AGENDA

Kent and Medway NHS and Social Care Partnership Trust

Title of Meeting Trust Board Meeting (Public)
Date 30th January 2025
Time 9.30 to 12.00
Venue MS Teams

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/24-25/109	1.	Welcome, Introductions & Apologies		Verbal	Chair	09.30
TB/24-25/110	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/24-25/111	3.	Personal Story –Veteran Advocate	FN	Verbal	DHS	09.35
TB/24-25/112	4.	Quality Improvement - Memory Assessment service at DGS	FN	Verbal	AR	09.45
STANDING ITEMS						
TB/24-25/113	5.	Minutes of the previous meeting	FA	Paper	Chair	09.55
TB/24-25/114	6.	Action Log & Matters Arising	FA	Paper	Chair	
TB/24-25/115	7.	Chair's Report	FN	Paper	JC	10.00
TB/24-25/116	8.	Chief Executive's Report	FN	Paper	SS	10.05
TB/24-25/117	9.	Board Assurance Framework	FA	Paper	AC	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/24-25/118	10.	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update	FN	Paper	JH	10.20
TB/24-25/119	11.	Right Care, Right Person Evaluation Report	FD	Paper	AR	10.35
OPERATIONAL ASSURANCE						
TB/24-25/120	12.	Integrated Quality and Performance Review	FD	Paper	SS	10.55
TB/24-25/121	13.	Finance Report for Month 9	FD	Paper	NB	11.15
TB/24-25/122	14.	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) paper	FN	Paper	SG	11.20
TB/24-25/123	15.	Freedom to Speak Up	FD	Paper	FTSU	11.40
TB/24-25/124	16.	Changes to Standing Orders and Standing Financial Instructions (SFI)	FA	Paper	NB	11.45
CONSENT ITEMS						
TB/24-25/125	17.	Report from Quality Committee	FN	Paper	SW	11.50
TB/24-25/126	18.	Report from People Committee (including Annual report on safe working hours)	FN	Paper	KL	
TB/24-25/127	19.	Report from Charitable Funds Committee	FN	Paper	SBK	
TB/24-25/128	20.	Report from Audit and Risk Committee	FN	Pape	PC	
TB/24-25/129	21.	Report from Finance and Performance Committee	FN	Paper	MW	
CLOSING ITEMS						
TB/24-25/130	22.	Any Other Business			Chair	11.55
TB/24-25/131	23.	Questions from Public			Chair	
	Date of Next Meeting: Thursday 27th March 2025					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Peter Conway	PC	Non-Executive Director
Sean Bone-Knell	SBK	Non-Executive Director
Stephen Waring	SW	Non-Executive Director
Dr MaryAnn Ferreux	MAF	Non-Executive Director
Mickola Wilson	MW	Non-Executive Director
Julius Christmas	JCh	Non-Executive Director
Sheila Stenson	SS	Chief Executive
Donna Hayward-Sussex	DHS	Chief Operating Officer and Deputy Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Nick Brown	NB	Chief Finance and Resources Officer
Sandra Goatley	SG	Chief People Officer
Dr Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Tony Saroy	TS	Trust Secretary
Daryl Judges	DJ	Deputy Trust Secretary
Kindra Hyttner	KH	Director of Communications and Engagement
Jane Hannon	JH	Programme Director
Rose Walters	RW	Deputy Service Director- Specialist Services, Forensic and Specialist Directorate (Personal Story)
Andrew Sharp	AS	Service User (Personal Story)
Sheeba Hakim	SH	Consultant (Quality Improvement)
Wendy Dewhurst	WD	Interim Service Director (Quality Improvement)
Apologies:		

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

Kim Lowe	KL	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 Public Board Meeting held at 09.30 to 12.00 on Thursday 28th November 2024
Via MS Teams

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Catherine Walker	CW	Deputy Trust Chair (Senior Independent Director)
	Sean Bone-Knell	SBK	Non-Executive Director
	Stephen Waring	SW	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Peter Conway	PC	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Dr MaryAnn Ferreux	MAF	Non-Executive Director
	Sheila Stenson	SS	Chief Executive
	Nick Brown	NB	Chief Finance and Resources Officer
	Donna Hayward-Sussex	DHS	Chief Operating Officer/Deputy Chief Executive
	Andy Cruickshank	AC	Chief Nurse
	Sandra Goatley	SG	Chief People Officer
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Dr Adrian Richardson	AR	Director of Partnerships and Transformation
Attendees:			
	Kindra Hyttner	KH	Director of Communications and Engagement
	Tony Saroy	TS	Trust Secretary
	Hannah Stewart	HS	Deputy Trust Secretary
	Julius Christmas	JCh	Observer
	Kathryn Harris	KHa	Physiotherapy Team Lead
	Carol	Carol	Service User
	Harriet Macdonald	HM	Sports and Exercise Technician
	Eric Barratt	EB	Health and Wellbeing Lead
	Sarah Atkinson	SA	Deputy Director of Transformation & Partnerships
Apologies:			

Item	Subject	Action
TB/24-25/82	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting and apologies were noted as above. All written reports were taken as read.	
TB/24-25/83	**Declarations of Interest** CW declared that she has been appointed to the Board of East Kent Hospital University Foundation Trust. Following advice from the Trust Secretary, no conflict of interest was identified.	
TB/24-25/84	**Personal Story – physiotherapists, sport and exercise technicians**	

Item	Subject	Action
	The Board welcomed KHa, HM and Carol. HM set out the provision of sports and exercise across the three adult wards at Priority House. This includes 1:1 gym sessions and groups sessions. Activities include football and basketball. The Board was informed of the positive impact sports and exercise has on the wellbeing of patients and the structure it offers them. The activities help reduce patient frustration and also improves sleep. The Board was delighted with the presentation, in particular understanding the positive impact on patients. The Board sought assurance that patients are supported with sport and exercise when discharged back in the community. The Board was informed that for some patients, sports and exercise forms part of their care plans and therefore supported in the community. There are community group offerings, as well as a fitness referral scheme operated by GPs. The Board **noted** the Personal Story – physiotherapists, sport and exercise technicians.	
TB/24-25/85	**The Innovation Den** The Board received information from the Innovation Den (Quality Improvement) item, which had been relaunched in October 2024. The Board was informed about two successful bids of innovation funding: • USB Charging Cables and • Top Behaviour Trump Cards. The provision of USB Charging Cables offered to patients reduced the points of friction on the ward, as patients had previously been frustrated with having to hand in their phones and equipment to staff for charging. The Top Behaviour Trump Cards aimed to incentivise patients to take positive steps in regards to their health and wellbeing. These include changes in diet, restricting smoking, and engaging in sport and exercise. The Board complimented the Trust for restarting the Innovation Den. The Board **noted** the Innovation Den.	
TB/24-25/86	**Minutes of the previous meeting** The Board **approved** the minutes of the 26th September 2024.	
TB/24-25/87	**Action Log & Matters Arising** The Board **approved** the action log, noting that all actions were completed or in progress. Dates that referred to January 2024 were to be amended to January 2025. Action: TB/24-25/77 - Workforce Deep Dive: Re-modelling and reshaping the workforce for the future: The Board was informed that this action was in fact two separate actions, the second of which requires a review of the clinical workforce	

Item	Subject	Action
	model which would be carried out by AC, DHS and AQ. The due date for that work would be May 2025.	
TB/24-25/88	**Chair's Report** The Board received the Chair's Report. The Board formally expressed its thanks to CW, who was attending her last Board meeting with the Trust. The Chair highlighted that a general theme from NED visits is that staff do not observe a decrease in the administrative burden within their roles, as anticipated in the Trust's current strategy. The Board was informed that the 'Getting the Basics Right' programme has commenced and will begin to have a positive impact for staff. **Action: DHS to produce an update paper on 'Getting the Basics Right' for the Quality Committee by January 2025. The paper must address the opportunities available, timelines of the workstreams and the clinical quality implications.** The Board was also informed that in the course of arranging visits, a NED identified that the telephony list on the Trust's website was out of date. DHS confirmed that she would investigate. The Board **ratified** the Chair's and Chief Executive's use of the reserved powers for the authorisation of the anti-ligature business case. The Board **noted** the Chair's Report.	**DHS**
TB/24-25/89	**Chief Executive's Report** The Board received the Chief Executive's Report and the following items were highlighted: • The Trust has rolled out the long service awards, which has received a positive response from staff, • The Trust has submitted the application to the Department of Health and Social Care to change its name, • SS has had EDI meetings with staff and staff members have stated that they are beginning to feel a change in culture. • The Trust has had staff shortlisted as finalists for national awards, including for Jag Bahia and his pharmacy team, and Dr Afifa Qazi. The Board expressed its pleasure regarding the Trust's EDI work, but requested that the Trust is clearer regarding its priorities. The Trust confirmed that work is ongoing with KPMG and that an update will be provided at the February board seminar. The Board **noted** the Chief Executive's Report.	
TB/24-25/90	**Board Assurance Framework (BAF)** The Board received the BAF, noting that a recent review has taken place of the risks on the BAF, with a number of the risks being re-worded and re-phrased. The Board reflected on the following matters: • Top risks:	

Item	Subject	Action
	○ Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – Extreme) ○ Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Rating of 20 – Extreme) ○ Risk ID 08173 – Delivery of a fit for purpose estate (Rating of 16 – Extreme) ○ Risk ID 07891 – Organisational Management of Violence and Aggression (Rating of 15 Extreme) ○ Risk ID 08065 – Inpatient Flow (Rating of 15 – Extreme) • A risk that has increased: ○ Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Increased from 16 (Extreme) to 20 (Extreme)) • A risk that is recommended for removal: ○ Risk ID 04706 – Organisational Risk - Transport Accident/Incident (including border flow disruptions at Port of Dover and Dartford crossing) (Rating of 12 (High)) The Board reflected on the BAF, highlighting that the timelines for mitigation appear long and some have only medium confidence of addressing the risk. Concerns were raised regarding the progress of the Community Mental Health Framework (CMHF) roll out. This was discussed further in a subsequent item. The Board raised that some of the risk levels do not appear to be correctly evaluated and the Trust stated that it is in the process of reviewing the risks. In terms of estate risks, NB confirmed that an updated paper is to be submitted at the Finance and Performance Committee. The Board **approved** the Board Assurance Framework.	
TB/24-25/91	**Mental Health, Learning Disability and Autism (MHDLA) Provider Collaborative Progress Report** The Board received the MHLDA Provider Collaborative Progress Report, with the Board noting that it had received a deep dive at its October seminar. The Board was informed that the ICB had confirmed that they are able to provide site-by-site footfall data for the A&E departments across the system. That data should be included in future iterations of the progress report. The Board was also informed that the Ashford Crisis House had gone live in November. The Board reflected on the report and it was highlighted that: • The Board needs to see more robust equality impact assessments and quality impact assessments. • Future reports should be clearer regarding which workstreams are off-track, what resources are being allocated to those workstreams, and when they will be back on track. • The work on bringing back patients with learning disability and autism from out of area has delivered a saving, which has been reinvested into community services. More detailed calculations are being carried out, but the Trust is not expecting a cost pressure from the work.	

Item	Subject	Action
	The Board **noted** the MHLDA Provider Collaborative Progress Report.	
TB/24-25/92	**Kent and Medway NHS Strategy** The Board received the Kent and Medway NHS Strategy for approval. The Board complimented the clear and straightforward nature of the of the strategy which was sufficiently flexibility in its wording to include mental health services. The Board **approved** the Kent and Medway NHS Strategy.	
TB/24-25/93	**Integrated Quality and Performance Review** The Board received the Integrated Quality and Performance Review (IQPR) and were informed that there were three areas of concern are dementia, mental health together and patient flow. The Board highlighted that it remains a concern that there continues to be a low number of patients with a care plan and expressed a lack of confidence given previous assurances given that the issue would be resolved. The Trust stated that it would take up to a year to achieve a consistent approach to care plans, with the shift to the use of Dialog. The Board sought assurance regarding our patients' experience when they are in A&E. The Trust confirmed that it would be learning from East Kent Hospital University Foundation Trust, which has carried out work in this area. The Trust will also be working on patient experience in A&E when the new Involvement and Engagement Team goes live. The Board **noted** the IQPR.	
TB/24-25/94	**Finance Report** The Board received the Finance Report and noted the following: • Year to date (YTD) agency spend is £4.16m which equates to 3.3% of Trust pay spend compared to an agency cap of 3.2% for the year. The highest usage is in East Kent medical agency and West Kent nursing agency. • There is an increased usage of external beds with unfunded external Acute beds averaging 6 beds through October. • Delays in the capital programme predominantly due to delays in the consultation process for the centralised s136. The majority of this scheme is expected to be delayed into 2025/26 and the associated funding will need to be managed accordingly. • The Trust's cash position has improved in month, with its cash balance £21.87m. The improvement predominantly relates to the NHS pay award, with some commitments not being paid until November 2024 The Board was informed that the £10k expenditure approval limit meant that any non-pay expenditure up to £10k would be an internal control and that anything above this limit would be a referral to the Kent and Medway Integrated Care Board.	

Item	Subject	Action
	The Board discussed the potential impact of the financial controls on the decision making within the Trust and requested this be addressed in future iterations of the financial report. **Action: By January 2025, NB to address any adverse impact on decision making caused by the additional financial controls in future iterations of the finance reports.** The Board also requested further information regarding patient flow and the use of out of area beds at the next board meeting. **Action: By January 2025, AQ to include commentary within the IQPR regarding the planned use of out of area beds.** The Board **noted** the Finance Report.	**NB** **AQ**
TB/24-25/95	**Workforce Deep Dive: Flexible Working** The Board received and commended the workforce deep dive paper. The Board discussed the volume of flexible working requests received and the impact that had on HR staff. The Board was assured that there was sufficient resource to manage the number of flexible working requests received. This could be aided in future by the use of artificial intelligence. The availability of irregular work patterns, so that weekend/evening work could be utilised by those who have caring obligations, was well received by the Board. The Board **noted** the Workforce Deep Dive Paper.	
TB/24-25/96	**Community Mental Health Framework Transformation Report** The Board received the Community Mental Health Framework (CMHF) Transformation Report. The Mental Health Together has been a challenging programme to roll out, with an increase in referrals as the services were stood up. There are multiple reasons for this increase in referrals, including GP referring patterns, as well as delays in setting up interventions and voluntary sector recruitment delays. Voluntary sector partners have now successfully recruited staff who are now coming into post. The Recovery College is helping the Trust in terms of delivering some of those interventions, which in turn is helping to reduce the number of patients that are on the waiting list. The Trust recognises that due to a large volume of referrals, a backlog has developed. Part of the solution will be the newly-recruited psychologists, which are fixed-term contract positions. The risks around patients who are on the waiting list are mitigated by effective triaging. The Board raised its concerns regarding the ability of the Trust to deliver the targets within the timelines as set out within the paper. The Board was informed that there	

Item	Subject	Action
	are multiple activities to address the demand issues, with talking therapies and better GP engagement being some of the activities that will yield improvement in Trust performance. The Board recognised that the CMHF work was a large programme and the Board would need more reflective time to discuss the programme. **Action: JC, SS and TS to set up a Board seminar on CMHF Transformation, with TS confirming the date of the Board seminar by January 2025.** The Board **noted** the Community Mental Health Framework Transformation Report.	
TB/24-25/97	**Health Inequalities Dashboard** The Board received the Health Inequalities Dashboard, with the Board noting that future iterations will have additional data in an IQPR style. As it currently stands, the Board found the Health Inequalities Dashboard difficult to understand, with data quality also being an issue and inadequate analysis presented. The Board expressed the view that the Friends and Family Test was an inadequate source for fully understanding patient experience. The Board requested that the Trust gets the dataset correct, with an initial focus on the four domains of age, gender, ethnicity, and post code deprivation. The Board **noted** the Health Inequalities Dashboard.	
TB/24-25/98	**Delivering Social Value and Net Zero – An Update** The Board received and complimented the Delivering Social Value and Net Zero Update paper. The Board agreed that the paper should be received on an annual basis from July 2025 and that future papers should address aspects of business continuity in terms of matters such as flooding. The Board **noted** the Delivering Social Value and Net Zero – An Update.	
TB/24-25/99	**Improving the Working Lives of Doctors in Training Update** The Board received and **noted** Improving the Working Lives of Doctors in Training Update.	
TB/24-25/100	**Mortality Review Highlight Report** The Board received and **noted** the Mortality Review Highlight Report for Q2 2024/25.	
TB/24-25/101	**Use of Trust Seal** The Board received and **noted** the use of the Trust Seal report.	

Item	Subject	Action
TB/24-25/102	**Report from Quality Committee** The Board received and **noted** the Quality Committee Chair's report.	
TB/24-25/103	**Report from People Committee** The Board received and **noted** the People Committee Chair's report.	
TB/24-25/104	**Report from Finance and Performance Committee** The Board received and **noted** the Finance and Performance Committee Chair's report.	
TB/24-25/105	**Report from Mental Health Act Committee** The Board received and **noted** the Mental Health Act Committee Chair's report.	
TB/24-25/106	**Report from Charitable Funds Committee** The Board received and **noted** the Charitable Funds Committee Chair's report.	
TB/24-25/107	**Any Other Business** None.	
TB/24-25/108	**Questions from Public** The Board received a question regarding the provision of physio services in the community. The Trust stated that the benefits of physiotherapy for patients with chronic mental health problem are clear and the Trust will work with KCHFT to see what may be offered to such patients.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 30th January 2025 via MS Teams.	

Signed …….. (Chair)

Date ……..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 17/01/2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JANUARY 2025								
25.07.2024	TB/24-25/50	Finance Report – Month 3	NB to produce a paper addressing the continued use of external beds for the September Quality Committee.	NB	September 2024	January 2025	Due to constraints on agenda, this item could not be added to the January Quality Committee and is to be taken to March Quality Committee.	**In progress**
26.09.2024	TB/24-25/77	Workforce Deep Dive: Re-modelling and reshaping the workforce for the future	By November 2024, the People Committee is to receive an analysis of the likely skills required to deliver mental health services over the next 2-5 years, and considers how we may adjust and fill gaps on the basis of competences rather than professions.	SG	November 2024	January 2025	Workforce planning assumptions paper for 2025/26 taken to January's People Committee meeting. Future workforce planning will be dependent on the clinical model, which is currently being reviewed by AC, AQ and DHS.	**In progress**
28.11.24	TB/24-25/88	Chair's Report	DHS to produce an update paper on 'Getting the Basics Right' for the Quality Committee by January 2025. The paper must address the opportunities available, timelines of the workstreams and the clinical quality implications.	DHS	January 2025		Paper taken to Quality Committee in January. To be closed.	**In progress**
28.11.24	TB/24-25/94	Finance Report	By January 2025, NB to address any adverse impact on decision making caused by the additional financial controls in future iterations of the finance reports.	NB	January 2025		Verbal update to be provided	**In progress**
28.11.24	TB/24-25/94	Finance Report	By January 2025, AQ to include commentary within the IQPR regarding the planned use of out of area beds	AQ	January 2025		Completed and in the IQPR. To be closed.	**In progress**
28.11.24	TB/24-25/96	Community Mental Health Framework Transformation Report	JC, SS and TS to set up a Board seminar on CMHF Transformation, with TS confirming the date of the Board seminar by January 2025.	SS	January 2025		It has been agreed between the Chair and Chief Executive that a lesson learned for CMHF will be conducted in April 2025. To be closed.	**In progress**
25.07.2024	TB/24-25/47	Right Care Right Person Report	AR to produce an end of project evaluation report for the Right Care Right Person programme, which includes evaluation of the costs of implementation. The report is to be presented at the January 2025 Board meeting.	AR	January 2025		On agenda. To be closed	**In progress**
25.07.2024	TB/24-25/49	IQPR	By January 2025, AC to include commentary regarding compliments, along with appropriate level of compliments data, within the IQPR.	AC	January 2025		Compliments data included. Verbal update to be provided.	**In progress**

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 17/01/2025

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
25.01.2024	TB/23-24/122	IQPR	By December 2024, DHS and AQ to deliver a Board Seminar in the future on those clinically ready for discharge, and how this links to the Purposeful Admissions Programme.	SS/AQ	December 2024		Board seminar timetable has not permitted this to occur. Available dates are March or June 2025.	In progress
ACTIONS NOT DUE OR IN PROGRESS								
30.05.2024	TB/24-25/16	Patient Survey Results	KH to bring an updated Patient and Participation Strategy to the Trust Board in November.	KH	November 2024	March 2025	Work on the updated Patient and Participation Strategy is underway, and the Quality Committee are being kept up to date. The final Strategy will come to the Board in Spring 2025.	Not Due
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
30.05.2024	TB/24-25/11	Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report	TS to arrange a Board seminar in the future, with a date to be agreed outside of the meeting, with the Programme Director of the Provider Collaborative, updating on the three main areas of the Collaborative.	TS	October 2024		This took place in October 2024.	Close
30.05.2024	TB/24-25/18	Social Value Update	NB to bring an update on the social value work to the Board in November, with a focus on compliance, equality and diversity, health inequalities and the Trust's desire to be an anchor institution.	NB	November 2024		This is on the agenda for discussion.	Close
25.07.2024	TB/24-25/49	IQPR	By November 2024, AC to produce a thematic review of compliments for the Quality Committee.	AC	November 2024		This went to the Quality Committee in November 2024.	Close
26.09.2024	TB/24-25/69	Chief Executive's Report	AC to take the CQC Gap Analysis to the next Quality Committee meeting, with an additional column being added to the report show why the Trust is doing each of the actions.	AC	November 2024		This went to the Quality Committee in November 2024.	Close
26.09.2024	TB/24-25/72	Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative Report	DHS to follow up with the provider collaborative as to when the missing equality impact assessments will be completed, ahead of the next Board meeting.	DHS	November 2024		This is completed and has been added to the relevant documents.	Close

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th January 2025**
Title	**Chair's Report**
Author	**Dr Jackie Craissati, Trust Chair**
Presenter	**Dr Jackie Craissati, Trust Chair**
Purpose	**For Noting**

1. Kent & Medway system and national activity

There continues to be significant discussion in Kent & Medway and at national level – where I have been involved as chair of two NHS Trusts – regarding the financial position of the NHS, the need for digital innovation, and productivity. Locally I have attended the Provider Collaborative Board and a meeting for the Chairs in Kent & Medway, with a workshop planned for both Chairs and CEOs in April.

2. Non-Executive Director Changes

In November the Board said goodbye to our longstanding NED, Catherine Walker. In December 2024, the Board welcomed our new NED, Julius Christmas. We received tremendous interest in our two Associate NED positions which we advertised with the express intent to attract a wider group of individuals who can bring a strong sense of our community to the Board discussions. I am delighted to say that we were successful in our recruitment strategy and we anticipate both NEDs formally joining the Board in February 2025.

3. Board Development

On 13th December, the Board had its Development day, which was externally facilitated. It was a great opportunity to discuss the Trust's new values, and how the Board will lead and engage with the new values.

As we come to the end of the second year of our three-year strategy, the Board also explored some preliminary thoughts about the direction of travel for a refreshed strategic focus from 2026 onwards.

4. Trust Chair and NED visits

Since the last Board meeting, the following visits having taken place.

Where	Who
January 2025	
Ashford Community Mental Health Team	Julius Christmas
Canterbury and Coastal Community Mental Health Team	Julius Christmas
St Martin's Hospital	Julius Christmas
Forensic and Outreach Liaison Service	Dr Jackie Craissati

Chair visit

I spent a morning with the Forensic and Outreach Liaison Service (FOLS), both meeting the team and going on a community visit with a support, time and recovery (STR) worker to meet a longstanding patient of the FOLS team. FOLS provide follow up care to those patients who have resided in the low and medium secure wards at KMPT, as well as bringing back the reducing number of patients from out of area. The teams' work has enabled the forensic service to reduce out of area beds and provide more timely discharge into the community; this is an important quality issue, as well as an effective allocation of resources. The patient visit was a salient reminder of the value of FOLS' longer term support to vulnerable individuals. The only area of significant concern for the team was their difficulty in effecting a transition of patients to the community mental health teams, and we spent some time discussing the obstacles to transfer and the model of care that might be required.

Julius Christmas' visits to Ashford Community Mental Health Team, Canterbury and Coastal Community Mental Health Team, and St. Martin's Hospital

I visited the community mental health teams in Ashford and Canterbury, as well as St. Martin's hospital as part of my NED induction. I was impressed with the welcome I received at all sites and the openness of senior staff in discussing challenges.

In Ashford, I spent time learning about Mental Health Together (MHT), the challenging transition to MHT and the support provided by the Rio platform. There have been improvements made to Rio over the last six months and colleagues had become more comfortable using it. However, there is still more work to do, e.g., on BI and pro-active system alerting.

In Canterbury, there was a sense of optimism that MHT was now embedding. With staff from the other agencies now onboard, inroads are starting to be made into the backlog of non-urgent referrals. Team capacity is still a concern: there is little or no headroom, so sickness/turnover has the potential to create backlog.

At St. Martins' hospital, I undertook a ward tour, attended a morning bed management meeting and met colleagues on the wards. Patient flow is clearly challenging, with more demand than capacity and discharge difficulties due to factors outside of Trust control.

Kent and Medway NHS and Social Care Partnership Trust

Chief Executive's Board Report

Date of Meeting: 30th January 2025

Introduction

I want to start off by saying a huge thank you to everyone that has worked over the Christmas and New Year period. This year was the first year we had our charity hold a Christmas appeal 'Give a Little Joy', which ensured that every inpatient spending Christmas in our care received a special gift. I would like to say a massive thank you to everyone who donated as this made such a difference for our patients who we were caring for in our inpatient wards over the Christmas period.

I also want to reflect back on everything we achieved last year, and look forward to 2025. 2024 has been a busy year for us, and at times a challenging one. We have been driving forward a large amount of transformational change, which I am incredibly proud of but I do also know that this can feel extremely challenging and overwhelming for staff at times, sadly when we may not have got it right first time.

I am looking forward to 2025 with much optimism as we have some very exciting things happening this year and I know we will strengthen KMPTs position in local communities and with our partners.

National and Regional Update

Planning Guidance

The NHS planning guidance remains outstanding; however, the continuation of the Mental Health Investment Standard (MHIS) has already been confirmed, this is fantastic news as we will be able to continue our investment in front line services and ensure parity of esteem with other sectors. Internal trust and system level planning is on-going and an update is anticipated to be brought to the March Board.

Ten Year NHS Plan

The government's *Change NHS* consultation is seeking input to shape the NHS's 10-Year Plan, focusing on three key proposals: shifting care from communities to hospitals, leveraging technology, and focusing on prevention. To contribute, we held a leadership team session using their 'workshop in a box' to discuss these proposals, with an emphasis on mental health. Here's some of the themes that were being advocated for:

- Mental health must receive equal priority as physical health.
- We need better collaboration across all sectors—primary care, hospitals, local authorities, voluntary organisations—to create seamless, patient-centred care.
- A national focus on dementia services is needed, with collaboration between researchers, charities, and service providers to build excellent community care.
- Digital services for mental health must match those in physical health, with clear benchmarks and improved training to reduce manual processes and increase patient-facing time.
- We need connected digital systems across care sectors to empower both patients and providers, keeping digital literacy and privacy in mind.
- Adoption of technologies like AI to free up time for front-line staff to focus on patients.
- Tackling health inequalities is critical, especially in Kent and Medway, where people with mental health issues die 10 years earlier. We need a unified approach to improving population health, breaking down service silos that lead to fragmented care.
- A focus on reducing the number of patients who are Clinically Ready for Discharge (CRFD), requiring collaboration across the system, including voluntary and housing sectors.

- Strengthening the working relationship between primary and secondary care.

These changes are essential for creating a more integrated, patient-focused NHS that addresses the needs of everyone. We will be making our submission next month as part of the national process.

Operational Update

KMPT Update

KMPT's 6 priorities and Year 3 of our Strategy

As we enter 2025 this brings us to the last year of our three-year strategy. We recognise that we need to strengthen the connection of our ambitious strategy with our front-line staff. Therefore, we will be re-positioning our last year of the strategy using a new improvement methodology, which we will be calling "Doing Well Together". This will empower staff at all levels to actively engage in shaping local improvements, making sure they see the direct impact of their efforts on both local outcomes and the broader strategic goals of the trust. We will present this approach at the February Board Seminar, and I'm excited to kick off Year 3 of our strategy in April. Building on this momentum, we will begin planning the next phase of our trust's ambitions over the summer.

CQC Inspection at Littlebrook

I am pleased to be able to share with you that the hard work of our acute teams and heart-warming feedback received from their patients has been recognised in a Care Quality Commission (CQC) report. Well done to all involved.

The inspection took place in March 2024, the final report was only recently published last week. The inspection had a specific focus on our acute wards for adults of working age and psychiatric intensive care units (PICU) – Cherrywood and Amberwood wards.

It was great to be able to read some fantastic feedback from patients on their experiences on the wards. This includes:

- that staff were always there when they needed them and they had been treated positively with dignity and respect
- that patients were confident in the staff team and the ward managers, and the team's ability to keep them safe

As well as hearing from patients, the report also shares more positive feedback from the observations made by the CQC. Including that:

- quality improvement plans had been developed and embedded in order to address the areas of concern identified from the incidents
- patients were being spoken with in a dignified manner and it was clear the staff knew the patients' needs well
- staff avoided using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the person or others safe

It is a credit to all the staff that the CQC has recognised the improvements that have been put in place and that our patients shared such positive experiences with them. As an organisation committed to continuous improvement we, of course, continue to learn from incidents when they occur, helping to

improve the quality of care we deliver for everyone who needs us. As this was a focused inspection the overall rating for Kent and Medway NHS and Social Care Partnership Trust is not affected by this inspection and remains good.

Littlebrook purchase

At the beginning of January, the Trust was able to complete the purchase of the Littlebrook site. This building was built under original PFI arrangements amounting to a long-term lease which the Trust had the opportunity to break after an initial 25-year period. This option was taken up at the beginning of January. I am delighted the Trust have been able to do this as it allows the Trust certainty around one of its key sites and enables us to plan for the future. I would like to express my sincere thanks to Nick Brown the trusts Chief Finance Officer for leading on the negotiations so expertly.

Violence & Aggression

The work regarding the priority to reduce violence and aggression on our inpatient wards continues at pace and we now have three teams in the Forensic inpatient services testing and learning. We are currently testing the use of Body Worn Video Cameras on two wards – which has been met favourably by both teams and patients on the wards. Initial feedback is that it is acting as a helpful deterrent and reassurance that should events occur, there is an accurate record. Several of the acute wards are sustaining their improvements and the use of zonal observations is being cited as a great help in improving relationships and engagement on the wards – helping to mitigate conflict and meet patients' needs. It was extremely positive to watch the short vlog filmed by a number of our staff on Pinewood ward recently talking about the positive impact this priority is having on their working days.

Leadership Development Programme

In KMPT we recognise that leadership is key to our success and that we must take the time to invest in our leaders for the future. To this end we are developing a leadership programme that will cover:

- Leading Self
- Leading Team
- Leading Organisation
- Leading in the System

I look forward to this programme launching in the coming months, we are aiming for the first module to be delivered before the end of this financial year and to run this development programme throughout 2025/2026. We have also started the delivery of our management development programme.

Rough Sleepers and BBC coverage

This month, Mark Norman from BBC South East interviewed John Lavelle, Service Director for West Kent, and Mariama Bah, a Specialist Mental Health Nurse, to highlight our Rough Sleeper team's life-changing work. They provide essential mental health support to those facing homelessness, and their impact is nothing short of inspiring. During the interview, Paul, a patient, shared how our team saved his life, saying, "Without them, I would be dead." The story appeared on BBC South East Today, BBC Radio Kent, and online. We're so proud of the Rough Sleeper team and all those who support our patients. A massive well done to the team and thank you to the communications team for securing such a fantastic opportunity to share the team's work with a wider audience.

Chief of Police Visit to Dartford Littlebrook Hospital Site

On Thursday 16th January, the Chief Constable Tim Smith and Deputy Chief Constable Peter Ayling joined myself and Adrian Richardson our Director of Transformation and Partnerships to visit a number of our wards on the Littlebrook Site. We have a good working relationship with Kent Police and I know we will continue to build on this relationship throughout the year. Staff were able to ask the Chief Constable and Deputy Chief Constable questions as we visited wards and this has given both parties ideas of what we can do next to build on our partnership working. I believe our work together this year will involve further support to our inpatient units when appropriate.

I would like to thank the Chief Constable and Deputy Chief Constable for their time, I know our staff appreciated this and were keen to speak to them.

Value in Practice Awards

We continue to receive lots of nominations for our Value in Practice Awards and the winners for November and December are included in the appendix to this report. Well done to all our staff it is brilliant to read about all the great work our staff do on a daily basis to support each other and our patients. We are all very KMPT proud.

Summary and Conclusion

As we start another year, I look forward to leading KMPT through its next year with some very exciting ambitions ahead, for example launching our new identity, changing the trust name (subject to DHSC approval), entering the final year of our 3-year strategy and developing our next 3-year strategy. I am proud of our organisation and what we do, I am also immensely proud of our colleagues who continue to work extremely hard to ensure the safety of our patients. Here's to 2025!

APPENDIX

Executive Team Visits

Sheila Stenson:

Ward visits: Jasmine, Willow, Amberwood, Cherrywood, Pinewood, Ruby, Orchards, Upnor, Boughton, Chartwell
Dartford Liaison
Maidstone Liaison
Maidstone Home Treatment Team
Maidstone Rapid Response Team
Dartford Community teams, including EIP, Older Adults and Mental Health Together
Forensic – Low Secure Unit (Allington Centre)
Maidstone and Dartford Pharmacy teams

Donna Hayward-Sussex

Britton House

Andy Cruickshank

Albion Place
Highlands House
Fern & Foxglove Wards
Rivendell
Ashford Liaison
West Kent EIP

Sandra Goatley

Riverhill and Marle Ward

Dr Afifa Qazi:

Ashford Liaison Services, William Harvey Hospital

Dr Adrian Richardson
Dartford Memory Assessment Service

Value in Practice Awards – November and December 2024

Directorate		November	December
North	Individual	Kerry Childs NK SLT Administrator	Amy Luchmun Lead Clinician, DGS (MHT+)
	Team	Medway Reception (Britton House)	Dartford, Gravesend and Swanley (DGS) CRHTT
East	Individual	Paul Swaffer	Martin McGahon, Operational Team Manager
	Team	Thanet Older People Psychology Service	Ashford Liaison Service
West	Individual	Kerryanne Laker, administration Assistant, Crisis Line	Andrew Williams, Administrator
	Team	Service User Network	Rough Sleepers Service
Forensic	Individual	Oluwapelumi Ogundeyi, Healthcare Worker	Melna John, International Nurse
	Team	Thrive	The Youth Pathway at Liaison, Diversion and Reconnect
Support services	Individual	Theresa Bull, Business Administration Assistant	Amy Draper, L&D
	Team	Switchboard	Central Investigations Team
Acute	Individual	Emily Manners	Rose Noakes, Housekeeper
	Team	Chartwell Ward	Pinewood Ward, OT Team and Dr Daly

Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30 January 2025
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 November 2024.

- No risks have been added to the BAF since reporting to Board in September:
- Two risks have changed their risk score since the BAF was reported to ARC in November
  - Risk ID 08146 – Maintenance of a Sustainable Estate (Reduced from 12 (High) to 8 (High))
  - Risk ID 08173 – Delivery of a Fit for Purpose Estate (Reduced from 16 (Extreme) to 12 (High))
- No risks are recommended for removal from the BAF this time

Governance

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

Version Control: 01

Kent and Medway
NHS and Social Care Partnership Trust

The Board Assurance Framework

The BAF was last presented to the Board on 28th November 2024.

