forensic secure wards** - The low secure services were piloting the implementation of the anti-racism strategy. A number of working groups were set up to lead in different areas including; embedding a culture which promotes equality, developing a patient group to explore the impact of racism and look at ways of being anti-racist allies, improve staff support procedures following incidents of racism, including closer working with the police and develop restorative practices to build connections and respond to racism.
- **Wards for older people with mental health problems** - Staff used several occupational therapy interventions that were innovative tools designed to improve the quality of life, care and treatment for patients living with dementia. They included doll therapy, where lifelike dolls or soft toy animals were used to promote feelings of relaxation and pleasure to help people who are withdrawn, distressed or anxious.

4. Positive patient feedback

The CQC obtained positive feedback from patients who were using the services at the time of the inspection as detailed below:

- ‘Patients told us that staff treated them with compassion and kindness. They said that staff respected patients’ privacy and dignity.’
- ‘Patients said staff were attentive, non-judgemental and caring.’
- ‘Patients also reported staff provided help, emotional support and advice when they needed it.’
- ‘Patients said staff treated them well and were responsive to their needs.’

5. Recommendation

The Trust Board are asked to acknowledge the inspection findings and will receive assurance from the Quality Committee that appropriate action is being undertaken in a timely manner.

Kent and Medway NHS and Social Care Partnership Trust

Inspection report

Trust Headquarters, Farm Villa
Hermitage Lane
Maidstone
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Tel: 01732520400
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Date of inspection visit: 9-11 November, 30 November-01 December 2021
Date of publication: 24/02/2022

Ratings

Overall trust quality rating	**Good**
Are services safe?	**Requires Improvement**
Are services effective?	**Outstanding**
Are services caring?	**Outstanding**
Are services responsive?	**Good**
Are services well-led?	**Good**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

We award the Use of Resources rating based on an assessment carried out by NHS Improvement. Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Overall summary

What we found

Overall trust

We carried out this unannounced, comprehensive inspection of the acute wards for adults of working age and psychiatric intensive care units (PICU), forensic inpatient or secure wards, and wards for older people with mental health problems of this trust as part of our continual checks on the safety and quality of healthcare services. At our last inspection we rated the trust as good overall.

Following this inspection, we rated the trust good overall. In addition, we rated each of the key questions. We rated safe as requires improvement; responsive and well-led as good, and we rated effective and caring as outstanding.

During this inspection we inspected three of the Trust's core services and rated all three as good.

We also undertook an inspection of how 'well-led' the trust was. We rated the trust as good.

Kent and Medway NHS and Social Care Partnership (KMPT) is a large mental health trust that provides mental health, learning disability, substance misuse and specialist services to approximately 1.8 million people across Kent and Medway. The trust works in partnership with Kent County Council and works closely with the local unitary authority in Medway. The trust is one of the largest mental health trusts in England and covers an area of 1,450 square miles. The trust has an annual income of £195 million and employs approximately 3,500 staff who work across 66 buildings on 33 sites. The trust provides services around key urban centres including Maidstone, Medway and Canterbury and more rural community locations. The trust services are commissioned by the Kent and Medway clinical commissioning group, and by NHS England, and by the Kent, Surrey, Sussex provider collaboratives.

Our findings

The trust provides a range of mental health services including acute, rehabilitation and forensic in-patient services for working age and older adults. The trust provides community based mental health services such as outpatient and community clinics. The trust provides services for people experiencing mental health crisis such as crisis and home treatment teams and health-based places of safety.

The trust provides the following services

- Community-based services for adults of working age
- Long-stay/rehabilitation wards for adults of working age
- Forensic inpatient and secure wards
- Acute wards for adults of workings age and psychiatric intensive care units (PICU)
- Wards for people with learning disability or autism
- Mental health crisis services and health-based places of safety
- Community-based services for older people
- Wards for older people with mental health problems
- Community based services for adults with a learning disability or autism
- Substance misuse services
- Mother and baby mental health unit

Our rating of the trust stayed the same. We rated it as good because:

- We rated safe as requires improvement; responsive as good, and we rated effective and caring as outstanding. We rated ‘well-led’ for the trust overall as good.
- We rated acute wards for adults of working age and psychiatric intensive care units as good. This had improved from the rating of requires improvement given at our last inspection. We rated wards for older people with mental health problems as good. This rating was unchanged since our last inspection. We rated forensic inpatient/secure wards as good. The rating for this service had gone down from the outstanding rating given at our inspection in October 2018. In rating the trust overall, we included the existing ratings of the nine previously inspected services not inspected during this inspection.
- Since the last inspection the trust had appointed a new chair and five new non-executive directors. The trust had also recently appointed a new executive director of nursing to take up post in 2022.
- The non-executive directors (NEDS) and executive directors provided high quality, effective leadership. Non-executive board members had a wide range of skills and experience. They all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance, organisational development, legal, fire service, research, real estate, human resources, working in partnership and transforming services. The non-executive directors were well supported and provided appropriate challenge to the trust board.
- There were regular board visits to services by executives and non-executives. These visits had continued during the COVID-19 pandemic in virtual form, to ensure they remained connected with frontline staff.

Our findings

- The trust leadership demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. The trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 pandemic. The trust's use of information technology had been expanded quickly during the pandemic. A new public crisis line was created and many community teams began more flexible working including extended opening times into weekends and evenings.
- The trust had a clear vision and a set of values which staff understood. The trust had a three-year strategy which had been refreshed in 2020. Leaders were well sighted on the ambition of the new strategy and there was a focus on aligning the strategy with both local and national priorities.
- The board was supported by six other committees including the audit committee. There were clear lines of accountability and governance arrangements in place to provide ward to board assurance. The board met regularly and had a clear agenda for discussion. Committee discussions were robust and provided escalation when required. The board regularly discussed board assurance, quality, safety, workforce delivery, strategy, transformation, finance and commissioning.
- There was a range of mechanisms in place for identifying, recording and managing risks, issues and mitigating actions. Individual services maintained their risk registers which were submitted to the trust's electronic risk management system. All staff had access to the risk register and were able to escalate concerns when required. Staff concerns matched those on the risk register.
- The trust continued to be financially stable and had strong financial expertise among the executives and non-executive directors (NEDS). The trust had an underlying deficit and was working with NHS England and other system partners to address and reduce this.
- The trust had responded positively to previous inspection findings in 2019 and findings from focused inspections in 2020 and 2021. Most of the required improvements from these inspections had been met.
- The board were committed to equality and inclusion. There was an active focus on equality, diversity and inclusion represented at board level. The trust had set itself a goal to become an anti-racist organisation. There were several staff networks who met regularly. These included Black Minority Ethnic (BME) staff network, LGBT+ staff network, the Faith network, and Disability networks.
- The trust was implementing a new engagement pool and engagement council for the users of the trust services to be more fully engaged and broaden the scope of patients' representation.
- Trust executives were working with other providers in the strategic development of mental health services within the Integrated Care System (ICS). The trust leadership placed system and partnership working within Kent and Medway as a key objective. The ICS Mental Health Learning Disabilities and Autism Board was chaired by the chief executive officer (CEO) of the trust.
- Patients told us that staff treated them with compassion and kindness. They said that staff respected patients' privacy and dignity. Patients said staff were attentive, non-judgemental and caring.
- The low secure services had implemented an anti-racism strategy. A number of working groups were set up to lead in different areas including; embedding a culture which promoted equality, developing a patient group to explore the impact of racism and to look at ways of being anti-racist allies.
- The acute wards for working age adults were part of the armed forces network (a multi-organisational group including mental health clinicians and armed forces agencies) and had recently completed a piece of work around the things to consider if a veteran was in a mental health setting.

However:

Our findings

- Several of the trust capital projects had experienced slippage due to insufficient leadership oversight and a lack of project management experience within the estates and facilities function. This had also led to a slow response to essential maintenance and repair across several core services. The trust leaders were open about this and were now aware of the issues and taking action. Additional oversight had been put in place; project management skills and experience had been brought into the estates and facilities directorate to ensure appropriate management of contract performance with the out-sourced maintenance company and a more flexible 'handyman' service had been established to quickly address low-level maintenance and repair issues.
- Despite these developments there were still outstanding maintenance, refurbishment and repair issues on all core services we inspected. The outstanding issues had been logged on the trust system by staff, but repairs had not been completed. The specific issues are described in the core service reports. They included a broken shower, a seclusion room awaiting repair before it could be used, a ward awaiting non-slip flooring, upgrading of vistamatic windows, and the safe provision of hot water for hot drinks for patients on several wards.
- Patients experiencing functional mental health concerns on Jasmine ward, reported that they did not always feel stimulated or engaged. We also found on Jasmine ward intermittent patient observations were not always carried out in line with the trust policy and there was not clear evidence that patients were involved in their care planning.
- Some staff we spoke with across several teams expressed concerns about speaking up and raising concerns to senior leadership. Some staff said they were reluctant to speak about their concerns because of fears of reprisals, or because they felt that their concerns would not receive a response from the senior team.
- Whilst the trust had a workforce strategy and was succeeding in the recruitment of international nurses, trust-wide there were a high number of vacancies with an overall staff vacancy rate of 15% against a target of 11.85%. Staff retention rates had declined across 2021 reaching 81.8% against a target of 87.3%
- The trust had an explicit commitment to equality and inclusion, however, the workforce race equality (WRES) data showed an increasing amount of racial bullying and harassment experienced by BAME staff. This had now increased to 42.9% from 35.6% in 2017.
- We received mixed feedback from patients regarding the food provided by the wards. Some patients were happy with the food provided, however others told us that the food portions were small and not of good quality. We observed staff prepare a cook chill meal on the forensic wards, and we could see portion sizes were small, with a small tray of chips identified for six patients as part of their lunchtime meal. The preparation of the food was carried out by the ward nursing staff and had a significant impact on their clinical time.

How we carried out the inspection

We used CQC's interim methodology for monitoring services during the COVID-19 pandemic including on site and remote interviews by phone or online.

We inspected all of the trust's mental health wards for older people which were open at the time of inspection, we inspected all the trust's adult inpatient wards and psychiatric intensive care units (PICU) with the exception of three adult wards at Little Brook Hospital, we inspected both the trust's forensic services at the Trevor Gibbens Unit and Allington Centre.

During the mental health wards for older people inspection, the inspection team:

Our findings

- undertook a tour of all six wards across five locations to look at the quality of the ward environments. At the time of inspection Orchards ward was temporarily located at Littlestone Lodge and was due to return to a newly refurbished ward in December 2021.
- looked at 31 care records across all six wards
- looked at 48 prescription charts and inspected clinic and treatment rooms across all six wards
- attended and observed multi-disciplinary team (MDT) handover meetings on Woodchurch ward, Ruby ward, Sevenscore ward, Heather ward and Jasmine ward
- spoke with 39 members of staff including a volunteer, nurses, healthcare assistants, occupational therapists, occupational therapy assistants, administration staff, ward managers, deputy ward managers, junior doctors, matrons, a consultant, and pharmacists
- observed a group activity on Orchards, Ruby and Jasmine wards
- spoke with 11 patients across three of the six wards
- spoke with 15 carers/ relatives across five of the six wards
- reviewed a range of policies, procedures and other documents relating to the running of the service

For the adults of working age and PICUs inspection, the inspection team:

- visited seven wards at the three sites and looked at the quality of the ward environment and observed how staff were caring for patients
- spoke with 11 patients who were using the service both in person and via telephone calls
- spoke with 3 carers
- spoke with the ward managers for each ward
- spoke with 2 matrons
- spoke with 41 other staff members; including Deputy ward managers, speciality doctors, a consultant, a deputy chief pharmacist, an inpatient senior practitioner, nurses (including a student nurse and nurse apprentice), occupational therapists (including a lead occupational therapist, occupational therapy assistant and an occupational therapy student), healthcare assistants, a psychologist and an assistant psychologist, and a peer support worker.
- attended and observed a bed management meeting, and two handover meetings
- reviewed 10 incident records
- looked at 35 care and treatment records of patients
- carried out a specific check of the medicine management on all wards and 39 prescription charts
- looked at a range of policies, procedures and other documents relating to the running of the service
- reviewed community meeting minutes for all wards

For the forensic inpatient/secure services inspection, the inspection team:

- visited five wards across two hospital sites, looked at the quality of the ward environment, management of the clinic rooms, and observed how staff were caring for patients

Our findings

- spoke with 21 patients and carers of people who were using the services
- spoke with the manager and/or matron of each ward
- spoke with 27 other staff members including nurses, clinical practice leads, a physical health lead nurse, social therapists, support workers, occupational therapists, psychologists, consultant psychiatrists, a clinical pharmacist, an assistant pharmacy technical officer, and a speech and language therapist
- spoke with six senior members of staff including the medical lead for forensic services, the head of nursing, the head of psychology services, the sexual safety lead for the service, and the drugs and alcohol lead for the service
- reviewed 22 care and treatment records of patients
- carried out a specific check of the medication management on Allington, Emmetts and Groombridge wards
- looked at a range of policies, procedures and other documents relating to the running of the service.

What people who use the service say

Patients told us that staff treated them with compassion and kindness. They said that staff respected patients' privacy and dignity. Patients said staff were attentive, non-judgemental and caring. Patients also reported staff provided help, emotional support and advice when they needed it. Patients said staff treated them well and were responsive to their needs.

We received mixed feedback from patients regarding the food provided by the wards. Some patients were happy with the food provided, however others told us that the food portions were small and not of good quality. One patient told us that food was sometimes served cold and most patients told us that salad is not regularly included, despite feedback from patients for more of this.

Outstanding practice

We found the following outstanding practice:

Trust

- As part of its participation and involvement strategy, the trust was implementing a new engagement pool and engagement council for the users of the trust services to be more fully engaged and broaden the scope of patients' representation. The Council had thirteen standing members who were self-nominated and selected from the engagement pool. The engagement pool was a wide range of service-users, carers and the public who have signed up to work with the trust on service development and improvement. At the time of inspection over 100 people had volunteered and been trained to become members of the engagement council. The council had yet to commence meetings.

Acute wards for adults of working age and psychiatric intensive care units (PICU)

Our findings

- The service was part of the armed forces network and had recently completed a piece of work around the things to consider if a veteran was in mental health settings. The trust had a variety of armed forces link workers and an armed forces champion who were involved in rolling out a training video across the trust. Link trainers were clinical staff who had the appropriate skills to support veterans and local NHS teams when the veteran was in crisis or was admitted to a mental health inpatient ward.

Wards for older people with mental health problems

- Staff used several occupational therapy interventions that were innovative tools designed to improve the quality of life, care and treatment for patients living with dementia. They included doll therapy, where lifelike dolls or soft toy animals were used to promote feelings of relaxation and pleasure to help people who are withdrawn, distressed or anxious. Staff used an age simulation suit to help their awareness of the impairments of older people and this was used during manual handling training. They also gave patients “playlists for life” which is a playlist of personal music which assisted people living with dementia to connect with the past through songs which held importance and meaning for them.

Forensic inpatient and secure wards

- The low secure services were piloting the implementation of the anti-racism strategy. A number of working groups were set up to lead in different areas including; embedding a culture which promotes equality, developing a patient group to explore the impact of racism and look at ways of being anti-racist allies, improve staff support procedures following incidents of racism, including closer working with the police and develop restorative practices to build connections and respond to racism. This initiative supported the trust intention to become an anti-racist organisation, and also sought to create a culture in this core service which would reduce the frequency of BAME staff experiencing racist bullying and harassment from patients and carers.

Areas for improvement

Action the trust MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the trust MUST take to improve:

We told the trust that it must take action to bring services into line with one legal requirement. This action related to one service.

Trust wide

- The trust must have an effective estates and facilities response to repairs and maintenance concerns in patient areas, and must ensure that these are addressed in a timely way once identified by staff or patients in these areas. (Regulation 15 (1)(e) HSCA (RA) Regulations Premises and equipment).

Acute wards for adults of working age and psychiatric intensive care units

- The trust must ensure that the outstanding maintenance issues on Fern ward, such as the overflowing drain and communal showers, are rectified in a timely way. (Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment)

Our findings

- The trust must ensure that all patients on Fern ward are able to lock their bedroom doors in order to keep their belongings safe. (Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment)

Wards for Older People with Mental Health Problems

- The trust must ensure intermittent observations are being carried out in accordance with trust policy on Jasmine ward. (Regulation 12(b): Safe care and treatment)
- The trust must move forward urgently to implement its plan to replace the flooring on Jasmine ward to ensure patients are safe. (Regulation 12(d): Safe care and treatment)
- The trust must ensure all patients have routine access to hot water to make hot drinks on all wards, who are risk assessed as safe to do so. (Regulation 12(e): Safe care and treatment)
- The trust must have a plan to address all the issues identified on Jasmine ward, including ward environment, activities and involvement of patients and carers in care plans, with appropriate oversight and leadership at ward level. (Regulation 17(2a and 2b): Good governance)

Action the trust SHOULD take to improve:

Trust wide

- The trust should ensure there is sufficient management oversight and project management resources available to deliver its capital projects. This includes financial and senior leadership oversight to ensure that slippage in planned costs is kept to a minimum.
- The trust should ensure that there is sufficient monitoring of outsourced functions, such as maintenance and food provision, and review contract performance informed by the feedback from patients and frontline staff.
- The trust should actively encourage staff to speak up, and have appropriate means to support this, including the implementation of the new Freedom to Speak UP provision for staff in 2022. This includes ensuring there is an open and transparent culture in which staff can raise their concerns to senior leaders without fear of retribution and reprisal.
- The trust should consider a more ambitious target and more concentrated focus to improve WRES outcomes and reduce the frequency of BAME staff experiencing bullying and harassment from patients, carers and the public.

Acute wards for adults of working age and psychiatric intensive care units

- The trust should ensure that the patient monies protocol is being followed on Fern ward.
- The trust should consider how maintenance issues are recorded and monitored on the wards at St Martin's, to ensure outstanding actions are completed.
- The Trust should ensure that patients receive updated copies of their care plans.
- The trust should ensure that all outstanding face to face training such as CPR and AED Practical, immediate life support, moving and handling patient and physical interventions are completed in line with trust policy.

Wards for Older People with Mental Health Problems

Our findings

- The trust should ensure improvements are made to the general ward environments on Sevenscore, Jasmine, and Woodchurch wards to ensure they are decorated to a good standard and fit for purpose.
- The trust should ensure the ramps in the outdoor spaces on Heather ward and Woodchurch ward are repaired and have appropriate safety markings.
- The trust should ensure patients on Ruby ward can routinely access fresh air and healthy snacks.
- The trust should ensure they review the blanket restrictions in place on several wards regarding patients holding keys to their bedroom doors.
- The trust should ensure that all patients who require physiotherapy and individual psychological therapies receive these in a timely way.

Forensic inpatient and secure wards

- The trust should ensure that the programme for the replacement of vision panels in doors is accelerated.
- The trust should ensure that it makes explicit in its admission criteria for Emmetts ward that the ligature risks on the ward are managed by the individual risks of the patient group and that the ward is suitable to have high levels of managed ligature risk.
- The trust should consider how it improves its response times for localised maintenance works
- The trust should resolve the issue with the quality of patient food and the impact the regeneration of food on the ward has on clinical staff's time.

Is this organisation well-led?

Our rating of well-led stayed the same. We rated it as good.

Leadership

The chair, non-executive directors and executive directors provided high quality, effective leadership. The trust executive team had the appropriate range of skills, knowledge and experience to perform its role and deliver mental health and learning disability services. The trust board consisted of the chair, chief executive, seven non-executive directors (NEDs) and five executive directors. The board had clear areas of responsibility and accountability. The executive directors had the support needed to undertake their roles.

Since the last inspection in November 2018, there had been some changes to the trust board. The trust had appointed a new chair, and five new non-executive directors had joined the trust in August 2020. The trust had appointed a new Director of Nursing to start in March 2022 following the departure of the current post-holder in December 2021. The trust had recently appointed two new directors to the senior management team for digital transformation and for quality improvement to ensure it had the right skills and experience to achieve its ambitions.

The NEDs had the appropriate range of skills, knowledge and experience. They all had experience as senior leaders in a range of organisations and brought skills such as a knowledge of finance, organisational development, legal, fire service, research, real estate, human resources, working in partnership and transforming services.

Our findings

All board members had lead areas including non-executive directors who chaired specific committees or were leads on areas of work. For example, one non-executive director led the Audit and Risk Committee. The NEDs sat on each other's committees. Emerging themes could be identified and discussed in each of the committees they sat on and routinely in regular meetings that took place between the chair and all NEDs. Feedback was shared between the NEDs and executive team.

Succession planning was in place throughout the trust and leadership development opportunities were available.

Fit and Proper Person checks were in place. The trust had an appropriate process for carrying out their duties in respect of the Fit and Proper Person Regulation. Information held by the trust was compliant and there was a yearly check and update process in place. However, the information was spread across several trust systems which was a challenge to maintain easy oversight and ongoing monitoring.

The trust board and senior leaders across the trust displayed integrity in carrying out their roles. The trust executives and non-executive directors were professional and demonstrated a high level of commitment to ensuring people who use services and their families received the best care and treatment as possible.

The trust board demonstrated a high level of awareness of the priorities and challenges facing the trust and how these were being addressed. The trust leadership had demonstrated an ability to adapt at a fast-changing pace during the COVID-19 pandemic. This included developing the single point of access service (SPoA) to offer a crisis phone line open to the public, and community mental health teams offering services on evenings and weekends. Leaders spoke with insight about the need to continue to work with external partners to meet the needs of the local population

Board members visited teams across the wide range of trust services regularly to meet staff and review services. This had slowed somewhat during the pandemic, but board members had completed virtual visits during this time, and all board members had a schedule of visits for face to face visits in place since pandemic restrictions had eased. Board members and NEDs told us they felt it was important to remain connected with frontline staff at such a pressurised time.

Directors and senior staff from across the trust whom we met all said the board members were open and challenged each other professionally and openly. We observed this when we attended the board meeting prior to the inspection with the NEDS tempering the optimism of some board discussion with realism and appropriate challenge.

The chief pharmacist was supported by a senior pharmacy team and had regular meetings with the chief medical officer. Medicines optimisation was integrated into the trust governance committee structure. The chief pharmacist had access to other members of the executive team like the executive director of nursing. Pharmacy staff including the medication safety officer worked closely with the governance team including the medical devices safety officer to manage alerts and recalls.

Pharmacy staff undertake a scheduled programme of audits and clinical review. These include the safe and secure storage of medicines including controlled drugs, administration records (blank box audit) and participation in Prescribing Observatory for Mental Health – (POMH-UK)

Vision and Strategy

The trust had developed a clear vision and values in collaboration with key stakeholders: 'to provide brilliant care through brilliant people and delivering quality care through partnerships'. The trust vision and values were displayed throughout the trust and on the trust's website.

Our findings

The trust strategic aims for 2020-2023 were:

To work with partners across Kent and Medway to deliver brilliant care through brilliant people

Quality: consistently deliver outcomes that matter to people through understanding quality of care that is underpinned by a mature approach to quality improvement

Use our expertise to lead and partner: partner effectively with other organisations in Kent and Medway to design and implement innovative primary and community care models for mental health, learning disability and substance misuse

Integration: support the integration of mental and physical health services across Kent and Medway to deliver seamless car for our service users and carers and support delivery of the NHS Long Term Plan

The trust vision included:

Respect: we value people as individuals, we treat others as they would like to be treated

Working together: we work together to make a difference to our service users

Open: work in a collaborative, transparent way

Innovative: we find creative ways to run efficient, high quality services

Accountable: we are professional and accountable for our actions

Excellence: we listen and learn to continually improve our knowledge and ways of working

Staff knew and understood the current vision and values of the trust. Values were embedded in the services we inspected. Staff were able to describe how they related to their area of work.

The trust launched a new three-year strategy in 2020. The strategy had been developed to align with national and local work for increased integration across health and care systems as referenced in the NHS Long Term Plan, and also to recognise and reflect the impact that COVID-19 had had on ways of working, collaboration across services and to build on positive developments such as the use of technology during the pandemic.

The trust was proactively working with other providers to facilitate the strategic development of mental health services within the Integrated Care System (ICS). The trust was actively involved across a wide range of workstreams and in ensuring that mental health and learning disability services achieved a parity of esteem and equity in resources. The trust chief executive had taken a lead role and chaired the newly formed Mental Health and Learning Disabilities and Autism Improvement Board within the new integrated care system. This brought together local commissioners, providers, clinical leaders and local authorities to focus on transformation projects across Kent and Medway and placed mental health and learning disabilities at the centre of the integrated system.

Culture

Our findings

Generally, staff were proud to work at the trust and demonstrated a passion for delivering high quality patient care. Staff put patients at the centre of everything they did. However, some staff we spoke with felt that there were issues that were not being addressed by the senior team, and some did not feel confident about speaking out in the organisation about concerns that they had.

The trust recognised staff success through awards and nominating work for national awards. The trust had developed, during the pandemic, a KMPTProud mechanism to recognise and celebrate the achievements of the trust staff. Staff could also nominate colleagues and teams for the trust annual awards which contained 10 categories including clinical, support and innovation.

The trust had a Freedom to Speak Up Guardian (FTSUG) which at the time of inspection was an internal post which reported to the Director of Workforce. The postholder had developed a network of 27 FTSU champions across the organisation to support staff with raising concerns. The organisation also had a 'Green Button' which staff could use to raise concerns remotely via the trust's electronic systems. Key themes identified by the FTSU Guardian included inter-staff relationship challenges, issues with staffing numbers, the rationale behind trust decision-making and unfair treatment on grounds of race.

Some staff we spoke with said they were confident to use the trust's FTSU processes. However, some black, Asian and minority ethnic staff (BAME staff) we spoke with and other clinical leaders were less confident using the trust FTSU processes. Some staff said that they felt there was no point in speaking up as there was insufficient follow-up and response to their issues by the trust if they did so. Others expressed some reluctance to speak up about their concerns because of fear of reprisals. Some staff we spoke to were uncomfortable talking about the senior leadership team and feared this would have negative consequences for their role or the service

As the current postholder was leaving the organisation, the trust had reviewed the FTSU function and had commissioned this the function to be delivered by an external agency starting in early 2022.

Staff Survey 2020

The trust was completing the staff survey for 2021 at the time of inspection. The trust target for staff completion of the survey for 2021 was 68% and it achieved 67.6%. The trust had focused attention on the 2021 survey, encouraging staff to complete this, as previous uptake from staff had been lower at 61%.

The trust scored comparatively with other similar providers in ten key themes in the 2020 NHS Staff Survey. The themes included equality, diversity and inclusion, health and wellbeing, immediate managers, morale, quality of care, safe environment, safety culture, staff engagement and team working.

The survey scores were however lower than benchmarked averages for similar providers in the areas of BAME staff experiencing bullying from patients, carers and members of the public; staff feeling recognised and valued for their work; recommending the trust as an employer and not intending to leave the organisation, and feeling safe to speak up within the organisation. The trust had developed an action plan to respond to these areas which was last reviewed in November 2021 and all actions were scheduled to be completed by March 2022.

Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. To comply with the WRES, trusts have to show progress against nine measures of race equality in the workforce.

Our findings

According to the trust WRES data, the number of black and minority ethnic (BAME) people in the trust workforce was 24.7% which was a growth of 5% in the last three years, and is higher than the average for the NHS South region at 20.1%. The largest group of BAME staff were working in Band 2 roles (55%) and in very senior manager roles (54%). The trust board ethnicity was 20% BAME which was higher than the mental health provider benchmark of 7.5%.

The number of BAME staff experiencing harassment, bullying or abuse from patients, relatives or the public had increased to 42.9% from 35.6% in 2017. The trust had set a target for this to reduce to 35.6% over two years. The likelihood of BAME staff experiencing the trust disciplinary process had increased and was four times more likely than white staff. BAME staff experiencing discrimination in the workplace was 15% against 6.4% for white colleagues.

It was the trust's intention to become an anti-racist organisation. Following an analysis of the WRES data the trust had put in place actions to take the next steps towards racial equality. They included an early resolution policy to reduce numbers of staff going through the disciplinary process, trust-wide discussion on what an ant-racist organisation means, and deliver positive action workshops to support job applications. The low secure services were piloting the implementation of the anti-racism strategy which could be rolled out to other services in time.

The trust produced an annual Equality, Diversity and Inclusion (EDI) annual report. The report for 2020/21 outlined four targets for inclusion which included a new equality impact assessment process, a reverse mentoring programme, accessibility information as standard training for frontline staff and a working group to improve the capture of demographic information. In February 2021 the trust launched a joint initiative with Kent Police to tackle hate crime and violence against KMPT staff, referred to as Operation Cavell.

Workforce Disability Equality Standard (WDES)

The trust had measured itself against the WDES standards. The WDES is a set of standards that aims to improve the experiences of Disabled staff in the NHS. From April 2019, all NHS trust had to measure themselves against ten data standards.

A total of 7% of the KMPT workforce shared that they identified as disabled on their staff record. Staff working in agenda for change (AfC) Band 6 roles had the largest proportion of disabled staff. The number of disabled staff feeling that the trust had made adequate adjustments had risen by 7.9% in the last 12 months to 84%.

Disabled staff experiencing harassment, bullying or abuse from patients, relatives or the public was 35% which was 4% higher than the benchmark for mental health providers.

A total of 24.5% of disabled staff experienced harassment, bullying or abuse from colleagues in contrast to 13.6% of non-disabled colleagues.

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.

The trust had rolled out disability awareness training to all staff and worked with the trust disAbility staff network to introduce a staff wellness passport. A WDES action plan was being developed with the involvement of the staff network. The trust was developing a managers' handbook to assist them with the right information to support staff with disabilities.

Staff Networks

Our findings

As part of the trust's work around equality, diversity and inclusion there were four established staff networks. The networks were focused on the promotion of diversity in the workplace. The networks were comprised of peer groups of staff who used the networks as a safe space for peer engagement and support as well as a forum for providing feedback to the trust senior leadership on areas and opportunities for improvement.

The networks in the trust were:

BAME Network: a staff network for black, Asian and minority ethnic staff and allies. The network had an executive level sponsor and was the largest staff network in the trust. The network chair had addressed the trust Board re the trust agenda to eradicate all forms of racism in the organisation, and ensure equity.

disABILITY Network: a staff network to promote disability awareness open to staff with or without a disability. The network had 58 members and was involved in reviewing the trust's policy on disability related sickness and reviewing the well-being passport.

LGBT+ Network: a staff network to empower and support LGBT+ staff and allies. The network had been involved in Pride months, LGBT History month and working to increase trans awareness.

Faith Network: a staff network to promote understanding and good relations between all religions and beliefs and inclusive of all religions and beliefs.

The networks by and large met every two months and had a small budget to use for resources and activities. All networks had a senior trust sponsor.

Staffing

Vacancies

The overall staff vacancy rate for all roles was 15% against a target of 11.85%. This position had worsened since November 2020 when the vacancy rate was 12.7%.

Staff retention rate for all roles was 81.8% against a target of 90%. Staff retention had declined since the earliest data reported in June 2021 of 87.3%.

The trust board had identified workforce recruitment and retention as one of the trust's key risks. The trust had taken initiatives to respond to recruitment and retention issues and progress of these was monitored and reviewed at trust board level. A nurse apprenticeship scheme was in place and the trust was recruiting nurses internationally with nine nurses starting employment in November 2021 which would increase to a total of 21 nurses by March 2022.

Staff Sickness

The overall staff sickness was 5% in October 2021. This was 1% above the trust target of 4%. A 0.75% portion of the staff sickness was due to sickness caused by COVID-19.

Mandatory training compliance

Our findings

The trust set a target of 90% for all staff completion of mandatory and statutory training. Overall, the trust target of 90% had been met for training. The trust overall completion rate was 93%.

Appraisal

All staff had the opportunity to discuss their learning and career development needs at an annual appraisal. At the time of the inspection the trust appraisal rate was 99% (including medics).

Managers across the trust addressed poor staff performance where needed. The trust had policies and procedures in place for managing staff capability and performance concerns.

Supervision

At the time of inspection the trust compliance for staff supervision was 80%. During the core service inspections, staff we spoke with said that they received regular supervision.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub board committees, executive-led assurance committees, directorate governance meetings and team meetings. Leaders regularly reviewed these structures. Board members understood their portfolio, remit and were able to challenge each other appropriately.

The board was supported by six sub-committees: Audit and Risk Committee, Quality Committee, Finance and Performance Committee, Mental Health Act Committee, Workforce and Organisational Development Committee, and Remuneration and Terms of Service Committee.

The NEDs were clear and well sighted on their areas of responsibility. They chaired board sub-committees and had Executive Leads who had defined areas of responsibility. They worked to ensure there was an appropriate level of communication between the sub-committees and the trust board.

The trust board met every two months. We observed a trust board meeting in the week before the well-led inspection. The board meeting was conducted in a warm, welcoming and professional way. The public board meeting opened with a personal story from a patient or carer's perspective which was used to inform the board. Patients, carers, staff members and the public could attend the public board via video-link as the board had been meeting virtually since the outbreak of the pandemic.

There was clear evidence of benchmarking the trust against peer organisations for the workforce metrics which was good practice and could be expanded to include other categories. Similarly, there was evidence of co-production in board papers between the board, staff and patients.

The board agenda covered board assurance, strategy and development, operational assurance and governance. Standing items included the board assurance framework, an action log and reports from the chair and the chief executive. The board reviewed an Integrated Quality and Performance Report (IQPR) at each meeting. The IQPR contained reports on current operational performance data from team level measured against expected performance. This key performance information was reviewed and discussed including an analysis of those areas where performance lay outside targets.

Our findings

The trust had an established Board Development Programme, with the next session being in December 2021. This was to be externally facilitated and focused on honing trust performance as a unitary board. However, the external review of the trust board had been postponed in 2020 due to the number of personnel changes in the board. The external audit of board effectiveness was due to be rescheduled in 2022.

There were items on the agenda for the private board meeting which could have been heard at the public meeting such as the presentation on learning from serious incidents.

Although standards of papers were generally good, there were a few areas where board papers fell short of good standards of governance in that papers were not numbered or lettered to correspond to the agenda item, often the 'overview of paper section' was a contents list rather than an overview, and there was inconsistency with the headings on cover sheets. We noted that a substantial item tabled with slides had not been included on the agenda for the board meeting we attended. These elements would enhance the understanding of participants and board attendees.

Complaints and compliments

The trust had received 437 complaints in the last year and 1642 compliments. Of the complaints, 12 (3%) were completed beyond the agreed response date and extended following conversation with the complainant, the remainder were completed on time.

Management of risk, issues and performance

The trust developed robust financial plans in line with national requirements and aligned to the organisation's overall strategy. The trust had a strong recent track record of delivering its financial plans, managing cash, capital and revenue effectively, however the trust was working with system partners to address an underlying deficit of £6 million, and had a target to reduce the annual spend on agency staff by £2 million.

Financial risks were recognised by the trust and partners in relation to the management of capital projects which had led to slippage in financial targets. We saw on the core services inspections that staff were struggling to get timely responses to basic maintenance needs, and repairs to equipment, that could impact on patient wellbeing. The trust recognised these concerns within the estates and facilities function. The trust was addressing how insufficient management oversight, including experienced project management, had contributed to this and an investigation into how this occurred was underway. The trust had appointed additional project management resources and the board had oversight of the issues, including reforming and monitoring the performance of the contract with the outsourced maintenance provider.

The Board Assurance Framework (BAF) had been reviewed and was now presented in a new template and this was reviewed at the trust board and actions from it where allocated to the appropriate board committees. The BAF aligned with the key corporate risks and listed trust risks under nine categories which described the risk, the controls in place, the top five assurances and planned actions and milestones. The BAF was used to provide assurance to the Board that there was a system of internal control in place to manage key risks. The new format BAF was comprehensive with clear governance arrangements around it. It was reviewed at board meetings and discussed at sub-board committees.

Arrangements were in place for identifying, recording and managing risks, issues and mitigating actions. Risks were identified, assessed and managed at all levels of the organisation. The risk management process in place set out the key

Our findings

responsibilities and accountabilities to ensure that risk was identified, evaluated and controlled. Risks were escalated as necessary. Services maintained their own risk register which was submitted to the trust's electronic risk management system. All staff had access to the risk register and were able to effectively escalate concerns as needed. Staff concerns matched those on the risk register.

Key trust performance risks identified with NHSE/I included poor performance in meeting demand for memory assessments within dementia services. A strategy had been developed to improve this. Trust performance in achieving the physical health checks for people with severe mental illness (SMI) was below target, and recruitment and retention of staff was a significant workforce risk. These risks and the plans to address these were on the trust risk register and plans had been developed in collaboration with commissioners.

The trust had outsourced the provision of meals to patients in its inpatient services. We heard mixed reviews from patients about the portion-size and quality of the food, especially in the wards where patients had a longer stay. Food was delivered to each ward and then reheated before serving. It was the task of nursing staff to carry out the reheating and monitor the temperature of all items before serving to patients. We observed that this was a time-consuming task which placed pressure on the ward team and removed staff from clinical roles.

Pharmacy staff including the medication safety officer worked closely with the governance team including the medical devices safety officer to manage alerts and recalls.

The trust had made improvements investigating and learning from serious incidents. The absence of detail and clarity of root cause analysis reports had been highlighted at the last well-led inspection. Since then the trust had created and developed a central investigation team to investigate and report on serious incidents. The reports we reviewed were consistent and of good quality with the involvement of carers and family within the investigation process identified.

Information Management

The trust was aware of its performance through the use of key performance indicators and other metrics. Information was in an accessible format, timely, accurate and identified areas for improvement. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

Since the last inspection the trust had continued to develop its clinical quality audit tool 'CliQ check'. The information was now available for team leaders and managers via a dedicated app. The CliQ audit system produced reports across a range of patient care indicators. Teams where performance was outside trust targets were given high impact actions to work on to improve performance.

The trust had guidance and processes in place to support information management. Staff were trained to understand recording processes and received information through the trust's reporting system.

Since the last inspection the trust had increased the use of digital technology which had been deployed during the COVID-19 pandemic. The trust had recently appointed a director for digital transformation. The trust was working towards a clinical technology strategy based on ten objectives developed in consultation with patients carers and staff. They included developing a culture of continuous digital improvement, cyber security, user-centred design of new systems, easy access to data and systems that support research and audit.

Our findings

The trust also had in place an informatics strategy to improve the collection, quality and sharing of key trust information.

The trust was working in partnership with other agencies in the county to develop a Kent and Medway integrated health and social care record (KMCR). The record could be accessed by GPs, local authorities, and other NHS and mental health providers. The expectation was that the shared information would assist clinical decision-making and reduce the need for patients to repeat their information to different parts of the system providing care and treatment.

Leaders submitted notifications to external bodies as required.

Engagement

The trust utilised a number of communication methods such as the intranet, newsletters and a quarterly trust magazine, 'Connected', to ensure staff, patients and carers could access the most up to date information. There were opportunities for patients, carers and staff to feedback on the service.

The trust had a participation and involvement strategy. Since the last inspection the trust was implementing a new engagement panel and engagement council for the users of the trust services to be more fully engaged and broaden the scope of patients' representation. The Council was formed from senior staff, service users, carers and members of the public. At the time of inspection 100 people had volunteered and been trained to become members of the engagement council.

The trust was a member of the Triangle of Care for both inpatient and community services. There were carers champions across all the trust teams whose role was to help promote carer awareness to their colleagues as well as being a designated point of contact for carers.

There were initiatives for staff to have easy access to the chief executive by messaging directly 'Tell Helen', and also for members of the public to do the same through 'Hello Helen'. The trust also had a weekly 'thank you' email to staff and a weekly well-being themed message. However, we heard mixed messages from staff as to whether the senior team were as sufficiently visible at ward and team level. Some staff commented that the senior leaders engagement was primarily via electronic communications, email and intranet, and that some messages from the senior team during the COVID-19 pandemic had focused on staff adapting to home-working rather than the experience of staff working directly with patients every day.

The trust was pro-actively engaged with the wider health economy and system locally. The trust had worked hard to support staff to manage during the pandemic and also extended this welfare offer to partner agencies. During the COVID-19 pandemic the trust had assisted an acute trust in Medway to meet the demand for inpatient beds by releasing one of its mental health wards for older people, which was located in the acute trust's hospital, to be used by the acute trust.

The staff networks provided staff with support and engagement opportunities with peer groups who shared the same protected characteristics.

Learning, continuous improvement and innovation

The trust had placed quality improvement (QI) as a core part of its strategy for 2020-2023. There was a small team of three within the QI department and oversight of the QI strategy sat with the trust Chief Medical Officer. The trust

Our findings

recognised that there was work to do to embed an understanding and confidence within the organisation of quality improvement approaches and methodology. To date the trust had completed five QI projects, with 15 others underway. All projects had a local rather than trust-wide focus. At the last well-led inspection the trust had yet to form a QI strategy, senior leaders confirmed that there was still much work to do to deliver the QI ambitions currently including better communication and training for staff, and having QI champions at trust board level.

NHS trusts can take part in accreditation schemes that recognise services' compliance with standards of best practice. Accreditation usually lasts for a fixed time, after which the service must be reviewed. The trust had a range of services accredited with national organisations including:

AIMS Rehab- A quality network for mental health rehabilitation services: accreditation for 111 Tonbridge Road, and Brookfield Centre

MSNAP- Memory Services National Accreditation Programme: seven community mental health teams for older people

Community of Communities: Ash Eton community and Brenchley Unit

QNFMHS- The Quality Network for Forensic Mental Health Services Trevor Gibbens Unit, Allington Centre and Tarentfort Centre

ECTAS- The Electroconvulsive Therapy Accreditation Service: Maidstone ECT service

PQN- Perinatal Quality Network: Kent and Medway Mother and Infant Mental Health Service and Rosewood Mother and Baby Unit

Key to tables					
Ratings	**Not rated**	**Inadequate**	**Requires improvement**	**Good**	**Outstanding**
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	➔➔	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement Feb 2022	Outstanding Feb 2022	Outstanding Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Mental health	Requires Improvement	Outstanding	Outstanding	Good	Good	Good
Overall trust	Requires Improvement Feb 2022	Outstanding Feb 2022	Outstanding Feb 2022	Good Feb 2022	Good Feb 2022	Good Feb 2022

The rating for the well-led key question is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions take into account the ratings for different types of service. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for mental health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community-based mental health services of adults of working age	Requires improvement Mar 2021	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2021	Requires improvement Mar 2021	Requires improvement Mar 2021
Substance misuse services	Good Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017
Acute wards for adults of working age and psychiatric intensive care units	Requires Improvement → ← Feb 2022	Good ↑ Feb 2022	Good → ← Feb 2022	Good → ← Feb 2022	Good ↑ Feb 2022	Good ↑ Feb 2022
Wards for people with a learning disability or autism	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017
Long stay or rehabilitation mental health wards for working age adults	Good Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017	Good Apr 2017	Outstanding Apr 2017	Outstanding Apr 2017
Forensic inpatient or secure wards	Good → ← Feb 2022	Good → ← Feb 2022	Good ↓ Feb 2022	Good → ← Feb 2022	Good ↓ Feb 2022	Good ↓ Feb 2022
Wards for older people with mental health problems	Requires Improvement ↓ Feb 2022	Good → ← Feb 2022	Good → ← Feb 2022	Good → ← Feb 2022	Good → ← Feb 2022	Good → ← Feb 2022
Mental health crisis services and health-based places of safety	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Community-based mental health services for older people	Good Mar 2019	Good Mar 2019	Outstanding Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Community mental health services for people with a learning disability or autism	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017	Good Apr 2017
Overall	Requires Improvement	Outstanding	Outstanding	Good	Good	Good

Overall ratings for mental health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Forensic inpatient or secure wards

Good ↓

Is the service safe?

Good →←

Our rating of safe stayed the same. We rated it as good.

Safe and clean care environments

All wards were safe, clean well equipped and well furnished, most wards were well maintained and fit for purpose. However, Emmetts ward and Walmer ward whilst homely and safe appeared tired and in need of refurbishment.

Safety of the ward layout

Across all wards at the Trevor Gibbons unit and the Allington centre there were regular annual ligature assessments taking place and focussed ligature audits when required. The wards had a strong culture of ligature awareness and the staff knew of the high risk areas of the wards and how to manage them.

Emmetts ward had multiple ligatures across the ward but the reason that these had not been removed was due to the patients being close to discharge and so ligature risk was managed by the individual risks of the patient group. When we reviewed the individual risk assessments for the patients, we could see that in the nursing assessment the risk of ligature was not always easily identified. We identified this with the clinical team at the Trevor Gibbons Unit and they took immediate action to identify a separate risk indicator for ligatures with guidance to the MDT to consider if the patient would be suitable in this environment.

The layout of the wards allowed staff to observe most areas of the ward. Risk mitigation plans were in place for areas with a restricted view. We observed good positioning of staff to monitor patients and the wards.

All wards displayed staff pictures and details of daily staffing levels. Notice boards contained all the information patients were likely to need, such as details of advocacy services, menus, how to complain and ward activities.

All wards were gender specific and the accommodation complied with the Department of Health guidance on mixed sex accommodation.

Staff had easy access to personal infrared transmitter alarms and patients had easy access to nurse call systems. The alarms for all wards were centrally managed and were given out from a reception area where it was each individual staff member responsibility to check the alarm was working using a wall mounted testing station.

Maintenance, cleanliness and infection control

Staff made sure cleaning records were up-to-date and the premises were visibly clean, other than some marks on the walls and ceiling of the seclusion facilities. Staff followed the infection control policy, including handwashing and it was evident that additional infection control procedures had been introduced and were being audited in order to manage the spread of COVID-9.

Forensic inpatient or secure wards

We observed that on Emmett's and Walmer ward at the Trevor Gibbons Unit (TGU) although clean and homely the décor felt a little tired and required refurbishment. The staff and patients had taken steps to make the wards feel like a therapeutic environment with well-kept furniture and pictures but the overall fabric of the building was showing its age.

We found maintenance issues across both hospital sites which staff had raised using the trust systems but had not been addressed. Some of these issues were longstanding and were impacting on the patient's wellbeing. At the TGU we found that patients on Emmetts / Bedgebury were having to walk to an alternative ward to use the shower as the one on the ward was out of use and had been for several months. We could see there had been action taken to order a part to repair the shower but the impact was that patients were walking outside in their dressing gowns to access a usable shower.

Seclusion room

The seclusion room on Penshurst ward met the required standard as described in the Mental Health Act code of practice. It was clean and well maintained with access to outside space, had air conditioning and an intercom which staff knew how to operate.

At the Allington centre the seclusion room had been out of action for over two months due to patient damage and was in the process of being costed for repairs, this was not happening in a timely manner which meant that the seclusion was effectively out of action.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. All clinic rooms had appropriate records to demonstrate that staff were monitoring emergency drugs, resuscitation equipment and fridge temperatures.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe. We reviewed the nursing and care vacancies across the whole core service and identified there were 28 vacancies for nurses and support workers. The most vacancies were on Walmer ward at the TGU where there were 11 vacancies and six of these were staff nurses.

The service used bank and locum agency staff to cover all leave, absences and sickness. Bank staff were familiar with the service and knew the patients they were supporting. Patients across the service said they knew most staff on the wards. Staffing numbers were displayed on each ward in their communal areas.

Staff felt there sometimes was a reliance on temporary staff to work across the wards although the temporary staff were felt to be comprehensively inducted onto the wards. Managers ensured an onsite induction was completed and induction forms were held locally.

The trust had taken steps to recruit to these positions with the introduction of an overseas nursing programme which had recruited 30 nurses across the trust in the last two years. In addition to this the trust had also adopted "a grow your

Forensic inpatient or secure wards

own" approach which involved having Trainee Nursing Associates that have graduated every year since 2019 from the Centre for Practice and Learning. In 2021, eight nursing associates graduated in September, with a further 10 graduating in September 2022. In 2021, 17 Registered Nurses Apprentices (RNA) and 11 Trainee Nursing Associates were also recruited across the trust. We saw evidence of this in Penshurst ward where nursing associates completed enhanced training on the job whilst they worked in a healthcare worker role. They were being supported to complete foundation degrees and eventually obtained qualified nursing associate status.

Staff stated they were supported by senior staff when shifts were short staffed due to unforeseen circumstances. Staff described the challenges of staffing the ward during the second peak of the COVID-19 pandemic when both staff and patients were unwell with the virus. Managers, senior leaders and therapy staff stepped in to support patient care when needed.

On all wards patients had a named nurse, a secondary nurse and a named healthcare worker assigned to them. Despite the fact that the wards were relying on temporary staff, patients could regularly spend time with their named nurse.

Patients rarely had their escorted leave or activities cancelled, this only happened when there was ad hoc sickness.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency. We reviewed the staffing structure for all wards and could see that the wards all had a full time responsible clinician (RC) and most wards had at least one speciality grade doctor supporting the RC.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. As well as statutory training which were mostly above the trust target of 90% across all wards. There was also specific training for working in a secure environment such as clinical risk awareness training and conflict management. All wards across the core service were below the trust target of 90% (for staff completion of this training) for their physical interventions training, We were told this was due to the complications in the face to face training of staff during the COVID-19 pandemic but the trust had already made plans to re-introduce this training.

Human Resources (HR) Managers monitored mandatory training and alerted ward managers and staff when they needed to update their training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction strategy.

Assessment of patient risk

Forensic inpatient or secure wards

Staff completed risk assessments for each patient on admission / arrival, using two recognised tools, the short term assessment of risk and treatability and the Historical Clinical Risk management 20 (HCR20) and reviewed these regularly with the multi-disciplinary team to identify and respond to any changes in risks, including after any incident.

Management of patient risk

Staff knew about any environmental risks to each patient and acted to prevent or reduce risks. On Emmetts ward there were multiple ligature risks around the ward. These were well documented in the environmental risk assessments and the staff were aware of their locations. Staff told us that potential ligature risks were mitigated in the ward by the ward admission criteria, which excluded those patients who presented a high suicide risk. However, it was not made explicit in the wards admission criteria that this was the case and it was not identified as part of the nursing assessment. We discussed this during the course of the inspection with the quality team who made sure the nursing assessment was addressed to reflect this however the admission criteria was not changed to reflect this.

At the older wards, Emmetts and Walmer, it was not as easy to maintain lines of sight as it was at the Allington centre. However, staff were able to able to move and observe patients in all areas and all staff followed local procedures to minimise risks where they could not easily observe patients.

Staff knew where the emergency grab bag was kept and it was checked by a nurse on each shift, so everything was always in order.

Staff monitored the physical health of patients regularly using the observation chart for the National Early Warning Scores (NEWS2). This is a tool that aids the detection and response to clinical deterioration in adult patients. Staff were aware of specific risk areas and acted to mitigate these risks. Staff were trained in the use of the NEWS2 chart to identify deteriorating patients. Staff said they were confident about using it and escalating issues as appropriate. We reviewed NEWS2 forms and found they were being filled in appropriately and as per policy.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

Use of restrictive interventions

Blanket restrictions were minimal and suitable to a forensic environment. They included locked access to the wards and the suitable management of contraband items in a forensic service. Staff explained the rationale to patients for restrictions on admission to the wards and reviewed decisions individually where appropriate.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The meetings had been infrequent over the 2020 period due to pressures from the COVID-19 pandemic, however the restrictive intervention and reduction programme was identified on all wards. We identified a blanket restriction at the Allington Centre relating to the locking of the garden courtyard. The acting ward manager explained that this had been put in place following a serious incident that had happened elsewhere in the trust. The blanket restriction had been identified in the minutes of the restrictive practice meeting and the intention was for this to be removed.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. Staff identified that restraint was infrequent and data from the trust identified this to be the case.

Forensic inpatient or secure wards

When a patient was placed in seclusion or long term segregation, staff kept clear records and followed best practice guidelines.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The wards had clearly identified safeguarding leads and a safeguarding vulnerable adults' protocol was in place. Staff knew how to make a safeguarding referral and who to inform if they had concerns

Staff understood how to protect patients from abuse and the hospital worked well with other agencies to do so. Staff had face to face training relevant to their role in safeguarding adults' level 1, 2 or 3 and safeguarding children. All wards were over the 90% trusts target compliance level for safeguarding training.

Staff could give clear examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the ward safe. There were allocated visitors rooms on both sites which had suitable rooms for children to visit, these were available to be booked dependent on the individual risks of the patients.

Patients said they felt safe on the wards. Staff understood their responsibilities to ensure that patients were protected from bullying and harassment. Patients reported they could raise any concerns at community meetings or confidentially in one to one meetings.

Staff access to essential information

Staff had easy access to clinical information and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

We reviewed 22 sets of care records and across all wards patient notes were comprehensive, stored securely and staff could access them easily using the electronic notes system. Staff recorded hourly observations on paper. These were stored in the nurses' office and uploaded to the electronic records. Staff were able to access paper and electronic records quickly.

Records were stored securely. Staff needed to enter a personal identification name, a password and an identity card in order to access the electronic patient record.

When patients transferred to a new team, there were no delays in staff accessing their records and all wards were able to access the notes of patients within the trust if required and clinically relevant.

Medicines management

Forensic inpatient or secure wards

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medications on each patient's mental and physical health.

We reviewed 42 medicines records and saw that staff followed the correct procedure and practices for prescribing and administering medicine. Medicines records were kept accurately and up-to-date. There was evidence of staff completing high dose monitoring of medicines for patients. Medication charts across all wards were well ordered with T2 consent to treatment forms attached to the cards with the renewal of section dates noted on the charts. Second opinion appointed doctor T3 certificates were attached to the charts when appropriate.

Ward staff could access advice from a clinical pharmacist on weekdays. Staff working out of hours could access the trust on-call pharmacy service for medicines advice. Pharmacists were able to access blood results in order to assist with the monitoring of certain medicines, for example, clozapine and lithium. Ward rounds took place weekly or fortnightly dependent on patient need and medicines were discussed and reviewed. There were also daily ward huddles where urgent medicines concerns could be raised

The wards ensured people's behaviour was not controlled by excessive and inappropriate use of medicines, this was closely monitored during ward rounds and included pharmacists' input. Staff told us that rapid tranquilisation was reviewed weekly. If it had not been used for a patient, the pharmacist would ask the team to review the need for the prescription to be continued. Staff explained that the trust had worked on reducing the use of restrictive practices, including reducing the use of rapid tranquilisation. Patients were part of the project in order to hear their views and have a better understanding of the impact of restrictive practices on them.

We observed staff following national practice to check patients had the correct medicines when they were admitted or when they moved between services.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them, when to raise concerns and report incidents and near misses in line with trust/provider policy.

The forensic core service had no never events on any wards in the 12 months prior to the inspection.

Staff were aware of their duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Forensic inpatient or secure wards

Staff met to discuss the feedback and look at improvements to patient care. Staff discussed safety incidents in the monthly staff meeting and the wards managers fed back incident performance information from the trust so that all staff were made aware of other incidents that had occurred elsewhere in the trust.

There was evidence that changes had been made as a result of feedback. We could see on Walmer ward that there had been incidents on the ward as a result of staff's management of the search process for patients returning to the ward from unescorted leave. The ward had implemented a randomiser button at reception which made searches random and not dependent on the perceived choice of the staff. This had resulted in a drop in the number of incidents at reception and a relieved pressure on staff carrying out the searches.

Is the service effective?

Good

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented. They included specific safety and security arrangements.

We reviewed 22 sets of care records across the seven wards we found across all wards that there was a comprehensive mental health assessment of each patient either on admission or soon after. Positive Behaviour Support (PBS) plans were in place for some patients who had particular communication needs and would benefit from staff taking a tailored approach when engaging with them

All patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Medical staff ensured the physical health assessments had actions which were being followed up by the nursing staff.

Staff developed a personalised, holistic and recovery-orientated care plan with each patient that met their mental and physical health needs. These were regularly reviewed and staff updated care plans when patients' needs changed. We attended part of a ward round and could see that care plans were discussed and reviewed with the patients present so they had an opportunity to feedback about their plan directly to their clinical team.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Forensic inpatient or secure wards

Staff delivered an occupational therapy activity program Monday to Sunday during the day and into the early evening this was in line with National Institute for Health and Care Excellence (NICE) guidelines which recommend meaningful and culturally appropriate activities seven days a week and not limited to 9am to 5pm. Patients felt that there was enough to do, across the wards. Staff provided a range of occupational therapy treatment suitable for the patients in the service.

Patients had opportunities to develop their living skills and to build on their work experience and education. For example, at the Trevor Gibbons unit some patients had volunteer responsibilities in the hospital café and looking after the animals. One patient at Walmer ward had enrolled on a psychology and criminology college course and others could apply to complete English and Maths qualifications.

All wards had full access to a team of psychologists with a lead psychologist allocated to each ward supported by assistant psychologists. Psychology sessions included: sex offender treatment programme interventions, reasoning and rehabilitation, managing emotions, offending behaviour, arson and substance use treatment programme.

There had been training in supporting the use of restorative justice with the patient group and the psychology team had continued to build on the restorative justice approach since the last inspection. A system of restorative justice champions had been embedded and patients had attended awareness days. Staff were now developing a restorative wards approach. This meant that staff were trained in restorative principles and encouraged to use affective statements when communicating to help others understand the impact of decisions on them as an individual. A new restorative circles programme was also in the process of being rolled out. This consisted of weekly 15-minute meetings where patients explained to each other the impact of any recent events on their thoughts, feelings and relationships.

Patients at the Trevor Gibbons Unit had access to pet therapy. A therapy dog was based at the unit and was used for both group and individual patient sessions.

Staff supported patients to lead a healthy lifestyle. A dedicated staff member at each location worked with patients to support them to lead a healthy lifestyle in line with the Commissioning for Quality and Innovation (CQUIN) quality goal. This involved developing healthy living passports with patients, coaching patients on exercise and diet, helping them achieve specific fitness goals and running health groups for patients to attend. Patients were also supported to stop or reduce their smoking and some occupational therapy staff were trained to give smoking cessation advice.

Staff met patients' dietary needs and assessed those needing specialist care for nutrition and hydration. Ward's multi-disciplinary teams included speech and language therapists and ward teams were able to access dieticians. These specialists worked with staff and patients to fully understand patients' nutrition and hydrations needs.

The management of patient food was a larger issue across both hospital sites. Patients told us food quality was poor, portion size was small and choices were limited. We observed the preparation of a cook chill meal and could see portion sizes were small, with a small tray of chips identified for six patients as part of their lunchtime meal.

In addition, food preparation time was having a significant impact on staff's clinical time. We observed the support workers preparing the lunch meal. Staff were having to remove themselves from patient areas at regular intervals during the two hours prior to the mealtime to temperature check and test the regeneration oven. All staff we met with across both hospital sites identified this was an issue and felt that it impacted on their ability to support the patients, especially during times when patients were distressed and required their support.

Forensic inpatient or secure wards

We discussed these issues at the time of the inspection with the trust who had in place action plans to address the concerns that had been expressed by patients and staff. The trust had made a commitment to refocus on their actions to improve food provision.

We saw evidence that medication was prescribed and monitored in line with the National Institute for Health and Care Excellence (NICE) guidance.

Staff used recognised outcome measures to measure how effective therapeutic interventions had been for specific patients. For example, psychology staff used outcome measures to monitor patients progress with trauma informed interventions. All group sessions also had pre and post assessment measures to help monitor their effectiveness.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. The trust provided an induction programme for new staff.

Staff were suitably skilled and experienced to work in a forensic service. There were opportunities for career progression and development within the service. Many staff had worked in the service for several years. They said they had developed their skills through formal training courses and learnt new skills from their colleagues and through learning events and meetings.

Patients on each ward had access to the full range of specialists required to meet their needs. This included occupational therapists, psychologists, art and music therapists, social workers and a range of other therapists.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a local induction to the service before they started work.

Patients on each ward had access to the full range of specialists required to meet their needs. This included occupational therapists, psychologists, social workers and a range of allied health professionals. Staff also made referrals to specialists when needed including speech and language therapists.

Staff accessed weekly group clinical supervision. This was facilitated by a clinical psychologist and helped staff understand how to take a trauma informed approach with patients.

Staff also received regular one to one supervision with their line managers and they found this useful.

Ward staff at the Trevor Gibbons Unit could access vicarious trauma workshops. These were facilitated by a clinical psychologist and helped staff manage the symptoms of secondary trauma.

Staff had also accessed various specialist training in physical health care areas such as diabetes management and nutrition.

Forensic inpatient or secure wards

Some staff working at the Allington Centre had also worked in the trust's forensic learning disability wards. They explained how they supported other staff to tailor their approach when meeting the needs of autistic people or who had a learning disability. Two healthcare workers on Penshurst ward had recently worked in schools for children with learning disabilities. Staff reported that these staff had supported them to give tailored support to patients with learning disabilities who had initially been admitted to Penshurst ward for a period of stabilisation whilst a bed on a learning disability specialist ward was identified.

Volunteer peer support workers supported patients at both hospital sites and the patients at The Allington Centre told us how supportive this person had been and how it had shown them there was opportunities available for them when they came out of hospital.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation and engaged with them early on in the patient's admission to plan discharge.

Staff held regular weekly multidisciplinary meetings to discuss patients and improve their care.

The ward at the Allington Centre they were piloting the use of a touchscreen patient information system. This was designed to replace the traditional patient information whiteboard and was a one stop, at a glance system for managing the patient journey. The system is designed to be updated from the electronic notes system and flag when areas of need required attention to make it easier for the staff. This was due to be rolled out across all wards following the pilot.

Multidisciplinary team members reported that they felt like equal team members and their contribution to discussions such as ward rounds was welcomed by the wider team.

Social workers explained how they liaised closely with community teams and housing teams to help ensure patients could be discharged in a timely way with suitable accommodation and support.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support. Patients had easy access to information about independent mental health advocacy.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Forensic inpatient or secure wards

Staff received, and kept up-to-date, with training on the Mental Health Act and the Mental Health Act (MHA) Code of Practice and could describe the Code of Practice guiding principles. Training records from the trust indicated That most wards were above the trust 90% compliance target for training in the Mental Health Act and Mental Health Act awareness training for non-registered clinical staff. This meant that Staff demonstrated a good knowledge and understanding of the Mental Health Act.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice from the MHA administrator based on each of the hospital sites.

Patients had available information on notice boards about independent mental health advocacy and patients who lacked capacity were automatically referred to the service.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Patients felt that the staff were always reading them their rights and they felt very clear about what they were entitled too and when.

All patients had care plans which included information about understanding their detention under the MHA.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

All wards were over or just under the trust training of 90% for training in the Mental Capacity Act and staff demonstrated a good understanding of the Mental Capacity Act. We saw that staff had recorded capacity assessments in patients' notes. Staff presumed that patients had capacity unless there was reason to consider otherwise.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

There were no patients subject to the Deprivation of Liberty Safeguards at the time of the inspection however staff were aware of when this may be applicable and who they should contact for advice.

Is the service caring?

Good

Our rating of caring went down. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Forensic inpatient or secure wards

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition. However, the wards at the Trevor Gibbons unit still had outdated vistamatic windows in a number of bedroom doors.

Staff were discreet, respectful, and responsive when caring for patients. Staff were warm, showed a genuine interest in patients' wellbeing. Staff used effective de-escalation skills to manage conflict well and confidently. Patients told us that staff were kind and involved their relatives in their care.

Staff supported patients to understand and manage their own care treatment or condition. All patients we spoke to felt staff involved them in their care planning process and had copies of their care plans given to them if they wanted them. All the care plans reviewed showed patient involvement in care planning. Patients told us they were involved in designing the therapeutic activities for the wards, both for their personal programmes and the wider group such as planning and taking part in multi-cultural cooking events.

Seven of the bedroom doors at Walmer ward and three of the doors seen at Walmer/Bedgebury ward had vistamatic windows which could be opened without the use of a key from the outside. This meant that the windows could be opened by any person walking past the door. We were told that the doors were being replaced on a rolling replacement programme but some of the doors had clearly been in place for over 10 years. The wards had systems in place to check the vistamatic windows were routinely kept shut but this did not mitigate this issue.

At the TGU we found that patients on Emmetts / Bedgebury were having to walk to an alternative ward to use the shower as the one on the ward was out of use and had been for several months. There was an impact on patients privacy and dignity as patients were walking outside in their dressing gowns to access a usable shower.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Patients were supported by staff to make decisions about their own care and treatment. For example, one patient reported that they had met with the ward consultant to discuss potential medicine options because they were dissatisfied with the side effects they were experiencing with their current medicine. The patient was supported to make a well informed decision about trialling an alternative medicine based on what staff told them about potential side effects.

Patients were encouraged to give feedback on the service. On Walmer ward leaflets were available to support patients to give feedback. At the Allington Centre patients attended a planning meeting each morning where feedback was welcomed, recorded and actions taken.

Each ward at the Trevor Gibbons Unit had a ward representative who attended patient council meetings, although other patients were also welcome to attend. This was a forum where feedback about the service could be passed to staff. The external food provider regularly attended these meetings to gather feedback about the quality of the food.

The trust had a well-established programme of peer support workers who worked with patients on the wards. For example, a peer tutor supported patients with recovery college courses and learning.

Forensic inpatient or secure wards

Staff involved patients in decisions about the service. For example, patients on Walmer ward completed taste sample tests to support staff to choose the most suitable food provider.

Staff made sure patients could access advocacy services throughout the recent pandemic using a combination of telephone and video conferencing. At the time of the inspection advocates visited the wards each week. The advocates would ring the wards weekly to find out if there had been new admissions or discharges.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff supported patients to keep in touch with the people who mattered to them. For example, during the COVID-19 pandemic staff across both hospital sites had actively facilitated regular video conferencing calls for patients whose relatives were unable to visit the wards due to government restrictions.

Staff helped families to give feedback on the service. For example, the service encouraged families and carers to complete a friends and family questionnaire. The service also held a carers forum where family members and carers could raise issues and concerns and provide feedback to the service. Family members and carers felt this was very valuable as it provided additional communication and understanding of how the service helped their loved one

A carers champion role was held by a nominated staff member on the wards. This meant that there was someone responsible for facilitating visits from patients loved ones and gathering feedback about the service from carers. The carers champion also held contacts for local carers support groups to signpost people to. They were also involved with improving the family room at the main reception area in the Trevor Gibbons Unit.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff planned discharge with patients to ensure it went well. They liaised well with services that would provide aftercare and were assertive in managing care pathways for patients who were making the transition to another inpatient service or to prison. As a result, discharge was rarely delayed for other than clinical reasons.

Bed management

Managers and staff worked to make sure they did not discharge patients before they were ready. Ward based clinical teams regularly reviewed length of stay for patients in ward round to ensure they did not stay longer than they needed to. In addition to this, a well run weekly referrals meeting reviewed all bed occupancy.

When patients went on leave there was always a bed available when they returned. The days we inspected two patients were on long term community leave and their beds were available for them when they returned.

Forensic inpatient or secure wards

Penshurst ward was a forensic admission ward. Patients generally stayed on Penshurst ward for a shorter time whilst they underwent a stabilisation period. Patients were generally either discharged or transferred to one of the other secure wards to complete their inpatient treatment.

There was a clear pathway for patient flow within this core service with Penshurst ward providing triage leading to Groombridge as a sub-acute ward and then on to Emmetts ward or the Allington Centre. Patients also being able to be discharged if appropriate at any point in the pathway.

Patients were moved between wards only when there were clear clinical reasons or it was in the best interest of the patient.

Discharge and transfers of care

Managers monitored the number of patients who experienced delays to their discharge and the main reasons for delaying discharge from the service were related to awaiting housing in the community.

Staff planned patients' discharge and worked with the patients, their care managers and coordinators to make sure this went well.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom with an en-suite bathroom and could keep their personal belongings safe. There were quiet areas for privacy. Patients could make hot drinks and snacks at any time.

Patients had their own key fobs for their bedrooms and patients were able to access their rooms throughout the day and night.

Patients told us that they felt the wards were not restrictive and they were happy with the amount of restrictions they were supported under and felt it was appropriate to meet their needs.

Patients had lockable storage in their rooms, that they could access. Patients also had a small locker on each of the wards, that contained high risk items. These were only accessed by the ward staff.

All wards had quiet areas and a room where patients could meet with visitors in private. In addition, patients could meet with visitors in rooms located at the reception of the hospital sites.

Most of the wards at the Trevor Gibbons Unit service had an outside space that patients could access. Patients on each ward could access ward gardens with the support of staff. The courtyard garden at the Allington Centre, low-secure wards, was kept locked at the time of the inspection but there were plans to address this as part of the reducing restrictive practices programme. Access to outside space on Penshurst ward was limited at the time of the inspection. This was because of a sink hole that had appeared several weeks beforehand in a tennis court.

Staff made efforts to ensure patients could be escorted around the main hospital grounds. However, this meant that some patients who would not ordinarily require an escort to access fresh air were restricted, and it meant that patients could not always access fresh air as and when they wanted to.

Forensic inpatient or secure wards

Patients could make their own hot drinks and snacks in the communal areas of the wards and were not dependent on staff.

Patient searches were conducted in the most dignified way possible. For example, on the medium secure wards staff used a randomiser to help ensure routine searches of patients were conducted on a truly random basis.

Although patients had various restrictions in place depending on their individual risks, patients were supported to make telephone calls and access the internet where this was appropriate for them. Patients on Walmer ward could book sessions on the ward laptop.

Facilities at the Trevor Gibbons unit included a sport centre, a lakeside lounge cafe where some patients volunteered to develop their work experience and a small animal enclosure. These were available for patients to use with support from staff at the Trevor Gibbons Unit. Where appropriate, patients participated in group sports events where patients from different wards mixed.

Patients could access kitchen facilities to build their cooking skills with support from occupational therapy staff.

Patients on all wards had access to a multi-faith room.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff told us that they could access translation services when needed. On Groombridge Ward, staff requested a tablet to use online translation services for the everyday needs of patients whose first language was not English.

Patients could make phone calls in private. Patients also had access to their own mobile phones.

Staff made sure patients had access to opportunities for education and work, and supported patients.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. On wards supporting patients with learning disabilities, care and treatment documents and other information was available in easy read and picture format.

Patients had access to spiritual, religious and cultural support.

Forensic inpatient or secure wards

The service was able to meet the diverse cultural, religious and linguistic needs of patients in the service. The service had information leaflets available in languages spoken by the patients and local community. This included information about mental health conditions and medicines. Leaflets could be translated into any language for patients who did not have English as their first language. Managers made sure staff and patients could get help from interpreters or signers to ensure patients and their families were fully included in care planning. Staff were also able to access a telephone interpreting service at short notice.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

We spoke to 21 patients, relatives and carers and all knew how to complain or raise concerns.

The wards clearly displayed information about how to raise a concern in patient areas and the staff understood the policy on complaints and knew how to handle them.

The trust used a system of patient feedback called the Patient Reported Experience Measure (PREM) The PREM questionnaire is the trust wide patient experience feedback mechanism. The PREM was available across the trust in a wide range of formats including an Easy Read format. The PREM can be completed by patients at touchpoints in their care or whenever they would like to give their views. It could also be completed online with a text service to help patients give their views on the quality of their care after discharge. The NHS Patient Friends and Family Test (FFT) question is part of the PREM.

Monthly patient experience smart reports informed the ward leads of the PREM and FFT results and were a key component in patient-centred quality of care. These included the data for the year so can show at a glance how a ward is performing based on the feedback received. The ward leaders were tasked to provide visible evidence on the ward to demonstrate any actions that have been taken because of feedback.

Complaints were managed locally in the first instance by the ward managers and then the complaints policy was followed if required to escalate complaints. The multi disciplinary team reviewed complex complaints in the local clinical governance meetings and themes and trends were fed back to the wards through the ward staff meetings.

There had been a total of seven reportable complaints made during the period 01/11/20 - 01/11/21 one remained open and under investigation

The service used compliments to learn, celebrate success and improve the quality of care.

Is the service well-led?

Good ↓

Our rating of well-led went down We rated it as good.

Leadership

Forensic inpatient or secure wards

Leaders at ward level demonstrated the levels of experience, capacity and capability needed to deliver good quality sustainable care. The Chief Medical Officer and the service director had the appropriate skills, experience and professional qualifications to perform their roles. Modern matrons worked closely with the ward managers and knew the patients and staff well. Managers were able to clearly explain how they led the wards and worked with their staff teams to ensure the quality of the service. Long standing staff members said when the leadership did change, the nurturing ethos was continued by the new leaders. Patients were familiar and comfortable with the leadership team. They could easily talk with leaders and managers at meetings and informally.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their teams.

Staff at all levels in the service had a clear understanding of the trusts vision which was 'To provide brilliant care through brilliant people. Staff were aware of the trust's work to refresh their values and strategy and their personal values aligned with the trust values of 'Respect, Open, Accountable Excellence, Innovative and Working Together'. Staff showed these values through their respectful and inclusive interactions and behaviours with patients. They felt they were improving the wellbeing and life skills of patients in the service. The trust's vision and values were heavily promoted, appearing on trust literature and computer screens. Staff said the vision and values were reflected in the care and treatment delivered and work done by staff and patients on the service's various quality improvement projects.

Each ward had its own vision for how they would support patients. For example, on Walmer ward the vision focussed on staff supporting patients to realise their options, next steps and their strengths, and that the ward staff would avoid taking total responsibility for decisions.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

Staff were proud of the organisation as a place to work and spoke highly of the culture. Staff felt positive about their work and reported good staff morale. All staff showed passion and commitment to providing high quality patient care. Staff described stable staff teams that worked well together and supported each other. Staff described an open culture where everyone was encouraged to share their views.

Many staff had worked for the trust for significant periods of time and they praised the opportunities for development that were available. Staff said there were development opportunities available, particularly for nurses and health care assistants. Many staff felt this was one of the best things about the trust. Staff were proactively supported and encouraged to acquire new skills, use their transferable skills, and share best practice.

The trust celebrated success through annual staff awards and annual people participation awards schemes.

Staff reported the trust strongly promoted equality and diversity in its work with patients and in terms of the workforce. The trust embraced cultural differences and valued the knowledge and understanding a diverse workforce brought to the service.

Forensic inpatient or secure wards

During the COVID-19 pandemic the trust recognised the increased impact this had on Black, Asian and Minority Ethnic staff and patients and put strong support structures in place. Staff felt supported throughout the pandemic. Executive and senior leaders supported teams within the service and maintained strong contact and communication throughout the pandemic.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The leadership, culture and governance at ward level were effective in the delivery of high quality, person centred care.

The service systematically monitored standards of care to continually improve outcomes for patients. All wards carried out a programme of audits to monitor areas such as care and treatment records, staffing levels, take up of planned leave by patients, medicines management and staff supervision and appraisals.

The service held a range of meetings at which it shared issues and concerns, identified actions and monitored progress. All wards had a framework of community meetings with patients, handover meetings, ward rounds and multi-disciplinary meetings and clinical improvement group meetings. Agendas for meetings were standardised across the service and covered learning from incidents, complaints and safeguarding cases. Patient representatives played an active part in these meetings voicing patient views and concerns. Senior managers ensured that information was fed in both directions between the board and the wards and that information was shared across the service.

Staff were clear about their roles and responsibilities and they understood the management structure within the service. The management team worked closely with staff to enhance learning and drive continual improvement.

Staff received appropriate mandatory and specialist training, supervision and their work performance was appraised.

There were enough staff to ensure that staff delivered patient care in a way that was safe and effective, and that risks were managed well.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Risk management in the forensic service was comprehensive, well embedded and recognised as the responsibility of all staff. Each ward had a local risk register and ward managers and clinical leads were aware of the key risk areas on their wards.

The risks were discussed at local clinical governance meetings. Common risks recorded included physical health issues, patient disengagement, patient acuity and relapse, alongside actions taken to mitigate each risk. The service had contingency plans for emergencies which wards reviewed as part of their risk registers. Wards carried out regular health and safety monitoring, including regular emergency simulations and fire drills.

Forensic inpatient or secure wards

Each day ward teams reviewed the risks for their wards and patients. The ward teams knew the patients very well and were able to defuse situations effectively before they escalated. They were well informed about incidents and used the multi-disciplinary team meetings to discuss any changes to patients' care or new insights into their presentation. There were systems in place to monitor risks associated with patients' physical health and any issues were quickly picked up and addressed.

The response time from the trust in relation to managing maintenance and small building works was slow. The shower had been broken on Walmer / Bedgebury ward for several months which had impacted on patient care and resulted in patients having to leave the building in their night clothes to use a shower in an adjacent building. In addition, the seclusion room at The Allington Centre had been out of action due to patient damage for several months and was awaiting parts to be sourced.

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Information management

Staff collected analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

The trust had effective systems to collect data from the service. The trust provided dashboards for ward managers which had accurate human resources information on staffing, complaints, safeguarding, care planning and incidents. Information was presented in tables and graphs and it was easy to understand.

Quality improvement initiatives were strongly embedded within the service. All staff were familiar with the process and methodology of quality improvement. While the work on some quality improvement projects had reduced during the pandemic, wards were in the process of re-energising them as resources returned to pre-pandemic level.

Engagement

Managers engaged actively across local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

The service was part of the Kent Surrey and Sussex Forensic Consortium and engaged well with local health and social care partners. Staff valued the positive relationships with other providers and said openness and sharing within the consortium was a two-way process. Learning and understanding was shared in areas such as sexual safety, positive behavioural support, mental health equality, and physical health management. For example, the service's drugs and alcohol team supported patients through their community groups and signposted and liaised with other local health and social care providers.

Learning, continuous improvement and innovation

Forensic inpatient or secure wards

There was a fully embedded and systematic approach to improvement, which built on the trust's quality improvement programme. Staff were encouraged to develop their skills in this area and contribute to the quality improvement initiatives in the trust. Staff said they never stopped learning and praised the opportunities they had for formal and informal training and mentoring, all supported by the trust's central quality improvement team. Staff were proud of the quality improvement projects within the service and safe innovation was celebrated.

There was continuous learning, improvement and innovation outside of the quality improvement programmes. For example, the Low Secure Forensic services had been awarded the Restorative Service Quality Mark (RSQM) in 2019.

Acute wards for adults of working age and psychiatric intensive care units

Good ↑

Is the service safe?

Requires Improvement →←

Requires improvement

Our rating of safe stayed the same. We rated it as requires improvement.

Safe and clean care environments

The wards at St Martin's Hospital had a wide range of maintenance issues that ward staff had escalated but the issue remained. On Fern ward, patients did not have a way to lock their bedrooms to keep their belongings safe. However, most wards were safe, clean well equipped and were well furnished and fit for purpose.

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all wards areas and removed or reduced any risks they identified.

Although three of the seven wards we visited, provided mixed sex accommodation, we saw that staff managed the ward environment safely. Patients on these wards had the ability to lock and unlock their own bedrooms. Bedrooms for male patients were on separate corridors to female patients. All of rooms were ensuite. There was a dedicated female only lounge on these wards, in line with national guidance.

Generally, patients had a secure place to store personal possessions. Patients on most wards had a key card or wristband that gave them access to their bedrooms. Patients also, had lockers available in a separate locked room, where they could store valuable or personal belongings. However, on Fern ward patients did not have a way to lock their bedrooms when not in use. They relied on staff to lock and unlock their bedrooms. These patient bedrooms did not have a secure place to store personal belongings. We were told that this was part of the action plan for refurbishment in 2022. However, on review of the refurbishment plans this was not explicitly mentioned.

Staff knew about any potential ligature anchor points and mitigated the risks to keep patients safe. We reviewed the ligature risk assessments the wards and found that all potential ligature points were included and mitigations identified.

Staff had easy access to alarms and patients had easy access to nurse call systems.

Maintenance, cleanliness and infection control

Ward areas were clean, well-furnished and fit for purpose, and the service had addressed maintenance issues raised at the December 2020 inspection of Littlebrook hospital. The doors on Willow suite had been reinforced and no longer posed a risk to patients and the ward environment had improved. However, the wards at St Martins were tired and in need of maintenance. We observed patched up walls, mouldy showers, floors peeling away from the walls in the shower rooms and torn furniture on Fern ward.

Acute wards for adults of working age and psychiatric intensive care units

Managers told us that showers were a problem on Bluebell ward and Fern ward. We were told bathrooms in all of the patient rooms on Bluebell, were prone to flooding as the floor was not sloped and led to pooling of water. On Fern ward, the manager told us that water sprayed out of the shower cubicle, resulting in pooled water in the result of the shower room. This had caused the floor to start peeling away from the walls. The trust informed us that the showers on Fern ward were included as part of the refurbishment project for 2022.

The ward manager on Fern ward told us that a drain, in a closed courtyard, overflowed with excrement when there is heavy rainfall and the drains on the ward often smell. The courtyard was locked due to other identified risks, however, was beneath the windows to patient bedrooms. The trust had explored the cause of the overflowing drain but no cause could be identified. Therefore, no resolution had been found. We shared this with the trust at the time of inspection and they told us that they would investigate further. We were told by the ward manager and matron that there were refurbishment plans to address these issues to start in 2022.

Staff made sure cleaning records were up-to-date and the premises were clean. All premises we visited were clean and tidy. We saw that housekeeping staff were employed on all the wards.

Staff followed infection control policy, including handwashing. Staff wore facemasks and cleaned their hands regularly.

Seclusion room

We observed the seclusion rooms at Priority House and at Littlebrook Hospital. The seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. The vital signs of patients in seclusion on Willow suite were monitored remotely.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. Staff had access to grab bags in case of an emergency and we saw that these were sealed.

Staff checked, maintained, and cleaned equipment. All equipment we saw was clean and stored appropriately.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

The service had enough nursing and support staff to keep patients safe.

The service had low vacancy rates. At the time of inspecting, the wards had 12.5 vacancies for band 2 healthcare assistants. However, the trust had over recruited to band 3 health care assistants. This meant overall, the trust was fully recruited to healthcare assistants. The trust had 16 vacancies for band 5 nurses. However, had over recruited to band 6 and 7 nurses. This meant that they only had 10 nurse vacancies across the acute wards and psychiatric intensive care units.

Acute wards for adults of working age and psychiatric intensive care units

Managers calculated and reviewed the number and grade of nurses and healthcare assistants for each shift. Staff told us that they were able to increase the number of staff needed on the wards to enable them to cover additional support needs of patients. However, managers told us at that they sometimes found it a challenge to find agency staff to fill these shifts, specifically day shifts Monday to Friday. This meant that the ward managers were sometimes absorbed into numbers to provide care.

Managers made sure all bank and agency staff had a full induction and understood the service before starting their shift. We reviewed induction checklists on three of the wards. These were all appropriately recorded, and competencies checked.

The service had low turnover rates over the previous 12 months (November 2020 to November 2021). There was an average turnover rate of 16.6% across the acute and PICU wards. The highest level of turnover was for Upnor ward at 32.9% and the lowest level of turnover was for Fern ward at 3.8%. The manager of Upnor Ward told us that the high turnover rate was due to staff taking up new positions within the trust.

Managers supported staff who needed time off for ill health.

Levels of sickness were low over the previous 12 months (November 2020 to November 2021). Chartwell ward had the highest average level of sickness at 7.84% and Amberwood ward had the lowest average level if sickness at 2.11%. Overall, the average level of sickness across the acute and PICU wards was 4.1%

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants for each shift. The ward manager could adjust staffing levels according to the needs of the patients. However, between November 2020 and November 2021 there were a number of staffing challenges affecting several wards, resulting in unfilled shifts. Managers followed protocols to ensure that the wards were safely staffed.

Patients had regular one to one sessions with their named nurse. We observed managers spending time with patients on the wards, and patients knew who their named nurses were.

Staff told us that patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. If needed, staff would re-arrange leave to a time when it was safe to do so. Staff told us that the occupational therapy team were always available to facilitate activities, even at weekends.

The service had enough staff on each shift to carry out any physical interventions safely.

Staff shared key information to keep patients safe when handing over their care to others.

Medical staff

The service had enough daytime and night time medical cover available to go to the ward quickly in an emergency. Staff could call an on-call consultant if needed. Staff told us that there was always a consultant on site.

Managers could call locums when they needed additional medical cover.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

Acute wards for adults of working age and psychiatric intensive care units

The mandatory training programme was comprehensive and met the needs of patients and staff.

On the whole, staff had completed and kept up-to-date with most of their mandatory training. However, some training modules fell significantly lower in completion rates than others. These were: Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) Practical – Yearly (70%), immediate life support (77%), Moving and handling patient yearly (63%) and physical interventions (76%). We were told that these courses had been delayed due to the COVID-19 pandemic, as it limited the amount of staff able to meet face to face. Managers assured us that staff had been booked onto these training courses and were due to complete them over the next few months.

Managers monitored mandatory training and alerted staff when they needed to update their training. Managers told us that they were notified when staff cancelled their training or compliance fell below target. Staff told us that managers were good at supporting them to keep up to date with training.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. All records we looked at had an up to date risk assessment which reflected the risks of each patient.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

Staff identified and responded to any changes in risks to patients, or posed by patients.

Staff followed procedures to minimise risks where they could not easily observe patients. Although the wards did not use convex mirrors to minimise risks to patients, ward managers told us that risks were mitigated through staff presence on the ward.

Staff followed trust policies and procedures when they needed to search patients or their bedrooms to keep them safe from harm.

The wards had a protocol in place for managing patient monies on the ward. The ward manager for Fern ward told us that due to patients wanting takeaways and the patient bank only being open twice a week, they had allowed patients to store more than £50 in the safe. There was no evidence that patient money or safe contents was being audited. This did not follow trust policy.

Use of restrictive interventions

Generally, the levels of restrictive interventions were reducing across all acute and PICU wards.

Acute wards for adults of working age and psychiatric intensive care units

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards. The ward teams had piloted quality improvement initiatives to reduce the number of restrictive practices on the wards. For example, Bluebell ward and Chartwell ward were trialling the use of the Broset Violence scale (a six-point violence risk assessment tool for imminent incidents). Staff told us that they had seen a decrease in the amount of physical restraints needed on these wards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe. We saw an incident on a ward, which was managed calmly by staff using the lowest level of restraint to guide the patient and de-escalate the situation. Staff used de-escalation effectively, the patient was listened to and the incident was minimised.

Episodes of physical restraint experienced by patients over the past 12 months were generally declining. The only outlier was Cherrywood ward, which after a period of reduced restraint levels, peaked in September and October to 16 and 13 episodes of physical restraint. Staff understood the Mental Capacity Act definition of restraint and worked within it. The wards had introduced safety pods. This was a bean bag type restraint intervention to support patients who require episodes of restraint. Staff told us that this had meant that there was less needed to restrain a patient on the floor. One ward manager told us that the intervention had been beneficial when working with patients with an autism diagnosis, as it felt more supportive to the patient.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation. Between October 2020 and October 2021, there had been 328 episodes of rapid tranquilisation, across the acute and PICU wards. The majority of the rapid tranquilisation were given to patients on Willow suite, Cherrywood ward, Chartwell ward and Amberwood ward.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. Staff kept up-to-date with their safeguarding training. All required safeguarding training completion levels met the trusts compliance target of 90%.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them.

Staff followed clear procedures to keep children visiting the hospital safe. Anyone under 18 years old were not allowed on the wards. Visiting could be facilitated in the family visiting rooms located off the wards.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Each ward had a safeguarding lead and the trust had a safeguarding team who staff could go to if they had concerns and needed advice. Ward managers told us they had good links with the safeguarding teams in the two local authorities.

Managers took part in serious case reviews and made changes based on the outcomes.

Acute wards for adults of working age and psychiatric intensive care units

Staff access to essential information

Staff had easy access to clinical information, and it was easy for them to maintain high quality clinical records – whether paper-based or electronic.

Patient notes were comprehensive, and all staff could access them easily. All notes were recorded on an electronic recording system.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. The electronic system was password protected and used an identity card for access. Staff stored paper records in a locked room when not being used.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. However, we noted that consent to treatment forms were not always kept with the patient medicines charts. We found that 9 out of 10 medicine charts did not contain the patient's legal status on Upnor ward. Although, these could be found on the computer system. This was an issue on most wards we visited. We fed this back at the time of the inspection, so the provider could take action.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Pharmacists were available on the wards daily and ran medicine clinics to give advice to patients about their medication.

Staff completed medicines records accurately and kept them up-to-date.

Staff, generally, stored and managed medicines and prescribing documents safely. However, the controlled drugs cupboard on Boughton ward was over stocked and nurses needed to remove most of the contents in order to find the medication they needed. We fed this back to the provider, who took action immediately. We also found medicine on Bluebell ward that had not been disposed of in a timely way. This was against trust policy, as the medicines should have been destroyed within 72 hours. The trust took action immediately and disposed of these medicines.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. We saw evidence that practice had been changed as a result of learning from medicines incidents.

The service ensured people's behaviour was not controlled by excessive and inappropriate use of medicines.

Staff reviewed the effects of each patient's medicines on their physical health according to NICE guidance. Staff had been trialling an electronic observation monitoring tool, to monitor and store patient physical health observations.

There was a system in place to review the use of high doses of anti-psychotic medicines.

Acute wards for adults of working age and psychiatric intensive care units

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them. Staff could explain recent incidents that had occurred on the ward.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. Staff offered debrief and support to patients after incidents.

Managers debriefed and supported staff after any serious incident. Staff had safety huddles every day to discuss any incidents on the ward and to seek support from colleagues. The psychology team will facilitate debriefs after any incident for those staff involved.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff met to discuss the feedback and look at improvements to patient care. Staff told us that learning outcomes from serious incidents, both locally and across the trust, were shared in a monthly locality meeting. Incidents were also discussed at ward team meetings once a week and staff received frequent emails from the patient safety team and the acute care governance group with any learning identified.

The trust had site specific police liaison officers. Ward managers told us that they offered good support and spoke to patients if there had been violence, aggression or racism. The police officer decides whether they need to be progressed to criminal charges based on the capacity of the patient in line with policy.

There was evidence that changes had been made as a result of feedback. For example, following an incident where a patient absconded from hospital, the trust had increased the fence the courtyard by one metre to minimise the risk of patients scaling the fence.

Is the service effective?

Good ↑

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Acute wards for adults of working age and psychiatric intensive care units

Staff assessed the physical and mental health of all patients on admission. They developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated them as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental health assessment of each patient either on admission or soon after.

Patients had their physical health assessed soon after admission and regularly reviewed during their time on the ward. Doctors and nurses worked with patients to assess their physical health needs and when the patients could not be assessed on admission, the teams worked with the patient at their pace to ensure it was completed.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. We reviewed 35 care and treatment records across the seven wards. The majority of the care plans, were personalised, reflected patients' views, were holistic and recovery orientated. There was evidence that staff regularly reviewed and updated care plans when patients' needs changed. However, we found that on Willow suite, there was a lack of care planning around meeting the cultural needs of the diverse patient group. We were also told that two patients, of the care records we looked at, had a learning disability diagnosis. However, there were no care plans that reflected this.

In most cases, it was documented that patients were given a copy of their care plan. However, some patients told us that they had not seen their care plans since their admission.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. Occupational therapy staff were available seven days a week for all wards we visited. All wards had a dedicated peer support worker who helped deliver occupational therapy activities. Each ward had their own timetable of structured activities including evenings and weekends.

Each ward had groups and one to one sessions delivered by psychology staff.

Staff identified patients' physical health needs and recorded them in their care plans. In all but one care plan, we saw that staff had developed care plans for the majority of patients that had physical health needs.

Staff made sure patients had access to physical health care, including specialists as required. The wards had access to physical health nurses. Each ward had a physical health care champion that took a lead on physical health observations. Some wards had introduced a patient physical health huddle, to review the physical health needs of all the patients.

Staff helped patients live healthier lives by supporting them to take part in programmes or giving advice. Patients were offered nicotine replacement therapies to help them quit smoking. There was a variety of fruit available for patients on all wards. Each of the three sites had recruited a sports therapist, to support patients engage in physical activity.

Acute wards for adults of working age and psychiatric intensive care units

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. Staff used the Health of the Nation Outcome Scales (HoNoS) at admission and again on discharge to assess patient outcomes. HoNoS is a method of measuring the health and social functioning of people with severe mental illness.

Staff used technology to support patients. As well as the introduction of the electronic observation tool, the wards had installed patient electronic flow boards. These two devices worked in together to provide a real-time picture of the ward capacity and patient status, such as bed status, clinical data, outstanding tasks and discharge plans.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements. Managers created action plans to address any issues highlighted in their audit checks and staff ensured these were completed.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had a full range of specialists to meet the needs of the patients on the ward. The wards we visited had access to psychiatrists, occupational therapists, registered nurses and psychologists. The trust had also recruited student nurse and nurse apprentices. The service had access to physiotherapists when needed. When there were vacancies the trust approved the use of locum and agency staff to address this.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff. Due to the high level of newly recruited staff, managers planned the rotas to ensure there was a good mix of skills and experience.

Managers gave each new member of staff a full induction to the service before they started work. We reviewed induction records across three wards and found all records to be comprehensive and stored appropriately.

Managers supported staff through regular, constructive appraisals of their work. Staff received an annual appraisal. Appraisal rates across acute and PICU wards were generally above 90%. At the time of inspection the rate for Upnor ward was 66%, however this had increased to 100% by the time of reporting.

Managers supported staff through regular, constructive clinical supervision of their work. Supervision took place every six weeks. We saw that all appropriate staff received clinical supervision between October 2020 and October 2021.

Managerial supervision was inconsistent across the wards. Fern ward had consistently low supervision rates below 65% for the period October 2020 and October 2021. However, most staff told us that they were up to date with supervision and felt supported by their manager. Staff said that managers were always available to have adhoc supervision, if requested.

Managers made sure staff attended regular team meetings or gave information from those they could not attend. Staff told us that team meetings occurred once a week.

Acute wards for adults of working age and psychiatric intensive care units

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us that ward managers were proactive and passionate about upskilling staff.

Managers made sure staff received any specialist training for their role. Deputy ward managers received additional management training and those who deliver supervision received training for the role.

Managers recruited, trained and supported peer support workers to work with patients in the service. Peer support workers provided assistance with occupational therapy activities.

Multi-disciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. The ward teams had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary meetings to discuss patients and improve their care. Patients were seen by the MDT at least weekly.

Staff made sure they shared clear information about patients and any changes in their care, including during handover meetings. We observed one handover meeting where recent incidents were covered for all patients, new and existing risks were discussed and any actions needing follow up such as repeated physical health observations.

Ward teams had effective working relationships with other teams in the organisation. The team could make referrals to the early intervention in psychosis team when needed and had good links with the community mental health teams when planning for discharge.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles. All non-clinical staff were required to complete Mental Health Act awareness training. At the time of inspection 99% of required staff had completed this training. Nurses were required to complete Mental Health Act training every two years. At the time of inspection 90% of all nurses had completed this training.

Staff had access to support and advice on implementing the Mental Health Act and its Code of Practice. Staff knew who their Mental Health Act administrators were and when to ask them for support.

The service had clear, accessible, relevant and up-to-date policies and procedures that reflected all relevant legislation and the Mental Health Act Code of Practice.

Patients had easy access to information about independent mental health advocacy (IMHA) and patients who lacked capacity were automatically referred to the service. We observed notice boards across all the wards we visited included information about the independent mental health advocate (IMHA) and how to contact them. We were told that the IMHA rarely visited the wards since COVID-19 but were available by phone.

Acute wards for adults of working age and psychiatric intensive care units

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time.

Staff made sure patients could take section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. We observed patients utilising their leave during our visit.

Staff requested an opinion from a Second Opinion Appointed Doctor (SOAD) when they needed to.

Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

Informal patients knew that they could leave the ward freely and the service displayed posters to tell them this.

Managers and staff made sure the service applied the Mental Health Act correctly by completing audits and discussing the findings.

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity. However, the trust did not meet its target for the completion of Mental Capacity Act training.

Staff received and kept up-to-date with training in the Mental Capacity Act and had a good understanding of at least the five principles. Mental Capacity Act training had been completed by 84% of staff. This is below the trust target of 90%. Metal capacity Act assessment recording training had been completed by 98% of staff who were required.

There was a clear policy on Mental Capacity Act and deprivation of liberty safeguards, which staff could describe and knew how to access.

Staff knew where to get accurate advice on the Mental Capacity Act and deprivation of liberty safeguards. Nurses and ward managers told us that the mental health act administrator kept them up to with any outstanding tasks or renewals.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision.

Staff made applications for a Deprivation of Liberty Safeguards order only when necessary and monitored the progress of these applications.

The service monitored how well it followed the Mental Capacity Act and acted when they needed to make changes to improve.

Acute wards for adults of working age and psychiatric intensive care units

Is the service caring?

Good ➔➔

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

Staff were discreet, respectful, and responsive when caring for patients. Patients said staff treated them well and behaved kindly. Patients told us that staff treated them with kindness and respect. Patients said that the nurses were nice and always available for them. We observed positive interactions between staff and patients. Staff took time to have positive meaningful interactions with the patients on the wards. We observed one staff member going off shift, who said goodbye to all patients and remained on the ward having meaningful interactions with a patient for some time.

Staff gave patients help, emotional support and advice when they needed it.

Staff supported patients to understand and manage their own care treatment or condition.

Staff directed patients to other services and supported them to access those services if they needed help.

Staff understood and respected the individual needs of each patient. Staff referred to each patient by name and had good knowledge and understanding of each patient.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients.

Staff followed the trust policy to keep patient information confidential.

Involvement in care

Staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced patients to the ward and the services as part of their admission. Each patient received a welcome pack when new to the ward.

Staff involved patients and gave them access to their care planning and risk assessments. However, some patients we spoke with had not seen a copy of their care plan since their admission.

Acute wards for adults of working age and psychiatric intensive care units

Staff made sure patients understood their care and treatment. Patients we spoke told us that staff took time to explain their care and treatment.

Staff involved patients in decisions about the service, when appropriate. At St Martin's, a new Multidisciplinary hub called "the Bubble" was in the final stages of being built. This was due to act as an occupational therapy space, physiotherapy space, gym and general communal area for the wards. The new space was well equipped with a patient kitchen, to enable occupational therapy to support patients with daily life skills assessments.

Patients could give feedback on the service and their treatment and staff supported them to do this. The trust used a patient reported experience measure (PREM) questionnaire to seek feedback from patients about their care. The PREM was available in a wide range of formats including an Easy Read format. Patients were asked a various point throughout their contact with the trust for feedback.

Monthly patient experience smart reports informed the ward leads of the PREM and friend and family test results. These included the data for the year and show how a ward is performing based on the feedback received.

Staff supported patients to make advanced decisions on their care.

Staff made sure patients could access advocacy services. All wards had information about advocacy services available. A photo of the independent mental health advocates was available on each ward along with contact details.

Involvement of families and carers

Staff informed and involved families and carers appropriately.

Staff gave carers information on how to find the carer's assessment. Managers told us that information regarding carers assessments were sent out to the patients next of kin, on admission.

We have received mixed feedback from the carers/ relatives of patients regarding the ease and level of communication from the wards. Two relatives raised concerns that when they rang the ward, there was no answer and they never heard a response when contacting the consultant. However, other relatives felt consultants were quick to respond.

Is the service responsive?

Good ➔➔

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit.

Bed management

Acute wards for adults of working age and psychiatric intensive care units

Managers regularly reviewed length of stay for patients to ensure they did not stay longer than they needed to. Ward managers dialled into a daily bed management meeting, that was attended by the patient flow team, head of occupational therapy, social services and members of the MDT (including the consultant). During these meetings each patient was discussed in detail regarding risk and options for discharge. We observed one management meeting where issues about post-discharge accommodation issues were discussed. The team discussed options for this patient and formulated a plan to make referrals to other housing schemes/associations and explore options with family for further support, in order to aide a timely discharge.

Managers and staff worked to make sure they did not discharge patients before they were ready.

When patients went on leave there was always a bed available when they returned.

Patients were moved between wards only when there were clear clinical reasons, or it was in the best interest of the patient. We observed ward teams working together to find the best solution for patients after incidents occurred. We observed timely arrangements being made to move a patient to an alternative ward (at the same location) after an incident with another patient.

Discharge and transfers of care

Staff carefully planned discharge with patients and worked with care managers and coordinators to make sure this went well.

Staff supported patients when they were referred or transferred between services.

Occupational therapy staff offered a moving-on leaflet at discharge. This covered a range of topics such as information on food banks, education access, mental health support and crisis team numbers. This was produced by a peer support worker and given to all discharged patients.

The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the ward supported patients' treatment, privacy and dignity. Each patient had their own bedroom and most rooms were ensuite. There were quiet areas for privacy. Patients had mixed reviews about the quality of food. Patients could make hot drinks and snacks at any time. However, patients at St Martins were reliant on staff to access hot drinking water due to maintenance issues.

Each patient had their own bedroom, which they could personalise.

Staff used a full range of rooms and equipment to support treatment and care. Each was had an occupational therapy room available for activities. Patients told us that there were always plenty of activities available. We observed table tennis being played on at least two of the wards and were informed that a table tennis tournament was taking place later that day.

The service had quiet areas and a room where patients could meet with visitors in private. We observed families visiting the wards to meet their relatives.

Acute wards for adults of working age and psychiatric intensive care units

Patients could make phone calls in private. Patients had access to their mobile phones unless risk assessed otherwise. Patients without phone access could use the ward phone if necessary.

Each ward had an outside space that patients could access easily. On all of the wards we visited, staff told us that the garden use needed staff supervision to use, due to ligature risks. We were told that the garden was open for at least 15 minutes every hour. We observed, on most wards that the door to the garden was open for patients to use. Patient were making use of the outside space, playing tennis and other garden games.

Most patients could make their own hot drinks and snacks and were not dependent on staff. However, the patient hot water taps on two of St Martin's wards did not work at the time of the inspection. We were told that the hot and cold tap on Bluebell ward had been broken since 17 September 2021. A temporary measure was in place, but we were told that the taps were always breaking. A permanent solution to this issue had not been found. Ward staff had put temporary measures in place to facilitate patient access to hot drinking water.

We received mixed feedback from patients regarding the quality of the food available. Most patients told us that the food portions were small and not of good quality. One patient told us that food is sometimes served cold and most patients told us that salad is not regularly included, despite feedback from patients for more. Relatives told us that patients were frequently buying takeaways as they do not enjoy the food on offer. Staff had tried to resolve the issue by giving feedback to the kitchen staff, the trust changed food providers and feedback about food is sought from the community meeting every week.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as work, education and family relationships.

Staff made sure patients had access to opportunities for education and work, and supported patients with this. St Martins hospital had a volunteer garden available for patients to use. Volunteers were made up of staff members and former patients. The service had plans to build a chicken coop (a small building to rear chickens), for patients to look after. The occupational therapy team used the produce to support patients to cook their own food.

Staff helped patients to stay in contact with families and carers. On the days of the inspection, we observed relatives visiting the wards. Patients told us they were able to use leave to visit relatives and friends.

Meeting the needs of all people who use the service

The service met the needs of all patients – including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

The service could support and make adjustments for disabled people and those with communication needs or other specific needs.

Staff made sure patients could access information on treatment, local service, their rights and how to complain.

Managers made sure staff and patients could get help from interpreters or signers when needed. Staff had access to translation services for those whose first language was not English.

Acute wards for adults of working age and psychiatric intensive care units

The service provided a variety of food to meet the dietary and cultural needs of individual patients. Patients told us that staff could cater to specialist dietary requirements.

Patients had access to spiritual, religious and cultural support. Staff could access religious leaders when requested by patients. Some sites had multi-faith rooms and those that did not had rooms that could facilitate religious activity. The trust celebrated different cultural festivals and encouraged patients to be included.

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with the whole team and wider service.

Patients and, most relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas. We observed information boards and leaflets on all wards stating how patients and carers could complain.

Staff understood the policy on complaints and knew how to handle them.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers investigated complaints and identified themes. There had been a total of 61 reportable complaints made during the period November 2020 to November 2021. At the time of inspection, 8 remained open and under investigation. Of the 53 complaints closed, five were upheld, 13 were partially upheld and 32 were not upheld. Managers told us that they apologised to patients and carers when things went wrong.

Staff protected patients who raised concerns or complaints from discrimination and harassment.

Managers shared feedback from complaints with staff and learning was used to improve the service.

Is the service well-led?

Good ↑

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Some staff felt underappreciated by senior executive team, who were rarely visible on the wards.

Staff felt there was a strong team working and mutual support between staff within wards and across the service. They felt respected, supported and valued. Staff were positive and proud about working for the trust and their teams and

Acute wards for adults of working age and psychiatric intensive care units

described the culture as good, open and honest. Staff were confident they could raise concerns without fear of retribution. Teams worked well together and where there were difficulties managers dealt with them appropriately. However, staff on the wards told us that they felt disconnected from the senior leadership team and, overall, were rarely visible on the wards. Some ward based staff felt underappreciated by the senior executive team. Some staff told us that the senior team were only in contact when things went wrong.

The ward manager for Fern ward and the modern matron for St Martin's were unclear on the plans for refurbishment and the timeframe in which these were to start and be completed. They shared that they needed time to manage patient risks and manage expectations of staff and patients. Staff feel that they were not consulted on what changes should be made as part of the refurbishment.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team.

Staff we spoke with understood the trusts values and said that they felt the teams they worked in lived up to them.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in daily work and provided opportunities for development and career progression. They could raise any concerns without fear.

All staff we spoke with said the culture was open and supportive.

Managers told us that the acuity of patients has been higher than usual and COVID-19 had affected staff. We were told that staff felt tired as a result. Managers were implementing initiatives to support staff wellbeing. For example, ensuring staff took breaks and reminding them about wellbeing support.

Staff knew how to use the whistle-blowing process and about the role of the Speak Up Guardian. The freedom to speak up guardian fed back to ward managers and the modern matrons regarding themes from recent concerns raised. Posters were on display around the wards on how to raise concerns.

Staff had access to a range of wellbeing initiatives. The trust had a Winter wellbeing fund for all staff. This gave £15 per staff member to spend on wellbeing. The trust also had staff recognition awards each year.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

Managers could access information from a variety of sources that allowed them to understand their team's performance against their identified key performance indicators. Managers used this information to find areas for improvement and work with the staff teams to address this.

The trust held regular governance meetings at all levels to discuss key risks and good practice across the acute and psychiatric intensive care core service.

Acute wards for adults of working age and psychiatric intensive care units

At the last inspection, we found that the service did not have an effective governance process in place to ensure that agency inductions were completed. During this inspection, we found that this concern had been addressed and all agency staff and new staff completed an induction. This was recorded and monitored appropriately.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

We were told by staff that there were outstanding maintenance issues across St Martin's Hospital. Some of these issues were reportedly dating back a few years. Staff told us that they escalated these issues to the estates team but often had to chase repeatedly for any action to be taken. This most recently included a toaster that had been broken on Foxglove ward for over two weeks and a maintenance hatch motor on Bluebell ward. Staff at St Martin's told us that estates issues were not appropriately acted on by the senior leadership team.

On review of the maintenance records on Foxglove ward and Fern ward, maintenance issues were recorded appropriately. However, maintenance concerns had been open since 2019, the log was not in date order and sheets were lost in the file. There was no way for ward managers to monitor which maintenance issues were still open to be fixed.

Managers could access information easily about their service and could compare their ward to similar services in the trust. This included information on the performance of the service, staffing and patient care.

Each ward had their own risk register which reflected the concerns of the service and the environmental concerns we found. Managers told us they could submit items to the trust risk register.

Managers told us there were strategies to address risks. For example, to address staffing issues they were recruiting from overseas, they were being creative with posts offering built in time for career development opportunities. The matron of St Martin's told us they were in discussion with NHS professionals to resolve issues around covering weekday shifts.

Information management

Staff collected and analysed data about outcomes and performance and engaged actively in local and national quality improvement activities.

Staff told us that systems in place to collect and analyse data were efficient and did not add to their workload. The information collected was easily available to staff so they could understand their team's performance.

Engagement

Managers engaged actively other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Staff understood the arrangements for working with other teams, both within the provider and external, to meet the needs of the patients. Managers encouraged staff from community teams and other health and social care to join relevant meetings and they could do this via video conferencing.

Acute wards for adults of working age and psychiatric intensive care units

Managers received feedback from patients, carers and staff and used it to make improvements. Patients and carers were involved in decision-making on how to improve the service. Managers used the outcome of patient experience questionnaires (PREM) to improve on the quality of care being delivered. The Trust wide patient and carer experience group monitored the patient experience indicators. If any scores were lower than the target over a consecutive 3-month period, the team lead would be contacted and asked about actions planned to improve the score. It was evident that food had been a concern to most patients and attempts to resolve this in collaboration with patients had been made.

Learning, continuous improvement and innovation

The wards had introduced a variety of innovative practices over the past 12 months. Some wards had been piloting he Broset Violence scale, to change practice and reduce the level of restraints. Staff told us that this had significantly reduced the levels of restraint on the ward. This practice was in the process of being rolled out to all wards.

Wards had introduced an electronic observation tool and patient electronic flow boards to support staff manage patient risks and enable good care. These two devices worked together to provide a real-time picture of the ward capacity and patient status, such as bed status, clinical data, outstanding tasks and discharge plans. However, on some ward there was an issue with patient confidentiality as the board is visible to patients. The matron was aware of the concerns and thinking about how they could manage this.

The service was working on a sexual safety quality improvement project in collaboration with the Royal College of Psychiatrists on Upnor ward. Leaflets had been devised for patients to explain about sexual safety and the reasons behind the project. Sexual safety now forms as part of the standing community meeting agenda.

Staff told us that they were encouraged to think innovatively. An occupational therapist told us that they were encouraged to attend Lego therapy for children training. They were looking to see if this could be extended to adult patients and were due to present their idea to the rest of the occupational therapy team in the upcoming months.

The service was part of the armed forces network (a multi-organisational group which includes members from the NHS, Ministry of defence, Armed Forces Reservists, mental and physical health clinicians, the Royal British Legion and other interested charities and organisations from across Kent and Medway) and had recently completed a piece of work around the things to consider if supporting a veteran using mental health settings.

Wards for older people with mental health problems

Good ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe went down. We rated it as requires improvement.

Safe and clean care environments

Safety of the ward layout

Staff completed and regularly updated thorough risk assessments of all ward areas and reduced any risks they identified. The service had clinical environment assistants who carried out weekly reviews of all the ward areas to identify environmental risks and take appropriate action. On Jasmine ward, staff told us that the ward flooring was not considered suitable for the patients as it was not anti-slip and the patients were considered at risk of falls. Replacement flooring had been approved, although, there was no specific timeline as to when this would be installed.

Staff could observe patients well on most wards. The nursing station on Ruby ward allowed good lines of sight to the patient areas and mirrors were in place to mitigate the blind spots. However, on Jasmine, Orchards and Woodchurch wards, lines of sight were less clear. Staff told us that this risk was mitigated by staff conducting regular checks although we did not observe these during inspection.

Jasmine, Woodchurch, Sevenscore and Heather wards provided mixed sex accommodation. All wards had female only lounges, apart from Jasmine ward. There were enough bath and shower facilities, however the only assisted bathroom facility on Woodchurch ward was within the female patients' bedroom area. Staff told us that they would escort any male patient to this bathroom should they need to use it.

Patients were able to store personal items and belongings and had access to communal space. Each bedroom area and the dormitories on Ruby ward provided enough storage for patients' belongings.

Patients on most of the wards did not have their own keys to their bedrooms. Patients needed to ask staff to open their bedroom doors to gain access unless they chose to leave them open. Patients on Jasmine and Heather wards did have armbands which unlocked their doors.

Staff knew about any potential ligature anchor points and mitigated most risks to keep patients safe. All wards had up to date ligature risk assessments and ligature risks were also recorded on the wards individual risk registers.

On most of the wards staff had easy access to safety alarms, and patients had access to nurse call systems. On Sevenscore ward, the personal alarms that staff held individually were not working but staff had access to the main emergency ward alarm which would signal on the ward and other wards if pressed.

Maintenance, cleanliness and infection control

Wards for older people with mental health problems

Staff kept each ward environment clean and well maintained. Housekeeping staff worked on each ward every day. Staff followed infection prevention and control (IPC) policies, including handwashing. Staff also had IPC boards on all wards to make sure they knew what they were required to do.

Staff carried out COVID-19 testing on all patients when admitted and isolated patients until their first test results were back (usually 24 hours) and were negative. They repeated this on day five and seven after admission, and then all patients were tested weekly.

Some of the ward environments needed improvement. For example, some living areas, including those on Heather ward, lacked decorative features such as paintings or clocks. The garden access ramps on Woodchurch and Heather wards required repair and safety markings. We are aware that since initial feedback the trust had escalated some of these issues to maintenance.

Clinic room and equipment

Clinic rooms were fully equipped, with accessible resuscitation equipment and emergency drugs that staff checked regularly. On all wards we saw clean and well-maintained clinic rooms. We also saw records that showed staff checked, maintained, and cleaned equipment regularly.

Safe staffing

The service had enough nursing and medical staff, who knew the patients and received basic training to keep people safe from avoidable harm.

Nursing staff

On all wards there were enough nursing and support staff to keep patients safe. The service had low vacancy rates and vacant shifts were covered by regular bank and agency staff or by permanent staff covering extra shifts. The ward managers also stepped in to cover when this was required. Managers made sure all temporary staff had a full ward induction and understood the service before starting their shift.

The service had low turnover rates. The service had an average turnover rate of 13%. The highest staff turnover was on Jasmine ward (29%) and Orchards ward (24%). Leaders explained that it was challenging to retain staff because neighbouring organisations were able to provide the additional salary High Cost Area Supplements because of their proximity to London.

Sickness rates across the service were 6% over the past year. Ward managers told us that they could adjust staffing levels according to the needs of the patients, for example based on increased risk or 1:1 observation.

There was evidence of one to ones taking place with other members of the multidisciplinary teams on these wards and patients told us that staff always engaged with them.

Patients rarely had their escorted leave or activities cancelled, even when the service was short staffed. Patients told us that they had not had therapy or activities cancelled due to staffing.

Wards for older people with mental health problems

Staff shared key information to keep patients safe when handing over their care to other services. We observed staff across the wards holding daily multidisciplinary handover meetings where they discussed each patient in detail to ensure all staff were up to date.

On Jasmine ward we saw a comprehensive patient board in the nurse's office which detailed clearly patients' risk and needs. Ward staff had safety huddles three times a day where all staff discussed any potential risks.

Medical staff

The service had enough daytime and night-time medical cover and a doctor available to go to the ward quickly in an emergency.

Managers could secure additional medical cover when needed. Staff on all wards told us that there was always medical cover based on the wards during core hours and they could access on-call doctors out of hours. Staff told us that on-call doctors were always quick to respond. All wards had protocols in place for emergencies and accessing acute services. For example, Ruby ward had a service level agreement where Doctors from Accident & Emergency or other specialist services would attend the ward to see patients.

Managers made sure all locum staff had a full induction and understood the service before starting their shift.

Mandatory training

The mandatory training programme was comprehensive and met the needs of patients and staff. For example, courses included Conflict Management, Duty of Candour, Food Allergens, Infection Control, Mental Capacity Act (MCA), Mental Health Act (MHA), and Safeguarding.

We saw that on most wards, staff compliance with mandatory training was at trust target or close to trust target, with the targets varying for each training course. However, training courses which did not always meet the trust target were classroom-based training courses which could potentially impact on patient safety. These included Moving and Handling where Heather ward had 47% compliance, Woodchurch ward had 67% compliance and Sevenscore ward had 74% compliance, as well as Physical Intervention training where Jasmine ward had 38% compliance and Ruby ward had 68% compliance. Staff told us COVID-19 had affected the delivery of these courses and that these were booked to be completed when COVID-19 pressures allowed.

Managers monitored mandatory training and alerted staff when they needed to update their training. On Orchards ward, managers told us that an administration assistant monitored the training matrix and sent out reminders to staff when these were due.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well and followed best practice in anticipating, de-escalating and managing challenging behaviour. Staff used restraint only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Assessment of patient risk

Wards for older people with mental health problems

Staff completed risk assessments for each patient on admission, using recognised tools. Patient risks were reviewed regularly including after any incident.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks.

On all wards, staff used a variety of tools to assess patient risks. These included the Waterlow tool to assess risks of pressure ulcers, pressure mats, and using 'falling star' symbols on patient's doors to indicate the risk of falling. Staff used a daily traffic light system to review and indicate levels of patient risks. These were reviewed regularly by the multi-disciplinary team.

Staff identified and responded to any changes in patient risk. Where risks changed, staff took action to update clinical records to make this clear. For example, we identified that staff on Ruby ward had reviewed and appropriately increased the observation level of a patient following an incident of self-harm behaviour.

Nursing staff had good access to clinical information via patient flow boards. These were an electronic whiteboard which showed key information about each patient taken from their patient record.

Patients did not have independent access to hot water to make drinks, except for Orchards ward. This was a blanket restriction following a safety incident. Staff reported that patients were drinking less fluids since this had been introduced. This could impact the fluid intake and hydration of patients and lead to other potential physical illnesses and increased complications such as delirium. Patients should have routine access to hot water to make hot drinks on all wards, where they are risk assessed as safe to do so.

Staff on Jasmine ward did not always carry out patient observations in line with the trust policy. The ward nursing staff were not carrying out these observations intermittently but at set times. We informed the trust at the time of inspection and they responded by reminding ward staff of the policy and having the observation sheet checked daily by qualified staff before the end of each shift.

Use of restrictive interventions

Staff used de-escalation techniques to ensure that physical restraint was used as a little as possible. The average number of restraints was 14 per month. These figures were higher on Sevenscore and Woodchurch wards and the trust explained that this was due to higher levels of personal care which required safe holds which were recorded. Restraint data was reviewed by clinical ward managers and the Promoting Safer Services (PSS) team so they could see the exact purpose of restrictive interventions being used.

All wards had de-escalation and quiet rooms available. Staff that we spoke to understood the need to know their patients and any triggers to aggressive behaviours and/or distress. The service was utilising the Broset Violence Checklist (BVC) which was a short-term violence prediction assessment. This was an initiative to improve the ward environment by predicting risk of violence, reduce incidents and improve safety for both patients and staff. All wards, with the exception of Ruby ward, had safety pods. Safety pods are pieces of equipment that are used to reduce the level of restriction and injury during physical interventions. There were no seclusion facilities on the wards.

Staff followed National Institute for Health and Care Excellence (NICE) guidance when using rapid tranquilisation, including the safe physical health monitoring of patients who had received medicine by rapid tranquilisation.

Wards for older people with mental health problems

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training on how to recognise and report abuse, appropriate for their role. All staff we spoke to felt confident in recognising safeguarding issues and were able to provide examples of how they would escalate and refer any concerns.

All staff had been trained in level three safeguarding adults training. Staff knew how to recognise adults and children at risk of or suffering harm.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. They followed the trusts safeguarding policy and used the electronic reporting system. The trust also had a safeguarding lead who acted as a point of contact for support and advice. Managers kept a log of open safeguarding concerns and they liaised with external local authority safeguarding teams.

Staff followed clear procedures to keep children visiting the ward safe. On Ruby ward, staff advised that when children visited the ward they had to be with an adult (if under 18) and that these visits took place in the first room on the ward to avoid them coming into the main ward area. On Orchards ward, no children were currently able to visit patients due to there being no family room on the ward. As this meant patients were not able to have this contact, the ward staff facilitated regular video and telephone calls.