The Top Risks are

- Risk ID 00580 - Organisational inability to meet Memory Assessment Service Demand (Rating of 20 – Extreme)
- Risk ID 08157 – Community Mental Health Framework Achieving Outcomes to Evidence Success (Rating of 20 – Extreme)
- Risk ID 07891 – Organisational Management of Violence and Aggression (Rating of 15 Extreme)
- Risk ID 08065 – Inpatient Flow (Rating of 15 – Extreme)

Risk Movement
Two risks have changed their risk score since the Board Assurance Framework was presented to Board in November:

- **Risk ID 08146 – Maintenance of a Sustainable Estate (Reduced from 12 (High) to 8 (High))**
  This risk has been reviewed and has reduced in risk score. The action related to a review of the present backlog maintenance position has been completed.
- **Risk ID 08173 – Delivery of a Fit for Purpose Estate (Reduced from 16 (Extreme) to 12 (High))**
  This risk has been reviewed and has reduced in risk score. 2025/26 Operational Capital programme prioritisation was completed in November. Option for early engagement of design services (Q4) to develop schemes prior to 2025/26 being considered. Capital funding for 2025/24 yet to be confirmed. The actions associated with this risk have been completed.

Risks Recommended for Removal
No risks are being recommended for removal at this time:

New Risks
No new risks have been added since the BAF was presented to Board in November

Emerging Risks
No new emerging risks have been identified for the BAF at this time.

Other Notable Updates

- **Risk ID 00580 – Organisational inability to meet Memory Assessment Service Demand**
  This risk was reviewed in Early January. Work is progressing on development of these services and implementing the KMPT improvement plan. This is being influenced by wider system actions and pressures, which has been updated on the gaps in controls and relevant actions on this risk record. There are initial signs of improvement in the 6 week data, (November 2024 showing 26.1%), there is further work to be done internally to address the unwarranted variation, and progressing into Phase 2 of the model. There is a lot of work to

be done for phase 3, the community model, and how we influence the system in terms of what needs to be commissioned and the timetable for that.

- **Risk ID 08065 – Inpatient Flow**
  This risk was last updated in December 2024. CRFD had reduced to 54 patients as at 17 December 2024, from 72 in August 2024, and the net bed occupancy was showing as 92%, which was meeting the December target. Net Bed occupancy needs to reduce to a target of 85% by end of March 2026. The Patient flow programme has started to show an impact on reducing CRFD and occupancy, but it is too early to predict if this will be sustained. This risk will remain closely monitored via the flow programme reporting every 2 weeks to EMT.

- **Risk ID 07557 – Trust Agency Usage**
  This risk was last updated in December 2024. Agency spend has been fluctuating over the past year. The highest level of spend was December 2023 when agency spend was at 4.2%. The lowest has been 2.3% in March 2024. Trust target was set at 3.2% for agency spend as percentage of total staff pay bill. October IQPR data shows Agency spend at 2.9%, November data shows this has increased to 3.2% of total pay bill. Over the past year, the Trust has met the target for 4 months, so the risk mitigation measure is showing as met. There is no forecast of worsening in spend in the coming months. There remains pressure in the wider local health economy which has led the ICB to introduce level 4 financial controls which we are compliant with.

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: 17 January 2025

NHS
Kent and Medway
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

1 - We deliver outstanding, person centred care that is safe, high quality and easy to access

1.1 - Improving Access to Quality Care

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.

31/10/2022

Since the introduction of the ICB, the clinical lead role for Dementia across K&M has been dissolved. This has created a gap in system leadership that casts doubt on the whether the Dementia workstreams in progress thorgh the SIG will be delivered on target.

15/05/2024

This risk has been reviewed and reframed. There remains an ongoing need for a system response to the demand for Memory Assessment services. Risk scores have increased due to the current position and anticipated growth in demand over the coming years.

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)
ID 00580	Jan 2022	Director of Partnerships and Transformation	**Organisational inability to meet Memory Assessment Service Demand** If KMPT remain the sole provider of Memory Assessment Services, despite the internal work to redesign services, and the ongoing system programme of work to redefine the community model Then there is a risk that patients will not receive a diagnosis in a timely manner and access to treatment and services. Resulting in continued failure to achieve Dementia Diagnosis Rate across Kent and Medway, potential harm to patients and their families who are unable to access necessary treatment of services, increased regional or national scrutiny, financial and reputation impact to the organisation and system, given the expectation of increased demand from population over the coming years.	5	5	25	System wide response to achieve improved Memory Assessment services across Kent and Medway through the Mental Health Learning Disability and Autism (MHLDA) Provider Collaborative and Ageing Well Board. - BI Functionality to drive performance at team, directorate and organisational level - Stand alone assessment model formed, currently being optimised - Completing the Demand and Capacity for the multi-disciplinary model for memory assessment within KMPT (to be rolled out across the organisation) - Community Model Task Force formed comprising KMPT and wider NHS and VCSE partners.	Weekly reporting of performance and issues with the optimisation of Phase 1 to Executive Management Team Highlight reports to Trust Leadership Team, FPC and QC on 6 week performance Reporting to MHLDA and Ageing Well Board	4	5	20	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Power BI reporting to support Improvement — Director of Partnerships and Transformation — Completed — G Phase 1: Pilot of standalone Memory Assessment Service in line with Community Mental Health Framework rollout — Director of Partnerships and Transformation — Completed — G Phase 2: Launch of multi-disciplinary assessment model within KMPT — Director of Partnerships and Transformation — 22/12/2025 — A System convening task and finish MHLDA Provider Collaborative task and finish to scope community and system involvement and convene pilots alongside Health Care Partnerships (HCP) — Director of Partnerships and Transformation — 31/03/2025 — A Optimisation of phase 1 stand-alone model — Director of Partnerships and Transformation — 26/05/2025 — A Phase 2 resourcing and implementation — Director of Partnerships and Transformation — 31/05/2025 — A Resourcing and roll-out of community model alongside ICB and community services — Director of Partnerships and Transformation — 31/03/2026 — A	Director of Partnerships and Transformation		3	4	12	31/03/2026

30/08/2023 — BAF Risk Opened

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)
ID 05075	Aug 2023	Chief Operating Officer	**Community Psychological Services Therapy Waiting Times** IF the demand on psychological services outstrips the services capacity. THEN there will be an increase in the number of clients waiting for assessments and therapy. RESULTING in an increase in waiting times. While patients wait they may experience a deterioration in the mental health symptoms. Therefore there is a risk of harm to self, including suicide may increase, poor patient experience, possible increase in complaints, increased stress for staff, reputational damage to the Trust.	4	4	16	1. Psychology Leads working with colleagues to move patients onto stepped care pathway. 2.Implementation of Clinical Care Pathways specifically the 'Initial interventions' and 'CED Pathway'. While this is becoming established and common practice wait times could go up due to the diversion of specialist psychological therapy staff into training and supervision of the Clinical Care Pathways. Once established the numbers of patients requiring further specialist psychological therapy should reduce. 3.PSYCHOLOGICAL SERVICES TO MAINTAIN SPREADSHEET DATABASE TO TRACK PATIENTS IN PATHWAY. 4.Waiting list action plan is in place which serves to increase flow of patients by providing clear guidance on treatment lengths, group work and transitions 5.Psychological Practice Dashboard in place to monitor numbers waiting and waiting times in real time as drawn 'live' from RiO.	Assurances from dashboard data	3	3	9	⟷	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Waiting list review for mental health together — Director of Psychological Therapies — 23/12/2024	Chief Operating Officer		1	2	2	30/08/2025

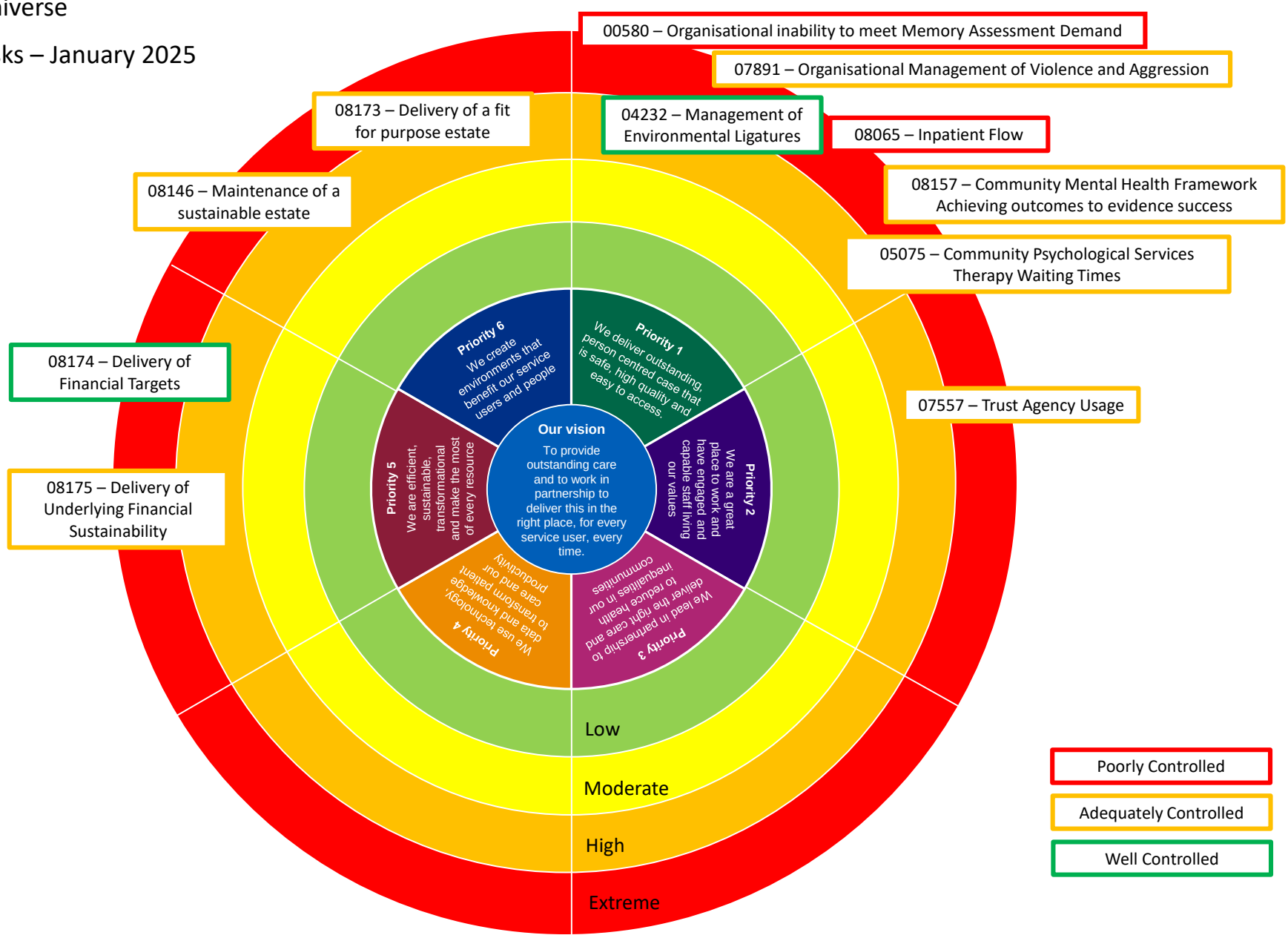
ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
	12/06/2024 Risk Opened																					
ID 08065	Jun 2024	Chief Operating Officer	**Inpatient Flow** If the long waits in ED, Community and the Place of Safety remain in excess of 12 hours for an inpatient admission to an acute psychiatric ward Then treatment maybe delayed, Resulting in risk of harm, poor patient outcomes and potential longer length of stay. Reputational damage with partners organisations and the wider NHS system is a risk.	5	3	15	Patient flow team jointly working with acute hospital colleagues, Liaison Psychiatry, Home Treatment and community services on case by case basis twice daily reports including the Place of Safety Breaches daily system calls review of current metrics to understand and agree when agreement to admit patient commences and when 'clock' starts business case approved through ICB to move to CORE 24 across all acute hospitals CRFD programme of work underway to release capacity within the KMPT bed stock- Discharge to Assess (D2A) transition arrangements for CRFD patients; internal pathway review CRFD Programme is a system wide programme in conjunction with the ICB Local Authority and supported through the Provider collaborative.	Weekly CRFD report Daily Bed state including Place of Safety and A&E Breaches	3	5	15	⇔	Accurate recording and reporting of 12 hour breaches	Director of Digital	30/08/2024	A	Chief Operating Officer		1	3	3	12/09/2025
													Countywide safe Haven Provision	Deputy Chief Operating Officer	30/12/2024	A						
													CRFD Programme	Deputy Chief Operating Officer	31/03/2025	A						
													High Intensity User Programme	Director of Psychological Therapies	31/03/2025	A						
													Implementtion of CORE 24 across all Hospital Liaison Services	Deputy Chief Operating Officer	30/06/2025	A						
													Crisis Houses across the County	Deputy Chief Operating Officer	28/07/2025	A						
	12/06/2024 Risk Opened																					
ID 08157	Aug 2024	Chief Operating Officer	**Community Mental Health Framework Achieving outcomes to evidence success** IF we don't complete enough paired DIALOG+ and are not able to meet the 4 week wait THEN we will a) not be able to assess outcomes for our service users and will b) delay commencement of treatment, RESULTING IN poor patient experience.	5	5	25	Fortnightly review of waiting lists at programme management level (1d) with measures for mitigation shared with all partners. Amendments to the front door are underway, the interface with GP's is undergoing improvement and the voluntary sector are moving resources to entry points to enable improved triage. Team level daily management. Tactical groups in all localities monitoring waits and clinical risk to patients (1c). Monthly deep dive by programme management to each locality (1a) Dashboard in place (1d)	Robust team level management Dashboards Caseload management tool Partnership Forums	5	4	20	⇔	Review of Mental Health Together Processes	Deputy Chief Operating Officer	31/01/2025	A	Chief Operating Officer		3	3	9	28/06/2025
													Integration of Provider workforce to aid skill mix and new ways of working	Deputy Chief Operating Officer	31/01/2025	A						
													Recruitment of 35 Assistant Psychologists on a 6 month contract to support the management of waiting lists.	Deputy Chief Operating Officer	06/01/2025	A						
1.2 - Creating safer and better experiences on our wards																						
	04/12/2014 BAF Risk Opened; 20/07/2023 Risk returned to BAF																					
ID 04232	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	Program for removing anchor points and restricting access to staff only areas 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 (now conducted jointly with Clinical ward staff and Estates staff) [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 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	3	4	12	⇔	Capital Expenditure on Environmental Ligature risk areas	Head of Capital Planning	31/03/2025	A	Chief Nurse		1	4	4	31/03/2025
	04/12/2014 BAF Risk Opened; 20/07/2023 Risk returned to BAF																					
ID 07891	Jan 2024	Chief Nurse	**Organisational Management of violence and aggression** IF KMPT do not manage violence and aggression effectively THEN staff and patients will be exposed to physical injury and psychological harm RESULTING IN increased incidents of seclusion and restraint; longer recovery times for patients; lack of staff confidence to report and in managing incidents of Violence and Aggression; increased staff sickness, reduced staff capacity to manage incidents and provide quality care, reduced staff retention, reputational damage, difficulties recruiting, reluctance of agency staff to work on wards with high levels of violence and aggression, reduced staff engagement with violence reduction strategies.	5	3	15	Restrictive Practice policy and guidance Violence Reduction Strategy PSS Strategy Use of Force Act CQUIN Operation Cavell Security strategy CCTV (where available) Trust Strategy identifies a reduction of V&A for inpatients and Racial incidents with associated workstreams to support this. How to manage challenging telephone calls Policy Therapeutic observations Policy Control of Ligatures Policy	Incident reporting via InPhase Quality Improvement Data	5	3	15	⇔	Quality Improvement project in place to implement and test evidence based interventions to reduce violence and aggression across all inpatient services.	Chief Nurse	30/03/2026	A	Chief Nurse		2	3	6	31/03/2026
													Regular, scheduled engagement with all participating inpatient teams	Chief Nurse	30/03/2026	G						
													Use of data and sharing ideas and learning across services via the QI team and senior leaders	Chief Nurse	30/03/2026	A						
													Weekly review of data and incidents with Trust leaders in Trust Safety Huddle	Chief Nurse	30/03/2026	G						
1.3 - Actively involving service users, carers and loved ones in shaping the services we provide.																						
			No Risks Identified against this Strategic Objective																			
2 - We are a great place to work and have engaged and capable staff living our values																						
2.1 - Creating a culture where our people feel safe, equal and can thrive																						
			No Risks Identified against this Strategic Objective																			

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)
2.2 - Building a sustainable workforce for the future																						
			No Risks Identified against this Strategic Objective																			
2.3 - Creating an empowered, capable and inclusive leadership team																						
			No Risks Identified against this Strategic Objective																			
3 - We lead in partnership to deliver the right care and to reduce health inequalities in our communities																						
3.1 - Bringing together partners to deliver location-based care through the community mental health framework transformation																						
			No Risks Identified against this Strategic Objective																			
3.2 - Working together to deliver the right care in the right place at the right time																						
			No Risks Identified against this Strategic Objective																			
3.3 - Playing our role to address key issues impacting our communities																						
			No Risks Identified against this Strategic Objective																			
4 - We use technology, data and knowledge to transform patient care and our productivity																						
4.1 - Have consistent, accurate and available data to inform decision making and manage issues																						
			No Risks Identified against this Strategic Objective																			
4.2 - Enhance our use of IT and digital systems to free up staff time																						
			No Risks Identified against this Strategic Objective																			
4.3 - Effective digital tools are in place to support joined-up, personalised care																						
			No Risks Identified against this Strategic Objective																			
5 - We are efficient, sustainable, transformational and make the most of every resource																						
5.1 Achieve financial sustainability																						
25/06/2024 → Risk Opened																						
ID 08174	Jun 2024	Chief Finance and Resources Officer	**Delivery of Financial Targets** IF the Trust is unable to deliver its financial targets THEN additional scrutiny will be attached to its financial position RESULTING IN sanctions from NHS England	3	5	**15**	Standing Financial Instructions Delegated budgets Agency recruitment restriction CIP Process Monthly statements to budget holders Budget holder authorisation Authorised signatories Trust Capital Group oversight Business Case review group	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	4	**12**	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Review of Trust Reporting Pack — Associate Director of Finance — Completed — G Alignment of Service line reporting (SLR) and Budget Reporting — Associate Director of Finance — 31/03/2025 — A				Chief Finance and Resources Officer		2	4	**8**	**31/03/2025**
25/06/2024 → Risk Opened																						
ID 08175	Jun 2024	Chief Finance and Resources Office	**Delivery of Underlying Financial Sustainability** IF the Trust does not focus on cost saving, productivity and efficiency to contain its run rate THEN funds will not be available to support the investment in services RESULTING IN the Trust potentially moving into financial deficit and unable to support the delivery of the Trust Strategy	3	4	**12**	Long term sustainability programme Cost Improvement Programme	Trust Board Reporting to NHSE Monthly Finance Reporting Finance position and CIP Update Internal Audit	3	4	**12**	⇔	**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Development of Service line reporting to improve understanding — Associate Director of Finance — 31/01/2025 — A Review of Cost Improvement reporting — Associate Director of Finance — 31/03/2025 — A Review of Trust controls on Non Pay — Associate Director of Finance — 31/03/2025 — A Review of Trust controls on Pay — Associate Director of Finance — Completed — G Review of Trusts Longer term planning cycle — Associate Director of Finance — 31/03/2025 — A				Chief Finance and Resources Officer		3	3	**9**	**31/03/2025**
5.2 Exceed the ambitions of the NHS Greener programme																						
			No Risks Identified against this Strategic Objective																			
5.3 Transform the way we work																						
			No Risks Identified against this Strategic Objective																			
6 - We create environments that benefit our service users and people																						
6.1 - Maximise our use of office spaces and clinical estate																						
			No Risks Identified against this Strategic Objective																			

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	Owner	Target Completion (end)	Status	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6.2 - Invest in a fit for purpose, safe clinical estate																						
29/03/2024 Risk Opened																						
ID 08173	Mar 2024	Chief Finance and Resources Officer	**Delivery of a fit for purpose estate** If the Trust is unable to invest in its estate Then the clinical and workplace environments may not be fully fit for purpose Resulting in the loss of services	4	4	**16**	Identifications of needs of Estates Regular updates to FPC regarding present options Robust design of estates requirements with operational leadership		4	3	**12**	⇩	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		3	3	**9**	**31/12/2024**
													Identification of potential next steps steps on high cost estates development	Director of Estates and Facilities	Completed	G						
													Implementation of a rolling, multiyear estates capital programme	Director of Estates and Facilities	Completed	G						
01/04/2020 Risk Opened																						
ID 08146	Aug 2024	Chief Finance and Resources Officer	**Maintenance of a Sustainable Estate** If the Trust is unable to support the maintenance of its estate Then clinical and workplace environments may not be fully fit for purpose Resulting In the loss of operational capacity	3	4	**12**	Robust contract specification for the delivery of safe, compliant and effective maintenance and upkeep of buildings. Proactive management of Hard FM contract. Robust governance of Hard FM through regular contract meetings and KPI's monitoring. Asset Planned Preventative Maintenance programmes (PPMs) Room availability performance monitored monthly Quality and performance monitoring monthly WSMT, quarterly support services QPR Investment in backlog maintenance prioritised in Operational Capital planning (2e) Backlog national benchmarking through ERIC annually	Reporting to FPC TiAA Audit Contract Monitoring Minutes	2	4	**8**	⇩	**Actions to reduce risk**	**Owner**	**Target Completion** (end)	**Status**	Chief Finance and Resources Officer		2	3	**6**	**31/03/2025**
													Review of the implementation of the new maintenance contract	Director of Estates and Facilities	15/02/2025	A						
													Review of the present backlog maintenance position	Director of Estates and Facilities	Completed	G						

Risk Universe

BAF Risks – January 2025



NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30 January 2025
Title of Paper:	Mental Health Learning Disability and Autism Provider Collaborative (MHLDA) Update
Author:	Raheel Anwar, Programme Manager Provider Collaborative
Executive Director:	Sheila Stenson, Chief Executive Officer

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper provides an overview of the continued developments of the Mental Health, Learning Disability and Autism Provider Collaborative (PC).

Issues to bring to the Board's attention

The report provides an update on programmes covered under the Provider Collaborative, including updated metrics for dementia and urgent and emergency care. Joint metrics for mental health urgent and emergency care are now in place and we are able to use these to strengthen our programme monitoring.

Governance

Implications/Impact:	KMPT Trust Strategy
Assurance:	Reasonable
Oversight:	Trust Board and Provider Collaborative (PC) Board

Kent and Medway Provider Collaboratives - Update for KMPT Board

Focus of this report

In this report site-level data for the Mental Health Urgent and Emergency Care (UEC) work is outlined which includes performance successes and challenges. There is also an update on Community Mental Health Framework (CMHF) implementation, Learning Disabilities & Autism out of area placements, the review as undertaken by the Housing Associations' Charitable Trust (HACT) and Dementia.

Mental Health Urgent and Emergency Care

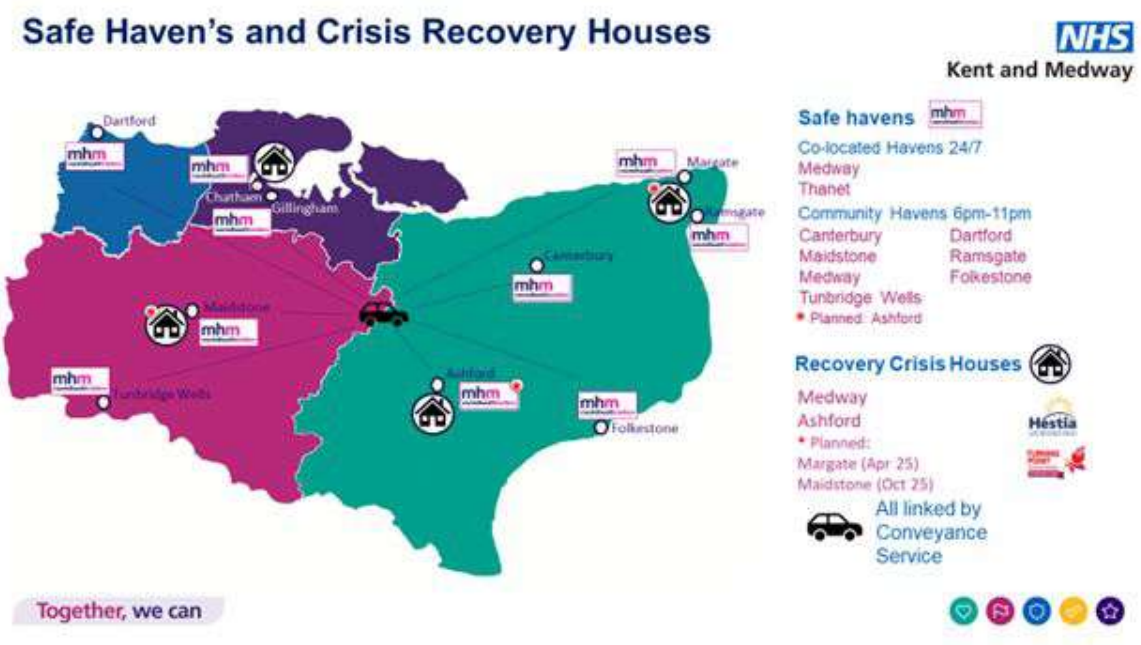
Systemwide Core24 Compliance

Work is underway to ensure Liaison Psychiatry Services across all six acute sites are CORE 24 compliant. An update on progress is given in the table below.

Key Action	Timeframe	Status	Comments
Recruitment to CORE 24 establishment.	End of April 2026	In progress	Staff consultation completed with recruitment commenced.
Model standards implemented alongside new staffing model.	End of July 2025	In progress	Model standards reviewed with practice changes being applied in line with recruitment to new posts.
Development and implement a plan to achieve accreditation.	End of July 2026	For review	The new model will be established by the end of July with accreditation being considered after 6 months. Plan for accreditation (phased) will be worked up by individual teams with shared learning across sites. Accreditation requires a timely application to avoid financial penalties and will be pursued at an appropriate time.

Success of safe havens and other alternatives to admission

- A&E attendances for mental health in Kent & Medway dropped from over 1,000 per month to 920 on average since April 2024.
- Safe Havens usage increased, with co-located sites seeing footfall rise from 380 in April to 653 in October 2024.
- While Safe Havens appear to ease A&E pressure, impact varies by location.



Site	Key information
Medway and Maidstone & Tunbridge Wells	- Medway Foundation Trust and Maidstone & Tunbridge Wells have significantly reduced mental health A&E visits over 2 years, with these halving for Maidstone and Tunbridge Wells. - The Medway impact is directly correlated with the co-located safe haven attendance. - The links between A&E attendance and safe haven footfall are less clear for MTW.
Dartford & Gravesham	- Haven footfall started slow but is steadily rising. Safe haven is not co-located. Next steps to be explored.
Thanet (QEQM)	- East Kent has seen a slower reduction in numbers over the past three years compared to other areas, with data from Q1 and Q2 showing a significant increase for 2024/25. - The Thanet co-located Safe Haven launched six months later than the Medway site, which affects comparisons. - Between January and March 2024, primary care cases increased at QEQM. - Increased communications and engagement activities are being carried out to boost Safe Haven attendance.
Ashford Crisis House (WHH)	- Opened November 2024. - Data from 20 January showed 60 percent occupancy

Thanet Co-located Safe Haven (QEQM): Changes in Haven footfall have not yet impacted A&E attendance. Open 24/7 since June 2024, the Haven launched six months after Medway's co-located Haven, which may explain some of this difference.

The Safe Haven model in Thanet differs to that in Medway. In Medway Rapid Response is co-located whereas in Thanet co-location is not possible (largely due to the demands across East Kent on the Rapid Response service). However, it should be noted that the Haven is supported by the liaison psychiatry team who operate in the same building.

The ICB team continues to refine pathways to target Safe Haven services toward those in mental health crises while addressing challenges like attendance dips and awareness of the benefits as an alternative to A&E for mental health crisis support.

Safe Haven Patient Feedback

Nine safe havens went live in June 2024. We have learning from the community havens and the two co-located sites that went live in 2023.

Here are some of the things people have said about the service so far:

"I am so thankful to [S] for informing me of the Medway Safe Haven. I went to the Safe Haven the other night ... . The Safe Haven was warm and clean. The [member of staff] I saw was welcoming and understanding. I felt safe, listened too and most importantly heard. Nothing was expected from me, I was asked a few questions for clarification purposes. I stayed in for about two hours and didn't feel rushed to leave. I really do recommend this service to anyone struggling with their mental health and in need of someone to listen." – Service User

"Medway Safe Haven is amazing. They have saved me on a couple of occasions. I tend to arrive after 9pm so that it's quieter and then I stay for as long as needed (taking into consideration their opening times). They are one of the best forms of support I have found. They accommodate my needs. An example being closing the door (when they're not supposed to) and having an extra member of staff in the room with us to ensure staff safety."- Service User

"I have used Safe Haven when very ill and found its softness and a satellite from all of the institutions beneficial to my mental health. It was a service I felt easier to trust so possibly aiding recovery." - Service user

Ambulance and police conveyance:

The purpose of the Kent Integrated Care Board's ambulance and police conveyance workstream is to create opportunities to reduce unnecessary ambulance and police conveyance where possible.

This builds on the successes achieved by the 836 line where the need for people to placed on a S136 has reduced.

Key goals:

- Reducing the number of ambulance and police conveyances.
- Providing alternative care pathways, such as community or mental health services.
- Enhancing collaboration between health, social care, and emergency services.

Effectiveness is monitored through:

1. **Data Analysis**: Tracking trends in ambulance and police conveyance rates to identify improvements or challenges.
2. **Feedback Mechanisms**: Gathering input from frontline staff and service users to understand the impact of interventions.
3. **Performance Metrics**: Measuring outcomes like response times, patient satisfaction, and the success of alternative care pathways.
4. **Regular Reviews**: Conducting regular assessments and evaluations to refine and adapt the approach based on emerging needs and evidence

A reduction in adult MH presentations by ambulance was noted since June 2024, attributed partly to new Safe Haven sites where ambulance crews can convey directly to a haven.

Next Steps

A bespoke mental health conveyancing service is in the process of being implemented. This will enable service users to be conveyed to an appropriate service thus avoiding Emergency Departments.

Community Mental Health Framework (CMHF)

Long Term Plan – CMHF Summary (NHS England and NHS Improvement and the National Collaborating Central for Mental Health)

Community mental health services have provided vital, localised care for over 30 years but required modernisation. The Framework offers an opportunity to transform care by:

- Shifting from siloed, hard-to-reach services to integrated, population-wide approaches.
- Redefining the purpose and identity of community mental health care.
- Supports the development of Primary Care Networks, Integrated Care Systems (ICSs), and personalised care to improve outcomes for people with severe mental illnesses.

Programme Updates (excluding Mental Health Together**)**	
SUN Model	**Eating Disorders**
- Feedback regarding the booking system has indicated that it is not user friendly. Work is underway to simplify and ensure is accessible - Currently 5 groups are available. These are in Margate, Gravesend, Maidstone & Canterbury. Online provision also available - More groups planned for 2025.	- Funding confirmed for Intensive Care Pathway focussing on ARFID admission avoidance – mobilising is required before advent of adults into this pathway - Clinical Lead for Enhanced pathway in post and development of this pathway continues - Stability and Support pathway launched for more longer-term presentations in progress with additional SSCM Specialised Supportive Clinical Management supervision groups - FREED national benchmarking continues well.
CYP	**Community Rehab**
- New Transition Pathway being rolled out in all localities in Kent & Medway (both KMPT & NELFT) - Plans ongoing to establish a clinical focus group to look at the clinical offer for YP (18-25) post transition. - Online training for KMPT staff working with young adult and transition now completed - New Transition protocol/policy for NELFT and KMPT is being developed with an anticipated date of completion by March 2025 - Direct transition pathway now established between young people services and NHS talking Therapy.	- Clinical staff recruitment almost complete - Social work posts delayed – due to triple lock process - Awaiting VCSE recruitment - contracting discussions underway - QIA is completed and signed off for baseline measure - Service specification and SOP are in final draft and will be reviewed and ratified once all VCSE posts are recruited - Evaluation plans are in place post go live and embedding of the model - 19 patients in West Kent have been through the service to date - Anticipated implementation dates: o North Kent May 2025 o East Kent March 2025

MHT & MHT+ Phase 1 and 2 Post Implementation

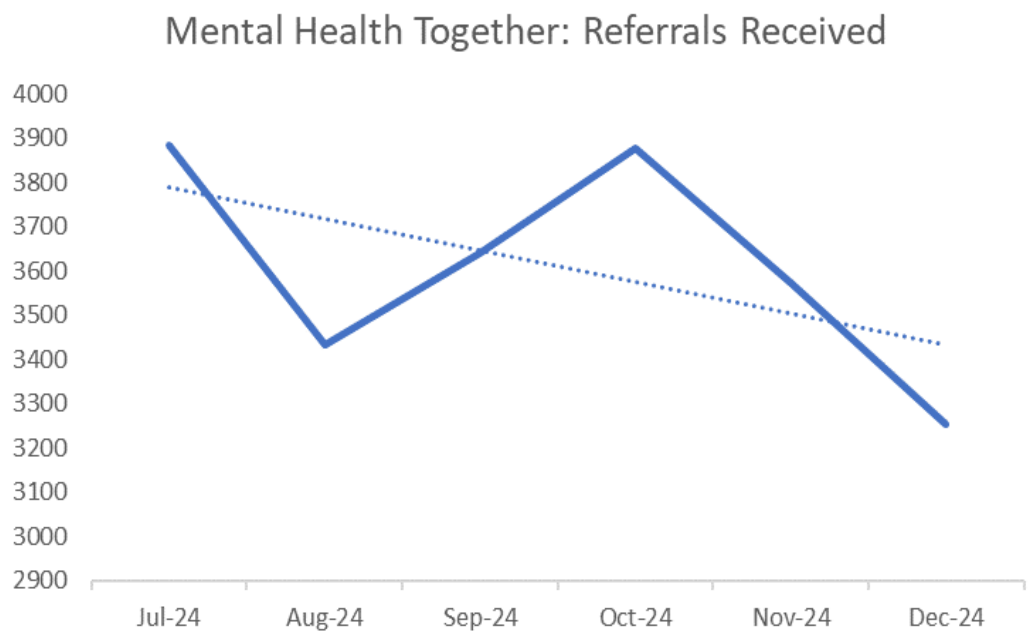
It is important to recognise the 'newness' of the established services with Mental Health Together Plus changes taking place in some areas in December 2024. It will take time for the new pathways and multi-agency approach to embed. Moreover, the creation of seamless pathways between Mental Health Together and Mental Health Together Plus where the focus of the programme is now concentrated along with refining the triage in Mental Health Together between January and April 2025.

Planned interventions are being gradually rolled out with in line with the VCSE staffing being in place. It is anticipated that this will be completed by June 2025 with the demand and capacity review commencing in March 2025.

Referrals and Waiting Lists Mental Health Together

Mental Health Together referrals decreased significantly in December. It is critical to monitor referrals throughout 2025 to be able to determine if the referral pattern stabilises or continues to fluctuate.

Demand for the service has been higher than what was originally modelled, it is approximately 3% above what was expected and will need to be monitored closely in the coming months.



As at 6th January 2,831 patients are awaiting their first contact with MHT, of these 1,662 (50.9%) have been waiting under 4 weeks to date. 3,395 have received their first contact and are currently awaiting the commencement of an intervention. Waiting lists have stabilised in the last month following a period of continual growth. Immediate actions remain in place to reduce the length of time people are waiting to commence treatment including the onboarding of staff from all agencies and the additional Assistant Psychologists to deliver initial interventions.

Programme Next steps:

Community Rehabilitation

- Expand the West Kent caseload and extend to North and East Kent during 2025.

Eating Disorders

- Develop tiered/stepped care adult pathway with SPEAKS/EMDR/ as part of stage 3 for complex presentations

Service User Network

- Expanding the F2F and online group offer.

Mental Health Together & Mental Health Together+

- Full implementation of the front door model. Anticipated full roll out March to April 2025.
- Full implementation of the clinical model - interventions being fully available. Anticipated full roll out June 2025
- Demand & Capacity review – March 2025.

Broader Developments for CMHF

- Development of Integrated Neighbourhood Teams.

Dementia

KMPT Memory Assessment Service

There has been progress made, as the data demonstrates, but there are challenges regarding capacity to meet demand.

Current Dementia Diagnosis Rate (DDR):

- Kent and Medway DDR: 60.5% (national average: 65.8%).
- To achieve a DDR of 66.7% by March 2026: 1,600 more diagnoses required.

Sustaining 66.7% DDR:

- Requires 440 diagnoses per month to account for growth and attrition. This is above the current capacity of KMPT.
- Current monthly average completely resourced by KMPT is: 408.5 diagnoses (June–November 2024).

Achievements on reducing delays:

- Six-week diagnosis rate improved from 4.6% (January 2024) to 26.1% (November 2024).

Remaining Challenge:

- 2,825 open referrals.
- Additional capacity needed to meet the six-week target.

Frontline improvements launching January 2025 aim to:

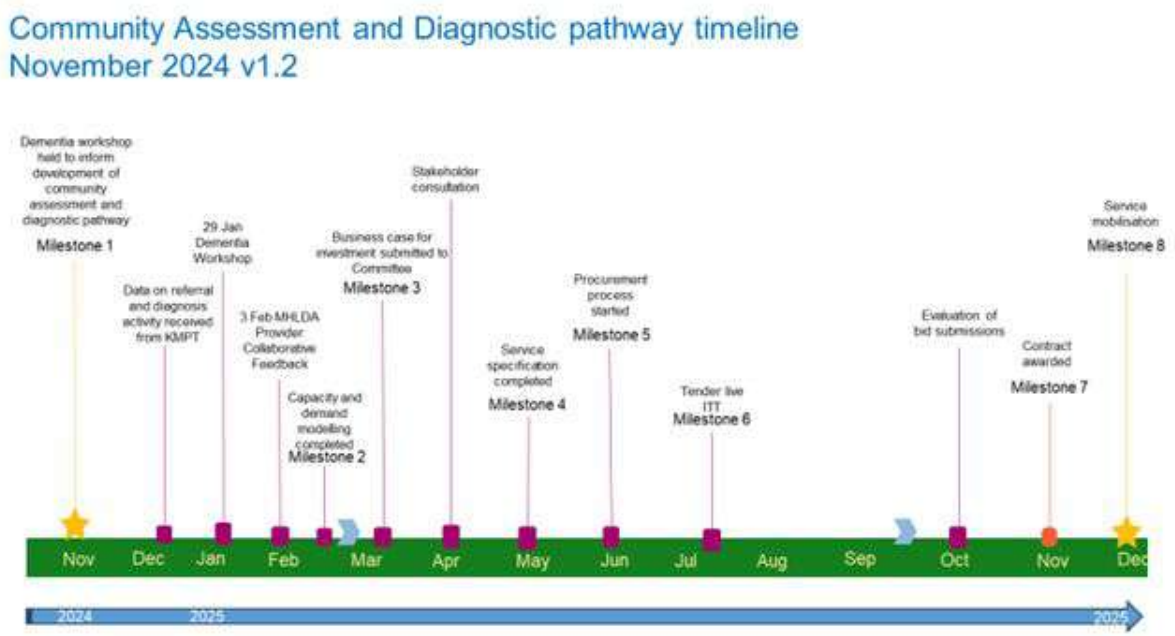
- Build on current progress
- Enhance efficiency and reduce unwarranted variation to make best use of the current resource within KMPT
- Building on demand and capacity calculations refine internal KMPT model

System Dementia Model

A provisional timeline has been developed by the dementia team. There is an ICB workshop running on 29 January with key stakeholders and clinicians, including from KMPT. Following this there will also be a presentation on the proposed community model at the MHLDA Provider Collaborative Board on 3 February. Preliminary focus areas for the community model have been suggested as:

- Diadem in care homes / utilising rapid in care home assessments to avoid patients having to come into assessment services
- Utilising primary care clinicians and other services to diagnose dementia in the community
- Utilising advanced skill sets within GPs with enhanced roles for more complex cases supported by KMPT where necessary

A further update will be brought to the March KMPT Board. Below is a draft timeline that will be discussed at the February workshop.



<u>HACT Mental Health Housing Strategy</u>

The ICB commissioned Housing Associations' Charitable Trust (HACT) to support the system in understanding the opportunities, key issues, and priorities towards greater collaboration with housing across the ICS.

The aim is to develop a strategic and coordinated approach to mental health and housing in Kent and Medway. The approach involves identifying opportunities for collaboration and addressing gaps across the system.

This work will be completed in three phases:

1 - Discovery | Sep 24 - Dec 24 - COMPLETED

Extensive stakeholder engagement exercise, HACT have conducted a series of one-to-one sessions and small focus groups.

WE ARE HERE

2 - Report Key Findings | Jan 25 - Feb 25

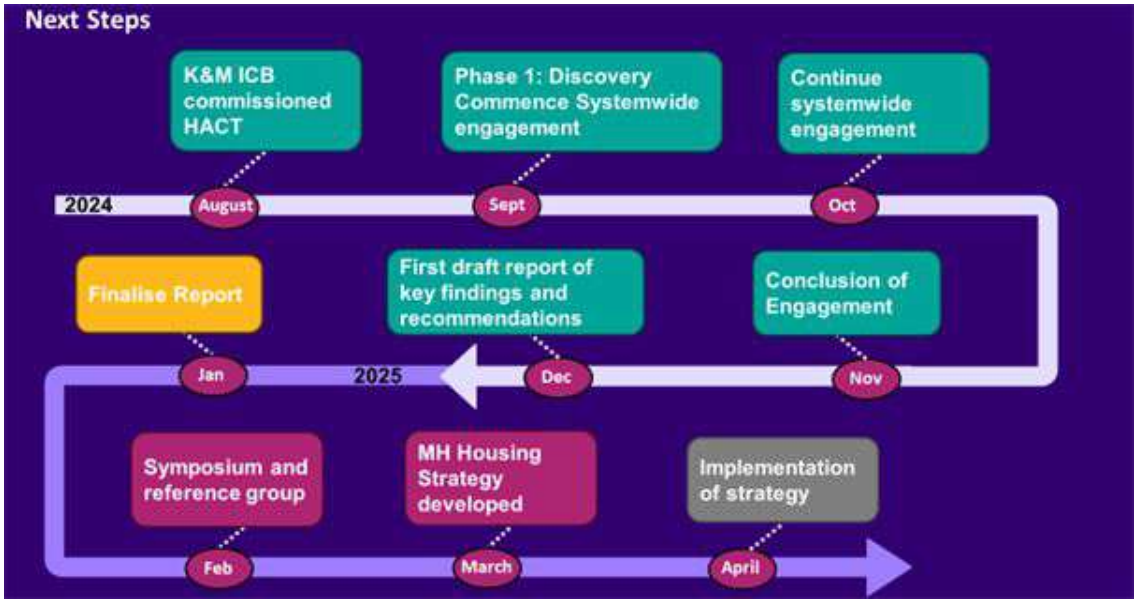
Present key findings and recommendations to inform the development of the strategy.

3 - Development of a Mental Health Strategy | Feb 25 -Apr 25

Work with key stakeholders and hold a Housing Symposium. Development of strategy.

An initial report has now been produced by HACT and is going through minor revisions based on feedback given by the ICB and the Provider Collaborative. The final report will be discussed at the MHLDA Provider Collaborative workshop in February where a high-level timeframe for delivering the strategy will be developed.

Proposed next steps:



An update on this work and in particular surrounding the symposium and reference group will be provided at the March KMPT Board.

<u>Reducing out of area placements for autistic inpatients</u>

The programme was established to review all inpatients out of area and to ensure that they are receiving the most appropriate care. We know that patients have an improved quality of life when

patients receive care closer to home and also when they can live their lives in their local communities.

Since we last reported to Board, there have been further discharges, bringing the total number of patient discharges to 20, with 17 of those being from Acute and 3 from Specialist settings. Against the target set for this programme, the cohort of patients has already been reduced by 25%. The current caseload of 40 patients is split as follows: Acute – 8, Specialist – 8, Locked Rehab – 7, Patients in Transition – 17, Review patients – 15.

A review of this programme will be completed prior to the 12-month programme end (May 2025) to establish whether this pilot should become a permanent service.

MHLDA Programme Timeline Overview

Please see an overview of programme timelines below, detailing key milestones to delivery for the year 2025

Programme	Milestone	By
Community Mental Health Framework	MHT+ roll out	Jan 25
	Front door refinement – proof of concept	Jan 25
	PMO handover	Mar 25
	Test and learn	Mar 25
	Evaluation	May 25
	Transition and sustainability	Sep 25
Dementia Pathway Transformation	Rollout of Front-Line Improvement in Memory Assessment Services	Jan 25
	Demand and Capacity Modelling Completed	Feb 25
	Business case for investment submitted to the ICB	Mar 25
	KMPT Service Specification Refresh	Mar 25
	Stakeholder Consultation	Apr 25
	Service Specification – GPwER, Dementia Coordinators and Crisis Services	May 25
	Procurement	Oct 25
	Service Mobilisation	Dec 25
Mental Health Urgent and Emergency Care	See and Treat 2 hr response planned	Mar 25
	Full Recruitment to CORE 24 in all Hospitals	Mar 25
	Publishing of revised Crisis 136 Standards	Mar 25
	Margate Crisis Recovery House Planned Go Live	Apr 25
	Centralised HBPOS Go Live	May 25
	Maidstone Crisis Recovery House Planned Go Live	Oct 25
Out-of-area LDA placements	10% of cohort stepped down or EDD established	Mar 25
Young Adults 16-25	Expansion of the care leavers social prescribing project.	Mar 25

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th January 2025
Title of Paper:	Right Care Right Person Evaluation
Author:	Christine Hemmings, Quality Assurance Director
	Holly Partridge, Senior BI Business Partner
Executive Director:	Adrian Richardson, Director of Transformation and Partnerships

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

The Right Care Right Person (RCRP) initiative was implemented across Kent and Medway in April 2024. An update was provided to Trust Board in May 2024 with a request to bring back an evaluation of the impact on the organisation.

Issues to bring to the Board's attention

- There is no evidence of a negative impact from RCRP to the returning of service users that are absent without leave to wards and the practice of asking the police to assist.
- There has been no notable increase in either the number of bookings or cost of returning service users that are absent without leave.
- No negative impact from RCRP can be evidenced in regards to concerns for welfare calls.
- There has been no observable impact on service users leaving an ED department without being discharged.
- There is no evidence to suggest RCRP has changed the number of service users detained under Section 136 of the Mental Health Act or the subsequent admission to in-patient beds.
- Sharing and use of data has proved challenging but data matching exercises have been undertaken and continue to be worked through.

Governance

Implications/Impact:	Patient safety
Assurance:	to be assigned
Oversight:	Quality Committee

Version Control: 01

Introduction

Right Care Right Person is a National Partnership Agreement between the Home Office, Department of Health & Social Care, the National Police Chiefs' Council, Association of Police and Crime Commissioners, and NHS England to work to end the inappropriate and avoidable involvement of police in responding to incidents involving people with mental health needs.

Police are often contacted in relation to people with mental health needs. This may lead to unwarranted police involvement. It is known that for some, police involvement can be distressing and can result in increased use of force and the criminalisation of mental health problems. However, it is recognised that policing on some occasions will have its part to play.

The Right Care Right Person (RCRP) initiative was implemented in Kent and Medway on April 2nd 2024.

The main areas of work evaluated are:

- The returning of service users that are absent without leave to wards and the practice of asking the police to assist. (AWOL)
- Requests/costs for the transport of AWOL mental health service users
- Requests by KMPT staff for the police to attend service users' normal places of residences when there is a concern for their welfare and they have not attended appointments. (Concern for Welfare).
- Concern that arises from service users leaving the Emergency Department. (ED walk out)
- Activity that involves the detention of service users by the police under section 136 of the Mental Health Act. (136)

Absent Without Leave incidents (AWOLs)

Pre and post RCRP implementation, figure 1 shows the numbers of AWOLs raised to Kent Police each month. This does show a reduction in the number of AWOLs being raised to Kent police in July to September but across the period, the numbers are within common variation. This could show early signs of slightly less AWOLs being raised with Kent Police as a result of RCRP.

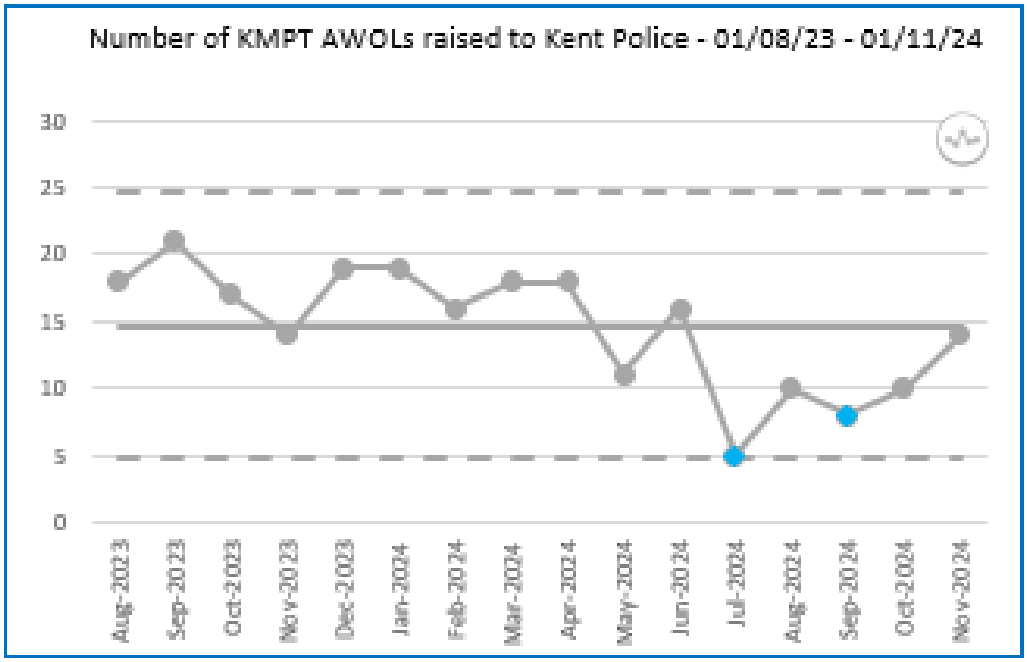

Figure 1 Number of KMPT AWOLs raised to Kent Police Aug 2023- Nov 2024. Data source: Kent Police

Figure. 2 shows the percentage of AWOLs that were subsequently resourced by Kent Police. This chart also demonstrates common cause variation throughout, i.e. no significant change. Combined, these charts demonstrate that the resourcing of KMPT AWOLs from Kent Police remains consistent at an average of 65%, despite variation in the numbers of AWOLs occurring and so no negative impact from RCRP can be evidenced.

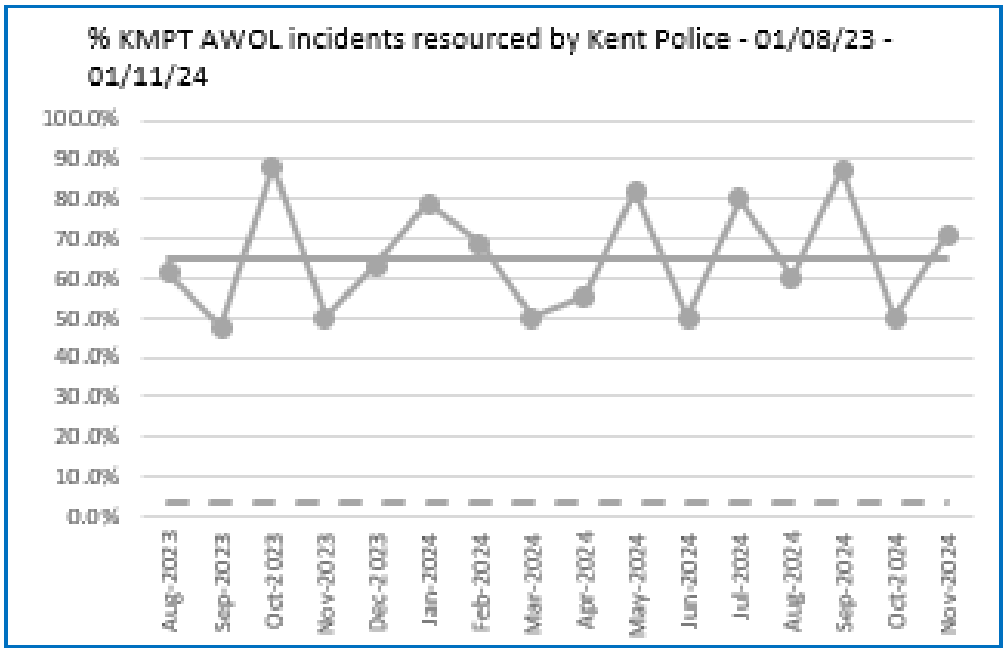

Figure 2 % KMPT AWOLS resourced by Kent Police Aug 2023- Nov 2024. Data source: Kent Police

Version Control: 01

Requests/costs for the transport of AWOL mental health service users

Requests for transport booking of patients who have gone AWOL has also been monitored through implementation and evidences no notable increase in either the number of bookings or cost, (table 1).

Month	Transport bookings for AWOL	Cost
Aug-23	0	-
Sep-23	0	-
Oct-23	1	£1,470.00
Nov-23	0	-
Dec-23	1	£297.50
Jan-24	0	-
Feb-24	0	-
Mar-24	0	-
Apr-24	0	-
May-24	1	£325.83
Jun-24	0	-
Jul-24	3	£1,225.42
Aug-24	0	-
Sep-24	0	-
Oct-24	0	-
Nov-24	0	-

Table 1 KMPT transport bookings for AWOL patients and cost. Data source: KMPT

Concern for Welfare Incidents (CFWs)

Requests by KMPT staff for the police to attend service users' normal places of residences when there is a concern for their welfare are shown below. Figure 3 demonstrates a common cause variation for the number of CFWs raised to Kent police. The resourcing of CFW incidents by Kent police in figure 4 also shows common cause variation. This supports the conclusion that the resourcing of KMPT CFW incidents from Kent Police remains consistent at an average of 29% and no negative impact from RCRP can be evidenced.

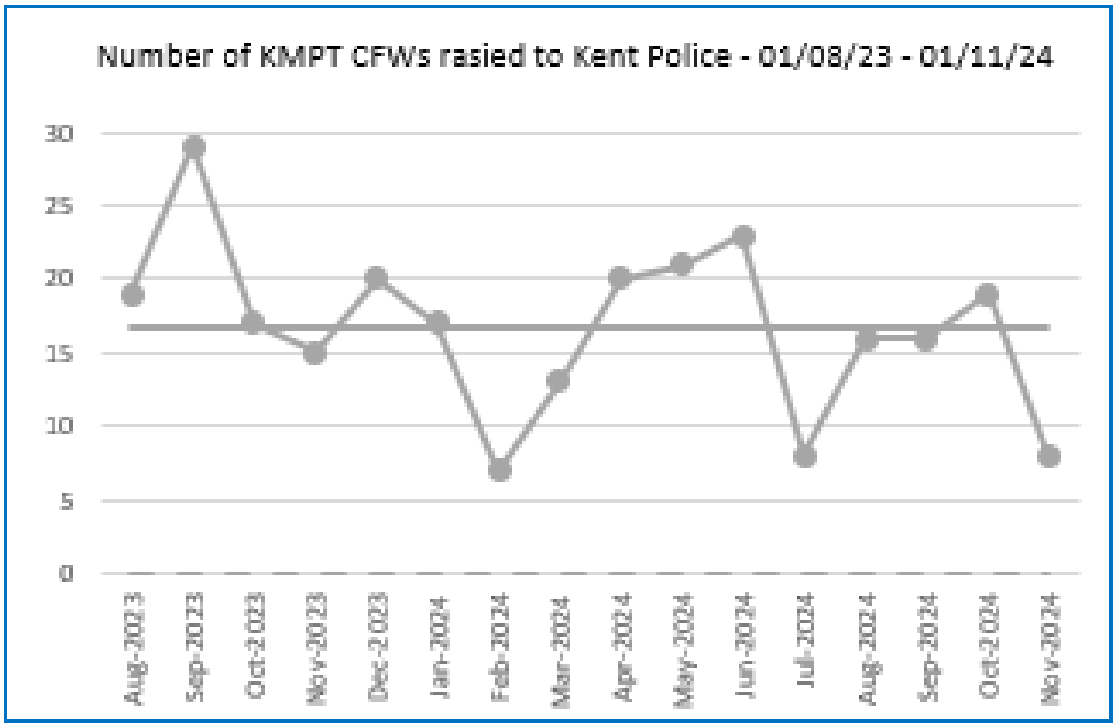

Figure 3 Number of KMPT CFWs raised to Kent Police Aug 2023- Nov 2024. Data source: Kent Police

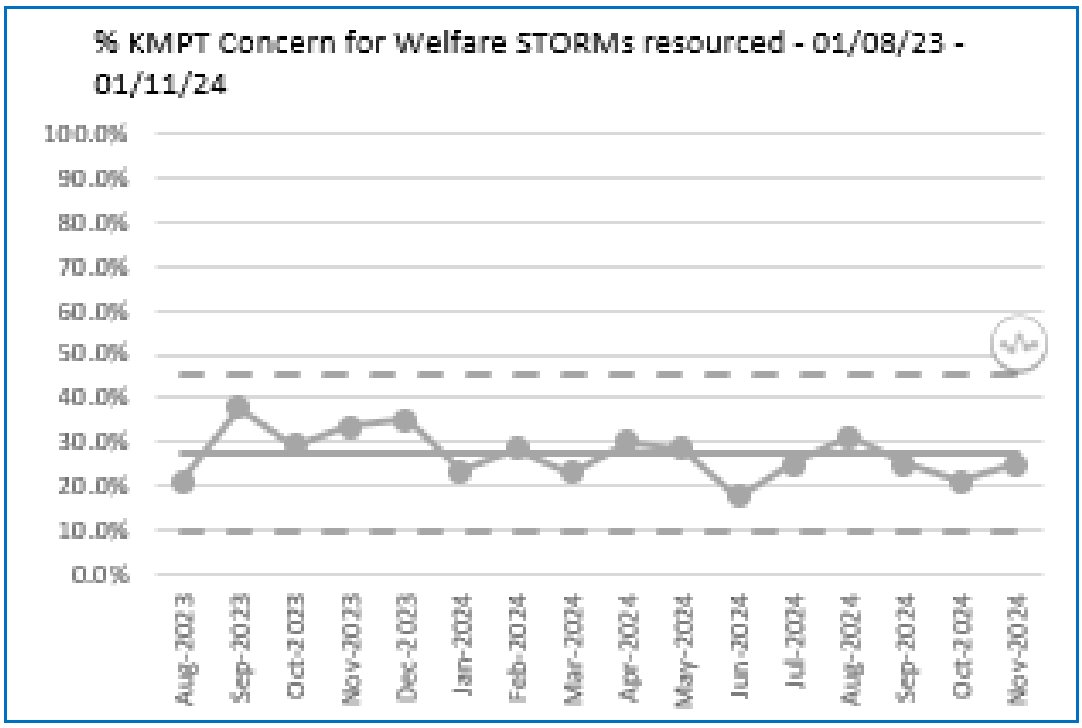

Figure 4 % KMPT CFWs resourced by Kent Police Aug 2023- Nov 2024. Data source: Kent Police

Version Control: 01

Liaison Psychiatry- walk outs from Emergency Departments

Figure 5 demonstrates common cause variation throughout RCRP both pre and post implementation. This evidences that there has been no observable impact as a result of this change.

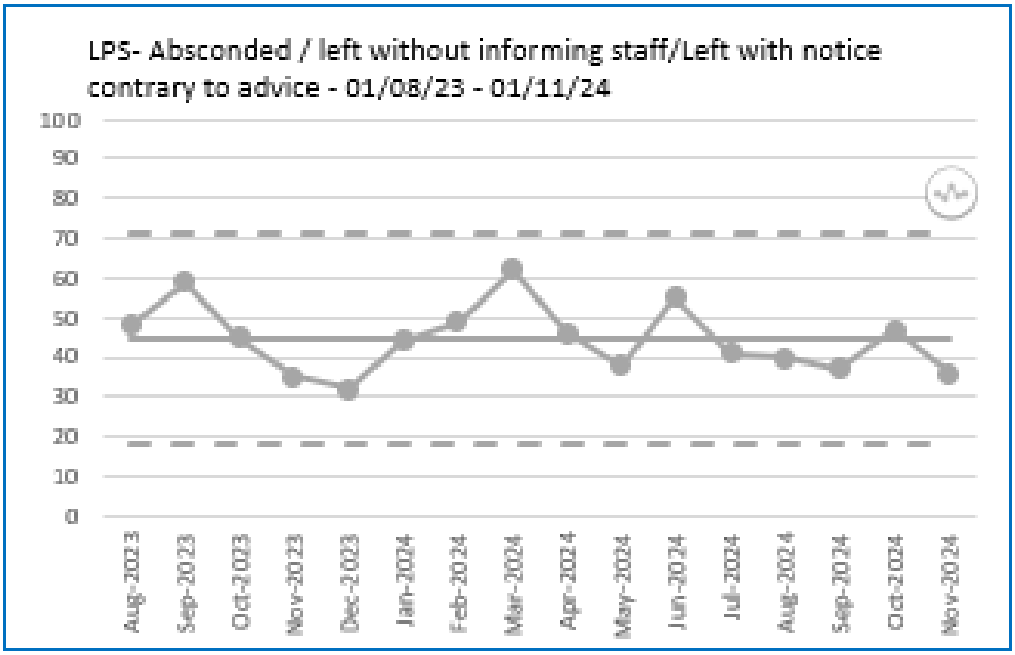

Figure 5 Number of walk outs from ED in Liaison Psychiatry in month. Data source: KMPT InPhase

Section 136 of the Mental Health Act

Activity that involves the detention of service users by the police under section 136 of the Mental Health Act. (136) has been reviewed pre and post RCRP implementation.
Figure 6 shows a positive reduction in the number of people being detained under section 136 of the Mental Health Act in September and October 2024. The reason for this improvement is not directly linked to RCRP but instead linked to the introduction of the 836 line and closer working between KMPT and Kent Police.

Despite this reduction, the number of S136 detentions going through to admission on an Acute MH ward remains consistent. This suggests that with less S136 detentions, those being admitted remains within common variation. Again, this activity is not attributed to RCRP.

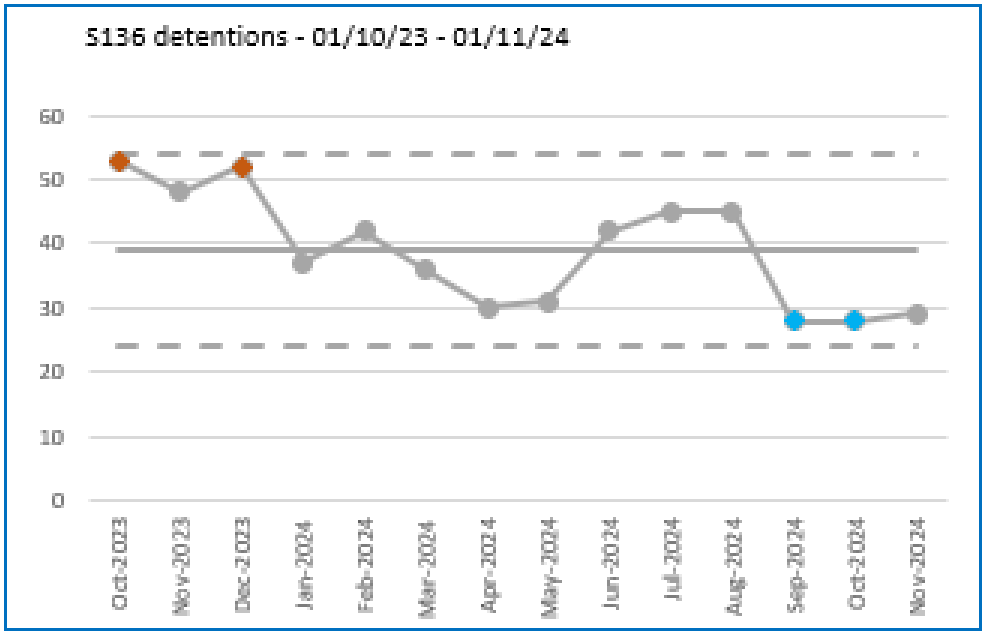

Figure 6 Number of S136 detentions in month. Data source: S136_S135 Report - Power BI

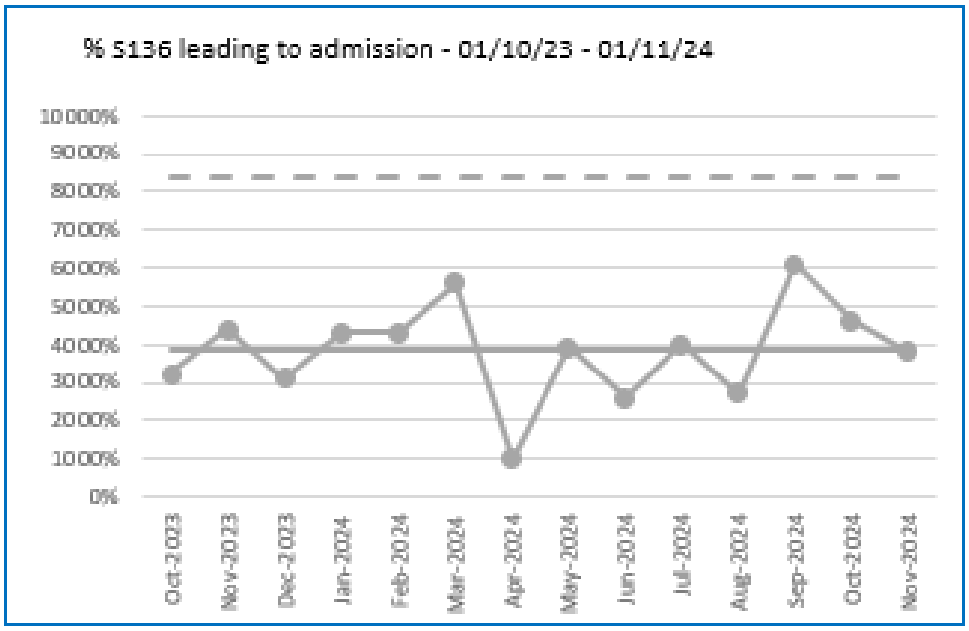

Figure 7 % of S136 detentions that resulted in admission in month. Data source: S136_S135 Report - Power BI

Case Studies

There have been no contributory or causative Serious Incidents to note that have involved the introduction of RCRP.

There was one Serious incident where a patient came to harm following an incident of Absent Without Leave. This Serious Incident raised areas of learning for both KMPT and Kent Police, particularly around different approaches to communication. A learning event was organised to give the opportunity to discuss this directly with Kent police. It was concluded that RCRP did not impact on the incident.

Version Control: 01

Data

Obtaining data to provide a system wide perspective for this evaluation has proved challenging. The main barrier to this evaluation has been in reconciling data between KMPT and Kent police. Kent police have regularly supplied data on AWOLs and CFW attendance, including whether these had police attendance. However, the number for these have been consistently lower than internally reported figures within KMPT.

A data matching exercise has been conducted in KMPT with police reference numbers. The outcome of this has confirmed that not all incidents logged on InPhase were processed through to Kent Police for various reasons e.g. downgrade. For this reason, Kent police data has been used where possible in this evaluation because it allows KMPT to view the key change from RCRP which is if Kent police resourced the incident.

Transition to Business As Usual and Next Steps

Regular reviews with KMPT and Kent Police have now been built into business as usual across the organisations. This also includes the review of activity data between KMPT and Kent Police.

Regular learning sessions between all system partners and Kent Police were scheduled throughout the implementation phase and have continued with the intention to reduce in frequency as we move forward.

Further work will also transition to focus on service user and staff experience, that will feed into any further optimisation of the initiative.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th January 2025
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Sheila Stenson, 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 three Ps' ("People we care for"; "People who work with us"; and "Partners we work with") from our trust strategy with aligned the targets and metrics.

Issues to bring to the Board's attention

The IQPR provides an overview of trust services across numerous indicators, this represents one element of the trusts Performance Management Framework and is supported by monthly Directorate Quality Performance Review meetings as well as local structures for reviews of performance within the directorates.

The Chief Executives Overview at the start of the report highlights the key areas of focus, specifically where performance has improved and also where continued focus is required to ensure we improve at pace. There are a number of areas where we need to do things differently to improve access to our services and deliver the best outcomes for our patients. My six priorities are these areas of focus, but as we move into the autumn, the 3 areas that will need relentless focus are dementia, mental health together and patient flow.

Governance

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

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Integrated Quality & Performance Report

(IQPR)

January 2025

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1. Chief Executive Overview

This report highlights trust performance, including where we are making improvements, as well as areas of concern and what actions we are taking to address this. My six priorities set out clearly our areas of focus. This month I want to highlight the following:

Mental Health Together

Demand for the Mental Health Together service has exceeded initial expectations by 1.8% (based on MHT Jul – Dec). This is due to a variety of factors, which we are actively addressing to reduce waiting times.

In April 2024, NHS England published new guidance for community mental health services waiting times, emphasising treatment should start within 4 weeks of referral (previously we were measuring waiting times for an initial assessment). While this is not a mandated target, we strive to meet this standard for our patients.

Key activity to note, includes:

- **Referrals**: December 2024 saw the lowest average referrals since July, a positive trend, but likely seasonal
- **Access:** 50.9% of patients awaiting initial contact have been waiting less than 4 weeks from referral
- **Partner integration:** Partners have successfully recruited and are onboarding staff from Shaw Trust (100% recruited, 50% seeing patients), Porchlight (5% recruited, 50% seeing patients), and Invicta (75% recruited, 45% seeing patients), with the goal of all staff actively treating patients from February 2025.
- **Enhanced support:** Assistant Psychologists are joining the team in January to support initial assessments, dialog+ and interventions. Overtime for existing staff is also being utilised.
- **Triage optimisation:** in response to staff engagement and partner feedback, we are undertaking a test and learn in Medway reviewing the triage process to better manage the high-volume of referrals, with a focus on social interventions. Once completed, we will evaluate based on the outcomes measured we have agreed and decide whether this should be introduced across all out teams.

Despite the increased demand, prioritising patient safety and wellbeing remains paramount. Patients with complex needs, and/or, high risk factors are seamlessly transitioned to Mental Health Together +, where they receive swift and dedicated ongoing support from the multidisciplinary team.

We are constantly learning and adapting. By analysing data, gathering feedback from staff, patients and partners, and implementing innovative solutions, we are committed to improving access to timely, high-quality mental health care for all.

Patient flow

Managing flow remains a critical area of focus. While bed occupancy improved in December, exceeding expectations at 92.6%, we acknowledge the ongoing challenges, particularly with readmissions and the use of non-contracted beds which are at their highest position for the year.

Our two-pronged approach focuses on:

1. **Addressing readmissions** by preventing avoidable readmissions and implementing strategies to minimise readmission rates; as well as strengthening community support for high intensity users to prevent unnecessary hospitalisations.
2. **Improving discharge processes** through purposeful admissions; our "Red to Green" initiative where we are streamlining the discharge process for patients ready to leave the hospital; and a new Transfer of Care Hub (ToCH).