Staff access to essential information

Patient clinical notes were comprehensive, and all staff could access them easily. Staff told us there had been some connectivity issues with the Patient Flow boards. However, staff could still access patient information via their electronic care records on computers.

On Orchards ward, staff told us that agency staff did not have access to the patient electronic record system and had to rely on permanent staff to update their records. The trust was already aware of this challenge and were looking to ensure that agency staff had this access before starting on the wards.

Medicines management

The service used systems and processes to safely prescribe, administer, record and store medicines. Staff regularly reviewed the effects of medicines on each patient's mental and physical health.

Staff followed systems and processes to prescribe and administer medicines safely. Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. On Orchards ward, the pharmacist met with patients each week to discuss medicines and any concerns the patient had about them. On Woodchurch and Sevenscore wards, the pharmacist met with all patients within 24 hours of admission.

Staff completed medicines records accurately and kept them up-to-date. Staff stored and managed all medicines and prescribing documents safely. Across all wards, all records were tidy, well-kept and had no gaps.

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Staff followed national guidance to check patients had the correct medicines. We saw that pharmacists carried out regular prescription chart audits and that they had not identified any recent issues.

The service had systems to ensure staff knew about relevant patient safety alerts and incidents. This meant that staff learnt from these and could implement any necessary changes to ensure patients continued to receive their medicines in the safest way possible. On medication rounds, the dispensing nurses wore tabards that showed they were managing medicines to prevent them being disturbed.

Decision making processes were in place to ensure patient's behaviour was not controlled by excessive and inappropriate use of medicines. We saw evidence that staff followed policies and NICE guidelines across the wards, including those involving patients experiencing other conditions as well as their primary mental health, such as diabetes. Staff reviewed the effects of each patient's medication on their physical health.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

Staff managed patient safety incidents well. They recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

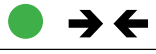
Staff knew what incidents to report and how to report them. The trust had 18 serious incidents recorded over the past 12 months and these related to COVID-19, allegations of sexual abuse, pressure ulcers and an incident where a patient scalded themselves with a hot drink.

Managers told us that incidents were always investigated, with 48 hour and 72 hour reports completed as part of this. Managers and clinical leaders investigated lower level incidents and the more serious incidents were investigated by the Central Investigation Team. Incidents were also discussed at monthly team meetings and shared at the inpatient forums which were held once a month. Managers debriefed and supported staff after any serious incident.

The care group patient safety team within the trust emailed staff with identified learning that had taken place from incidents across the trust. Jasmine ward staff told us that they learnt many lessons from their first COVID-19 outbreak, and they took this learning to control transmission during the second outbreak on the ward. This learning included staff having improved knowledge and application of infection prevention and control practices, acting earlier with positive cases and managing isolation and testing more effectively.

Staff explained their understanding of the duty of candour and gave patients and families a full explanation when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify clients (or other relevant persons) of 'certain notifiable safety incidents'.

Is the service effective?

Good 

Wards for older people with mental health problems

Our rating of effective stayed the same. We rated it as good.

Assessment of needs and planning of care

Staff assessed the physical and mental health of all patients on admission. Staff developed individual care plans which were reviewed regularly through multidisciplinary discussion and updated as needed. Care plans reflected patients' assessed needs, and were personalised, holistic and recovery-oriented.

Staff completed a comprehensive mental and physical health assessment of each patient either on admission or soon after, and these were regularly reviewed. Staff on all wards told us that patients had a full examination on admission and this included an assessment of their weight, blood test, urine analysis, their heart rhythm, Waterlow (a tool to assess pressure ulcers) and a body map (to identify potential bruising). Staff also recorded and monitored physical health using the national early warning score (NEWS2) tool which is designed to identify patients with declining conditions so staff can act fast to seek the necessary help.

Staff developed a comprehensive care plan for each patient that met their mental and physical health needs. On all wards, we saw that care plans set out clear interventions for individual patients which covered their identified risks. Staff regularly revised and updated care plans when patients' needs and risks changed.

Care plans we reviewed were personalised and holistic, with person-centred goals which were recovery orientated. However, the completeness of care plans was less consistent on Jasmine ward where we saw some care plans without full patient and carer involvement.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales, such as an Abbey Pain Score assessment, to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for most patients in the service. Staff told us that doctors were available on wards and completed weekly ward rounds as standard, as well as any additional physical health care when required.

There were a range of activities seen across the wards including well-being groups, arts and crafts, drama therapy, exercise classes and music groups. Some of these were delivered by staff specifically employed to deliver these groups, for example a music and art therapist. Occupational therapy staff also provided interventions and tools to improve the quality of life, care and treatment of patients living with dementia. These included doll therapy, an age simulation suit and "playlists for life". Doll therapy was an intervention where lifelike dolls or soft toy animals were used to promote feelings of relaxation and pleasure. The age simulation suit was used as part of manual handling training and is used to help improve staff awareness in understanding the impairments of older people. "Playlists for life" was a playlist of personal music which assisted people living with dementia to connect with the past through songs which held importance and meaning for them.

However, patients on Jasmine ward reported that the therapeutic activities on offer did not meet their needs. They told us that they did not always enjoy the therapies or activities, either due to lack of interest, suitability or feeling that these

Wards for older people with mental health problems

were not helpful to their own recovery. Patients said that they would prefer to do other things and would also have liked to have been around other patients who were able to communicate and engage with them. Within the trust wide patient feedback questionnaire, which was called the Patient Reported Experience Measure (PREM), issues with stimulation and boredom were main themes across the service.

Staff identified the physical health needs of patients and recorded them in their care plans. Each ward had a physical health nurse. On all wards we saw positive input from the physical health nurses, including care planning, information sharing with doctors and liaison with acute services.

Staff made sure patients had access to physical health care, including specialists as required. Staff made referrals to dieticians, speech and language therapists, tissue viability nurses and physiotherapists. Staff also supported patients to get their COVID-19 vaccinations and boosters.

Patients' nutrition and hydration needs were assessed and monitored. Staff had a good awareness of individual nutritional needs, such as the type of diet required and how this affected patient's overall wellbeing. On all wards, patients had food and fluid intake charts in place where necessary. Where continued monitoring was required, staff care planned this and supported patients individually. Staff on Jasmine, Ruby and Heather wards encouraged patients to drink fluids regularly. In addition, the service had implemented finger food menus which were helpful for patients with dementia diagnoses as they can often find cutlery difficult to manage, as well as eating a full meal, so finger foods make it easier for patients to enjoy food.

Staff used recognised rating scales to assess and record the severity of patients' conditions and care and treatment outcomes. An Abbey Pain Score assessment was used which is an assessment tool developed for use with patients that have dementia and those who cannot verbalise. The occupational therapy teams also used the Model of Human Occupation Screening Tool (MOHOST) in order to assess performance and organisation of skills in the everyday environment.

Staff used technology to support patients. We observed staff using Reminiscence Interactive Therapy Activities (RITA) machines which are digital therapy systems using apps and games and other leisure activities as part of their recovery. These were in place across the service.

Staff took part in clinical audits, benchmarking and quality improvement initiatives. Managers used results from audits to make improvements.

Skilled staff to deliver care

Staff had access to the full range of specialists required to meet the needs of patients on the wards, however some patients did not have timely access to specialist therapies. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

All wards had a complement of staff from a range of disciplines that included mental health nurses, physical health nurses, doctors, and occupational therapists. However, we observed that the access to psychological therapies and physiotherapists was inconsistent across the wards. Some wards had dedicated clinical psychology and physiotherapy. Other wards did not have this in place which meant patients needed to be referred to other services to access these therapies.

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Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. This included bank and agency staff who accessed clinical supervision the same as permanent staff. They gave each new staff member a full induction before they started work and supported staff through regular, constructive appraisals of their work. Trust data showed that since August 2021, all wards had achieved above 85% supervision compliance. One hundred per-cent of staff working on Ruby and Orchards wards had received their planned supervision between August and November 2021.

Ward staff attended monthly team meetings or had access to the minutes if they were unable to attend the meeting. However, these meetings had not consistently taken place on Woodchurch and Heather wards during the last six months.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Managers also made sure staff received any specialist training for their role. For example, staff received additional training on pressure ulcers, wound management and talking mats to assist with caring for the patients within the service.

Managers recruited, trained and supported volunteers to work with patients in the service. Ruby ward had a volunteer who assisted patients in engaging with meaningful activity.

Multi-disciplinary and interagency teamwork

Staff from different disciplines worked together as a team to benefit patients. They supported each other to make sure patients had no gaps in their care. They had effective working relationships with other relevant teams within the organisation and with relevant services outside the organisation.

Staff held regular multidisciplinary handover meetings to discuss patients and made sure they shared clear information about patients and any changes in their care. Staff shared relevant information about patients, including risks, incidents, safeguarding and medication changes, and demonstrated good knowledge of patients. Ward managers attended regular meetings to share best practice and learning across the service.

Ward teams had effective working relationships with external teams and organisations. Staff maintained contact with both internal and external professionals including acute ward colleagues, care co-ordinators, GPs and social workers. They were invited to ward reviews and meetings if appropriate. Staff liaised with external agencies, especially around discharges.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Health Act Code of Practice and discharged these well. Managers made sure that staff could explain patients' rights to them.

Staff received and kept up-to-date with training on the Mental Health Act (MHA) and the Mental Health Act Code of Practice and could describe the Code of Practice guiding principles.

Staff knew who their Mental Health Act administrators were and when to ask them for support. Most wards referred to the trust MHA team who they could contact.

Wards for older people with mental health problems

Staff gave patients easy access to information about independent mental health advocacy and automatically referred patients who lacked capacity to the service. We saw evidence of advocacy contact details available on notice boards and within the welcome packs provided to patients. Staff told us that the advocates phoned and visited the wards regularly. On Jasmine ward, staff told us that advocates were often invited to ward rounds.

Staff explained to each patient their rights under the Mental Health Act in a way that they could understand, repeated as necessary and recorded it clearly in the patient's notes each time. Staff made sure patients could take Section 17 leave (permission to leave the hospital) when this was agreed with the Responsible Clinician. Staff stored copies of patients' detention papers and associated records correctly and staff could access them when needed.

The service displayed posters to tell informal patients that they could leave the ward. Staff allowed informal patients to leave the wards freely, so long as it was assessed as safe to do so. Although, these patients needed to ask staff to leave on most of the wards due to the locked ward doors.

Good practice in applying the Mental Capacity Act (MCA)

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 (MCA) and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff received and kept up-to-date with training in the MCA and had a good understanding of at least the five principles. Staff knew where to get accurate advice on the MCA and Deprivation of Liberty Safeguards (DOLs).

Staff supported patients to make specific decisions for themselves before deciding a patient did not have the capacity to do so. Staff assessed and recorded capacity to consent clearly each time a patient needed to make an important decision, for example when their prescribed medicines were changed. When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history, as well as inclusion of their family.

We saw evidence on all wards of appropriate MCA documentation within care plans, as well as regular reviews of capacity assessments and consent to treatment both at ward rounds, and within multidisciplinary handover meetings.

Is the service caring?

Good

Our rating of caring stayed the same. We rated it as good.

Kindness, privacy, dignity, respect, compassion and support

Staff treated patients with compassion and kindness. They respected patients' privacy and dignity. They understood the individual needs of patients and supported patients to understand and manage their care, treatment or condition.

All patients said staff were friendly, compassionate and kind. Carers said staff treated their relatives with respect and dignity.

Wards for older people with mental health problems

Staff were discreet, respectful, and responsive when caring for patients. Patients told us staff knocked on their bedroom door or called out before entering. They said staff treated them with dignity and were respectful when helping with personal care. Although, one patient on Ruby ward told us that night staff were noisy during the evening staff changeover which, on occasion, woke up patients who were sleeping.

Staff gave patients help, emotional support and advice when they needed it. Patients said staff listened to them. We observed warm and friendly interactions between patients and staff across all wards visited. Staff also referred to patients by their name.

Staff understood and respected the individual needs of each patient. They supported patients to understand and manage their own care, treatment or condition. Staff directed patients to other services and supported them to access those services if they needed help.

Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards patients. They followed policy to keep patient information confidential.

Involvement in care

Most staff involved patients in care planning and risk assessment and actively sought their feedback on the quality of care provided. They ensured that patients had easy access to independent advocates.

Involvement of patients

Staff introduced new patients to the ward during community meetings and all patients were given welcome packs on admission.

We saw that staff made sure patients understood their care and treatment and found ways to communicate with patients who had communication difficulties. However, half of the patients we spoke with on Jasmine ward said they were unaware of their care plan, and in half of the plans we reviewed on this ward, we saw that patient and carer involvement, including patients signing and being given a copy of their care plans, could be improved.

Staff involved patients in decisions about the service. Staff held weekly community meetings where patients gave feedback on the service and their treatment. Staff supported patients to do this through a suggestion box and informal discussions with individual patients. The service used 'you said, we did' noticeboards to show patients how their feedback was applied to the service. On Jasmine ward, there had been negative feedback around the laundry service and so the ward staff introduced allocated laundry days for each room, in addition to any emergency laundry that was needed. The trust wide patient feedback questionnaire, Patient Reported Experience Measure (PREM), gave an overall score and a satisfaction score. Over the last 12 months, the service scored above the trust target (six-seven out of 10 is good and above eight is very good) with an overall score of 7.8, and satisfaction score of 8.9.

Staff supported patients to make decisions about their care and made sure patients could access advocacy services. On all wards, advocacy contact information was available on noticeboards in communal areas. Staff told us that they could make referrals to independent advocacy services on a patient's behalf. On Heather and Ruby wards, staff were able to book individual appointments for patients to see advocates who regularly attended and contacted the ward.

Involvement of families and carers

Wards for older people with mental health problems

Staff informed and involved families and carers appropriately.

Carers told us the staff on the wards were helpful and responsive to their relatives' needs.

Carers and relatives felt that staff supported, informed and involved them in their relatives' care plan and treatment. Managers told us that carers were offered a monthly slot with the ward manager to discuss their relative. This improved communication, carer involvement and patient treatment.

Staff helped families to give feedback on the service and gave carers information on how to find the carer's assessment. Staff facilitated weekly contact with carers and relatives using video and telephone calls. They also held monthly virtual carers meetings to update on the wards. Staff on Orchards ward told us a monthly newsletter was sent to carers and relatives with a packet of biscuits and a sachet of tea or coffee to encourage them to relax and take time for themselves, along with the monthly meeting invite. Staff and carers told us that carer champions were available to speak with, which helped carers and relatives to communicate their feedback.

Is the service responsive?

Good

Our rating of responsive stayed the same. We rated it as good.

Access and discharge

Staff managed beds well. A bed was available when needed and patients were not moved between wards unless this was for their benefit.

Bed management

Managers monitored bed occupancy, length of stay and leave. Across all wards, bed occupancy was above 85%. No patients from the local area had been placed out-of-area at the time of the inspection.

Managers and staff worked to make sure they did not discharge patients before they were ready. When patients went on leave there was always a bed available when they returned.

Patients were moved between wards during their stay only when there were clear clinical reasons or if it was in the best interest of the patient. For example, where patients needed treatment for their physical health. Staff did not move or discharge patients at night or very early in the morning. Staff also rarely discharged patients on a Friday, in the evenings or over the weekends.

Discharge and transfers of care

Managers monitored the number of patients who experienced delays to their discharge. Most patients whose discharge was delayed were waiting for suitable community placements.

Wards for older people with mental health problems

Ward staff escalated any delays to ward managers and the service had weekly bed management calls with social services to have oversight of these.

Staff planned patients' discharge and worked with the patients, their care managers and coordinators to make sure this went well. An occupational therapist recently carried out a home visit with a patient from Ruby ward for a home assessment prior to discharge. Staff supported patients when they were referred or transferred between services. The service followed national standards for transfer.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of the wards did not always support patients' treatment, privacy and dignity. However, all patients told us that their privacy and dignity was maintained. All patients could keep their personal belongings safe. There were quiet areas for privacy. The food was not always of good quality. Patients could always access snacks; however, these were not always healthy and they could not always make hot drinks independently on all wards.

The design, layout and furnishings of most wards did not always support patients' treatment, dignity and respect. The walls on Heather ward were bare without any decorative touches and the family room on Jasmine ward lacked warmth and comfort.

Not all bedrooms included an en-suite toilet, shower or bath. Across wards bedrooms varied, some with full en-suite and others with hand basins. Staff on Woodchurch ward ensured the privacy and dignity of male patients using the assisted bathroom, which was in the female bedroom area, by escorting them to and from when they used this and ensuring no female patients were in the area.

Patients on Ruby ward could not routinely access outdoor space. Patients on Ruby ward were escorted to an outdoor area which was a short walk from the main ward. The trust had a proposal in place to replace this ward by 2023. The outdoor space on Orchards ward was kept locked and only accessible with staff supervision due to ligature risks, although staff made sure patients were able to access this when requested. All other outside areas were accessible to patients during daylight hours.

On Jasmine, Woodchurch and Sevenscore wards, bedroom doors had been designed to look like a 'front door' to help patients feel at home and create a familiar, welcoming environment, in keeping with everyday home life. Patients on Ruby ward told us their privacy and dignity were maintained despite sharing dormitories. Patients on all other wards had their own bedrooms. Staff told us that patients could personalise their bedroom areas with cushions or photos placed onto the walls if it was risk assessed as safe to do so, although most patients told us that they were not aware that they were able to do this. Patients told us that their personal belongings were always kept safe and that they had a secure place to keep them.

Staff used a full range of rooms and equipment to support treatment and care. Staff would always engage with patients wherever they felt most comfortable, whether this was in their bedrooms, communal areas or a private quiet room. Most wards had quiet areas and rooms where patients could meet with visitors in private.

Patients told us that they could make phone calls in private. Staff gave patients cordless ward phones to use if they did not have mobile phones. Staff kept chargers for patients' mobile phones and would charge their phones on request.

Wards for older people with mental health problems

The patients we spoke with had mixed feedback about the food. About half reported they liked the food and half said they found it boring, repetitive and lacking taste. Carers we spoke with from Woodchurch ward were uncomplimentary about the ward food.

We saw that patients on Ruby ward did not have access to healthy snacks such as fruit. However, patients had access to soft drinks and snacks outside of mealtimes. Staff on Jasmine ward accommodated the needs of a patient whose preference was goat's milk.

Patients' engagement with the wider community

Staff supported patients with activities outside the service, such as family relationships.

Staff helped patients stay in contact with families and carers via telephone calls and visits. Because of the ongoing risk around the Covid-19 pandemic the visiting arrangements on most wards were still limited to two one-hour slots, with each patient being allowed one visit per week. Carers told us that the limited visiting hours were restrictive and that visiting times on Woodchurch ward did not always meet patient and carer needs. The trust assured us that on some of the wards, individual visiting arrangements including additional visits, could be agreed to suit the needs of the patients, carers and relatives. Ward staff also facilitated video calls and telephone calls to relatives and carers when required.

Staff encouraged patients to develop and maintain relationships both in the service and the wider community. Staff took patients out to the local garden centre and facilitated visits to local mosques and churches. Patients and carers told us they or their relative had made friends with other patients.

Meeting the needs of all people who use the service

The service met the needs of patients, including those with a protected characteristic. Staff helped patients with communication, advocacy and cultural and spiritual support.

All wards were located on one level and were easily accessible to people with mobility needs. There were assisted bathrooms and walk-in showers. Staff used stand aids and hoists to assist with moving patients. We also saw staff on Ruby ward adapting the exercise group for a patient in a wheelchair so they could join in.

Staff made sure patients could access information on treatment, local services, their rights and how to complain. The service had information leaflets available in languages spoken by the patients. Staff ensured patients could get help from interpreters or signers when needed.

Staff told us that a patient on Ruby ward whose first language was not English had regular access to an interpreter for ward rounds. Staff across the wards were also being trained in the use of talking mats which promoted person-centred care. Talking mats use picture cards and a mat to enable communication with individuals who struggle to verbalise. Four staff on each ward are currently trained.

The service provided a variety of food to meet the dietary and cultural needs of individual patients including halal, kosher, vegetarian and free-from options.

Patients had access to spiritual, religious and cultural support. For example, we saw that a patient on Heather ward had access to appropriate washing facilities when they needed to pray. Staff facilitated visits to places of worship to meet the spiritual needs of patients and a chaplain also visited patients regularly.

Wards for older people with mental health problems

Listening to and learning from concerns and complaints

The service treated concerns and complaints seriously, investigated them, learned lessons from the results, and shared these with the whole team and wider service.

Patients, relatives and carers knew how to complain or raise concerns. Patients told us that they felt confident in being able to make a complaint and felt assured that they would be listened to. Staff clearly displayed information about how to raise a concern in communal areas.

Staff understood the policy on complaints and knew how to handle them. Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Managers investigated complaints and identified themes.

Staff protected patients who raised concerns or complaints from discrimination and harassment. Managers shared feedback from complaints with staff and learning was used to improve the service. The service used compliments to learn, celebrate success and improve the quality of care. Governance and team meeting minutes showed how managers took on board feedback from patients and acted on this. For example, we saw evidence that patients had requested specific food to be introduced onto the breakfast menu on Jasmine ward, and this had been actioned.

Is the service well-led?

Good ➔➔

Our rating of well-led stayed the same. We rated it as good.

Leadership

Across the wards, we saw that leaders had the skills, knowledge and experience to perform their roles. They had a good understanding of the services they managed and were visible in the service and approachable for patients and staff. Staff on all wards told us that the ward managers knew patients well and were approachable. Some staff reported that senior leaders did not visit the wards often enough.

Most ward managers and matrons were clear about their roles, and they had a good understanding of quality performance, risks and regulatory requirements. However, on Jasmine ward, the range of risk and quality issues that were found indicated a lack of overall leadership at ward level.

Vision and strategy

Staff knew and understood the provider's vision and values and how they applied to the work of their team. All staff showed awareness of the trust's values and worked within these.

Wards for older people with mental health problems

Staff told us that they had support from their ward managers, that they felt satisfied with their jobs and they felt confident within their teams. We saw that staff wanted to do the best possible job they could in delivering patient care with respect, excellence and innovation. Staff we spoke to told us that patients were a priority and at the forefront of everything they did. Patients told us that they felt that staff cared for them and their wellbeing, and that they were committed to this.

Culture

Staff felt respected, supported and valued. They said the trust promoted equality and diversity in its daily work and provided opportunities for development and career progression.

Several staff told us that they felt able to raise any concerns and would feel comfortable escalating issues to their ward managers in the first instance. Staff across the wards also demonstrated knowledge of the whistleblowing policy and Freedom to Speak Up (FTSU) guardians and how they could access information on these through the 'green button' on the trust's intranet page.

Staff told us that there were plenty of opportunities to develop and access further training and that they were supported with their professional development. All staff across all wards reported happy and friendly teams with high morale. Staff told us that they felt respected and appreciated. Some staff said that they were regularly thanked for their hard work by the ward managers and deputy ward managers. The trust also carried out recognition of excellence within staff awards.

Managers told us that they were responding to diversity and culture issues on some wards which they felt were underpinned by a lack of cultural awareness within the teams. Managers confirmed that there had not been any obvious prejudicial or discriminatory behaviour reported or witnessed, though they planned to improve team morale and understanding through inputs from the trust's Black, Asian and Minority Ethnic (BAME) staff network representatives and team building days for each ward.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at ward level on most wards and that performance and risk were managed well. However, we did see a series of issues on Jasmine ward which would have benefited from improved governance structure and management oversight. As these identified concerns were across different areas on this individual ward, there was a clear lack of governance and leadership around the identification of the issues or a clear action plan in place to resolve these.

We saw evidence of information, including risk registers, being escalated and addressed appropriately within meeting structures from local ward level team meetings, to inpatient forum meetings, and clinical governance meetings, as well as feedback from the higher-level meetings filtering down to ward level. This meant that relevant information was being shared across the right channels.

The service had audit systems in place to assess and monitor the standards of care and action was taken where shortfalls were identified. For example, audits were carried out on medication management. No issues had been identified recently through this audit. Other audits included occupational therapy interventions, ward environment risks, ligatures and restrictive interventions.

Information management

Wards for older people with mental health problems

Teams had access to the information they needed to provide safe and effective care and used that information to good effect. The service completed outcome monitoring and monitored performance across numerous governance platforms. The staff routinely completed Health of the Nation Outcome Scales (HONOS), which is a recognised rating scale to assess and record outcomes for patients. Managers also told us that the service was accredited through Accreditation for Inpatient Mental Health Services (AIMS) which recognises high standards of organisation and care.

Managers engaged actively with other local health and social care providers to ensure that an integrated health and care system was commissioned and provided to meet the needs of the local population. Managers from the service participated actively in the work of the local transforming care partnership.

Engagement

Staff gave feedback through a yearly staff survey and monthly team meetings. Patient feedback was captured at weekly community meetings and via the trust wide Patient Reported Experience Measure (PREM) questionnaire. Staff provided this questionnaire to patients to complete throughout their care and whenever they would like to give feedback. The NHS patient Friends and Family Test (FFT) is part of the Patient Reported Experience Measure (PREM) and enables carers and relatives the opportunity to engage. Carer champions were also available to speak with, which helped carers and relatives to communicate their feedback informally.

Learning, continuous improvement and innovation

The trust produced monthly reports from the Patient Reported Experience Measure (PREM) questionnaires to inform ward leaders what feedback had been received. Ward leaders produced and action plan in relation to this feedback. The trust wide patient and carer experience group monitored the patient experience indicators. If any scores were lower than the target over a consecutive 3-month period, the team lead was contacted and asked about actions planned to improve the score.

Across the trust, occupational therapy leads were undertaking improvement work on falls, to identify how better working can reduce falls, and care plans, to identify what a care plan means to the patient.

Staff reported that research findings were implemented, and staff were encouraged to participate in innovative practice. For example, Ruby ward staff had taken part in pilots for new blood glucose monitoring forms and described the introduction of the safety huddles on the ward. Additionally, the service was utilising safety pods and Broset Violence Checklist (BVC) as initiatives to improve the ward environments by predicting risk of violence, reducing incidents and improving safety for both patients and staff. The electronic Patient Flow boards enabled more efficient ways of working with patients and ensuring the proactive delivery of their care.

Leaders reported that the trust were using the The King's Fund initiative programme, which recommends improvements to ward environments, to help them plan for the upcoming refurbishment projects of Ruby and Orchards wards.

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KMPT QUALITY IMPROVEMENT PLAN (QIP) – TRUSTWIDE – CORE SERVICE WITH WELL-LED INSPECTION – DRAFT v1

This quality improvement plan has been developed in order to address the regulatory breaches identified during the core service with well-led inspection by the CQC in November and December 2021. This QIP will be monitored at the CQC Oversight Group and quarterly updates are provided to the Quality Committee. This will also be reviewed and updated by the estates and workforce directorates.

Improvement plan owners:	Care Group Heads of Service/Senior Management Team (SMT)
Implementation monitoring:	CQC Oversight Group
Action plan date:	17 March 2022
Executive sponsor:	Chief Nurse
Reporting to:	Quality Committee

RAG KEY:	
Green	**Complete**
Amber	**Work in progress but not overdue**
Red	**Overdue**

Requirements:
Must do
Should do

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
Premises and equipment (HSCA Regulation 15)						
	1. The trust must have an effective estates and facilities response to repairs and maintenance concerns in patient areas, and must ensure that these are addressed in a timely way once identified by staff or patients in these areas.	1. Review Estates and Facilities current management structure, performance, governance and assurance. 2. Continue with the recruitment of Maintenance Assistants to respond efficiently to minor building repairs and works. 3. Redesign Estates and Facilities management and governance structure.	**Director of Estates and Facilities**	1. Completed – February 22 2. End Q1 (2022/23) 3. End Q1 (2022/23) 4. End Q1 (2022/23) 5. End Q3 (2022/23)	1. (Confidential) Interim draft structure to EDoF&E. 2. Job descriptions and confirmation of recruitment. 3. Structure chart. 4. Monthly performance and assurance report. 5. ICOM improvement plan.	The Trust have recently appointed a Director of Estates & Facilities. Maintenance assistant posts have been advertised, first recruit going through on-boarding process.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		4. Develop monthly EFM quality and performance metrics and assurance report. 5. Review the estates maintenance ICOM contract and develop a supporting improvement plan.				
Capital works/food provision						
	1. The trust should ensure there is sufficient management oversight and project management resources available to deliver its capital projects. This includes financial and senior leadership oversight to ensure that slippage in planned costs is kept to a minimum.	1. Review of current Estates project management resourcing arrangements. 2. Recommendations report for Estates Capital Development management and resourcing and governance structure. 3. Establishment of new Estates Capital Development management arrangements (detail subject to EFM review outputs). 4. Establish Estates & Finance Capital Working Group (CWG) providing oversight of Estates project programmes and financial spend profile.	**Director of Estates and Facilities** **Deputy Director of Finance**	1-4. End Q1 (2022/23)	1. Project Management structure and process 2. Recommendations report. 3. Team structure chart 4. Working Group minutes and terms of reference.	
	2. The trust should ensure that there is sufficient monitoring of outsourced functions, such as maintenance and food provision, and review contract performance informed by the feedback	**Maintenance** 1. Undertake internal assurance audit of contract performance (TIAA) 2021. 2. Review TIAA audit assurance report and agreed actions. 3. Review BDR/ICOM contract monthly performance reporting of planned maintenance and	**TIAA** **Associate Director of Estates**	1. Completed – Autumn 21 2. Completed – December 21 3. Completed – November 21 4. Completed – November 21	1. Audit report. 2. Action plan. 3. Performance reports. 4. Meeting minutes and terms of reference. 5. Help desk process. 6. Portal in place. 7. Contract improvement plan.	The Trust have an outsourced maintenance contract with BDR / ICOM. The contract covers reactive and planned maintenance on a 24/7 - 365 day service. The actions are key elements of the performance improvement plan.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	from patients and frontline staff.	reactive maintenance activity against agreed KPI's. 4. Establishment of Performance Improvement monthly meeting. 5. Review Help Desk process for assessing requests and assignment of priority status (1 to 4) and send it on to BDR / ICOM for action. 6. Develop self-service request reporting portal. 7. Initiate Hard FM Services Contract Improvement Group (Meeting Monthly). 8. BDR/ICOM contract to expire June 2023. Develop new Terms and Conditions, scope and performance criteria for new contract coordinating with KCHT. 9. Tender contract and select preferred bidder.		5. Completed – November 21 6. End Q3 (2022/23) 7. Completed – November 21 8. End Q4 (2022/23) 9. End Q1 (2023/24)	8. Terms and conditions and performance criteria. 9. New contract in place.	
		Facilities 1. Continue to have regular contract meetings with ISS to review performance against contract KPIs. 2. Develop and strengthen KPIs for the Grounds and Gardens Contractor. These will be reviewed via monthly meetings.	**Head of Facilities**	1. Ongoing 2. End Q1 (2022/23) onwards	1. Meeting minutes and improvement plan. 2. Meeting minutes and KPIs.	1. A new Catering Compliance Manager is now in post who will oversee and monitor the food contract/review the quality of food provision. 2. Completed - Ground control agreed to changes on 03/03/22.
Workforce – speak up culture and WRES						

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	3. The trust should actively encourage staff to speak up, and have appropriate means to support this, including the implementation of the new Freedom to Speak UP provision for staff in 2022. This includes ensuring there is an open and transparent culture in which staff can raise their concerns to senior leaders without fear of retribution and reprisal.	**Freedom to speak up** 1. Identify and implement a new guardian service which will be objective and external, providing a confidential service for all staff to access 24/7, 365 days a year. 2. Monitor the concerns raised identifying any themes/trends and ensure that appropriate action is taken.	**Director of Workforce Organisational Development**	1. End Q1 (2022/23) 2. Q2 (2022/23) onwards	1. New guardian service in place. 2. FTSU data.	FTSU service provider has been selected.
		Culture 1. Undertake a recognised anonymous psychological safety questionnaire. 2. Partake in a ½ day session to explore 'Psychological safety in a compassionate culture' and consider and agree ways to address improvement areas and also consider implications for KMPT teams. 3. Implement psychological safety development programme so that it is extended to other senior leaders in their respective team environments. 4. Compassionate Culture introductory session is offered to all Leaders in an extended Leaders Event in February 2022. To be followed up with a further session later in the year to introduce the new national	**Director of Workforce Organisational Development**	1-5. End Q4 (2022/23)	1. Questionnaire results. 2. Training resource materials. 3. Psychological safety development programme. 4. Presentation slides. 5. Speak up campaign training and materials.	

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		NHS leadership model 'Our Leadership Way'. 5. To coincide with the launch and embedding of essential training in Speaking Up for all staff an employee voice campaign is run (Oct 2022-Speak Up Month) with OD, EDI & FTSU working together. "I Speak Up because…"				
	4. The trust should consider a more ambitious target and more concentrated focus to improve WRES outcomes and reduce the frequency of BAME staff experiencing bullying and harassment from patients, carers and the public.	1. New WRES action plan to be developed with Black, Asian Minority Ethnic Staff Network. 2. Active Ally training to be written and piloted. 3. Colleague Harassment Task and Finish group to analyse bullying and harassment Staff survey and DATIX data to provide a care group and teams picture. This will be shared with Care Groups to develop a response. 4. Black, Asian Minority Ethnic Staff Network offering drop in sessions for staff to raise concerns about experiences in the workplace.	**EDI Manager** **Chair of BAME network**	1. End Q2 (2022/23) 2. End Q1 (2022/23) 3. End Q3 (2022/23) 4. End Q3 (022/23)	1. New action plan. 2. Pilot courses run with staff networks completed. 3. Data, People Pulse Survey specific questions and communications/ engagement plan 4. List of concerns shared.	Meeting with Black, Asian, Minority Ethnic Staff Network arranged to look at data April 2022. Training modules in final stages of development. Colleague Harassment Task and Finish Group set up and data is being gathered for analysing. First BAME drop in session held in 03/03/22.

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KMPT QUALITY IMPROVEMENT PLAN (QIP) – ACUTE AND PICU WARDS CORE SERVICE INSPECTION – DRAFT v1

This quality improvement plan has been developed in order to address the regulatory breaches identified during the core service inspection to the acute and PICU wards undertaken by the CQC in November 2021. This QIP will be monitored at the CQC Oversight Group and quarterly updates are provided to the Quality Committee. This will also be reviewed and updated at the Acute Care Group Quality Meeting.

Improvement plan owners:	Care Group Heads of Service/Senior Management Team (SMT)
Implementation monitoring:	CQC Oversight Group
Action plan date:	17 March 2022
Executive sponsor:	Chief Nurse
Reporting to:	Quality Committee

RAG KEY:	
Green	Complete
Amber	Work in progress but not overdue
Red	Overdue

Requirements:
Must do
Should do

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
Premises and Equipment (HSCA Regulation 15)						
	1. The trust must ensure that the outstanding maintenance issues on Fern ward, such as the overflowing drain and communal showers, are rectified in a timely way.	1. Compile and submit a project change document (PCD) to the Trust Capital Group for approval which includes the proposal to refurbish Fern Ward and includes the drainage of the communal showers.	**Director of Estates and Facilities**	1. End Q1 (2022/23)	1. Ward will have fully functioning showers to required standard.	PCD completed and has been submitted for approval at the Trust Capital Group on 22/03/22. Timeframes to then be agreed although works are estimated to take 12 weeks to complete.
	2. The trust must ensure that all patients on Fern ward are able to lock their	1. Compile and submit a project change document (PCD) to the Trust Capital Group for the approval of new Kingsway	**Director of Estates and Facilities**	1. End Q1 (2022/23)	1. Patients will be have lockable bedroom doors to keep their belongings safe.	New Kingsway doors complete with Vistamatic vision panels and Paxton locks are included in the WC/Showers project outlined in the

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	bedroom doors in order to keep their belongings safe.	doors which will come complete with Vistamatic vision panels and Paxton locks ensuring that patients are able to keep their belongings safe whilst maintaining privacy and dignity.				action above. These will be installed within the 12-week project programme.
Maintenance						
	3. The trust should consider how maintenance issues are recorded and monitored on the wards at St Martin's, to ensure outstanding actions are completed.	1. See action 1 in trustwide QIP.				A systemwide approach is being adopted and so the impact of implementation will be seen at the wards at St Martins Hospital.
Processes						
	4. The trust should ensure that the patient monies protocol is being followed on Fern ward.	1. Audits of receipt and expenditure logs to be shared for all wards by the Inpatient Matrons with the Inpatient Service Manager on a monthly basis for oversight. Inpatient Service Manager to address any concerns and escalate as required	**Inpatient Matrons** **Inpatient Service Manager**	1. End Q1 (2022/23)	1. Copies of completed receipt and expenditure logs	
Patient involvement						
	5. The Trust should ensure that patients receive updated copies of their care plans.	1. Continued monitoring of care plan distribution via CliQ Checks and performance 2. All teams with a distribution rate lower than 75% to highlight this via QuEST and develop actions to improve alongside a realistic trajectory. For these	**Head of Nursing (ACG)** **Clinical Quality Manager** **Head of AHP (ACG)**	1-3. End Q1 (2022/23)	1. CliQ results and performance data 2. Copies of QuEST 3. Copies of meeting minutes and actions as appropriate	

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		action to be based on learning from other teams 3. Continued monitoring of Inpatient PREM results both locally and at the Care Group governance meeting – to focus on the question of being involved in care and to agree a service target of 7 or above				
Mandatory training						
	6. The trust should ensure that all outstanding face to face training such as CPR and AED Practical, immediate life support, moving and handling patient and physical interventions are completed in line with trust policy.	1. Monthly report to be shared within the Inpatient Matrons and Inpatient Service Manager which highlights all training compliance for the forthcoming 6 months. Managers to action as required.	**Inpatient Matrons** **Inpatient Service Manager**	1. End Q1 (2022/23)	1. Training reports.	
Remaining actions from 2020/21 QIP for Littlebrook Hospital						
Meeting nutritional and hydration needs (HSCA Regulation 14)						
	7. The trust must take action to ensure that patient's nutritional needs are assessed and provide food to meet their dietary needs including cultural and religious needs	**Training, tools and policy actions** 1. Ensure all clinical staff complete the MUST e-learning which is a once only course or arrange a refresher with the dieticians. 2. Dieticians to provide another communication to staff concerning the importance of nutritional assessments and the link to the Dietician referral	**Deputy Director of Nursing and Practice** **Deputy Director of Nursing and practise**	1. End of Q2 2. End of Q1 3. End of Q2 4. End of Q1 5. End of Q3 6. End of Q3 7. End of Q2 & Q4	1. Training data for MUST training compliance 2. Evidence of staff communication 3. Nutritional assessment tool review completed 4. Audit of current practice 5. EObs to have integrated Food &	1. Completed – compliance currently sitting at 92%. 2. Completed 3. Completed 4. Completed 5. Completed – work sitting with RiO programme analysts 6. Completed 7. Completed

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		details on the Physical Health page on I-Connect. 3. Review of the nutritional assessment tool to explore other evidence-based options that have been designed for use in mental health settings. 4. Conduct a review of practice against the Nutritional policy. 5. Diet and Fluid charts to be placed on eObs for ease of recording. 6. Update the Nutrition Policy with referral process to dietetic provision (SLA). 7. Agree target and trajectory for improvement in nutritional assessments.			Fluid charts in use across inpatient wards 6. Nutrition Policy reviewed and updated 7. Audit and repeat audit completed to demonstrate improvement in completion of nutritional assessments	
	8. Same as above	**Oversight and monitoring** 1. Fortnightly oversight of nutrition reports by SMT – individual teams requiring support to be identified and input provided to enable improvement. 2. CliQ to include a request for service user nutritional requirements in order to review the associated care plan and information transfer during handover. 3. Increase the awareness of the need to raise record as an incident each time a meal	**Deputy Director of Nursing and Practice** **Head of Nursing**	1. On-going 2. Bi-monthly & on-going 3. End of Q1 & Q3	1. SMT to continually identify and source support for improvement of nutritional assessments 2. CliQ outcome results and reports 3. Evidenced via incident forms raised	1. Completed 2. Completed 3. Completed

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		arrives which does not meet the requested needs of the patient				
	9. Same as above	**Food/mealtime experience** 1. Patient surveys implemented ward by ward to determine areas requiring improvement in the quality of food provided – information to be formed into an action plan for resolution. Resurvey to evaluate impact. 2. Menu planning to continue to be carried out with care groups and ISS including both dietitians, including patient tasting. 3. Paper produced for the internal CQC oversight meeting setting out the clear actions the Trust are taking in response to the feedback on the food. 4. EDoN to take over chairing the Nutritional Steering Group to ensure that the actions from point 3 above are delivered in a timely manner.	**Executive Director of Nursing, AHPs and Quality**	1. On-going 2. On-going & Bi-annually 3. Completed 4. Completed	1. Patient surveys 2. Menus displayed – changed twice a year, including nutritional calories. I connect menus displayed including special diets and nutritional information along with all other catering information. 3. Paper to CQC Oversight Group 4. Nutritional Steering Group Minutes	1. Completed 2. Discussion & action from the nutrition group 3. Completed 4. Completed
Good governance (HSCA, Regulation 17)						
	10. The trust must ensure that staff are able to identify blanket restrictions and take action to ensure that the least restrictive practice is always used.	1. Issue a directive to staff that blanket rules are not to be used and any individual restrictions would need to be risk assessed, recorded appropriately and reviewed at	**Head of Service Deputy Director of Nursing and Practice**	1. End Q2 2. End Q2 3. End Q4 4. End Q3 5. End Q3	1. Directive to staff 2. Minutes of meetings/email cascade 3. QI Project Reports 4. Policy 5. Datix	1. Completed 2. Complete/ongoing 3. We currently have quality improvement programs planned around restrictive practices which will be led by

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	The trust must have a system to record and review blanket restrictions affecting patients on the wards.	the earliest opportunity to downgrade/remove restriction. 2. Staff to be reminded about restrictive practices through the following existing forums; patient safety meetings, reflective practice session and via the promoting safer services agenda. 3. To plan and complete quality improvement programmes around restrictive practices which will be led by the Head of Nursing alongside the promoting safe services lead. 4. Refresh and publish the promoting safer services policy to outline a process for the recording and monitoring of blanket restrictions. 5. Introduce a trustwide system for recording and monitoring blanket restrictions. This can then be audited against the standards set out in the trust policy.				the Head of Nursing alongside the promoting safe services lead. 4. All blanket rules are not to be used and any individual restrictions would be risk assessed, recoded appropriately and reviewed at the earliest opportunity to downgrade/remove restriction. 5. Blanket Restrictions Poster.docx

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KMPT QUALITY IMPROVEMENT PLAN (QIP) – FORENSIC SECURE WARDS CORE SERVICE INSPECTION – DRAFT v1

This quality improvement plan has been developed in order to address the regulatory breaches identified during the core service inspection to the Forensic secure wards undertaken by the CQC in November 2021. This QIP will be monitored at the CQC Oversight Group and quarterly updates are provided to the Quality Committee. This will also be reviewed and updated at the Forensic and Specialist Care Group Quality (Patient Safety) Meeting.

Improvement plan owners:	Care Group Heads of Service (HoS) / Senior Management Team (SMT)
Implementation monitoring:	CQC Oversight Group
Action plan date:	17 March 2022
Executive sponsor:	Chief Nurse
Reporting to:	Quality Committee

RAG KEY:	
Green	**Complete**
Amber	**Work in progress but not overdue**
Red	**Overdue**

Requirements:
Must do
Should do

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
Estates and maintenance						
	1. The trust should ensure that the programme for the replacement of vision panels in doors is accelerated.	1. Continue with the programme to replace the Vistamatic viewing panels.	**Director of Estates and Facilities**	1. TBA 2022/23	1. Vistamatic windows in place that meet required standard.	A programme to replace the Vistamatic viewing panels within the Trevor Gibbens Unit is included within the proposed 2022/23 Capital Programme. The Capital allocation to fund the Trust Capital Programme for 2022/23 is subject to final approval by the ICS. The Trust have submitted its full plan to the ICS and is planning to undertake the replacement of vision panels at Trevor Gibbens Unit as a priority in 2022/23.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	2. The trust should consider how it improves its response times for localised maintenance works	1. See action 1 in trustwide QIP.				A systemwide approach is being adopted and so the impact of implementation will be seen within the Forensic secure wards.
Ligature risks						
	3. The trust should ensure that it makes explicit in its admission criteria for Emmetts ward that the ligature risks on the ward are managed by the individual risks of the patient group and that the ward is suitable to have high levels of managed ligature risk.	2. Agree Emmetts ward admission criteria as part of the ward nursing assessment. 3. Admission criteria for the ward to be published on the KMPT website.	**TGU matron/ward Responsible Clinician** **Communications Team**	1. End Q2, 2022/3 2. End Q3, 2022/3	1. Emmetts ward nursing assessment. 2. Admission criteria available on KMPT website.	
Food preparation and quality						
	4. The trust should resolve the issue with the quality of patient food and the impact the regeneration of food on the ward has on clinical staff's time.	**Quality of patient food** 1. Carry out food observations on all forensic wards to identify areas for improvement to action 2. Attend food meetings on all forensic wards to identify areas for improvement to action 3. Identify ways that the current 3-week rotation of menu could be improved (e.g. 6-week rotation). 4. Review points 1, 2, 3 and set further actions.	**Catering Compliance Manager (CCM)** **Care Group Quality & Governance Coordinator (Q&GC)**	1-3. End Q1 (2022/23)		1. Meeting held between Q&CG and newly recruited CCM to agree first steps. The CCM to visit all forensic wards.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		Impact of regeneration on clinical staff time 1. Business case to be submitted requesting non clinical staff carry out the task of regeneration of patient foods on the ward, in order to reduce the impact on clinical staff time.	**Deputy Director of Nursing & Practice (DDN&P)**	1. End Q1 (2022/23)	1. Practice of non-clinical staff carrying out the task of regeneration of foods on the wards.	

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KMPT QUALITY IMPROVEMENT PLAN (QIP) – OLDER ADULT WARDS CORE SERVICE INSPECTION – DRAFT v1

This quality improvement plan has been developed in order to address the regulatory breaches identified during the core service inspection to the wards for older people with mental health problems undertaken by the CQC in November 2021. This QIP will be monitored at the CQC Oversight Group and quarterly updates are provided to the Quality Committee. This will also be reviewed and updated at the Older Adults Care Group Quality, Workforce, Finance and Performance meeting.

Improvement plan owners:	Care Group Heads of Service/Senior Management Team (SMT)
Implementation monitoring:	CQC Oversight Group
Action plan date:	17 March 2022
Executive sponsor:	Chief Nurse
Reporting to:	Quality Committee

RAG KEY:	
Green	**Complete**
Amber	**Work in progress but not overdue**
Red	**Overdue**

Requirements:
Must do
Should do

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
Safe care and treatment (HSCA Regulation 12)						
	1. The trust must ensure intermittent observations are being carried out in accordance with trust policy on Jasmine ward.	1. Discuss Therapeutic Observation policy at ward meetings including handover, safety huddles and ward business meeting on Jasmine ward. 2. Continue with the quality improvement programme that was implemented at the time of the inspection whereby the observation sheets are checked daily by qualified staff before the end of each	**Service Manager** **Matron**	1. End of Q1 (2022/23) 2. Ongoing 3. Q1 (2022/23) onwards 4. Completed – March 22. 5. End of Q1 (2022/23) 6. End of Q1 (2022/23)	1. Minutes of handovers, safety huddles and ward business meeting evidencing discussion. 2. Observation sheets. 3. Completed audit. 4. Inpatient Forum minutes. 5. Competency compliance forms. 6. List of therapeutic activities.	The therapeutic observations policy has been discussed at safety huddles and handover immediately following CQC feedback in November 2021. Further discussion was tabled on the agenda of the Inpatient Forum on 10th March 2022.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		shift. 3. Complete an audit of a sample of patient RiO records to check compliance on Jasmine ward. 4. To discuss Therapeutic Observation Policy and learning from CQC visit at Inpatient Forum to ensure that the other ward managers are confident that their staff are adhering to the policy. 5. To review the ongoing therapeutic observation competency compliance for staff on Jasmine. 6. To explore with ward managers and OT's the activities provided to patients on Therapeutic Observations.				
	2. The trust must move forward urgently to implement its plan to replace the flooring on Jasmine ward to ensure patients are safe.	1. Jasmine Centre flooring to be replaced in all patient areas to future proof the building.	**Director of Estates and Facilities** **Head of Service**	1. End of Q1 (2022/23)	1. Completion of works to required standard.	Jasmine ward decanted to Littlestone Lodge on 9th February 2022. Work commenced on replacing flooring on 14th February 2022.
	3. The trust must ensure all patients have routine access to hot water to make hot drinks on all wards, who are risk assessed as safe to do so.	1. All hot water machines to be in the communal area and have a lockable cover. 2. All patients to be risked assessed for level of mobility and dexterity to access hot water machine to ensure they can make drinks safely.	**Service Manager** **Ward Managers**	1-5. End Q1 (2022/23)	1. Hot water machine that have lockable covers. 2. Audit results. 3. Variety of cups in place on each ward. 4. Hot flasks in place on each ward.	5 travel cups delivered to all wards. Clinical Lead OT East is exploring what would be a suitable therapeutic cup option as agreed at Inpatient Forum in January 2022.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		Decisions made will be documented within the patients care plan. 3. Supply a range of cups for patients including travel mugs and therapeutic cups to reduce spillage and thus risk of scalds. All patients will be risk assessed to determine which cup type meets their safety needs. 4. Explore the additional option of having flasks available with hot water for patients to use on each ward. 5. RCA for the scalding incident to be discussed at Inpatient Forum and taken to Ward business meetings.			5. Minutes of Inpatient Forum meeting.	
Good governance (HSCA Regulation 17)						
	4. The trust must have a plan to address all the issues identified on Jasmine ward, including ward environment, activities and involvement of patients and carers in care plans, with appropriate oversight and leadership at ward level.	1. Community meeting to have standing agenda item regarding feedback from patients on Menu of Interventions. 2. Continue to utilise CLiQ checks to evidence care plans are person centred and reflect carers views. 3. Ward team to review activities offered to patients and ensure a wide choice of activities are provided.	**Clinical Lead OT's / Ward Manager / ward OT's and Modern Matrons**	1. End of Q1 (2022/23) 2-4. Q1 (2022/23) onwards	1. Community meeting minutes. 2. CLiQ check reports. 3. Ward Menu of Intervention activity board. 4. Staffing establishment review outcome.	New Band 6 OT in post. 2 HCA's on a 3-month secondment as OTA's on ward.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		4. Explore options around increasing therapeutic lead staff within the MDT on Jasmine ward.				
Ward environment/estates						
	5. The trust should ensure improvements are made to the general ward environments on Sevenscore, Jasmine and Woodchurch wards to ensure they are decorated to a good standard and fit for purpose.	1. Estates to review all 3 listed ward environments and complete immediate works including call bell, broken door on Sevenscore and painting walls on Woodchurch. 2. Commence the Jasmine flooring project. Business case for anti ligature taps and sinks to be completed. 3. Refurbishment / new build of TMHU to be completed by 2024/25.	**Director of Estates and Facilities** **Head of Service**	1. End of Q1 (2022/23) 2. End of Q1 (2022/23) 3. Date TBC – 2024/25	1. List of planned capital works for the 3 wards. 2. Jasmine Ward flooring complete to required standard. 3. Plans for new build.	Staff engagement meetings regarding the Thanet mental health unit new build commenced in February 2022. Replacement Taps and Sinks business case for Jasmine Ward approved at Business Case Group on 14th February 2022 and procurement commencing tendering process.
	6. The trust should ensure the ramps in the outdoor spaces on Heather ward and Woodchurch ward are repaired and have appropriate safety markings.	1. To replace ramp on Heather ward. 2. To repair / replace ramp outside Woodchurch ward.	**Associate Director of Estates**	1-2. End Q1 (2022/23)	1-3. Appropriate ramps in place on both wards.	1. Completed - New ramp in situ outside Heather ward. 2. Replacement ramp has been ordered for Woodchurch Ward.
Blanket restrictions						
	7. The trust should ensure patients on Ruby ward can routinely access fresh air and healthy snacks.	1. Patients to continue to be offered daily walks and access to the Forget Me Not Garden within Medway Maritime Hospital as part of Menu of	**Service Manager** **Ward Manager**	1-4. Q1 (2022/23) onwards	1. Daily task allocation sheets. 2. Meeting minutes evidencing discussions.	Task allocation sheets revised to include Menu of Interventions activities. To be distributed to all wards including Ruby ward.

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
		Interventions. A review of daily task sheets to be completed. 2. To discuss at ward business meeting and reinforce importance of daily access to fresh air to staff and also discuss at community meetings with patients. 3. To utilise the Task Allocation sheets to allocate staff to this activity. 4. To ensure healthy snacks are provided by Medway Maritime Hospital as per the Service Level Agreement. To monitor this by obtaining feedback at patient community meetings.			3. Task allocation sheets evidencing staff allocation to daily walks. 4. Community meeting minutes.	
	8. The trust should ensure they review the blanket restrictions in place on several wards regarding patients holding keys to their bedroom doors.	1. To ensure all patients are individually assessed on a regular basis as clinical presentation changes to determine if they can have their room key / fob. 2. To discuss blanket rules at the Inpatient Forum in April 2022. 3. To discuss key and fob provision at ward business meetings.	**Ward Managers** **Matrons**	1-4. End Q1 (2022/23)	1. Audit of RiO care plan and progress notes for evidence of discussion and review as appropriate. 2. Minutes of Inpatient Forum. 3. Ward business meeting minutes.	
Access to treatment						
	9. The trust should ensure that all patients who require physiotherapy and individual psychological	1. To review the Quest tool to be able to monitor referrals being actioned within 72 hrs which is the target Physio are working to.	**Head of AHP**	1-3. End Q2 (2022/23)	1. Quest tool 2. Increased physiotherapy staff in post.	Physiotherapy staff recruitment continues and one vacancy left to recruit to. TAMHIC monies agreed in principal and being discussed at

RAG	ISSUE IDENTIFIED/OUTCOME	ACTIONS TO BE TAKEN	PERSON RESPONSIBLE	TARGET COMPLETION DATE	EVIDENCE TO BE PROVIDED	PROGRESS TO DATE
	therapies receive these in a timely way.	2. To increase Physio resource via TAMHIC monies to avoid delays in assessment & treatment. 3. Psychological staff recruitment process to continue.			3. Psychology staff in post and embedded in ward teams.	next Business Case Review meeting on 21st March 2022. 2 Clinical Associate Psychologists commenced in post in March 2022. 8B Clinical Psychologist commenced in March 2022 for the East wards and interviewing for West equivalent post shortly. 3-month Lead Art Therapist secondment agreed and interviews taking place in March 2022.

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Deep Dive Workforce Report – Temporary Staffing
Authors:	Jennie Cogger, Deputy Director of Workforce and Organisational Development, Victoria French, Deputy Director of Finance, Tumi Banda, Deputy Director of Nursing, Kirsten Lawson, Deputy Medical Director
Executive Director:	Sandra Goatley, Director of Workforce and Organisational Development

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

A paper setting out an in-depth analysis of temporary staffing issues affecting the Trust.

Issues to bring to the Board's attention

The Trust's year to date spend on agency fees is £6.3 million and is causing an issue with respect to the Trust's ability to tackle the underlying deficit. The risks connected to this is being overseen by the Finance and Performance Committee, but in order to resolve the impact of agency fees, etc, the Trust's Workforce and OD Directorate is working with Operational Leads. Such work includes Mental Health Optimal Staffing Tool (MHOST) review, Workforce model review (including medical staff benchmarking), workforce planning (including international recruitment), recruitment and retention strategies, agency strategy (including temporary staffing resource and implementation of direct engagement and Working collaboratively across the Integrated Care System (ICS) for temporary staffing and Recruitment and Retention.

Regular reporting of temporary staffing usage is included in the monthly finance reports, with regular updates on workforce matters taken to the Workforce Committee.

Governance

Implications/Impact:	Impact on ability to deliver financial balance if high premium costs continue. Impact on patient safety and quality of service delivery if consistent safe staffing levels cannot be maintained.
Assurance:	Limited Assurance at this stage
Oversight:	Oversight by Workforce and Organisational Development Committee and Finance and Performance Committee

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1. Overview of temporary staffing use in KMPT

Brilliant Care through Brilliant People is our simple aim. In order to achieve that, we must ensure that we attract and retain the best staff, substantively. The use of temporary staffing is something that we will need to rely on as an NHS organisation and can be cost effective to cover certain situations. However, we recognise that the vacancy levels we carry are too high and our level of temporary staffing usage puts quality of service and cost effectiveness at risk.

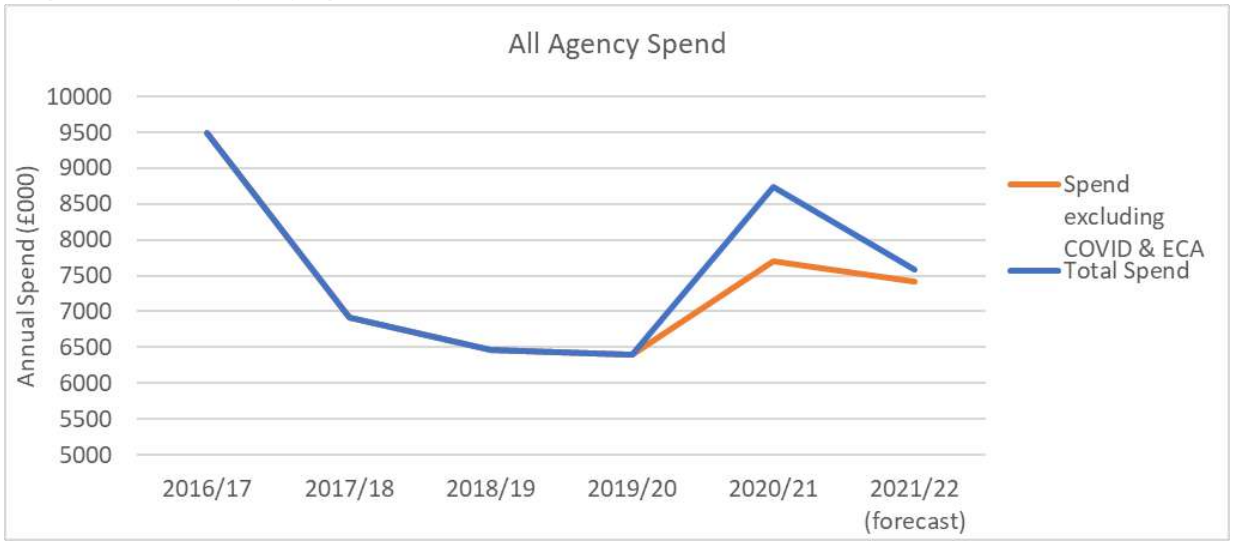
We use NHS Professionals (NHSP) for temporary staff (not Medics) and we use our own internal locum bank for medics. The issue we have is that our demand far outweighs what NHSP and our locum bank can provide and we then resort to using agency to cover the unfilled shifts. This position is not acceptable and we need to address this at pace to ensure quality of service and financial sustainability.

1.1 Spend data - Update on position previously reported to Board in July 2021

Agency spend at KMPT had been reducing consistently over a four-year period, following an increased focus and control on spend introduced in 2016/17. Spend in 2016/17 peaked at £9.5m, but quickly reduced to an average of between £6.5m and £7m for the proceeding three years, with marginal reductions year on year.

In 2020/21 during the pandemic, there was a significant rise in spend from just below £6.5m per annum to £8.7m, as shown in the graph below. The graph also illustrates the level of pressure that COVID-19 and the Extra Care Area (ECA) has created, both of which were externally funded as exceptional items. The increase in spend has continued into 2021/22, with agency spend currently at £6.3m after 10 months. The forecast outturn for 2021/22 on agency spend is £7.6m based on current trends. If we remove the exceptional spend (Covid and extra care area – which we were funded for) this would be £7.4M

Graph 1: Historic Agency Spend



The majority of agency spend is within the Medical (highest cost) and Nursing staff groups as indicated in Table 1 below. These are the areas with high vacancies and bring the highest risk if these posts are not covered. As a result, there is a reliance on temporary workers to maintain safe services using the agreed safer staffing rotas and workforce model.

We have improved the agency spend on health care workers which was at its highest point 5 years ago at £831,000.00 and this year the forecast is £22,000.00.

Table 1: Overall Agency Spend by Staff Group

Staff group	2016-17 £'000	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 forecast £'000
Admin, Clerical & Management	563	138	165	75	96	187
Healthcare Assistants	831	822	353	92	45	22
Medical	3,903	2,670	3,111	3,019	3,598	3,233
Nursing	3,376	2,669	2,442	3,097	4,550	3,910
Other Non-Clinical	518	511	323	87	289	109
Scientific, Therapeutic & Technical	302	114	65	25	161	89
Total spend	**9,492**	**6,924**	**6,459**	**6,395**	**8,740**	**7,590**

1.2 Data by Care Group – Year to Date Spend

Table 2 below shows the profile of spend by Care Group based from April 2021 to January 2022. The largest area of agency spend is within Community Recovery, where there is a 17% vacancy rate in the medical staff group in this area

Table 2: Overall Agency Spend by Care Group

Staff group	2021-22 £'000	2021-22 % of agency spend
Community Recovery	2,780	44%
Acute	1,576	25%
Older Peoples Services	767	12%
Forensic and Specialist Services	751	12%
Support Services	274	4%
Central expenses	175	3%
Total	**6,323**	**100%**

1.3 Care Group Position

The table below provides the month 10 position by Care Group:

Table 3: Agency spend target and forecast by Care Group

Care Group	Total spend to month 10	Forecast agency spend @ MONTH 9	Forecast agency spend @ Month 10	Agency spend target £	Gap
Acute	1,576,168.07	1,863,797.60	1,842,067	1,965,318	- 123,250
Community Recovery	2,779,510.29	3,345,993.72	3,343,352	3,063,946	279,406
Forensic and Specialist Services	751,487.64	914,979.97	935,434	757,352	178,082
Older Peoples Services	767,471.90	942,522.34	942,409	856,627	85,782
Support Services	273,873.68	301,087.60	291,097	285,014	6,083
COVID	174,522.97	222,073.31	220,517	173,094	47,423
TOTAL	**6,323,035**	**7,590,455**	**7,574,877**	**7,101,352**	**473,525**

Each care group was set an agency spend target for this financial year and we can see from the above table as at month 10 that Community Recovery and Forensics and Specialist Services are over the target.

1.4 Drivers of temporary staffing spend

1.4.1 Vacancies

On average KMPT has been running with around 420 vacancies for the last two years. Overall, the number of staff employed has increased by 211 during this time, including 88 nursing staff (from January to December 2021 there was a net gain 62 band 5 registered nurses). The average vacancy number has, however, remained around 420.

Table 4: Establishment and vacancy information

	2020/21	**2021/22**
Establishment	3342.24 WTE (as at 1/4/20)	3604.09 (as at 1/4/21)
Vacancy gap	12.6%	11.6%
In year changes	261.85 WTE	98.12 WTE
End position	3604.09 WTE	3702.21 WTE
End vacancy gap	11.6%	11.3%

Also to note: Investment into mental health services increasing establishments, making the gap between staff employed and funded posts bigger (for example, the increase in establishment 20/21 was 261.85 WTE, of which newly introduced roles equate to about 113 WTE)

See **Appendix 1** for turnover data

1.4.2 Nursing and Health Care Assistants (HCA)

Table 5: Nursing establishments excluding support services (as at 21/3/22)

Care Group	**Establishment (WTE)**	**Substantive (WTE)**	**Vacancies (WTE)**
Older Adults	189.5	173.07	16.43
CRCG	235.01	185.56	49.45
Forensic & Specialist	427.71	346.41	81.3
Acute	174.06	138.07	35.99
TOTAL	**1026.28**	**843.11**	**185.51**

Table 6: HCA establishments (as at 21/3/22)

Care Group	**Establishment (WTE)**	**Substantive (WTE)**	**Vacancies (WTE)**
Older Adults	144.8	132.51	12.29
CRCG	88.44	90.89	-2.45
Forensic & Specialist	189.03	153.11	35.92
Acute	224.84	200.49	24.35
TOTAL	**647.11**	**579.00**	**70.11**

In inpatients we cover the gaps in shifts by using NHS Professionals (NHSP) and then if we can't cover through NHSP we have to go out to agency. This is monitored through SafeCare.

Community Recovery do not use health roster and book NHSP and agency as required.

1.4.3 Reasons for booking temporary staff

When NHSP and agency shifts are booked the reasons for the booking are recorded. At **appendix two** the reasons for booking shifts in February 2022 are detailed. Managers are encouraged to use their

substantive staff to cover planned absences such as study leave, annual leave, management days and not use NHSP or agency. However due to the level of vacancies, sickness and other demands this can be problematic. The main reasons for using temporary staff are:

- Substantive vacancies – currently running at 15% for nursing
- Sickness – currently running at 4.6%
- Maternity cover/Paternity cover
- Additional work/observations/patients needing to isolate
- Annual leave, study leave, training
- Supernumerary

Attached at **Appendix 3** is the reporting outcome of the patients on enhanced observations between August 2021 and February 2022.

1.4.4 Medical establishment - as of 28/2/2022

Table 7: Consultant establishments

Care Group	Establishment	Consultant (WTE) - substantive	Consultants (WTE) - Acting Up	Total in post	Unfilled (WTE)	% unfilled	*Agency (WTE)*
Older Adults	24.9	21.3	3	24.3	0.6	1 %	*1*
CRCG – CMHTs	29.6	22.9	5	27.9	1.7	5.7%	*4*
CRCG - specialist	15.0	12.8	2	14.8	0.2	0	*1*
Forensic & Specialist	27.95	23.8	1	24.8	3.15	11.3 %	*4*
Acute	16.3	12	4	16	0.3	0	*0*
TOTAL	**118.35**	**92.8**	**15**	**107.8**	**10.55**	**8.9%**	***10***

Table 8: Specialty doctor establishments (excluding trainees)

Care Group	Establishment	Specialty Doctor (WTE)	Unfilled (WTE)	% unfilled	*Agency (WTE)*
Older Adults	10.91	6.4	4.51	41%	*1*
CRCG – CMHTs	9.64	5.0	4.64	48%	*0*
CRCG - specialist	2.9	3.9	0	0	*1*
Forensic & Specialist	12.75	10.22	1.53	12%	*1*
Acute	12.9	6.77	6.13	48%	*1*
TOTAL	**49.1**	**32.29**	**14.81**	**30%**	***4***

The total medial vacancy rate has improved by 7% in the last 2 years.

Appendix 4 details the current medical agency usage with the reasons for using agency and whether the rates are within cap or over cap.

2. Benchmarking

Appendix 5 details the most recent benchmarking information available for agency spend, vacancies, sickness and turnover

3. Actions to date

There have already been a number of actions taken during 2021/22 to support reduction of agency.

3.1 Actions to reduce the use of temporary staffing – nursing and health care workers

- Quality Improvement project started on the use of therapeutic observations – outcome of project to be delivered in July 2022
- Mental Health Optimal Staffing Tool (MHOST) review on staffing establishments in in patients due to report in May 2022
- Student conversion rate – aiming to increase from 30% to 90% in August 2022
- International recruitment 19 recruited and a further 11 due to start. Another cohort planned for 22/23
- Register Mental Health Nurse degrees and Trainee Nursing Associates and trainee Occupational Therapists being educated through the apprenticeship programme
- Replaced 23 Clinical Associate Psychologist (CAPS) posts in February 2022 which were vacant psychology or wider team posts which were hard to recruit to
- Monthly nursing agency meetings which the Executive Director of Finance, the Chief Nurse and the Director of Workforce and OD to challenge agency spend
- Rosters agreed 12 weeks in advance and 95% of the rosters were completed within this time frame by 1st March 2022
- The aim is the gaps in shifts are sent to NHSP 28 days ahead of the day of the shift being worked, this currently stands at 22 days.
- A monthly roster check and challenge is held and we have seen improvements in the lead times for rostering, including when shifts are available for fill by temporary staff
- The roster KPIs are monitored in the Safer Steering Group that meets bi-monthly
- Development programme for health care workers being introduced
- Focused recruitment work with INDEED and centralised recruitment panels.
- KMPT retention strategies – improved onboarding, promotion of flexible working opportunities, emphasis on improved health and wellbeing, introduction of career paths and improved data from exit interviews, supervision and Appraisals (including Health and Wellbeing Conversations and Talent Conversations) and Executive 6 month induction check in

3.2 Actions to reduce the use of temporary staffing – medical

- Medical vacancy skill mixing has occurred within care groups (e.g. independent prescriber posts recruited from Specialty Doctor vacancies, Advanced Clinical Practitioner posts from Consultant vacancies, multidisciplinary Approved Clinicians from Consultant vacancies).
- Weekly agency spend reports are produced and distributed.
- Weekly medical agency scrutiny meeting of usage and spend which the Executive Director of Finance, the Chief Medical Officer and the Director of Workforce and OD attend. Actions have been identified and posts will reduce in March and April 2022.

The current actions (for 21/22), led by the Deputy Medical Director and Deputy Director of Workforce and Development, under the Workforce pillar of the Long-Term Sustainability Programme, supporting KMPT wide cost savings are as follows:

ACTIONS TO BE TAKEN by 31/3/22	IMPACT	CONFIDENCE
Review of agency controls for medical and nursing. New controls implemented and communicated to the organisation. The controls will be designed based on the financial hierarchy for approval.	High impact - financially	High confidence – process and culture changes required to support this

Progress to date – draft approval process to include appropriate medical managers, in line with Standing Financial Instructions		
* Finalise review of Direct Engagement model and draft a proposal for the Executive with clear timeframes for implementation	High impact – financially (c. £300k) Expected savings to be achieved in 22/23	High confidence – process and culture changes required to support this
* Clear programme that sets out how we will reduce agency. Particular focus on medical posts and our options for longer term recruitment.	High impact – financially (costs being finalised)	Medium confidence – process and culture changes required to support this
* Clear programme that sets out how we will reduce agency. The nursing plan will focus on developing a plan for improved roster management (including Improving usage in CRCG)	High impact – financially and staff health and wellbeing Savings TBC for 22/23	Medium confidence – culture change required to support this
Job Planning to be completed with clear Trust principles agreed and signed off. Develop a suite of reports that enables us to monitor performance	High impact – financially and patient quality	Medium confidence – process and culture changes required to support this Will also require performance information and may be affected by benchmarking review

* see below for longer term actions

4 Next steps/long term steps

Some of the current actions described above will require continuing focus in 2022/23, and form our long-term strategy management of temporary staffing usage. They are being led by the Deputy Medical Director, Deputy Director of Nursing and Deputy Director of Workforce and OD:

- Procurement and implementation of Direct Engagement model in Q1 22/23, with estimated £300k savings
- To ensure ongoing safe and stable delivery of clinical services across KMPT there now needs to be a formal benchmarking exercise as to the required number of Doctors (at each grade and skill) before further safe skill mixing can occur. This will ensure that the activities that only Doctors with certain training can do can be sustained. Planned for Q1 22/23
- The next deep dive Board paper, in May 2022, will be on inpatient establishments and presented jointly by Director of Workforce and OD and the Chief Nurse
- Mental Health Optimal Staffing Tool (MHOST) review, including options for nursing model changes. Paper to May 2022 Board for recommendations
- Develop an agency strategy which is Trust wide and will cover: Workforce model/plan that addresses the long standing vacancies, what alternative workforce models we need to consider; our approach to this (working with agencies to recruit specific posts, working with the third sector for example and agency controls in place and the impact on cost)

We will set agency reduction KPI's by 30/4/22, to get us back to pre-pandemic lowest spend, and these will be monitored on a monthly basis.

Additional actions to support long term change are:

- Introduction of Temporary Staffing and resourcing focussed role in Workforce and Organisational Development team in Q1 22/23. This will support development of a focussed strategy and monitoring of set KPI's
- Working collaboratively across the Integrated Care System (ICS) for temporary staffing and Recruitment and Retention, led by Director of Workforce and OD. Recruitment workstream, focussing on temporary staffing £23k saving, improved rostering, recruitment and automation. Retention focussing items such as flexible working and on-boarding workstreams
- KMPT retention strategies – improved onboarding, promotion of flexible working opportunities, emphasis on improved health and wellbeing, introduction of career paths and improved data from exit interviews, supervision and Appraisals (including Health and Wellbeing Conversations and Talent Conversations) and Exec 6 month induction check in
- Workforce planning introduced to identify the gaps for nursing and medical to consider increasing international recruitment strategies
- Recruitment strategy for high turnover and hard to fill roles so that we recruit ahead of people resigning
- Workforce model review across hard to recruit staff groups, geographies and Care Groups to implement and extend different workforce models to support improved provision of patient care
- Care Group recruitment and retention strategies in place to support achievement of targets, supported by Human Resources Business Partners, by 30/4/22. This includes challenging innovation in the workforce model, as described above.

5 Conclusion

As part of our commitment to Brilliant Care Through Brilliant People, we will be prioritising recruitment and retention of staff to reduce our temporary staffing usage and cost, resulting in quality patient care and financial stability.

We do not have a NHSEI cap for 22/23. In 22/23 the target is to reduce agency spend by £1M to £6.4M through the above actions. To note this will be a gross reduction in agency spend, not a net reduction in pay spend, because if we are then recruiting, a £1m reduction in agency would probably convert to about a £200k benefit overall. This target will be supported by improving the vacancy gap to 10% and then a year on year reduction.

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APPENDIX 1

Turnover for last 6 months by staff group and Care Group

Indicator	Service	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
Staff Turnover (Overall)	Trust wide	12.2%	12.6%	12.8%	13.6%	13.1%	13.4%
	Acute Service	14.6%	14.8%	14.4%	14.5%	15.0%	16.2%
	Community Recovery Service	12.3%	12.8%	13.6%	13.6%	13.6%	13.0%
	Older Adult	11.4%	12.4%	12.3%	12.9%	12.0%	12.3%
	Forensic & Specialist	14.0%	14.4%	14.9%	15.8%	15.4%	15.7%
	Corporate Services	8.5%	8.5%	9.0%	9.5%	9.7%	10.6%
Staff Turnover (Additional Clinical Services)	Trust wide	13.1%	15.1%	16.2%	15.6%	15.3%	17.8%
	Acute Service	18.1%	19.0%	19.7%	20.0%	19.4%	20.7%
	Community Recovery Service	10.5%	12.8%	14.6%	15.3%	14.9%	14.0%
	Older Adult	14.6%	16.7%	16.8%	17.6%	17.7%	17.6%
	Forensic & Specialist	14.9%	16.4%	18.8%	17.7%	17.7%	18.4%
	Corporate Services	10.0%	10.5%	11.1%	7.5%	6.8%	11.3%
Staff Turnover (Nursing)	Trust wide	10.6%	9.9%	9.1%	10.1%	9.9%	10.6%
	Acute Service	10.3%	9.5%	8.3%	8.8%	10.1%	10.7%
	Community Recovery Service	12.3%	11.9%	11.5%	11.5%	10.4%	10.7%
	Older Adult	10.3%	10.1%	8.5%	9.1%	7.1%	8.3%
	Forensic & Specialist	13.3%	13.0%	12.6%	13.7%	12.9%	13.4%
	Corporate Services	6.9%	5.1%	4.8%	7.4%	9.1%	9.2%
Staff Turnover (Medical)	Trust wide	12.5%	12.4%	13.2%	13.2%	13.6%	12.9%
	Acute Service	11.7%	11.4%	11.1%	5.7%	5.7%	5.7%
	Community Recovery Service	8.2%	7.6%	12.5%	12.3%	11.9%	6.9%
	Older Adult	3.1%	3.2%	3.2%	3.2%	3.1%	3.2%
	Forensic & Specialist	10.5%	10.3%	9.9%	16.1%	18.8%	18.5%
	Corporate Services	29.2%	29.6%	29.3%	28.6%	28.2%	24.0%

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APPENDIX 2

Reasons for bookings (nursing)

	Acute	Community Recovery	CRCG	Forensic & Specialist	Older Adults	Grand Total
COVID19	198	10		107	60	375
COVID-19 Isolation	3	2		2	4	11
Escalation	148	5		2	1	156
Initiative	34			14	4	52
Maternity	52		18	1	10	81
Military					1	1
Paternity		2				2
Planned Leave	264	98		569	196	1127
RM Supervised Practice	1					1
Seasonal Pressures				1		1
Sickness	201	231		130	148	710
enhanced observations	517	2		399	68	986
Training	49	20		42	15	126
Unfulfilled Role Cover	306	93		78	11	488
Unplanned Leave	44	31		9	11	95
Vacancy	2132	584	40	1287	705	4748
Workload Increased	450	64		189	474	1177
Grand Total	**4353**	**1142**	**58**	**2830**	**1708**	**10137**

APPENDIX 3

Observation details by Care Group (August 2021 to February 2022)

	Level of observation August 2021- February 2022			
Care Group	**1:1**	**2:1**	**3:1**	**4:1**
Older Adult	3346	1673	1673	358
Acute	4712	1974	1702	0
Forensic and Specialist	3784	1891	1891	0
Total	**11842**	**5538**	**5266**	**358**

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APPENDIX 4

Current medical agency cover arrangements

	Rate of pay	Rationale for use
Older Adults		
Consultant	Over cap	Vacancy
Specialty Doctor	Over cap	Vacancy
CRCG - CMHTs		
Consultant	Over cap	Vacancy
Consultant	Over cap	Vacancy
Consultant	Over cap	Vacancy
Consultant	At cap	Vacancy
Specialty Doctor	Over cap	Vacancy
CRCG - Specialist		
Consultant	Over cap	Vacancy (service expansion)
Speciality Doctor	Below cap	Vacancy
Forensic & Specialist		
Consultant	Over cap	Vacancy
Consultant	Over cap	Ongoing legal case
Consultant	Over cap	Vacancy
Consultant	Over cap	Long term sickness
Speciality Doctor	Over cap	Vacancy
Acute		
Speciality Doctor	Over cap	Vacancy

APPENDIX 5

The below table summarises the most recent benchmarking data available for the main key performance indicator (KPI) areas:

	KMPT	SLAM	Oxleas	Sussex Partnership	Avon and Wiltshire Partnership
Agency spend - £000 (YTD 20/21- as at December 2021)	£5.6m 4% of total pay	£15.7m 6% of total pay	*Data not available*	£15.5m 11% of total pay	£20.78m 12% of total pay
Vacancies (as at December 2021)	14.9%	20.6%	*Data not available*	19%	13%
Sickness (as at August 2021)	4.2%	4.0%	4.9%	4.8%	6%
Turnover (as at September 2021)	12.2%	13.3%	18%	11.1%	14.6%

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Strategic Priorities 2022-23
Author:	Helen Greatorex, Chief Executive
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Approval
Submission to Board:	Board requested

Overview of Paper

This brief paper sets out on one side of A4, the Board's three overarching strategic priorities for the year 2022-23.

Issues to bring to the Board's attention

The Trust has a well-established system of developing, implementing and cascading its Trust Strategy. As the Care Quality Commission recognised in their February 2022 Well Led inspection review report for KMPT, 'the trust had a clear vision and a set of values which staff understood.'

The new style one side of A4 strategic priorities strengthens our approach making it as easy as possible for everyone to see what KMPT is making a priority, and why. It balances the Board's ability to hold the Trust and itself to account in the delivery of the priorities with being easy to understand and meaningful to our service users, their loved ones, our staff and partners.

The Board has agreed that our focus will be on driving up the quality of what we do, recruiting and retaining the best people, and working in partnership across our health and social care system.

These three priorities evolved as a result of the board's facilitated development workshop in December 2021 and have been further informed and refined through discussion and reflection across KMPT over the last three months.

Once approved by the board, the three overarching aims will be supported by a detailed delivery plan with clear and measurable quarterly targets, progress against which will be reported in public.

Governance

Implications/Impact:	Delivery of Trust Strategy
Assurance:	Not applicable at this stage
Oversight:	The Board shall receive assurance on the delivery of the agreed priorities through its sub-Board committees.

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Our Mission 3 Priorities	BRILLIANT CARE BRILLIANT PEOPLE					
	Accelerating an empowered culture to improve the quality of services		**Improving employee recruitment, retention and wellbeing**		**Building partnerships with a purpose to improve key pathways of care**	
SMART Goals	Increase the QI team to 14 full time posts (cost neutrally)	Deliver 20 QI projects	Launch a new, confidential and independent 24/7 Freedom to Speak Up Service for all to safely speak up	Reduce our vacancy gap from 14% to 10% through improved recruitment and retention	Actively support and promote the development of the KMPT Engagement Council	Establish new partnerships to improve Dementia Diagnosis rates and other priority areas
	Establish a formal QI partnership with an expert organisation	Start every public board meeting with an example of QI in practice	Open a new staff restorative space in the three main sites; Dartford, Canterbury and Maidstone	Develop a KMPT strategy for psychological safety in the workplace	Establish robust 3rd sector representation and service user voice in the Improvement Board	Build on our partnership with KCHFT to identify and deliver three more areas for joint working
This means that	Everyone is responsible for creating and finding ways to improve the quality of services		KMPT staff are confident, skilled and deliver consistently brilliant care		KMPT and its partners work together to reduce mental health inequalities and improve services and outcomes for our users and their loved ones	
Over the next 12 months we will be	• Streamlining clinical work by making our systems more efficient • Improving how our workforce systems serve our people • Coordinating and improving systems to make it easy to connect, share and hold one version of data		• Eliminating our underlying financial deficit • Reducing our use of temporary staff • Creating a better work-life balance • Creating new roles and new opportunities • Ensuring all staff feel safe to speak up and responding to what they share • Building our employer brand		• Listening to our engagement council and service users to improve services • Learning from best practice • Co-designing better pathways of care • Improving care through innovation • Supporting third sector partners • Meeting national improvement targets	

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Mental Health Learning Disability and Autism Improvement Board
Author:	Catronia Toms
Executive Director:	Helen Greatorex

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview update for Board on:

a) Current headline position and improvement plan for each of the key priority areas identified by the MHLDA IB, with the actions and timescale.
b) Updates on additional areas overseen by the MHLDA IB in the last quarter

Issues to bring to the Board's attention

Significant improvements have been noted across the system in the delivery of physical health assessment for people with serious mental illness – this progress has been commended by the regional assurance team.

A review of the KMPT Memory Assessment Service aligned with new system resources, including 42 new neighbour (Primary Care Network level) dementia co-ordinators from April 2022, to support an improvement plan is expected to deliver improvements in the diagnosis and support of people with dementia across Kent and Medway in the coming months.

The Kent and Medway Better Mental Health Programme has completed a listening exercise at Health and Care Partnership level – the analysis of this will form the basis on place and system action plans in spring / summer 2022.

Transition of the existing board, to a new Provider Collaborative Board from April 2022.

Governance

Implications/Impact:	KMPT Trust Strategy - Use our expertise to lead and partner
Assurance:	reasonable
Oversight:	ICS MHLDA Improvement Board

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MHLDA IB - Improvement Priorities Overview

During this quarter the MHLDA Improvement Board has continued to leverage its strategic influence, to provide support and assurance on the following priorities which remain key challenges for the system.

Priority Area	Kent & Medway System Target / Performance Q1-2	RAG Rating	Comments
Dementia Diagnosis Rate (DDR)	National Target - 66.7% by Q4 2021/22 Q3 Dec 2021 - 57.3% against local target of 58%		Improvement plan in place to increase delivery capacity Review of KMPT MAS completed
Children and Young People's Services (CYP)	17,703 CYP accessing services by March 2022 • Q1 June 2021 - 16,915 • Q2 Sept 2022 – 17,285		Recognition of increasing demand – Improvement plans in place to manage demand
Community Mental Health Framework Transformation	National KPIs are in place for post implementation delivery only – K&M commenced reporting but are below trajectory Programme implementation is progressing to planned milestones. Financial spend is below projection		• Core model developed – to implement in 3 pilot PCNs in M&S HCP • Eating Disorder and Community Rehabilitation Business Cases developed • Underspend secured • Regional team assessment of K&M system progress in Feb 2022 positive
Physical Health Checks for Serious Mental Illness	National 60% Target by Q4 2021/22 Q2 Sept 2021 - 18.3% Q3 Dec 2021 – 22.7% = 2992 individuals (non-validated data indicating 30%)		Delivery of improvement plan is showing positive impact with strong improvement noted by regional team.
Out of Area Placements (Acute)	Inappropriate OoAPs (general acute overspill bed days) to be eliminated by 2020/21 Trajectory in place to achieve by 2021/22 • Sept 2021 - 205 bed days against a target of 97 • Dec 2021 – 184 bed days against a target of 59		Improvement plan in place to address • Delayed Transfers of Care (DToC) • improve patient flow • service availability i.e. for Psychiatric Intensive care beds
	Acute Length of stay: Dec 2021 26.85 against a local trajectory of 25 days		
Section 136	There has been a 32% reduction when comparing April to Dec 20/21 with April to Dec 21/22		Significant success as a result of interagency, integrated working
Annual Health Checks for people who have Learning Disabilities (AHC LD)	Dec 2021 26% which is above trajectory for Q3		
Perinatal Mental Health	2021/22 Target for Specialist Community Perinatal Access – 8.6% • Q3 2021/22 6.4%		Improved marketing has increased access rates

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1. Community Mental Health Framework (CMHF) Transformation

1.1. There is system confidence in the process for patient engagement, local clinical involvement and pilot plans for Medway and Swale Health and Care Partnership. The PMO is delivering positive outcomes under the leadership of the Clinical Commissioning Group's Programme Lead Clinical Lead and Lived Experience Lead.

1.2. Acknowledgment of the delay in recruitment and the active mobilisation - Key risk identification - Low spend in Q1-2 2021/22 against budget allocation. The investment remains protected for the programme. The multi-agency Oversight Group is working collaboratively to develop the business and governance arrangements. The team is currently reviewing the models that could fit: provider leadership board / alliance, lead provider model and shared leadership model. Work is still underway to understand the impact it could have specifically around reporting on expenditure, responsibility and accountability before reaching a final agreement.

1.3. A large number of key partners (PCNs, lived experience experts, third sector) are involved in the four core workstreams that fall under the CMHF Transformation work and it is highlighted that the Health and Care Partnerships (HCPs/ICPs) involvement requires strengthening in some areas.

1.4. The new agreed core model (Mental Health Together) for CMHF will be piloted in three M&S HCP PCNs during Q4 2021/22. The core model team is called **Mental Health Together (MHT)** and brings together the Mental Health Room, Physical Health Room and the Whole Life Room in an integrated, multidisciplinary team working directly to a defined Primary Care Network (PCN) or PCN cluster, dependent on the size and demand within the PCN. The main function of Mental Health Together is to draw mental health interventions, physical health support and 'whole life' support together in what are described as 'Rooms'. This is to reflect an ability to easily move between the different types of support and to access different type of support concurrently.

2. Developing MHLDA IB Engagement with 3rd Sector Partners

2.1. In 2021, the MHLDA IB commissioned an external consultant to investigate ways of strengthening engagement of 3rd sector partners in MHLDA services and make recommendations about how they could support our collective focus on system improvement.

2.2. The Board endorsed recommendations establishing joined up approaches to formal engagement with the voluntary sector and allocated a place on the board. Third sector representation on the new, Provider Collaborative MHLDA Board is the process of being established.

3. Additional Roles Reimbursement Scheme (ARRS) Mental Health Practitioners

3.1. KMPT is the lead and host organisation for these new roles working jointly with Primary Care Networks.

3.2. There are now 18 practitioners in place with plans to recruit a further 5-7.

4. Physical Health Checks and Serious Mental Illness

4.1. The national Clinical Director has praised the improvement in this area of Kent's ICS – currently achieving 16% above our local target. This remains a high priority for the system.

5. Increasing Access to Psychological Therapies Service (IAPTS)

5.1. The two main targets of recovery rate and waiting times are being achieved. The 21/22 target is to reach 35,000 people entering treatment.

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5.2. IAPT System Maturity tool for systems to self-assess themselves. A development and improvement plan is underway.

5.3. The recruitment to key posts has been approved to improve the referral to completed treatment pathway, and outreach engagement.

6. Learning Disability Deep Dive Report

6.1. Dynamic Support Register [DSR] – Now fully implemented in Kent and Medway for Children and Young People and Adults.

6.2. Annual Health Checks for people who have Learning Disabilities – Kent and Medway on track to meet 73%, with improvement in numbers on the LD register and holding Health action plans.

6.3. Learning from the deaths of people with Learning Disability (LeDer) – Kent and Medway have cleared all backlog reviews, with new LeDer policy, operational from April 2022.

6.4. Care (Education) Treatment Reviews [C(E)TR] – A regional task and finish group has been established to review quality; preadmission CETR's – working with CYP Primary Care to address poor performance on preadmission CETRs.

7. Prevention Concordat – Better Mental Health for Kent and Medway

7.1. The national Prevention Concordat and the locally adapted Kent and Medway Better Mental Health Programme provides the ICS with a nationally approved framework to:

- Demonstrate partners' shared commitment to support local action to prevent mental health problems and promote good mental health.
- Structure and monitor the Public Mental Health work and ensure strong co-operation and co-ordination across partners.

7.2. At the end of the listening and engagement phase (due March 2022), a report incorporating all data will be drafted and shared across all structures within the ICS to ensure all partners have an opportunity to address the issues raised and contribute to the final action plan through workshops to planned from spring summer 2022 at place and system levels.

8. Recommissioning K&M Community Mental Health and Wellbeing Service

8.1 The MHLDA Board approved the following recommendations:

- The Live Well Kent and Medway becomes part of the CMHF Transformation Programme
- To progress the Live Well Kent and Medway approach
- To support the Strategic Partnership model and Jointly commission the programme

8.2 The Board received clarification that KCC will go out to contract to voluntary sector organisations.

9. Mental Health Investment Standard

9.1 The current forecast is compliant with the MHIS for 21/22. Potential slippage continue to be identified in IAPT and prescribing. Other slippage has been identified in non-recurrent funding areas: CMHF, ARRS recruitment.

9.2 The MH Finance Planning Group is sighted onslippage and working to addressing these issues, reinvesting the monies into other mental health areas such as Mental Health MDTs in primary care settings.

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10. Dementia Diagnosis Rates [DDR]

10.1 The DDR monitors those over 65 on the dementia register versus established prevalence based on a 2014 study. Young onset dementia patients are not monitored against the 66.7% DDR ambition. Kent and Medway do have a higher than anticipated prevalence of young onset. In December 2021 DDR for EK HCP was 22.3% (1145 people) against national target of 66%. Kent and Medway at ICS level is 57.3%.

10.3 New roles to provide additional support to people experiencing dementia and their families are being invested in at system level. This includes 42 dementia coordinators (1 for each PCN).

10.4 General practice is being asked to use the data quality toolkit to identify patients who are not on the dementia register but who are being treated for dementia.

Summary and Conclusion

The Board has since its inception in 2019, ensured a clear line of sight from the Integrated Care Board, to the performance against national key performance indicators.

Strong performance is evident in some areas, where in others there remain significant challenges. For each there is a clear plan to address and resolve poor performance, working as a system.

The next stage of development in this work will be the establishment of a new, Mental Health, Learning Disability and Autism Provider Collaborative. Operating at strategic level and reporting directly to the Integrated Care Board, this new group chaired by KMPT's chair will step up the ambition to not only meet but exceed the national targets.

Version Control: 01

Kent and Medway NHS
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	**31st March 2022**
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

Whilst this report (which presents February's activity) includes targets met and some areas of improvement, it also clearly sets out areas of challenge where targets have been missed, helping to inform future priorities

The Board's attention will naturally focus on those areas below target, seeking assurance that measures are in place to rectify the situation. The report shows continued pressure in some of our key workforce metrics along with examples of the work in train to improve the situation. Turnover continues to be above 13% against a target of 9% for the third successive month, however it is positive to note a reduction in Staff Sickness rates in the first two months of 2022. Recruitment and retention retains a strong focus and is a priority area included in the trust's strategic priorities for 2022-23.

Bed pressures is an area of focus for the Executive Team, this is partially driven by high levels Delayed Transfers of Care. Bed days lost to delayed transfer are particularly high in acute beds:

- YA Acute: 14.1% Dec 21-Feb 22 compared to 10.1% for 2021/22 Q1
- OP Acute: 27.6% Dec 21-Feb 22 compared to 15.5% for 2021/22 Q1

The largest proportion of delayed bed days are attributable to Social Care (>50%) with patients requiring residential/nursing home placements being the prominent reason for delays.

The Chief Operating Officer if overseeing a detailed review of this area, actions in place include twice-weekly escalation calls with the Social Care and planning a Multi Agency Discharge Event involving internal and external partners.

For other indicators however, the cause of the problem is multifactorial and requires a system approach. Examples of these instances include our ability to meet the significant increase in demand for Memory Assessment Services combined with ongoing backlogs accrued during the pandemic for our older patients. The executive working with Heads of Service, Clinical Directors and the wider system, is reviewing the areas where the solution is not solely in the gift of KMPT and agreeing trajectories for improvement. Where required this approach agreed 2022/23 forecast for the systems annual plan.

The Trust will need to focus on the delivery of recurrent efficiencies as we move into the new financial year to ensure deliver of a break-even position. KMPT's spend on temporary staffing continues to be above plan and remains a significant concern in relation to both quality and cost. Further work is being done to understand the drivers of the increase and address this issue including: weekly medical agency meetings, proposals for developing a locum bank and sharing the learning from opportunities to use existing resource and locum resource more effectively.

Governance

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

Kent and Medway NHS
NHS and Social Care Partnership Trust

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): Chief Nurse
Lead Board Committee: Quality Committee

Issues of Concern
No areas of concern to raise this month.

Executive Commentary

Restrictive interventions (011-013.S)

The Trust's approach to the use of restraint is carefully monitored and reviewed in line with national best practice. The use of restraint is always a last resort and staff are trained in de-escalation techniques which are always considered before restraint is implemented.

There were 83 reported incidents of restraint needing to be used in February 2022, a decrease of seven from the previous month. The Acute Care Group (ACG) have shown a reduction of 12 incidents, with both the Forensic and Specialist care group (FSCG) and the Older Adult care group (OACG) showing an increase of three incidents each. The majority of restraints occurred in the Acute Care Group (ACG) with 56 reported in February. All use of restrictive interventions are monitored in line with Trust policy with strategic oversight by the Promoting Safe Care group which has membership from all care groups and subject matter experts.

Prone restraints increased from last month from two to four reported incidents in February 2022. Two prone restraints were used to administer IM medication. No physical harm was reported in any of these restraints.

The use of seclusion has decreased from 17 instances in January to 8 in February. The majority of these occurred in the Acute Care Group (6) with the remaining two in the Forensic & Specialist Care Group. All eight seclusions involved just five patients with one patient being secluded four times. This patient is now being nursed on our PICU unit and is responding well to treatment. All instances of seclusion are reviewed and an overview retained in order to identify outliers or patterns.

KMPT's Promoting Safe Services have been awarded the national accreditation for meeting the standards for its Physical Interventions training. This provides assurances to the CQC and stakeholders that KMPT adheres to best practice within this area of staff training. Along with the implementation of the Broset Violence Checklist (a risk prediction tool) and safety pods within all our inpatient wards, we are aiming to see a reduction in the use of restrictive practices.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
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	95.5%	95.8%	94.7%	94.5%	94.2%	93.2%	92.8%	92.3%	92.9%	93.0%	93.2%	93.5%
003.S	% Inpatients With A Physical Health Check Within 72 Hours		90%	L	96.4%	96.2%	96.5%	98.8%	96.5%	95.8%	97.1%	97.5%	98.4%	96.2%	95.9%	95.2%
005.S	Number Of Unplanned Absences (AWOL and Absconds on MHA)		-	-	22	17	23	22	25	21	32	21	19	9	21	23
006.S	Serious Incidents Declared To STEIS		-	-	21	24	17	13	11	13	21	20	23	20	18	26
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	5	2	3	4	4	1	0	0	0	0	1	0
010.S	All Deaths Reported On Datix And Suspected Suicide		-	-	155	150	75	146	75	122	107	91	97	120	172	153
011.S	Restrictive Practice - All Restraints		-	-	146	103	145	88	151	96	82	62	72	71	88	83
012.S	Restrictive Practice - No. Of Prone Incidents		0	L	6	4	8	4	6	5	11	4	2	2	2	4
013.S	Restrictive Practice - No. Of Seclusions		-	-	24	12	21	21	26	19	17	12	17	19	17	8
015.S	Ligature Incidents - Ligature With Fixed Points (moderate to severe harm)		0	L	1	0	0	0	0	0	0	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	1	0	0	0	0
017.S	RIDDOR Incidents		-	-	3	2	6	0	2	2	3	3	2	5	3	1
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	108.8%	108.9%	110.1%	110.7%	110.5%	110.5%	110.5%	110.3%	110.2%	100.6%	102.5%	
020.S	Unplanned Readmissions within 30 days		8.8%	L	5.2%	6.3%	4.2%	3.8%	7.8%	11.0%	5.6%	8.5%	5.8%	7.2%	5.3%	4.5%

Kent and Medway NHS
NHS and Social Care Partnership Trust

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

Bed Pressures: Delayed Transfer of Care remain high (13.1%) resulting in additional pressure on bed availability and continued Lengths of Stay which are higher than average on YA Acute Wards in particular.

DToC is considerably higher than at the start of 2021/22 in acute settings. The largest proportion of these delayed bed days were attributable to Social Care (>50%) with patients requiring residential/nursing home placements being the prominent reason for delays.

Trust actions to reduce delayed transfer of care cases:

- Facilitating and attending twice-weekly escalation calls with the Social Care in reach team to discuss the patients current discharge pathway and allocate actions to ensure accountability as well as prompt and timely discharge.
- Commissioning an Older Adult speciality post to take a lead on delayed transfer of care cases across the Older Adult Care Group as well as improve links with Older Adult Social Care colleagues.
- Introductions of call handlers to release senior clinical time to support MDT's in discharge planning.
- Multiple performance reports circulated by the performance team to support oversight and scrutiny of the currently delays across the Care Groups.
- KMPT facilitate a week long Multi Agency Discharge Event across the Younger and Older Adult Care Group involving internal and external partners to review all delayed transfer patients and patients with a significant length of stay in hand with the ward multi-disciplinary team.
- Introduction of a Programme Manager to lead of reduction of delays including review of system wide issues such as commissioning of placements, review of current available providers and the placement referral pathway.

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	-59.5	135.9	38.2
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			125.0	0.0	20.2	262.7	141.4
4	**Trust Total**			125.0	0.0	13.4	341.7	177.6

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

Kent and Medway NHS
NHS and Social Care Partnership Trust

February saw a fifth successive month of reductions in the use of out of area beds not procured by KMPT, in February 125 bed days were used (0 Acute and 125 PICU). This decrease was achieved despite restrictions in capacity on the Trust's PICU ward, Willow Suite, due to the admission of a patient with complex needs. 37 of the 125 beds days used have been as a direct result of the capacity challenges on Willow Suite requiring male patients to be placed externally. This relates to three patients all of which were still placed externally as at 22nd March with a further placement having taken place on March 4th. Therefore, this increase will be reported in the March performance position. The Chief Operating Officer continues to review closely with patient flow services, noting the national requirement to aim for zero out of area non-contracted bed use by the 1st of April 2022.

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			66.7%	95.0%	50.6%	94.5%	72.6%
2	CRCG			88.5%	95.0%	86.7%	92.5%	89.6%
3	FSS			95.4%	95.0%	91.0%	97.9%	94.5%
4	OPMH			97.6%	95.0%	94.3%	99.4%	96.9%
5	Trust Total			90.2%	95.0%	88.4%	93.2%	90.8%

	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			71.3%	95.0%	66.0%	71.5%	68.8%
2	FSS			76.0%	95.0%	66.3%	80.3%	73.3%
3	OPMH			71.5%	95.0%	67.2%	76.1%	71.7%
4	Trust Total			73.4%	95.0%	68.0%	73.9%	70.9%

Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Common Cause - no significant change *Non CPA PSP & Care Plans:* Special cause of **Improving** nature to **higher** values
Assurance	Variation indicates consistently **failing short of target**

Narrative

CPA Care Planning

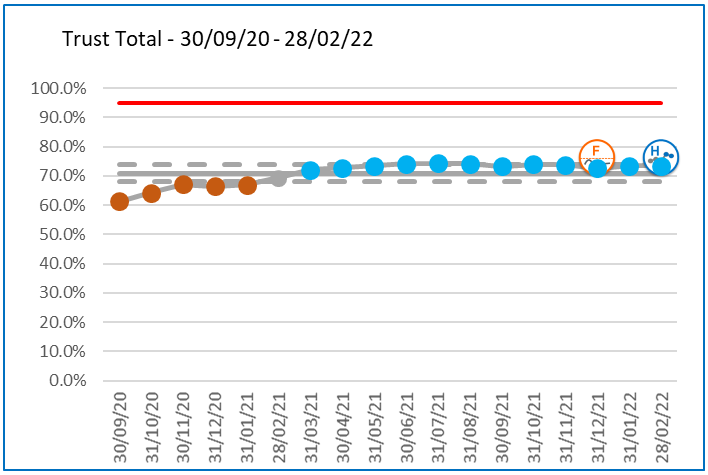
The percentage of patients on CPA with a valid Care Plan remains stable, it has been 90% (+/- 1.5%) for over 12 months and continues to show common cause variation.

FSCG have been working with 2 specific teams to address non-compliance and this has led to an above target position in month with plans in place to continue on this upward trajectory.

Non CPA Care Plans and Personal Support Plans (PSP):

This indicator continues to show special cause variation of an improving nature due to a succession of points above the mean of the last 18 months, as shown below. Despite this the indicator

continues to fall short of the target and performance improvement has reduced, the position as at the end of February 2022 is 1.3% higher than as at the end of March 2021.



This standard, along with CPA, are the two keys area the leadership is focussing on. QPR meetings will be used to discuss improvement approaches and challenges in improving performance.

NHS
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NHS and Social Care Partnership Trust

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	98.3%	98.9%	97.3%	97.8%	97.8%	96.4%	96.3%	95.2%	95.3%	96.2%	98.5%	98.6%
001b.E	CPA patients receiving follow-up within 72hours of discharge				88.4%	86.7%	84.0%	82.7%	86.5%	86.6%	81.7%	87.5%	88.0%	80.0%	78.6%	85.0%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	95.8%	95.8%	96.0%	95.9%	95.7%	95.7%	95.9%	95.9%	95.8%	95.6%	95.6%	95.4%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	181	189	192	351	201	103	205	175	153	138	136	125
006.E	Delayed Transfers Of Care		7.5%	L	8.5%	8.7%	8.6%	8.4%	8.8%	9.0%	10.6%	11.9%	9.6%	10.6%	13.1%	13.1%
011.E	Number Of Home Treatment Episodes		224	L	250	241	270	291	246	242	250	231	234	222	224	242
012.E	Average Length Of Stay(Younger Adults)		25	L	27.75	25.94	26.42	33.92	28.23	27.68	29.78	36.63	33.96	26.85	35.99	33.63
013a.E	Average Length Of Stay(Older Adults - Acute)		52	L	70.97	101.79	61.63	65.75	53.24	56.90	72.25	80.22	85.18	85.90	53.88	57.41
015.E	%Patients with a CPA Care Plan		95%	L	89.5%	90.3%	89.0%	89.9%	90.7%	91.3%	89.5%	88.7%	91.4%	90.7%	90.6%	90.2%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	56.2%	56.7%	58.9%	60.9%	63.5%	64.4%	65.4%	66.3%	67.9%	71.7%	74.2%	73.3%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		95%	L	72.1%	72.7%	73.4%	74.1%	74.4%	74.2%	73.2%	74.0%	73.7%	72.6%	73.5%	73.4%

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
Staff Sickness & **Staff Turnover** continue to exceed target, breakdown detailed within narrative below.

Executive Commentary

Staff Sickness (001.W-W)

February 2022 - Sickness is 4.27% (including covid). This is above the target for 2021/22 (4%).
If we remove the Covid sickness which is 0.24%, the sickness for the month is 4.03%
February 2022 - Short term sickness is 1.64%, compared to 1.92% last month. Long term sickness is 2.40%, compared to 2.82% the previous month.
Year to date (April 2021 to February 2022) - Sickness is 4.39% including covid and 4.28% excluding covid

Comparisons to other local Trusts as follows, as at October 2021 (last available benchmarking) sickness:

- SLAM – 4.06%
- Oxleas – 5.8%
- Sussex Partnership – 4.75%
- *KMPT – 5%*

The latest national benchmarking for all NHS Trusts, as at October 2021, shows the overall sickness absence rate for England was 5.7% (we were below this figure). This is higher than September 2021 (5.4%) and higher than October 2020 (4.5%).

Activities in place to reduce sickness absence include:

- Successfully closed 32 long term sickness absence cases.
  - 26 employees are returning to same post
  - 5 employees are no longer employed at KMPT
  - 1 was redeployed
  - We are currently actively supporting managers with 54 cases of sickness absence.

- Part of 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
- £30k funding received for health and Wellbeing.

Staff Turnover (019.W-W)

February 2022 - turnover is 13.4% for rolling 12 months. This is an increase of 0.3% since previous month. The biggest increase is in Acute Care Group. Year to date (April 2021 to February 2022) - turnover is 11.8% against 9% target

Activities to reduce turnover:

- Getting recruitment right first time
- Onboarding and first 2 years in service
- Enhancing flexible working
- Staff feedback from Staff Survey and quarterly People Pulse
- Staff wellbeing
- Development, internal opportunities and career pathways
- Understanding why people are leaving- improvements to Exit surveys
- A recruitment and retention group is also supporting strategies to address turnover.

Comparisons to other local Trusts for the rolling 12 months to September 2021 (last available benchmarking – no update since last report) is:

- SLAM – 13.3%
- Oxleas – 18%
- Sussex Partnership – 11.1%
- *KMPT – 12.2%*

Staff Retention (015.W-W)

February 2022 - retention rate is 85.4%.

Year to date (April 2021 to February 2022) – retention is 84% against a target set for 2021/22 of 90%.

The year to date position for the reported staff groups is as below:

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

Activities to support retention are reflected in turnover:

- Getting recruitment right first time
- Onboarding and first 2 years in service
- Enhancing flexible working
- Staff feedback
- Staff wellbeing
- Development, internal opportunities and career pathways
- Understanding why people are leaving

Comparisons to other local Trusts for September 2021 (last available benchmarking – no update since last report) is:

- SLAM – 86.4%
- Oxleas – 82.3%
- Sussex Partnership – 88.5%
- *KMPT – 87.6%*

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Kent and Medway
NHS and Social Care Partnership Trust

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
001.W-W	Staff Sickness - Overall	✓	4.00%	L	3.5%	3.7%	4.0%	4.6%	4.6%	4.2%	4.6%	5.0%	4.9%	4.7%	4.3%	4.3%
005.W-W	Appraisals And Personal Development Plans		99%	L	98.1%	98.1%							98.8%	99.0%	99.0%	99.0%
006.W-W	Vacancy Gap - Overall		11.85%	L	14.2%	15.3%	15.5%					15.0%	14.9%	14.9%	15.1%	15.2%
007.W-W	Vacancy Gap - Medical			-	28.8%	28.8%	29.8%					28.5%	31.3%	31.4%	15.1%	30.4%
008.W-W	Vacancy Gap - Nursing			-	15.4%	16.2%	16.5%					12.6%	13.7%	13.9%	14.6%	14.9%
009.W-W	Vacancy Gap - Other			-	12.2%	13.6%	13.5%					13.1%	13.1%	13.6%	12.1%	13.9%
012.W-W	Essential Training For Role		90%	L	91.2%	91.8%	92.4%	92.4%	90.4%	90.5%	92.6%	91.5%	92.7%	93.1%	92.5%	93.0%
015.W-W	Staff Retention (overall)		90%					87.3%	82.7%	84.3%	81.8%	81.8%	81.0%	83.2%	85.9%	85.4%
016.W-W	Staff Retention (Additional Clinical Services)		90%					85.1%	82.3%	83.9%	77.6%	78.8%	81.5%	80.8%	81.4%	82.1%
017.W-W	Staff Retention (Nursing)		91%					87.0%	80.5%	82.1%	78.9%	79.3%	81.6%	81.6%	81.6%	85.9%
018.W-W	Staff Retention (Medical)		92%					89.2%	86.8%	88.4%	82.2%	82.6%	85.8%	85.8%	85.8%	85.3%
019.W-W	Staff Turnover (Overall)		9.00%		9.4%	10.1%	10.5%	9.5%	10.9%	11.3%	12.2%	12.6%	12.8%	13.6%	13.1%	13.4%
020.W-W	Staff Turnover (Additional Clinical Services)		10.00%					11.9%	13.1%	12.7%	13.1%	15.1%	16.2%	15.6%	15.3%	17.8%
021.W-W	Staff Turnover (Nursing)		9.00%					9.1%	10.8%	9.7%	10.6%	9.9%	9.1%	10.1%	9.9%	10.6%
022.W-W	Staff Turnover (Medical)		8.00%					8.1%	10.4%	12.2%	12.5%	12.4%	13.2%	13.2%	13.6%	12.9%

- *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**, a number of actions have been agreed at the new weekly meetings, in particular for medical agency spend which should see a positive impact on the average trend.
- Recurrent efficiency programme for 22/23

Executive Commentary

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

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
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)		-	-	3	0	(0)	(0)	0	0	(0)	0	0	0	0	0
006.W-F	In Month Variance (£000)		-	-	3	(0)	(0)	0	0	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%	0.00%	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)		-	-	767	699	661	520	664	658	687	562	536	741	595	516
009.W-F	Agency - In Month Variance from budget (£000)		-	-	340	272	234	93	237	231	260	135	109	314	168	89
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	75.78%	74.68%	73.02%	69.04%	60.85%	59.31%	51.76%	48.88%	45.97%	49.04%	48.08%	45.60%

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

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): Chief Nurse & Chief Operating Officer
Lead Board Committee: Quality Committee

Issues of Concern
No areas of concern to raise this month.

Executive Commentary

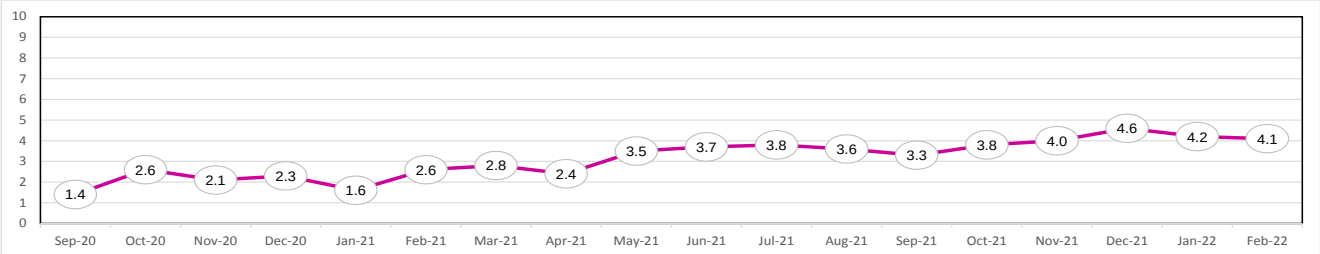
Patient Reported Experience Measures (PREM) (014-015.S)

The Trust target is to receive 10% of unique patient numbers, this would equate to over 1,500 PREMs collected each month. There has been gradual improvement over time. This is a result of the embedding of the PREM which has extended its reach and uptake. Currently, performance can be expected to vary in the range between 4% and 4.6%. The highest response rate so far for the new-look PREM was 4.6% in December 2021.

- 651 were collected in January 2022 which is a 4.2% response rate
- 634 were collected in February 2022 which is a 4.1% response rate (provisional data)

The target shortfall is primarily for three care groups with the exception of the acute care group who are above target. The Acute care group had a 17% response rate in January 2022 and a 15% response rate in February 2022. Graph 1 below shows the Trust PREM response rate going back to October 2020.

Graph 1 PREM response rate month on month tracking

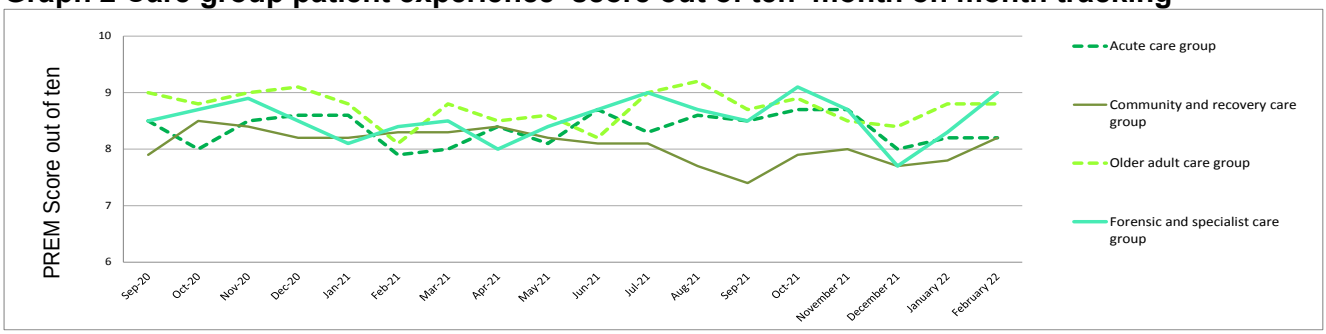


Analysis of the PREM results indicates a positive position for the Trust. The patient experience indicator is being well maintained with a score of 8.3 out of 10 in January 2022 and 8.3 out of 10 in February 2022. All of the care group are in the range where patients 'strongly agree' that they experience their services positively. The forensic and specialist care

group are achieving the best patient experience. The progress of the care group scores can be seen in Graph 2 below. It is vital that results and information on changes resulting from feedback should be made readily available to the public and patients so that they can see that feedback is being listened to and acted on.

The Trust-wide patient experience 'scores out of ten exception reporting' provides assurance for the targets set for the patient reported experience measures (PREM). The targets are being consistently met. There is variation but it is common cause variation which demonstrates that there is no significant change. Currently performance can be expected to vary in the range of between 8 and 9 out of 10.

Graph 2 Care group patient experience 'score out of ten' month on month tracking



Patient Friends and Family Test (FFT)

In terms of how we compare nationally and regionally for the quantity of NHS FFT submitted, the analysis is positive. We are exceeding the national response rate (note: there is no formal national target). KMPT submitted 4% compared with all mental health trusts who submitted 2% in November 2021. We are exceeding a regional response rate comparison with Sussex Partnership NHS Foundation Trust who submitted 2%. The NHS FFT tracking in Graph 3 below shows the month on month tracking of the NHS FFT response rate.

In terms of how we compare nationally and regionally for performance, analysis observes improvement which requires maintenance. We were above the national 'positive percentage' in November 2021 where nationally patients were 86% positive about their experience (down by 1% from October 2021). For KMPT, patients were 88% positive about their experience (compared to 86% in October 2021). This is in the range where overall patient experience of our services is 'very good'. KMPT is exceeding regionally as Sussex Partnership NHS Foundation Trust patients were 77% positive. The NHS FFT tracking in Graph 4 below shows the month on month tracking of the NHS FFT 'positive percentage'.

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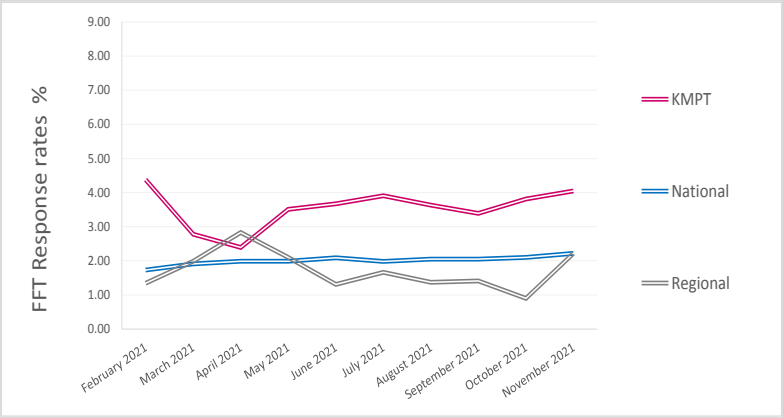
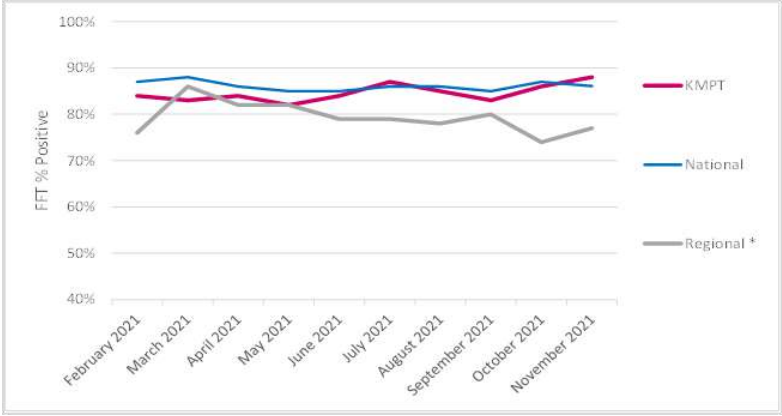
Graph 3 NHS FFT response rate month on month tracking



Graph 4 NHS FFT positive percentage month on month tracking



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IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N	82.6%	84.4%	82.4%	84.4%	87.2%	85.1%	82.5%	85.6%	87.8%	81.3%	84.5%	84.9%
003.C	Complaints - actuals		-	-	29	36	48	45	28	47	36	46	34	33	26	37
004.C	Complaints - per 10,000 contacts		-	-	6.88	9.29	12.84	11.27	7.19	13.36	9.83	12.94	8.78	10.15	7.25	10.99
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	100.0%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.0%	99.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	100.0%	100.0%	95.0%	98.0%	98.0%	98.0%	100.0%	96.0%	98.0%	100.0%	98.0%	98.0%
007.C	Compliments - actuals		-	-	122	111	100	120	141	121	106	106	195	148	187	131
008.C	Compliments - per 10,000 contacts		-	-	28.93	28.65	26.74	30.06	36.20	34.39	28.93	29.83	50.38	45.53	52.16	38.93
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%	99%	100%	100%	100%	100%	100%	99%	99%	98%
012.C	PALS - actuals		-	-	110	97	75	94	83	62	70	85	95	57	78	70
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	447	372	550	591	611	541	526	585	641	653	651	634
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	2.8	2.4	3.5	3.7	3.8	3.6	3.3	3.8	4.0	4.6	4.2	4.1
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.1	8.3	8.2	8.3	8.4	8.3	8.2	8.2	8.4	8.0	8.1	8.2

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

Ongoing challenges of meeting **waiting times within CMHTs and CMHSOPs** due to recent increases in referrals, creating additional pressure on already pressured capacity**.**

Executive Commentary

	013.R - 0.15R: Referrals	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Acute			1,385		1,517.0	2,269.3	1,893.1
2	CRCG			5,246		4,401.5	6,449.1	5,425.3
3	FSS			1,373		1,549.5	2,110.3	1,829.9
4	OPMH			1,439		1,261.9	1,696.6	1,479.2
5	Trust Total			9,443		9,169.6	12,085.5	10,627.6

Interpretation of results (Trust wide)	
Variation	Special cause variation of a reducing nature
Assurance	N/A – not set target

Narrative

Following a period of increased referrals in many care groups, three of four care groups are now shown as special cause variation of reducing nature. Only OPMH continue to show common cause variation. Within the OPMH Care Group CMHSOPs continue to show Special Cause variation, driven by Maidstone CMHSOP due to sustained higher pressure compared to the mean of the last 18 months.