Activity to note, includes:

- **Readmission reduction:** We are conducting a thorough analysis of recent bed occupancy data to identify areas for improvement and learning.
- **Strengthened partnerships:** We will continue to strengthen our partnerships with key stakeholders, including Kent County Council, to ensure seamless transitions of care and optimise resource utilisation. My Chief Medical Officer, Chief Nurse and I have met with Kent County Council twice in the last month to agree how we can together manage patients that are Clinically ready For Discharge (CRfD) and awaiting social care support. We have agreed this will be managed by effectively commissioning the appropriate care pathways across health and social care. I will keep the Board sighted as this work progresses.
- **The new, Transfer of Care Hub (ToCH)** will facilitate seamless transitions of care by bringing together health, social care, and voluntary sector partners. It will specifically manage CRfD to support the care needs of our patients in the community, and reduce the time that it takes to set up onward care. The ToCH went live in East Kent on 13th January 2025. The approach will be refined if required before roll-out across other areas of Kent and Medway.

Dementia

While we've seen a positive downward trend in dementia diagnosis wait times (now 17.8 weeks compared to the 12-month average of 22 weeks), we remain committed to achieving the 6-week target and have a lot of work to do as a Kent and Medway system to meet this.

429 diagnoses were recorded in December. This number is below what is needed to positively impact the Kent and Medway system dementia diagnosis rate (DDR) target.

As a comparator, the most recent National Audit of Dementia from the Royal College of Psychiatrists (2023) shows that nationally waits were 151 days, 21.6 weeks.

Our focus remains on:

- **Medical engagement, leadership and staff buy-in to the new model**, embedding standards of practice and reducing variation is being driven through improvement sessions held with the directorates.
- **Data quality and robust dashboards to manage the service effectively**. Positive progress has been made on a bespoke MAS team dashboard which is now live and accessible by teams. The next step is to ensure robust use of this information by clinical teams to manage waiting lists/times.
- **Review of the triage process,** currently focused on ensuring the operational policies and standard operating procedures are in place and robust, further supporting the teams to reduce variation.
- **System wide collaboration.** The Mental Health and Learning Disability Provider Collaborative is meeting in early February to review the proposed system dementia model. This is phase 3 of this priority.

Further areas I'd like to note;

- **Care Planning:** While overall CPA compliance was at 80% in December 2024, we are addressing the lower compliance rates in Mental Health Together Plus which are 15% below the trust average and equates for a third of all CPA activity. At the end of December this service had 203 patients on CPA who required a new or updated care plan. A detailed review has been undertaken. The expectation is that compliance will increases in January and February. The percentage of patients on non-CPA pathways requiring a Care Plans or Personal Support Plan continues to decrease, this is in light of the changes taking place in Mental Health Together Plus which will eventually result in care plans being informed by Dialog+. Compliance was 55.8% at end of December compared to consistent achievement of approx. 70% up until June 2024. MHT teams are not included in this measure,

these are monitored against Dialog+ completion separately. Going forward, we are transitioning towards a more modern care planning approach, utilising Dialog+ as a core component from April 2025. This is aligned to national guidance.

- **Crisis response:** Positively, we are consistently meeting targets for our crisis response, with significant improvements in response times for urgent presentations and those requiring triage by liaison teams. This has improved from 4.4% in Jan 24 to 87.6% in Dec 24, this is a remarkable achievement by the teams involved and a much-improved service for our patients.

- **Essential training**: We've achieved significant improvements in essential training compliance, particularly in areas including Basic Life Support and Immediate Life Support.

- **Improved staff retention:** Our voluntary leave rate is below target, reflecting the positive and supportive work we have been doing to create a supportive work environment and the work of our culture, identity and staff experience priority.

2. Report Guide

Statistical Process Control (SPC) is used to assist in the identification of significant change (see appendix for detailed information regarding this process), the tables within the next section of this report summarises variation in performance over time and assurance where targets exist. The intelligence from this analysis is used alongside wider intelligence within the organisation to highlight the areas of celebration and challenging within the Chief Executives Overview.

Section four presents a 12-month trend for all indicators by domain, within the summary tables levels of performance are colour coded against stated target (where they exist). Where an indicator is rated as amber, this denotes that the current level of achievement is within 10% of achieving its target. Red denotes a metric breaching the target and green where achieving.

Within each domain the indicators identified as subject to significant variation through the use of SPC are analysed further with supporting information regarding the definition, any known data quality and key variances across the directorates.

The latest published position for the Single Oversight framework is shown in the appendix. The majority of the indicators are annual measures and therefore not contained within the monthly IQPR, however it is important to ensure the trust continues to work to improve in these areas alongside those included within the IQPR.

3. Integrated Quality and Performance Summary

Variation Summary (where targets exist)

The following table summarises trends of variation and assurance for those indicators where targets are identified.

Variation	Assurance			
		Variation indicates consistently (P)assing the target.	Variation indicates inconsistently passing and falling short of the target.	Variation indicated consistently (F)alling short of the target.
	Special cause of improving nature of lower pressure due to (H)igher or (L)ower values.	3.1.02: Vacancy Gap – Overall 3.1.03: Essential Training For Role 3.1.05: Leaver Rate (Voluntary)	3.1.06: Safer staffing fill rates	
	Common cause – no significant change.		1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral 1.2.01: Average Length Of Stay (Younger Adults Acute) 1.2.02: Average Length Of Stay (Older Adults - Acute) 1.3.01: Mental Health Scores from Friends And Family Test – % Positive 1.3.08: Complaints acknowledged within 3 days (or agreed timeframe) 1.3.09: Complaints responded to within 25 days (or agreed timeframe) 1.4.04: Restrictive Practice - No. Of Prone Incidents 1.4.05: Decrease Violence and aggression on our wards 2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge) 3.1.01: Staff Sickness – Overall 4.1.07: Agency spend as a % of the trust total pay bill	2.1.04: Clinically Ready for Discharge: YA Acute 2.1.05: Clinically Ready for Discharge: OP Acute 4.1.01: Bed Occupancy (Net)
	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.	3.1.07: Increase percentage of BAME staff in roles at band 7 and above	1.2.06: Readmissions within 30 days (YA & OP Acute) 1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	1.2.10: %Patients with a CPA Care Plan 1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans

Variation Summary (No targets)

The following indicators do not currently have an identified target nationally or locally and therefore can only be measured against trends in variation. Work is under way to establish local targets for an increased number of IQPR indicators.

Variation		
	Special cause of improving nature of lower pressure due to (H)igher or (L)ower values.	1.1.02: Open Access Crisis Line: Abandonment Rate (%) 1.1.03: Assess people in crisis within 4 hours 1.1.04: People presenting to Liaison Services: triaged within 1 hour 1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks 1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab) 1.3.04: Compliments - per 10,000 contacts
	Common cause – no significant change.	1.1.06: Place of Safety LoS: % under 36 hours 1.1.09: % MHLD referrals commencing treatment in 18 weeks 1.2.03: Adult acute LoS over 60 days % of all discharges 1.2.04: Older adult acute LoS over 90 days % of all discharges 1.2.05: Patients receiving follow-up within 72 hours of discharge 1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) 1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end 1.3.02: Complaints - actuals 1.3.03: Compliments - actuals 1.3.05: Patient Reported Experience Measures (PREM): Response count 1.3.06: Patient Reported Experience Measure (PREM): Response rate 1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly % 1.4.03: Restrictive Practice - All Restraints 1.4.06: Medication errors 4.1.04: In Month Budget (£000) 4.1.05: In Month Actual (£000) 4.1.06: In Month Variance (£000)
	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values.	4.1.02: DNAs - 1st Appointments 4.1.03: DNAs - Follow Up Appointments
	Special cause variation where movement is not necessarily improving or concerning	1.1.01: Open Access Crisis Line: Calls received 1.4.02: All Deaths Reported And Suspected Suicide 2.1.03: MHT 2+ contacts

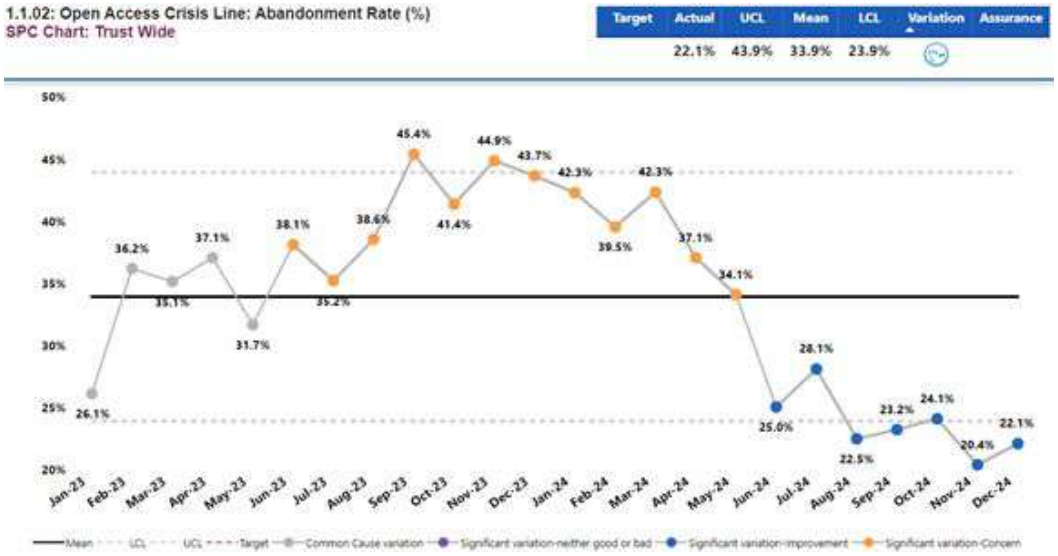
4. Trust Wide Integrated Quality and Performance Dashboard

People We Care For: Access

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
1.1.01: Open Access Crisis Line: Calls received		5,842	4,737	4,900	3,604	3,258	3,022	3,640	3,415	3,607	3,509	3,195	3,287
1.1.02: Open Access Crisis Line: Abandonment Rate (%)		42.3%	39.5%	42.3%	37.1%	34.1%	25.0%	28.1%	22.5%	23.2%	24.1%	20.4%	22.1%
1.1.03: Assess people in crisis within 4 hours		71.4%	76.0%	66.5%	75.8%	70.5%	83.8%	76.0%	76.5%	86.6%	90.7%	92.5%	90.7%
1.1.04: People presenting to Liaison Services: triaged within 1 hour		4.4%	5.2%	9.9%	30.1%	46.0%	58.4%	69.5%	77.4%	81.1%	81.5%	88.3%	87.6%
1.1.06: Place of Safety LoS: % under 36 hours		50.0%	56.0%	40.5%	60.5%	57.8%	74.5%	69.8%	79.7%	61.7%	56.0%	60.0%	79.2%
1.1.07: People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60.0%	71.4%	61.5%	66.7%	53.3%	76.5%	100.0 %	61.1%	60.0%	61.9%	59.1%	85.0%	66.7%
1.1.08: % of people referred for a dementia assessment diagnosed within 6 weeks		4.6%	6.2%	7.5%	7.7%	8.8%	25.5%	11.1%	16.9%	14.5%	18.3%	26.1%	25.6%
1.1.09: % MHLD referrals commencing treatment in 18 weeks		80.0%	67.7%	84.2%	62.5%	78.6%	79.3%	67.7%	78.1%	75.0%	72.1%	83.3%	87.1%
1.1.10: Perinatal assessments (against annual target)	2,103	145	139	113	485	138	157	160	114	127	155	166	146

Note: *1.1.10 Perinatal Access – Target is for annual position, national methodology results in a significantly larger figure reported in April compared to other months.*

Areas of Improvement & Sustained Achievement of Target



Data Source
8 by 8

What is being measured?
% of calls to the open access crisis line which are terminated before answered

Data Quality Confidence
No known Issues.

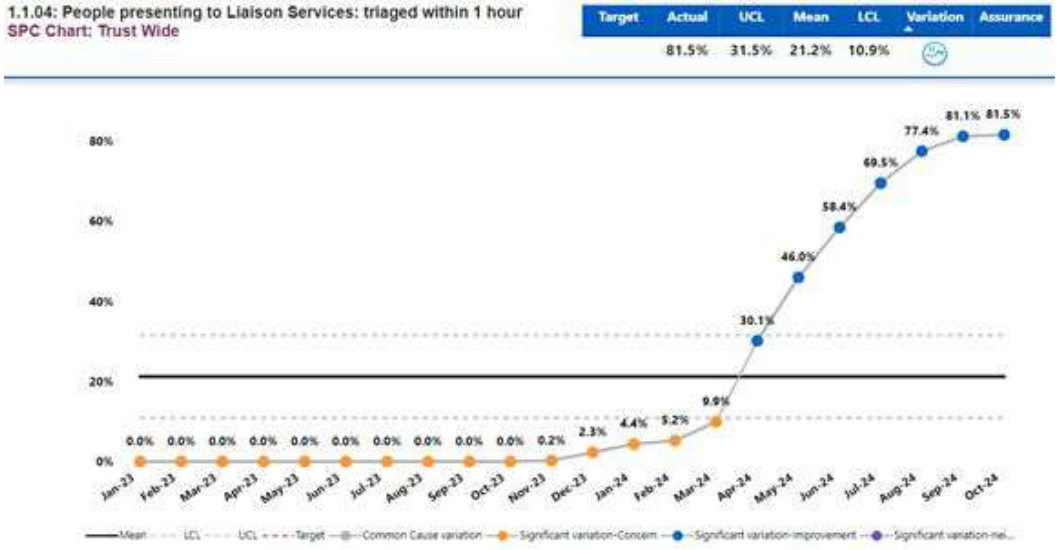
What is the data telling us?
There has been a significant improvement in the previous five months, this corresponds with an approximate 30% reduction in total call volumes compared to 203/24 levels.

Data Source
Rio

What is being measured?
Time from referral to 1st assessment, where the referral urgency is recorded as ‘emergency’. This relates to Rapid Response and Home Treatment Teams.

Data Quality Confidence
Previous issues identified with recording of referral urgency have seen improvements.

What is the data telling us?
Overall trust activity for this measure reflects 161 crisis assessments in month. West Kent was previously an outlier but in recent months directorate comparisons are more aligned.



Data Source

Rio

What is being measured?

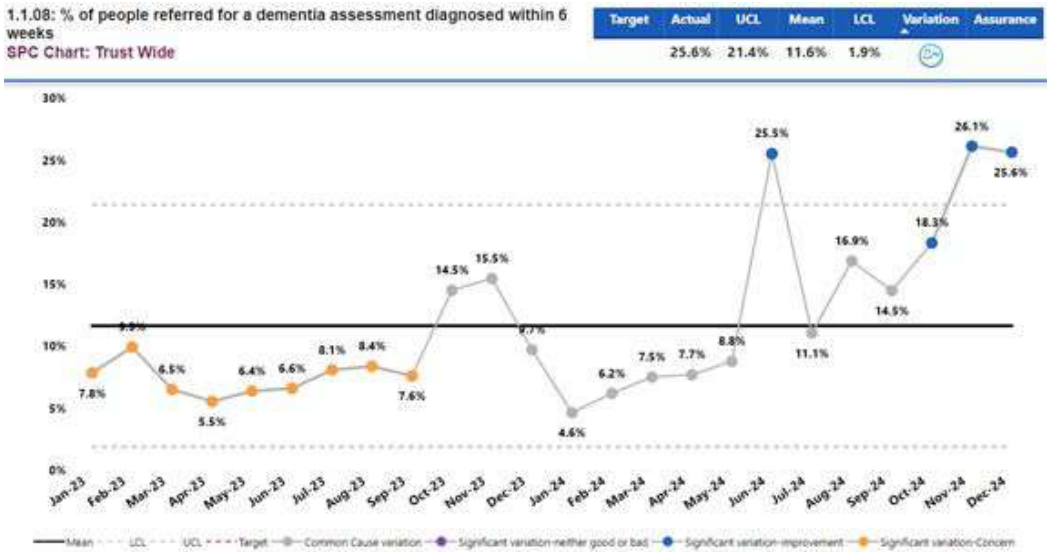
Time from referral to a 'triage' assessment within 1 hour.

Data Quality Confidence

A new code of 'Triage' was implemented to support a new model of care. This took some time to embed but increasingly reflecting a level of completeness in line with comparable historic data. Small variations continue to be investigated individually

What is the data telling us?

Regardless of the category used, all patients seen by a KMPT mental health professional within A&E settings will be triaged even when this is part of a fuller assessment.



Data Source

Rio

What is being measured?

Time between a referral into the Memory Assessment Service and a confirmed diagnosis.

Data Quality Confidence

A confirmed diagnosis is not always recorded correctly on Rio, even though the diagnosis may have been confirmed with the patient and the GP via a letter.

What is the data telling us?

An improvement in the number of diagnosis recorded and % within 6 weeks is shown. 429 diagnosis were recorded in December, the highest number since a high of 642 in July 2024. Wait times for diagnosis (where this was recorded) was on average 17.8 weeks in December, below the year to date average of 22.0 weeks.

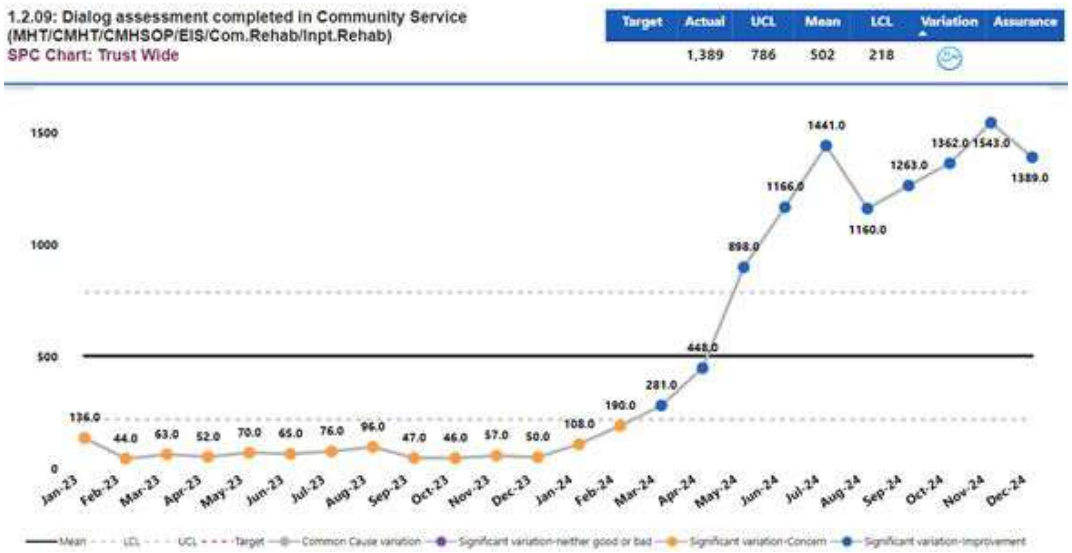
People We Care For: Care Delivery

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
1.2.01: Average Length Of Stay (Younger Adults Acute)	34.0	45.0	38.0	31.9	44.8	36.3	42.9	37.5	43.6	37.0	34.0	34.2	40.3
1.2.02: Average Length Of Stay (Older Adults - Acute)	77.0	96.2	80.8	96.0	106.7	81.2	97.9	100.6	79.8	84.2	85.8	95.2	103.2
1.2.03: Adult acute LoS over 60 days % of all discharges		16.3%	12.8%	10.8%	17.5%	11.9%	15.3%	15.5%	14.9%	12.9%	13.9%	13.7%	16.5%
1.2.04: Older adult acute LoS over 90 days % of all discharges		32.0%	34.6%	46.2%	38.7%	29.0%	34.8%	37.0%	44.4%	37.9%	42.3%	41.4%	31.3%
1.2.05: Patients receiving follow-up within 72 hours of discharge		79.7%	85.1%	88.9%	83.3%	81.6%	77.5%	85.6%	80.3%	84.8%	78.4%	82.6%	79.6%
1.2.06: Readmissions within 30 days (YA & OP Acute)	8.8%	6.3%	9.8%	13.1%	13.8%	11.0%	13.1%	10.4%	13.2%	12.7%	18.0%	11.6%	13.1%
1.2.07: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		263	350	280	242	291	245	340	377	454	373	303	264
1.2.08: Active Inappropriate Adult Acute Mental Health Out of Area Placements (OAPs) at period end		9	12	9	9	8	9	13	13	17	11	9	9
1.2.09: Dialog assessment completed in Community Service (MHT/CMHT/CMHSOP/EIS/Com.Rehab/Inpt.Rehab)		108	190	281	448	898	1,166	1,441	1,160	1,263	1,362	1,543	1,389
1.2.10: %Patients with a CPA Care Plan	95.0%	81.6%	83.3%	85.4%	86.4%	86.0%	87.8%	86.6%	85.6%	82.5%	80.6%	82.4%	80.0%
1.2.11: % Patients with a CPA Care Plan which is Distributed to Client	75.0%	77.1%	77.4%	75.6%	76.8%	75.2%	73.8%	73.7%	72.9%	72.3%	71.4%	72.2%	72.1%
1.2.12: %Patients with Non CPA Care Plans or Personal Support Plans	80.0%	69.8%	69.9%	68.6%	70.9%	68.8%	69.0%	67.0%	65.0%	64.0%	62.3%	60.1%	55.8%

Notes:

1.2.07 & 1.2.08 Out of Area Placements – these figures include beds used for Females PICU under contracted beds due to the absence of female PICU beds in Kent and Medway. 264 bed days were used in December 2024, 205 were female PICU patients within contracted beds resulting in 59 out of area placement days as an accurate reflection of trust performance.

Areas of Improvement & Sustained Achievement of Target



Data Source
Rio
What is being measured?
The number of Dialog+ assessments recorded on Rio for all community teams.
Data Quality Confidence
No known issues
What is the data telling us?
The ability to benchmark across teams is emerging now that MHT has been implemented in all localities. A significant increase in the number of Dialog+ assessments across community team was observed up to July, with >1,000 dialog scores being recorded consistently monthly since. Subsequent work is underway to monitor paired scores, insights into patient presentations and measurable improvements. These measures will become more robust as more Dialog+ roll out continues and more patients' complete interventions.

DIALOG+ will eventually be used in place of the Care Programme Approach (CPA) across Community Adult Mental Health services. Dialog+ is a set of questions where patients rate their satisfaction with life domains and treatment aspects. The scale has been shown to have good psychometric properties and is widely used to evaluate treatment. Measuring outcomes provide a way for patients, clinicians, services and the Trust to understand the impact of the care provided. Services using DIOLOG+ are already using the data to inform practice.

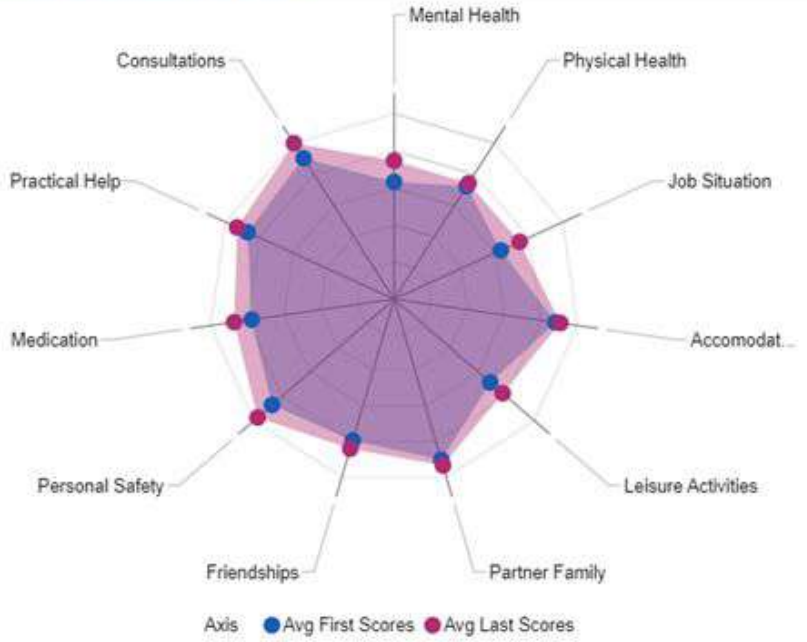
Whilst the focus of this measure in 2024/25 is to measure the uptake of Dialog+ the intention remains to develop this further to extract the resulting intelligence from the outcome scores captured. There are increasing numbers of paired scores being created as patients move through their episodes of care but sample sizes for in depth analysis remain low. Monitoring tools exist to allow analysis of paired scores where they exist as per the example below for those discharged from MHT with a paired score demonstrating improvements, particularly in the domains of Mental Health, Personal Safety and Medication.

DIALOG / DIALOG+ Service Level Monitoring Report

Questions Summary - Average Scores (for referrals closed last 12 months)

Questions showing Average Scores for First and Last DIALOG

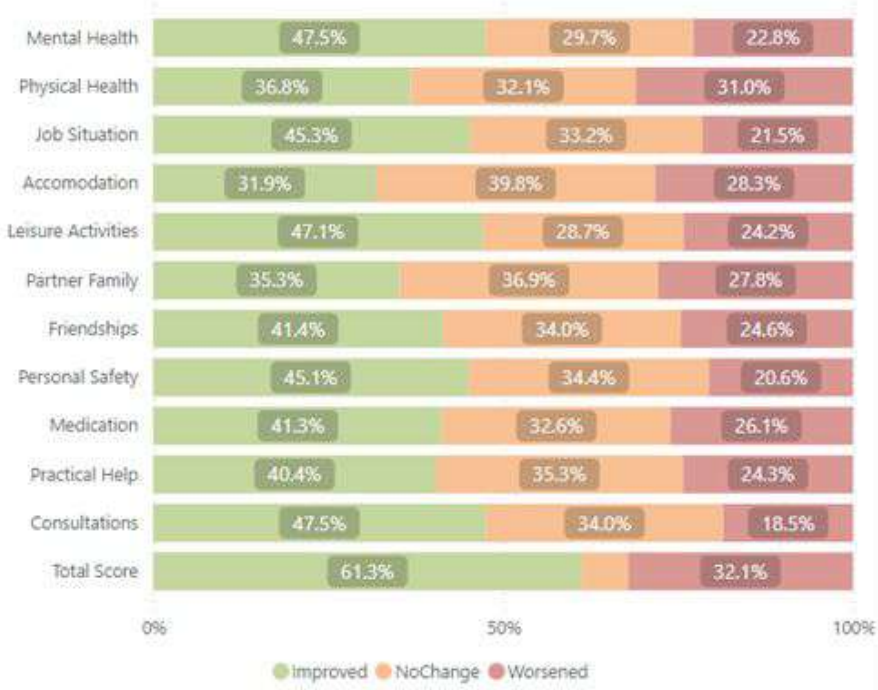
(Where a patient has a paired score recorded)



The results of each question in the radar chart above are displayed on a scale of 1 to 7

Questions showing numbers by outcome between First to Last DIALOG

(Where a patient has a paired score recorded)



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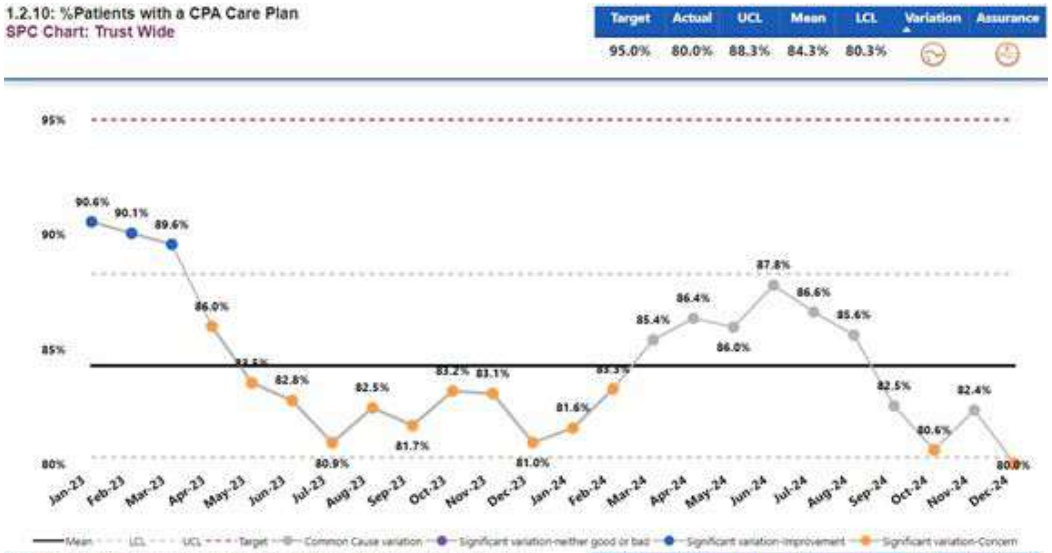
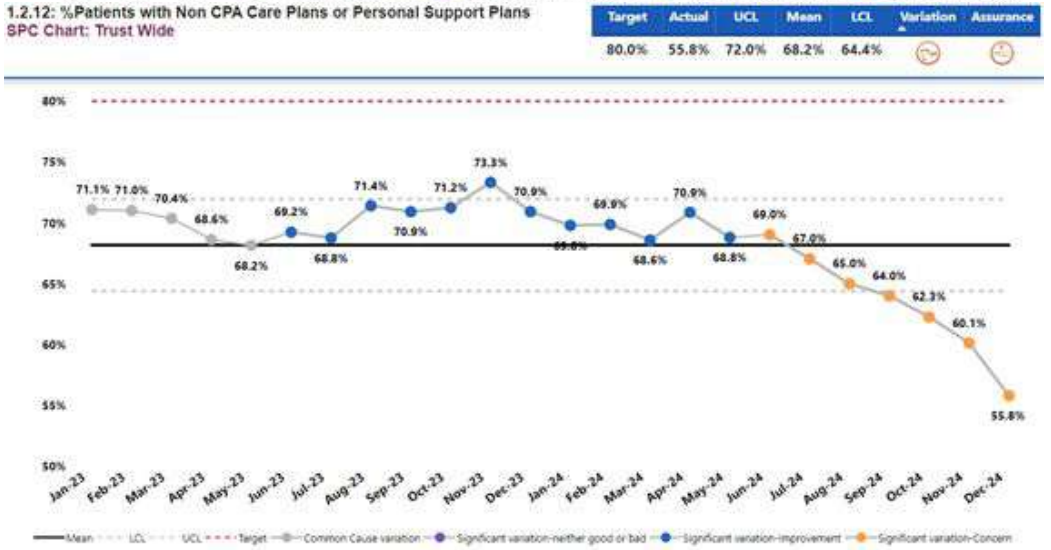
Areas of Concern





Data Source

Rio

What is being measured?

The % of patients where a CPA Care or Personal Support Plan created or updated in the last 6 months.

Data Quality Confidence

Care Plans and Personal Support Plans are not always recorded within the appropriate Rio Form and therefore not counted. Some are held as separate documents and uploaded into Rio.

These measures report against pathways on RiO (care coordinator/lead HCP), MHT does not use this functionality and are therefore not reflected in the measures, despite the agreed use of dialog+ as a care plan in this service.

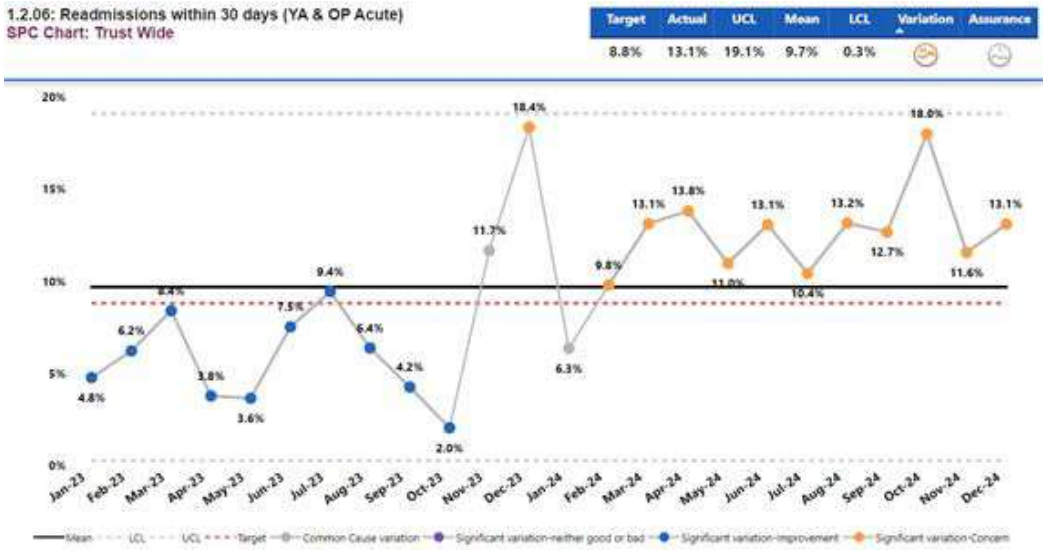
Note: some patients are accessing depots and therefore do not require a Care or Personal Support Plan.

What is the data telling us?

KMPT is consistently and significantly below targets set by ourselves and has been for the past 12 months for both measures.

Workstreams are underway to define future requirements for care planning.

The work of the Retire from CPA project group is identifying the care planning needs for the trust going forward which incorporates the use of dialog+ as a care plan where appropriate.



Data Source

Rio

What is being measured?

Admissions in period where there was a previous discharge within the previous 30 days

Data Quality Confidence

Ongoing audit work to assure that transfers are correctly recorded and not therefore incorrectly showing as readmissions.
NHS data rules dictate that a patient can not occupy more than one NHS bed at any point in time and therefore any patients transferred for physical health needs will count as a readmission upon their return to a KMPT bed.

What is the data telling us?

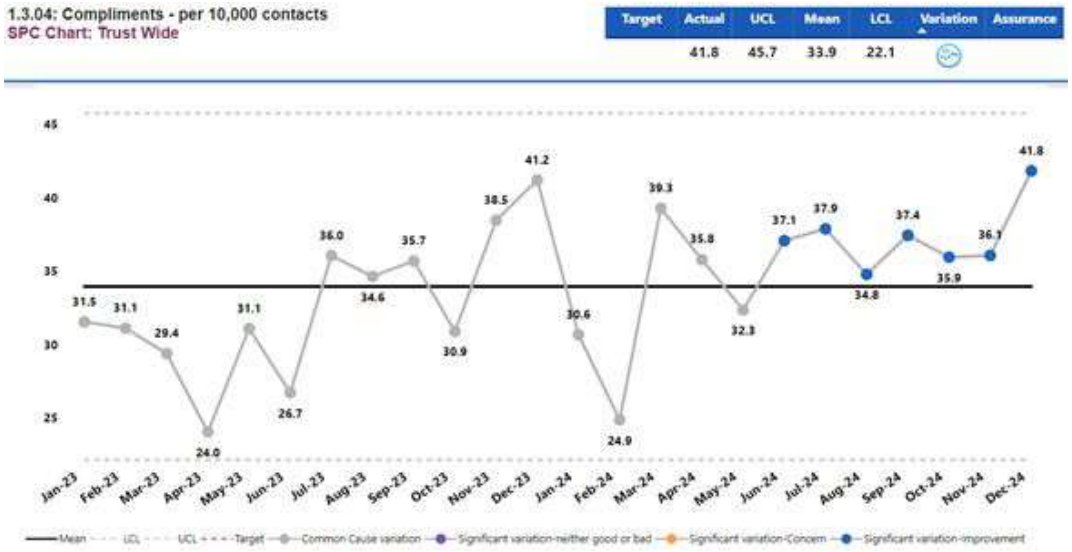
YA acute readmissions rates were 13.8% in December compared to 11.1% in OP acute beds. Significant variation exists across wards with a range of 0-25%, these percentages are impacted by low numbers of discharges in some wards. When performance is viewed over a 12 month period the range of readmission rates is 6.25–19.7%

People We Care For: Patient Experience

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
1.3.01: Mental Health Scores From Friends And Family Test – % Positive	86.0%	85.9%	86.5%	87.9%	87.6%	89.8%	89.4%	89.0%	89.5%	88.5%	88.8%	87.3%	89.4%
1.3.02: Complaints - actuals		44	44	35	42	43	40	46	56	38	37	39	41
1.3.03: Compliments - actuals		112	82	126	120	110	119	133	110	125	133	126	129
1.3.04: Compliments - per 10,000 contacts		30.6	24.9	39.3	35.8	32.3	37.1	37.9	34.8	37.4	35.9	36.1	41.8
1.3.05: Patient Reported Experience Measures (PREM): Response count		417	452	496	596	674	538	721	542	478	580	510	594
1.3.06: Patient Reported Experience Measure (PREM): Response rate		3.0	3.1	3.4	4.0	4.5	4.0	4.7	3.8	3.2	3.6	3.3	4.1
1.3.07: Patient Reported Experience Measure (PREM): Achieving Regularly %		8.3	8.1	8.5	8.4	8.4	8.5	8.5	8.5	8.2	8.5	8.2	8.3
1.3.08: Complaints acknowledged within 3 days (or agreed timeframe)	100%	98%	100%	99%	100%	99%	100%	97%	98%	100%	92%	100%	100%
1.3.09: Complaints responded to within 25 days (or agreed timeframe)	100%	87%	91%	100%	95%	96%	95%	95%	89%	79%	63%	67%	88%

1.3.09: Complaints acknowledged within 25 days: There were some delays with allocations and approvals within directorates and from clinicians investigating in late 2024, a meeting was held to address which has resulted in improved performance in December.