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	Referrals Received	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			73.0		42.2	105.7	73.9
2	Canterbury CMHSOP			147.0		103.7	194.2	148.9
3	DGS CMHSOP			111.0		69.2	143.7	106.4
4	Dover & Deal CMHSOP			57.0		31.3	90.4	60.8
5	Maidstone CMHSOP			147.0		107.9	154.5	131.2
6	Medway CMHSOP			135.0		94.0	160.7	127.3
7	Sevenoaks CMHSOP			70.0		40.8	86.2	63.5
8	Shepway CMHSOP			77.0		35.8	110.0	72.9
9	Swale CMHSOP			46.0		30.0	76.6	53.3
10	Thanet CMHSOP			110.0		76.5	131.5	104.0
11	Tunbridge Wells CMHSOP			72.0		51.3	85.8	68.6
12	CMHSOP Total			1,045.0		858.0	1,164.0	1,011.0

	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**CRCG**			65.3%	95.0%	55.7%	92.3%	74.0%
2	**OPMH**			55.4%	95.0%	27.0%	68.3%	47.6%
3	**Trust Total**			59.2%	95.0%	41.1%	72.0%	56.6%

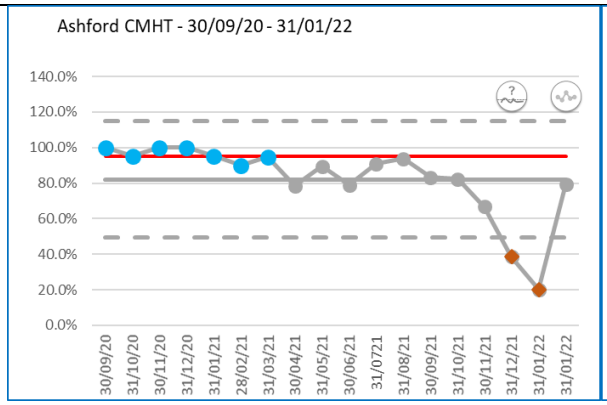
Interpretation of results (Trust wide)	
Variation	Common Cause - no significant change in month
Assurance	Variation indicates consistently **failing short of target**

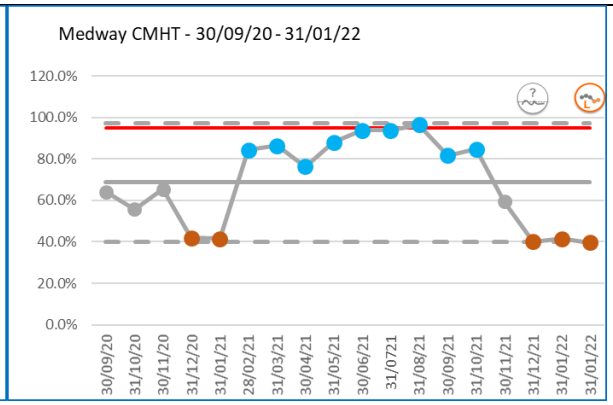
Narrative

The challenges concerning this measure are generally an issue of demand outstripping capacity and with referral rates having recently been high (above historic levels). There is significant work in place as previously noted in the IQPR and at subcommittees to address the challenges.

Having shown special cause variation of a concerning nature in January CMHTs have improved their position in February and are now subject to common cause variation.

It is positive to note the increase in performance for Ashford CMHT following previous decreases highlighted in previous reports. The remaining CMHT showing special cause variation of a concerning nature is Medway CMHT who have experienced three months around the lower control level.





The Medway CMHT continues to show a decline as a result of long-term sickness and the significant backlog this created. 2 x full time clinicians are job planned to complete assessments until the backlog of assessments are cleared. This would routinely be 1 full time clinician. The team have also got 3 assessment days booked in for end of March / April to increase availability of slots.

Older Adult performance against the 4 week wait in February is 43.8% (up 14.5% in month) for routine Memory Assessment Service (MAS) and 82.3% (up 21.4% in month) for functional and complex dementia referrals. This is to be commended and demonstrates the clinical prioritisation of patients being seen within 28 days. Referral rates have been high, but as previously noted are now levelling off around 1000 per month consistently. Additional memory assessment clinics which have been delivering 50 additional assessments per month since mid-September will cease to operate at the end of March 2022 as plan.

Work is ongoing to define the Memory Assessment pathway and agree the most suitable measurement of access for this patient group with the intention to introduce new measures during 2022/23.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			92.1%	95.0%	86.2%	97.9%	92.1%
2	OPMH			72.7%	95.0%	59.5%	81.6%	70.5%
3	Trust Total			81.7%	95.0%	73.3%	86.3%	79.8%

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	

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Overall performance (81.7%) improved by 4.9% in month but remains below previous levels achieved, as recently as August 2021 performance was in excess of 89% and increasing monthly.

The increased referrals observed in the summer has the potential to impact this indicator in future months as patients progress through assessment and into treatment. This will be subject to ongoing monitoring through existing weekly waiting list management processes.

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IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	80.0%	71.4%	69.2%	75.0%	87.5%	78.6%	85.2%	82.8%	75.0%	73.7%	81.3%	85.7%
005.R	% of Liaison (urgent) referrals seen within 1 hour		-	-	82.5%	93.1%	88.3%	87.5%	85.7%	85.6%	83.9%	80.0%	89.3%	87.3%	79.8%	78.9%
006.R	% of Liaison (urgent) referrals seen within 2 hours		-	-	90.7%	88.2%	93.9%	89.1%	90.2%	96.0%	91.3%	93.8%	95.3%	92.1%	91.6%	93.0%
007.R	DNAs - 1st Appointments		-	-	11.3%	8.3%	8.7%	9.8%	11.0%	11.2%	11.5%	11.2%	10.3%	9.6%	10.0%	10.7%
008.R	DNAs - Follow Up Appointments		-	-	9.4%	8.1%	8.2%	10.7%	12.4%	9.8%	8.7%	8.5%	8.4%	7.8%	8.5%	7.8%
009.R	Patient cancellations- 1st Appointments		-	-	0.8%	1.5%	1.4%	2.0%	1.9%	2.0%	2.5%	1.9%	2.1%	2.7%	2.2%	1.9%
010.R	Patient cancellations- Follow Up Appointments		-	-	2.7%	3.5%	3.9%	3.9%	4.2%	4.5%	4.5%	4.5%	4.9%	5.0%	4.7%	4.9%
011.R	Trust cancellations- 1st Appointments		-	-	3.3%	2.9%	3.5%	3.9%	4.3%	3.9%	4.6%	4.9%	5.2%	5.4%	4.0%	3.9%
012.R	Trust cancellations- Follow Up Appointments		-	-	8.9%	8.0%	8.8%	8.9%	8.5%	9.7%	10.2%	10.4%	10.0%	10.8%	10.4%	11.4%
013.R	Referrals Received (ave per calendar day)		-	-	399.0	360.0	361.6	372.0	359.5	335.1	345.5	320.9	341.6	299.0	308.8	325.6
014.R	Referrals Received (ave per working day)		-	-	459.6	427.4	458.7	434.8	427.0	405.9	404.7	400.5	406.3	371.7	388.7	402.8
015.R	Referrals Received (per 10,000 Kent and Medway Registered GP population))		-	-	744.7	643.0	633.0	696.3	697.8	631.1	653.3	621.7	649.3	574.1	572.7	576.4
016.R	Referral to Assessment with 4 weeks Care Spell		95%	-	70.4%	68.9%	67.7%	63.6%	62.1%	57.3%	43.8%	51.4%	55.4%	59.0%	44.7%	59.2%
017.R	Referral to Treatment within 18 weeks Care Spell		95%	-	78.6%	84.1%	87.7%	90.0%	88.8%	89.1%	83.3%	83.5%	83.4%	80.2%	76.8%	81.7%
018.R	% Patients waiting over 28 days from referral		-	-	23.1%	28.0%	30.4%	28.5%	33.7%	43.3%	41.2%	39.9%	37.5%	45.0%	39.0%	35.9%
019.R	Urgent referrals seen within 72 Hours		95%	-	63.1%	59.6%	62.3%	62.4%	59.2%	62.6%	59.8%	60.4%	61.3%	65.1%	62.3%	60.2%

A further breakdown of 016.R is provided below which shows performance by all contributing teams with an additional split of CMHSOP activity.

016.R - Service Type & CMHSOP Split	Target	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Feb-22 Care Spell Assessments	Feb-22 Average Wait (days)
CMHT	95%	86.6%	74.8%	75.1%	72.4%	79.1%	73.9%	66.4%	76.0%	74.5%	69.0%	55.1%	65.3%	415	31.4
Open Dialogue	95%	0.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100.0%	100.0%	66.7%		0	-
CMHSOP*	95%	61.3%	65.4%	63.9%	58.9%	51.2%	48.5%	30.4%	39.9%	46.2%	53.9%	39.4%	55.4%	680	37.4
CMHSOP routine memory assessment	95%					42.7%	40.3%	22.1%	32.5%	37.9%	46.9%	29.2%	43.8%	473	43.7
Functional, Urgent, Complex Memory Ass.	95%					64.6%	63.6%	51.2%	57.4%	63.3%	63.9%	60.8%	82.3%	203	22.9

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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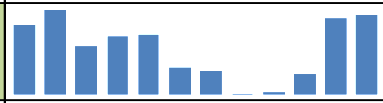
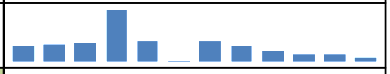
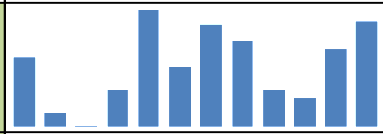
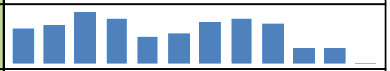
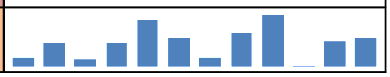
IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Jan-22	Feb-22	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%	98.5%	98.6%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		78.6%	85.0%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		136	125	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	81.3%	85.7%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.6%	95.4%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	4.0%	4.3%	4.3%	
002.C	Mental Health Scores From Friends And Family Test – % Positive		84.5%	84.9%	

**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).

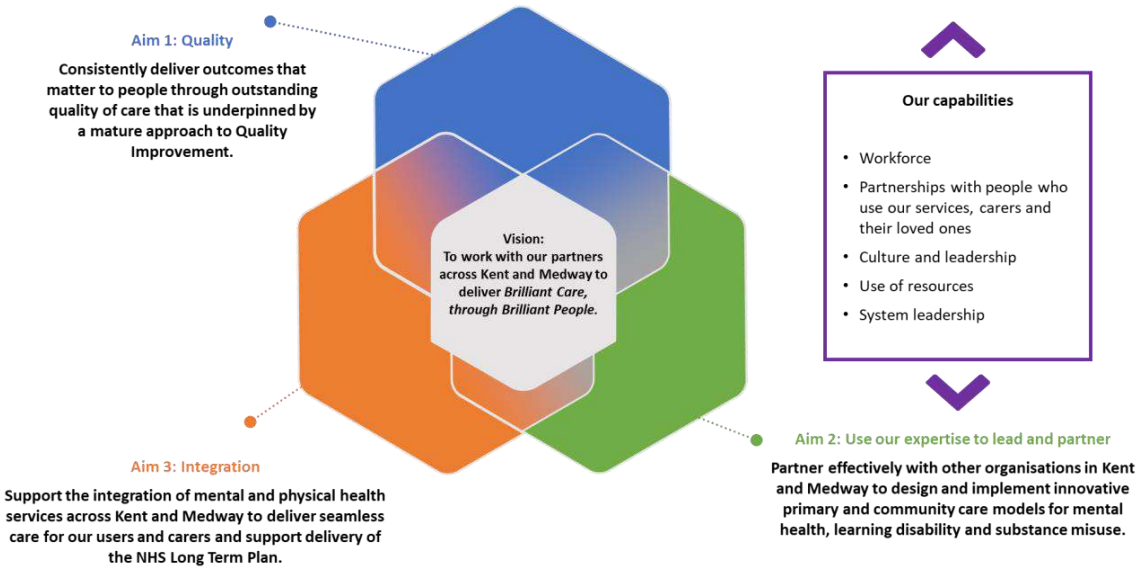
Good examples of IQPRs from high performing organisations change and improve over time. KMPT's is no different, and continues to be adjusted and improved in the light of feedback from internal and external stakeholders. Any changes to indicators are clearly documented and the report will include the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


Aim 1: Quality
Consistently deliver outcomes that matter to people through outstanding quality of care that is underpinned by a mature approach to Quality Improvement.
Vision:
To work with our partners across Kent and Medway to deliver Brilliant Care, through Brilliant People.
Our capabilities
Workforce
Partnerships with people who use our services, carers and their loved ones
Culture and leadership
Use of resources
System leadership
Aim 2: Use our expertise to lead and partner
Partner effectively with other organisations in Kent and Medway to design and implement innovative primary and community care models for mental health, learning disability and substance misuse.
Aim 3: Integration
Support the integration of mental and physical health services across Kent and Medway to deliver seamless care for our users and carers and support delivery of the NHS Long Term Plan.

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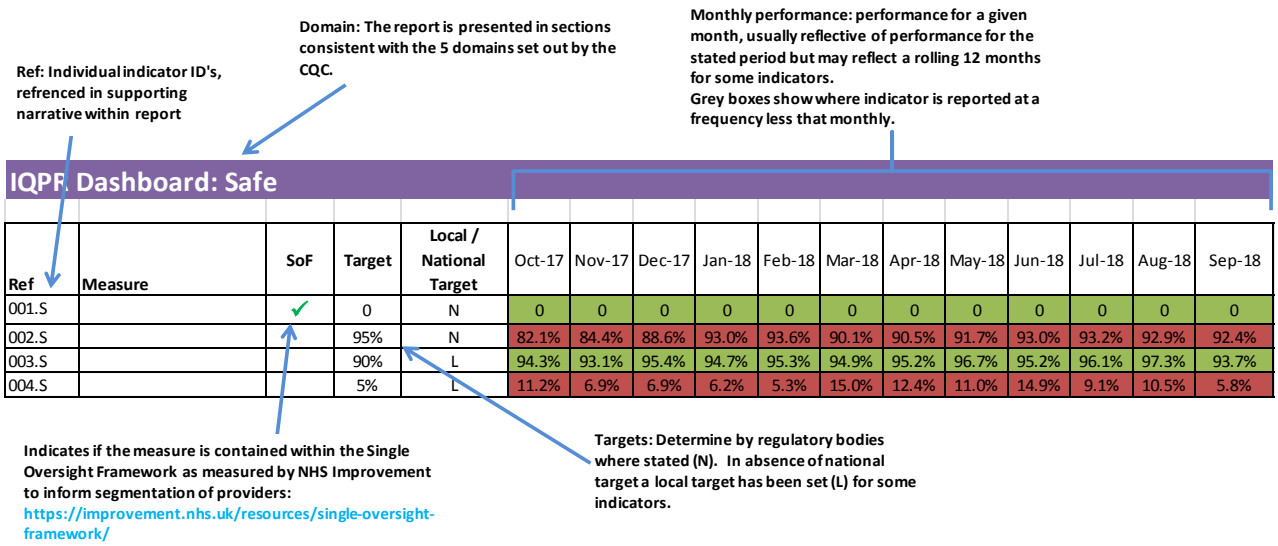
NHS and Social Care Partnership Trust

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.



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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:

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

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Finance Report for month 11 (February 2022)
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 11 (February 2022). This is consistent with the position submitted to NHS Improvement in the Month 11 Financial Performance Return.

Items of focus

As at the end of December 2021, Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with forecast and expectation for H2.

The 2022/23 draft plan was submitted on 17 March with the final plan submission due for submission on 28th April. Business planning continues internally with Check and Challenge sessions planned for early April.

Focus needs to also remain on ensuring a breakeven position is delivered for this financial year.

1. The 21/22 efficiency target has a small unidentified balance and it is imperative that focus must be on identifying recurrent and sustainable efficiencies for the forthcoming financial year. Whilst work continues on the efficiency programme there are very few robust delivery plans in place which urgently needs to be addressed across the organisation.

2. Agency control totals for each care group have been put into place which continue to not be delivered against. Further changes have however been made within Medical which will see further reductions in spend in the next financial year. Weekly meetings continue to take place to monitor the agency utilisation position

3. Page five of the finance report highlights the exceptions to bring to the Board's attention: Temporary Staffing Spend: Agency, Private Placement Spend, Planned and Reactive maintenance and Clinical Supplies.

The Trust Capital year to date position is underspent by £7.2m, of which £3.6m relates to estates and £3.8m on strategic schemes and the Improving Mental Health Services programme.

The cash position remains strong at £21.95m at the end of February.

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

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Finance Report

Trust Board

February 2022

Kent and Medway NHS and Social Care Partnership Trust

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Kent and Medway NHS and Social Care Partnership Trust

Executive Summary

Key Messages for February 2022

At the end of February, the Trust continues to report a breakeven position both in month and year to date. This is in line with the expectation for H2.

The Business planning process for 2022/23 has continued to progress with the draft planning template submitted to the national team on 17th March. Final plans are due on 29th April. Discussions with K&M CCG have taken place to ensure the income envelope represent commitments made to date and include new investment for 22/23. Discussions continue with other Commissioners.

The Long Term Sustainability Programme delivery plan continues to be monitored on a weekly basis to ensure pace and progress is maintained on efficiency savings. The plan identifies key objectives for each of the pillars, to which Deputy leads have been aligned and are providing a weekly progress update to the Executive team. Deep Dives have been completed for operational services that review service line reporting and support action plans to reduce the underlying deficit. CIP plans for 22/23 are still to be finalised.

Income and Expenditure

Within the breakeven position reported, there are several key factors. There are continued high use of temporary staffing due to vacancies and staff absence. Year to date agency spend at the end of February was £6.8m, £1.1m lower than the same period last financial year.

Agency spend decreased in month, some of which is expected due to February being a shorter month. Medical agency has reduced following the regular agency review meetings set up by the Executive Director of Finance, the Executive Director of Workforce and OD and Medical Director. Nursing agency has reduced particularly in Community Recovery.

There are still high levels of spend in Estates maintenance as we address backlog issues across the Trust

Year to Date

	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(205,399)	(203,516)	1,882
Employee Expenses	157,663	155,113	(2,550)
Operating Expenses	43,097	43,610	512
Operating (Surplus) / Deficit	**(4,638)**	**(4,794)**	**(155)**
Finance Costs	4,638	4,794	155
(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 year to date position is underspent by £7.2m, £3.6m on estates and £3.8m on strategic schemes and the Improving Mental Health Services programme.

The forecast of £9.6m has been updated to reflect changes in timelines for commencement of estates schemes. No organisations within the Kent and Medway system were able to utilise the additional slippage, as a result we will not receive this back in 2022/23 which will put pressure on the future capital programme. Tthe slippage will be used to support the national capital position.

The draft plan submitted by KMPT for 2022/23 totalled £24m and includes ward refurbishments, estates maintenance and digital developments.

Cash

The cash position increased by £0.9m in month to £22m mainly due to additional cash received from CCG related to Integrated care team, Dementia crisis and MAS recovery.

The forecast for year-end has been increased by £1.5m to £20m reflecting the change in the capital expenditure forecast.

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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	(19,120)	(18,996)	124	(205,399)	(203,516)	1,882
Employee Expenses	14,558	14,435	(123)	157,663	155,113	(2,550)
Operating Expenses	4,130	4,149	19	43,097	43,610	512
Operating (Surplus) / Deficit	**(432)**	**(412)**	**20**	**(4,638)**	**(4,794)**	**(155)**
Finance Costs	431	412	(20)	4,638	4,794	155
(Surplus) / Deficit	**(0)**	**(0)**	**0**	**0**	**0**	**(0)**

Commentary

Pay continues to underspend and is £2.5m underspent at the end of February. Within this, substantive pay is £4.7m underspent. This is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives, some of which have commenced later than originally planned due to recruitment challenges. For these areas, corresponding income has also been deferred to match and performance is being closely monitored between the Trust and ICS colleagues.

Operating expenses are overspent by £512k. The key area contributing to the overspend is planned and reactive maintenance, where a renewed focus has been put on addressing backlog issues across our sites.

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)	(92)	75	(1,833)	(1,144)	689
Workforce	(1,000)	(100)	(27)	73	(900)	(269)	631
Service Line Reporting	(1,000)	(167)	0	167	(833)	0	833
Patient Pathways	(1,500)	(163)	(80)	82	(1,338)	(883)	455
Procurement and Purchasing	(1,000)	(100)	(41)	59	(900)	(451)	449
Commercial Development	(500)	(56)	(15)	40	(444)	(197)	247
Non-recurrent slippage	0	0	(304)	(304)	0	(3,073)	(3,073)
Total	**(7,000)**	**(751)**	**(559)**	**192**	**(6,249)**	**(6,017)**	**232**

Commentary

The majority of schemes are progressing through H2. Due to the nature of some of these schemes in-depth work needs to be undertaken with Care Groups and external stakeholders. To ensure the gap is mitigated for this financial year, non-recurrent slippage of £3.1m has been identified, with a forecast full year value of £3.4m. Currently the gap for 21/22 is £422k of the £7m full year target.

The agency spend targets are still in place and are monitored monthly and in addition to this weekly meetings are taking place to review medical agency spend and actions. A number of actions have already been agreed to reduce agency spend and are being monitored such as medics joining on a NHS Locum contract instead of agency placements. Whilst agency spend has seen some reduction, it is still exceeding the target set.

The SLR pillar has seen deep dive information being shared with Care Groups and these packs are a key driver in the Business Planning process for 22/23.

To ensure pace is maintained, a weekly delivery plan continues with key objectives for each of the pillars, to which Deputy leads have been aligned and will provide to EMT a weekly progress update.

Exception Report

Top 4 Variances

	Plan £000	Actual £000	Variance £000	Proportionate Overspend	Reported Last report
Agency	6,052	6,839	786	13%	16%
Planned and reactive maintenance	2,192	3,263	1,072	49%	61%
External Placements	2,485	2,746	261	11%	11%
Clinical supplies	2,851	3,003	152	5%	11%

1. Temporary Staffing Spend: Agency £786k

Although agency spend remains a high variance, the percentage is lower than that reported in January at 13% and total spend is 4.4% of the overall pay cost. This is forecast to remain at lower levels over the rest of the year. A separate deep dive report is being shared with Trust Board this month on temporary staffing use.

Weekly agency meetings are taking place to review the position and mitigations put in place to reduce the level of spend particularly within Medical. As a result some agency roles have been reduced and the benefits of this will continue into 2022/23.

	2017/18	2018/19	2019/20	2020/21	2021/22 YTD	2021/22 FOT
Bank	11,131	11,390	13,560	16,968	15,798	17,068
Agency	***6,924***	***6,459***	***6,395***	***8,740***	***6,839***	***7,590***
Total	18,055	17,849	19,955	25,708	22,637	24,658

2. Planned and reactive maintenance £1.072m

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. For 2021/22 this spend has increased and represents a significant year on year increase as well as an overspend against budget.

At the end of the month 11 spend is above budget by £1.1m. The Executive Director of Finance is working with the estates function and key suppliers to manage both spend and the overall maintenance schedule, whilst balancing this with the need to address backlog maintenance issues across our sites to maintain safety for patients and staff.

This continues to be an area of focus for the newly appointed Director of Estates.

3. External placements £261k

For 21/22 the Trust has seen an increase in spend on external placements and whilst the overspend has reduced during the year it does still present a financial pressure.

In February there was an average of 7 patients within PICU beds and an average of 4 patients in Acute beds. This is an increase compared to recent months. The Acute Care Group has seen an increase in spend when compared to previous months and the financial risk is being closely monitored and where necessary costs are being recharged to the Commissioner.

The level of funding provided for external placements within our block contract is being discussed as part of business planning with Commissioners and whilst levels of usage has reduced, it is imperative that this is addressed as a system and the Trust is funded at adequate levels.

4. Clinical supplies £152k

For 21/22 the Trust has seen a consistent increase in spend on Clinical Supplies. The overspend is predominantly within the Limbs and ECS service where spend clinical supplies have been higher than plan and have returned to pre-Covid levels. This percentage overspend has reduced again to 5% from the 11% reported last month

There has been an increase in the average cost per patient for this financial year which will continue to be monitored and are part of the 22/23 contractual discussions with NHS England.

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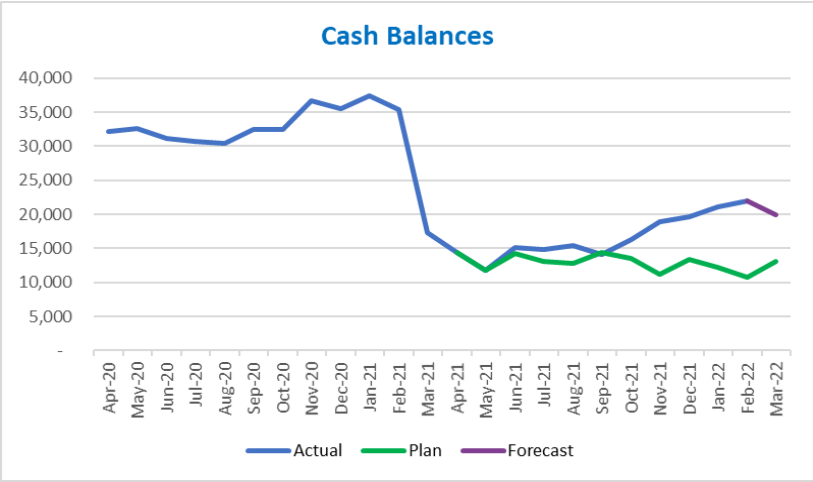
Appendices

Statement of Financial Position Overview

Statement of Financial Position	Opening 31st March 2021 Actual £000	Prior Month 31st January 2022 Actual £000	Current Month 28th February 2022 Actual £000
Non-current assets	130,002	129,828	130,003
Current assets	22,682	28,598	29,338
Current liabilities	(24,777)	(30,063)	(31,069)
Non current liabilities	(11,976)	(11,040)	(10,948)
Net Assets Employed	**115,931**	**117,323**	**117,323**
Total Taxpayers Equity	**115,931**	**117,323**	**117,323**



Commentary

Non-current assets

Non current assets has increased by £0.2m, reflecting the increased capital expenditure in February which offset depreciation.

Current Assets

The cash position remains strong with an increase of £0.9m, mainly due to additional cash received from CCG relating to the Integrated care team, Dementia crisis and MAS recovery. This is reflected in the movement in trade receivables.

Receivables have decreased by £0.1m. The reduction in trade receivables of £0.7m (discussed above) plus a decrease in prepayments of £0.3m, was largely offset by an increase in accrued income of £0.8m (mainly associated with Health Education Englant Learning Development Agreement and NHS Kent and Medway CCG) and the VAT receivable of £0.1m.

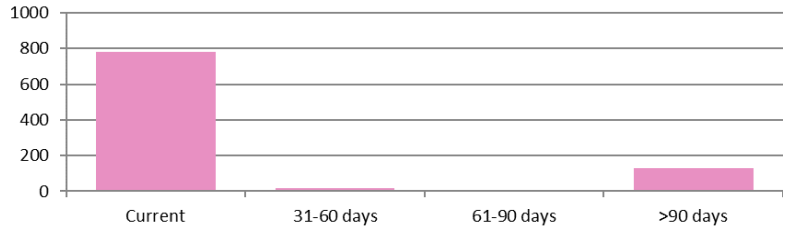
Current Liabilities

Trade and other payables have increased by £1m largely due to an increase in general accruals of £0.6m (mainly related to Clinical Excellence Awards and Catering) and the monthly PDC accrual of £0.3m.

Aged Debt

Our total invoiced debt is £0.9m, of which £0.8m is within 30 days. Debt over 90 days stands at £0.1m.

Aged Debt Analysis



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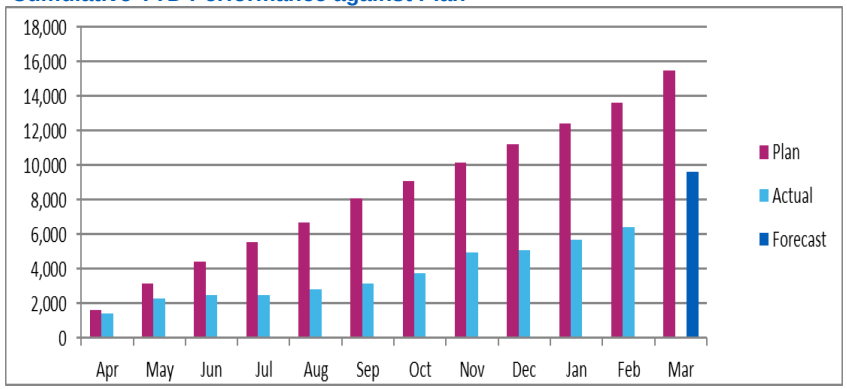
Capital Expenditure

	Current Month			Year to Date			Full Year	
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000	*Actual* £000	*Variance* £000	*Forecast* £000	*Plan* £000
Information Management and Technology	225	362	137	2,341	2,492	151	3,420	2,856
Capital Maintenance & Minor Schemes 2021/22	16	19	3	2,623	183	(2,440)	841	3,256
Capital Maintenance & Minor Schemes from 2020/21	0	253	253	3,100	2,120	(980)	2,825	2,799
Capital Maintenance & Minor Schemes Prior Year Adj	0	0	0	0	(143)	(143)	(143)	(143)
Strategic Schemes - Orchards Ward	0	10	10	1,045	687	(358)	700	910
Improving Mental Health Services (Maidstone)	984	47	(938)	4,482	1,023	(3,460)	1,923	5,787
PFI 2020/21	3	3	0	37	37	0	40	40
Total Capital Expenditure	**1,228**	**693**	**(535)**	**13,628**	**6,398**	**(7,230)**	**9,605**	**15,505**

Cumulative YTD Performance against Plan



Commentary

In February, the Trust spent £0.7m against the plan of £1.2m, £0.9m underspend related to the Improving Mental Health Services Programme, with increased spend on Estates due to more work taking place in the last few months of the year.

The year to date position is underspent by £7.2m, £3.6m on estates and £3.8m on strategic schemes and the Improving Mental Health Services programme. The main reasons for the underspend in estates are delays in completion of prior year schemes and commencing new schemes, and VAT reclaims/ retention adjustments.

The forecast shown reflects the likely-case in line with the position previously notified to the system. The forecast has been updated to reflect the rechanges in timelines for commencement of estates schemes. The increased slippage in the programme will place further pressure on the capital budget for 22/23 which will be closely monitored and managed via the Trust Capital Group.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 31st March 2022

Title of Paper: The Year of the Community Team Update

Author: Dr Kirsten Lawson and Dr Efiong Ephraim. Clinical Directors

Executive Director: Helen Greatorex Chief Executive

Purpose of Paper

Purpose: Noting

Submission to Board: Board requested

Overview of Paper

Over 2021/22 the year of the community team, there has been a significant quantity of work in relation to the 3 S's - Staffing, Streamlining and Specialism which are closely linked and interdependent.

There has been significant progression in workforce modelling with comprehensive skill mixing, including a range of training posts so that we can develop our own workforce of the future. External recruitment is improving with international recruitment as part of this. Rates of supervision and appraisal are excellent across discipline. Wellbeing is being focussed on and staff are reporting high levels of morale despite the challenges of the year.

The whole process from point of referral to transition back to primary care has been reviewed and key developments made to streamline the process for staff and patients. This has included using partner agencies much earlier in the clinical journey.

Finally, the Community Mental Health Transformation framework offers a once in a lifetime opportunity to relaunch 'community mental health' as a very distinct speciality in itself; akin to Mental Health of Learning Disability or Perinatal Psychiatry. Staff have responded very positively and are excited (and apprehensive) in relation to the changes that will need to happen. Cross KMPT workshops are in place to support the proposed operationalisation of the model and the associated governance required.

Issues to bring to the Board's attention

The first in a series of internal KMPT workshops in relation to the Framework was held on 23rd March 2022. From these workshops there will be proposals presented via our governance structures in relation to how we operationalise the significant transformation that the Community Mental Health Framework will require.

Governance

Implications/Impact: No risks identified from this update

Assurance: not applicable

Oversight:

Kent and Medway NHS and Social Care Partnership Trust

The Year of the Community Team Update

Background

Following the Board Seminar in March 2021, 2021/22 has been the year of the community team. This has included focus on 3 key areas of Staffing, Streamlining and Specialism, which as you can imagine are closely linked and interdependent.

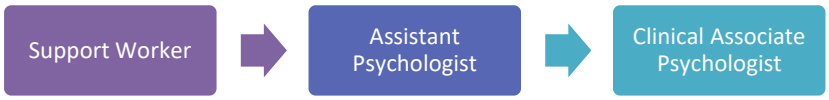
Within this paper we will outline the progress in the 3 areas over the past year whilst also looking forward to how these areas will be shaped in the next year(s). Unless specifically specified, this information relates to both younger and older adult teams.

Staffing

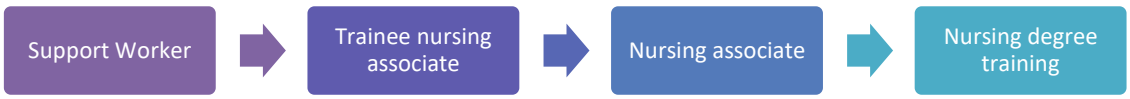
Workforce modelling

- A comprehensive skills mix has been undertaken in the teams and a number of new roles have been implemented including Clinical Associate Psychologists, Mental Health Wellbeing Practitioners, Assistant Psychologists, Mental health Social Workers, Clinical Nurse Specialists, Advanced Clinical Practitioners, Non-medical Prescribers, Nurse Degree Apprenticeships, OT Degree Apprenticeships, Trainee Nursing Associates, Trainee health & wellbeing practitioners and expanded support workers including peer support workers. This has enabled the professionally qualified staff to focus on delivering interventions within their specialism which has been well received.
- Within the professional groups we have used any existing vacancies to support reconfiguring the structure of the qualified establishment – reducing the number of higher banded posts to create a more equitable career progression within the teams. This will enable us to retain and develop staff throughout their career whereas previously they would have had to look elsewhere.
- We have been clear to include training roles to develop a sustainable workforce of the future. 'Real life' career journeys are included below to show how we can support staff to progress:

JF's career journey so far…



HC's career journey so far…



JMcK's career journey so far…

Recruitment

- International nursing recruitment – 6 nurses in the first cohort (across younger and older adult) and posts identified for further cohorts
- The vacancy rates and turnover rates within the teams remains relatively stable, however it is noted from exit interviews that staff who are leaving are increasingly moving to career progression within KMPT as opposed to leaving the teams or organisation.
- There have been an increased number of external appointments, enhanced by the larger range of roles available and the focus on qualified professionals delivering their specialist skills. The recruitment process can now follow a competency-based approach which increases the number of available candidates.
- Excellent appraisal and supervision compliance rates. The teams have seen an improved position with Medical Supervision compliance from 58% in February 2021 to 71% in February 2022 with the CMHT Medics achieving a 90% compliance rate for the Window that closed on 2nd February.
- Robust Job Plans are in place for every staff member
- Essential Training performance has been maintained
- Continued reduction in agency spend including Medical Agency usage

Wellbeing

- Staff sickness overall has remained static although there have been periods of increased COVID related sickness during the year. Wellbeing initiatives are in place in each team to support staff rebuild resilience and focus on their wellbeing
- CLiQ checks within younger adult CMHTs consistently report good levels of morale despite the challenges in relation to demand
- The Community Recovery Care Group have seen an improvement on their Staff Survey Engagement score for the last 4 years

Streamlining

The whole process from point of referral to transition back to primary care has been reviewed and key development points are highlighted below:

- Referral screening occupies a significant quantity of time, with 30-40% of referrals in younger adult teams being signposted elsewhere. We have created multi agency referral screening meetings with Live Well Kent and Medway and Primary Care Mental Health Services (initially) which enables an alternative provider to accept the referral directly; saving time and improving the patient journey. The Local Medical Committee representing GPs has been involved and are in full agreement with the process. By early May '22 this system will be in all younger adult CMHTs with a view that additional agencies e.g. substance misuse services will join with the eventual aim that all age functional referrals will be reviewed in this format
- Initial assessment processes for both functional and memory assessments have been streamlined to reduce the time required on RiO
- The Clinical Care pathways menu of interventions implementation has enabled staff to deliver interventions that match their skill set. This has created clear pathways of care for patients and a clinical framework which enables regular review of needs and where the person is in their recover journey. This encourages regular consideration of engagement with 3rd sector organisations and self care strategies.

- Red Board meetings and the duty systems have reviewed to enable timely responses to deteriorating patients and patients in crisis
- Where specific interventions have not been available we have utilised cross locality working to share the clinical resources to ensure timely patient care. We have also made interventions available across age groups to ensure equity of access to the interventions as required
- Administrative processes have been reviewed and updated to release time to care for all professions and this is ongoing work in relation to how we can maximise our data quality within RiO
- Operational policies have been updated with improved streamlining of the clinical and administrative processes both within the teams and the interfaces between the teams e.g. SPoA, Liaison and Crisis teams – ensuring that SMART timescales for follow up are in place.
- There has been significant work and progress on system wide developments for a dedicated memory pathway including a range of providers.
- The Kent and Medway Care Record Service (shared information across providers) is live which has provided timely access to a wider range of clinical information.

Specialism

The year of the community team coincided with the start of the national programme of work implementing The Community Mental Health Transformation Framework which challenges all health and social care systems across England to implement the following before April 2024:

- Improve the clinical offer and care pathways across mental health provision from primary care through to specialist mental health care for patients with Severe and Enduring Mental Illness
- Focus on meaningful interventions and outcomes
- Develop robust community responses through partnership working and co-production
- Expand local based workforce including 3rd Sector and Voluntary Care Social Enterprise (VCSE)
- Cease the use of the Care Programme Approach (CPA)

Specific areas of transformation to be focussed on include the 'core model', 18-25 year olds, over 65year olds, community rehabilitation, complex emotional difficulties and eating disorders. This has provided the opportunity to relaunch 'community mental health' as a very distinct speciality in itself; akin to Mental Health of Learning Disability or Perinatal Psychiatry.

You will see that 'Community Mental Health Teams' are not specifically mentioned in these transformation areas and that is because the Framework includes proposals for CMHTs to be superseded by a multi-agency 'Core Model' and a 'Complex Interventions Team' within a Specialist Model.

Representatives from younger and older adults have been closed involved in the design process of the models from the bid stage through to ongoing partner agency workshops and will continue to be involved over the next 2 years.

As way of introduction, I am sharing the Kent and Medway's Framework 5 key principles and outline below in the text and Figure 1.

The level of support increases based upon the increasing complexity of needs; the model therefore draws upon the THRIVE framework for system change:

Getting advice - at an individual and family level to empower people to look after their own mental wellbeing and prevent deteriorating mental health

Getting help – at a local Primary Care Network (PCN) level (approx. 50K population) = Core model

Getting more help – at a locality level (approx. 250k population) = Specialist Model, including Complex Interventions Team

Getting risk support - risk support and management will be present in all groupings above. However, this separate category denotes those for whom despite extensive input are not able to use help and they remain a risk to self or others i.e. at a point of crisis.

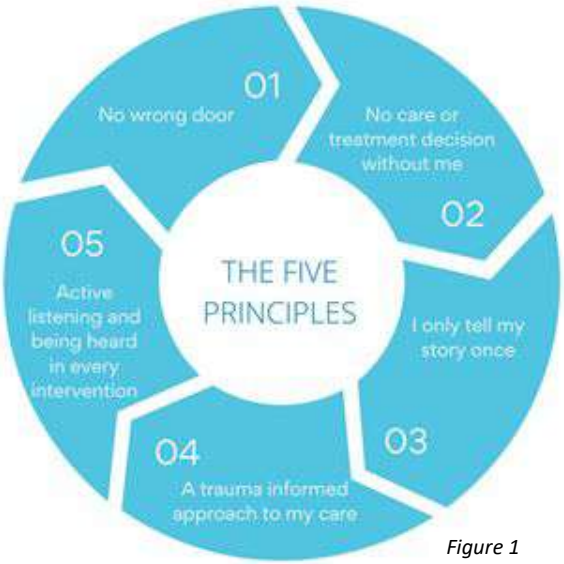


Figure 1

The 'Core Model' has been developed with views from an expert reference group comprising of key stakeholders, people with lived experience and clinicians across Kent and Medway. This is currently an iterative and evolving process, adapting and evolving for different local demographics and needs

Within Younger Adult CMHTs we have created a transitional model which will enable teams to start to navigate the significant transformation that will be required, whilst taking steps towards embracing community mental health as a speciality in its own right. Staff have responded very positively and are excited (and apprehensive) in relation to the changes that will need to happen.

The model has 3 clear components:

- Evidence based interventions; as per the Clinical Care Pathways programme
- Red Board Support; ensuring high quality safe care for people who require unscheduled input or who are experiencing an acute mental health episode in the community and promote consistency in the management and review of risks in the formulation of treatment plans and
- Active Support Active Support will deliver low intensity interventions and review the needs and risks of patients whilst they are waiting for a high intensity or specialist secondary care intervention. This will ensure that patients can access evidence-based treatments whilst monitoring their safety throughout their time with the CMHT.

Within Older Adult CMHTs there is an additional level of complexity to be navigated as the teams offer interventions to patients with functional illness and to those with organic illness (memory services) and so considered thought and engagement will be required to clarify the potential shape of services.

The first in a series of internal KMPT workshops in relation to the framework was held on 23rd March 2022. From these workshops there will be proposals presented via our governance structures in relation to how we operationalise this significant transformation and maintain the appropriate governance required.

Summary

Over 2021/22 the year of the community team, there has been a significant quantity of work in relation to the 3 S's - Staffing, Streamlining and Specialism which are closely linked and interdependent.

There has been significant progression in workforce modelling with comprehensive skill mixing, including a range of training posts so that we can develop our own workforce of the future. External recruitment is improving with international recruitment as part of this. Rates of supervision and appraisal are excellent across discipline. Wellbeing is being focussed on and staff are reporting high levels of morale despite the challenges of the year.

The whole process from point of referral to transition back to primary care has been reviewed and key developments made to streamline the process for staff and patients. This has included using partner agencies much earlier in the clinical journey.

Finally, the Community Mental Health Transformation framework offers a once in a lifetime opportunity to relaunch 'community mental health' as a very distinct speciality in itself; akin to Mental Health of Learning Disability or Perinatal Psychiatry. Staff have responded very positively and are excited (and apprehensive) in relation to the changes that will need to happen. Cross KMPT workshops are in place to support the proposed operationalisation of the model and the associated governance required.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Register of Board Members Interests – March 2022
Author:	Tony Saroy, Trust Secretary
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Noting
Submission to Board:	Regulatory Requirement

Overview of Paper

The paper sets out the Trust's Register of Board members' interests, which will be published on the Trust website.

Issues to bring to the Board's attention

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

It is the Trust's practice to formally update the Register of Interests twice a year but interests should be declared as they arise and opportunity is given at the start of each meeting to declare new interests or any specific to decisions or discussions during that meeting. The Register for the Board is attached.

All Board members have made declarations to the Trust Secretary who has the responsibility of maintaining the Register of Interests including where the member had no interests to declare.

This information will be made publicly available on the Trust website following the meeting.

Governance

Implications/Impact:	Compliance with regulatory requirements
Assurance:	Reasonable
Oversight:	Audit and Risk Committee/Remuneration and Terms of Service Committee

Version Control: 01

The NHS Code of Accountability and NHS England's guidance on managing conflicts of interest in the NHS requires Board Directors to declare any interests which are relevant and material to the Board. This includes any interest that could conflict with the impartial discharge of their duties and which could cause conflict between their private interests and their NHS duties.

Interests fall into the following categories:

- Financial Interests Where an individual may get direct financial benefit (or avoidance of a loss) from the consequences of a decision they are involved in making.
- Non-Financial Professional Interests Where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career.
- Non-Financial Personal Interests Where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career.
- Indirect Interests Where an individual has a close association with another individual who has a financial interest, a non-financial professional interest or a non-financial personal interest and could stand to benefit from a decision they are involved in making.

The Register of Interests is held by the Trust Secretary, in the Chief Executive's Office and Board Directors are asked twice a year to declare their interests

REGISTER OF BOARD MEMBERS INTERESTS
MARCH 2022

Director	Position	Interest declared
Jackie Craissati	**Trust Chair**	Jackie's current company, Psychological Approaches is on the NHS England framework for Independent Serous Incident Investigations but does not undertake investigations relating to KMPT. Jackie is Trustee on the Board of Samaritans and Independent Governor on the Board of the University of East London
Venu Branch	**Deputy Trust Chair**	None declared
Catherine Walker	**Non-Executive Director** (Senior Independent Director)	Catherine is Lay Chair of the Consultant Appointments Committee at Kings College Hospital NHS Foundation Trust, London Catherine works for Walkers Solicitors of which her husband, Ivan Walker, is the Principal. Walkers is an Employment law practice specialising in Pensions. Walkers acts for the majority of UK Trade Unions including a number of Trade Unions active in the Health sector. Walkers' Health sector Union clients are The Chartered Society of Physiotherapy, The Royal College of Midwives and the Prison Officers Association. (Walkers Solicitors do not act for the NHS but clients do negotiate with the NHS – declared to ensure full transparency) Member of an advisory and scrutiny Panel of the National Employment Savings Trust (' NEST') Corporation. NEST is the pension auto enrolment vehicle used by KMPT for workers who are not members of the NHS pension scheme.

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		Catherine is also a member of the Health Service Products (Pricing Cost Control and Information) Appeals Tribunal.
Fiona Carragher	**Non-Executive Director**	Fiona is an Executive Director – Alzheimer's Society and a Trustee of the UK Dementia Research Institute
Kim Lowe	**Non-Executive Director**	Kim is a Non-Executive Director – Central Surrey Health Kim is also a Non-Executive Director at Kent Community Health Foundation Trust. Lay member – University of Kent
Mikola Wilson	**Non-Executive Director**	None declared
Sean Bone-Knell	**Non-Executive Director**	None declared
Peter Conway	**Non-Executive Director**	Non-Executive Director – Kent Community Health NHS Foundation Trust
Helen Greatorex	**Chief Executive Officer**	Helen's husband is Director of Talking Therapies and may compete for business in the Trust's area. From 1 April 2019 Helen's husband commenced job with Priory
Vincent Badu	**Executive Director of Partnerships and Strategy**	None declared
Donna Hayward-Sussex	**Chief Operating Officer**	None declared
Sheila Stenson	**Executive Director of Finance**	Sheila is the Chair HFMA Kent, Surrey and Sussex
Afifa Qazi	**Executive Medical Director**	None declared
Andrew Cruickshank	**Chief Nurse**	None declared
Sandra Goatley	**Director of Workforce and OD**	None declared

Version Control: 01

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Managing Conflicts Policy
Author:	Tony Saroy, Trust Secretary
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Approval
Submission to Board:	Regulatory Requirement

Overview of Paper

A paper setting out the main changes to the Trust's Managing Conflicts – Interests, Gifts, Hospitality and Sponsorship

Issues to bring to the Board's attention

The Policy has been reviewed and a number of amendments made. At its March meeting, the Trust's Audit and Risk Committee agreed that the policy be put before the Trust Board for approval.

There are four main areas that have been updated within the policy, which are summarised as follows:

- The Policy has been made easier to read for frontline staff by breaking the policy into parts and collating linked paragraphs into one part, rather than dispersed as previously drafted.
- The introduction of the new ESR reporting system for any declarations of interests.
- Details on how the Trust is to handle any cash given to staff by service users.
- Information on legacy and bequests.

The Audit and Risk Committee has recommended an easy ready pamphlet be created to make it quicker for frontline staff to consider. Trust Secretariat will work with the Trust's Communications and Engagement Team to create that pamphlet.

Governance

Implications/Impact:	Ensuring the Trust is in line with best practice guidance and Annual reporting requirements
Assurance:	**R**easonable
Oversight:	Audit and Risk Committee

Version Control: 01

Summary of Key Changes

Paragraph No.	Change to Policy	Reason
	Terminology	Throughout the whole policy, wording has been updated from 'should' to 'must' to emphasise that staff must comply with this policy.
6.3 & Appendix 4	New reporting module on ESR	Reference has been made to the new reporting module on ESR for staff. Previously staff were asked to report via a paper form and email this to Trust Secretariat whereas the new ESR module will streamline the process and make it easier for staff to declare any declarations. A guidance document has also been added under appendix 4.
8.1	Monetary Value declarations	The policy now advises that any gift of monetary value should be declined under all circumstances however, when a monetary value gift is left for a staff member without their knowledge this must be surrendered to the Finance department, who will apply the money in accordance with the relevant Finance department rules. The policy also now identifies that this also includes crowd funding.
10	Legacies & Bequests	A new section has been added to the policy for legacies and bequests left to staff. This section gives guidance to staff on what steps they need to take if they are unknowingly left a bequest or legacy. Reference has also been made to guidance from relevant staffing bodies, such as the NMC and GMC. Information has also been included on how legacies and bequests left to the Trust should be handled.

Version Control: 01

Kent and Medway
NHS and Social Care Partnership Trust

Managing Conflicts – Interests, Gifts, Hospitality and Sponsorship

Policy and Procedure

Document Reference No.	KMPT.CorG.049.03
Replacing document	KMPT.CorG.049.02
Target audience	Trust wide
Author	Trust Secretary
Group responsible for developing document	Audit and Risk Committee
Status	Authorised
Authorised/Ratified By	Audit and Risk Committee
Authorised/Ratified On	TBC
Date of Implementation	TBC
Review Date	September 2024
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	September 2024
Number of Pages	34
Contact Point for Queries	kmpt.policies@nhs.net
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DOCUMENT TRACKING SHEET

Managing Conflicts – Interests, Gifts, Hospitality and Sponsorship Policy and Procedure

Version	Status	Date	Issued to/approved by	Comments
0.1	Draft	Nov 13	IARC	*First draft for IARC consideration*
1.0	Approved	Jan 14	IARC	Ratified
1.1	Draft	Jan 17	IARC	Trust Secretary review
2.0	Approved	April 17	IARC	Ratified
2.1	Approved	February 18	Policy Manager	Separated the Equality Impact Assessment screening from document. Amended 'service line' to 'care group' throughout the document.
3.0	Draft	Sept 18	Trust Secretary/IARC	Inclusion of Interest in GH&S policy Virtually approved.
4.0	Draft	Sep 21	Trust Secretary/ARC	Inclusion of legacy information, cash gifts & the new process for logging gifts and hospitality declarations
5.0	Draft	Feb 22	Trust Secretary/ARC	Adjustment to the flow of document to make it easier for front line staff

REFERENCES

Bribery Act 2010
Standards of Business Conduct for Staff, set out in HSG(93)5
Professional Codes of Conduct (GMC, NMC etc)
Mental Capacity Act
Commercial Sponsorship – Ethical Standards for the NHS, 2000
Code of Conduct and Code of Accountability in the NHS.
Code of Practice for the Pharmaceutical Industry Second 2012 Edition

RELATED DOCUMENTS

All Trust and health economy documents which relate in any way to this document	*Current Reference code of document*
Standing Orders and Standing Financial Instructions	KMPT.Fin.003
Code of Conduct	KMPT.HR.020
Whistle-blowing Policy (Raising Concerns, Being Open)	KMPT.HR.002
Anti Fraud, Bribery, Corruption Policy	KMPT.Fin.004
Procurement Policy	KMPT.Fin.007
Safeguarding Vulnerable Adults Policy	KMPT.CliG.006
Mental Health Act Policy	
Patient Monies Policy	KMPT.Fin.013
Personal Boundaries Policy	KMPT.HR.034
Fit and Proper Person Employed Policy	

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1 DOCUMENT SUMMARY

1.1 This policy sets out the Trust's approach to managing conflicts of interests including offers of gifts, hospitality and sponsorship. It provides clear guidelines as well as detailing the procedures to be followed. It reflects the Trust's core values – including specifically that of being open and honest – and aims to ensure that the conduct of staff is scrupulously impartial, honest and beyond reproach at all times. It alerts staff to the implications of the Bribery Act 2010 and provides protection for staff and the organisation from potential conflicts or accusations of inappropriate behaviour.

1.2 The document provides guidance on the interests to be declared and level of gifts, hospitality and sponsorship that it is appropriate to accept. It applies to all staff, directors, temporary staff and volunteers. It reminds staff that failure to adhere to this policy might result in disciplinary action being taken against them

1.3 To make it easier to read, the policy is split into various parts. Part A focuses on Declarations of Interests, Part B focuses on gifts, hospitality and sponsorship, Part C on more specific matters and Part D on procedures.

1.4 Summary of Declaring interests, gifts, hospitality and sponsorship

1.4.1 All interests must be declared. The interest can be actual or potential. Interests can be financial, non-financial, professional or personal and can be direct or indirect.

1.4.2 All offers of gifts, hospitality or sponsorship with a value of over £25 must be declared and recorded on the trust Gifts and Hospitality register, regardless of whether or not they are accepted. These can be obtained from Trust Secretary or use the form at Appendix 1 or available on the Intranet.

1.4.3 All gifts, hospitality or sponsorship with a value over £25 must be authorised by your line manager or director before being accepted.

1.4.4 All offers of gifts, hospitality or sponsorship with a value over £100 must be approved by the relevant Service Director or Executive Director (or Chair in the case of Non-executive Directors).

1.4.5 If staff are in any doubt as to whether the offer of a gift, accepted or not, must be recorded in the Register they should err on the side of caution and declare it.

2 RESPONSIBILITIES AND DUTIES

2.1 The **Chief Executive**, as Accountable Officer, has the overall responsibility for this policy.

2.2 The **Chair** is responsible for ensuring that Non-Executive Directors (NEDs) are made aware of the policy and understand their responsibilities regarding declarations of interests and the acceptance of gifts and hospitality.

2.3 The **Director of Finance** is the nominated officer in relation to the Bribery Act 2010.

2.4 The **Trust Secretary** will provide advice and guidance in relation to the application of this policy. The Trust Secretary is also responsible for maintaining the Corporate Register of Interests and the Corporate Register of Gifts, Hospitality and Sponsorship and escalating concerns to the Chair, Chief Executive or Directors as appropriate.

2.5 **Executive Directors, Care Group Directors, Assistant Medical Directors** are responsible for considering, agreeing action to be taken and approving the receipt of gifts, hospitality and sponsorship in accordance with the policy set out below. Directors are responsible for ensuring that staff within their directorate are made aware of the policy and understand their responsibilities regarding declarations of interests and the acceptance of gifts and hospitality and maintaining their Directorate Registers.

2.6 **Assistant Directors, Lead Nurses, Service Managers and Ward Managers** are responsible for ensuring that their staff are aware of and adhere to the policy.

2.7 **Line managers** must also sign off any declarations of gifts or hospitality made by staff.

2.8 **All individuals** to whom this policy applies are responsible for ensuring that they adhere to this policy and where directed seek approval in advance, record and declare interests, hospitality and sponsorship and record, declare and surrender gifts. Additionally, all individuals must seek approval in advance of giving any gifts or hospitality and record these as set out in the related procedure. They are recommended to refuse all offers of gifts or hospitality which might be seen to compromise their personal judgment or integrity.

2.9 **Audit and Risk Committee**
The Audit and Risk Committee is responsible for ratifying the policy and ensuring that it is monitored through the Trust Internal Audit Programme or Counter Fraud Workplan. The Trust Board will review the Register of Interests annually. The Audit and Risk Committee will also review the Gifts and Hospitality Register twice yearly to confirm compliance with the policy.

2.10 **Local Counter Fraud Specialist (LCFS)**
The LCFS is nominated to receive allegations of bribery on behalf of the Trust to ensure that they are dealt with in accordance with the procedures under The Bribery Act legislation. Their contact details are included in Section 8 of this document. Alternatively contact the NHS Fraud and Corruption Reporting Line (0800 028 40 60) or the online fraud reporting form at www.reportnhsfraud.nhs.uk

3 PRINCPLES

3.1 Principles of good governance for consideration include those set out in the following:

- The Seven Principles of Public Life (commonly known as the Nolan Principles)
- The Good Governance Standards of Public Service
- The Seven Key Principles of NHS Constitution
- The Equality Act 2010
- The Bribery Act 2010

3.2 The Bribery Act 2010 (the Act) has consolidated previous UK Legislation relating to Bribery and introduces four new offences which are set out below:

3.2.1 Making a bribe – the promise or giving of an advantage with the intention of inducing or rewarding the improper performance of a relevant function or activity;

3.2.2 Accepting a bribe – the receipt or acceptance of an advantage for the improper performance of a relevant function or activity;

3.2.3 Bribery of a foreign official where the intention is to influence an individual in the official capacity in order to win or retain business; and

3.2.4 Failing to prevent bribery, this is a strict liability corporate offence where a commercial organisation fails to prevent bribery by those performing services on its behalf.

3.3 Since the introduction of the Act industry and public focus has centred on Gifts, Hospitality and Sponsorship.

3.4 The prosecution of offences under the Act suggests that sensible, reasonable hospitality, gifts or promotional expenses (and business trips) which, in their broader context, are not aimed at influencing performance and decision making, will remain outside the scope of the Act. Only where the payment, gift or hospitality is extraordinary or lavish, or has the ability to influence or reward improper behaviour by the recipient, will the payment be considered under the Act.

3.5 The Act makes offering or accepting bribes illegal, therefore adherence to this policy places a number of responsibilities on individuals which are set out clearly in this policy.

3.6 In addition, in May 1995 the Nolan Committee set out the 'Seven Principles of Public Life' which apply to all in the public service. These Principles have been adopted by the Board and are shown as Appendix 1 for reference. They are relevant to this policy in terms of the conduct the Trust expects of its staff in their dealings with sponsors, partners and suppliers and apply equally to giving or receiving gifts, hospitality and sponsorship.

3.7 Breaches of this policy will be investigated under the Trust's disciplinary policies and procedures, and where bribery is suspected the individual will be subject to criminal investigation by the Local Counter Fraud Specialist and referred on to the City of London Police.

3.8 Should any member of staff have a concern about the application of this policy by other individuals please refer to the Trust's Raising Concerns at Work Policy for guidance or contact the Trust Secretary.

3.9 This policy applies to gifts, hospitality and sponsorship offered to or given by members of staff as an employee of the Trust. However, staff must not seek out or accept beneficial rates or benefits in kind for private transactions carried out with suppliers with which they have, or may have, official dealings with on behalf of the Trust. This does not apply to schemes negotiated for all employees e.g. discount schemes with local businesses etc.

PART A – DECLARATIONS OF INTERESTS

4 DEFINITION

4.1 A conflict of interest includes any situation in which an individual or corporation is in a position to exploit a professional or official capacity in some way for their personal or corporate benefit, or where an individual's ability to exercise judgment or act in one role is or could be impaired or otherwise influenced by his or her personal or professional involvement in another role or relationship. The conflict exists even if the individual does not actually exploit his or her position or obtain an actual benefit, financial or otherwise.

4.2 A conflict of interest may be:

- Actual - there is a material conflict between one or more interests
- Potential – there is the possibility of a material conflict between one or more interests in the future

4.3 The perception of a conflict of interest can be damaging even if none exists, so it is important always to err on the side of caution and to declare any interest or role where there might be perceived to be the potential for conflict.