Areas of Improvement & Sustained Achievement of Target



Data Source

Gthr

What is being measured?

Feedback tool for people who use NHS services to have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

Data Quality Confidence

No known issues

What is the data telling us?

As a result of seven points above the mean sustained improvement has been demonstrated. This represents 129 compliments received in December 2024.

People We Care For: Safety

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
1.4.01: Occurrence Of Any Never Event	0	0	0	0	0	0	0	0	0	0	0	0	0
1.4.02: All Deaths Reported And Suspected Suicide		162	154	150	160	144	127	145	97	144	136	134	109
1.4.03: Restrictive Practice - All Restraints		67	78	99	129	107	69	78	61	70	97	87	67
1.4.04: Restrictive Practice - No. Of Prone Incidents	0	3	5	10	23	1	5	2	4	6	6	6	7
1.4.05: Decrease violence and aggression on our wards	(7.5%)	11.6%	24.4%	20.6%	36.7%	29.6%	31.5%	52.2%	16.7%	0.6%	35.4%	8.3%	(2.6%)
1.4.06: Medication errors		55	40	50	30	49	55	60	43	50	31	53	43

Areas of Concern

No areas of concern or improvement identified form SPC analysis in month

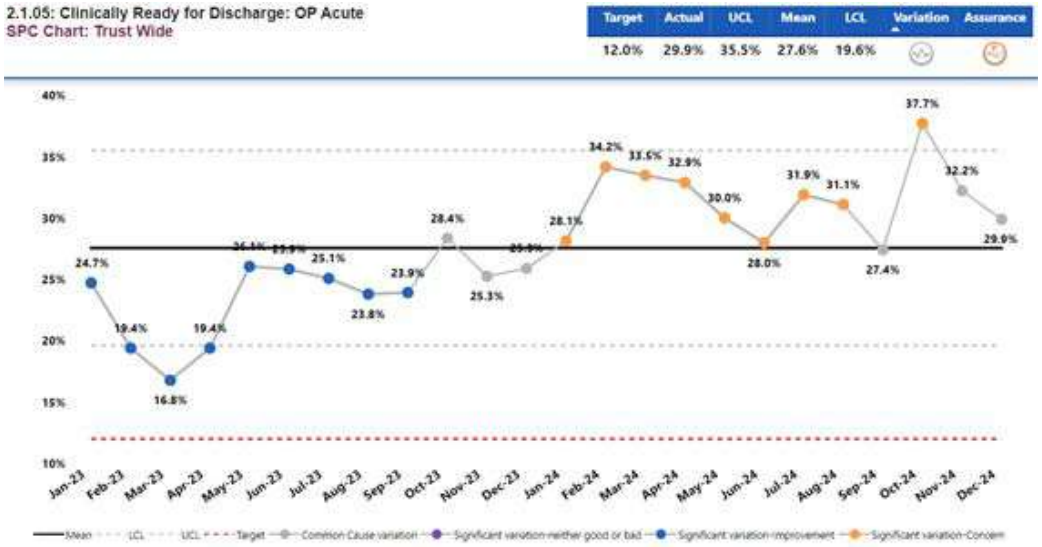
Partners we work with

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
2.1.01: Referrals to MHT & MHT+ commence treatment within 4 weeks			100.0%	40.0%	32.6%	44.2%	30.9%	25.6%	12.6%	9.7%	9.8%	12.7%	12.2%
2.1.02: MHT & MHT+ waiting list size		49	193	387	772	1,687	2,493	3,705	4,280	5,072	5,595	5,704	6,007
2.1.03: MHT 2+ contacts		16,455	16,459	16,385	16,493	16,590	16,559	16,627	16,684	16,602	16,833	17,246	17,866
2.1.04: Clinically Ready for Discharge: YA Acute	7.0%	22.3%	24.3%	20.8%	20.9%	16.4%	14.8%	12.2%	15.2%	19.8%	20.9%	21.3%	20.6%
2.1.05: Clinically Ready for Discharge: OP Acute	12.0%	28.1%	34.2%	33.5%	32.9%	30.0%	28.0%	31.9%	31.1%	27.4%	37.7%	32.2%	29.9%
2.1.06: Ave LoS for Clinically Ready for Discharge (at discharge)	44.0	69.0	61.0	71.4	99.3	74.7	89.2	89.9	45.1	46.8	46.7	47.0	67.8

Note: *MHT 2+ contacts (2.1.03) is measured nationally as a measure of Overall Access to Core Community Mental Health Services for Adults and Older Adults with Severe Mental Illnesses and highlighted as an area of concern by the ICB as is subject to special cause variation of a negative nature and an Oversight Framework bottom decile metric, This has presented a high degree of complexity in establishing methodology applied to MHSDS data, work is ongoing with the current position being that local KMPT data does not support what is published nationally.*

MHT & MHT+ waiting list size (2.1.02) The following tables show the overall waiting list by locality and of those awaiting their first appointment by their length of wait to date. Currently all waits are measured against the MHT teams, this will be developed further to measure waits across episodes of care for team within the Community Mental Health Framework following new national guidance clarifying methodology and the implementation of MHT+ teams. Waiting list sizes quoted in supporting text may differ slightly from reported position within the table due to different extract dates.

Areas of Concern



Data Source

RiO

What is being measured?

% of bed days lost to CRFD's of all occupied bed days

Data Quality Confidence

No known issues

What is the data telling us?

936 YA acute bed days were lost in December (30.2 beds per day), the greatest impact continues to be housing.

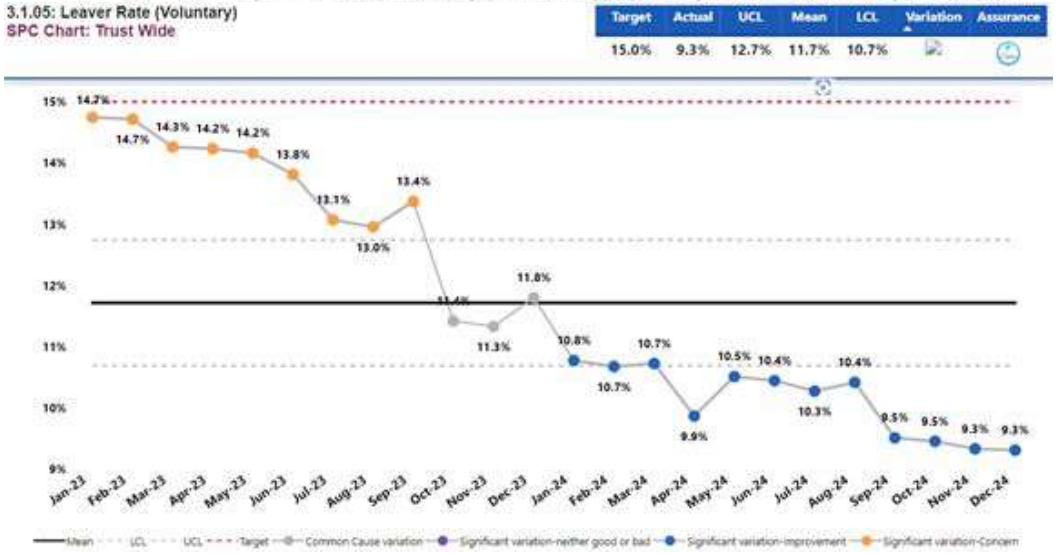
OP Acute bed days lost have reduced in the previous two months, in December 803 bed days were lost (25.9 beds per day), the greatest impact continues to be those awaiting nursing home placements and funding decisions.

As of 10th January there were 61 CRFD's in acute beds of which 45 required support from Social Care. The main reasons for delays accounting for 60% of CRFD's are awaiting residential and nursing placements, public funding and housing.

People who work for us

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
3.1.01: Staff Sickness - Overall	5.3%	4.8%	4.2%	4.5%	4.4%	4.5%	4.4%	4.5%	4.4%	4.8%	5.1%	4.6%	5.1%
3.1.02: Vacancy Gap - Overall	15.5%	11.8%	11.9%	11.9%	12.5%	12.6%	12.6%	12.8%	12.2%	11.8%	12.0%	11.0%	11.1%
3.1.03: Essential Training For Role	90.0%	94.0%	94.3%	93.9%	94.0%	94.2%	94.4%	94.7%	94.8%	93.8%	94.3%	94.7%	95.1%
3.1.04: Leaver Rate	16.5%				14.7%	14.6%	14.6%	14.6%	14.6%	14.3%	14.1%	13.4%	13.3%
3.1.05: Leaver Rate (Voluntary)	15.0%	10.8%	10.7%	10.7%	9.9%	10.5%	10.4%	10.3%	10.4%	9.5%	9.5%	9.3%	9.3%
3.1.06: Safer staffing fill rates	80.0%	108.1%	112.5%	111.7%	112.4%	108.9%	103.7%	114.8%	116.4%	108.2 %	112.0%	116.1%	108.7%
3.1.07: Increase percentage of BAME staff in roles at band 7 and above	26.5%	14.6%	14.7%	14.0%	13.6%	15.5%	15.2%	26.2%	26.7%	26.7%	27.0%	27.0%	27.1%
3.1.08: The number of minority ethnic staff involved in conduct and capability cases: variation against the numbers of white staff affected.	0.75%	0.14%	0.06%	0.42%	0.54%	0.47%	0.80%	0.44%	0.31%	0.63%	0.02%	0.27%	0.18%

Areas of Improvement & Sustained Achievement of Target



Data Source

ESR

What is being measured?

Vacancy- Calculated using in post FTE against the Vacant FTE on the 1st of each month.

Leaver Rate: For Voluntary Leavers we use a selected set of reasons. The calculation is average staff in post (FTE) against the leavers (FTE) in that same period (Usually reported as 12 Months).

Data Quality Confidence

No known issues

What is the data telling us?

Sustained improvements below mean of last 24 months in both indicators.

Individual targets exist for each directorate based on historic performance, all directorates achieving their vacancy gap target with exception of East Kent who are within 1%.

Data Source

Eroster & NHSP

What is being measured?

Planned vs Worked hours

Data Quality Confidence

Difficulty obtaining data from NHSP between May and July in a timely manner due to a reporting platform closing. This has now been resolved

What is the data telling us?

An increase in fill rates since February. The target of at least 80% fill rate for the safe staffing return is met throughout

Data Source

iLearn

What is being measured?

Data Quality Confidence

No known issues

What is the data telling us?

Overall essential training has 4 months of continuous improvement and this has driven by the higher compliance rates for a number of areas of essential training. Two of the biggest drivers for this improvement is the compliance for Basic Life Support and Immediate Life Support. Both these areas have been traditionally difficult to achieve the 90% compliance.

Additional reporting has been put into place which provides the Directorates with information on compliance highlighting more granular information on who is not compliant and not booked and who is going out of date and not booked.

Efficiency

Measure Name	Target	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
4.1.01: Bed Occupancy (Net)	92.0%	95.2%	96.9%	96.7%	95.8%	95.8%	96.5%	97.6%	95.9%	96.4%	97.2%	96.8%	92.6%
4.1.02: DNAs - 1st Appointments		10.0%	10.1%	9.9%	10.2%	10.9%	11.6%	10.5%	10.4%	10.5%	10.4%	10.7%	11.6%
4.1.03: DNAs - Follow Up Appointments		9.4%	9.3%	9.6%	9.8%	9.2%	10.0%	9.9%	9.6%	9.5%	9.5%	10.1%	10.9%
4.1.04: In Month Budget (£000)	0	(13,746)	(13,746)	(13,754)	(13,524)	(13,619)	(13,850)	(13,767)	(13,735)	(14,233)	(19,323)	(14,814)	(15,042)
4.1.05: In Month Actual (£000)		(14,226)	(14,201)	(14,630)	(14,080)	(14,655)	(14,437)	(13,900)	(14,555)	(13,822)	(18,717)	(14,756)	(14,960)
4.1.06: In Month Variance (£000)		(480)	(456)	(876)	(556)	(1,035)	(587)	(133)	(820)	411	606	58	82
4.1.07: Agency spend as a % of the trust total pay bill	3.2%	4.0%	3.4%	2.3%	3.0%	3.6%	2.9%	3.5%	3.8%	3.5%	2.9%	3.2%	2.8%

Areas of Concern

Data Source

RiO

What is being measured?

Occupied bed days as a % of available bed days. Acute wards only.

Data Quality Confidence

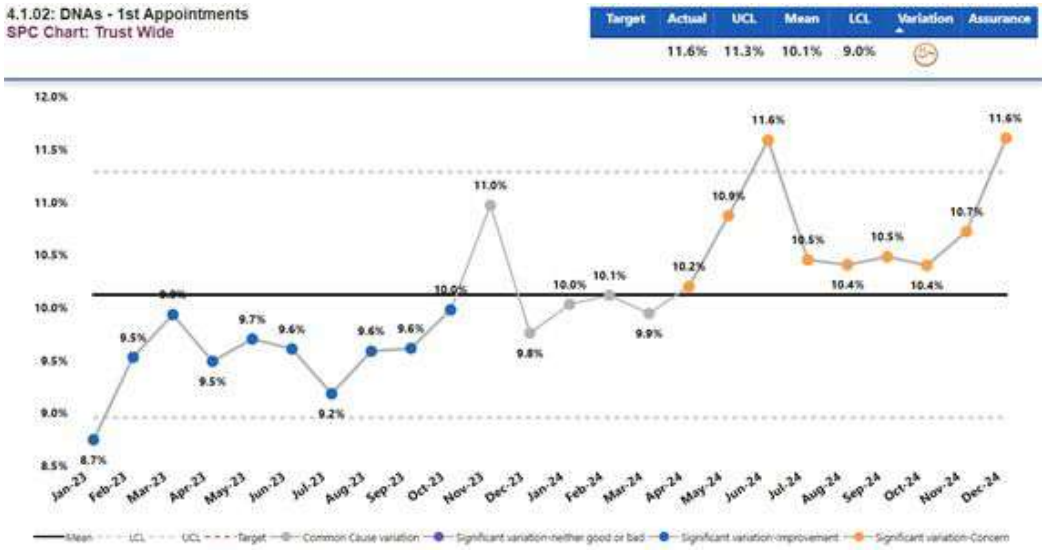
No known issues.

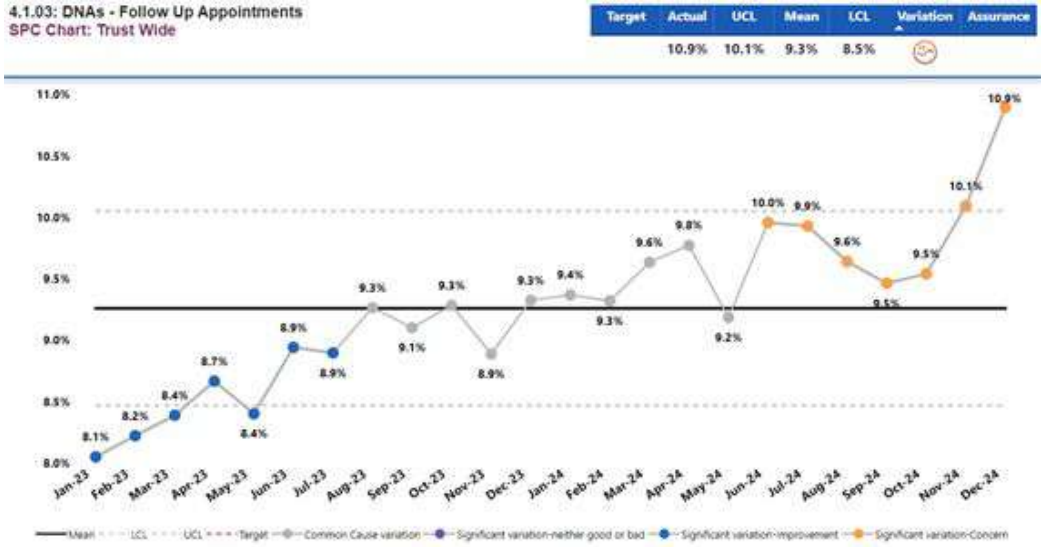
What is the data telling us?

Levels of bed occupancy are driven by other aspects such as CRFDs, numbers of admissions and length of stay.

The 92% target is the level the trust hopes to achieve by March 2025 requiring improvements in the remainder of 2024/25. Seven wards achieved the target in December 2024 occupancy may have been impacted by Christmas although such reduction was not observed in December 2023.

Level of occupancy between YA acute and OP Acute in December were 92.1% and 93.6% respectively. This equates to an average of 145.5 beds occupied out of 158 available YA acute beds and 88.2 beds occupied out of 91 available OP acute beds.





Data Source

RiO

What is being measured?

% of appointments outcomed on RiO as DNA

Data Quality Confidence

Potential of DNA's to be recorded inappropriately when unplanned phone calls that are unsuccessful are recorded as a DNA.

What is the data telling us?

This equates to approximately 750 1st appointments and 2,750 follow up appointments being recorded as DNA's per month.

As is to be expected there is wider variation in DNA levels across different service types, MHT services accounted for 52% of 1st contact DNA's in December and are above trust average significantly with DNA rates for first appointments at 26.6% in month. This is being investigated within the work to address MHT waiting lists and could correspond with large volumes of referrals.

For follow up appointments Mental Health Together Plus teams account for 35% of all DNA's followed by MHT with 28%.

A project group within the Getting the Basics Right programme is reviewing the underlying cause of the DNA's. This is multi-faceted and will take time to work through both findings and change ideas.

5. Appendices

System Oversight Framework

Overview

The Single Oversight Framework (SOF) sets out how NHS England (NHSE) oversees Integrated Care Boards (ICB) and NHS trusts, using one consistent approach. The purpose of the NHS Oversight Framework is to:

- ensure the alignment of priorities across the NHS and with wider system partners
- identify where ICBs and/or NHS providers may benefit from, or require, support
- provide an objective basis for decisions about when and how NHS England will intervene.

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 2 as highlighted below, this is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met:

Segment	Description	Scale and nature of support needs
1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place based and overall ICB priorities.	No specific support needs identified. Trusts encouraged to offer peer support. Systems are empowered to direct improvement resources to support places and organisations, or invited to partner in the co-design of support packages for more challenged organisations.
2	Plans that have the support of system partners in place to address areas of challenge. Targeted support may be required to address specific identified issues.	Flexible support delivered through peer support, clinical networks, the NHS England universal support offer (e.g. GIRFT, Right Care, pathway redesign, NHS Retention Programme) or a bespoke support package via one of the regional improvement hubs
3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts)	Bespoke mandated support, potentially through a regional improvement hub, drawing on system and national expertise as required.
4	In actual or suspected breach of the NHS provider licence (or equivalent for NHS trusts) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support	Mandated intensive support delivered through the Recovery Support Programme

The following tables represent the latest position for KMPT's Provider Oversight against which the trust responds to Key Lines of Enquiry. It is recognised that delays exist in nationally published data for a number of metrics, many as a result of being reflective of the annual staff survey results.

Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
S000a: NHSOF Segmentation	Month	2024 10	2:Flexible support					
S035a: Overall CQC rating	Month	2024 10	3 - Good					13/62
S059a: CQC well -led rating	Month	2024 10	3 - Good					15/62
S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual: calendar year	2023	8.88%	9.94%		↑		49/66
S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual: calendar year	2023	15.2%	17.7%		↑		45/66
S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users,	Annual: calendar year	2023	28.1%	25.1%		↓		60/66
S067a: Leaver rate	Month	2024 09	8.11%	7.07%		↓		57/67
S068a: Sickness absence rate	Month	2024 06	4.44%	4.91%		↓		11/67
S069a: Staff survey engagement theme score	Annual: calendar year	2023	6.89/10	6.99/10		↓	↓	56/66
S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual: calendar year	2022	13.1%		12%	↓		26/64
S071b: Proportion of staff in senior leadership roles who are women	Month	2024 09	60.1%		62%	↓	↓	37/43
S071c: Proportion of staff in senior leadership roles who are disabled	Annual: calendar year	2023	7.22%		3.2%	↑		11/64
S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientatio	Annual: calendar year	2023	57.5%	56.4%		↓	↓	45/67

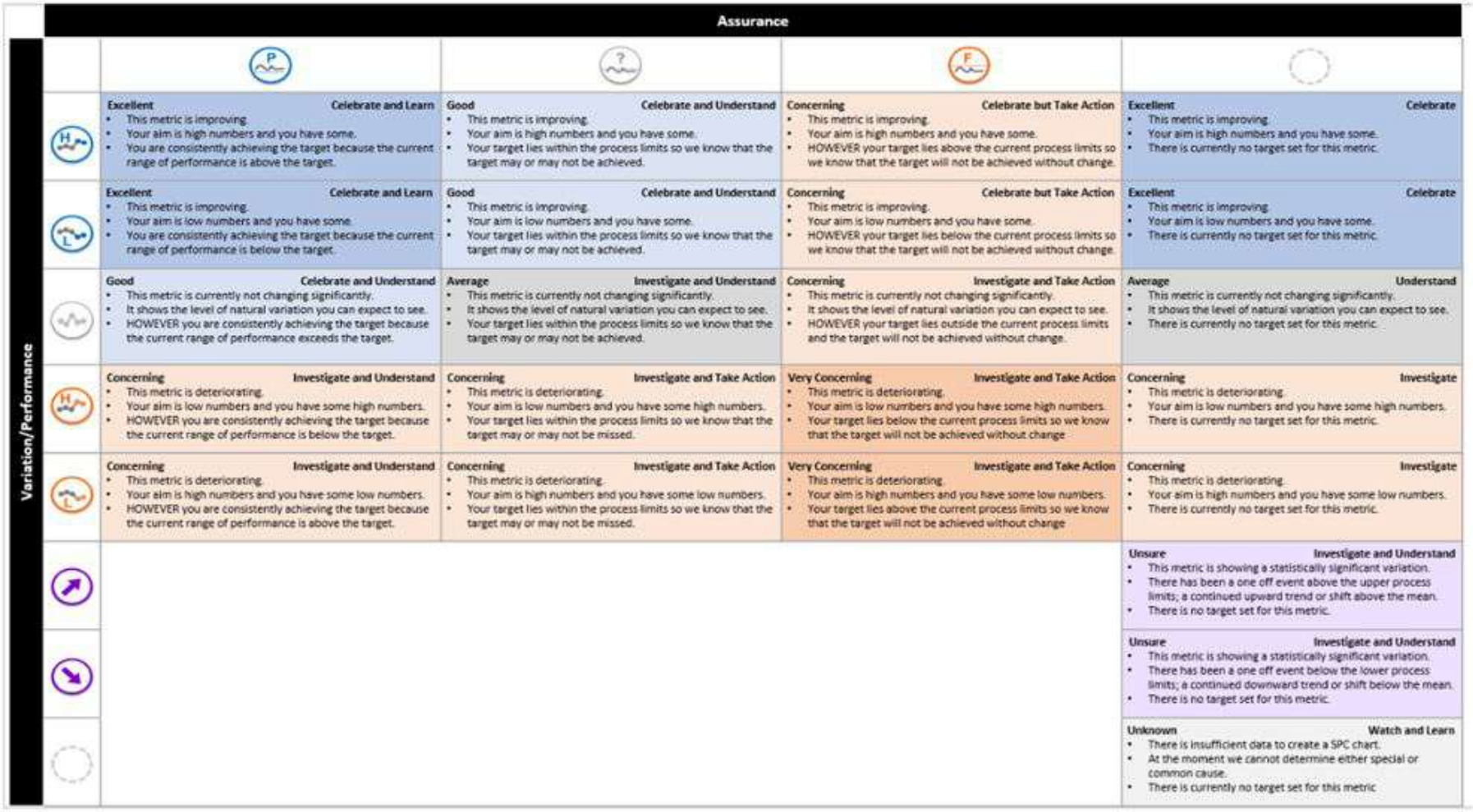
Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
S086a: Inappropriate adult acute mental health placement out -of-area placement bed days	Month	2024 03	0		0			1/52
S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2023	6.88/10	7.09/10		↓		61/66
S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2023	6.5/10	6.46/10		↓		53/66
S125a: Adult Acute LoS Over 60 Days % of tota discharges	Month	2024 03	13%					5/50
S125b: Older Adult Acute LoS Over 90 Days % of total discharges	Month	2024 03	38%			↑		19/50
S133a: Staff survey - compassionate and inclusive theme score.	Annual; calendar year	2023	7.42/10	7.3/10		↓		54/66
S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual; calendar year	2023	1.9		1	↑		45/64
S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual; calendar year	2023	1.2		1	↓		51/64

Note: *some areas exist where KMPT does not recognise national data there is ongoing work with NHSE colleagues to align methodology. Within the SoF it is known that S086a, Inappropriate acute out of area placements, is under representing the accurate position due to issues faced with national reporting portals.*

Following a national consultation an updated version of the Single Oversight Framework is expected in late 2024.

Exception Reporting Guide

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



NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING

Meeting details

Date of Meeting:	30th January 2025
Title of Paper:	Finance Report for Month 9 (December 2024)
Author:	Jenni Grover, Deputy Director of Finance (Interim)
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

The attached report provides an overview of the financial position for month 9 (December 2024).

Items of focus

For the period ending 31st December 2024, the Trust is reporting delivery against plan; with the Trust reporting a surplus of £0.45m excluding technical adjustments.

The trust is forecasting to deliver its financial plan and deliver a £0.72m surplus in year.

The board are asked to note,

- Year to date agency spend is £5.24m which equates to 3.24% of Trust pay spend compared to an agency cap of 3.2% for the year. This run rate is expected to continue resulting in the Trust exceeding the agency cap in year by £0.44m.
- Use of external beds remains a risk. In month the Trust utilised 7 external female PICU beds and 2 male PICU beds (7 PICU beds funded). This position is lower than previous months with no external male acute beds being used. This position continues to be monitored.
- As at 31st December the overall capital position is £1.57m underspent, with a forecast spend position of £13.81m against the annual plan of £15.38m. The underspend relates to the delay in the s136 scheme. The Trust is working with the system to manage this position in year as well as securing funding for the scheme for 2025/26.
- The report includes a snap shot of the position around the impact of system level controls.

Governance

Implications/Impact:	If the Trust fails to deliver on its 2024/25 financial plan then this could impact on the long-term financial sustainability agenda.
Assurance:	Reasonable
Oversight:	Finance and Performance Committee

NHS
Kent and Medway
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Finance Report
December 2024

Trust Board

Brilliant care through brilliant people

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Executive Summary

Key Messages

For the period ending 31st December 2024, the Trust has reported a surplus of £0.45m excluding technical adjustments which is inline with plan.

The trust is forecasting to deliver its financial plan of a £0.72m surplus in year.

The key financial challenges for the Trust are:

Agency spend

- Year to date (YTD) agency spend is £5.24m which equates to 3.24% of Trust pay spend compared to an agency cap of 3.20% for the year. The highest usage is in East Kent medical agency and West Kent nursing agency.
- Agency spend was £0.49m in December, a decrease of £0.09m largely due to seasonal factors. The Trust is now £0.08m above its phased plan and is unlikely to hit the agency cap for the year; with agency expected to return to November's run rate for the remainder of the year.
- Nursing agency spend remains high in Liaison, CMHT, and Crisis Services. This is to support waiting list work and to cover vacancies. Recruitment continues in all three areas with MHT staff from VCSE partners starting in December and the Liaison consultation moving into a recruitment phase.

Bank spend

- Bank spend has decreased by £0.09m in month to its lowest level this financial year. This follows successful recruitment to Acute wards.
- Run rates remain high in some areas with all bar two Acute Inpatient wards using bank staff above rostered levels. Zonal observations are being rolled out across all wards and are anticipated to support further reductions.

External beds

- In month, the Trust utilised 7 external female PICU beds and 2 male PICU beds (7 PICU beds funded). No external Acute beds were used in month.

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

As at 31st December the overall capital position is £1.57m underspent, with a forecast spend position of £13.81m against the annual plan of £15.38m.

The underspend relates to the delay in the s136 scheme. The Trust is working with the system to manage this position.

Cash

The closing cash position for December was £19.85m which was a decrease in month of £0.34m driven by an increase in capital payments over the previous month.

The cash position will significantly reduce next month due to the purchase of Littlebrook lease which went through 9th January 2025.

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RESPECT OPEN ACCOUNTABLE WORKING TOGETHER INNOVATIVE EXCELLENCE

Income and Expenditure

Statement of Comprehensive Income

	Annual	Current Month			Year to date		
	Budget	Budget	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000
Income	284,095	24,045	24,346	301	212,708	211,693	(1,015)
Employee Expenses	(216,272)	(18,247)	(17,900)	348	(162,235)	(161,667)	567
Operating Expenses	(62,471)	(5,352)	(6,085)	(733)	(46,459)	(47,014)	(555)
Operating (Surplus) / Deficit	**5,352**	**446**	**362**	**(84)**	**4,014**	**3,011**	**(1,003)**
Finance Costs	(5,352)	(446)	(272)	174	(4,014)	(2,557)	1,457
System control Surplus / (Deficit)	**(0)**	**(0)**	**90**	**90**	**(0)**	**454**	**454**
Excluded from System control (Surplus) / Deficit:							
Technical adjustments	0	0	35	35	0	(241)	(241)
Surplus / (deficit) for the period	**(0)**	**(0)**	**125**	**125**	**(0)**	**213**	**213**

Commentary

The Trust has a small, planned surplus of £0.45m for the period ending 31st December 2024.

At month 9, there is a favourable pay variance to budget of £0.57m. This includes a significant underspend on substantive pay of £17.92m due to the level of vacancies, which is offset by agency and bank usage (£17.35m over plan).

Agency spend in December totalled £0.49m which represents a 30.1% reduction on spend seen for the same period in 2023/24 and a 15.7% decrease on spend in November. Spend reduced across all categories but is likely to rise again in January with fewer bank holidays and more availability of agency staff.

Spend levels were highest in East Kent (42.2% of overall agency spend), due to medical vacancies, but were also high in West Kent (30.5%) and North Kent (21.5%) due to pressures within Liaison services, CMHTs and Crisis teams. The current forecast is for total agency spend of £7.02m against a cap of £6.58m, £0.44m over the cap.

Bank spend decreased in month by 5.5% with WTEs 35.9 lower. This is 13.1% (£0.25m) lower than December 2023. Run rates remain high in some areas with all bar two Acute Inpatient wards using bank staff above rostered levels to fill vacancies and staff for high levels of observations. Tarentfort ward also have an EPCs requiring additional staff.

Non-pay

In month, the Trust utilised 7 external female PICU beds and 2 male PICU beds (7 PICU beds funded). External bed usage is down for the second month in a row due to no Acute beds being utilised.

Cost improvement plans 24/25

	Target	Delivery		
		Recurrent	Non Recurrent	Total
	£'000s	£'000s	£'000s	£'000s
Low and Medium Secure	1,100	1,100		1,100
MHLD	800	800		800
Community Teams (CMHT & CMHSOPs)	2,000		2,000	2,000
Early Intervention	500	500		500
Acute Inpatient	600	320		320
Support Services	3,568		1,693	1,693
Patient Flow	200			-
Crisis Teams	1,000		1,000	1,000
Budget Review	-	1,476		1,476
Non Recurrent	972		1,851	1,851
Forecast Position	**10,740**	**4,196**	**6,544**	**10,740**

Commentary

The Trust submitted a breakeven financial plan for 2024/25 and this is predicated on the basis of delivering the CIP plan, which totals £10.74m, in full.

Plans which are currently risk rated as Green relate to initiatives already underway having been worked on as part of the loss making services review and include:

- EIP **£0.50m**
- Provider Collaborative Contract negotiation **£1.10m**
- MHLD service review **£0.80m**

These schemes will be fully achieved in year and recurrently.

Plans rated as Amber include schemes which have been identified and are being further developed to ensure delivery in year and include:

- Community services and productivity review **£2.00m**
- Crisis teams model review **£1.00m**
- Utilising Acute resource **£0.60m**
- Back office / corporate cost review **£3.57m**

Of this £7.20m (74%) will be delivered in year through a combination of identified schemes and mitigating slippages and 100% will be delivered recurrently. The balance will be mitigated through further stretch schemes and other non-recurrent slippages, primarily delayed starts in new and developing services.

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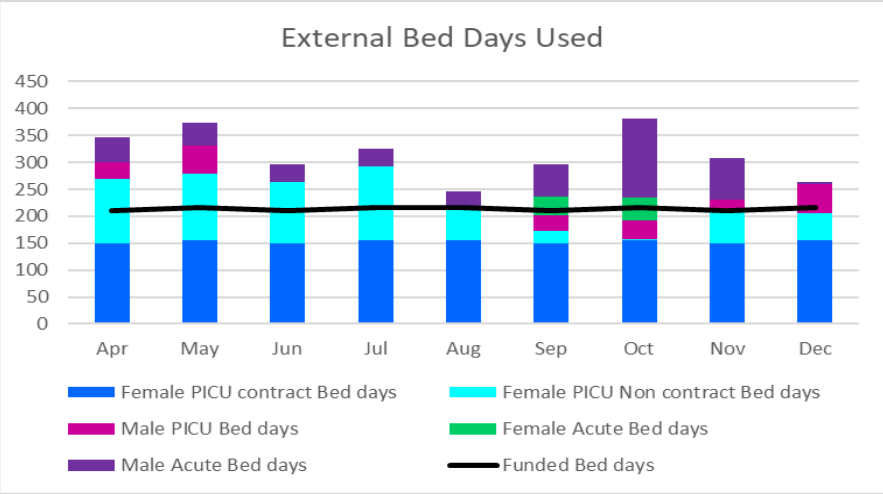
Exception report – External beds



The pressure on external bed usage over and above the funded levels has been driven by the consistent need for external Acute Male beds.

Contributing factors

- Demand for external Acute beds due to:
  - Numbers of bed days lost to Clinically Ready for Discharge (CRfD) patients
  - Levels of bed occupancy
  - System demand for beds

Risks to delivery

- Increasing demand for Acute beds (£25k per bed per month)
- Increasing complexity of PICU patients increasing demand for PICU beds (£28k per bed per month)

Key actions taken

- Work on-going to identify steps to reduce the impact of CRfD patients on the Trust's overall bed stock.

Exception report – Temporary Staffing

There has been a downwards trend on agency spend with significant progress being made in medical agency. The challenges continue in East Kent. Slower than expected recruitment amidst growing waiting lists has required the Trust to bring in agency staff in Community Mental Health from Quarter 2.

Contributing Factors

- Medical vacancies in East Kent keeping medical agency costs high
- MHT backlogs in East, North & West Kent increasing nursing agency use
- Liaison consultation leading to vacancies being held in Liaison and Crisis teams
- Additional observations and EPCs on wards utilising high levels of bank and agency HCAs.