4.4 Interests fall into the following categories:

1. **Financial interests**: where an individual may get direct financial benefit from the consequences of a decision the individual are involved in making;
2. **Non-financial professional interests**: where an individual may obtain a non-financial professional benefit from the consequences of a decision they are involved in making, such as increasing their professional reputation or promoting their professional career;
3. **Non-financial personal interests**: where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit, because of decisions they are involved in making in their professional career;
4. **Indirect interests**: where an individual has a close association with another individual or entity who or which has a financial interest, a non-financial professional interest or a non-financial personal interest who would stand to benefit from a decision they are involved in making.

5 DECLARATION OF INTERESTS – FOR TRUST BOARD MEMBERS & LEADERSHIP TEAM

5.1 All relevant interests must be declared by Board of Directors and the Leadership Team at their earliest opportunity (no later than 28 days of the interest arising), on joining the Trust and on an annual basis to the Trust Secretary. This includes, but is not limited to, any Directorship of a company, any interest in an organisation providing health and social care services to the NHS, a position of authority in a charity or voluntary organisation in the field of health and social care, any affiliation to a special interest group campaigning on health and social care issues, and any connection with an organisation or entity entering into or having entered into financial arrangement with the Trust, including but not limited to, banks or lenders.

5.2 Every such declaration shall be formally recorded on the register and, where relevant, the minutes.

5.3 Directors must also declare details of any significant transactions which they, their close families or entities controlled by any of these, have undertaken with the Trust or anyone associated with the Trust, such as management contracting, NHS mergers or acquisitions, and operating in competition with the Trust. The Trust is required to disclose in its annual report details of such transactions. Board members and the Leadership Team should notify the Trust Secretary within 28 days of any changes to the declarations of interest.

5.4 The Board should refer to its Standing Orders for guidance on managing conflicts of interest in Board meetings.

6 DECLARATION OF INTERESTS – KEY DECISION-MAKING STAFF

6.1 The following members of staff are identified by NHS England as Key Decision-Making Staff for the purposes of reporting compliance with this policy:

- Members of advisory groups which contribute to director-delegated decision making on the commissioning or provision of taxpayer funded services;
- Senior Managers at Agenda for Change band 8d and above;
- Procurement staff and staff involved in decision making concerning the commissioning of services, purchasing of goods, medicines, medical devices or equipment, and formulary decisions.

6.2 Key Decision-Making Staff with any interest, direct or indirect, in contracts or other matters shall be subject to the provisions of Statutory Instrument 2024 [the National Health Service Trusts (Membership and Procedure Regulations) 1990]. Key Decision-Making Staff who participate in tender exercises must make a written declaration of their potentially conflicting interests before they are able to participate in a tender process. If a conflict of interest occurs staff will be excluded from the tender process.

6.3 Key Decision-Making Staff must promptly inform their line manager as soon as a potentially conflicting interest arises, and ensure that within 28 days they declare their relevant interest on ESR through the Conflict of Interest Declaration Module.

6.4 The Trust Secretariat will request declarations of potentially conflicting interest from Agenda for Change band 8d and above staff on an annual basis. Those staff shall also update their ESR as soon as a potentially conflicting interest arises and notify the Trust Secretary of any such changes no later than 28 days of the event.

6.5 Key Decision-Making Staff of the Trust's Procurement Department should ensure that their Department keeps records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes.

7 MANAGEMENT OF INTERESTS – ADVICE IN SPECIFIC CONTEXTS

7.1 Strategic decision-making groups

7.1.1 In common with other NHS bodies, KMPT uses a variety of different groups to make key strategic decisions about things such as:

- Entering into (or renewing) large scale contracts

- Awarding grants
- Making procurement decisions
- Selection of medicines, equipment, and devices

7.1.2 The interests of those who are involved in these groups should be well known so that they can be managed effectively.

7.1.3 These groups should adopt the following principles:

- Chairs should consider any known interests of members in advance, and begin each meeting by asking for declaration of relevant material interests.
- Members should take personal responsibility for declaring material interests at the beginning of each meeting and as they arise.
- Any new interests identified should be added to the organisation's register(s).
- The vice chair (or other non-conflicted member) should chair all or part of the meeting if the chair has an interest that may prejudice their judgement.

7.1.4 If a member has an actual or potential interest the chair should consider the following approaches and ensure that the reason for the chosen action is documented in minutes or records:

- Requiring the member to not attend the meeting.
- Excluding the member from receiving meeting papers relating to their interest.
- Excluding the member from all or part of the relevant discussion and decision.
- Noting the nature and extent of the interest, but judging it appropriate to allow the member to remain and participate.
- Removing the member from the group or process altogether.

7.1.5 The default response should not always be to exclude members with interests, as this may have a detrimental effect on the quality of the decision being made. Good judgement is required to ensure proportionate management of risk.

7.2 Procurement

7.2.1 Procurement must be managed in an open and transparent manner, compliant with procurement and other relevant law, to ensure there is no discrimination against or in favour of any provider. Procurement processes should be conducted in a manner that does not constitute anti-competitive behaviour - which is against the interest of patients and the public.

7.2.2 Those involved in procurement exercises for and on behalf of the organisation must keep records that show a clear audit trail of how conflicts of interest have been identified and managed as part of procurement processes. At every stage of procurement, steps must be taken to identify and manage conflicts of interest to ensure and to protect the integrity of the process. The Trust Procurement Policy must be followed in all cases.

PART B – GIFTS, HOSPITALITY AND SPONSORSHIP

8 GIFTS, HOSPITALITY AND SPONSORSHIP

8.1 **Gifts received / offered**: Staff must refuse all monetary (or monetary equivalent) gifts. If a gift of monetary value is left for a staff member or team without their knowledge this must be surrendered to the Finance department, who will apply the money in accordance with the relevant Finance department rules. This also includes any type of crowd funding, for example just giving pages. NHS time and resource should not be used to set up any type of crowd funding for the Trust. Staff must not accept any gift with an estimated value of £25 or more. Should an individual receive a number of gifts within a twelve-month period where the total of gifts received from one source exceeds £100 any subsequent gift must be declined. Where it is impractical to decline the gift, either because it may cause offence or there is no way to return the gift, the gift must be shared (where appropriate) across the ward or department or surrendered to the Trust Secretary who will either destroy or make use of the gift for charitable purposes. All gifts given MUST be recorded using Appendix 4 and those above £25 must be recorded and the item surrendered to the Trust Secretary.

8.2 The table below gives examples of gifts that may be received, whether they can be accepted and retained and any action required. The list is not exhaustive and common sense should be applied in deciding whether or not an item may be retained

. **Value of Gift / Type of Gift**	**Acceptable**	**Recordable using Appendix 2**	**Surrender**
Small gifts to hospital staff from patients or relatives valued at less than £25	Yes	No	No
Diaries or calendars valued at less than £25 (including from suppliers)	Yes	Yes	No
Gifts of cash or vouchers to individual members of staff from patients, relatives or suppliers.	No	Yes	Monetary gift MUST be refused
Gifts of cash or vouchers to ward or departmental charitable funds	Yes	No	No
Several small gifts from the same source within the space of 12 months totalling more than £100	No	Yes	Yes
Larger gifts with a value of £25 or over such as food hampers or cases of wine.	No	Yes	Yes
Gifts of any kind from suppliers.	No	Yes	Yes

8.3 **Hospitality received:** Staff must exercise caution when accepting hospitality or sponsorship from suppliers or potential suppliers as this can be perceived as impacting on their independence or impartiality in decision making. It is important that the Trust can defend itself against any possible suggestion of undue influence and can reply to any requests for information under the Freedom of Information Act 2000.

8.4 **Sponsorship**: means NHS funding from an external source, including funding of all or part of the costs of a member of staff, NHS research, staff, training, pharmaceuticals, equipment, meeting rooms, costs associated with meetings, meals, gifts, hospitality, hotel and transport costs (including trips abroad), provision of free

services (speakers), buildings or premises." ('Commercial Sponsorship: Ethical Standards for the NHS', Department of Health, November 2000).

8.5 **Commercial Sponsorship**: As a general principle, all offers of hospitality received from commercial third parties must be refused. Attendance at relevant commercially sponsored conferences and courses is acceptable, but only where acceptance will not, and cannot be seen as compromising purchasing or other decisions in any way. Receipt or provision of such sponsorship must be recorded. Individuals should pay particular attention to the circumstances in which hospitality is offered: the provision of hospitality by an individual or organisation during a tendering process or where a contract is shortly to end, or where performance of the contract is in question, or in any other circumstance where acceptance might compromise the position of the individual or of the Trust, is not acceptable.

8.6 Whether it is appropriate to accept specific hospitality / sponsorship will be a matter of judgment but, as a general rule follow the table below

Example of Hospitality	**Acceptable**	**Recordable using Appendix 2**	**Approval level**
Working breakfast or lunch on Trust premises NHS staff only	Yes	No	None
Working breakfast or lunch at third party premises, NHS staff only	Yes	No	None
Working breakfast / lunch not on either party's premises, NHS staff only	Yes	Yes	Prior approval is required from: ≤ £100 = Assistant Director > £100 = Executive Director
Drinks reception which involves a networking opportunity	Yes	Yes	Prior approval from Assistant Director
Hospitality (e g lunch/diner) whilst attending conference/trade fairs (where not included in any cost of conference)	Yes	Yes	Prior approval from Assistant Director
Hospitality relating to any form of entertainment such as sporting events or dinner events beyond the scale of hospitality which the NHS as an employer would be likely to offer	No	Yes	
Sponsorship for attending conferences either within the UK or abroad – **Attendee only** (e g no partner or spouse)	Yes	Yes	Prior approval sought based on value of the trip. Value Approved by < £500 Assistant Director £500 to £1500 Care Group Director (unless for CD in which case relevant Director) £1500 - £5000 Executive Director >£5000 CEO or FD
Personal sponsorship to attend trade or training event	Yes	Yes	Value Approved by <£500 Assistant Director £500 to £1500 Care Group Director (unless CD in which case relevant Director) £1500 to £5000 Executive Director >£5000 CEO or FD

Sponsorship of Trust training events	Yes	Yes	Prior approval from AMD or Care Group Director A written agreement must be in place and the sponsorship disclosed in any papers relating to the meeting, including any minutes taken
Hospitality provided by existing suppliers either on or off site	Yes	Yes	Prior approval from CEO Head of Communications to be informed
Hospitality of any kind from suppliers whilst they are involved in the procurement process	No	Yes	
Visits to supplier sites paid for by the supplier at a time when the Trust is procuring goods or services.	No	Yes	Costs must be borne by the Trust to ensure probity

8.7 **Gifts given**: No gifts should be given by any individual in any circumstances.

8.8 **Hospitality Given**: It is acceptable for individuals to provide modest hospitality in the way of working lunches where meetings are held over the lunchtime period. However, the hospitality must be secondary to the purpose of the meeting and the level must be appropriate and in proportion to the event. The costs involved must not exceed the level which the recipients would normally adopt when paying for themselves at such an event.

8.9 The use of NHS monies for hospitality and entertainment at conferences and seminars or other events should be carefully considered to be able to demonstrate good value in incurring public expenditure.

8.10 All hospitality given must be approved by the budget holder prior to offering the hospitality.

8.11 **Last Will and Testament:** On occasions an employee may become the subject of a Last Will and Testament of a service user. As with gifts, this may be an expression of gratitude for the service he/ she has received. In all cases, if you are a named beneficiary or **have been told you are included in a service user's Will** you must inform your service director and make a declaration immediately.

8.11.1 A member of staff must not act as an Executor in respect of the Will of a person you are providing care or treatment (or recently have provided care) in a professional capacity.

8.11.2 In all cases, if you are approached to act as a service user's executor or witness a Will, you must inform your line manager who will seek the advice of the Director of Workforce and OD and Finance Director. Each case will be considered on its own merits.

8.12 **Private transactions:** Under no circumstances must staff benefit privately from having official business with suppliers of goods and services. No favour or preference as regards price or otherwise, which is not available to the general public, can be sought or accepted.

8.13 **Non-financial or personal conflicts:** These occur where individuals or directors receive no financial benefit, but are influenced by external factors or where individuals use their position in the Trust to gain personal advantage. For instance: to gain some other intangible benefit or kudos, or, influencing or awarding contracts to friends or personal business contacts.

9 DONATIONS

9.1 Donations made by suppliers or bodies seeking to do business with the organisation should be treated with caution and not routinely accepted. In exceptional circumstances they may be accepted but must always be declared. A clear reason must be recorded as to why it was deemed acceptable, alongside the actual or estimated value.

9.2 Staff must not actively solicit charitable donations unless this is a prescribed or expected part of their duties for the organisation, or is being pursued on behalf of the organisation's own registered charity or other charitable body and is not for their own personal gain.

9.3 Staff must obtain permission from the organisation if in their professional role they intend to undertake fundraising activities on behalf of a pre-approved charitable campaign for a charity other than the organisation's own.

9.4 Donations, when received, must be made to a specific charitable fund (never to an individual) and a receipt must be issued.

9.5 Staff wishing to donate to a charitable fund in lieu of receiving a professional fee may do so, subject to ensuring that they take personal responsibility for ensuring that any tax liabilities related to such donations are properly discharged and accounted for.

10 LEGACIES AND BEQUESTS

10.1 Trust staff who are nursing and medical professionals registered with the relevant professional regulators of NHS staff must, at all times, uphold the professional standards outlined in the codes of practice of their respective regulatory body and act with honesty and integrity in any financial dealings they have with everyone they have a professional relationship with, including people in their care.

10.2 In cases where nursing professionals employed by the Trust and registered with the Nursing and Midwifery Council (NMC) have been unknowingly left a bequest or legacy they should ask themselves if they may have influenced the deceased in any way, treated the deceased in a preferential manner, or breached the NMC code. Where the answer to these questions is 'no' NMC guidance states that accepting the bequest does not put the professional in contravention of the *NMC Code of professional standards of practice and behaviour*. However, prior to deciding to accept the bequest Trust staff must consider any reputational implications for the Trust and therefore immediately seek the Trust Secretary's advice on whether acceptance may constitute a potential conflict of interest. The Trust Secretary will also be responsible for advising staff on how to declare this.

10.3 Doctors employed by the Trust must have regard for the provisions of the General Medical Council's (GMC) *Good Medical Practice* guide in relation to legacies and bequests. The guidance states that doctors receiving a bequest or legacy from a patient or their relative should consider the potential damage this could cause to their patient's trust in them and the public' trust in the profession. The GMC guidance also states that all bequests should be refused where they could be perceived as an abuse of trust, and prohibits doctors from putting pressure on patients or their families to make bequests to other people or organisations.

10.4 If any legacies or bequests are left to the Trust or an area within the Trust, rather than an individual, it will be dealt with in accordance with the donor's wishes as far as possible or otherwise in accordance with the principles in this policy.

10.5 Any Trust staff who have received prior advice from the Trust Secretary which indicates that they may accept a bequest or legacy, should inform their line manager and ensure that within 28 days they add this to their declaration on ESR

PART C - SPECIFIC MATTERS

11 OUTSIDE EMPLOYMENT

11.1 Staff must declare any existing outside employment on appointment and any new outside employment when it arises.

11.2 Where a risk of conflict of interest arises, the general management actions outlined in this policy should be considered and applied to mitigate risks.

11.3 Where contracts of employment or terms and conditions of engagement permit, staff may be required to seek prior approval from the organisation to engage in outside employment.

11.4 The organisation may also have legitimate reasons within employment law for knowing about outside employment of staff, even when this does not give rise to risk of a conflict.

12 CLINICAL PRIVATE PRACTICE

12.1 Clinical staff must declare all private practice on appointment, and/or any new private practice when it arises[1] including:

- Where they practise (name of private facility).
- What they practise (specialty, major procedures).
- When they practise (identified sessions/time commitment).

12.2 Clinical staff must (unless existing contractual provisions require otherwise or unless emergency treatment for private patients is needed):

- Seek prior approval of their organisation before taking up private practice.
- Ensure that, where there would otherwise be a conflict or potential conflict of interest, NHS commitments take precedence over private work.[2]
- Not accept direct or indirect financial incentives from private providers other than those allowed by Competition and Markets Authority guidelines: https://assets.publishing.service.gov.uk/media/542c1543e5274a1314000c56/Non-Divestment_Order_amended.pdf

12.3 Hospital Consultants should not initiate discussions about providing their Private Professional Services for NHS patients, nor should they ask other staff to initiate such discussions on their behalf.

12.4 The following must be declared in relation to Private Practice

- Staff name and their role with the organisation.

[1] Hospital Consultants are already required to provide their employer with this information by virtue of Para.3 Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf

[2] These provisions already apply to Hospital Consultants by virtue of Paras.5 and 20, Sch. 9 of the Terms and Conditions – Consultants (England) 2003: https://www.bma.org.uk/-/media/files/pdfs/practical advice at work/contracts/consultanttermsandconditions.pdf)

- A description of the nature of the private practice (e.g. what, where and when staff practise, sessional activity, etc).
- Relevant dates.
- Any other relevant information (e.g. action taken to mitigate against a conflict, details of any approvals given to depart from the terms of this policy).

13 PATENTS

13.1 Staff must declare patents and other intellectual property rights they hold (either individually, or by virtue of their association with a commercial or other organisation), including where applications to protect have started or are ongoing, which are, or might be reasonably expected to be, related to items to be procured or used by the organisation.

13.2 Staff must seek prior permission from the organisation before entering into any agreement with bodies regarding product development, research, work on pathways etc, where this impacts on the organisation's own time, or uses its equipment, resources or intellectual property.

13.3 Where holding of patents and other intellectual property rights give rise to a conflict of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

14 SHAREHOLDINGS AND OTHER OWNERSHIP ISSUES

14.1 Staff must declare, as a minimum, any shareholdings and other ownership interests in any publicly listed, private or not-for-profit company, business, partnership or consultancy which is doing, or might be reasonably expected to do, business with the organisation.

14.2 Where shareholdings or other ownership interests are declared and give rise to risk of conflicts of interest then the general management actions outlined in this policy should be considered and applied to mitigate risks.

14.3 There is no need to declare shares or securities held in collective investment or pension funds or units of authorised unit trusts.

15 LOYALTY INTERESTS

15.1 Loyalty interests must be declared by staff involved in decision making where they:

15.1.1 Hold a position of authority in another NHS organisation or commercial, charity, voluntary, professional, statutory or other body which could be seen to influence decisions they take in their NHS role.

15.1.2 Sit on advisory groups or other paid or unpaid decision-making forums that can influence how an organisation spends taxpayers' money.

15.1.3 Are, or could be, involved in the recruitment or management of close family members and relatives, close friends and associates, and business partners.

15.1.4 Are aware that their organisation does business with an organisation in which close family members and relatives, close friends and associates, and business partners have decision making responsibilities.

PART D - PROCEDURES

16 RECORDS AND PUBLICATION

16.1 Maintenance

16.1.1 The Trust will maintain a Corporate Register of Interest and a Corporate Register of Gifts, Hospitality and Sponsorship. (Appendices 3 and 5)

16.1.2 All declared interests that are material will be promptly transferred to the register by the Trust Secretary who is responsible for maintenance the registers.

16.2 Publication

16.2.1 We will:

- Publish the interests declared by decision making staff in Corporate Register of Interests
- Refresh this information annually.
- Make this information available in hard copy via the Trust Secretariat and via the Trust Website.

16.2.2 If decision making staff have substantial grounds for believing that publication of their interests should not take place then they must contact the Trust Secretary to explain why. In exceptional circumstances, for instance where publication of information might put a member of staff at risk of harm, information may be withheld or redacted on public registers. However, this would be the exception and information will not be withheld or redacted merely because of a personal preference.

16.3 Wider transparency initiatives

16.3.1 KMPT fully supports wider transparency initiatives in healthcare, and we encourage staff to engage actively with these.

16.3.2 Relevant staff are strongly encouraged to give their consent for payments they receive from the pharmaceutical industry to be disclosed as part of the Association of British Pharmaceutical Industry (ABPI) Disclosure UK initiative. These “transfers of value” include payments relating to:

- Speaking at and chairing meetings
- Training services
- Advisory board meetings
- Fees and expenses paid to healthcare professionals
- Sponsorship of attendance at meetings, which includes registration fees and the costs of accommodation and travel, both inside and outside the UK
- Donations, grants and benefits in kind provided to healthcare organisations

16.3.3 Further information about the scheme can be found on the ABPI website:

http://www.abpi.org.uk/our-work/disclosure/about/Pages/default.aspx

17 MANAGEMENT OF INTERESTS – GENERAL

17.1 If an interest is declared but there is no risk of a conflict arising then no action is warranted. However, if a material interest is declared then the general management actions that could be applied include:

17.1.1 restricting staff involvement in associated discussions and excluding them from decision making

17.1.2 removing staff from the whole decision-making process

17.1.3 removing staff responsibility for an entire area of work

17.1.4 removing staff from their role altogether if they are unable to operate effectively in it because the conflict is so significant

17.2 Each case will be different and context-specific, and KMPT will always clarify the circumstances and issues with the individuals involved. Staff must maintain a written audit trail of information considered and actions taken.

17.3 Staff who declare material interests must make their line manager or the person(s) they are working to aware of their existence

18 DEALING WITH BREACHES

18.1 Failure to record interests or offers of gifts, hospitality or sponsorship

18.1.1 There will be situations when interests will not be identified, declared or managed appropriately and effectively. This may happen innocently, accidentally, or because of the deliberate actions of staff or other organisations. For the purposes of this policy these situations are referred to as ‘breaches’.

18.1.2 Should an interest or offer of a gift, hospitality or details of sponsorship not be declared in accordance with this policy the Trust’s disciplinary procedures will apply and where bribery is suspected this will be investigated by the Local Counter Fraud Specialist with a referral to the Police where necessary.

18.2 Identifying and reporting breaches

18.2.1 Staff who are aware of actual breaches of this policy, or who are concerned that there has been, or may be, a breach, must report these concerns to their line manager in the first instance.

18.2.2 To ensure that interests are effectively managed staff are encouraged to speak up about actual or suspected breaches. Every individual has a responsibility to do this. For further information about how concerns should be raised refer to the Trust Policy on Raising Concerns.

18.3 The Trust will investigate each reported breach according to its own specific facts and merits, and give relevant parties the opportunity to explain and clarify any relevant circumstances.

18.4 Following investigation, the organisation will:

- Decide if there has been or is potential for a breach and if so the what severity of the breach is.

- Assess whether further action is required in response – this is likely to involve any staff member involved and their line manager, as a minimum.
- Consider who else inside and outside the organisation should be made aware.
- Take appropriate action as set out in the next section.

18.5 Acting in response to breaches

18.5.1 Action taken in response to breaches of this policy will be in accordance with the disciplinary procedures of the organisation and could involve organisational leads for staff support (e.g. Human Resources), fraud (e.g. Local Counter Fraud Specialists), members of the management or executive teams and organisational auditors.

18.5.2 Inappropriate or ineffective management of interests can have serious implications for the organisation and staff. There will be occasions where it is necessary to consider the imposition of sanctions for breaches.

18.5.3 Sanctions should not be considered until the circumstances surrounding breaches have been properly investigated. However, if such investigations establish wrong-doing or fault then the organisation can and will consider the range of possible sanctions that are available, in a manner which is proportionate to the breach. This includes:

- Employment law action against staff, which might include
  - Informal action (such as reprimand, or signposting to training and/or guidance).
  - Formal disciplinary action (such as formal warning, the requirement for additional training, re-arrangement of duties, re-deployment, demotion, or dismissal).
- Reporting incidents to the external parties described above for them to consider what further investigations or sanctions might be.
- Contractual action, such as exercise of remedies or sanctions against the body or staff which caused the breach.
- Legal action, such as investigation and prosecution under fraud, bribery and corruption legislation.

18.6 Learning and transparency concerning breaches

18.6.1 Reports on breaches, the impact of these, and action taken will be considered by ARC annually.

18.6.2 To ensure that lessons are learnt and management of interests can continually improve, anonymised information on breaches, the impact of these, and action taken will be prepared and may be published as appropriate, or made available for inspection by the public upon request.

19 PROCEDURE FOR MANAGEMENT AND CONTROL OF GIFTS, HOSPITALITY AND SPONSORSHIP

19.1 In line with the policy statements above the following procedure for management and control of Gifts, Hospitality and Sponsorship will be adopted.

19.2 The Trust Secretary retains the responsibility of completing and reporting the Trust wide Register of Interests and the Register of Gifts, Hospitality and Sponsorship and for reporting this to ARC every six months.

19.3 The Trust Secretary will complete the Trust wide register on the basis of information received from Care Groups, Corporate Departments and Trust Board members.

19.4 Directorates and Departments will be required to nominate a corporate governance lead who will maintain the register for their Directorate or Department. These registers will be submitted to the Trust Secretary every six months and be available for inspection and scrutiny at any time.

19.5 The detailed Interests and Gifts Hospitality and Sponsorship declaration form must be used which records the person authorising or ratifying the acceptance of Gifts Hospitality and Sponsorship received.

19.6 Directorates and Departments are required by this policy to take measures to raise staff awareness of the requirement to report all Interests and Gifts Hospitality and Sponsorship.

THE TABLE BELOW SUMMARISES THE FORMAL AUTHORISATION LEVELS OF EACH STAFF GROUP.

Staff Group	**Authorisation Required**	For Financial Limits please refer to Section 7
Chair	SID (Senior Independent Director)	
Non-Executive Directors	Chair	
CEO	Chair	
Executive Directors	CEO	
Care Group Directors	Executive Director	
Assistant Medical Directors	Medical Director	
Assistant Directors	Care Group Directors	
Service Managers	Assistant Directors	
Consultants	Assistant Medical Director	
Lead Nurse	Deputy Director of Nursing	
Team Leaders/Ward Managers	Lead Nurse	

20 IMPLEMENTATION INCLUDING TRAINING AND AWARENESS

20.1 The following table sets out the dissemination, implementation and training and awareness provisions associated with this Policy.

Plan Elements	**Plan Details**
The Dissemination Lead is:	Trust Secretary
This document replaces existing documentation:	No
Document will be disseminated by:	Publication on Trust Intranet Staff newsletter Inclusion in Induction programme Service Team briefings Clinical Cabinet and Staff Forum Payroll slips will be used to raise awareness
This document is to be disseminated to:	Trust Board of Directors, Trust Management Executive, Care Group Directors
Training is required:	No

PART E – GOVERNANCE OF POLICY

21 STAKEHOLDER, CARER AND USER INVOLVEMENT/CONSULTATION

21.1 This policy and procedure applies to all KMPT staff, clinical and non-clinical, Trust Board members including Non-Executive Directors, Bank and temporary staff, seconded staff, staff on fixed term contracts and volunteers.

22 EQUALITY IMPACT ASSESSMENT

22.1 The Equality Act 2010 places a statutory duty on public bodies to have due regard in the exercise of their functions. The duty also requires public bodies to consider how the decisions they make, and the services they deliver, affect people who share equality protected characteristics and those who do not. In KMPT the culture of Equality Impact Assessment will be pursued in order to provide assurance that the Trust has carefully considered any potential negative outcomes that can occur before implementation. The Trust will monitor the implementation of the various functions/policies and refresh them in a timely manner in order to incorporate any positive changes. The Equality Impact Assessment screening for this document can be found on the Equality and Diversity pages of the trust intranet.

23 HUMAN RIGHTS

23.1 The Human Rights Act 1998 sets out fundamental provisions with respect to the protection of individual human rights. These include maintaining dignity, ensuring confidentiality and protecting individuals from abuse of various kinds. Employees and volunteers of the Trust must ensure that the trust does not breach the human rights of any individual the trust comes into contact with.

24 MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THIS DOCUMENT

What will be monitored	***How will it be monitored***	***Who will monitor***	***Frequency***	***evidence to demonstrate monitoring***	***Action to be taken in event of non-compliance***
The policy	Reviewed every three years or earlier if legislation changes require	Audit and Risk Committee	Every three years or earlier if legislation changes require	ARC minutes and document control	Chair of ARC report to Trust Board
Trust Register of Interests	Twice a year through Trust Secretary report from submitted declarations.	Trust Secretary	Audit Committee	ARC report and IARC chair signature	Trust Secretary report to ARC and Trust Board and Annual Governance Statement and Annual Report

Trust Gifts, Hospitality and Sponsorship Register	Twice a year through Trust Secretary report from submitted declarations. To include a review by the finance department in conjunction with the procurement team regarding any significant changes to contracts and suppliers which may have resulted from a gift or hospitality	Trust Secretary	Audit Committee	ARC report and ARC chair signature	Trust Secretary report to ARC
Directorate Gifts, Hospitality and Sponsorship Register	Submission to Trust Secretary for review	Trust Secretary and Deputy Director of Finance	Twice yearly	Trust Secretary signature on register	Escalation to relevant Executive Director
Annual declaration of compliance as part of Annual Governance Enquiry	Annually through return of Annual Governance Enquiry process	Trust Secretary	Annually	Completion of Forms	Escalation to Finance Director / Chief Executive

25 EXCEPTIONS

25.1 There are no exceptions to this policy.

APPENDIX 1 SEVEN PRINCIPLES OF PUBLIC LIFE

SELFLESSNESS
Holders of public office should act solely in terms of the public interest. They should not do so in order to gain financial or other material benefits for themselves, their family, or their friends.

INTEGRITY
Holders of public office should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their official duties.

OBJECTIVITY
In carrying out public business, including making public appointments, awarding contracts, or recommending individuals for rewards and benefits, holders of public office should make choices on merit.

ACCOUNTABILITY
Holders of public office are accountable for their decisions and actions to the public and must submit themselves to whatever scrutiny is appropriate to their office.

OPENNESS
Holders of public office should be as open as possible about all the decisions and actions that they take. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands.

HONESTY
Holders of public office have a duty to declare any private interests relating to their public duties and to take steps to resolve any conflicts arising in a way that protects the public interest.

LEADERSHIP
Holders of public office should promote and support these principles by leadership and example.

APPENDIX 2 DECLARATION OF INTERESTS FORM

Declaration of interests for KMPT Board members and employees

Name:				
Position within KMPT				
Detail of interests held (complete all that are applicable):				
Type of Interest* *See reverse of form for details	**Description of Interest (including for indirect interests, details of the relationship with the person who has the interest)**	**Date interest relates From & To**		**Actions to be taken to mitigate risk (to be agreed with line manager or a senior Trust manager)**

The information submitted will be held by the KMPT for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and, in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest in the NHS) may be published in registers that KMPT holds.

I confirm that the information provided above is complete and correct. I acknowledge that any changes in these declarations must be notified to the Trust Secretary for KMPT as soon as practicable and no later than 28 days after the interest arises. I am aware that if I do not make full, accurate and timely declarations then civil, criminal, or internal disciplinary action may result.

Decision making staff should be aware that the information provided in this form will be added to KMPT's registers which are held in hardcopy for inspection by the public and published on KMPT's website. Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will be held in hardcopy for inspection by the public and published on KMPT's website and must inform the third party that KMPT's privacy policy is available on KMPT's website. If you are not sure whether you are a 'decision making' member of staff, please speak to your line manager before completing this form.

Signed: **Date**:

Signed: **Position:** **Date:**
(Line Manager or Senior KMPT Manager)

Please return to the Trust Secretary

Type of Interest	Description
Financial Interests	This is where an individual may get direct financial benefits from the consequences of a commissioning decision. This could, for example, include being: • A director, including a non-executive director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations. This includes involvement with a potential provider of a new care model; • A shareholder (or similar ownership interests), a partner or owner of a private or not-for-profit company, business, partnership or consultancy which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations; • A management consultant for a provider; or • A provider of clinical private practice. This could also include an individual being: • In employment outside of KMPT (see paragraph 79-81); • In receipt of secondary income; • In receipt of a grant from a provider; • In receipt of any payments (for example honoraria, one-off payments, day allowances or travel or subsistence) from a provider; • In receipt of research funding, including grants that may be received by the individual or any organisation in which they have an interest or role; and • Having a pension that is funded by a provider (where the value of this might be affected by the success or failure of the provider).
Non-Financial Professional Interests	This is where an individual may obtain a non-financial professional benefit from the consequences of a decision, such as increasing their professional reputation or status or promoting their professional career. This may, for example, include situations where the individual is: • An advocate for a particular group of patients; • A clinical with special interests • An active member of a particular specialist professional body (although routine membership of a Royal College, British Medical Association (BMA) or a medical defence organisation would not usually by itself amount to an interest which needed to be declared); • An advisor for the Care Quality Commission (CQC) or the National Institute for Health and Care Excellence (NICE); • Engaged in a research role; • The development and holding of patents and other intellectual property rights which allow staff to protect something that they create, preventing unauthorised use of products or the copying of protected ideas;
Non-Financial Personal Interests	This is where an individual may benefit personally in ways which are not directly linked to their professional career and do not give rise to a direct financial benefit. This could include, for example, where the individual is: • A voluntary sector champion for a provider; • A volunteer for a provider; • A member of a voluntary sector board or has any other position of authority in or connection with a voluntary sector organisation; • Suffering from a particular condition requiring individually funded treatment; • A member of a lobby or pressure group with an interest in health and care.
Indirect Interests	This is where an individual has a close association with an individual who has a financial interest, a non-financial professional interest or a non-financial personal interest in a commissioning decision (as those categories are described above) for example, a: • Spouse / partner; • Close family member or relative e.g., parent, grandparent, child, grandchild or sibling; • Close friend or associate; or • Business partner.

APPENDIX 3 REGISTER OF INTERESTS

Kent and Medway NHS and Social Care Partnership - Register of interests

Name	Current position (s) held in KMPT i.e. Trust Board member; Committee member; KMPT employee or other	Declared Interest (Name of the organisation and nature of business)	Type of Interest			Is the interest direct or indirect?	Nature of Interest	Date of Interest		Action taken to mitigate risk
			Financial	Non-Financial Professional	Non-Financial Personal			From	To	

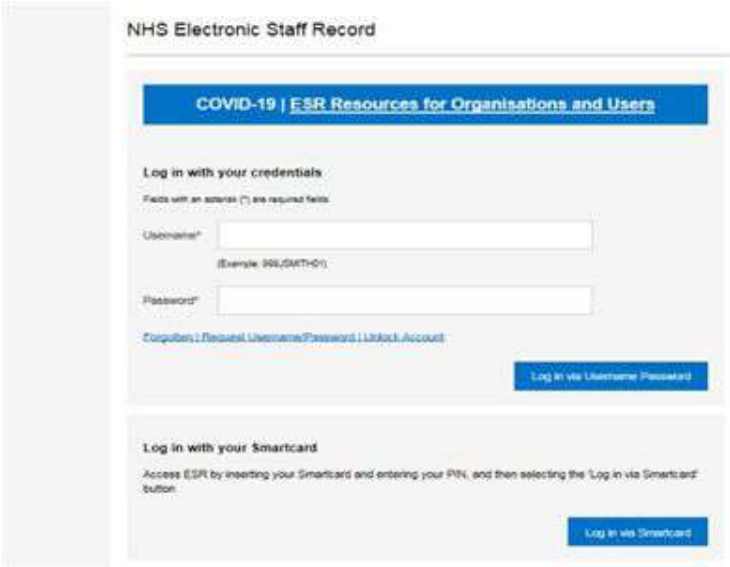
APPENDIX 4 GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATION ESR USER GUIDE

1. Log into ESR in order to record your declaration of interest by clicking the following link: https://my.esr.nhs.uk

   The link will open a new page for you to login, if you are smartcard user, you will first need to insert your smartcard and entering your PIN then you will need to select the "log in via smartcard" to proceed.

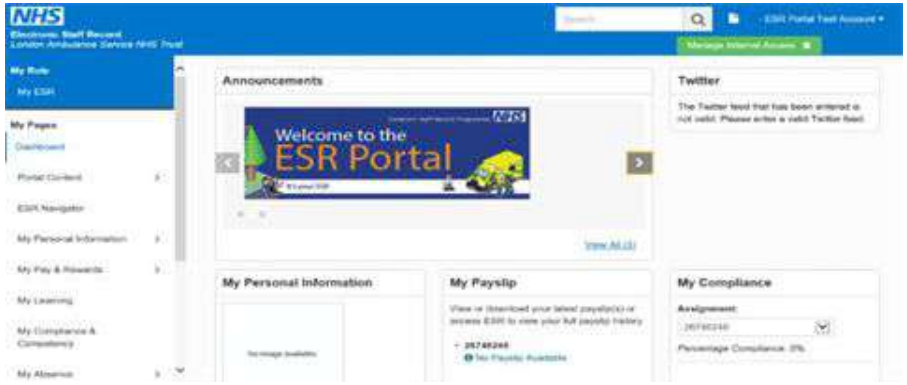
   If you are not a smartcard user you will need to login using your username and password.

- Enter your **Username** (example – 282XXXXXX01)
- Enter your **Password**
- Click on **Log in via Username and Password**



The details of who to contact if you have ESR login queries can be found at the bottom of this document.

You now have access to your ESR Portal and should see the screen below:



2. Click on to expand my personal information to see Conflict of Interest Declaration at the end of the list.

3. Clicking the 'Conflict of Interest Declaration' link opens a new page for the employee to record their Conflict of Interest Declarations as follows:

By default, there will be no declarations recorded.

The employee can click on the 'Add Declaration' button to enter a new declaration.

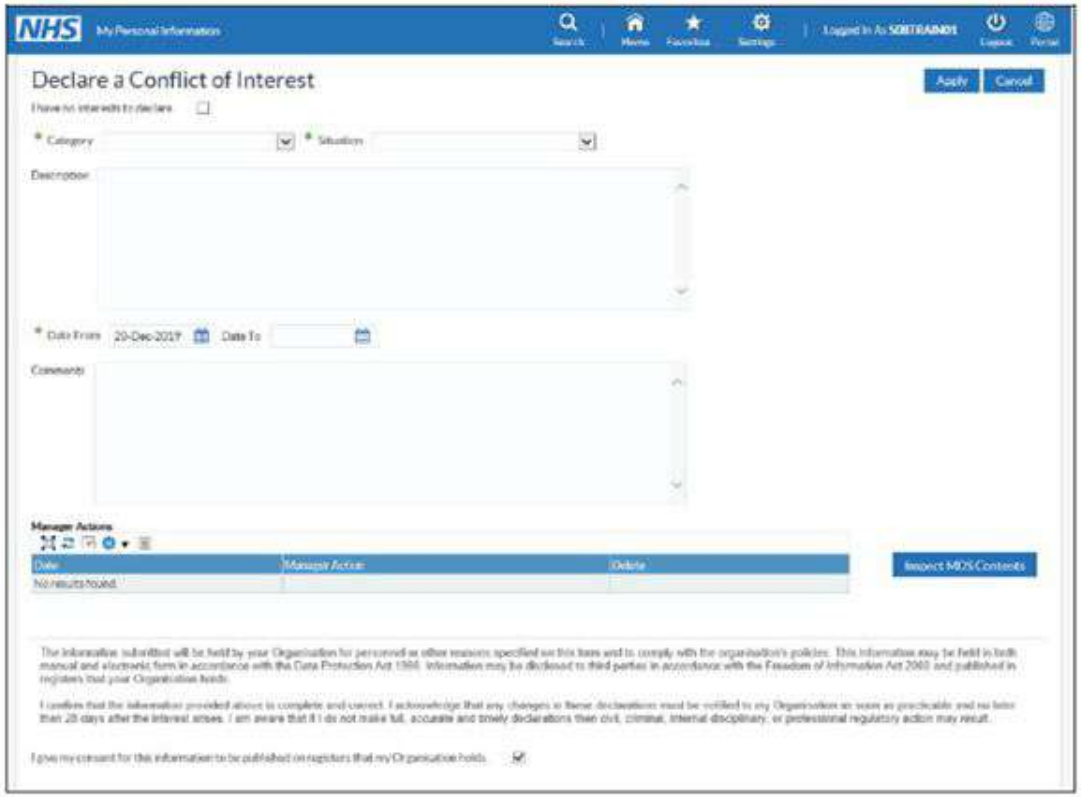
4. If there are no interests to declare, the employee should ensure that the 'I have no interests to declare' checkbox is ticked and the record saved:

5. To enter an interest the appropriate Category and Situation must be entered. Additional details can be entered into the Description and Comments fields as required. If you would like to have more information on the categories, then please review the policy attached to the page.

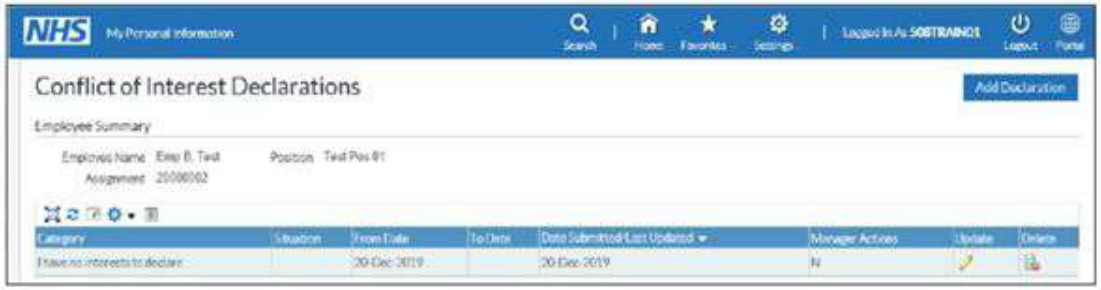
   Relevant dates can be entered for when the interest arose and, if relevant, when it ceased.

   The Date From will default to today, but this can be amended as required.

   Click the **Apply** button.



6. When the declaration is applied it will then be available to review on the summary page:



The information submitted will be held by KMPT for personnel or other reasons specified on this form and to comply with the organisation's policies. This information may be held in both manual and electronic form in accordance with the Data Protection Act 1998. Information may be disclosed to third parties in accordance with the Freedom of Information Act 2000 and in the case of 'decision making staff' (as defined in the statutory guidance on managing conflicts of interest in the NHS), may be published in registers that KMPT holds.

Decision making staff should be aware that the information provided in this form will be added to KMPT's registers which are held in hardcopy for inspection by the public and published on KMPT's website. Decision making staff must make any third party whose personal data they are providing in this form aware that the personal data will be held in hardcopy for inspection by the public and published on the KMPT's website and must inform the third party that KMPT's privacy policy is available on KMPT's website. If you are not sure whether you are a 'decision making' member of staff, please speak to your line manager before completing this form.

APPENDIX 5 ANNUAL GOVERNANCE ENQUIRY RETURN INCLUDING GIFTS, HOSPITALITY AND SPONSORSHIP DECLARATION

To: Trust Secretary

Ref: Corporate Governance Enquiries

I have read your letter dated h March 20XX setting out my responsibilities under the Trust's Governance Regulations, and reply as follows:-

Please answer Yes(√) / No(x)

1 Notification of Interests

Having regard to the above letter,

a) are there any interests which you wish to notify? ☐

b) if the answer to question 1(a) is yes, give details of the interest you wish to notify in the space below.

Please answer Yes(√) / No(x)

2 Related Party Transactions

a) Are there any related party transactions to report for the year ended 31st March 20XX? ☐

b) If the answer to question 2(a) was yes, please complete the following details:

Name of Related Party……

Nature of Relationship……

Description of Transaction……..

Amounts involved……

Any other information which might help to understand the transaction

Any amounts owing at 31st March 20XX ……

Any amounts written off debts during the period……

Please answer Yes(√) / No(x)

3 Other Standards of Business conduct

a) I have read and understood Standing Order 9 ☐

In relation to the matters raised in Standing Order 9, in addition to the declaration of interests dealt with in sections 1 and 2 of this form, I notify you as follows:

b) Appointments (9.3)

In relation to the above paragraphs, are there any matters relating to canvassing, recommendations or discussion of appointments which you wish to declare? ☐

c) Relatives (9.4)

In relation to the above paragraphs, are there any applications by your relatives for employment by the Trust which you wish to declare? ☐

d) Other pecuniary activities (9.4.4)

In relation to the above paragraphs, are there any pecuniary activities outside your employment by the Trust which you wish to declare? ☐

e) Gifts, Hospitality or Sponsorship (9.5)

In relation to the above paragraphs, have you received any gifts, hospitality and offers of such which you wish to declare? ☐

f) Fraud (9.5.16)

In relation to the above paragraphs, have you been subject to any complaints and allegations of which you are aware against yourself or other employees of the Trust? ☐

If any of the answers to questions (b) to (f) were 'yes', please give details below of the declaration you now wish to make:

Please answer Yes(√) / No(x)

4 Audit Information

Have you declared all relevant information to Kent and Medway NHS and Social Care Partnership Trust's auditors? ☐

If the answer to question 4 is no please provide details below:

Signed

……..

Name (*block capitals*)

……..

Job Title

……..

Date ……..

Please note

1. ***Do not include salaries paid by the Trust***
2. ***Please sign and send the original completed form to, Trust Secretary, Trust Headquarters, Farm Villa, Hermitage Lane, Maidstone, Kent ME16 9PH***
3. ***Please continue on a separate sheet if necessary***

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD

Meeting details

Date of Meeting:	31 March 2022
Title of Paper:	Changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation
Author:	Victoria French, Deputy Director of Finance
Executive Director:	Sheila Stenson, Executive Director of Finance

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

Following the UK's exit to the EU, a series of changes were made to legislation and procurement regulations.

The Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board, Scheme of Delegation are required to be reviewed on an annual basis. The next review date is November 2022 however due to these legislative changes, the policy needs to be updated sooner.

Items of focus

There has been a rise in the number of Single Tender Waivers in the organisation so part of the proposed changes is to increase thresholds and allow more autonomy for budget holders to procure low level spend items. The Public Procurement Regulations have a limit of £50,000, below which discretion can be used when sourcing suppliers. The existing limit at KMPT Is £10,000. This results in a significant amount of work when very few STW requests are rejected.

Governance

Implications/Impact:	The changes align the policy to current legislation and increase thresholds to be more akin to other trusts and procurement regulations
Assurance:	**S**ignificant
Oversight:	Oversight by EMT and ARC

Summary of Key Changes

Changes are highlighted in the table below along with the reason for suggested changes. These are also highlighted in yellow in the draft policy, shared as an Appendix.

SO/SFI number	Current wording	New wording	Reason
5.8.2	Executive Medical Director	Chief Medical Officer	Change to job title
5.8.3	Executive Director of Nursing and Quality	Chief Nurse	New post holder with different job title
25.5.1	All tendering must be carried out via the authorised e-tendering platform and be compliant with the Trust policies and procedures. Issue of all tender documentation will be undertaken electronically through a secure website with controlled access using secure login, authentication, audit and viewing rules. All tenders will be received into a secure electronic vault so that they cannot be accessed until the published closing time and date. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports	No change to wording Move to 25.6.2	Follows on from points made in the subsequent section.
25.5.2	UK and EU Directives governing public procurement	The Public Contract Regulations 2015 and The Public Procurement (Amendment etc.) (EU Exit) Regulations 2020 which govern public procurement along with supporting legislation must be followed.	The Procurement legislation changed in 2020 following Britain's exit from the EU. Amendment required to give clarity to sentence.
25.5.3	Where relevant, United Kingdom and European Union directives on public sector purchasing procedures for awarding contracts shall have effect as if incorporated in these SFIs.	Where relevant, United Kingdom public procurement regulations and World Trade Organisation (WTO) Government Procurement Agreement (GPA) for awarding contracts shall have effect as if incorporated in these SFIs.	Following Britain's exit from the EU the UK government secured independent membership of the GPA which aims to open government markets across its members.
25.5.4 **NEW**		Prior to commencing a competitive tender process or entering into a formal contract or SLA, relevant budget approval must be sought. If the requirement is new and/or additional budget needs to be allocated, a business case must be prepared for any expenditure see para 23.4	To set out the need for budget approval prior to a competitive tender process protecting the Trust's finances.

SO/SFI number	Current wording	New wording	Reason
25.6.1	The Trust shall ensure that competitive tenders are invited for the supply of goods, materials, works and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.	The Trust shall ensure that competitive tenders are invited where the Threshold contained in Appendix D of the SFIs dictate that this is required. Competitive tenders are required for the supply of all goods, services, and works, except those exempt as per para 25.6.8. See also para 23.1 in relation to the provision of NHS services to patients.	Provides clarity as to when a tender process is required relating to a relevant financial Threshold.
25.6.1a	in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures and the circumstances are detailed in the appropriate Trust record; or	in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable and the circumstances are detailed in the appropriate Trust record; or	The chief executive need not decide or confirm that due to the estimated expenditure or income being below the threshold that a formal tendering procedure is not required.
25.6.1b	where the timescale genuinely precludes competitive tendering, do note that failure to plan is not regarded a justification ; or	Where the timescale genuinely precludes competitive tendering, for example force majeure situations or national pandemic. Do note that failure to plan is not regarded a justification; or	Government guidance was changed in 2020 to allow emergency purchasing due to a national pandemic.
25.6.1g **NEW**		for the provision of works contracts a waiver can be sought from undertaking a competitive open tender for below Threshold procurements and instead select a minimum of 3 suppliers to submit competitive quotes/tender. This should be completed electronically via the portal with the assistance of the Procurement Team.	The Works Threshold is significantly higher than the goods and services threshold. These types of tenders often have detailed technical information included. The market responds better where there is a restricted competition.
25.6.6	It is not possible to legally waiver any requirement in excess of the published OJEU Threshold applicable and in effect, as varied from time to time	It is not possible to legally waiver any requirement in excess of the published Government Thresholds applicable and in effect, as varied from time to time unless 25.6.2 applies	Removal of the word OJEU since Britain left the EU.

SO/SFI number	Current wording	New wording	Reason
25.6.7	Tendering procedures are set out in Appendix A of this policy.	Procurement and tendering procedures are set out in the Spending the Trust's Money (STTM) policy.	There is no appendix A to the SFIs. Sets out where to find further information.
25.6.8 **NEW**		The Public Contract Regulations do not apply to contracts for the acquisition or rental of land, buildings or other immovable property, broadcasting and media services, for arbitration, mediation or conciliation services, direct employment contracts, limited financial services including loans. Further advice should be sought from the Procurement Team.	Clarity over exclusions from the Public Procurement Directives.
25.7.1	All spend must be in accordance with Spending the Trust's Money (STTM) and advice must be sought from the Procurement Team where necessary.	All purchasing must be done in accordance with Spending the Trust's Money (STTM) guidance document. Advice must be sought from the Procurement Team where necessary and for any procurement above the value of £50,000.	To provide clarity on the intent of the STTM and when to contact the Procurement department
25.7.2	At least one written quotation must be obtained where the total estimated contract value is below £10,000.	At least one written quotation must be obtained where the total estimated contract value is below £15,000.	To increase the threshold by £5,000, in line with rising prices and levels of spend. The threshold under Public Procurement Regulations is £50,000 so this is still significantly below regulatory requirements. This will be reviewed again after 6 months to see if we can recommend a further increase.
25.7.3	At least three written quotations, with at least one quote from a Kent and/or Medway based business, must be obtained where the total estimated contract value is between £10,000 and £49,999.	At least three written quotations, with at least one quote from a Kent and/or Medway based business, must be obtained where the total estimated contract value is between £15,000 and £49,999.	To increase the lower threshold by £5,000 as above.

SO/SFI number	Current wording	New wording	Reason
25.7.4	A full competitive procedure must be conducted where the total estimated contract value is £50,000 and above. This must include a published award criteria.	A full competitive procedure must be conducted where the total estimated contract value is £50,000 and above. This must be undertaken electronically and advertised on Contracts Finder. This must include published award criteria and a full set of procurement documents including a draft contract.	To provide clarity on the process and where the tender must be advertised.
25.7.5	A full competitive OJEU procedure must be conducted where the total estimated contract value exceeds the relevant OJEU threshold in force as varied from time to time	A full competitive procedure must be conducted where the total estimated contract value exceeds the relevant procurement Threshold as set out by the government. All tenders must be carried out electronically and advertised on Find a Tender Service	To provide clarity on the process and where the tenders must be advertised in line with legislation.
25.7.7	Any award must utilise the Trust's standard contract	A contract must be entered into and signed by both parties following the conclusion of a quote or tender process as set out in the scheme of delegation. The NHS standard terms and conditions must be utilised unless alternative terms and conditions are agreed by the Associate Director of Procurement (e.g JCT and NEC contracts). The contract must be forwarded to the Procurement Team for inclusion on the Contracts Register.	To give clarity on having a signed contract in place and to ensure contracts are signed by appropriate officers.
25.7.8 **NEW**		The Trust shall not divide or split requirements in order to avoid a Threshold, this is in breach of Public Contract Regulations and the Aggregation Rules.	To ensure that the Trust is not manipulating the contract value in order to avoid running a competitive tender process as required by legislation.

SO/SFI number	Current wording	New wording	Reason
25.7.9 **NEW**		The use of other public sector organisations' Framework Agreements is permitted at any Threshold. The Procurement Team should be consulted to ensure these are utilised compliantly.	To ensure the provision is included to allow use of Framework Agreements.
25.8	Where tendering or competitive quotation is not required the Trust should adopt one of the following alternatives:	For expenditure below the value of £10,000 where tendering or competitive quotation is not required the Trust should adopt one of the following alternatives:	To give clarity as to when competitive tendering is not required.
25.8.1	The Trust shall use NHS Supply Chain for procurement of all goods and services (and will not be required to obtain competitive quotations) unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented	The Trust shall use NHS Supply Chain, or other appropriate approved NHS framework for procurement of all goods and services (and will not be required to obtain competitive quotations) unless the requirement cannot be filled via this route or the Associate Director of Procurement deem it inappropriate.	To allow the use of an alternative means if the NHS Supply Chain does not have suitable contracts to cover the requirements.
25.8.2	If the Trust does not use NHS Supply Chain (where tenders or quotations are not required, as set out in this policy), the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance	If the Trust does not use NHS Supply Chain, or other approved NHS framework (where tenders are quotations are not required, as set out in this policy) the Trust shall procure goods and services in accordance with the procurement procedures set out in in the Spending the Trust Money policy.	To give clarity on the rules to be used.
25.17 c	UK and EU Directives and other statutory provisions; and	UK and WTO legislation and other statutory provisions; and	Removal of reference to EU
25.17.2	Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. Any significant deviation should consider the legal risk of alteration.	Contracts shall be in or embody the same terms and conditions of contract as was the basis on which the tender or quote were invited. Deviation from this may result is exposing the Trust to legal risk. Advice should be sought from the Procurement Team.	To provide clarity.

SO/SFI number	Current wording	New wording	Reason
Scheme of Delegation (Management of Capital Schemes)	Selection of architects, quantity surveyors, engineers and other professional advisors within EU Regulations	DELETE	Deleted as this is covered by procurement regulations and procedures and scheme of delegation relating to signing of contracts.
Scheme of Delegation (Quotation, tendering and contract procedures	At least one written quotation Below £10,000 (or delegated manager e.g, Estates) At least 3 written quotations From £10,000 to £49,999 (Undertaken by Procurement and budget holder) Full Competitive Tender Process From £50,000 to OJEU tendering undertaken (Undertaken by Procurement and budget holder) Full Competitive Tender Process In excess of OJEU Threshold tendering undertaken (Undertaken by Procurement and budget holder)	DELETE	Not required – this is setting out the procurement procedures rather than a scheme of delegation and is also covered by section 25.7
Scheme of Delegation **NEW**		Signing of Contracts and SLAs: Up to £1,000 – Budget Holder From £1,001 - £10,000 – Associate Director / Head of Service From £10,001 - £50,000 – Director / Chief Operating Officer in consultation with Associate Director of Procurement From £50,001 - £249,999.00 – Deputy Director of Finance and relevant Operational Lead for the contract. From £250,000 - £499,999 – Chief Executive and Director of Finance (or nominated Deputy).	To give clarity of scheme of delegation for the signing on Contracts and SLAs.

SO/SFI number	Current wording	New wording	Reason
		Above £500,000 – Finance and Performance Committee Approval (signature by Chief Executive and Director of Finance (or nominated deputy).	
Scheme of Delegation	Engagement of Trust's Solicitors other than for litigation Head of Legal Services to £5,000	Engagement of Trust's Solicitors Head of Legal Services to £10,000	Remove phrase "other than for litigation". This implies no limit on litigation, which isn't included elsewhere in the scheme of delegation, and delegated authority should apply to all legal spend. Increase value to reflect a more relevant cost, based on current litigation spend

Kent and Medway
NHS and Social Care Partnership Trust

Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board – Scheme of Delegation

Policy Reference No.	KMPT.Fin.002.09
Replacing document	KMPT.Fin.002.08
Scope	Trust wide
Originator	Executive Director of Finance and Trust Secretary
Responsible Group	Trust Board
Status	Authorised
Version No	10.0
Authorised by	Trust Board
Date of Implementation	November 2021
Review Date	March 2022
Review	This document will be reviewed prior to review date if a legislative change or other event otherwise dictates.
Distribution date	January 2022
Number of Pages	82
Contact Point for Queries	kmpt.policies@nhs.net
Copyright	Kent and Medway NHS and Social Care Partnership Trust 2021

DOCUMENT TRACKING SHEET

Standing Orders, Standing Financial Instructions and Reservation of Powers to the Board – Scheme of Delegation

Version	Status	Date	Issued to/approved by	Comments
5.1	Approved	Sept 2017	IARC	Reviewed by IARC
6.0	Approved	Sept 2017	Trust Board	Authorised
6.1	Approved	Sept 2018	IARC	3 month review date extension approved and changed from Sept 18 to Dec 18
6.2	Draft	April 2019	Internal review	
6.3	For Review	May 2019	Integrated Audit & Risk Committee	Ratified
7.0	Final	May 2019	Trust Board	Approved
7.1	Updated	September 2019	IARC	Minor changes to wording. Approved.
7.2	Draft	November 2020	Integrated Audit & Risk Committee	
8.0	Final	November 2020	Trust Board	Approved
9.0	Final	November 2021	Trust Board	Approved
10.0	Draft	March 2022	Trust Board	TBC

REFERENCES

RELATED DOCUMENTS

SUMMARY OF CHANGES

Date	Author	Page	Changes (brief summary)
May 2019	Deputy Director of Finance		Combined the individual Standing Financial Instructions, Standing Orders and Reservation of Powers to the Board – Scheme of Delegation into one document
Sept 2019	Trust Secretary		Addition of risk management wording, removal of Strategy Steering Group
Nov 2020	Trust Secretary and Deputy Director of Finance		Full review of policy, updated for current practices and new roles and committees
Nov 2021	Trust Secretary & Deputy Director of Finance		Full review of policy, updated for current practices and new roles and committees
March 2022	Deputy Director of Finance		Legislative changes to procurement thresholds and regulations reflected

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FOREWORD

Standing Orders, together with Standing Financial Instructions, provide a regulatory framework for the business conduct of the Trust. They fulfil the dual role of protecting the Trust's interests and protecting staff from any possible accusation that they have acted less than properly.

The Standing Orders, Scheme of Delegation and Standing Financial Instructions provide a comprehensive business framework, and shall apply irrespective of the source of funding. All Executive and Non-Executive Directors, and all members of staff, should be aware of the existence of these documents and, where necessary, be familiar with the detailed provisions. Failure to comply with standing orders and standing financial instructions is a disciplinary matter which could result in dismissal.

INTRODUCTION

1 GENERAL

1.1 This document comprises the Standing Orders (SOs), Standing Financial Instructions (SFIs), and Reservation of Powers to the Board (Scheme of Delegation).

2 STATUTORY FRAMEWORK

2.1 The Kent and Medway NHS and Social Care Partnership Trust (the Trust) is a body corporate which has been established under the Establishment Order.

2.2 NHS Trusts are governed by Act of Parliament. Most health legislation since 1997 has been consolidated into the National Health Service Act 2006 (the NHS Act 2006), the National Health Service (Consequential Provisions) Act 2006 and the Health and Social Care Act 2012 (HSCA 2012).

2.3 The functions of the Trust are conferred by this legislation.

2.4 As a body corporate the Trust has specific powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable as well as to the Secretary of State. The Trust also has a common law duty as a Bailee for patients' property held by the Trust on behalf of patients.

2.5 The Code of Governance requires the Trust to adopt Standing Orders (SOs) for the regulation of its proceedings and business. The Trust must also adopt Standing Financial Instructions (SFIs) as an integral part of SOs setting out the responsibilities of individuals.

2.6 The Trust will also be bound by such other statutes and legal provisions which govern the conduct of its affairs.

3 NHS FRAMEWORK

3.1 In addition to the statutory requirements the Secretary of State through the Department of Health and Social Care issues further requirements and guidance. These are normally issued under cover of a circular of letter.

3.2 In April 2016 the NHS Trust Development Authority (NTDA) and Monitor became NHS Improvement (NHSI) (and now called NHS England/Improvement) with responsibility for the governance and performance arrangements in NHS Trusts and Foundation Trusts. NHSI adopted the Foundation Trust Code of Governance on the basis that NHS Trusts were required to comply as far as they were able. In addition the Single Oversight Framework was issued, which contains further requirements and guidance for NHS Trusts.

3.3 The Code of Governance requires that, inter alia, Boards draw up a schedule of decisions reserved to the Board, and ensure that management arrangements are in place to enable responsibility to be clearly delegated to senior executives (a scheme of delegation). The code also requires the establishment of audit and remuneration committees with formally agreed terms of reference. The Codes of Conduct makes various requirements concerning possible conflicts of interest of Board Directors.

3.4 The Code of Practice on Openness in the NHS, as revised by the Freedom of Information Act 2000 and the Environmental Information Regulations 2004 sets out the requirements for public access to information on the NHS.

3.5 The Trust has power to delegate and make arrangement for delegation. This document sets out the detail of these arrangements.

3.6 Under the SOs relating to the Arrangements for the Exercise of Functions by Delegation (SO 7) the Board exercises its powers to make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee appointed by virtue of SO 5 or by an officer of the Trust, in each case subject to such restrictions and conditions as the Board thinks fit or as the Secretary of State may direct. Delegated Powers are covered in sections 39 and 40 of this policy.

3.7 Trust Boards are now encouraged to move away from silo governance and develop integrated governance that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, information and research governance. Integrated governance will better enable the Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, quality and financial objectives.

4 INTERPRETATION

4.1 Save as permitted by law, at any meeting the Chairperson of the Trust shall be the final authority on the interpretation of the SOs and SFIs (on which he/she should be advised by the Chief Executive) and the decision shall be final and binding except in the case of manifest error.

4.2 Any expression to which a meaning is given in the NHS Act 2006, the HSCA 2012 and other Acts relating to the National Health Service or in the Regulations or Orders made under such Acts shall have the same meaning in this policy and in addition:

4.2.1 "ACCOUNTABLE OFFICER" shall be the Officer responsible and accountable for funds entrusted to the Trust. He/she shall be responsible for ensuring the proper stewardship of public funds and assets. For this Trust it shall be the Chief Executive;

4.2.2 “ASSOCIATE NON-EXECUTIVE DIRECTOR” shall mean a Non-Executive Director who is non-voting and who has been appointed by the Chairperson following open competition, which has been conducted by NHSE/I

4.2.3 “BOARD" means the Chairperson, Non-Executive Directors and Executive Directors of the Trust collectively as a body;

4.2.4 "BUDGET" shall mean a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

4.2.5 "BUDGET HOLDER" means the Director or Officer with delegated authority to manage finances (income and expenditure) for a specific area of the Trust;

4.2.6 "CHAIRPERSON” is the person appointed by the NHSI on behalf of the Secretary of State for Health to lead the Board and to ensure that it successfully discharges its overall responsibility for the Trust as a whole. The expression “the Chairperson of the Trust” shall be deemed to include the Deputy Chairperson of the Trust if the Chairperson is absent from the meeting or is otherwise unavailable;

4.2.7 "CHIEF EXECUTIVE" shall mean the chief officer of the Trust;

4.2.8 "COMMITTEE" shall mean a committee created and appointed by the Trust functioning as an internal committee;

4.2.9 "COMMITTEE MEMBERS" shall be persons formally appointed by the Board to sit on or to chair specific Committees;

4.2.10 "DEPUTY CHAIRPERSON" means the non-executive director appointed to take on the Chairperson's duties if the Chairperson is absent for any reason;

4.2.11 "DIRECTOR" shall mean a person appointed as a director in accordance with the Membership and Procedure Regulations and includes the Chairperson;

4.2.12 "DIRECTOR OF FINANCE" shall mean the chief finance officer of the Trust;

4.2.13 "ESTABLISHMENT ORDER" shall mean the Kent and Medway National Health Service and Social Care Partnership Trust (Establishment) and the West Kent National Health Service and Social Care Trust and the East Kent National Health Service and Social Care Partnership Trust (Dissolution) Order 2006 (SI 2006/825);

4.2.14 "EXECUTIVE DIRECTOR" shall mean a member of the Board who is an executive director or a person to be regarded as an executive director pursuant to Regulation 5 of the Membership and Procedure Regulations;

4.2.15 "EXECUTIVE MANAGEMENT TEAM" means the group of Executive Directors of the Trust appointed by the Chief Executive as defined in SO 5.8 or minimum of three of that group

4.2.16 "EXECUTIVE ASSURANCE COMMITTEE" means the group of Executive Officers and Senior Officers appointed by the Chief Executive and listed in the Terms of Reference of the Committee responsible for matters as set out in its Terms of Reference.

4.2.17 "FUNDS HELD ON TRUST" shall mean those funds which the Trust holds on the date of incorporation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

4.2.18 "GBS" means the Government Banking Service;

4.2.19 "HSCA 2012" means the Health and Social Care Act 2012;

4.2.20 "MEMBERSHIP AND PROCEDURE REGULATIONS" shall mean the National Health Service Trust (Membership and Procedure) Regulations 1990 (SI 1990/2024) as subsequently amended (SI 1996/1775, SI 1998/1975, SI 2000/2434, SI 2001/378/6, 2008/1269 and SI 2014/784);

4.2.21 "MOTION" means a formal proposition to be discussed and voted on during the course of a meeting;

4.2.22 "NHS ACT 2006" means the National Health Service Act 2006;

4.2.23 "NOMINATED OFFICER" means an officer charged with the responsibility for discharging specific tasks within SOs and SFIs;

4.2.24 "NON-EXECUTIVE DIRECTOR" shall mean a member of the Board who is not an Officer of the Trust;

4.2.25 "NHSI" means NHS England and Improvement responsible for the oversight of NHS trusts and NHS foundation trusts, with delegated authority from the

Secretary of State for the appointment of the Non-Executive Directors, including the Chairperson;

4.2.26 "OFFICER" means employee of the Trust or any other person holding paid appointment or office with the Trust;

4.2.27 “SECRETARY” means a person appointed to act independently of the Board to monitor the Trust's compliance with the law, SOs, guidance from NHSI and Department of Health;

4.2.28 “SENIOR INDEPENDENT DIRECTOR (SID)” means the Non-Executive Director appointed by the Board to provide a sounding board for the Chair and to serve as an intermediary for other directors when necessary

4.2.29 "SFIs" means Standing Financial Instructions;

4.2.30 "SOs" means Standing Orders; and

4.2.31 "TRUST" means Kent and Medway NHS and Social Care Partnership Trust.

4.2.32 "TRUST CAPITAL GROUP" means the operational management group responsible for the monitoring and review of the capital programme.

4.3 With respect to the appointment and powers of the Senior Independent Director, the following shall apply:

4.3.1 The Board of Directors may appoint any member of the Board, who is also a Non-Executive Director, to be the Senior Independent Director, for such period, not exceeding the remainder of their term as a member of the Board, as they specify on appointing him/her. For the avoidance of doubt, the Deputy Chairperson may also be the Senior Independent Director.

4.3.2 The Senior Independent Director will provide a sounding board for the Chairperson and act as intermediary for other directors as and when necessary

4.3.3 The Senior Independent Director will be available to the other Non-Executive Directors and Executive Directors to address any concerns or issues they feel have not been adequately dealt with through the usual channels of communications; and

4.3.4 Meet at least annually with Non-Executive Directors without the Chairperson present to lead the review of the Chairperson’s performance and to provide feedback to the Chairperson

4.4 Any reference to an Act of Parliament, Statutory Instrument, Direction or Code of Practice shall be construed as a reference to any modification, replacement or re-enactment for the time being in force.

4.5 All reference to the masculine gender shall be read as equally applicable to the feminine gender and vice-versa.

4.6 Wherever the title “Chief Executive”, “Director of Finance”, or other nominated Officer is used in these SFIs, it shall be deemed to include such other Director or Officer who have been duly authorised to represent them.

4.7 Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Trust when acting on behalf of the Trust.

STANDING ORDERS

5 THE TRUST

5.1 All business shall be conducted in the name of the Trust.

5.2 All funds received in trust shall be in the name of the Trust as corporate trustee. In relation to funds held on trust, powers exercised by the Trust as corporate trustee shall be exercised separately and distinctly from those powers exercised as a Trust.

5.3 The Trust has the functions conferred on it by Schedules 4 and 5 of the NHS Act 2006 and by its Establishment Order.

5.4 Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to the Secretary of State for Health.

5.5 The Trust has a central Board Assurance Framework, which is documented and tabled at Trust Board meetings held in public. There is also a Risk Management Strategy which is available on the Trust website.

5.6 The Trust has resolved that certain powers and decisions may only be exercised or made by the Board in formal session. These powers and decisions are set out in sections 39 and 40.

5.7 **Composition of the Trust** - In accordance with the Establishment Order and Membership and Procedure Regulations the composition of the voting membership of the Board shall be:

5.7.1 The Chairperson of the Trust and;

5.7.2 Seven Non-Executive Directors and;

5.7.3 Seven Executive Directors.

5.8 The following are Executive Directors of the Trust:

5.8.1 Chief Executive;

5.8.2 Chief Medical Officer (a medical practitioner);

5.8.3 Chief Nurse (a registered nurse or midwife on the register maintained by the Nursing and Midwifery Council);

5.8.4 Executive Director of Finance

5.8.5 Director of Partnerships and Strategy (Deputy Chief Executive); and

5.8.6 Director of Workforce and Communications; (non-voting)

5.8.7 Chief Operating Officer (non-voting)

5.9 **Appointment of the Chairperson and Directors** - The Chairperson and Non-Executive Directors are appointed by the Secretary of State, as advised by NHSI.

5.10 The Trust shall appoint a panel whose members shall be the Chairperson and some Non-Executive Directors of the Trust whose function will be to appoint the Chief Executive of the Trust.

5.11 The Trust shall appoint a panel whose members shall be the Chairperson, some Non-Executive Directors and the Chief Executive whose function will be to appoint the Executive Directors of the Trust other than the Chief Executive.

5.12 **Terms of Office of the Chairperson and Directors** - The regulations governing the period of tenure of office of the Chairperson and Directors and the termination or suspension of office of the Chairperson and Directors are contained in the Membership and Procedure Regulations and as directed by NHSI, under its delegated authority from the Secretary of State.

5.13 **Appointment of Deputy Chairperson** - For the purpose of enabling the proceedings of the Trust to be conducted in the absence of the Chairperson, the Directors of the Trust may appoint a Non-Executive Director from amongst them to be Deputy Chairperson for such a period, not exceeding the remainder of his/her term as Non-Executive Director of the Trust, as they may specify on appointing him/her.

5.14 Any Non-Executive Director so elected may at any time resign from the office of Deputy Chairperson by giving notice in writing to the Chairperson. The Directors of the Trust may thereupon appoint another Non-Executive Director as Deputy Chairperson in accordance with SO 5.12.

5.15 **Powers of Deputy Chairperson** - Where the Chairperson of an NHS Trust has died or has otherwise ceased to hold office or where he/she has been unable to perform his/her duties as Chairperson owing to illness, absence from England and Wales or any other cause, references to the Chairperson in the Schedule to these Regulations shall, so long as there is no Chairperson able to perform his/her duties, be taken to include references to the Deputy Chairperson.

5.16 **Role of Members** - The Board will function as a corporate decision-making body. Executive and Non-Executive Members will be full and equal members. Their role as members of the Board of Directors will be to consider the key strategic and managerial issues facing the Trust in carrying out its statutory and other functions.

5.16.1 Executive Members shall exercise their authority within the terms of the Standing Orders, Standing Financial Instructions and the Scheme of Delegation.

5.16.2 The Chief Executive shall be responsible for the overall performance of the Executive functions of the Trust. He/she is the Accountable Officer for the Trust and shall be responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accountable Officer Memorandum for Trust Chief Executives.

5.16.3 The Director of Finance shall be responsible for the provision of financial advice to the Trust and to its members and for the supervision of financial control and accounting systems. He/She shall be responsible along with the Chief Executive for ensuring the discharge of obligations under relevant Financial Directions.

5.16.4 Non-Executive Members shall not be granted nor shall they seek to exercise any individual Executive powers on behalf of the Trust. They may however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

5.16.5 The Chairperson shall be responsible for the operation of the Board and shall chair all Board meetings when present. The Chairperson has certain delegated Executive powers and must comply with the terms of appointment and with these Standing Orders.

5.16.6 The Chairperson shall liaise with NHSI over the appointment of the Non-Executive Directors and once appointed shall take responsibility either directly or indirectly for their induction, their portfolios of interests and assignments, and their performance.

5.16.7 The Chairperson shall work in close harmony with the Chief Executive and shall ensure that key and appropriate issues are discussed by the Board in a timely manner with all the necessary information and advice being made available to the Board to inform the debate

6 MEETINGS OF THE TRUST

6.1 **Calling meetings** - Ordinary meetings of the Board shall be held at such times and places as the Board may determine. A minimum of 5 meetings shall be held each year.

6.2 The Chairperson may call a meeting of the Board at any time.

6.3 If the Chairperson refuses to call a meeting after a requisition signed by at least one-third of the whole number of Directors, has been presented to him/her, or if, without so refusing, the Chairperson does not call a meeting within seven days after such requisition has been presented to him/her, at the Trust Headquarters, such one third or more Directors may forthwith call a meeting.

6.4 **Notice of Meetings** - Before each meeting of the Board a written notice of the meeting, specifying the business proposed to be transacted at it, and approved by the Chairperson or by an Officer authorised by the Chairperson to sign on his behalf shall be delivered to every Director electronically, or sent by post to the usual place of residence of such Director, so as to be available to him/her at least three clear days before the meeting.

6.5 Lack of service of the notice on any Director shall not affect the validity of a meeting.

6.6 In the case of a meeting called by Directors in default of the Chairperson, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

6.7 Failure to serve such a notice on more than three Directors will invalidate the meeting. A notice shall be presumed to have been served at the time at which the notice would be delivered in the ordinary course of the post.

6.8 Before each meeting of the Board a public notice of the time and place of the meeting, and the public part of the agenda, shall be displayed at the Trust's office at least three clear days before the meeting (Required by s1(4)(a) of the Public Bodies (Admission to Meetings) Act 1960).

6.9 **Setting the Agenda** - The Board may determine that certain matters shall appear on every agenda for a meeting of the Board and shall be addressed prior to any other business being conducted.

6.10 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Chairperson at least 10 clear days before the meeting, subject to SO 6.9. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Chairperson.

6.11 The agenda will be sent to Directors four clear days before the meeting and supporting papers, whenever possible, shall accompany the agenda, but will certainly be despatched no later than four clear days before the meeting, save in emergency.

6.12 **Notices of Motion** - A Director of the Trust desiring to move or amend a motion shall send a written or electronic transmission notice thereof to the Chairperson at least 10 clear days before the meeting. The Chairperson shall include in the agenda for the meeting all notices so received that are in order and permissible under the appropriate regulations.

6.13 SO 6.12 shall not prevent any motion being moved or withdrawn at the meeting without notice on any business mentioned on the agenda for the meeting.

6.14 **Emergency Motion -** A Director of the Trust may give written notice of an emergency motion after the issue of the notice of meeting and agenda, up to one hour before the time fixed for the meeting. The notice shall state the grounds of urgency. If in order, it shall be declared to the Board at the commencement of the business of the meeting as an additional item included in the agenda. The Chairperson's decision to include the item shall be final.

6.15 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

6.16 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

6.16.1 An amendment to the motion.

6.16.2 The adjournment of the discussion or the meeting.

6.16.3 That the meeting proceeds to the next business. (*)

6.16.4 The appointment of an ad hoc committee to deal with a specific item of business.

6.16.5 That the motion be now put. (*)

- * In the case of sub-paragraphs denoted by (*) above to ensure objectivity motions may only be put by a Director who has not previously taken part in the debate.
- No amendment to the motion shall be admitted if, in the opinion of the Chairperson of the meeting, the amendment negates the substance of the motion.

6.17 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Chairperson.

6.18 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director(s) who gives it and also the signature of four other Directors.

6.19 When any such motion has been disposed of by the Board, it shall not be competent for any Director other than the Chairperson to propose a motion to the same effect within six months; however, the Chairperson may do so if he/she considers it appropriate. SOs 6.18 and 6.19 shall not apply to motions moved in pursuance of a report or recommendation of a committee or the Chief Executive.

6.20 **Written Motions** - In urgent situations and with the consent of the Chairperson, business may be affected by a Director's written motion to deal with business otherwise required to be conducted at a meeting of the Board of Directors.

6.21 If all members of the Board of Directors have been notified of the proposal and a majority of the Directors entitled to vote at the meeting of the Board of Directors confirms acceptance of the written motion either in writing to electronically to the Secretary within five clear days of dispatch then the motion will be deemed to have been resolved notwithstanding that the Directors have not gather in one place.

6.22 The effective date of the resolution shall be the date that the last confirmation is received by the Secretary and, until that date, a Director who has previously indicated acceptance can withdraw and the motion shall fail.

6.23 Once the resolution is passed, a copy certified by the Secretary shall be recorded in the minutes of the next ensuing meeting where it shall be signed by the person presiding at it.

6.24 **Chairperson of Meeting** - At any meeting of the Trust the Chairperson, if present, shall preside. If the Chairperson is absent from the meeting the Deputy Chairperson, if there is one and he/she is present, shall preside. If the Chairperson and Deputy Chairperson are absent such Non-Executive Director as the Directors present shall choose shall preside.

6.25 If the Chairperson is absent from a meeting temporarily on the grounds of a declared conflict of interest the Deputy Chairperson, if present, shall preside. If the Chairperson and Deputy Chairperson are absent, or are disqualified from participating, such Non-Executive Director as the Directors present shall choose shall preside.

6.26 **Chairperson's ruling** – Statements of Directors made at meetings of the Board shall be relevant to the matter under discussion at the material time and the decision of the Chairperson of the meeting on questions of order, relevance and regularity (including procedure on handling motions) and the interpretation of the SOs and SFIS, at the meeting, shall be observed.

6.27 **Quorum** - No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of the Directors are present including on or after the operational date at least one Executive Director and one Non-Executive Director.

6.28 An officer in attendance for an Executive Director but without formal acting up status may not count towards the quorum.

6.29 If a Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest (see SO 9) he/she shall no longer count towards the quorum. If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be

recorded in the minutes of the meeting. The meeting must then proceed to the next business.

6.30 The requirement at SO 6.27 with in respect of at least one Executive Director forming part of the quorum shall not apply where the Executive Directors are excluded from a meeting (for example, when the Board considers the recommendations of the Remuneration and Terms of Service Committee).

6.31 **Voting** - Every question at a meeting shall be determined by a majority of the votes of the Directors present (as defined in SO 6.27 – 6.30) and voting on the question and, in the case of any equality of votes, the person presiding shall have a second or casting vote.

6.32 All questions put to the vote shall, at the discretion of the Chairperson of the meeting, be determined by oral expression or by a show of hands. A paper ballot may also be used if a majority of the Directors present so request.

6.33 If at least one-third of the Directors present so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

6.34 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

6.35 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

6.36 An Officer who has been appointed formally by the Board to act up for an Executive Director during a period of incapacity or temporarily to fill an Executive Director vacancy, shall be entitled to exercise the voting rights of the Executive Director.

6.37 An Officer attending the Board meeting to represent an Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Executive Director. An Officer's status when attending a meeting of the Board shall be recorded in the minutes.

6.38 **Joint Directors** - Where the office of an Executive Director is shared jointly by more than one person:

6.38.1 Either or both of those persons may attend or take part in meeting of the Board;

6.38.2 If both are present at a meeting they should cast one vote if they agree;

6.38.3 In the case of disagreements no vote should be cast;

6.38.4 The presence of either or both of those persons should count as the presence of one person for the purposes of SO 6.27 (quorum);

6.39 **Record of Attendance** - The names of the Chairperson and Directors present at the meeting shall be recorded in the minutes.

6.40 If a Director is not present for the entirety of the meeting, the minutes shall record the items that were considered whilst they were present.

6.41 **Minutes** – At each meeting of the Board the Chairperson shall appoint a person attending to record the minutes and proceedings. The Minutes will be submitted for

agreement at the next ensuing meeting where they will be signed by the person presiding at it.

6.42 No discussion shall take place upon the minutes except upon their accuracy or where the Chairperson considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

6.43 Minutes shall be circulated in accordance with Directors' wishes. Where providing a record of a public meeting the minutes shall be made available to the public (required by the Code of Practice on Openness in the NHS).

6.44 **Annual Public Meeting** - The Board will publicise and hold an annual public meeting by 30 September each year for the purpose of presenting audited accounts, annual reports and any reports on the accounts.

6.45 **Admission of public and press** - The public and representatives of the press shall be afforded facilities to attend all formal meetings of the Board but shall be required to withdraw upon the Board resolving as follows:

- "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest" (Section 1(2) Public Bodies (Admission to Meetings) Act 1960).

6.46 The Chairperson (or Deputy Chairperson) shall give such directions as he/she thinks fit in regard to the arrangements for meetings and accommodation of the public and representatives of the press such as to ensure that the Board's business shall be conducted without interruption and disruption and, without prejudice to the power to exclude on grounds of the confidential nature of the business to be transacted, the public will be required to withdraw upon the Board resolving as follows:

- "That in the interests of public order the meeting adjourn for (the period to be specified) to enable the Board to complete business without the presence of the public" (Section 1(8) Public Bodies (Admission to Meetings) Act 1960).

6.47 Matters to be dealt with by the Board following the exclusion of representatives of the press, and other members of the public, as provided in SOs 6.45 and 6.46 above, shall be confidential to the members of the Board.

6.48 Non-Executive Directors and Executive Directors or any employee of the Trust in attendance shall not reveal or disclose the contents of papers marked 'in confidence' or minutes headed 'items taken in private' outside of the Trust, without the express permission of the Trust. This prohibition shall apply equally to the content of any discussion during the Board meeting which may take place on such reports or papers.

6.49 Nothing in these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place without the prior agreement of the Board.

7 ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

7.1 Subject to SO 5.2 and such directions as may be given by the Secretary of State, the Board may make arrangements for the exercise, on behalf of the Trust, of any of its functions by a committee or sub-committee, appointed by virtue of SO 8.1 below or by a Director or an Officer of the Trust. In each case these arrangements shall be subject to such restrictions and conditions as the Board thinks fit.

7.2 **Emergency Powers** - The powers which the Board has retained to itself within these SOs may in emergency be exercised by the Chief Executive and the Chairperson (acting jointly) after having consulted at least two Non-Executive Directors. The exercise of such powers by the Chief Executive and the Chairperson shall be reported to the next formal meeting of the Board for ratification.

7.3 **Delegation to Committees** - The Board shall agree from time to time to the delegation of specific powers to be exercised by committees or sub-committees, which it has formally constituted. The terms of reference of these committees and their specific executive powers shall be approved by the Board.

7.4 **Delegation to Officers** - Those functions of the Trust which have not been retained as reserved by the Board or delegated to a committee of the Trust, shall be exercised on behalf of the Board by the Chief Executive. The Chief Executive shall determine which functions he/she will perform personally and shall nominate Officers to undertake the remaining functions for which he/she will still retain accountability to the Board.

7.5 **Schedule of Reservation of Powers to the Board and Delegation of Powers** – the Board shall adopted a schedule of Reservation of Powers to the Board and Delegation of Powers ("Scheme of Delegation") setting out the matters for which approval is required by the Board and details of the Directors and Officers of the Trust to whom responsibility has been delegated for deciding particular matters. The Chief Executive may periodically propose amendment to the Scheme of Delegation which shall be considered and approved by the Board.

7.6 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Director of Finance or other Executive Directors to provide information and advise the Board in accordance with any statutory requirements.

7.7 The Scheme of Delegation is found in sections 39 and 40 below.

8 COMMITTEES

8.1 **Appointment of Committees** - Subject to SO 5.3 and such directions as may be given by, or on behalf of, the Secretary of State, the Trust may appoint Committees of the Trust, consisting wholly or partly of Directors of the Trust or wholly of persons who are not Directors of the Trust. Committees will be subject to review by the Board from time to time.

8.2 A Committee appointed under SO 8.1 may, subject to such directions as may be given by, or on behalf of, the Secretary of State or the Board, appoint Committees consisting wholly or partly of members of the committee (whether or not they include directors of the Trust) or wholly of persons who are not members of the Trust committee (whether or not they include directors of the Trust).

8.3 The SOs of the Trust, as far as they are applicable, shall apply with appropriate alteration to meetings of any Committees or Governance Group.

8.4 Each Committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board), as the Board shall decide. Each Committee shall approve the terms of reference of each Governance Group reporting to it. Such terms of reference shall have effect as if incorporated into the SOs.

8.5 Committees may not delegate their powers unless expressly authorised by the Board.

8.6 The Board shall approve the appointments to each of the Committees and Governance Group which it has formally constituted. Where the Board determines that persons, who are neither Directors nor Officers, shall be appointed to a Committee, the terms of such appointment shall be determined by the Board. The payment of travelling and other allowances shall be in accordance with such sum as may be determined by the Secretary of State with the approval of the Treasury (see section 233 of the NHS Act 2006).

8.7 Minutes of any Committee appointed under this SO 8 shall be made available to all Board Members, except for the Remuneration and Terms of Service Committee, the minutes of which shall only be available to its Members.

8.8 With the exception of those items that are required to be reported to the Board under these Standing Orders or as a statutory/regulatory requirement, the Chairs of Committees will have a discretion as to matters to be brought to the Board's attention.

8.9 Minutes, or a representative summary of the issues considered and decision taken of any Governance Group shall be submitted for inclusion onto the agenda of the next Committee meeting to which it reports.

8.10 Where the Trust is required to appoint persons to a committee and/or to undertake statutory functions as required by the Secretary of State, and where such appointments are to operate independently of the Trust such appointment shall be made in accordance with the regulations laid down by the Secretary of State.

8.11 The Committees to be established by the Trust will consist of statutory and mandatory and non-mandatory Committees.

8.12 The Committees established by the Trust are:

8.12.1 **Audit and Risk Committee**

Primary Role: To ensure effective internal control arrangements are in place. In addition, the Audit and Risk Committee provides a form of independent check upon the executive arm of the Board.

8.12.2 **Remuneration and Terms of Service Committee**

Primary Role: To determine and approve appropriate remuneration and terms of service for the Chief Executive, other Executive Directors and other senior Officers.

8.12.3 **Workforce and Organisational Development Committee**

Primary Role: 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. 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 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.

8.12.4 **Quality Committee**

Primary Role: 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. 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 ability to deliver excellent quality health and social care that these are being managed in a controlled and timely way.

8.12.5 **Finance and Performance Committee**

Primary Role: 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. To assure the Board, through consultation with the Audit and Risk Committee that structures, systems and processes are in place and functioning to support broad and long term Financial, 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.

8.12.6 **Mental Health Act Committee**

Primary Role: To provide the Board with assurance concerning all aspects of Mental Health Act and Mental Capacity Act activities. Specifically 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), Mental Capacity Act 2005 and other related legislation within inpatient and community settings.

8.12.7 **Charitable Funds Committee**

Primary Role: The Charitable Funds Committee will act on behalf of the Corporate Trustee, with delegated responsibility for overseeing, monitoring and evaluating

all charitable activities to ensure they are in accordance with the charity's objectives.

Its purpose, on behalf of the Board, is to:

- advise the Board on the management of the funds of the Charity;
- apply scrutiny and constructive challenge to the Charity's financial information and systems of control, including the annual accounts;
- provide assurance to the Board that the administration of charitable funds is distinct from its exchequer funds and compliant with legislation and Charity objectives.

8.13 **Confidentiality** –There is no requirement for meetings of Committees and Governance Groups to be held in public, or for agendas or records of these meetings to be made public. However, the records of any meetings may be required to be disclosed, should a valid request be made under the Freedom of Information Act 2000 and there is no legal justification for non-disclosure.

8.14 Other than by the circulation of draft minutes a member of a Committee shall not disclose a matter dealt with by, or brought before, the Committee without its permission until the Committee shall have reported to the Board or shall otherwise have concluded on that matter.

8.15 A Director of the Trust, a member of a Committee or any other employee of the Trust shall not disclose any matter reported to the Board or otherwise dealt with by the Committee, notwithstanding that the matter has been reported or action has been concluded, if the Board or Committee shall resolve that it is confidential.

9 DECLARATIONS OF INTERESTS AND REGISTER OF INTERESTS

9.1 **Declaration of Interests** – All existing Directors and any senior Officers who may act up to an Executive Director post should declare interests which are relevant and material to the Board on an annual basis, or as otherwise required. Any Directors or senior Officers appointed subsequently should declare these interests on appointment.

9.2 Interests which should be regarded as "relevant and material" are:

9.2.1 Directorships, including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies);

9.2.2 Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS;

9.2.3 Majority or controlling shareholding in organisations likely or possibly seeking to do business with the NHS;

9.2.4 A position of authority in a charity or voluntary organisation in the field of health and social care; and/or

9.2.5 Any connection with a voluntary or other organisation contracting for NHS services.

9.3 If Directors have any doubt about the relevance of an interest, this should be discussed with the Chairperson.

9.4 At the time Directors' interests are declared, they should be recorded in the Board minutes. Any changes in interests should be declared at the next Board meeting following the change occurring.

9.5 If a conflict of interest is established during the course of a Board meeting, whether arising from a declared interest or otherwise, the Director concerned should withdraw from the meeting and play no part in the relevant discussion or decision. The declared conflict of interest should be recorded in the minutes of the meeting.

9.6 Directors' directorships of companies likely or possibly seeking to do business with the NHS should be published in the Trust's annual report. The information should be kept up to date for inclusion in succeeding annual reports.

9.7 **Register of Interests** - The Trust Secretary will ensure that a Register of Interests is established and maintained to record formally declarations of interests of Directors. In particular, the Register of Interests will include details of all directorships and other relevant and material interests which have been declared by both Executive Directors and Non-Executive Directors.

9.8 These details will be kept up to date by means of an annual review of the Register of Interests in which any changes to interests declared during the preceding twelve months will be incorporated.

9.9 The Register of Interests will be available to the public via the Trust website.

10 DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

10.1 Subject to SO 11 and the provisions of this SO, if a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Trust at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

10.2 The Secretary of State may, subject to such conditions as he may think fit to impose, remove any disability imposed by this SO in any case in which it appears to him/her in the interests of the NHS that the disability shall be removed.

10.3 The Board, or any Committee or Governance Group, shall exclude a Director from a meeting of the Board Committee or Governance Group (as relevant) while any contract, proposed contract or other matter in which he/she has a pecuniary interest, direct or indirect, is under consideration.

10.4 Any remuneration, compensation or allowances payable to a Director by virtue of section 233 of the NHS Act 2006 shall not be treated as a pecuniary interest for the purpose of this SO.

10.5 For the purpose of this SO the Chairperson or a Director shall be treated, subject to SO 11.2 – 11.4 and SO 11.8 – 11.12, as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

10.5.1 he/she, or a nominee of his/hers, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

10.5.2 he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration;

10.5.3 And in the case of married persons or persons living together the interest of one spouse shall, if known to the other, be deemed for the purposes of this SO to be also an interest of the other.

10.6 A Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

10.6.1 Of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

10.6.2 Of an interest in any company, body or person with which he/she is connected as mentioned in SO 10.5 above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

10.7 Where a Director:

10.7.1 Has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body, and

10.7.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company or body, whichever is the less, and

10.7.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class,

10.7.4 this SO shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter, or from voting on any question with respect to it without prejudice however to his/her duty to disclose his/her interest.

10.8 SO 10 applies to Committees or Governance Groups of the Board as it applies to the Board and applies to any member of any such Committee or Governance Group (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

11 STANDARDS OF BUSINESS CONDUCT

11.1 Policy – All Officers must comply with the national guidance contained in HSG(93)5 `Standards of Business Conduct for NHS staff', 'Code of Conduct for NHS Managers', 2002, the seven principles set out by the 'Committee on Standards in Public Life', published by the Professional Standards Authority, November 2012, and the Trust's policy as amended from time to time. The following provisions should be read in conjunction with these documents.

11.2 Interest of Officers in Contracts - If it comes to the knowledge of a Director or an Officer that a contract in which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Chief Executive of the fact that he/she is interested therein. In the case of married persons or persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

11.3 An Officer must also declare to the Chief Executive any other employment or business or other relationship of his/hers, or of a cohabiting spouse, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust.

11.4 The Trust requires interests, employment or relationships so declared by Officers to be entered in a Register of Interests. All parties involved within a Procurement procedure shall be required to register any interests held which may represent a Conflict of Interest. This shall be undertaken by the Procurement Department with any Conflicts of Interest mitigated as deemed appropriate.

11.5 **Canvassing of, and Recommendations by, Directors in Relation to Appointments** - Canvassing of Directors or members of any Committee directly or indirectly for any appointment under the Trust shall disqualify the candidate for such appointment. The contents of this SO shall be included in application forms or otherwise brought to the attention of candidates.

11.6 Directors shall not solicit for any person any appointment under the Trust or recommend any person for such appointment: but this SO shall not preclude a Director from giving written testimonial of a candidate's ability, experience or character for submission to the Trust.

11.7 Informal discussions outside appointments panels or Committees, whether solicited or unsolicited, should be declared to the panel or Committee.

11.8 **Relatives of Directors or Officers** - Candidates for any staff appointment shall when making application disclose in writing whether they are related to any Director or Officer of the Trust. Failure to disclose such a relationship shall disqualify a candidate and, if appointed, render him/her liable to instant dismissal.

11.9 Directors and Officers of the Trust shall disclose to the Chief Executive any relationship with a candidate of whose candidature that Director or Officer is aware. It shall be the duty of the Chief Executive to report to the Board any such disclosure made.

11.10 On appointment, Directors (and prior to acceptance of an appointment in the case of Executive Directors) should disclose to the Trust whether they are related to any other Director or Officer of the Trust.

11.11 Where the relationship of an Officer or another Director to a Director of the Trust is disclosed, the SO headed `Disability of directors in proceedings on account of pecuniary interest' shall apply.

11.12 In order to protect the interests of both Officers and the Trust, a confidential register is to be maintained by the Chief Executive or such senior Officer as he/she may designate, listing all employees who have any pecuniary activities outside of their employment with the Trust, including such activities as other employment, directorships, consultant work,

etc. It shall be the duty of all Officers falling within these and similar categories to declare such activities and they will also be entitled to see what information is recorded against their name. The list may be limited to the Board and those Senior Officers and other staff who occupy positions where they are able to influence the awarding of contracts.

11.13 **Gifts and Hospitality -** The following paragraphs in this section of SOs describe the legal position and set out guidance concerning gifts, rewards and hospitality. They are framed to protect individual Officers as well as the Trust.

11.14 The Chief Executive shall ensure that all Officers are aware of the Trust's policy on acceptance of gifts or benefits in kind by Officers as included in the Bribery Act 2010 and the Department of Health's guidance.

11.15 It is a criminal offence for an Officer corruptly to solicit or accept any gift or consideration as an inducement or reward. If the gift or consideration is from someone holding or seeking a contract with the Trust, it is deemed to have been received corruptly unless the Officer proves to the contrary. And it is a criminal offence for Officers to accept, as Officers, any fee or reward other than their proper remuneration. Accepting any gift or consideration in the knowledge or belief that it is intended as an inducement or reward is an offence, whether the Officer receiving it is actually influenced or not.

11.16 A gift or offer of hospitality may sometimes be so lavish that any reasonable person would consider that it is made with the intention of corrupting. Even if it is not as lavish as that, however, there may still be the possibility of corruption.

11.17 If an Officer of the Trust is in any doubt about what to do about any offer of a gift or hospitality, the advice of a more senior Officer should be sought. The question to be considered is whether the acceptance is likely to raise reasonable doubts about the person's integrity.

11.18 Although the offer of casual gifts by contractors, organisations, firms or individuals may not be in any way connected with the performance of official duty so as to constitute an offence, the offer should nevertheless, as a general rule, be declined.

11.19 The only exceptions to the rule are:

11.19.1 Small gifts or office equipment or stationery given by way of trade advertisements to a range of Officers or for use in the office. Nothing more elaborate than calendars, diaries, rulers or blotters would fall within this exception.

11.19.2 Small gifts of only token value given on the conclusion of an official courtesy visit, e.g. to a factory or other premises.

11.19.3 Gifts to an Officer of the Trust or a member of their family where the donor is a personal friend. Extreme care needs to be taken with gifts in this category, bearing in mind the legal position described above. Gifts which do not fall clearly within these exceptions and which are offered in person to an Officer of the Trust should be politely declined, and the person or organisation offering it should be told of the Trust's rule about gifts.

11.20 If a gift outside the exceptions noted above arrives without warning it must be handed over to the appropriate senior Officer to decide whether the gift should be returned (or passed to some good cause) and to ensure that the donor is informed of what has happened.

11.21 These rules apply also to offers by firms to members of staff of discounts going beyond those on general offer.

11.22 Offers of hospitality should always be approached with caution. Members of staff should ask themselves what a member of the public, who may be critical or suspicious, might think; and offers of hospitality, where any suggestion of improper influence is possible, must be refused. Hospitality should only be accepted when it is reasonably incidental, and on a scale appropriate, to the occasion or the circumstances. Acceptance may make it difficult to avoid some obligation to the party offering it, and might later be thought to have affected an officer's impartiality in dealing with official matters.

11.23 Some offers of hospitality are clearly unacceptable: offers of holiday accommodation are one example. Invitations to sporting fixtures or evenings at the theatre may only be acceptable when they are clearly required for the conduct of Trust business. Any hospitality on a lower scale than this might also be unacceptable. No absolute dividing line can be laid down.

11.24 There is an important difference between, for example, attendance in an official capacity at a function organised by a public authority and accepting hospitality from a private individual or firm standing to benefit from the goodwill of the Trust. Particular care should be taken in dealing with contractors, developers, and firms or individuals in a comparable position.

11.25 However, it will not always be possible or even desirable to reject offers of hospitality on a modest scale. Acceptable examples would include official hospitality of a kind mentioned in the previous paragraph; a drink and a sandwich following a site visit; or a working lunch of a modest standard to enable the parties to continue to discuss business. The decision whether to accept or not must depend on the circumstances in each case. Where it is clearly evident that the work of the Trust would be facilitated, invitations to attend receptions, luncheons, cocktail parties and the like may be accepted under the following rules.

11.26 No member of staff below the rank of Senior Manager or equivalent may accept an invitation without first obtaining the approval of a senior officer at that level or above. In exceptional circumstances where it is not possible to seek prior approval, the facts should be reported immediately afterwards.

11.27 Invitations involving attendance outside normal working hours may be accepted only on the authority of a Director.

11.28 A confidential register is to be maintained by every Director in which, in relation to every offer of a gift or hospitality (apart from the exceptions for gifts set out above and the drink and sandwich level of hospitality), offered to a member of staff in their Directorate, including themselves, the following information will be (briefly) recorded:

- The person or body making the offer
- The member of staff to whom the offer was made
- The gift or hospitality offered
- The circumstances in which the offer was made
- The action taken by the member of staff concerned
- The action taken (if any) by the Director

11.29 In general, gifts will either fall within the exceptions, or ought to be refused; so far as gifts or hospitality are concerned, therefore, the register will mainly record offers where the value approximates to £25.00 or above and has been refused.

11.30 Every member of staff who receives or is offered a gift or is offered hospitality, which these guidelines require to be registered, is required to report the circumstances to their Director so that the record may be kept. Every member of staff is entitled to see what is recorded in the register against their name, and the Chief Executive is to have access to every register maintained.

11.31 A confidential register is also to be maintained by the Chief Executive giving full details and recording information on action taken regarding all complaints or allegations of corruption or fraud against any officer or officers of the Trust (see also the Trust's Fraud Policy and Response Plan). All those who have knowledge of such complaints or allegations are required to report the matter to the Chief Executive. Every member of staff is entitled to see what information is recorded against their name.

12 CUSTODY OF SEAL AND SEALING OF DOCUMENTS

12.1 **Custody of Seal** - The Common Seal of the Trust shall be kept by the Chief Executive in a secure place.

12.2 **Sealing of Documents** - The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by the Board, or a Committee of the Board, or the Chairperson, or the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegation.

12.3 Before any building, engineering, property or capital document is sealed it must be approved and signed by two members of the Board.

12.4 The Seal shall be affixed in the presence of the signatories.

12.5 **Register of Sealing** - An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose.

12.6 A report of all sealing shall be made to the Board at least quarterly. (The report shall contain details of the seal number, the description of the document and date of sealing).

13 SIGNATURE OF DOCUMENTS

13.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Chief Executive, unless any enactment otherwise requires or authorises, or the Board shall have given the necessary authority to some other person for the purpose of such proceedings.

13.2 The Chief Executive or nominated Officers shall be authorised, by resolution of the Board, to sign on behalf of the Trust any agreement or other document (not required to be executed as a deed) the subject matter of which has been approved by the Board or Committee to which the Board has delegated appropriate authority.

13.3 Following formal approval of Board minutes by the Board, the Trust Secretary is authorised to apply the electronic signature of the Chairperson to those minutes.

Following formal approval of Committee minutes by that Committee, the Trust Secretary is authorised to apply the electronic signature of the Committee Chair to those minutes.

13.4 The application of an electronic signature is an administrative function, with decisions of the Board and Committees taking effect at the time of its making and not the time of the application of an electronic signature.

14 MISCELLANEOUS

14.1 **Suspension of Standing Orders** - Except where this would contravene any statutory provision or any direction made by the Secretary of State, any one or more of the SOs, except for SO 14.6 (which may not be suspended), may be suspended at any meeting, provided that at least two-thirds of the Directors of the Trust are present, including one Executive Director and one Non-Executive Director, and that a majority of those present vote in favour of suspension.

14.2 A decision to suspend SOs shall be recorded in the minutes of the meeting.

14.3 A separate record of matters discussed during the suspension of SOs shall be made and shall be available to the Directors.

14.4 No formal business may be transacted while SOs are suspended.

14.5 The Audit and Risk Committee shall review every decision to suspend SOs.

14.6 **Variation of Standing Orders** - These SOs shall be amended only if:

14.6.1 A notice of motion under SO 6.12 has been given; and

14.6.2 No fewer than half the appointed Non-Executive Directors vote in favour of variation; and

14.6.3 At least two-thirds of the Directors who are eligible to vote are present; and

14.6.4 The variation proposed does not contravene a statutory provision or direction made by the Secretary of State.

14.7 SO 14.6 may not be varied.

14.8 **Availability of Standing Orders** - It is the duty of the Chief Executive to ensure that all existing Directors and Officers and all new appointees are notified of and understand their responsibilities within SOs and SFIs. Updated copies shall be made available through the Trust's Intranet.

14.9 **Documents having the standing of Standing Orders** - SFIs and Scheme of Delegation have been incorporated in to this, one single document.

14.10 **Review of Standing Orders** – SOs shall be reviewed annually by the Board.

STANDING FINANCIAL INSTRUCTIONS

15 OVERVIEW OF SFIS

15.1 The SFIs detail the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in

accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness in all financial matters concerning the Trust.

15.2 These SFIs identify the financial responsibilities which apply to everyone working for the Trust. They do not provide detailed procedural advice and should therefore be read in conjunction with the detailed departmental and financial procedure notes published by the Trust. All financial policies must be approved by the Director of Finance.

15.3 Should any difficulties arise regarding the interpretation or application of any of the SFIs, the advice of the Director of Finance must be sought before acting. The user of these SFIs should also be familiar with, and comply with, the provisions of the SOs and the Reservation of Powers to the Board and the Detailed Scheme of Delegation.

15.4 These SFIs apply to all Officers, including temporary contractors, volunteers and staff employed by other organisations to deliver services in the name of the Trust. Failure to comply with the SFIs and SOs is a disciplinary matter that could result in dismissal.

15.5 Overriding SFIs – If for any reason these SFIs are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit and Risk Committee for referring action or ratification. All members of the Board and Executive Management Team and Officers have a duty to disclose any non-compliance with these SFIs to the Director of Finance as soon as possible.

16 RESPONSIBILITIES AND DELEGATION

16.1 The Board exercises financial supervision and control by:

16.1.1 formulating the financial strategy of the Trust;

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

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

16.1.4 defining specific responsibilities placed on members of the Board/ Executive Management Team and Officers as indicated in the 'Reservation of Powers to the Board'.

16.2 The Board has resolved that certain powers and decisions may only be exercised by the Board in formal session.

16.3 The Board will delegate responsibility for the performance of its functions in accordance with the Reservation of Powers to the Board, Delegation of Powers adopted by the Trust.

16.4 Within these SFIs, it is acknowledged that the Chief Executive is the Accountable Officer of the Trust and:

16.4.1 is ultimately accountable to the Board, and as accountable officer to the Secretary of State, for ensuring that the Board of Directors meets it obligation to perform the Trust's functions within the available financial resources;

16.4.2 has overall executive responsibility for the Trust's activities and is responsible to the Board for ensuring that the Trust's financial obligations and targets are met;

16.4.3 has overall responsibility for the Trust's system of internal control; and

16.4.4 is responsible for ensuring that all members of staff of the Trust are aware of and understand their responsibilities within these SFIs

16.5 Save for the decisions and actions reserved to the Board, the Chief Executive has full operational authority to approve the financial transactions of the Trust and to delegate such powers to post-holders within the Trust management.

16.6 The Chief Executive and Director of Finance may, within reason, delegate their detailed responsibilities, but they remain accountable for financial control.

16.7 The Director of Finance is responsible for:

16.7.1 implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

16.7.2 maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these SFIs;

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

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

16.7.4 the provision of financial advice to other members of the Board and Executive Management Team and Officers;

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

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

16.8 All members of the Board and Officers of the Trust, severally and collectively, are responsible for:

16.8.1 the security of the property of the Trust;

16.8.2 avoiding loss;

16.8.3 exercising economy and efficiency in the use of resources; and

16.8.4 conforming with the requirements of the SOs, SFIs and the Scheme of Delegation

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

16.10 For any Officers of the Trust who carry out a financial function, the form in which financial records are kept and the manner in which the Board, Executive Management Team and Officers of the Trust discharge their duties must be to the satisfaction of the Director of Finance.

16.11 Financial framework – the Director of Finance shall ensure that members of the Board are aware of the financial aspects of NHSIs Code of Accountability and Single Oversight Framework, within which the Trust is required to operate.

17 AUDIT

17.1 Audit and Risk Committee

17.1.1 In accordance with SO 8 the Board shall formally establish an Audit and Risk Committee, with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;

b) reviewing financial systems and monitoring the integrity of the financial statements and reviewing significant financial reporting judgments;

c) monitoring compliance with SOs and SFIs;

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

e) reviewing the information prepared to support the annual governance declaration statements prepared on behalf of the Board and advising the Board accordingly.

as set out in the terms of reference approved by the Board.

17.1.2 Where the Audit and Risk Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairperson of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to NHSI.

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

17.2 Fraud and Corruption

17.2.1 In line with their responsibilities as set out in HSG(96)12 and Bribery Act guidance, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the Department of Health Directions on fraud, corruption and bribery.

17.2.2 The Director of Finance shall ensure that the Trust's Counter Fraud and Corruption Policy is maintained and remain up to date.

17.2.3 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist to deliver the requirements of the Trust's Counter Fraud and Corruption Policy.

17.2.4 The Local Counter Fraud Specialist shall report to the Director of Finance and shall work with staff in NHS Counter Fraud Authority, when required.

17.2.5 The Local Counter Fraud Specialist will provide a written report to the Audit and Risk Committee, on an annual basis at least, on the counter fraud work completed within the Trust.

17.3 Director of Finance

17.3.1 The Director of Finance is responsible for:

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

b) ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;

c) ensuring that the Head of Internal Audit is sufficiently qualified and experienced to perform that role; to facilitate the effective discussion of the results of internal audit with senior management

d) ensuring that there is effective liaison with the relevant Counter Fraud Authority on all suspected cases of fraud and corruption and all anomalies which may indicate fraud or corruption before any action is taken;

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

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

- a clear opinion on the effectiveness of internal control in accordance with current assurance framework guidance issued by the Department of Health and Social Care,
- major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- progress against plan over the previous year,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year;

g) ensuring the police are informed at the right time, in cases of misappropriation and other irregularities not involving fraud or corruption;

h) ensuring there is effective liaison with the Trust's Local Counter Fraud Specialist or NHS Counter Fraud Authority on all suspected cases of fraud and corruption and all anomalies which may indicate fraud and corruption.

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

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

b) access at all reasonable times to any land, premises or members of the Board and Executive Management Team or Officers of the Trust;

c) the production of any cash, stores or other property of the Trust under the control of a member of the Board or the Executive Management Team or an Officer; and

d) explanations concerning any matter under investigation.

17.4 Role of Internal Audit

17.4.1 Internal Audit shall:

a) Provide an independent and objective assessment for the Chief Executive, the Board and the Audit and Risk Committee on the degree to which risk

management, control and governance arrangements support the achievement of the Trust's objectives.

b) Operate independently of the decisions made by the Trust and its Officers; and of the activities which it audits. No member of the Internal Audit team will have executive responsibility.

17.4.2 Internal Audit will review, appraise and report upon:

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

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

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

- fraud, bribery and other offences,
- waste, extravagance, inefficient administration,
- poor value for money or other causes.

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

17.5 Head of Internal Audit

17.5.1 The Head of Internal Audit shall develop and maintain an internal audit strategy for providing the Chief Executive with an objective evaluation of; and opinions on the effectiveness of the Trust's risk management, control and governance arrangements.

17.5.2 The Head of Internal Audit shall ensure that the audit team is adequately staffed and that there is access to the full range of knowledge, skills, qualifications and experience needed to deliver the internal audit plan in line with the NHS Internal Audit Manual.

17.5.3 The Head of Internal Audit will normally attend Audit and Risk Committee meetings and has a right of access to all Audit and Risk Committee members, the Chairperson and Chief Executive and all Directors of the Trust.

17.5.4 The Head of Internal Audit shall be accountable to the Director of Finance. The reporting system for internal audit shall be agreed between the Director of Finance, the Audit and Risk Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years.

17.6 External Audit

17.6.1 The external auditor is appointed by the Audit and Risk Committee via competitive tender and paid for by the Trust. The Audit and Risk Committee must ensure a

cost-efficient service is provided. Should there appear to be a problem concerning the service provided by the external auditor, this should be raised with the external auditor and referred via the escalation process stipulated in the contract if the issue cannot be resolved.

18 ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL, AND MONITORING

18.1 **Preparation and Approval of Business Plans and Budgets** - The Chief Executive will compile and submit to the Board an annual business plan which takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

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

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

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

a) be in accordance with the aims and objectives set out in the annual business plan;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds; and

e) identify potential risks.

18.1.4 The Director of Finance shall monitor financial performance against budget and business plan, periodically review them, and report to the Board.

18.1.5 All Budget Holders must provide information as required by the Director of Finance to enable Budgets to be compiled. All Budget Holders will sign up to their allocated Budgets at the commencement of each Financial Year.

18.1.6 The Director of Finance has overall responsibility for ensuring that adequate training is delivered on an on-going basis to Budget Holders to help them manage their Budget successfully.

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

18.2.1 the amount of the Budget;

18.2.2 the purpose(s) of each Budget heading;

18.2.3 individual and group responsibilities;

18.2.4 authority to exercise virement;

18.2.5 achievement of planned levels of service; and

18.2.6 the provision of regular reports.

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

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

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

18.6 **Budgetary Control and Reporting** - The Director of Finance will devise and maintain systems of budgetary control. These will include:

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

- income and expenditure to date showing trends and forecast year-end position;
- movements in working capital;
- capital project spend and projected outturn against plan;
- explanations of any material variances from plan;
- details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation;

18.6.2 the issue of timely, accurate and comprehensible advice and Budget statements to each Budget holder, covering the areas for which each is responsible;

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

18.6.4 monitoring of management action to correct variances; and

18.6.5 arrangements for the authorisation of budget transfers/virements.

18.7 Each Budget Holder is responsible for ensuring that:

18.7.1 any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Chief Executive and should be reported to the following Board meeting;

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

18.7.3 no permanent Officers are appointed other than those provided for within the available resources and manpower establishment as approved by the Board.

18.8 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Business Plan and a balanced Budget.

18.9 **Capital Expenditure -** The general rules applying to budgetary delegation, budgetary control and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained below.)

18.10 **Monitoring Returns -** The Director of Finance on behalf of the Chief Executive is responsible for ensuring that the appropriate financial monitoring forms are submitted to the requisite monitoring organisation.

19 ANNUAL ACCOUNTS AND REPORTS

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

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

19.1.2 prepare and submit annual financial reports to the Secretary of State certified in accordance with current guidelines; and

19.1.3 submit financial returns to the Secretary of State for each financial year in accordance with the timetable prescribed by the Secretary of State

19.1.4 submit periodic monitoring and financial returns to external organisations, such as NHSI, in accordance with the timetables set by those organisations.

19.2 The Trust's annual accounts must be audited by an auditor appointed by the Audit and Risk Committee. The Trust's audited accounts shall be presented to a public meeting and made available to the public, within the timescales set by the Secretary of State.

19.3 The Trust will publish an annual report, in accordance with guidelines on local accountability, and present it at a public meeting. The document will comply with the Department of Health and Social Care's Group Accounting Manual.

20 BANK AND GBS ACCOUNTS

20.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance/ Directions issued from time to time by the Department of Health and Social Care.

20.2 The Board shall approve the banking arrangements.

20.2.1 Bank and GBS Accounts

20.2.2 The Director of Finance is responsible for:

a) bank accounts and Government Banking Service (GBS) accounts;

b) establishing separate bank accounts for the Trust's non-exchequer funds if held;

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

d) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

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

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

20.3.2 the limit to be applied to any overdraft; and

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

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

21 TENDERING AND REVIEW

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

21.2 Benchmarking for commercial accounts should be undertaken at least every 5 years. The results of the benchmarking should be reported to the Board. Where benchmarking indicates the Trust is not achieving best value, alternative banking arrangements should be sought in line with Procurement requirements.

22 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

22.1 Income Systems

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

22.1.2 The Director of Finance is also responsible for ensuring a procedure is in place for the prompt banking of all monies received.

22.2 Fees and Charges

22.2.1 The Trust shall follow the DHSC's advice in the costing manual in setting prices for NHS service agreements.

22.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the DHSC or by statutory regulation. Independent professional advice on matters of valuation shall be taken as necessary.

22.2.3 All Officers must not commit the Trust but inform the Director of Finance promptly of money due to the Trust from transactions which they initiate/deal with including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

22.2.4 The Director of Finance shall approve all property leases, property rentals and tenancy agreements. The Director of Estates and Capital Projects shall advise on these arrangements.

22.3 Debt Recovery

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

22.3.2 Income invoiced but not received should be treated as a bad debt and dealt with in accordance with the losses procedures. Disputed NHS transactions are not treated as bad debts but cleared via a credit note.

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

22.3.4 In the event an external party is engaged to seek the recovery of monies due, this must be undertaken in accordance with the Concession Contract Regulations (2016).

22.4 Security of Cash, Cheques and Other Negotiable Instruments

22.4.1 The Director of Finance is responsible for:

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

b) ordering and securely controlling any such stationery;

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

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

22.4.2 Official money shall not under any circumstances be used for the encashment of private cheques.

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

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

23 NHS SERVICE AGREEMENTS FOR PROVISION OF SERVICES

23.1 The Chief Executive, as the accountable officer, is responsible for ensuring the Trust enters into suitable Contracts or Service Level Agreements (SLAs) with service commissioners for the provision of NHS services to patients. The Chief Executive should take into account:

23.1.1 the standards of service quality expected;

23.1.2 National Operating Framework

23.1.3 the relevant National Service Framework (if any);

23.1.4 the provision of reliable information on cost and volume of services;

23.1.5 the NHS Long Term Plan;

23.1.6 the NHS National Performance Assessment Framework;

23.1.7 that SLAs build where appropriate on existing Joint Investment Plans;

23.1.8 that SLAs are based on integrated care pathways.

23.2 A good contract or SLA will result from a dialogue of clinicians, users, carers, public health professionals and managers. It will reflect knowledge of local needs and inequalities. This will require the Chief Executive to ensure that the Trust works with all partner agencies involved in both the delivery and commissioning of the service required. In this way the Trust can jointly manage risk with all interested parties.

23.3 The Director of Finance on behalf of the Chief Executive, as the accountable officer, will produce monthly reports to the Board detailing actual and forecast income from activity contracts and SLAs.

23.4 The approval limits as stipulated in the Trust's Business Case policy are as follows:

23.4.1 Director of Finance or nominated officer will approve services up to £75,000;

23.4.2 The Executive Assurance Committee will approve all services from £75,001 to £250,000;

23.4.3 The Finance and Performance Committee will approve services from £250,001 to £750,000;

23.4.4 The Board shall approve all services over £750,000.

23.5 The Director of Finance shall provide up to date advice on:

23.5.1 Standard NHS contractual terms and conditions, issued by the Department of Health and Social Care;

23.5.2 Costing and pricing of services;

23.5.3 Payment terms and conditions;

23.5.4 Amendments to contracts, SLAs and extra-contractual arrangements.

23.6 The Director of Finance shall ensure that all SLAs are other contractual and extra contractual arrangements:

23.6.1 Are devised so as to limit the risk to the Trust, whilst enabling opportunities to generate income;

23.6.2 Are financially sound; and that any contractual arrangement pricing at marginal cost are approved by the Director of Finance and reported to the Board.

23.6.3 The Director of Finance is responsible for ensuring that systems and processes are in place to record patient activity, raise invoices and collect monies due under the agreement for the provision of healthcare services.

23.7 The Director of Finance shall produce regular reports, to the Board or its Committees detailing the Trust's forecast financial performance.

23.8 Budget holders with responsibilities for managing delivery against service agreements must ensure they understand and use the contract monitoring information for the financial management of their service areas.

24 TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND OFFICERS

24.1 Remuneration and Appointments

24.1.1 In accordance with SO 8 the Board shall establish a Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting (Remuneration and Terms of Service Committee).

24.1.2 The Remuneration and Terms of Service Committee will:

a) determine appropriate remuneration and allowances, and the other terms and conditions of office of the Chief Executive;

b) approve the appropriate remuneration and allowances and the other terms and conditions of service for other Executive Directors and the Senior Management Team to ensure they are fairly rewarded for their individual contribution to the Trust – having proper regard to the Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate

24.1.3 The above to include:

- all aspects of salary (including any performance-related elements/ bonuses);
- provisions for other benefits, including pensions and cars;
- arrangements for termination of employment and other contractual terms.

24.1.4 The Remuneration and Terms of Service Committee shall report in writing to the Board the basis for its decisions. Minutes of the Board's meetings should record such decisions.

24.1.5 The Board will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those Officers not covered by the Remuneration and Terms of Service Committee.