Risks to delivery

- Observation levels rise
- Unsuccessful medical recruitment leads to more agency
- Pressure to reduce MHT waiting lists increases need for temporary staffing
- Additional clinics to increase dementia diagnosis required

Bank Spend £'000	23/24 Qtr 3	23/24 Qtr 4	24/25 Qtr 1	24/25 Qtr 2	24/25 Qtr 3
Nursing	2,114	2,560	2,339	2,291	2,071
HCAs	3,086	3,568	2,955	2,881	2,756
Other	390	370	282	332	257.12
Total	**5,590**	**6,498**	**5,576**	**5,505**	**5,084**

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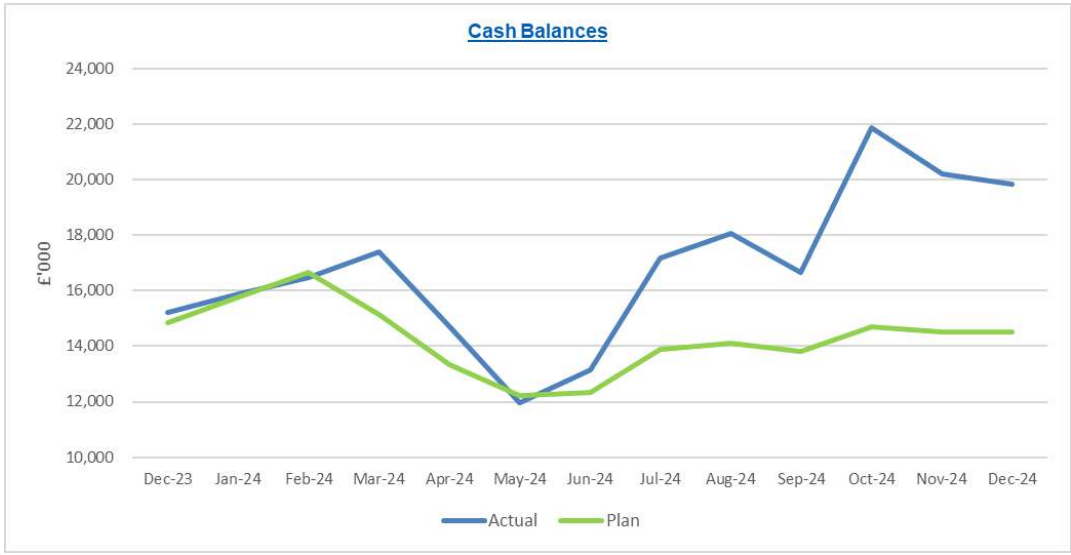
Appendices

Balance Sheet

Statement of Financial Position

	Opening 31st March 2024 Actual £000	Prior Month 30th November 2024 Actual £000	Current Month 31st December Actual £000
Non-current assets	169,254	172,162	167,958
Current assets	23,068	28,845	27,793
Current liabilities	(29,558)	(37,959)	(37,772)
Non current liabilities	(47,291)	(47,494)	(42,300)
Net Assets Employed	**115,473**	**115,554**	**115,679**
Total Taxpayers Equity	**115,473**	**115,554**	**115,679**



Commentary

Non-current assets

Non-current assets have decreased by £4.20m in December. This reflects a correction to the capital position relating to the Beacon. This position offsets against the total liabilities position.

Current Assets

Current assets have decreased by £1.05m. This reflects the movement in the cash position of £0.34m and that trade and other receivables have decreased by £0.71m.

Total Liabilities

Overall total liabilities has decreased by £5.38m as a result of the impact of the change in the non-current assets £4.20m, and a £0.81m reduction in the trade and other payables position.

Aged Debt by Month

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Capital Position

	Full year			In Month			Year to Date		
	Plan	Forecast	Variance	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000	£000	£000	£000
System Capital Funding:									
Information Management and Technology	2,000	2,709	709	0	531	(531)	108	688	(580)
Capital Maintenance and Minor Schemes	4,166	3,367	(799)	506	310	196	1,974	972	1,002
Section 136 development	948	0	(948)	0	0	0	575	0	575
Mental Health Response Vehicle	29	29	(0)	0	0	0	29	0	29
Total System funding	**7,144**	**6,105**	**(1,039)**	**506**	**841**	**(335)**	**2,686**	**1,660**	**1,026**
PDC funding :									
Section 136 development	2,708	1,300	(1,408)	635	75	560	1,100	542	558
Capital Maintenance and Minor Schemes	0	1,408	1,408	0	0	0	0	0	0
DCF (EPR) IT	1,736	1,039	(697)	0	0	0	397	422	(25)
Other	0	93	93	0	0	0	0	0	0
Mental Health Response Vehicle	198	198	0	150	43	107	198	111	87
Total PDC funding	**4,642**	**4,038**	**(604)**	**785**	**118**	**667**	**1,695**	**1,075**	**620**
Other Capital Funding:									
PFI 2024/25	117	117	0	10	10	0	87	87	0
Leases New	605	279	(326)	0	0	0	605	244	361
Leases Remeasurement	2,872	3,271	399	0	72	(72)	2,872	3,261	(389)
Total Other Capital Funding:	**3,594**	**3,667**	**73**	**10**	**82**	**(72)**	**3,564**	**3,592**	**(28)**
Total Capital Expenditure	**15,380**	**13,810**	**(1,570)**	**1,301**	**1,041**	**260**	**7,945**	**6,327**	**1,618**

Year to date and forecast performance against Plan

The Capital Programme in December 2024 is under spent by £0.26m, which brings the overall year to date position to £6.33m which is an underspend of £1.62m against plan. The YTD position reflects a £1.13m underspend against Section 136, £1.00m in Estates and an overspend of £0.58m for IT

The Section 136 project will not meet its planned spend by £2.36m; schemes from the 2025/26 estates programme has been pulled forward to reduce the underspend to £1.57m, a total spend of £13.81m.

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System Controls (Board Requested)

Following the move to Level 4 of the NHS England Monitoring regime. The trust agreed to system level controls which require all new revenue investments with a full-year effect of more than £10k for non-pay and £50k for pay to require sign off from the Trust executive and the ICB.

To support service delivery it was agreed that the following expenditure items were exempt

1. Supplies and Services – clinical (excluding drugs)
2. Drug Costs
3. Clinical Negligence fees
4. Audit Fees

The full process has been in operation since September and the below table sets out the impact on decision making and the time taken by the process

Control	Count	Agreed	Rejected	Outstanding	Decision Time
Pay Controls (£50k equivalent of Band 7)	15	9	0	6	41 days from manager submission through the process, this includes the Trust's own vacancy panel (30 days for ICB decision)
Non Pay (£10k)	12	9	2	1	40 days from manager submission through the process, this includes internal trust processes (37 days for the ICB decision)

The board are asked to note that the system have tried to work collaboratively on this approach, and the trust has noted that early engagement with leads has supported the decision making process. In recent weeks, the Trust is noting a stronger line being taken around non pay, with spend identified as discretionary being rejected by the panel.

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TRUST BOARD MEETING

Meeting details

Date of Meeting:	30th January 2025
Title of Paper:	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) paper
Author:	Yasmin Damree-Ralph – Equality, Diversity and Inclusion Manager
Executive Director:	Sandra Goatley – Chief People Officer

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This paper presents a strategic six-month progress update on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plan. It provides an evaluation of ongoing actions, highlights significant achievements, and identifies priority areas that require further attention and improvement. The progress update was discussed at January's People Committee meeting and is now presented to Board for noting.

Issues to bring to the Board's attention

The integrated Workforce Race Equality Standard (WRES) and Workforce Disability and Workforce Disability Equality Standard (WDES) action plan is a cornerstone of KMPT's wider Equality, Diversity and Inclusion (EDI) plan, as well as being closely aligned with NHS England's high impact actions. This interconnected approach supports not only quick improvements, but also fosters a culture of sustained inclusivity and systemic equity, advancing KMPT's mission to deliver transformative change.

The initiatives cited in this plan relate specifically to the WRES and WDES, and are designed to address critical areas of the WRES and WDES, delivering measurable and sustainable improvements in these areas.

Areas to celebrate include:

- Increased BAME representation in KMPT's workforce;
- Reduction in the proportion of BAME staff entering formal disciplinary processes;
- Reduction in the proportion of staff with disabilities entering formal capability processes;
- Access to non-mandatory training and development has almost equalised when comparing BAME staff and white staff;
- There has been a small but notable increase in the number of staff declaring a disability;
- Staff at KMPT are more likely than the national average to report incidents of bullying or harassment at work when they have experienced them.

Version Control: 1

Kent and Medway NHS and Social Care Partnership Trust

Although early days, a number of interventions which form part of the plan are now underway, and anticipated to have a positive impact over coming months. These include the recruitment of 15 Cultural Inclusion Ambassadors (who will support interview panels, addressing WRES Indicator 2), the successful implementation of Safety Culture Bundles across all inpatient wards to address experiences of violence and aggression, a positive pilot of allyship training, and the establishment of a centralised reasonable adjustment process.

There are also a number of areas requiring ongoing attention, which include:

- Recruitment disparities, with white staff being 2.58 times more likely than BAME staff to be appointed, and the likelihood of disabled staff being appointed still being below the national average (although improved)
- Declining confidence of both BAME staff and disabled staff that they have equal opportunities for promotion or career progression;
- Rising reports by both BAME staff and disabled staff of harassment, bullying or abuse from patients, relatives or the public;
- Declining satisfaction amongst disabled staff with how they are valued by the organisation.

Areas of focus over the next three months are:

Diversity Data Campaign: The “Update Your Diversity Details” campaign is in final preparation for launch. This initiative aims to increase ethnicity and disability declarations and reduce unknown data statuses, improving alignment with WRES and WDES metrics.

BAME Talent Strategy: A talent programme focused on increasing career opportunities for BAME staff is in development. Progress has been delayed slightly, but mitigation strategies are underway to minimise impact and accelerate delivery.

Refreshing the DAWN Network: The goals, terms of reference and work plan of each of KMPT’s staff networks has been recently revisited, however this review is slightly behind for the DAWN Network as a result of staff absence. This Network clearly has a critical role to play in relation to the WDES, and so is being supported with this work as a priority.

Governance

Implications/Impact:	Impact on KMPT Culture, reputation, recruitment and retention
Assurance:	Reasonable
Oversight:	People Committee

Version Control: 1

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KMPT's Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) update

WRES & WDES Update

Theme	Action	Lead(s)	Target completion date	WRES Action Yes/No	WDES Action Yes/No	Link to indicator/metrics	Link to wider actions
Increase staff diversity data	Ensure staff understand why KMPT ask for equality data, who sees it and why. What KMPT does with the information and what the impact is on staff, the organisation and patients. ESR initiative – launch the 'update your personal details' on ESR Self-Service portal. Develop staff easy to follow guidance on how to update their details including equality details. Send out why we collect data to all staff.	EDI Manager EDI Practitioner (Workforce Lead) Workforce Information Manager Power BI team	January 2025	Yes	Yes	WRES Indicator 1 WDES Metric 1	EDI Plan Priority Area 3 Staff Survey

Update: Action on track

Current data is as follows:

WDES/ Electronic Staff Records (ESR) Disabled staff: 7.69%, Non-disabled staff: 70.53%, unknown 21.78%
Staff survey data: Disabled staff: 30.5%, Non-disable staff: 68.0% Unknown 1.6% *(this is based on the number of staff responses to the staff survey)*

Although year on year we have increased our disabled staff declaration, we are working to address the unknown status, to increase declaration to 10% over the next three years. Since 2021 workforce disability declarations have progressively increased year on year (2021: 6.77%, 2022: 6.84%, 2023: 7.33%. 2024: 7.69%, 2025 year to date 7.81%)

Working group set up to review and improve staff ESR data (Business Intelligence Team, Workforce Information, Communications and Equality Diversity Inclusion team). Data cleanse 'update your personal details' exercise has commence with a target group identified, whole trust roll out to commence with Comms input. The purpose of this work is to increase staff diversity data, reducing the anomalies such as blank fields and to reduce the number of status unknown declarations, so that KMPT has a true understanding of its workforce diversity.

Diversity Dashboard (workforce) is currently being developed, based on current ESR information.
It is too early to measure the impact of the introduction of the centralised reasonable adjustments and staff declarations currently.

WRES & WDES Update

Recruitment	Improve BAME appointments into KMPT, reduce the likelihood from 2.58 in line with national average of 1.59 Specific targeted actions in recruitment process to: • All recruiting managers/panels to attend Resourcing and Selection Training. • Re-introduce inclusion ambassadors onto recruitment panels.	Head of Resourcing EDI Manager EDI Practitioner (Workforce lead) Recruitment Manager BAME Network	July 2025	Yes	Yes	WRES Indicator 2	High Impact Action 2 Staff Survey

Update: Action on track

The current data shows that applicants from a Global Majority (formerly BAME) background are 2.2 times less likely to be appointed to roles within KMPT. This is a small improvement from 2.58, our aim is to reduce this to be in line with the national average.

The Recruitment Team has developed recruitment training to be delivered to all recruiting managers – training will be available via e-learning in early 2025 for roll out.

Culture Inclusion Ambassadors (CIAs) are now an integral part of interview panels. Recruitment maintains a list of enthusiastic ambassadors and encourages managers to involve a CIA when organising interviews. This exciting initiative is in its early stages, and while only a few CIAs have participated in panels so far, comprehensive recruitment training and guidance are scheduled for January 2025 to ensure their effective involvement, ready for roll out in February 2025.

The impact of this initiative will be measured via WRES indicator 2 where we will expect to see improvements to the likelihood of BAME staff being appointed.

WRES & WDES Update

Learning and Development	Embed a learning culture around people management with lessons learned from internal and external cases, taking on board the actions or initiatives explored from the `too hot to handle' report, launch of the Restorative Just and Learning Culture questions, to support decision-making in investigations.	Deputy Chief of People – ER EDI Manager HRBPs Central Investigations Team DAWN and BAME Network	December 2024	Yes	Yes	WRES Indicator 3 WDES Metric 3	EDI Plan, Focus Area, 2, 3, 4 Strategic Object 2.1 High Impact Action 4

Update: Action on track

Roger Kline attended a People Team SMT to discuss “Too hot to handle” report and recommendations including the actions KMPT is taking. A review of all cases and lessons learned exercise to understand what could have been done differently (if appropriate) takes place. ER team is working to introduce restorative just learning culture next year across the trust which will support and align with the PSIRF model.

We are currently obtaining feedback from everyone involved in a HR Process. We have 2 people training in Restorative Just Learning Culture run by Northumbria University which takes the learnings from Merseycare, and will be looking to roll this out in 25/26. We are also looking at ‘harm’ and ‘impact’ when we are conducting cases. We will look at measuring the success of this by how many cases are resolved through Just Learning/ Early Resolution and continuing to gather feedback from colleagues involved in processes.

WRES & WDES Update

Staff Experience	Reduce violence and aggression towards staff from patients currently for BAME. V&A incidents is at 17.1% for verbal abuse. Physical violence incidents in 2022 was 24.6% and in 2023 26%, an increase of 2.6% data from 23/24 staff survey. Reporting is anticipated to increase as Safety Culture Bundles are rolled out across inpatient wards.	Chief of Nurse HRBP – Acute HRBP – Forensic V&A Strategic group & sub group EDI Manager	April 2026	Yes	Yes	WRES Indicators 5 & 6 WDES Metric 4a-4c	EDI Plan Focus Area 1 Strategic Objective 2.1 High Impact Action 4 & 6

Update: Action on track

Safety Culture Bundles, including safety cross reporting, are in place across all inpatient wards. Incident reports are analysed by protected characteristics (e.g., Race, Gender) to identify trends and address issues. There was significant progress on Pinewood, Chartwell and Cherrywood wards in particular in the first few months of the roll-out (with 100%, 71% and 67% respectively).

Allyship training due to be piloted on Ruby Ward in December with roll out to all acute/forensic wards from March 2025. Trauma informed care training still in its development stage, in discussion with Kent Police Hate Crime division to look at delivery of Hate Crime workshops to staff. The training is one element to the reduction of violence and aggression staff experience in their working day. It is anticipated that the training will provide staff with the tools to intervene and challenge behaviours as well as being able to support staff as an ally, therefore providing a united message to patients and staff that discriminatory behaviours are not tolerated.

WRES & WDES Update

Staff Experience	19.6% of staff with disabilities say they have experienced pressure from their manager to attend work, compared with 11.4% of staff without disabilities. Create a culture where our people feel safe, equal and can thrive. Value people as individuals and treat others as we would like to be treated.	Disability and Wellness Network EDI Team Culture, Identity and Staff Experience Strategic Group Comms Team	May 2025	No	Yes	WDES Metric 6	EDI Plan Focus Area 2, 3, 4, 5 Strategic Objective 2.1 High Impact Action 4

Update: Action on track

Work has commenced to improve KMPTs disabled staff experiences, managers understanding of disability and neurodiversities.

KMPT now has a neurodiversity network in place for staff who are neurodivergent, staff with families who are neurodivergent and allies.
The new central reasonable adjustments process is now in place, with a total of 50 people since April 2024 to date submitting a formal request for a workplace reasonable adjustment, this averages approximately 2-3 requests per week. Cost so far £66,093.66 paid with £58,450.00 claimed back.

Work and wellness passport has been introduced for staff with a disability or neurodivergent condition to complete and discuss support with their managers. As well as a new e-learning module that covers disability, neurodiversity, reasonable adjustments and Equality, the training is aimed at all staff including managers creating awareness and understanding.

The above interventions enable managers to have proactive conversations with staff to better understand their disabilities/neurodiversities, needs and support. These interventions help create a culture where KMPT's disabled and neurodivergent staff feel that they are valued and being listened to, and will help reduce disabled staff feeling pressured by their managers to attend work if they are unwell.

WRES & WDES Update

Staff Experience & Development	47.3% of BAME staff stated that they believe the Trust provide equal opportunities for career progression or promotion. KMPT's BAME Band 7 and above Talent development and success strategy is currently in development with strategies including coaching and mentoring, assessment centre, address of work with days.	EDI Manager Deputy Chief of People – OD and Resourcing Head of OD	March 2025	Yes	No	WRES Indicator 7	EDI Plan, Focus Area 2 and 3 Strategic Objective 2.2

Update: Action on track with slight delay

The first draft of the BAME Band 7 and above Talent Development and Success Strategy is currently under review. A dedicated working group has been established to provide consultation, feedback, and additional insights to ensure the strategy is comprehensive and effective. This group is tasked with identifying areas for improvement, incorporating best practices, and aligning the strategy with organisational goals for equity, diversity, and inclusion. The aim is to create a robust framework that supports the professional growth and success of BAME staff in senior roles, addressing potential barriers and promoting career progression within the organisation. Ultimately, this will aim to increase the number of BAME staff in roles at Band 7 and above.

WRES & WDES Update

Staff Experience	Only 41.2% of staff with disabilities are satisfied with the extent to which the organisation values their work, compared with 51.5% of staff without disabilities. Create a better inclusive work environment. Insights gained to inform Culture programme and to develop initiatives to promote an inclusive work environment i.e. sunflower campaign, celebrate purple day	Disability and Wellness Network EDI Team Comms Team	March 2025	No	Yes	WDES metric 7	EDI Plan Focus Area 2, 3, 4, 5 Strategic Object 2.1 High Impact Action 4

Update: Action on track with slight delay

Over the coming 12 months, there will be a series of targeted campaigns and events designed to promote awareness, inclusivity, and support for staff with disabilities and wellness needs, which will be led by the Disability and Wellness Network (DAWN). It is hoped that these activities will foster a greater understanding of both the needs and the strengths of staff with disabilities, and highlight their achievements.

However, due to a temporary change in the DAWN chair, progress on some planned activities has been delayed.

Discussions are currently underway with DAWN members to develop new plans for 2025/26. These future plans aim to build on the network's ongoing efforts, ensuring alignment with organisational goals and addressing emerging needs within the workforce. The focus will be on creating a sustainable strategy that fosters engagement, drives impactful initiatives, and strengthens the support system for staff.

It is also anticipated that the new values and leadership and management development will support more positive behaviours and relationships more broadly.

WRES & WDES Update

Staff Experience & Accountability	13.7% of BAME staff stated that they had personally experienced discrimination. The 2023 staff survey indicates that this is an increased for our BAME staff from 2022 which was 10.8%. Accountability for fostering an inclusive workplace culture, includes regular reviews of efforts to combat discrimination in conjunction with the 6 priority areas of the EDI plan to enable the Trust to work towards creating a more inclusive and equitable work environment for all staff.	BAME Network HRBPs EDI Team OD Team Culture, Identity and Staff Experience Strategic Group Comms Team	March 2026	Yes	No	WRES Indicator 8	EDI Plan, Focus Area 4 Strategic Objective 2.1 High Impact Action 4 & 6

Update: Action on track

KMPT has officially launched its Equality, Diversity, and Inclusion (EDI) Plan, structured around six key focus areas aimed at fostering a more inclusive and equitable workplace culture (across all protected characteristics). Each focus area is led by a dedicated subject matter expert responsible for driving initiatives, providing expertise, and ensuring progress. To reinforce accountability and leadership, each focus area is also supported by an executive sponsor who advocates for its goals at the highest level of the organisation. This collaborative approach ensures that the EDI Plan is effectively implemented, with clear direction and alignment with KMPT's broader cultural transformation objectives.

This is expected to achieve a reduction in race discrimination reported.

NHS
Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	30th January 2025
Title of Paper:	Freedom to Speak Up 6th Month Report
Author:	Rebecca Crosbie, the Guardian Service
	(Cover sheet authored by Sheila Stenson, Chief Executive)
Executive Director:	Sheila Stenson, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Regulatory Requirement

Overview of Paper

A paper updating the Board on the six-monthly performance (1 April to 30th September 2024) of the Freedom to Speak Up (FTSU) Guardian Service.

Issues to bring to the Board's attention

The report covers the period 1st April to 30th September 2024.

During this 6-month period, 61 cases were raised to the Guardian Service, an increase of 40 cases in the same period of the previous year and 45 for the year before that with the most prevalent themes being systems/processes (38%) and management issues (34%). This is in line with the top three themes for the same period the previous year. Of these cases 77% of cases fell into the 'green' category, general workplace concerns, 13% amber and 8% red.

Directorate numbers were as follows, West Kent (3.13%) and East Kent (2.4%) these directorates saw the highest number of their staff raising concerns. Within these numbers, 26% of staff in Sevenoaks raised concerns and 15.5% in Dover.

Of the 61 cases raised, 46% used the Guardian Service because they believed that they had raised the concerns previously internally but did not feel heard and 47% used the service due to it being an external, impartial option.

In terms of staffing groups that are most likely to speak up this was the nursing and allied health professionals. 2% of total nurses raised concerns and 2.45% of allied health professionals.

Work continues with our local improvement plan and leadership development will be starting in the next few months.

Version Control: 01

Governance

Implications/Impact:	Trust Strategy: Growing our capability to deliver
Assurance:	Reasonable
Oversight:	Oversight by Workforce Committee/Trust Board

Version Control: 01

Kent and Medway NHS and Social Care Partnership Trust

The Guardian Service
Here to listen

Half Year Report
1st April to 30th September 2024

Circulation:
Public Board

Main point of contact:
Sheila Stenson
CEO & Executive Lead for FTSU

Prepared by:
Rebecca Crosbie
Lead Guardian
The Guardian Service Ltd.

Date: December 2024

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1. Executive summary

This document presents the Freedom to Speak Up (FTSU) Guardians' Six-Month Report for the period 1st April-30th September 2024. It provides and overview of the activity and themes that took place for the first half of the 2024/25 year. This reporting period is in line with national guidelines.

- 61 cases were raised during this period. This is an increase from 40 cases in the same period of the previous year and 45 for the year before that.

- The most prevalent themes were Systems/Processes (38%) and Management Issue (34%). This is in line with the top three themes for the same period of the previous year. It is worth noting an increase in cases relating to Management Issues each year since the service went live.

- In addition to the 61 cases raised 20 were carried over from the previous reporting period, 3 of these remain open at the time of writing the report. In all 3 of these cases there is room for learning and improvement in relation to escalation response, actions taken, impact on staff and follow-up/feedback.

- The majority of concerns raised (77%) fell into the category of 'green' concerns, general workplace concerns. 13% were 'amber' concerns and 8% 'red' concerns. Red concerns contain an element of patient safety, quality of care.

- Of the concerns raised 43% of them remained within the remit of the Guardian Service and were not escalated to KMPT. 30% of staff felt confident to escalate with full disclosure and only 3% remained anonymous to both the Guardian and KMPT.

- When looking at concerns raised in relation to staffing numbers in each directorate West Kent (3.13%) and East Kent (2.4%) saw the highest number of their staff raising concerns. In terms of location 26% of staff in Sevenoaks raised concerns and 15.5% in Dover.

- When looking at job groups nurses and allied health professionals were most likely to speak up with 2% of total nurses raising concerns and 2.45% of allied health professionals.

- Of the 61 cases raised 46% of staff used the Guardian Service due to a belief that they had raised their concerns internally previously but did not feel heard and 47% used the service due to it being an external, impartial option.

- Reflections welcomed on three recommendations which explore leadership intervention to prevent stress sickness absence, review of the work related stress risk assessment and awareness around detriment or impact to staff as a result of speaking up experiences.

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2. Purpose of the paper

The purpose of this paper is to give insight to the progress and development of the service and a summary of themes arising from the cases received by the FTSU Guardian.
This report provides an overview from 1st April 2024 to 30th September 2024. The report follows the guidance from the National Guardian Office (NGO) on the content FTSU Guardians should include when reporting to their Board which include: Assessment of cases, Action taken to improve speaking-up culture, Recommendations.

3. Background to Freedom to Speak Up

Following the Francis Inquiry[1] 2013 and 2015, the NHS launched 'Freedom to Speak Up' (FTSU). The aim of this initiative was to foster an open and responsive environment and culture throughout the NHS enabling staff to feel confident to speak up when things go or may go wrong; a key element to ensure a safe and effective working environment.

4. The Guardian Service

The Guardian Service Limited (GSL) is an independent and confidential staff liaison service. It was established in 2013 by the National NHS Patient Champion in response to The Francis Report. The Guardian Service provides staff with an independent, confidential 24/7 service to raise concerns, worries or risks in their workplace. It covers patient care and safety, whistleblowing, bullying, harassment, and work grievances. We work closely with the National Guardian Office (NGO) and attend the FTSU workshops, regional network meetings and FTSU conferences. The Guardian Service is advertised throughout the Trust as an independent organisation. This encourages staff to speak up freely and without fear of reprisal. Freedom to Speak Up is part of the well led agenda of the CQC inspection regime. The Guardian Service supports the Trust's Board to promote and comply with the NGO national reporting requirements.

The Guardian Service Ltd (GSL) was implemented in Kent and Medway NHS and Social Care Partnership Trust (KMPT) on 6th June 2022.

Communication and marketing have been achieved by meeting with senior staff members, joining team meetings, site visits, the Intranet and the distribution of flyers and posters across the organisation. All new staff will become aware of the Guardian Service when undertaking the organisational induction programme.

5. Access and Independence

Being available and responsive to staff are key factors in the operation of the service. Many staff members, when speaking to a Guardian, have emphasised that a deciding factor in their decision to speak up and contacting GSL was that the Guardians are not NHS employees and are external to the Trust.

6. Categorisation of Calls and Agreed Escalation Timescales

The following timescales have been agreed and form part of the Service Level Agreement.

Call Type	Description	Agreed Escalation Timescales

[1] https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry

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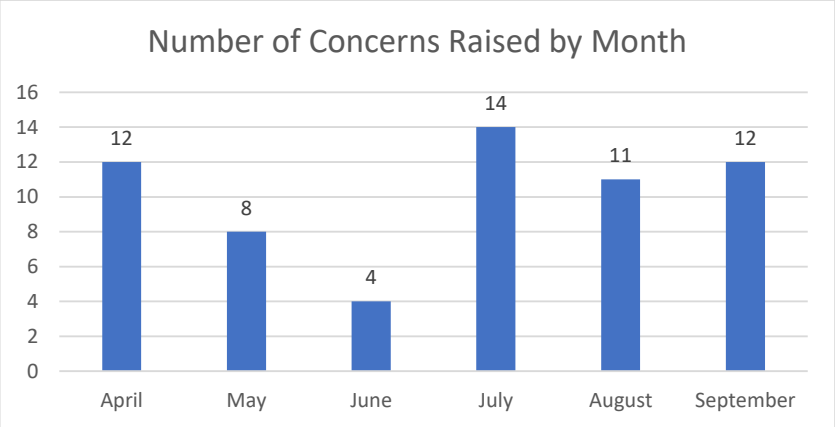
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours
White	No discernible risk to organisation.	No organisational response required

Open cases are continually monitored, and regular contact is maintained by the Guardian with members of staff who have raised a concern to establish where ongoing support continues to be required. This can be via follow up phone calls and/or face to face meetings with staff who are in a situation where they feel they cannot escalate an issue for fear of reprisal. Guardians will also maintain contact until the situation is resolved or the staff member is satisfied that no further action is required. Where there is a particular complex case, setbacks or avoidable delays in the progress of cases that have been escalated, these would be raised with the organisational lead for the Guardian Service at regular monthly meetings.

Escalated cases are cases which are referred to an appropriate manager, at the request of the employee, to ensure that appropriate action can be taken. As not all employees want their manager to know they have contacted the GSL, they either progress the matter themselves or take no further action. There are circumstances where cases are escalated at a later date by the Guardian. A staff member may take time to consider options and decide a course of action that is right for them. A Guardian will keep a case open and continue to support staff in such cases. In a few situations contact with the Guardian is not maintained by the staff member.

7. Number of concerns raised

For the period 1st April – 30th September 2024, which is the first half of the financial year, 61 concerns were raised with The Guardian Service (GSL). Month by month these are displayed below with an overall monthly average of 10.1, increasing from 8.4 in the previous year. Please not that these figures do not include any concerns raised internally via other routes and only includes those raised with the FTSU Guardian.



Of the 61 concerns raised 5 of them were RAG rated as **Red** with an element of patient safety or quality of care. Of these 5 concerns 3 are closed and the most recent two remain open with immediate risk mitigated awaiting feedback and reassurance for those who raised the concerns.

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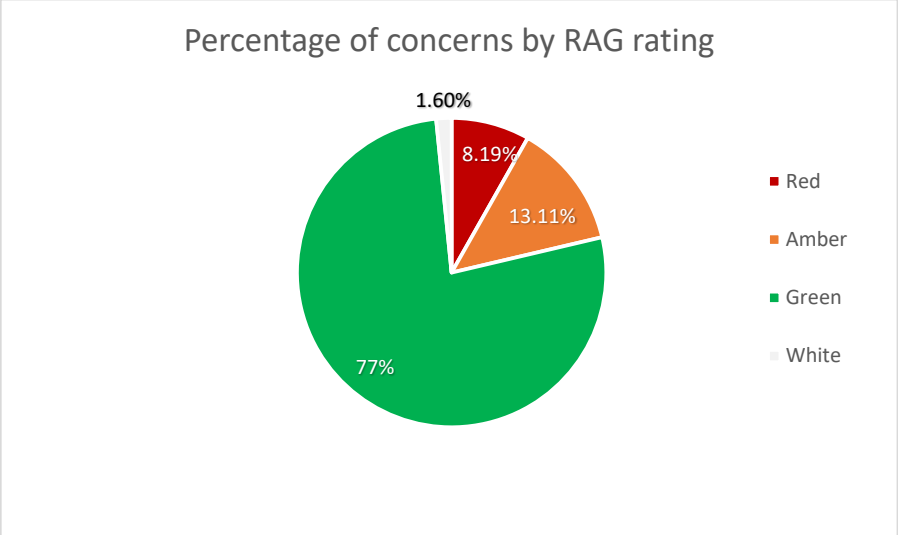

8. Confidentiality

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	26	42.62%
Permission to escalate with name	20	30.79%
Permission to escalate without name	13	21.31%
Permission to escalate anonymously	2	3.28%
Total	**61**	

9. Themes

Concerns raised are broken down into the following categories: Primary Theme or Multi Theme Occurrences. Multi Theme Occurrences are in line with NGO recording requirements and allow us to see all concerns which have an element of each theme.

Primary Theme	Total
A Patient Safety / Quality of Care	3
B Management Issue	21
C System Process	23
D Bullying and Harassment	3
E Discrimination / Inequality	1
F Behavioural / Relationship	5
G Other (Describe)	0
H Worker Safety	5
Grand Total	**61**

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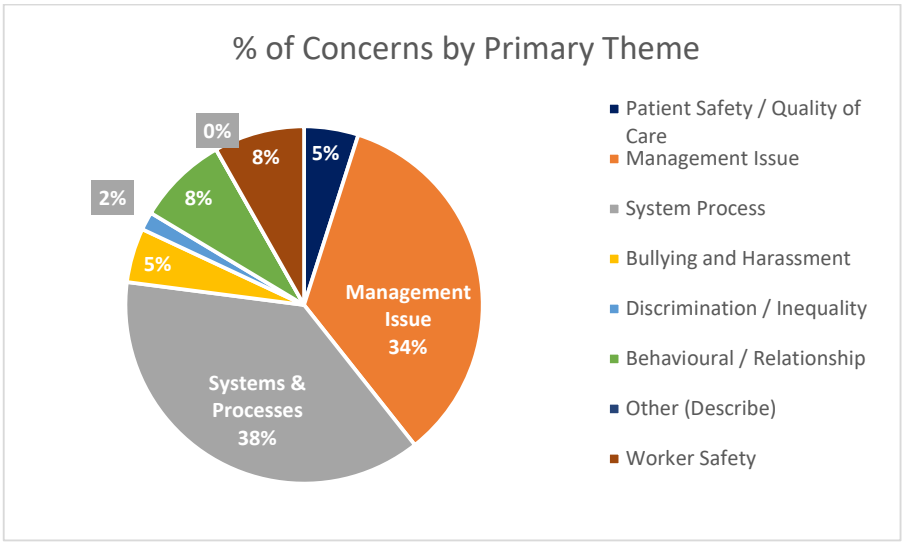
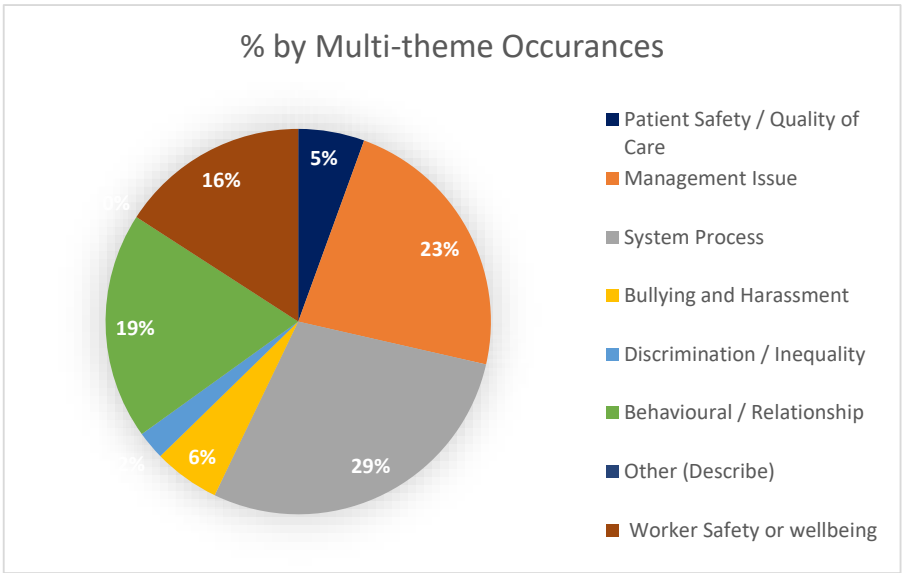


Multi Theme Occurrences	Total
A Patient Safety / Quality of Care	7
B Management Issue	29
C System Process	36
D Bullying and Harassment	7
E Discrimination / Inequality	3
F Behavioural / Relationship	24
G Other (Describe)	0
H Worker Safety or wellbeing	20



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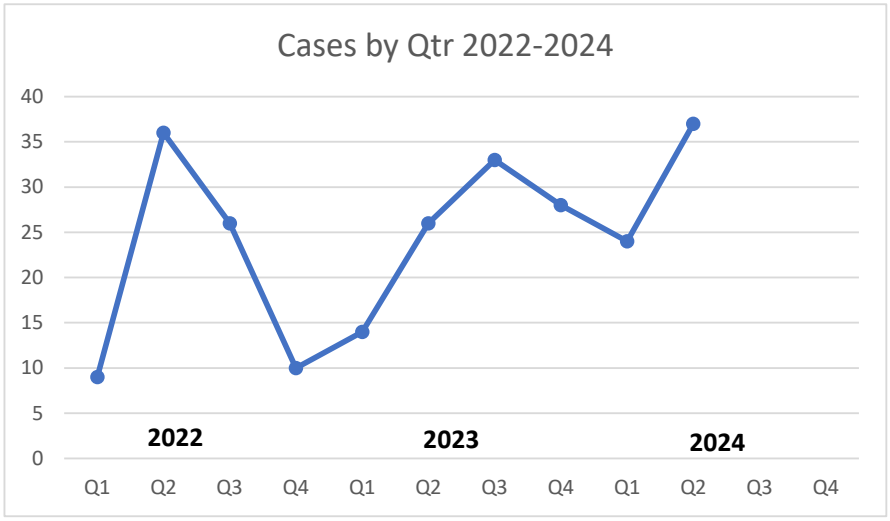
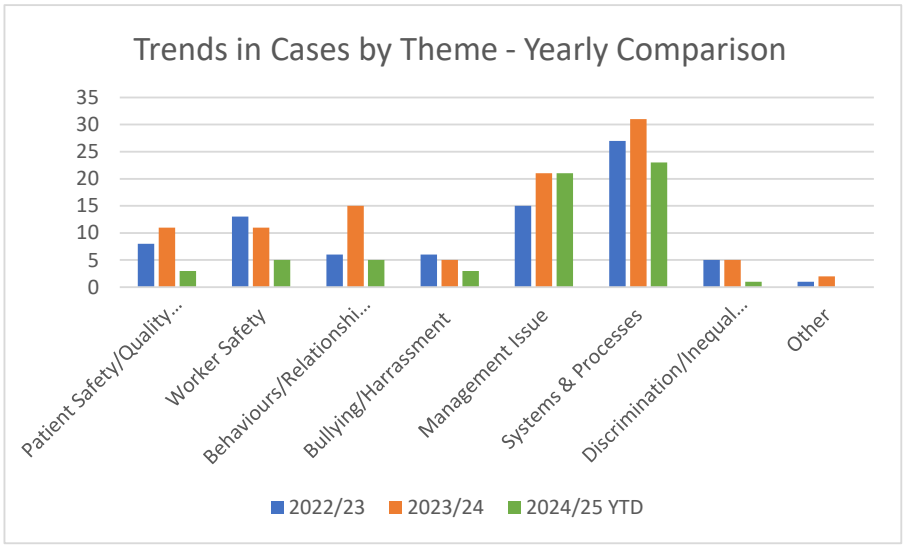
10. Trends in Cases

The charts below show the trends in case numbers and cases by theme between June 2022 and September 2024. Note that the service only went live at the end of Q1 2022 and data for 2024/25 is only inclusive of the first six months of the year.



The data shows a year-on-year increase in themes relating to the theme of 'Management Issue'. Despite only having data for the first half of the 2024/25 year we can see the figures are already at the same level for the full years period of the previous year.



11. Assessment of Cases

The top two primary themes for the period are as follows:

1. **Systems & Processes**

Systems and Processes can include all internal operational or HR/ER systems and processes. This is the leading theme for both primary and multi-theme occurrences. Within this theme we saw concerns relating to:

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- Consultation and restructure – staff raised concerns about perceptions of poor communication during this process particularly with those whose roles may be directly impacted. Staff felt that the processed lacked consideration around impact on both staff and the client/patient group. Staff felt that the pre-engagement piece prior to consultation could have been more proactive at understanding the day-to-day experience and reality of staff in their roles.
- Local induction and probationary review processes – Staff reported concerns about their experience of joining the organisation or changing roles and what they perceived as a lack of resources to offer appropriate shadowing or local induction into their role. In addition to this several staff reported negative experiences of the probationary review process with a feeling that this was either being used maliciously or that there hadn't been robust checks and goals set at the necessary stages to help them to succeed in the role. There were also concerns where managers were unsure how to have difficult conversations with staff around their performance and conduct. This meant staff weren't aware of issues and how to resolve these. In some cases, certain conversations and actions hadn't been appropriately recorded meaning some processes or outcomes lacked credibility.
- Staffing levels – Staff raised concerns about capacity in the workplace. Staff reported feeling that staff teams were reducing in size and gave examples of perceptions that when someone left the team either through retirement, secondment or resignation that these posts weren't always backfilled. Staff also reported impact on staffing levels and capacity following restructure or transformation. Staff felt they were having to pick up case loads larger than what they saw as sustainable or safe. These concerns were predominantly from community-based teams and services with staff reporting impact on their overall wellbeing and workplace experience.
- Follow up and feedback – 46% of staff who contacted The Guardian Service report doing so due to an experience of having raised their concern internally but not feeling listened too. Staff consistently reported a lack of feedback, follow up or action when raising concerns. In many cases this led to staff taking periods of sickness absence or exploring alternative employment opportunities outside of KMPT. Staff were mindful that some concerns may be difficult to resolve or may take time but felt that if they received regular feedback and check ins around their concerns this may reduce the impact of not feeling heard or supported.

2. Management Issues

The theme of Management Issues relates to concerns raised about staff experience of leadership and management in the workplace. 29 out of 61 cases had an element of a management issue and 21 cases reported this as the primary them.

- Management style, behaviour or communication – staff reported a belief that managers were communicating or behaving in a way that did not align with trust values and had an impact on their overall performance and wellbeing. Staff felt compassionate leadership was lacking and that micromanagement was disempowering.
- Management visibility and capacity to lead – staff reported feeling that management were too busy to lead or be visible to teams which left teams feeling unsupported and unsure how to deal with certain situations.
- Minimising or not addressing concerns – staff reported that they repeatedly raised concerns that they felt management were minimising or not supporting with early resolution options. Staff felt that this led to concerns becoming more difficult to resolve and, in some cases, leading to work related stress sickness absence or staff seeking alternative employment.
- Abuse of power – some staff described an abuse of power where they felt managers were using process to 'manage staff out' or damage reputation due to speaking up or challenging a narrative they didn't feel was fair.

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Within the multi-theme occurrences there are 2 additional leading themes worth noting.

3. **Behaviours/Relationships**

   Behaviour between colleagues and team dynamics – staff reported concerns that negative behaviour between colleagues or within teams was having a negative impact on individuals and services. Staff felt a lack of support was in place to deal with these concerns and in most cases felt management weren't offering enough early interventions or resolution leading to worsening of situations.

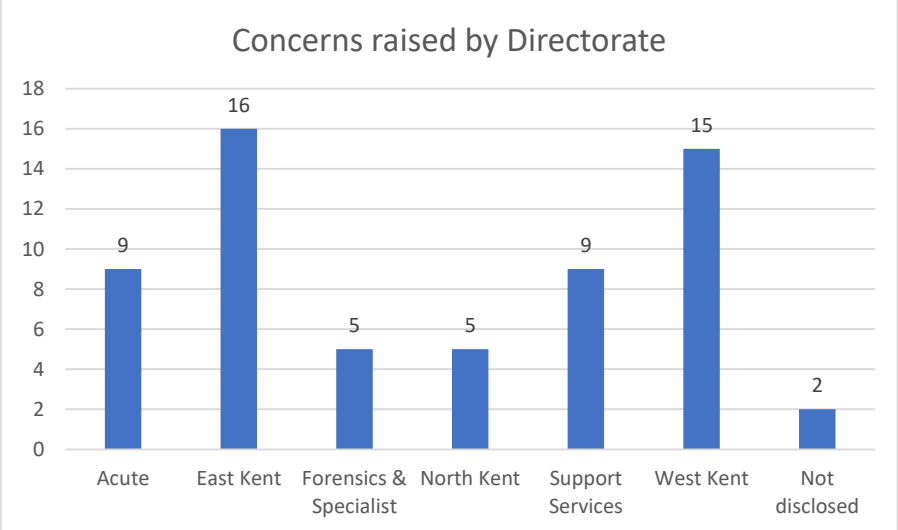
   Managers dealing with difficult behaviours – managers reported concerns that they felt unable to deal with certain behaviours due to fear of perceived discrimination and felt unsupported by the organisation and its processes.

4. **Worker Safety or Wellbeing**

- Work related stress risk assessment – within all themes we saw experiences of staff taking extended periods of sickness absence for reported work-related stress. Either due to the initial concern itself or due to a feeling that things weren't being resolved proactively enough, with timeframes extending beyond what they would consider reasonable. This led to staff being less able to cope and taking time out. During this time out staff often reported a lack of communication from managers and in some cases had to request for occupational health assessments as these were not initially actioned. Staff also gave feedback that when engaging in a work-related stress risk assessment that they did not find this meaningful or that following completion there was a lack of action, follow up or check in to see if things had improved. When discussing these staff experiences with managers, some managers reported a challenge in how to improve situations following the risk assessment and that it did sometimes feel like a tick box exercise.

12. Statistical Graphs

Concerns raised by Directorate



Directorate	Head Count	Concerns	% of staff raising concerns to GSL
Acute	677	9	1.32%
East Kent	664	16	2.40%
Forensics	757	5	0.70%

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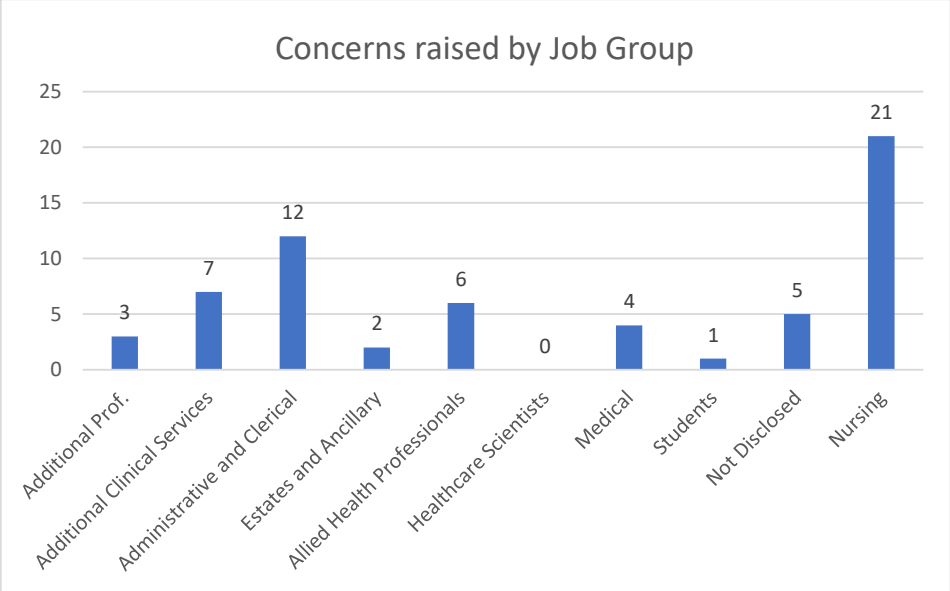
North Kent	498	5	1%
Support Services	899	9	1%
West Kent	478	15	3.13%
Not disclosed		2	

Concerns raised by Location

Location	Count of Employee Number	Concerns	% of staff raising concerns to GSL
Dartford & Gravesham	769	4	0.50%
Sevenoaks	27	7	26%
Tonbridge and Malling	275	1	0.36
Maidstone	1012	14	1.38%
Tunbridge Wells	114	2	1.75%
Swale	72	0	0.00%
Ashford	119	2	1.68
Canterbury	752	4	0.53%
Folkstone and Hythe	102	2	1.96%
Dover	78	12	15.38%
Thanet	312	3	0.96
Medway	315	4	1.26%
Unspecified	39		
Not disclosed		6	
Grand Total	**3986**	**61**	

Concerns raised by Job Group



Job Group	Head count	Concerns	% of group raising concerns to GSL
Add Prof Scientific and Technic	376	3	0.80%
Additional Clinical Services	933	7	0.75%

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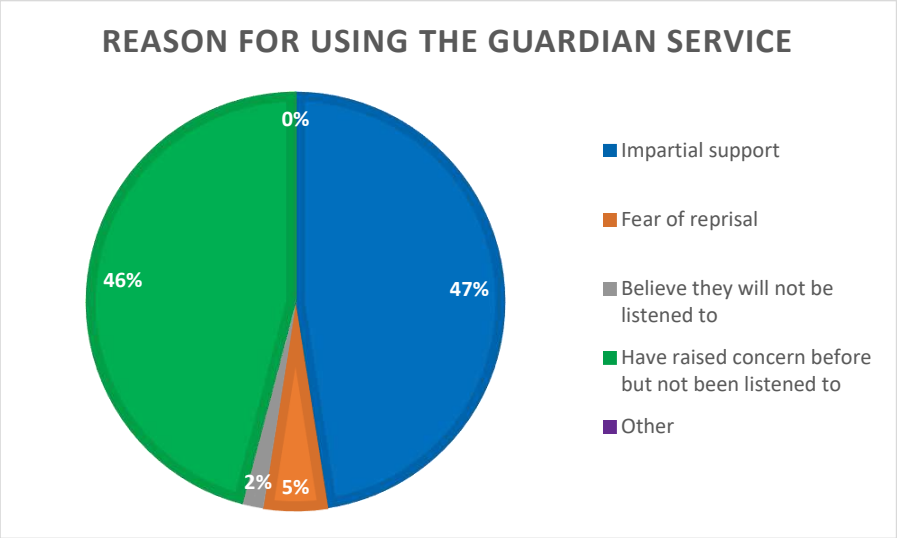
Administrative and Clerical	958	12	1.25%
Allied Health Professionals	244	6	2.45%
Estates and Ancillary	175	2	1.14%
Medical and Dental	238	4	1.68%
Nursing and Midwifery Registered	1049	21	2%
Not disclosed		5	
Students	Unknown	1	
	3973	61	

13. Why do staff use The Guardian Service?



14. Detriment

Currently detriment is recorded when a case is closed and only at this point does it show up on the monthly data report. If it is a case which had been opened in the previous reporting year, then it will not show on the current years report. This is a feature we are currently testing for upgrade to ensure we can log detriment at any time and not just once a case is closed.

Within this period two cases carried over from the previous period have reported feeling that they have suffered a detriment because of raising concerns. Both declined raising this with the organisation due to fears of recrimination. One reported change to their working hours and one decided to resign from employment due to reported psychological impact.

Two additional cases carried over from the previous reporting period remain open and both staff members feel that due to the extended period taken to investigate their concerns that there has been an impact which they would describe as detriment including a perception of personal psychological injury and/or damage to career.

In both open cases there is room for reflection around timeframes. In one instance the Guardian has been supporting an individual for beyond two years and their concerns had been raised internally for upwards of a year prior to the guardian's input. In the other case it reportedly took six months for an investigation to begin which caused the staff member to feel that they suffered additional stress because of trying to feel heard. In both cases these individuals felt that feedback and updates during the ongoing

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investigations was lacking and reported impact on their experience in the workplace and psychological wellbeing.

15. Action taken to improve the Freedom to Speak Up Culture

The trust has launched its new Staff Room app to replace the intranet and the FTSU Guardian liaised with the communications team to ensure FTSU had the appropriate placement and information within the app. Staff have reported this is now easier to find.

During FTSU month the guardian offered a selection of virtual drop-in appointments for staff to have 1-1 confidential conversations with the guardian. These were popular and more will be booked in throughout 2025.

The guardian continues to meet with the Exec Lead monthly and has regular meetings with the NED for FTSU, CPO and other relevant individuals within the trust to share themes and data.

The organisations CEO has continued to hold regular 'Speak to..' events for staff to raise concerns directly with the executive team and to encourage staff to speak up.

The trust now has an action plan in place to review recommendations from within the FTSU board reports.

Work is being carried out with the top 50 leaders to support best practice around the listen up, follow up elements of the speaking up process including consideration to make the follow up training mandatory for leadership roles.

16. Learning and Improvements

Investigations

Experiences of formal investigations has been featuring as a theme since the service went live in 2022. Since the introduction of the Central Investigations Team (CIT) in 2024 there has been a reduction in timeframes in cases investigated by the CIT. On average cases are being investigated within 31 days with continued improvement to these figures quarterly.

The CIT investigated 13% of investigations since they launched. Cases falling outside of this team had an average timeframe of 98 days with 11 of those cases taking over 100 days increasing the average figure quite substantially.

Despite improvements since the launch of the CIT staff still report inconsistent experiences for processes which sit outside of the CIT and feel there is a lack of objectivity overall when concerns are investigated.

17. Comments & Recommendations

1. With many concerns leading to staff taking extended periods of sickness due to perceived work-related stress is there any reflection around how to better engage or utilise early resolution and compassionate leadership skills to ensure staff feel heard and supported. This may prevent the need for sickness absence which can in turn reduce risk of resignation or further challenges in resolving workplace concerns. The guardian has dealt with a large portion of concerns where staff report feeling that their absence could have been prevented had there been interventions and compassionate communication from managers.
2. Consideration to review and explore the effectiveness of the stress risk assessment to ensure that staff find this meaningful and that managers have the tools and understanding to use it effectively.
3. To explore the trusts processes and understanding around experiences of detriment following raising concerns to ensure minimal negative impact on staff who are speaking up.

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4. Staff Feedback

Staff have given positive feedback on their experiences when using The Guardian Service however, staff report feeling that the trust itself does not respond in the way they would expect. Staff report feeling that improvements could be made in communication towards staff who raise concerns and feedback to staff is felt to be lacking.

More detailed feedback from the feedback survey will be provided in the next annual report.

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Kent and Medway
NHS and Social Care Partnership Trust

TRUST BOARD MEETING

Meeting details

Date of Meeting:	30th January 2025
Title of Paper:	Changes to Standing Orders and Standing Financial Instructions
Author:	Jo Newton- Smith, Associate Director of Procurement
Executive Director:	Nick Brown, Chief Finance and Resources Officer

Purpose of Paper

Purpose:	Approval
Submission to Board:	Statutory

Overview of Paper

The government has introduced new procurement legislation (The Procurement Act 2023 and Procurement Regulations 2024) which take effect from 24th February 2025.

This requires changes to be made to the Trust's Standing Orders, Standing Financial Instructions and Scheme of Delegation in order to ensure compliance with the law.

Items of focus

The paper sets out the changes required in order to comply with procurement legislation. The key changes are due to; new transparency requirements which require the Trust to publish notices on a central digital platform throughout the procurement lifecycle and introduces lower thresholds by which there is more public accountability.

The Scheme of Delegation has been changed to reflect new requirements of the Procurement Act which includes a lower threshold of £12,000 (including VAT) where a contracts details notice must be published following conclusion of contract award. All the thresholds within the Act now include VAT. The update therefore seeks to move the previous threshold of £15,000 to £12,000 by which a quotation process must be undertaken and notices published.

It is proposed that the £50k threshold is adjusted for VAT (and moved to £60k); with the £1m contract award threshold remaining the same whilst the impact of the changes are reviewed.

The Board are asked to note that the Trust's Spending the Trust Money policy which supports the Standing Orders, Standing Financial Instructions and Scheme of Delegation also needs substantial amendments. As the Cabinet Office are still publishing guidance documents it is recommended that this policy is stood down whilst this is finalised with any procurement above the value of £12,000 (including VAT) is done in association with the procurement team so that all the new legislative requirements can be followed. This is expected to be a short-term

measure with an updated Spending the Trust Money brought to March Finance and Performance committee for approval.

Governance

Implications/Impact:	Well-Led: Governance
Assurance:	Significant
Oversight:	Oversight by Audit and Risk Committee

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Key Changes Requested for Approval

Changes are highlighted in **bold** in the table below.

SO/SFI number	Current wording	New wording	Reason
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 consider: 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.	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 Health Care Services (Provider Selection Regime) Regulations 2023 shall be followed in the commissioning of health care services.** The Chief Executive should consider: 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.	The Provider Selection Regime is a set of rules for procuring health care services in England. The Provider Selection Regime (PSR) was introduced by regulations made under the Heath and Care Act 2022. It came into force on 1st January 2024.
25.5.1	The Public Procurement (International Trade Agreements) (Amendment) Regulations 2023, The Public Contract Regulations 2015 and The Public Procurement (Amendment etc.) (EU Exit) Regulations	**The Procurement Act 2023 and the Procurement Regulations 2024 which govern public procurement, along with any Directives and Statutory Acts and supporting legislation issued by UK Government**	On October 28th 2024 the laws relating to public sector procurement fundamentally change. This amendment is

SO/SFI number	Current wording	New wording	Reason
	2020 which govern public procurement along with supporting legislation must be followed	**must be followed. The Act and Regulations cover the procurement of all goods, works and services. The Healthcare Services (Provider Selection Regime) Regulations 2023 cover the procurement and commissioning of health care services.**	to reflect the new Act and Regulations which govern procurement and commissioning decisions.
25.5.3	Prior to commencing a competitive tender process or entering into a formal contract or SLA, over a total contract value of £250,000 relevant approval must be sought via a procurement project control form submitted to the Deputy Directors Group. If the requirement is new and/or additional budget needs to be allocated, a business case must be prepared first for any expenditure to be approved in advance of a procurement process (see para 23.4)	Prior to commencing a competitive tender process or entering into a formal contract or SLA, over a total contract value of £250,000 (including VAT) relevant approval must be sought via a procurement project control form submitted to the **Trust Leadership Team (TLT).** If the requirement is a new revenue commitment and/or additional budget needs to be allocated, a business case must be prepared first for any expenditure **over the threshold as dictated by the Business Case Policy** to be approved in advance of a procurement process (see para 23.4), **unless relating to capital expenditure whereby a Project Control Document (PCD) must be submitted and approved by Trust Capital Group**	The Deputies Group no longer exists and has been replaced by TLT. Clarification of the threshold levels whereby a business case is required.
25.6.2	All tendering must be carried out via the authorised e-tendering platform and be compliant with the Trust policies and procedures	All tendering must be carried out via the authorised e-tendering platform **as provided by NHS England** and be compliant with the Trust policies and procedures. **Where a framework provider is undertaking the tendering process on behalf of the Trust their e-tendering platform can be utilised.**	Clarification on the name of the e-tendering platform to be used.
	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	The Associate Director of Procurement must be consulted on any **request to waive any competitive quotation or tendering procedures that fall within the remit of the Procurement Act 2023**, in accordance with the Single Tender Waiver process. The Chief Executive (and any persons whom powers have been	Change in order to comply with Law. Previously STW were permitted for NHS to NHS contracts however these now fall under the Provider Selection Regime

SO/SFI number	Current wording	New wording	Reason
		delegated to) can choose to waive a formal tendering procedure where	and therefore new regulations must be followed.
25.6.3 g	g) 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.	for the provision of **goods, services** and works contracts a waiver can be sought from undertaking a competitive open tender for below Threshold procurements **not covered by the Procurement Act** 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.	Due to changes in the Act and Regulations this is now permitted for any procurements that are not deemed a public contract and therefore not a Covered Procurement.
25.6.6	A single tender waiver will be required in circumstances where the cumulative total of expenditure with an individual supplier in any financial year is more than £15,000 (excluding VAT). For example, if goods or services are procured totalling £14k and then a further purchase of £5k is made with the same supplier then an STW will be required for the additional purchase. It should be noted that requirements cannot be knowingly split in order to avoid a quotation process.	A single tender waiver will be required in circumstances where the cumulative total of expenditure with an individual supplier in any financial year is more than **£12,000 (including** VAT). For example, if goods or services are procured totalling **£10,000** and then a further purchase of £3k is made with the same supplier **then a competitive tender process** or an STW will be required for the additional purchase. It should be noted that requirements cannot be knowingly split in order to avoid a quotation process.	This is to reflect new requirements to publish transparency notices for contracts valued at more than £12,000 including VAT. It is also to give clarity over aggregation of expenditure rules.
25.6.7	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 Chief Finance and Resources Officer to the Audit and Risk Committee.	Where it is decided that competitive **quotation** or tendering **process** is not applicable and should be waived by virtue of the single tender waiver process, the reasons should be documented and reported by the Chief Finance and Resources Officer to the Audit and Risk Committee. **This justification must be published on the central digital platform as part of a contract details notice which is required to be published for any STWs above the value of £12,000 (including VAT).**	This is to reflect new requirements to publish transparency notices for contracts valued at more than £12,000 including VAT

SO/SFI number	Current wording	New wording	Reason
25.6.8	An exemption list of suppliers for whom a waiver is not required and are not covered by the full provision of the Public Contract Regulations will be held by the Procurement Team and reported annually for approval to the Audit and Risk Committee. This list will only include suppliers for whom there are no reasonable substitutes such as universities, other NHS Trusts or professional bodies	An exemption list of suppliers for whom a waiver is not required and are not covered by the full provision of the **Procurement Act 2023 and Procurement Regulations 2024** will be held by the Procurement Team and reported annually for approval to the Audit and Risk Committee. **Contracts entered into with these exempt suppliers will still require a contract details notice to be published on the Central Digital Platform which includes the justification for the direct award.**	Update to legislative references and inclusion of new requirement to publish notices when a contract is entered into at a lower threshold.
25.6.9	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	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 **25.6.1 applies or the provisions for direct award contained within the Act and Regulations apply.**	Change in paragraph numbering and reference to new Act and Regulations.
25.6.11	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	**The Procurement Act 2023 and Procurement Regulations 2024** 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, **and some health care related services where the Healthcare Services (Provider Selection Regime) Regulations 2023 apply.** Further advice should be sought from the Procurement Team	Update to legislative references.
25.7.1	All purchasing must be done in accordance with Spending the Trust's Money (STTM) guidance document. Advice must be sought from the	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	The new procurement rules require much more rigour within our procurement process and there are

SO/SFI number	Current wording	New wording	Reason
	Procurement Team where necessary and for any procurement above the value of £50,000.	procurement above the value of **£12,000 (including VAT)**.	additional transparency requirements which effect any contract above the value of £12,000. Therefore, engagement with the procurement team is required at a lower threshold
25.7.2	At least one written quotation must be obtained where the total estimated contract value is below £15,000.	At least one written quotation must be obtained where the total estimated contract value is below **£12,000 (including VAT).**	The threshold has been lowered as there are now new requirements to publish transparency notices for contracts worth £12,000 or more. Thresholds are now also inclusive of VAT as per requirements of the legislation.
25.7.3	At least three written quotations, with at least one quote from a Kent and/or Medway based business where possible, must be obtained where the total estimated contract value is between £15,000 and £49,999 (excluding VAT) for goods and services contracts and between £15,000 and £100,000 (excluding VAT) for Works Contracts.	At least three competitive written quotations, with at least one quote from a Kent and/or Medway based business where possible, must be obtained where the total estimated contract value is between **£12,000 and £59,999 (including VAT) for goods, services and works contracts. A contract details notice must be published on the central digital platform once the contract has been awarded.**	The £15k threshold by which a quotation must be undertaken has been lowered as there are now new requirements to publish transparency notices for contracts worth £12,000 or more, these are now called notifiable below threshold procurements. The guidance also states that all notifiable below threshold procurements above the value of £12,000 must be advertised on the central

SO/SFI number	Current wording	New wording	Reason
			digital platform, unless other local arrangements are in place, for example a quotation process. Thresholds are now inclusive of VAT as per requirements of the legislation therefore the upper threshold has been increased to reflect this and inflation. This will also allow us to encourage local and SME suppliers to quote who may be put off by a full open competitive tendering process.
25.7.4	A full competitive procedure must be conducted where the total estimated contract value is £50,000 and above for goods and services contracts and £100,000 and above for Works contracts. 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.	A notifiable below threshold competitive procedure must be conducted where the total estimated contract value is **£60,000 for goods, services and works contracts up to the relevant procurement Threshold as set out by the UK Government bi-annually for all goods, services and works contracts (including VAT), see also Appendix D**. **The Procurement team must be informed**. This must be undertaken electronically and advertised on the **central digital platform**. This must include published award criteria and procurement documents including a draft contract. **All relevant transparency notices must be published pre and post tender and during the contract life as required by the Act and Regulations.**	Changes to thresholds to include VAT. Where the public sector must advertise tenders has changed and is now called the Central Digital Platform. There are now greater requirements to publish notices pre and post tender and during the contract life.

SO/SFI number	Current wording	New wording	Reason
26.7.5	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	A full competitive procedure must be conducted where the total estimated contract value exceeds the relevant procurement Threshold as set out by the UK Government bi-annually, see Appendix D. These tenders are public contracts known as a **Covered Procurement.** All tenders must be carried out electronically and advertised on the **central digital platform. This must include published award criteria and procurement documents including a draft contract**. **All relevant transparency notices must be published pre and post tender and during the contract life as required by the Act and Regulations.**	Changes to terminology as required by the legislation.
25.7.6	Before any contract is awarded approval must be sought as set out in the Scheme of Delegation. Following approval suppliers can be notified of the outcome.	Before any contract is awarded or signed approval must be sought in writing as set out in the Scheme of Delegation. **A contract award report must to prepared for any contract above the value of £250,000 (including VAT) and submitted to EMT for approval. For capital projects approval is via a Project Control Document (PCD) approved by Trust Capital Group. For any contracts (including Capital projects) above the value of £1,000,000 (including VAT) report must be approved by Finance & Performance Committee and Trust Board.** Following formal approval suppliers can be notified of the outcome **in line with the Procurement Act and Regulations requirements.**	Change to wording to give clarity and ensure that the correct processes are used for awarding contracts and notifying suppliers

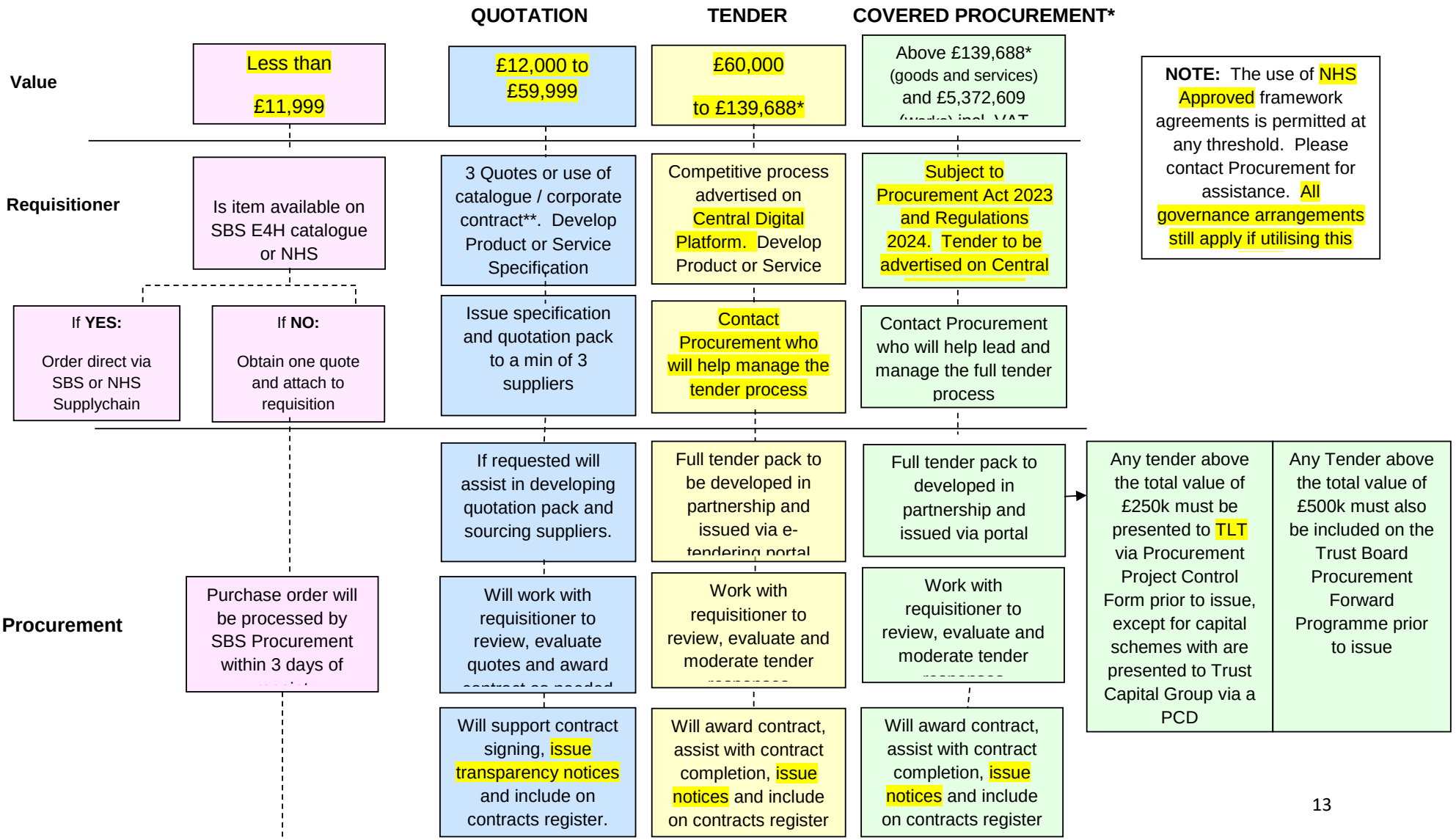
SO/SFI number	Current wording	New wording	Reason
25.8	For expenditure below the value of £12,000 where tendering or competitive quotation is not required the Trust should adopt one of the following alternatives: 25.8.1 The Trust shall use NHS Supply Chain, or other appropriate approved NHS framework 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. 25.8.2 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.	For expenditure below the value of **£12,000 (including VAT)** 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, **SBS E4H Catalogue or other approved contract** (and will not be required to obtain competitive quotations) unless the requirement cannot be filled via this route or the Associate Director of Procurement deems it inappropriate. **25.8.2 Where goods and services are not available by NHS Supply Chain or existing contracts then one quote should be sought which should be confirmed in writing. A purchase order must be raised.** **25.8.3 The Trust shall procure goods and services in accordance with the procurement procedures set out in in the Spending the Trust Money policy.**	A change to threshold as detailed previously. New wording to give clarity on low value purchases.
25.9	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.	The use of other public sector organisations or **central purchasing bodies'** Framework Agreements is permitted at any Threshold **if they are an approved provider by NHS England, although there are some exemptions to this related to Dynamic Markets.** The Procurement Team should be consulted to ensure these are utilised compliantly.	NHS England now have an accreditation programme and NHS Trusts are only able to utilise framework agreements that they have approved. This now means not all framework agreements are available for use. The new rules have also changed how dynamic markets operate and these

SO/SFI number	Current wording		New wording		Reason
					cannot be used for below-threshold procurements.
Appendix D			Please see Appendix D attached with changes highlighted.		Amended to reflect the contents of this paper.
Scheme of Delegation – Post Tender contract award approval	Up to £2,500	Level 1	Up to £2,500	Level 1	To align with new thresholds in the Procurement Act and Regulations where there are now transparency reporting requirements at a lower threshold.
	£2,500 - £14,999	Level 2	£2,500 - **£11,999**	Level 2	
	£15,000 - £49,999	Level 3	**£12,000** - £**59,999**	Level 3	
	£50,000 - £249,999	Level 4	£60,000 - £249,999	Level 4	
	£250,000 - £999,999	Level 5 Level 6	£250,000 - £999,999	Level 5 Level 6	
	£1,000,000 +	Level 7 Level 8	£1,000,000 +	Level 7 and Level 8	
Scheme of Delegation - Signing of Contracts and SLAs	Up to £2,500	Level 1	Up to £2,500	Level 1	To align with new thresholds in the Procurement Act and Regulations where there are now transparency reporting requirements at a lower threshold. To align with Hierarchy of roles as per Scheme of Delegation in SFIs
	£2,500 - £14,999	Level 2	£2,500 - **£11,999**	Level 2	
	£15,000 - £49,999	Level 3	**£12,000 - £59,999**	Level 3	
	£50,000 - £249,999	Level 4	£**60,000** - £249,999	Level 4 and Level 5	
	£250,000 - £999,000	Level 6	£250,000 - £999,000	Level 6	

SO/SFI number	Current wording		New wording		Reason
	£1,000,000 +	Level 8	£1,000,000 +	Level 6 (following Level 8 approval)	

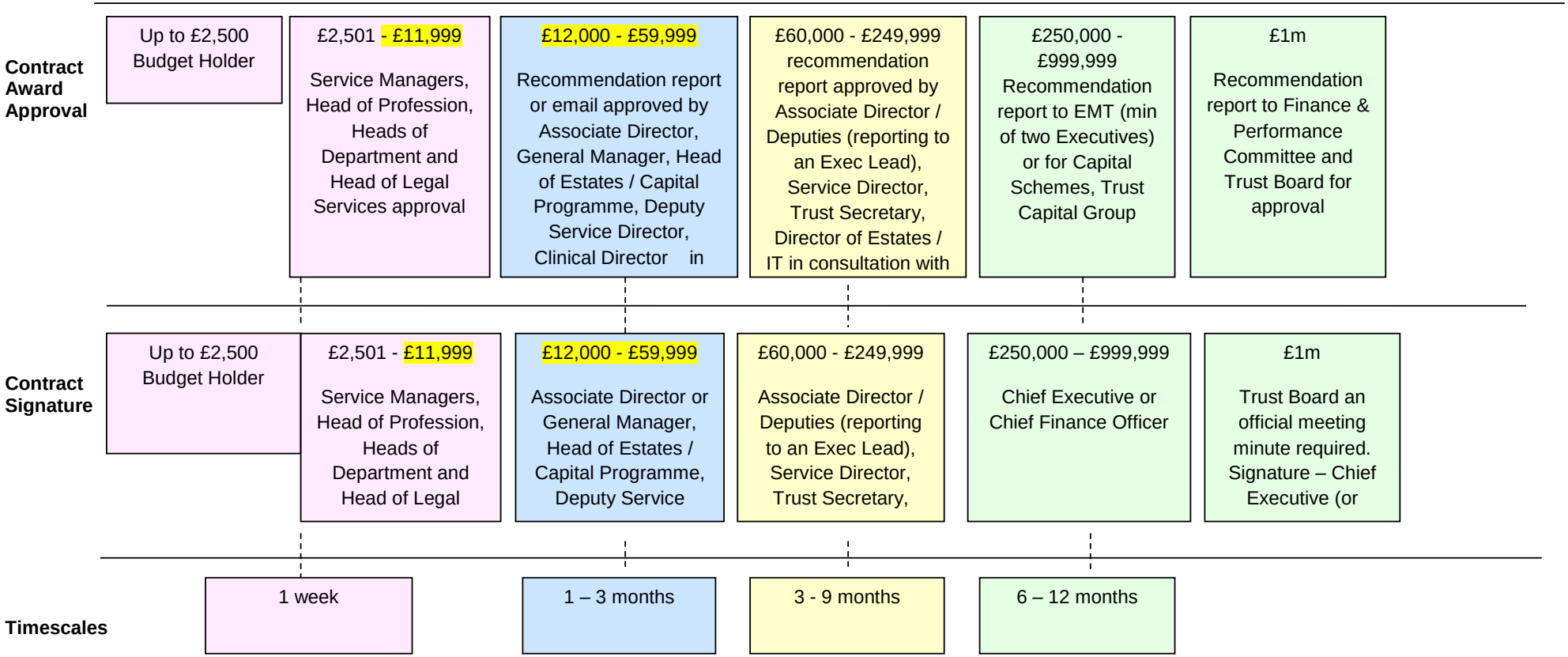
NHS
Kent and Medway
NHS and Social Care Partnership Trust

APPENDIX D - TENDER THRESHOLDS. GOVERNANCE AND TIMESCALES



NOTE: The use of NHS Approved framework agreements is permitted at any threshold. Please contact Procurement for assistance. All governance arrangements still apply if utilising this

13



Notes:
* Figures As of 1st January 2024. The Government Thresholds for **Covered Procurements** change bi-annually. The next change is due on 1st January 2026, the figures are inclusive of VAT.