24.1.6 The Trust will remunerate the Chairperson and Non-Executive Directors in accordance with instructions issued by the DHSC.

24.2 Funded Establishment

24.2.1 The manpower plans incorporated within the annual Budget will form the funded establishment.

24.2.2 The funded establishment of any service may not be varied in excess of its financial envelope.

24.2.3 The approval limits for posts in excess of the agreed funded establishment either permanent or temporary as stipulated by the business case policy are as follows:

a) Executive Management Team will approve requests up to £75,000;

b) The Executive Assurance Committee will approve requests from £75,001 to £250,000;

c) The Finance and Performance Committee will approve requests from £250,001 to £750,000; and

d) The Board will approve all requests over £750,000.

24.3 Staff Appointments

24.3.1 No Director or Officer may re-grade Officers, either on a permanent or temporary nature, or agree to changes in any aspect of remuneration unless authorised to do so by the Director of Workforce and Organisational Development and Director of Finance; and within the limit of the approved Budget and funded establishment.

24.3.2 No Director or Officer may engage, re-engage, either on a permanent or temporary nature, or hire agency staff, unless within the limit of the approved budget and funded establishment.

24.3.3 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, conditions of service, etc., for Officers.

24.4 Processing of Payroll

24.4.1 The Director of Finance is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances save for those determined by the Remuneration Committee;

c) making payment on agreed dates;

d) agreeing method of payment.; and

e) Specifying and agreeing the contractual arrangements for the provision of payroll services.

24.4.2 The Director of Finance will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of Officers and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act 1998;

g) methods of payment available to various categories of Officers;

h) procedures for payment by cheque, bank credit, or cash to Officers;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash; and

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Trust.

24.4.3 Appropriately nominated Officers and the Senior Management Team have delegated responsibility for:

a) submitting time records, and other notifications in accordance with agreed timetables;

b) completing time records and other notifications in accordance with the Director of Finance's instructions and in the form prescribed by the Director of Finance; and

c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an Officer's resignation, termination or retirement. Where an Officer fails to report for duty or to fulfil obligations in circumstances that suggest

they have left without notice, the Director of Finance must be informed immediately.

24.4.4 Regardless of the arrangements for providing the payroll service, the Director of Finance shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

24.5 Contracts of Employment

24.5.1 The Board shall delegate responsibility to the Director of Workforce and Communications for:

a) ensuring that all Officers and Executive Directors are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

b) dealing with variations to, or termination of, contracts of employment.

25 NON-PAY EXPENDITURE

25.1 Delegation of Authority

25.1.1 The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to Budget Holders.

25.1.2 The Chief Executive will set out:

a) the list of Officers who are authorised to place requisitions for the supply of goods and services; and

b) the maximum level of each requisition and the system for authorisation above that level.

25.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services. In the first instance this will ordinarily be the Procurement Department.

25.1.4 The approval limits funding requests in excess of current delegated levels as stipulated in the Business Case policy are as follows:

a) Executive Management Team can approve all requests to £75,000;

b) Executive Assurance Committee or Business Case Review Group with delegated authority from Executive Assurance Committee can approve all requests from £75,001 to £250,000;

c) The Finance and Performance Committee can approve all requests from £250,001 to £750,000;

d) The Board can approve all requests over £750,000.

25.2 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services

25.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's Procurement Department shall be sought.

25.2.2 The Director of Finance shall be responsible for the prompt payment of accounts and claims. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

25.2.3 The Director of Finance will:

a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in these SFIs and the Scheme of Delegation (as appropriate) and regularly reviewed;

b) prepare procedural instructions on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for the prompt payment of all properly authorised accounts and claims;

d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

- A list of Directors, Senior Management Team and Officers with an authorisation limit authorised to certify invoices.

- Certification that:

  A goods have been duly received, examined and are in accordance with specification and the prices are correct;

  B work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

  C in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

  D where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;

  E the account is arithmetically correct;

  F the account is in order for payment.

- A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early accounts subject to cash discounts or otherwise requiring early payment.
- Instructions to Officers regarding the handling and payment of accounts within the Trust's Finance Department.
- be responsible for ensuring that payment for goods and services is only made once the goods and services are received, (except as below).
- Prepare and issue procedures regarding Value Added Tax.

25.3 Prepayments

25.3.1 Prepayments are only permitted where exceptional circumstances apply (for the avoidance of doubt, this includes pre-payments made via Escrow and other similar functions). In such instances:

a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e., cashflows must be discounted to NPV) and the intention is not to circumvent cash limits;

b) the appropriate Director or member of the Senior Management Team must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments and the contractual provisions to be put in place which will safeguard the Trust’s financial position. This will ordinarily include an appraisal of the supplier’s financial position;

c) the Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the relevant

provisions of these SFIs, the Public Contract Regulations and other provisions including with regard to State Aid where the contract is above a stipulated financial threshold); and

d) the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and he must immediately inform the appropriate Director or Chief Executive if problems are encountered.

25.4 Official Orders

25.4.1 Official Orders must:

a) be consecutively numbered;

b) be in a form approved by the Director of Finance;

c) state the Trust's terms and conditions of trade, including the provision to access the prevailing document referred to; and

d) only be issued to, and used by, those duly authorised by the Chief Executive.

25.4.2 Officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

a) all contracts (other than for a simple purchase permitted within the Scheme of Delegation or delegated budget), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

b) contracts above specified thresholds are advertised and awarded in accordance with relevant legislation on public procurement;

c) where consultancy advice is being obtained, the procurement of such advice must be in accordance with these SFIs and any relevant guidance issued by the DHSC and NHSI;

d) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to Directors or Officers, other than:

e) isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

f) conventional hospitality, such as lunches in the course of working visits.

g) no requisition and/or order is placed for any item or items for which there is no Budget provision, unless authorised in advance and in writing by the Director of Finance on behalf of the Chief Executive;

h) all goods, services, or works are ordered on an official order except as approved on the exception list and purchases from petty cash;

i) verbal orders must only be issued very exceptionally. These must be confirmed at the earliest possible time by an official order and clearly marked "Confirmation Order" and approved by a Budget Holder.

j) orders are not disaggregated, split or otherwise placed in a manner devised so as to avoid the financial thresholds set out in these SFIs, the Scheme of Delegation or any relevant statute;

k) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase in breach of these SFIs and that all trials or loans are supported by a contract for the term proposed;

l) changes to the list of Directors, members of the Senior Management Team and Officers authorised to certify invoices are notified to the Director of Finance;

m) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; and

n) petty cash records are maintained in a form as determined by the Director of Finance.

25.4.3 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the 'Estate Code' guidance. The technical audit of these contracts shall be the responsibility of the relevant Director.

25.5 Tendering and Contract Procedure

25.5.1 All tendering must be carried out via the authorised e-tendering platform and be compliant with the Trust policies and procedures. Issue of all tender documentation will be undertaken electronically through a secure website with controlled access using secure login, authentication, audit and viewing rules. All tenders will be received into a secure electronic vault so that they cannot be accessed until the published closing time and date. All actions and communication by both procurement staff and suppliers are recorded within the system audit reports.

25.5.2 UK and EU Directives governing public procurement

25.5.3 Where relevant, United Kingdom and European Union directives on public sector purchasing procedures for awarding contracts shall have effect as if incorporated in these SFIs.

25.6 Formal Competitive Tendering

25.6.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials, works and manufactured articles and for the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DHSC); for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals.

25.6.2 The Associate Director of Procurement must be consulted on any formal tendering procedures that may be waived, in accordance with the Single Tender Waiver process. The Chief Executive (and any persons whom powers have been delegated to) can choose to waive a formal tendering procedure where:

a) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures and the circumstances are detailed in the appropriate Trust record; or

b) where the timescale genuinely precludes competitive tendering, do note that failure to plan is not regarded a justification ; or

c) where specialist expertise is required and is genuinely available from only one source. This would include specialist Original manufacturer (OEM) parts, maintenance and repairs; or

d) there is a clear benefit to be gained from maintaining continuity with an existing

Contract. The benefits of continuity must outweigh any potential financial advantage to be gained by competitive tendering; or

e) where the market has been tested and/or an opportunity has been published and an insufficient number of bids has been received; or

f) for the provision of legal advice and services that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England & Wales for the conduct of their business (or by the Bar council for England and Wales in relation to the obtaining of counsel's opinion) and are generally recognised as having sufficient expertise in the area of working for which they are commissioned

25.6.3 The waiver can be granted without reference to the Chief Executive where:

a) the estimated expenditure does not, or is not reasonably expected to, exceed £49,999; or

b) where the supply is proposed under special arrangements negotiated by the DHSC in which event the said special arrangements must be complied with; or

c) specialist expertise is required and is available from only one source; or

d) in exceptional circumstances, the Associate Director of Procurement has granted approval, in consultation with an Executive Director and the urgency genuinely outweighs the consulting of the Chief Executive. In such instances the Chief Executive shall be informed immediately at the earliest opportunity

25.6.4 The limited application of the single tender waiver process should not be used to avoid competition or for administrative convenience or to award further work to a consultant originally appointed through a competitive procedure including via a framework.

25.6.5 Where it is decided that competitive tendering is not applicable and should be waived by virtue of the single tender waiver process, the reasons should be documented and reported by the Director of Finance to the Audit and Risk Committee.

25.6.6 It is not possible to legally waiver any requirement in excess of the published OJEU Threshold applicable and in effect, as varied from time to time

25.6.7 Tendering procedures are set out in Appendix A of this policy.

25.7 Spending the Trust's Money

25.7.1 All spend must be in accordance with Spending The Trust's Money (STTM) and advice must be sought from the Procurement Team where necessary.

25.7.2 At least one written quotation must be obtained where the total estimated contract value is below £10,000.

25.7.3 At least three written quotations, with at least one quote from a Kent and/or Medway based business, must be obtained where the total estimated contract value is between £10,000 and £49,999. Where the lowest priced supplier is not chosen, the relative benefits of the chosen supplier must be formally logged demonstrating the achievement of value for money.

25.7.4 A full competitive procedure must be conducted where the total estimated contract value is £50,000 and above. This must include a published award criteria.

25.7.5 A full competitive OJEU procedure must be conducted where the total estimated contract value exceeds the relevant OJEU threshold in force as varied from time to time.

25.7.6 Quotations and Tenders must be evaluated in accordance with the published award criteria.

25.7.7 Any award must utilise the Trust's standard Contract.

25.8 **Where tendering or competitive quotation is not required** the Trust should adopt one of the following alternatives:

25.8.1 The Trust shall use NHS Supply Chain for procurement of all goods and services (and will not be required to obtain competitive quotations) unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

25.8.2 If the Trust does not use NHS Supply Chain (where tenders or quotations are not required, as set out in this policy), the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

25.9 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided under contract or in-house. The Board may also determine from time to time that in-house services should be market tested by competitive tendering.

25.10 **In-house services**

25.11 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided by the Trust on an in-house basis. The Trust may also determine from time to time that in-house services should be market tested by competitive tendering or benchmarking.

25.12 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

25.12.1 "specification group", comprising the Chief Executive or Nominated Officer(s) and specialist(s);

25.12.2 "in-house tender group", comprising representatives of the in-house team, a nominee of the Chief Executive and appropriate technical support; and

25.12.3 "evaluation group", comprising a specialist Officer, a Procurement Officer and a representative of the Director of Finance. For services having a likely annual expenditure exceeding £500,000, a Non-Executive Director shall be a member of the evaluation group.

25.13 All groups referred to above shall work independently of each other but individual Officers may be a member of more than one group. No member of the "in-house tender group" may, however, participate in the evaluation of tenders.

25.14 In all cases the approval of tenders shall be governed in accordance with the Scheme of Delegation. The "evaluation group" shall make recommendations to the Board.

25.15 The Chief Executive shall nominate an Officer to oversee and manage the in-house service.

25.16 Personnel and Agency or Temporary Staff Contract

25.16.1 The Chief Executive shall nominate Officers with delegated authority to enter into contracts for the employment of other Officers and enter into contracts for the engagement of agency staff or temporary staff, or others under service contracts. The appointment of staff via an agency or other such intermediary falls within the scope of procurement requirements, and so advice should be sought as appropriate.

25.17 Compliance requirements for all contracts

25.17.1 The Trust may only enter into contracts within its statutory powers and shall comply with:

a) the SOs;

b) these SFIs;

c) UK and EU Directives and other statutory provisions; and

d) any relevant guidance or directions issued by the Secretary of State.

25.17.2 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited. Any significant deviation should consider the legal risk of alteration.

25.17.3 For the purposes of these SFIs, 'contracts' shall include all agreements, leases, licences and hire purchase contracts to which the Trust is a party.

25.17.4 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

25.18 **Prevention of corruption**

25.18.1 Except where specific provision is made in model Forms of Contracts or standard schedules of conditions approved for use within the National Health Service, there shall be inserted in every written contract entered into by the Trust, a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation, if:

a) the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust; or

b) for showing or forbearing to show favour or disfavour to any person in relation to the contracts or any other contract with the Trust, or if the like acts shall have been done by any person employed by him/her or acting on his/her behalf (whether with or without the knowledge of the contractor), or

c) in relation to any contract with the Trust, the contractor or any person employed by him/her or acting on his/her behalf shall have committed any offence under the Prevention of Corruption Acts or any other appropriate legislation.

25.18.2 Determination of contracts for failure to deliver goods or material

a) The Trust's standard Contract must be utilised. This ensures the supply of goods or materials entered into by the Trust contains a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereof within the time or times specified in the contract, the Trust may (without prejudice to any other rights under the contract) determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good (a) such default, or (b) in the event of the contract being wholly determined the goods or materials remaining to be delivered. The clause shall further secure that the amount by which the cost of so purchasing other goods or materials exceeds the amount which would have been payable to the contractor in respect of the goods or materials shall be recoverable from the contractor.

26 TREASURY MANAGEMENT

26.1 The Director of Finance will ensure that the principles of the Treasury Management policy are followed, particularly in relation to:

26.1.1 achieving the most competitive return on surplus cash within the agreed risk profile'

26.1.2 ensuring the availability of flexible, competitively priced funding at all times within the constraints of the Prudential Borrowing Code;

26.1.3 identifying and managing the financial risks, including interest rates, arising from operational activities;

26.1.4 ensuring compliance with all banking covenants;

26.1.5 maintaining appropriate cash headroom to meet anticipated requirements; and

26.1.6 managing the Trust's liabilities and investment assets prudently ensuring commitments can be made as they fall due.

27 EXTERNAL BORROWING AND INVESTMENTS

27.1 External Borrowing

27.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing, within the limits set by the DHSC and/or NHSI and the Trust's Treasury Management Policy. The Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

27.1.2 Any application for a loan or overdraft will only be made by the Director of Finance or by an Officer so delegated by him.

27.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for loans and overdrafts.

27.1.4 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Director of Finance.

27.1.5 All long term borrowing must be consistent with the plans outlined in the current Business Plan and within the Trust's authorised Prudential Borrowing Limits.

27.2 Investments

27.2.1 Temporary cash surpluses must be held only in such public or private sector investments as notified by the Secretary of State and/or NHSI and authorised by the Board.

27.2.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

27.2.3 The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

28 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

28.1 Capital Investment

28.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without confirmation of purchaser(s) support and the availability of resources to finance all revenue consequences, including capital charges.

28.1.2 For every material capital expenditure proposal the Chief Executive shall ensure:

a) that a business case (in line with the guidance provided by DHSC) is produced setting out:
   - ii an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;
   - iii appropriate project management and control arrangements; and
   - iv the involvement of appropriate Trust personnel and third parties;

b) that the Director of Finance has certified professionally the costs and revenue consequences detailed in all business case proposals, and the relevant thresholds to determine the approval route.

28.1.3 The approval limits for capital investments is as stipulated in the Business Case Policy.

28.1.4 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations in the 'Estate Code' guidance. The Director of Finance shall assess on an annual basis the requirement for the operation of the 'Construction Industry Scheme' in accordance with any guidance issued by HM Revenue and Customs.

28.1.5 The approval of the annual capital programme by the Trust Board shall constitute approval for expenditure against that scheme.

28.1.6 The Chief Executive shall issue to the manager responsible for any approved capital scheme:

a) specific authority to commit expenditure;

b) authority to proceed to tender;

c) approval to accept a successful tender.

28.1.7 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the "Estate Code" guidance and the SOs.

28.1.8 The Finance Director shall:

a) issue procedures for the regular reporting of expenditure and commitment against authorised expenditure;

b) issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. These procedures shall fully take into account any guidance or best practice advice issued by the DHSC or NHSI regarding investment decisions by NHS Trusts.

28.2 Private Finance

28.2.1 The Trust should normally test for 'Private Finance Initiative' funding when considering material capital procurement. When the Trust proposes to use private finance which is to be provided by the private sector the following procedures shall apply:

a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

b) Where the sum involved exceeds delegated limits, the business case must be referred to the NHSI for approval or treated as per current guidelines.

c) The proposal must be specifically agreed by the Trust in light of such professional advice as should reasonably be sought in particular with regard to vires.

d) The selection of a contractor and/or finance company must be on the basis of competitive tendering or quotations

28.3 Asset Registers

28.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

28.3.2 The Trust shall maintain an asset register recording fixed assets. The minimum data set to be held within these registers shall be as specified in the Capital Accounting Chapter as issued in the DHSC's Group Accounting Manual.

28.3.3 Additions to the fixed asset register must be clearly identified to an appropriate Budget Holder and be validated by reference to:

a) Notification of project completion by the relevant project manager who is responsible for ensuring properly authorised and approved agreements,

architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

b) Purchase and installation of equipment;

c) Stores, requisitions and wages records for own materials and labour including appropriate overheads; and

d) Lease agreements in respect of assets held under a finance lease and capitalised.

28.3.4 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate). Where assets are disposed of, best value must be achieved in consideration of the same principles as when procuring them.

28.3.5 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on fixed asset registers.

28.3.6 The value of each asset shall be depreciated using methods and rates as specified in the DHSC's Group Accounting Manual.

28.3.7 The Director of Finance shall calculate and pay capital charges as specified in the DHSC's Group Accounting Manual.

28.4 Security of Assets

28.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

28.4.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

e) periodic verification of the existence of, condition of, and title to, assets recorded;

f) identification and reporting of all costs associated with the retention of an asset; and

g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

28.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

28.4.4 Whilst each Officer has a responsibility for the security of property of the Trust, it is the responsibility of Directors, Senior Management Team members and senior Officers in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

28.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by Directors and Officers in accordance with the procedure for reporting losses.

28.4.6 Where practical, assets should be marked as the property of the Trust.

28.4.7 The Trust's property must not be used by Officers for private purposes nor removed from the normal workplace except as specifically authorised by senior management/ Officers.

29 STORES AND RECEIPT OF GOODS

29.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be kept to a minimum.

29.2 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stocks and stores shall be delegated to an Officer by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental Officers and stores managers and/or keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer; the control of fuel, oil, coal, gas etc. shall be the responsibility of the designated Estates Manager.

29.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/Pharmaceutical Officer. Wherever practicable, stocks should be marked as 'Health Service Property'.

29.4 The designated manager/Pharmaceutical Officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice (see Disposals and Condemnations, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

29.5 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those Officers authorised to requisition and accept goods from the store. The authorised Officers shall check receipt against the delivery note before accepting the charge. All discrepancies must be reported within 24 hours of receiving goods.

30 DISPOSALS AND CONDEMNATIONS, LOSSES AND SPECIAL PAYMENTS

30.1 Disposals and Condemnations

30.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to Directors and relevant Officers.

30.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

30.2 Disposals Generally

30.2.1 All disposals shall be in accordance with these SFIs and the Scheme of Delegation.

30.2.2 Competitive tendering or quotation procedures shall not apply to the disposal of:

a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his Nominated Officer;

b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

c) items to be disposed of with an estimated sale value of less than £5,000 (this figure to be reviewed annually by the Director of Finance); or

d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract.

30.2.3 Disposals of Businesses, Business Units, etc. must be determined by the Board and subject to a recommendation from the Chief Executive supported by a statement from the Director of Finance setting out the financial implications.

30.2.4 Disposal of serviceable assets, mainly land, buildings and equipment, will be subject to the Trust's Capital Procedure and subject to the limits set out in the Scheme of Delegation. All material transactions will be determined by the Board and subject to a recommendation from the Chief Executive supported by a statement from the Director of Finance setting out the financial implications.

30.3 Disposal of Unserviceable Articles

30.3.1 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an Officer authorised for that purpose by the Director of Finance;

b) recorded by the condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second Officer authorised for the purpose by the Director of Finance.

30.3.2 The condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action. Even where an item has nil or negligible value, such items are to be disposed of in accordance with these SFI's and Officers of the Trust are not permitted to obtain such items without the prior written authorisation of a Senior Manager.

30.4 Losses and Special Payments

30.4.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments.

30.4.2 Any Director or Officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an Officer charged with responsibility for responding to concerns involving loss or fraud confidentially. This Officer will then appropriately inform the Director of Finance and/or Chief Executive. .

30.4.3 The Board shall delegate its responsibility to approve the writing-off of losses and to authorise special payments in accordance with the Scheme of Delegation.

30.4.4 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in bankruptcies and company liquidations.

30.4.5 For any loss, the Director of Finance should consider whether any risk pooling or insurance claim can be made.

30.4.6 The Director of Finance shall maintain a 'Losses and Special Payments Register' in which write-off action is recorded.

30.4.7 No special payments exceeding delegated limits shall be made without the prior approval of the Board, or contrary to any guidance or best practice advice issued by the DHSC.

30.4.8 The Director of Finance must report all losses and special payments to the Audit and Risk Committee.

31 FRAUD AND CORRUPTION

31.1 In line with their responsibilities, the Chief Executive and Director of Finance shall monitor and ensure compliance with any relevant guidance issued by DHSC or NHS Counter Fraud Authority on fraud and corruption in the NHS.

31.2 The Director of Finance is responsible for the promotion of counter fraud measures within the Trust and, in that capacity, he will ensure that the Trust co-operates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the prevention, detection and investigation of fraud in the NHS.

31.3 The Trust will appoint at least one person (who may be either an Officer or a person whose services are supplied to the Trust by an outside organisation) as a Local Counter Fraud Specialist, in accordance with any guidance issued by DHSC or the NHS Counter Fraud Authority on the suitability criteria for such appointees.

31.4 The Director of Finance will ensure that the Trust's Local Counter Fraud Specialist receives appropriate training in connection with counter fraud measures and that they are accredited by the Counter Fraud Professional Accreditation Board.

31.5 Where the Trust appoints a Local Counter Fraud Specialist whose services are provided to the Trust by an outside organisation, the Director of Finance must be satisfied that the terms on which those services are provided are such to enable the Local Counter Fraud Specialist to carry out his functions effectively and efficiently and, in particular, that he will be able to devote sufficient time to the Trust.

31.6 The Local Counter Fraud Specialist shall report directly to the Director of Finance and shall work with NHS Counter Fraud Authority.

31.7 The Local Counter Fraud Specialist and the Director of Finance will, at the beginning of each Financial Year, prepare a written work plan outlining the Local Counter Fraud Specialist's projected work for that Financial Year.

31.8 The Local Counter Fraud Specialist shall be afforded the opportunity to attend Audit and Risk Committee meetings and other meetings of the Board, or its committees, as required.

31.9 The Director of Finance will ensure that the Local Counter Fraud Specialist:

31.9.1 keeps full and accurate records of any instances of fraud and suspected fraud;

31.9.2 reports to the Board any weaknesses in fraud-related systems and any other matters which may have fraud-related implications for the Trust;

31.9.3 has all necessary support to enable him to efficiently, effectively and promptly carry out his functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of his work;

31.9.4 receives appropriate training and support, as recommended by NHS Counter Fraud Authority; and

31.9.5 participates in activities which NHS Counter Fraud Authority is engaged, including national anti-fraud measures.

31.10 The Director of Finance must, subject to any contractual or legal constraints, require all Trust Officers to co-operate with the Local Counter Fraud Specialist and, in particular, that those responsible for human resources disclose information which arises in connection with any matters (including disciplinary matters) which may have implications in relation to the investigation, prevention or detection of fraud.

31.11 The Director of Finance must also prepare a “fraud response plan” that sets out the action to be taken both by persons detecting a suspected fraud and the Local Counter Fraud Specialist, who is responsible for investigating it.

31.12 Any Officer discovering or suspecting a loss of any kind must either immediately inform the Chief Executive and the Director of Finance or the Local Counter Fraud Specialist, who will then inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved, but if the case involves suspicion of fraud, and corruption or of anomalies that may indicate fraud or corruption then the particular circumstances of the case will determine the stage at which the police are notified; but such circumstances should be referred to the Local Counter Fraud Specialist.

31.13 For losses apparently caused by theft, fraud, arson, neglect of duty or gross carelessness, except if trivial and where fraud is not suspected, the Director of Finance must immediately notify:

31.13.1 the Board of Directors; and

31.13.2 the Auditor.

32 INFORMATION TECHNOLOGY RELATING TO FINANCIAL RECORDS AND INFORMATION

32.1 Responsibilities and duties of the Finance Director

32.1.1 The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of the Trust, together with the Director of IT, who is responsible for wider procedures in respect of information governance, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware for which he is responsible from accidental or intentional disclosure to unauthorised

persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1984 and any other relevant legislation;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as he may consider necessary are being carried out.

32.1.2 The Director of Finance shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, the Director of Finance must obtain from that organisation assurance of adequacy prior to implementation.

32.1.3 The Director of Finance will devise procedures which ensure that orders for the acquisition of computer hardware, software and services (other than consumables) are placed in accordance with the Trust's information technology strategy.

32.1.4 The Director of Finance will ensure that separate control procedures are put in place for computer systems. This procedure will include:

a) The acquisition and disposal of information technology, systems and equipment; and

b) The decommissioning of systems containing confidential data in accordance with any relevant guidance issued by DHSC, or as required under statute.

32.2 Responsibilities and duties of other Directors and Officers in relation to computer systems of a general application

32.2.1 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of Health Service Bodes in the region wish to sponsor jointly) all responsible Directors and Officer will send to the Director of Finance:

32.2.2 details of the outline design of the system;

32.2.3 in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

32.3 Contracts for computer services with other Health Service Bodies or outside agencies

32.3.1 The Director of Finance shall ensure that contracts for computer services for financial applications with another Health Service Body or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

32.3.2 Where another Health Service Body or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

32.4 Risk Assessment

32.4.1 The Director of Finance shall ensure that risks to the Trust arising from the use of information technology are effectively identified and considered and appropriate action is taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

32.5 Requirements for computer systems which have an impact on the Trust's corporate financial systems

32.5.1 Where computer systems have an impact on the Trust's corporate financial systems the Director of Finance shall satisfy himself that:

a) systems acquisition, development and maintenance are in line with the Trust's policies, including but not limited to the Trust's Clinical Technology Strategy;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) staff have access to such data; and

d) such computer audit reviews as are considered necessary are being carried out.

33 PATIENTS' PROPERTY

33.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

33.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission by:

33.2.1 notices and information booklets,

33.2.2 hospital admission documentation and property records,

33.2.3 the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Health Service premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

33.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all Officers whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

33.4 Where any guidance by the DHSC requires the opening of separate accounts for patients' monies, these accounts shall be opened and operated under arrangements agreed by the Director of Finance.

33.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of probate or letters of administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

33.6 Officers should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

33.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

34 ACCEPTANCE OF GIFTS BY OFFICERS

34.1 The Chief Executive shall ensure that all Officers are aware of the Trust's policy on acceptance of gifts or benefits in kind by Officers.

34.2 All Officers are subject to the provisions of section 7 of the Staff Code of Conduct which sets out clearly the rules which apply to the acceptance of gifts and hospitality. Nothing may be accepted by Officers which would constitute a breach of the provisions of the Bribery Act 2010.

35 RECORDS MANAGEMENT

35.1 The Chief Executive shall be responsible for the management of all NHS records by the Trust, regardless of the media on which they are held.

35.2 The Chief Executive shall ensure that the Trust adopts information governance arrangements which comply with the principles and guidelines contained in the DHSC's Records Management: NHS Code of Practice as may be varied from time to time.

35.3 The documents held in archives shall be capable of retrieval by authorised persons in accordance with the provisions of the Records Management Code.

35.4 Records held by the Trust under the Records Management Code shall only be destroyed at the express instigation of the Chief Executive. The Chief Executive shall ensure that records are maintained of documents so destroyed.

36 RISK MANAGEMENT & INSURANCE

36.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with NHS guidelines, which must be approved and monitored by the Board.

36.2 The programme of risk management shall include:

36.2.1 a process for identifying and quantifying risks and potential liabilities;

36.2.2 engendering among all levels of Officers a positive attitude towards the control of risk;

36.2.3 management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

36.2.4 contingency plans to offset the impact of adverse events;

36.2.5 audit arrangements including; Internal Audit, clinical audit, health and safety review;

36.2.6 decisions on which risks shall be included in the NHSLA risk pooling schemes;

36.2.7 arrangements to review the Trust's risk management programme

36.3 The Chief Executive will be responsible for ensuring that the existence, integration and evaluation of the above elements will provide a basis to make a statement on the effectiveness of internal control as required by the DHSC guidance from time to time.

36.4 The Board shall decide if the Trust will insure via the risk pooling schemes administered by the NHS Litigation Authority under Section 71 (Schemes for meeting losses and liabilities, etc. of certain health service bodies) of the NHS Act 2006) or 'self insure' for some or all of the risks covered by the schemes for any risk area (clinical, property, and non-clinical third party liability) covered by the scheme. This decision shall be reviewed annually.

36.5 Subject to the following exceptions, the Trust may not enter into insurance arrangements with commercial insurers:

36.5.1 insuring motor vehicles owned or leased by the Trust including third party liability arising from their use; and

36.5.2 where the Trust is involved with a consortium in a Private Finance Initiative contract and the other consortium members require that commercial insurance arrangements are entered into. In case of doubt the Finance Director should consult with NHSI.

36.6 Where the Board decides to use the risk pooling schemes administered by NHS Resolution the Director of Finance shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Director of Finance shall ensure that the documented procedures that cover these arrangements.

36.7 Where the Board decides not to use the risk pooling schemes administered by NHS Resolution for one or other of the risks covered by the schemes, the Director of Finance will draw up a formal documented procedure for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

36.8 All risk pooling schemes require members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure that documented procedures also cover the management of claims and payments below the deductible in each case.

37 SECURITY MANAGEMENT

37.1 The Chief Executive is responsible for the security of Officers and people engaged in activities for the purposes of the functions of the Trust.

37.2 The Chief Executive is responsible for within the Trust:

37.2.1 security management matters; and

37.2.2 the promotion of security management measures.

37.3 The Trust will appoint at least one person as a Local Security Management Specialist, in accordance with any guidance issued by DHSC or Secretary of State (Home Office). on suitability criteria for such appointees.

37.4 The Chief Executive will ensure that the Trust's Local Security Management Specialist receives appropriate training in connection with security management measures in order to meet the requirements and objectives set out by DHSC or Secretary of State (Home Office).

37.5 The Local Security Management Specialist shall report directly to the Chief Executive.

37.6 The Chief Executive will ensure that the Trust co-operates with NHS Counter Fraud Authority to enable them to efficiently and effectively carry out their respective functions in relation to the security of people and property across the NHS.

37.7 The Chief Executive will ensure that the Trust has effective arrangements in place to ensure that:

37.7.1 breaches of security and weakness in security-related systems are reported as soon as practicable to the

a) Local Security Management Specialist;

b) Audit and Risk Committee; and

c) Auditor,

37.7.2 any confidentiality of information relevant to the investigation of breaches of security is protected; and

37.7.3 where possible, the Trust recovers money lost through breaches of security.

37.8 The Local Security Management Specialist and the Chief Executive will, at the beginning of each financial year, prepare a written work plan outlining the Local Security Management Specialist's projected work for that financial year.

37.9 The Local Security Management Specialist shall be afforded the opportunity to attend Audit and Risk Committee meetings and other meetings of the Board of Directors, or its Committees, as required.

38 FREEDOM OF INFROMATION AND INFORMATION DATA REQUESTS

38.1 The Chief Executive shall publish and maintain a 'freedom of information publication scheme' or adopt a model publication scheme approved by the Information Commissioner. A publication scheme is a complete guide to the information routinely published by a public authority. It describes the classes or types of information that the Trust makes publicly available.

RESERVATION OF POWERS TO THE BOARD – DETAILED SCHEME OF DELEGATION

39 RESERVATION OF POWERS TO THE BOARD

39.1 Standing Orders (SOs) and Standing Financial Instructions (SFIs) set out in some detail the financial responsibilities of the Chief Executive (CE), the Director of Finance (DoF) and other directors. These responsibilities are summarised below in section 39.5.

39.2 Certain matters needing to be covered in the scheme of delegation are not covered by SFIs or SOs or they do not specify the responsible officer. These are:

Area of responsibility	Overall responsibility
Data Protection Act Requirements	Caldicott Guardian
Health and Safety Arrangements	Chief Executive

39.3 This scheme of delegation covers only matters delegated by the Board to Directors and nominated officers.

39.4 Throughout the Scheme of Delegation reference to a “Nominated Deputy” will mean the person advised in writing by the lead delegated officer.

Detailed list of reservation of powers to the Board

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
INTRODUCTION					
4.1	Final authority in interpretation of SOs.				
MEETINGS OF THE TRUST					
6.1	Calling meetings of the Trust Board at any time				
6.46	Chair all Board meetings and associated responsibilities				
DECLARATION OF INTERESTS					
9.7				Maintain register of interests	Trust Secretary
CUSTODY OF SEAL AND SEALING OF DOCUMENTS					
12.1		Keep seal in safe place			
12.3				Approve and sign all building, engineering, property or capital documents that require to be sealed.	2 members of the Board
12.5				Maintain register of sealing	Trust Secretary
SIGNATURE OF DOCUMENTS					
13.1		Approve and sign all documents which are a necessary step in legal proceedings involving the Trust (or Board approved officer)			
13.2		Sign on behalf of the Trust any agreement or document not required to be executed			

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Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
		as a deed (or nominated officer)			
RESPONSIBILITIES AND DELEGATION					
16.4.4		To ensure all employees and directors are notified of and understand SFIs.			
16.7			Implement the Trust's financial policies and co-ordinating corrective action. Ensuring detailed financial procedures and systems are prepared, documented and maintained.		
16.8				Responsible for security of the Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming to SOs, SFIs, financial procedures and the Scheme of Delegation.	All Directors and Employees:
16.10			Form and manner of discharge of financial functions		
AUDIT					
17.2.1		Ensure compliance with counter fraud and the DHSC directions on Fraud, Bribery and corruption	Ensure compliance with counter fraud and the DHSC directions on Fraud, Bribery and corruption		
17.3			Liaise with LCFS and internal audit.		

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Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
			Ensure annual internal audit report is prepared and presented to Audit and Risk Committee and Board. Ensure police are informed at the right time in cases not involving fraud or corruption		
BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING					
18.1		Submit Annual Business Plan to Board Submit 5 year Integrated Business Plan	Submit annual budgets to Board for approval. Monitor performance against budget, submit to Board financial estimates and forecasts.		
18.2		Delegate budget to budget holders and submit monitoring returns.	Devise and maintain systems of budgetary control.	Sign up to their allocated budget at the commencement of each financial year	All budget holders
ANNUAL ACCOUNTS AND REPORTS					
19.1			Prepare, submit and present Annual Accounts		
19.3	Prepare, submit and publish an Annual Report				
BANK AND GBS ACCOUNTS					
20.1.1			Managing the Trust's Banking arrangements.	Managed via Deputy Director of Finance, requires one requisitioner and one approver.	Deputy Director of Finance
INCOME FEES AND CHARGES					
22.1.1			Systems for recording and collecting Income		

Trust Board - Public-31/03/22

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
NHS SERVICE AGREEMENTS FOR PROVISON OF SERVICES					
23		Negotiating and signing contracts for provision of patient services.	Monthly reports of actual and forecast income contract receipts.		
TERMS OF SERVICE AND PAYMENT OF DIRECTORS AND OFFICERS					
24.3.1			Re-grading or changing terms of employment of existing employee	Re-grading or changing terms of employment of existing employee	Director of Workforce and Communications
24.3.2				Must not engage staff permanent or temporary above establishment.	All staff
24.4				Ensure all employees are issued with a Contract of Employment and dealing with variations to, or termination of, contracts of employment	Director of Workforce and Communications
NON PAY EXPENDITURE					
25.1		Determine, and set out, level of delegation of non pay expenditure to budget managers.			
25.2		Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current departmental guidance.	Prompt payment of accounts. Ensure that arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with current departmental guidance.		

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
25.5		Formal tendering waived when notified in writing. Best value for money is demonstrated for all services provided under contract or in house.	Formal tendering waived when notified in writing.		
TREASURY MANAGEMENT					
26			Ensure that the principles of the Treasury Management Policy are followed.		
EXTERNAL BORROWING AND INVESTMENTS					
27			Application for Loans and Short term borrowing- in accordance with Standing Orders, Standing Financial Instructions and Treasury Management Policy		
CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTER AND SECURITY OF ASSETS					
28.1		Determine priorities for capital expenditure.	Certify professionally the cost and revenue consequences.		
28.2		Overall responsibility for fixed assets.	Maintenance of asset registers	Responsibility for security of Trust assets including notifying discrepancies to DoF, and reporting losses in accordance with Trust procedure.	All Senior Staff
STORES AND RECEIPT OF GOODS					
29		Identify persons authorised to requisition and accept goods from NHS Supply Chain.	Responsible for systems of control over stores and receipt of goods.		

Trust Board - Public-31/03/22

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
DISPOSALS AND CONDEMNATIONS					
30.1			Prepare detailed procedures for the disposal of assets including condemnations		
30.2			Prepare procedures for recording and accounting for losses and special payments and informing NHS Executive of all frauds and informing Police in cases of suspected arson or theft.		
INFORMATION TECHNOLOGY IN RELATION TO FINANCIAL RECORDS AND INFORMATION					
31.1		.	Responsible for accuracy and security of computerised financial data		
PATIENT PROPERTY					
32.1		Responsible for ensuring patients and guardians are informed about patients' money and property procedures on admission.			
ACCEPTANCE OF GIFTS BY STAFF					
33		All staff are aware of Trust policy			
RECORDS MANAGEMENT					
34		Retention of document procedures. Management of all NHS records			
RISK MANAGEMENT AND INSURANCE					

Ref.	Chairperson	Chief Executive	Director of Finance	Other	Detail of other
35		Risk management programme. Insurance arrangements.	Risk pooling arrangements and procedure.		
SECURITY MANAGEMENT					
36		Security management and the promotion of security management measures.			

40 DETAILED SCHEME OF DELEGATION

Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive. The delegation shown below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate. All items concerning Finance must be carried out in accordance with Standing Financial Instructions and Standing Orders.

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	Associate Director/ Head of Service	Director/Deputy Chief Operating Officer	Deputy Director of Finance	Chief Executive, Director of Finance or nominated Deputy	Committee of the Board
MANAGEMENT OF BUDGETS (SFI section 18)						
Responsibility of keeping expenditure within budgets	At individual budget level (pay and non pay)	For Care Group	For the totality of Responsibility	For all other areas		
Approving expenditure higher than tender/ contracted price			up to 10% or £15k (in the aggregate) whichever is the higher	up to 10% or £15k (in the aggregate) whichever is the higher	> 10% or > £15k. Up to £25k.	
NON PAY REVENUE AND CAPITAL – REQUISITION AND APPROVAL OF GOODS AND SERVICES (SFIs section 25)						

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Each purchase/ non Pharmacy expenditure	To £1,000	From £1,001 to £10,000	From £10,001 to £50,000	To £249,999 in conjunction with Director	From £250,000 to £499,999	Above £500,000: Finance and Performance Committee
Each Pharmacy order	Up to £74,999 Head of Pharmacy				£75,000 to £250,000 Each requisition and order exceeding 12 month period	£250,001 to £750,000 CE and Chairperson for reporting to next Board meeting
Business cases					EMT to £75,000. Executive Assurance Committee from £75,001 to £250,000	From £250,001 to £750,000 Finance and Performance Committee Above £750,000 Trust Board
Independent Legal and/or Professional Advice						Audit and Risk Committee has authority to obtain outside legal or other independent professional advice and to secure the attendance

Trust Board - Public-31/03/22

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
						of outsiders with relevant experience and expertise if it considers this necessary
MANAGEMENT OF CAPITAL SCHEMES (SFIs section 28 and SO section 12)						
Selection or architects, quantity surveyors, engineers and other professional advisors within EU regulations			Director of Capital Planning and Estates			Following approval as set out in Business case policy
Financial monitoring and reporting on all capital scheme expenditure			DoF & Director of capital planning & estates	Deputy DoF		
Granting, extension and termination of leases with annual rent up to :				To £249,999 with Director	From £250,000 to £499,999	From £500,000: Finance and Performance Committee
Business cases per scheme		Trust Capital Group to £75,000			Executive Assurance Committee or Business Case Review Group from £75,001 to £250,000	From £250,001 to £750,000 Finance and Performance Committee Above £750,000 Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
QUOTATION, TENDERING AND CONTRACT PROCEDURES (SFI section 25, SO section 12)						
At least one written quotation	Below £10,000 (or delegated manager e.g, Estates)					
At least 3 written quotations	From £10,000 to £49,999 (Undertaken by Procurement and budget holder)					
Full Competitive Tender Process	From £50,000 to OJEU tendering undertaken (Undertaken by Procurement and budget holder)					
Full Competitive Tender Process	In excess of OJEU Threshold tendering undertaken (Undertaken by Procurement and budget holder)					
Waiving of quotations and tenders subject to Standing Orders (SO 10.5)					CE if over £50k. All to be considered by Procurement	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
SETTING OF FEES AND CHARGES (SFI section 22)						
Private patient, overseas visitors, Income Generation and other patient related services				DoF or Deputy Director of Finance	DoF or Deputy Director of Finance	
Price of NHS contracts				To £75,000	DoF above £75,000	
ENGAGEMENT OF STAFF AND CONSULTANTS NOT ON THE ESTABLISHMENT (SFI section 24)						
Non medical Consultancy staff		Where aggregate commitment in any one year (or total commitment) is less than £75,000			Executive Assurance Committee where aggregate commitment in one year is over £75,001 to £250,000	From £250,001 to £750,000 Finance and Performance Committee
Engagement of Trust's Solicitors ~~other than for litigation~~	Head of Legal Services to £10,000		Head of Legal Services with relevant Director/ Head of Service to £20,000		Head of Legal Services with CE to £75,000	Head of Legal Services with CE (or DOF) and with Audit Committee NED over £75k
Booking of Bank or Agency staff	Budget Holder if costs are within budget of vacant posts.	Costs beyond budget of vacant posts but within	Costs beyond Care Group budget			

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
		total Care Group budget				
AGREEMENTS/LICENCES (SFI Section 25)						
Preparation and signature of all tenancy agreements/licences for all staff subject to Trust Policy on accommodation for staff			Director of Capital Planning and Estates			
Extension to existing licenses/agreements not exceeding one year						
Letting of premises to outside organisations						
Approval of rent based on professional assessment			Director of Capital Planning and Estates with DoF			
Terminating agreements/licences			Director of Capital Planning and Estates			
DISPOSALS CONDEMNING AND DISPOSAL OF ASSETS/EQUIPMENT (SFIs section 30)						
Minor current replacement price;-	price less than £50		Above £50 Director of			

Trust Board - Public-31/03/22

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
			Capital Planning and Estates			
Disposal of mechanical engineering plant		Less than £1,000 per sale; Head of Estates	Above £1,000 per sale; Director of Capital Planning and Estates			
Disposal of Land, Building and Equipment				Up to £19,999 - Equipment only	£20,000 - £74,999; CE or DOF £75,000 - £249,000; CE or DoF and Director of Capital planning and Estates	From £250,001 to £400,000; CE and Chairperson reporting to next Board meeting. From £400,000 to £749,999 Finance and Performance Committee. Board over £750,000
LOSSES, WRITE-OFF AND COMPENSATION (SFIs section 30.2)						
Losses and cash due to theft, fraud, overpayment.					CE and DoF ; up to £50,000	Report to Audit & Risk Committee under Losses and Compensation procedures.
Fruitless payments (including abandoned Capital Schemes).					CE and DoF ; up to £250,000	
Bad debts and claims abandoned. Private					• Associate Director of Finance	

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
patients, overseas visitors and others.					(Financial Accounting) - £10,000 • Deputy Director of Finance – up to £250,000 • Chief Executive and Director of Operations – above £250,000	
Damage to buildings, fittings, furniture and equipment and loss of equipment and property in stores and in use due to culpable causes (e.g. fraud, theft, arson)			Director of Capital planning & Estates - up to £50,000		Chief Executive - up to £50,000	
Compensation payments made under legal obligation.					Up to £99,999	
Extra Contractual payments to contractors					Up to £50,000	

Trust Board - Public-31/03/22

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Ex Gratia payments to service users and staff for loss of personal effects					Chief Executive and Director of Finacne	
Clinical negligence (negotiated settlements) based on legal advice					Up to £1,000,000	
For personal injury claims involving negligence where legal advice has been obtained and guidance applied	Where settled within 'insurance excess';-	Head of Legal Services and DOF			Including plaintiff's costs, up to £1,000,000	
Other uninsured settlements, except cases of mal-administration where there was no financial loss by claimant,					Up to £50,000	
REPORTING OF INCIDENTS TO THE POLICE (SFIs sections 17 and 31)						
Where a criminal offence is suspected	Criminal offence of a violent nature;- Duty Manager		Director of Workforce and Communications			

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
Where a criminal offence is suspected where a fraud is involved;	LCFS					
PETTY CASH DISBURSEMENTS (SFIs section 25.4)						
Approval of Petty cash vouchers	Expenditure up to £50 per item (Limited to 125 claims per week)	In excess of £50;- Director/ Head of Service (Limited to 125 claims per week)				
RECEIVING HOSPITALITY (SOs section 11 and SFIs section 34)						
Applies to both individual and collective hospitality receipt items in excess of £25 per item received	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	Declaration required in Trust's Hospitality Register	
IMPLEMENTATION OF INTERNAL AND EXTERNAL AUDIT RECOMMENDATIONS (SFIs section 17)						
Maintenance and update of Trust Financial Procedures.					Present up to date procedures	Approved by Finance and performance Committee
HUMAN RESOURCES AND PAY (SFIs section 24)	Fill funded post on the establishment with permanent staff				All requests for re-banding	

Trust Board - Public-31/03/22

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
	Additional staff to the establishment with specifically allocated finance			Additional staff to the establishment without specifically allocated finance	Additional staff to the establishment without specifically allocated finance	
	Complete standing data forms					
	Authorise overtime					
	Authorise travel and subsistence expenses					
	Approval of annual leave					
	Compassionate leave up to 4 days	Over 4 days				
	Special leave arrangements incl paternity leave etc.	Leave without pay				
	Time off in lieu – paid and unpaid					
	Maternity leave – paid and unpaid Automatic approval (with guidance HR final approval)					

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DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
	Sick Leave		Extension of sick leave			
	Study leave		Medical Staff - Medical Director		Study Leave outside the UK	
Removal Expenses, Excess Rent etc.			Up to £8k Director		Over £8k Director of Workforce and Communications	
Renewal of Fixed Term Contract up to a maximum of one year	Budget Holder in conjunction with HR					
Redundancy, Health retirement, Dismissal (as set out in the Policy)					Redundancy, Health retirement, Dismissal (as set out in the Policy)	
AUTHORISATION OF NEW DRUGS						
Estimated total additional cost		Annual cost below £25k; Drugs and Therapeutic Committee, Medical Director and Chief Pharmacist			Annual cost above £25k; Drugs and Therapeutic Committee, in accordance with NICE guidelines; Medical Director and CE	
Sponsorship deals	Up to £5k				CE, Medical Director, Chairperson of Research Committee, DoF	

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DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
RESEARCH PROJECTS						
Research projects (Approval)					Up to £50k per year, Medical Director, Chairperson of Ethics committee, DoF.	
Clinical Trials (Approval)					Up to £50k per year, Medical Director, Chairperson of Ethics committee, DoF.	
PATIENTS AND RELATIVES COMPLAINTS						
Ensuring that all complaints are dealt with effectively		Investigation; - Director/ Head of Service	Overall responsibility; DCOO			
Medico-Legal Complaints Co-ordination of their management		Director of Nursing and Quality or Head of Legal Services				
INTRODUCTION OR DISCONTINUANCE OF ANY SIGNIFICANT ACTIVITY OR OPERATION OTHER THAN BY TENDER						
Introduction or Discontinuance of any significant activity or operation other than by tender		Up to £250,000 Head of Service and DoF or with DCOO			£250,000 - £750,000 Executive Assurance Committee	Above £750,000 Trust Board

DELEGATED MATTER	AUTHORITY DELEGATED TO					
	Budget holder	**Associate Director/ Head of Service**	**Director/Deputy Chief Operating Officer**	**Deputy Director of Finance**	**Chief Executive, Director of Finance or nominated Deputy**	**Committee of the Board**
FACILITIES FOR STAFF NOT EMPLOYED BY THE TRUST TO GAIN PRACTICAL EXPERIENCE						
Professional recognition, Honorary contracts and insurance of Medical staff			Medical Director			
Work experience students		Head of Workforce and Communications / Director/ Head of Service				

Trust Board - Public-31/03/22

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	31st March 2022
Title of Paper:	Quality Committee Terms of Reference
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 attached Quality Committee (QC) Terms of Reference have been updated to reflect changes to the membership and job titles of members. This is consistent with the Committee's annual Terms of Reference review.

Issues to bring to the Board's attention

The annual review of the QC Terms of Reference takes place in March every year. The Board is asked to review the suggested changes and approve the updated Terms of Reference. The changes are as follows:

- The number of Non-Executive Director members reduced from three to two.
- The update of job titles throughout the Terms of Reference.

Governance

Implications/Impact:	Maintenance of sound governance systems
Assurance:	Significant
Oversight:	Oversight by Trust Board

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Terms of Reference

Name of Committee	**Quality Committee (QC)**	
Date	**15 March 2022**	
Version	**V.13**	
Approval	**QC**	**Date: 15/03/2022**
	Trust Board	*Date: xx/xx/22 (pending)*
Next review due	**March 2023**	

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
V13	Draft	15.03.22	Quality Committee	Change in the Non-Executive Director membership

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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:

- Two Non-Executive Board members (one of whom will Chair the Committee)
- Chief Medical Officer
- Chief Nurse
- 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 Chief Medical Officer or Chief Nurse.

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

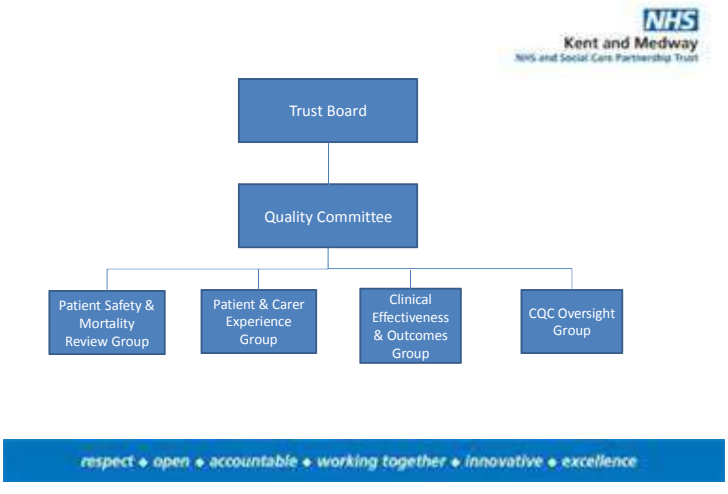
Scheduled reports from the various annual programmes including:

- 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.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**31 March 2022**
Title	**Quality Committee Report**
Author	**Fiona Carragher, Non-Executive Director and Committee Chair**
Presenter	**Fiona Carragher, Non-Executive Director and Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention

- NHSE/I require trusts to repeat their self-assessments in February 2022 to ensure that IPC quality standards are maintained and that any gaps in assurance are mitigated. The Committee reviewed and endorsed KMPT's approach to the new NHSE/I Infection Protection and Control framework and were assured appropriate measures and mitigations were in place
- The Committee discussed KMPT's approach and performance of Duty of Candour. Verbal Duty of Candour is being completed within the legal timeframe in 81% of cases, and 100% of cases of sharing the investigation findings were completed in line with legal requirements. However, whilst this is an improving picture, only 57% of Duty of Candour initial letters are being sent within the legal timeframe. This is an area of concern for the Committee. A deep dive into the process, particularly focussing on recommendations for improvements, will be tabled at the May Committee
- Good practice around reduction in ligatures, seclusion and restraints discussed and noted
- Good practice around blank boxes noted, and implementation of electronic prescribing later this month

Items referred to other Committees (incl. reasons why)

- Pharmacy pressures around resourcing and capacity escalated to Workforce Committee

The Quality Committee was held on 15 March 2022. The following items were discussed and scrutinised as part of the meeting:

1. Quality Impact Assessments
2. Quality Risk Register
3. IPC Board Assurance Framework
4. Quality Digest
5. Quality Account
6. CQC Report
7. Operational Hot Spots
8. Consultant Case Load Capping and Contacts Report
9. Active Review Process and SOP
10. Patient Experience Thematic Report
11. NICHE Action Plan Report
12. Annual Medicines Management Report
13. Quality Committee Terms of Reference
14. Quality Committee Workplan

The Board is asked to:

1) **Note the content of this report.**

Title of Meeting	KMPT Public Board Meeting
Meeting Date	31st March 2022
Title	Workforce & OD Committee (WFODC) Report
Author	Venu Branch, Chair of WFODC
Presenter	Venu Branch, Chair of WFODC
Executive Director Sponsor	Sandra Goatley, Director of Workforce & OD
Purpose	Assurance

Matters to be brought to the Board's attention

- **Community Recovery Care Group** – Continued reduction in agency spend, including Medical Agency usage. Significant improvement over the last year, with Medical Supervision compliance from 58% to 71% and CHMT Medics achieving 90% compliance for the window that closed on 2nd February 2022.
- **Recruitment of Nurses** – A Deep Dive for Band 5 Vacancies will be undertaken, along with reviewing Band 2's. There is a piece of work being completed by the HR Business Partners, looking at the vacancy turnover within the last 12 months to see where the gap is and where we need to recruit**,** which will help with the agency spend. This will be brought back to WFODC once completed. Partnerships with other Trusts and Universities are well established, which is creating real opportunities. The Committee is encouraging focus on specific areas where impact can be achieved.
- **Staff Survey** – outlined 4 areas that were flagged as key areas of concern: Pay, staffing levels, need to increase autonomy and advocacy. There was agreement on areas of focus for improvement, with encouragement to align these to the Strategic Plan. The detail of these are outlined in the Committee Minutes. Plus there is a requirement to create an environment for the employee's voice to encourage influence and engagement.

Items referred to other Committees (incl. reasons why)

- None

WFODC met on 15th March 2022 to consider and note assurance as follows:

Significant assurance:

- The Workforce Main Slide Deck: Clear overview of key areas, with good comparator information, and clear achievements as we approach the year end.
- Staff Survey 2021: Clear areas of concern led to key areas of focus for the coming year.

Reasonable assurance:

- Community Recovery Care Group Presentation: Good report on challenges and achievements. Good level of questioning and some interesting potential efficiencies that could be achieved through partnerships with the Third Sector.
- Nursing recruitment: Challenges continue, but a paper bringing forward clear focus points which will lead to a reduction in the Vacancy Gap / Retention.
- Gender Pay Gap : Minor adjustments were suggested to complete the report
- HR Risk Register: Ongoing engagement with key challenges – Recruitment, Retention, Vacancy Gap, Turnover.

Limited assurance

- Exit Interview Report

Other items considered but not relevant to the above categories:

Enhanced Payments Protocol

Policy Handbook Review

Lone Working Safety Devices Strategy Report

	Title of Meeting	**Board of Directors**
	Meeting Date	**31st March 2022**
	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 1 March 2022 to consider:

- Risk Registers and a Risk Deep-Dive (Dormitory Eradication Project)
- Auditors' Progress Reports and Annual Plans 2022-23
- Finance Matters (including Year-End Timetable and Accounting Policies)
- Internal Controls and Assurance (including H&S, EPRR, Fire Safety)
- Information Governance and Controls
- Other Items (Gifts and Hospitality Policy, ARC ToR, Regulatory, Legal and Code of Conduct update)

Area	Assurance	Items for Board's Consideration and/or Next Steps
Risk Registers and Risk Deep Dive (Dormitory Eradication)	*Reasonable Assurance*	(1) Continued progress in the evolution of the risk registers. A number of the risks need to be refreshed (eg. CMHSOP demand, hybrid working, external market forces) and confidence assessments populated. Memory assessment risk to be updated for previous Board discussions (2) ARC recommends the following risks are removed from the BAF - SPoA, Management of Environmental Ligatures (subject to Exec support), PPE, staff vaccinations, research & innovation, clinical engagement in strategy, H2 planning) (3) Dormitory Eradication - robust risk management in place. The significant risks of inflation and capital allocations have been mitigated
External Audit	Annual Plan	Agreed. Similar to last year's Plan and Timetable. Fees will increase from £53k to £60k
Internal Audit	Progress Report - *Reasonable Assurance*	(1) 3x reasonable assurance reports (Safer Staffing, Duty of Candour, Serious Incidents and Learning Processes) (2) all recommendations up to date apart from one - Appointment of Locum Medical Staff Policy which will now be completed 15 months after the agreed date. This was a concern and might be indicative of wider pressures (3) TIAA advised ''good amount of progress'' regarding Facilities Management Reactive Maintenance pending their

		formal follow-up to their previous Limited Assurance Audit
	Annual Plan	Agreed subject to the inclusion of QI and Estates Audits (precise scopes to be agreed) and no increase in overall 240 days. Plan reflects the 3 priorities of staff, digital and quality
Counter Fraud	Progress Report - *Reasonable Assurance*	No items for Board attention
	Annual Plan	Agreed
Finance Matters	Year-End Timetable and Accounting Policies	Proposals agreed - similar to last year, Board to sign the AR&A in June (latest, but possibly in May). No material changes to Accounting Policies
	Single Tender Waivers, Losses/ Special Payments and Write-offs *Reasonable Assurance*	STWs to be refreshed including reporting levels and calibration of underlying tendering risks. Update to ARC at May meeting
	Budget 2022-23	Draft submission to NHSI by 17.3 and final by 29.4. FP&C to be briefed for draft and Board approval sought for final.
Internal Controls and Governance	Data Quality - *Reasonable Assurance*	(1) DQ: Data Quality Group is introducing more independent assessments across a wider range of systems. Meantime, ESR and workforce systems are flagged as relatively weaker areas.
	Log4shell - *Reasonable Assurance*	Further detail can be provided and questions answered in a part 2 meeting for reasons of commercial confidentiality
	Cyber Security - Reasonable Assurance	Further detail can be provided and questions answered in a part 2 meeting for reasons of commercial confidentiality
Information Governance and controls	Data Quality	Paper noted and enhanced update requested for next ARC in March 2022
Other items	Gifts and Hospitality Policies	(1) Gifts and Hospitality Policies: Ratified. The policies need to be more staff friendly and Tony is discussing with Kindra

	ARC Terms of Reference Reg, Legal and Conduct Update	(2) ARC ToR: minor tweaks suggested which will be formally approved by Board in the next ToR cycle (3) Regulatory, Legal and Code of Conduct Update: Tony reported robust controls in place for the Bribery Act, Declarations of Interest, and Fit and Proper Persons. He identified some fragmentation of evidence retention in respect of Fit and Proper Persons which he will resolve.