For any value procurement a Framework Agreement can be utilised as an alternative to the route to market as set out above, if the framework provider has been accredited by NHS England. The Framework Agreement must be accessed following the Framework Provider terms and conditions and in a compliant manner. Please allow sufficient time for the above processes to be executed.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th January 2025**
Title	**Quality Committee Chair's Report**
Author	**Stephen Waring, Non-Executive Director**
Presenter	**Stephen Waring, Non-Executive Director**
Executive Director Sponsor	**Andy Cruickshank, Chief Nurse**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• Violence and Aggression Report	• Quality Impact Assessments • Getting the Basics Right – Programme Focus • Medicines Optimisation Strategy • Quality Digest	• Chief Nurse's Report • Quality Risk Register • CQC Report • Mortality Report • Quality Impact Assessments • Closed Cultures Report

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Chief Nurse Report	**Serious Incidents, PSIRF and learning** The Committee noted that, compared to Sussex Partnership NHS Foundation Trust (SPFT) and Surrey and Border NHS FT (SABFT) the Trust was reporting slightly fewer suspected suicides. The Committee acknowledged the lack of availability of benchmarking data due to the transition to PSIRF.	Reasonable Assurance	The Committee emphasised the importance of a clinical overview when storing information regarding serious incidents, to enable the identification of any patterns.
	Independent Homicide Reviews and Improvements The Quality Assurance Review recommended the following 5 recommendations for improvement; 1. Family engagement following mental health homicides 2. Embedding of learning from previous reviews 3. Effective risk management processes in front-line services 4. The implementation of a dual diagnosis policy 5. Effective management and governance of trust policies and procedures.	Reasonable assurance	The Committee acknowledged the further work which was required in relation to the following recommendations; 1. Family engagement following mental health homicides 2. The implementation of a dual diagnosis policy

	Whistleblowing and Safety An issue was raised on staffing at Chartwell Ward in Priority House.	Reasonable assurance	The Committee supported the immediate changes which had been put in place to ensure that the ward was safe, and noted the focus on the leadership and development needs of staff.
Quality Risk Register	The Committee expressed concerns regarding the increase in the number of poorly controlled risks.	Limited Assurance	The Trust Capital Group, which is chaired by the Chief Nurse will continue to review the capital requirements to resolve poorly controlled risks and the associated challenges, and will refer them to the appropriate Committees, as required.
Violence and Aggression Report	The Committee noted the significant improvement which has been seen across acute wards since the safety culture bundle (SCB) implementation. The Committee supported the initial findings of the Body-worn video camera pilot which commenced in November across two pilot wards. Staff were encouraged to report racial incidents and we are starting to see an increase in reporting. Change ideas are being delivered through safety culture bundles (interdependency) safety cross-bundle data and Inphase data. Proposal to change the target of a staff survey to using Inphase data.	Reasonable assurance	The committee will receive further updates at the next meeting in March.
Getting the Basics Right – Programme Focus	The Committee noted the work conducted by the trust in relation to the complete redesign of the Mental Health Together (MHT) processes, making it much easier to track a	Reasonable assurance	The Committee suggested that further consideration should be given to the name of the programme of work, to support staff

	patient through referral, assessment, and treatment to discharge and enabled consistency on how information is recorded onto Rio to improve data quality. Assurance was received that the redesigned process has reduced non-value-adding activities and achieved high-quality outcomes that support the organisation to improving patient care.		engagement and involvement and several ideas where posed by Committee members.
Medicines Optimisation Strategy	The Committee approved the Medicines Optimisation Strategy, which outlined the key areas of service development to ensure the organisation continued to deliver high-quality and safe pharmacy services. Over the last five years, clinical pharmacy services have expanded into community and specialist services.	Reasonable assurance	The 5-year strategy focused on the following areas; • Medicines safety • Medicines Quality and Value • Medicines Governance • Data and Digital Technology • Education and Training • Workforce • Partnership At the request of the committee, the document has been renamed as Medicines Optimisation Plan, to differentiate it from the single overall Trust strategy.
Mortality Report	The Committee noted the special cause variation in incidents of inpatient self-harm in October, which subsequently reduced during November. The latest three months of data have been identified as an early warning indicator and will continue to be monitored.	Limited Assurance	It was agreed to share/compare data with neighbouring trust, to identify any trends and consider what improvements can be made.
Free Text -			

Title of Meeting	**Public Board Meeting**
Meeting Date	**30th January 2025**
Title	**People Committee Chair's Report**
Author	**Kim Lowe, People Committee Chair, Non-Executive Director**
Presenter	**Kim Lowe, People Committee Chair, Non-Executive Director**
Executive Director Sponsor	**Sandra Goatley, Chief People Officer**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
• People Committee Main Report • Guardian of Safe Working Hours Report • Sickness absence deep dive • Workforce planning assumptions for 2025/26 • WRED and WDES update • EDI High Impact Actions update • Freedom to Speak Up		• Recruitment Audit • People Risk Register • HR Policies and Procedures

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Main Report	There is a plan to adjust the workforce model across the NHS, with mental health services modelling its workforce slightly differently to acute hospitals. The Committee was sighted on the matter and the Board shall be updated in due course.	Reasonable Assurance	
Sickness Absence Deep Dive	The Committee noted that musculoskeletal, and stress and anxiety continue to be the main drivers of sickness absence for staff. However, the Trust is not an outlier for staff sickness, which sits at about 4%, which is below the sickness absence rate in the NHS of 5.2%.	Reasonable Assurance	There was as request for HR to look again at our Mental Health support offer. As it may be an invest to save opportunity. With good evidence that reducing absence has a very positive effect on the bottom line.
People Risk Register	There are very few risks on the People Risk Register and most of those risks are sufficiently controlled. The Committee was concerned with Risk ID – 8246 Access to Blink for non-substantive staff. The Committee was unclear as to how this situation arose that non-substantive staff are not able to access the staff intranet and Trust policies. There are additional controls regarding vacancies with there now being a vacancy control panel. The Trust reports to the ICB regarding the authorising of vacancy.	Limited Assurance	The Committee noted that the Trust is carrying out attempts to remedy the situation and the various options available to it. The Committee is concerned that, following a request from the ICB, the Trust has added hurdles to the Trust's recruitment processes which is unnecessary and administratively burdensome, given that the Trust is planning to deliver a surplus by year-end.

Recruitment Audit	Despite the receipt of the limited assurance report regarding the recruitment audit, the Committee opined that many of the recommendations made were matters of best practice, which may not be appropriate from a business efficiency perspective.	Reasonable Assurance	Refer the matter to the Audit and Risk Committee for closure.
Free Text – Annual Guardian of Safe working hours report attached.			

ANNUAL REPORT ON ROTA GAPS AND VACANCIES: DOCTORS IN TRAINING KMPT

August 2023 through July 2024

Executive summary

This report covers August 2023 through July 2024. There were 23 exceptions during this time and 15 of them were upheld.
Four exceptions (4) did result in fines to the trust- total of £312.26. There have been no work schedule reviews, however, the time of handovers at Thanet Mental Health Unit has been moved to 4.30 pm, as a result of exception reports.

The total amount of fines up to July 2024 was £936.47.

Summary of breach upheld in KMPT:

Date	Type of Breach	On-call / Regular work	Education Implication	Advance notice	Compensated with money or time
03/09/2023	Exceeded maximum 13-hour shift	On-call	None	Yes	Payment + fine
11/10/2023	Late finish, Exceeded 9-5pm shift	Regular work	None	N/A	N/A
14/10/2023	Exceeded maximum 13-hour shift	On-call	None	N/A	TOIL+ fine
31/10/2023	Exceeded maximum 13-hour shift	On-call	None	N/A	TOIL *
07/12/2023	Late finish, Exceeded 9-5pm shift	Regular work	None	N/A	TOIL
21/12/2023	Late finish, Exceeded 9-5pm shift	Regular work	None	N/A	Payment
18/03/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	N/A	TOIL
15/04/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	N/A	TOIL
01/05/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	N/A	TOIL

Version control: 1

05/05/2024	Exceeded maximum 13-hour shift	On-call	None	No. Late finish.	Payment+ fine
10/05/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	No. Late finish.	TOIL
15/05/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	No. Late finish.	TOIL
07/06/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	No. Late finish.	Payment
23/06/2024	Exceeded maximum 13-hour shift	On-call	None	No. Late finish	TOIL+ fine
26/07/2024	Late finish, Exceeded 9-5pm shift	Regular work	None	No. Late finish.	Payment

* The trainee left 0.75 h late due to circumstances beyond the trainee's or the trust's control and therefore no fine was raised.

Introduction

Trainee doctors in Kent and Medway NHS and Social Care Partnership Trust are subject to the Terms & Conditions of the 2016 contract.

There are clear guidelines on safe working hours and adequate supervision, this is closely monitored and overseen by the Guardian of Safe Working Hours with support from medical staffing.

The Guardian of Safe Working Hours is introduced to trainees at induction and provides a talk about safe working hours, exception reporting and contact details of relevant people in the organisation including medical education and medical staffing teams. All trainees are provided with a link to our reporting DRS4 system (https://drs.realtimerostering.uk/Home.aspx). Trainees are encouraged to challenge any breaches which can be addressed immediately or reported if needed. Trainees are guided how to report an exception as well as work-based schedules and clinical supervision with their clinical supervisors. Medical staffing support trainees with exception reporting with a member of staff dedicated to this function.

Exception reports are raised by junior doctors where there is disparity in their agreed working schedules (including differences in the educational opportunities), breaches to their working hours as guided by the terms in the 2016 contracts. Reports are raised electronically through the DRS system. The educational supervisor is notified to review the exception report and take appropriate action to rectify. Such action may include time off in-lieu (TOIL) or payment for additional hours worked. Where issues are not resolved or a significant concern is raised, the Guardian may request a review of the doctor's work schedule to monitor patterns of breach of either working hours or regularity in educational attendance.

The Guardian of Safe Working Hours is required to report quarterly to the LNC and to the Trust Board via the Peoples Committee with an exception report as well as provide them an annual report. This report gives information on numbers of junior doctors in the Trust, exception reports raised and outcomes, work schedule reviews and vacancies.

Version control: 1

In line with the 2016 Terms and Conditions of Service (TCS) a Junior Doctors Forum has been convened which is chaired by the Guardian of Safe Working Hours. The Guardian of Safe Working Hours has regular communications with the junior doctors' representatives, as well as the Director of Medical Education. The Junior Doctor Forum (JDF) met with Director of Medical Education, medical staffing and the BMA Representative on quarterly basis. (Last meeting took place on the 23rd of July 2024). The Guardian of Safe Working Hours has extended the invitation to JDF to all junior doctors in training. (Previously, only trainee representatives were invited to JDF).

High level data

Number of doctors / dentists in training (total):	565
Number of doctors / dentists in training on 2016 TCS (total):	565
Annual vacancy rate among this staff group:	9.38%

Annual data summary

Trainees within the Trust

Specialty	Grade	August 2023 – Oct 2023	Nov 2023 – January 2024	Feb 2024 – April 2024	May 2024 – July 2024	Total vacancies (average WTE)	Number of on call shifts uncovered (over the year)	Average no. of on call shifts uncovered (per week, divide per year figure by 52)
Psychiatry	FY + GP	61	69	69	66	35	0	0
Psychiatry	CT + HT	69	66	71	50	18	0	0
Psychiatry	MTI + LAS + WAST	11	12	8	13	0	0	0
Total		**141**	**147**	**148**	**129**	**53**	**0**	**0**

a) **Exception reports (with regard to working hours)**

August – October 2023

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	0	0	0
F2	0	0	0	0
CT1-2 / ST1-2	0	4	4	0
CT3	0	0	0	0
ST4-ST7	0	0	0	0
Total	0	4	4	0

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November 2023 – January 2024

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	3	3	0
F2	0	0	0	0
CT1-2 / ST1-2	0	6	6	0
CT3	0	0	0	0
ST4-ST7	0	1	1	0
Total	0	10	10	0

February – April 2024

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	2	2	2
F2	0	0	0	0
CT1-2 / ST1-2	0	0	0	0
CT3	0	0	0	0
ST4-ST7	0	0	0	0
Total	0	2	2	0

May – July 2024

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	3	3	0
F2	0	0	0	0
CT1-2 / ST1-2	0	2	2	0
CT3	0	2	2	0
ST4-ST7	0	0	0	0
Total	0	7	7	0

b) Work schedule reviews by Guardian

Work schedule reviews by grade	
F1	0
F2	0
CT1-2 / ST1-2	0
CT3	0
ST4-ST7	0

Version control: 1

c) Locum work carried out by trainees

August – October 2023

Locum work by trainee: Individual Shifts

Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual hours worked per week (rounded up)	Opted out of WTR?
FY2	3	21.5	40	44.50	No
CT2	1	4.5	40	44.50	No
CT1	2	17	40	44.50	No
MTI	3	21.5	40	44.25	No
CT1	1	12.5	40	44.25	No
CT2	3	21.5	40	46.50	No
CT2	2	9	40	44.25	No
CT1	2	25	40	44.25	No
GPST2	3	13.5	40	44.25	No
CT2	3	29.5	40	45.75	No
CT2	3	13.5	40	45.75	No
CT1	5	38	40	45.75	No

Above are the trainees that worked the most hours/shifts over this period. These shifts would be done through the bank covering junior doctor on call.

Locum bookings by reason*					
Reason	Number of shifts requested Eve | W/N	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies	18 | 42	60	0	606	606
Sickness	6 | 12	18	0	177	177
Other	29 | 63	92	0	918	918

NB: Evenings are 4.5-hour shifts. Weekend/nights are 12.5-hour shifts. Number of “other” locum bookings was higher due to shadow support for August rotation.

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November 2023 – January 2024

Locum work by trainee: Individual Shifts

Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual hours worked per week (rounded up)	Opted out of WTR?
CT1	2	17	40	44.25	No
CT3	2	9	40	46.50	No
CT1	3	21.5	40	44.25	No
CT2	7	47.5	40	46	No
CT2	4	42	40	46	No
CT1	7	71.5	40	46	No
CT1	1	4.5	40	46	No
CT3	1	12.5	40	46	No
MTI CT3	2	17	40	44.25	No
LAS	3	21.5	40	44.50	No
CT2	1	12.5	40	44.50	No
CT2	1	4.5	40	44.50	No
CT2	1	4.5	40	44.50	No
CT2	1	12.5	40	46	No
CT1	1	4.5	40	44.50	No

Above are the trainees that worked the most hours/shifts over this period. These shifts would be done through the bank covering junior doctor on call.

Locum bookings by reason*					
Reason	Number of shifts requested Eve | W/N	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies	14 | 45	60	0	625	606
Sickness	18 | 46	64	0	656	656
Other	24 | 50	74	0	733	733

NB: Evenings are 4.5-hour shifts. Weekend/nights are 12.5-hour shifts. Number of “other” locum bookings was higher due to shadow support for August rotation.

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February – April 2024

Locum work by trainee: Individual Shifts

Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual hours worked per week (rounded up)	Opted out of WTR?
CT3	1	12.5	40	44.25	No
CT3	2	25	40	46.50	No
CT1	3	13.5	40	44.25	No
LAS	1	12.5	40	46	No
CT1	8	52	40	46	No
CT1	2	9	40	46	No
CT1	3	26	40	46	No
LAS	7	55.5	40	46	No
MTI CT3	1	12.5	40	44.25	No
CT1	4	42	40	44.50	No
CT1	2	9	40	44.50	No
CT1	3	29.5	40	44.50	No
F2	1	42	40	44.50	No
CT1	3	13.5	40	46	No
CT2	4	34	40	44.50	No
CT1	1	4.5	40	44.50	No
CT1	2	25	40	44.50	No
CT1	2	9	40	44.25	No
CT1	1	12.5	40	44.50	No

Above are the trainees that worked the most hours/shifts over this period. These shifts would be done through the bank covering junior doctor on call.

Locum bookings by reason*					
Reason	Number of shifts requested Eve | W/N	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies	21 | 76	97	0	1044.5	1044.5
Sickness	14 | 28	42	0	413	413
Other	25 | 44	69	0	662.5	662.5

NB: Evenings are 4.5-hour shifts. Weekend/nights are 12.5-hour shifts. Number of “other” locum bookings was higher due to shadow support for April rotation.

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May, June and July 2024

Locum work by trainee: Individual Shifts

Grade	Number of shifts worked	Number of hours worked	Number of hours rostered per week	Actual hours worked per week (rounded up)	Opted out of WTR?
CT1	3	21.5	40	40	No
CT1	6	43	40	40	No
CT1	9	48.5	40	40	No
CT1	6	35	40	40	No
CT3	5	62.5	40	40	No
CT1	2	17	40	40	No
CT1	6	35	40	40	No
CT1	5	26	40	40	No
CT1	2	25	32	32	No
LAS	2	25	40	40	No
CT3	1	4.5	40	40	No
CT1	1	4.5	40	40	No
MTI CT3	1	4.5	40	40	No
CT1	4	50	40	40	No
CT3	1	4.5	40	40	No
CT3	5	62.5	40	40	No
CT1	1	12.5	40	40	No

Above are the trainees that worked the most hours/shifts over this period. These shifts would be done through the bank covering junior doctor on call.

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Locum bookings by reason*					
Reason	Number of shifts requested Eve | W/N	Number of shifts worked	Number of shifts given to agency	Number of hours requested	Number of hours worked
Vacancies	24 | 55	79	0	795.5	795.5
Sickness	17 | 19	36	0	298	298
Other	5 | 37	42	0	485	485

NB: Evenings are 4.5-hour shifts. Weekend/nights are 12.5-hour shifts. Number of "other" locum bookings was higher due to shadow support for April rotation.

d) Agency

We do not currently have agency doctors where there are junior doctor vacancies, this work would be covered internally/on calls would be shared out or covered by locums so doctors aren't working too many hours.

Locum bookings (agency) by grade				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
CT1-2	0	0	0	0
ST3-8	0	0	0	0
Total	0	0	0	0

e) Vacancies

August – October 2023

Vacancies by Month:

Dartford

Grade	August	September	October	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	2	2	2	2
CT1-3	0	0	0	0
ST4-7	1	1	1	1

Medway

Grade	August	September	October	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	3	3	3	3
CT1-3	1	1	1	1
ST4-7	0	0	0	0

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Maidstone

Grade	August	September	October	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	4	4	4	4
CT1-3	0	0	0	0
ST4-7	2	2	2	2

East Kent

Grade	August	September	October	Total gaps (average)
F1	1	1	1	1
F2	1	1	1	1
GPST1/2	0	0	0	0
CT1-3	1	1	1	1
ST4-7	0	0	0	0

November 2023 – January 2024

Vacancies by Month:

Dartford

Grade	November	December	January	Total gaps (average)
F1	0	0	0	0
F2	1	1	1	1
GPST1/2	0	0	0	0
CT1-3	0	0	0	0
ST4-7	1	1	1	1

Medway

Grade	November	December	January	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	0	0	0	0
CT1-3	1	1	1	1
ST4-7	0	0	0	0

Maidstone

Grade	November	December	January	Total gaps (average)
F1	0	0	0	0
F2	1	1	1	1
GPST1/2	2	2	2	2
CT1-3	0	0	0	0
ST4-7	1	1	1	1

East Kent

Grade	November	December	January	Total gaps (average)
F1	2	2	2	0
F2	2	2	2	2
GPST1/2	1	1	1	1
CT1-3	1	1	1	1
ST4-7	0	0	0	0

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February – April 2024

Vacancies by Month:

Dartford

Grade	February	March	April	Total gaps (average)
F1	0	0	0	0
F2	0	0	1	1
GPST1/2	0	0	0	0
CT1-3	0	0	0	0
ST4-7	0	0	0	0

Medway

Grade	February	March	April	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	1	1	1	1
CT1-3	0	0	0	0
ST4-7	0	0	0	0

Maidstone

Grade	February	March	April	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	1	1	1	1
CT1-3	0	0	0	0
ST4-7	1	1	1	1

East Kent

Grade	February	March	April	Total gaps (average)
F1	0	0	2	2
F2	0	0	0	0
GPST1/2	0	0	0	0
CT1-3	0	0	0	0
ST4-7	0	0	0	0

May - July 2024

Vacancies by Month:

Dartford

Grade	May	June	July	Total gaps (average)
F1	2	2	2	2
F2	2	2	2	2
GPST1/2	0	0	0	0
CT1-3	0	0	0	0
ST4-7	1	1	1	1

Medway

Grade	May	June	July	Total gaps (average)
F1	0	0	0	0
F2	0	0	0	0
GPST1/2	0	0	0	0
CT1-3	1	1	1	1

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ST4-7	0	0	0	0

Maidstone

Grade	May	June	July	Total gaps (average)
F1	0	0	0	0
F2	2	2	2	2
GPST1/2	0	0	0	0
CT1-3	0	0	0	0
ST4-7	2	2	2	2

East Kent

Grade	May	June	July	Total gaps (average)
F1	2	2	2	2
F2	2	2	2	2
GPST1/2	0	0	0	0
CT1-3	4	4	4	4
ST4-7	0	0	0	0

f) **Fines**

Fines by department this year		
Department	Number of fines levied	Value of fines levied
Psychiatry	4	£312.26

Fines (cumulative)			
Balance at end of last report (Aug 2022 – July 2023)	Fines this year (August 2023 – July 2024)	Disbursements this year (August 2023 – July 2024)	Balance at end of this year (August 2023 – July 2024)
£624.21	£312.26	£0.00	£936.47

Qualitative information

Issues arising

The trainees have decided to spend the money raised from historical and this year's exception reporting fines paid by KMPT, on trainees' wellbeing event. The process of releasing the funds from exception reports has now been agreed between medical staffing and the finance department.

There was a positive development, and permanent increase in locum pay to £45 for core trainees (Tier 1) and £55 for higher trainees (Tier 2) has been agreed in December 2023.

There was a planned expansion of junior doctors' posts in KMPT from August 2023. There were 9 additional Core Trainees and 7 additional Higher Trainees which has had impact on the rotas.
The main change was that Medway rota has ceased to exist and the Maidstone rota has been split into two equal, smaller rotas, so two doctors are rostered for each shift on Tier 1 rota in Maidstone. The Maidstone rota set-up was run as a pilot, initially, and it was agreed this arrangement will continue for the rotation in August 2024.

There was a meeting between medical staffing, medical education and the guardian on 23/11/2023 to address the time of handover (between the day and evening shift) at Thanet Mental health unit to avoid regular breaches of 9-5pm working pattern. A new, earlier time for handover in the evening (at 4.30 pm) was agreed and the Thanet on-call guide was updated accordingly.

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During this reporting period (August 2023- July 2024) there were further rounds of junior doctors' industrial action (IA). KMPT made provision for a "shadow rota" during these periods, to allow safe running of services whilst respecting junior doctors' rights to take part in industrial action.

Actions taken to resolve issues

1. The process of releasing the funds from exception reports has now been agreed between medical staffing and the finance department. The funds raised from the historical and this year's fines will be used on trainees' wellbeing event, as agreed by trainees' representatives.

2. A permanent increase in locum pay to £45 for core trainees (Tier 1) and £55 for higher trainees (Tier 2) has been agreed during this reporting period.

3. The Step-Down Policy, now called Emergency Cover policy, designed to minimize delays in finding doctors at short notice has been ratified in principle.

4. The Guardian of Safe Working Hours has extended the invitation to JDF to all junior doctors in training. (Previously, only trainee representatives were invited to JDF).

5. Medical staffing launched virtual "drop in" sessions with trainees which proved to be popular. Medical staffing are planning to include further face to face drop in sessions, in addition to the virtual ones in the future.

6. Medical staffing worked closely with the medical management to arrange "shadow rotas" during the junior doctors' industrial action to ensure safe running of services whilst respecting junior doctors' rights to take part in industrial action.

Summary

KMPT provides high quality training to all trainees which is evident in the annual GMC survey where KMPT features in the top quartile (KMPT Ranked 44th out of 204 NHS Trusts).

We have a robust system in place to ensure recruitment processes are run smoothly. All our clinical and educational supervisors received training for their roles which are monitored by the Medical Education Department. We have an efficient medical staffing team with dedicated staff for trainee support. With their increased staffing and outstanding policies, unfilled shifts are less likely to occur and errors should be more quickly rectified.

There were 23 exception reports during this reporting year and 15 of them were upheld (increase from 14 the previous year).
There were four (4) fines levied in 2023/2024 of £312.26 which are yet to be paid. The total amount of fines up to July 2024 was £936.47.
The emergency-cover policy which was designed to reduce the risk of any last-minute gaps on the rotas was ratified in principle in September 2024.

There has been further planned expansion of junior doctors' posts in KMPT from August 2024 (increase from 140 to 153).

This report was updated on 08/01/2025

Dr Ivana Pristicova

Consultant Psychiatrist and Guardian of Safe Working Hours for KMPT

Version control: 1

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th January 2025**
Title	**Charitable Funds Committee Chair's Report**
Author	**Sean Bone-Knell, Committee Chair**
Presenter	**Sean Bone-Knell, Committee Chair**
Executive Director Sponsor	**Adrian Richardson, Director of Partnerships and Transformation**
Purpose	**Noting**

Agenda Items

People items	**Patient items**	**Finance & Governance items**
•	• Quarterly Impact Report	• Finance Report • Charity Operational Plan and Branding • Annual Report and Accounts • Charity Risk Register

Agenda Items by exception	Assurance narrative by exception. Key items to be raised to the Board.	None Limited Reasonable Substantial	Actions, mitigations and owners Refer to another committee.
Quarterly Impact Report	The Charity conducted a number of successful appeals over the festive period including the 'Give a little joy' appeal and the 'Fundraise for Wards' initiative.	Limited	The Committee sought clarity regarding the replacement of equipment and the lessons learned process in relation to the give a little joy appeal. The Committee also highlighted concerns in regarding the reduction of capacity within the volunteering team due to vacancies and sickness absence within the team.
Charity Operational Plan and Branding	There are a range of activities planned for 2025/26; with a clear deadline for grant applications. The Committee was assured that the operational plan was reasonable and achievable.	Reasonable	The Committee requested that the Charity consider the implementation of fundraising appeals to coincide with the anniversary of Victory Europe day.
Annual Report and Accounts	The Committee received details of the latest updates to the Annual Report and Accounts and was provided assurance that no further material amendments were expected.	Reasonable	The Committee referred the Annual Report and Accounts to the Charity Trustees Meeting, for approval.
Finance Report	The charity has forecast a positive year-end position for 2024/25; although it was acknowledged that a proportion of the forecast donations were an 'at risk' position.	Reasonable	
Charity Risk Register	The Committee received the latest iteration of the Charity Risk Register and noted the further work to standardise the Risk Register with the format of the Trust's Risk Register.	Reasonable	
Free Text -			

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th January 2025**
Title	**Audit and Risk Committee Chair's Report**
Author	**Peter Conway, Audit and Risk Committee Chair**
Presenter	**Peter Conway, Audit and Risk Committee Chair**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Board to endorse/amend the actions proposed**

Agenda Items

Finance and Regulatory items	
● Board Assurance Framework ● Trust Risk Register ● Risk and Governance Review ● External Audit Report ● Internal Audit Report ● Anti-Crime Report ● Director of Finance Items	● Single Tender Waivers Update ● Information Governance Assurance (incl data quality and cyber security) ● Losses and Special Payments ● Procurement Legislative Changes ● Managing Conflicts, Interests, Gifts, Hospitality and Sponsorship Policy

Agenda Items by exception	**Assurance narrative by exception. Key items to be raised to the Board.**	**None Limited Reasonable Substantial**	**Actions, mitigations and owners Refer to another committee.**
Action Log and Matters Arising	ARC's role in Freedom to Speak Up		ARC recommends that it's ToR be amended to consider assurance from the CEO on the effectiveness of FTSU across the Trust when

			considering the Annual Governance Statement
Board Assurance Framework (BAF)	BAF risks are broadly the right ones but the detailed content is a bit mixed. Improvements are needed in (1) risk descriptions, (2) actions being taken by when and (3) triangulation between these actions, the current risk rating and the target position after mitigations.	Limited Assurance	Exec, risk owners and risk team to address ARC recommends that the BAF includes a new risk for the ICB's level four status and the impact this may have on the Trust's funding and efficiency.
Trust Risk Register (TRR)	TRR requires the same improvements as the BAF	Limited Assurance	
Risk Strategy and Risk Policies Review	The Risk Strategy and Risk Policies were endorsed. The Risk Strategy will published without as risk appetite statement	Limited Assurance	The Board will consider a risk appetite statement at a future development day
Internal Audit Report	Five final reports have been issued, of which four received reasonable assurance (Bed Flows, Waiting List Management, Sire Visits, Project Planning Process) and the one limited assurance (Recruitment Processes)	Reasonable Assurance	People Committee have since received positive assurance on Recruitment Processes
Information Governance Assurance (incl data quality and cyber security)	The Committee received an excellent report regarding the management of Information Governance and the compliance with Data Subject rights from within the UK GDPR.	Substantial Assurance	The Committee will be updated on who carried out penetration testing for digital services on behalf of the Trust.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**30th January 2025**
Title	**Finance and Performance Committee 28.01.2025 - Chair's Report**
Author	**Peter Conway, Non-Executive Director**
Presenter	**Peter Conway, Non-Executive Director**
Executive Director Sponsor	**Nick Brown, Chief Finance and Resources Officer**
Purpose	**Discussion**

Agenda Items

People items	**Patient items**	**Finance items**
	• IQPR • Dementia Diagnosis Update • Getting the Basics Right – Programme Focus	• Finance Report • Financial Planning for 2025/26 • Finance Risks 2024/25 • Digital and IT • Littlebrook Settlement • Firewall Refresh Business Case

Agenda Items by exception	**Assurance narrative by exception. Key items to be raised to the Board.**	**None-Limited-Reasonable-Substantial Assurance**	**Actions, mitigations and owners Refer to another committee.**
IQPR	**MHT** - some encouraging signs **Patient Flow** - deteriorating position and unlikely to improve in the short term	Limited	The Board is well sighted on the challenges illustrated in the IQPR. There has been encouraging progress and potentially momentum is starting to build.

	Dementia - better local information now in place which should boost progress. The Community Dementia Model remains the system wide solution to achieving the national targets **Private Placements/Out of Area** - the Committee received assurance that the Trust adopts a clinically led risk-based approach to placements and budgets are only exceeded in extreme cases and/or patient safety issues **1 hour triage and rapid response** - excellent progress		
Business Cases	Firewall Refresh agreed (£650k)		
Finance Report – Month 9	The Trust will marginally exceed the agency cap for 2024/25 as a conscious decision arising from the clinical pressures Cash will reduce following the Littlebrook purchase to c£7m. There is ample headroom to meet short-term obligations The current underspend against the capital plan is due to a delay in a s136 scheme. The Trust is working with the system to manage the capital position this year and next	Reasonable	
Financial Planning 2025/26	Planning guidance from NHS England has not yet been issued. In the meantime, an initial planning exercise has been conducted which suggests a gap of c£12m (before CIPs etc).	Limited	The Committee encouraged the exploration of transformational change (medical models and pathways) as options the Board might consider if there is the capacity and capability to do these as well as all the other plans/priorities

	System and NHS pressures could lead to additional stretch once the planning guidance has been received and hence the limited assurance at the stage		