# AGENDA

**Title of Meeting** Trust Board Meeting (Public)
**Date** 29th July 2021
**Time** 09:30 to 11:30
**Venue** Boardrooms A & B, Farm Villa and video-conferencing

| Agenda Item | DL | Description | FOR | Format | Lead | Time |
|---|---|---|---|---|---|---|
| **TB/21-22/22** | 1. | Welcome, Introductions & Apologies | | Verbal | Chair | 9.30 |
| **TB/21-22/23** | 2. | Declaration of Interest | | Verbal | Chair | |
| **PERSONAL STORY** | | | | | | |
| **TB/21-22/24** | 3. | Community Mental Health Services for Older People: Patient and family member stories | | Verbal | EE/CL | 9.35 |
| **STANDING ITEMS** | | | | | | |
| **TB/21-22/25** | 4. | Minutes of the previous meeting – 27/05/2021 | FA | Paper | Chair | 9.45 |
| **TB/21-22/26** | 5. | Minutes of the Extraordinary meeting 24/06/2021 | FA | Paper | Chair | |
| **TB/21-22/27** | 6. | Action Log & Matters Arising | FN | Paper | Chair | |
| **TB/21-22/28** | 7. | Chair's Report | FN | Paper | JC | 10.00 |
| **TB/21-22/29** | 8. | Chief Executive's Report | FN | Paper | HG | |
| **OPERATIONAL ASSURANCE** | | | | | | |
| **TB/21-22/30** | 9. | Integrated Quality and Performance Report – Month 3 | FD | Paper | HG | 10.10 |
| **TB/21-22/31** | 10. | Finance Report: Month 3 | FD | Paper | SS | 10.30 |
| **TB/21-22/32** | 11. | Finance Exception Report - Agency | FD | Paper | SS | |
| **TB/21-22/33** | 12. | CQC Quality Improvement Plan | FD | Paper | MM | 10.40 |
| **TB/21-22/34** | 13. | Progress on Turning the Tide; Tackling Racism | FD | Paper | HG | 10.50 |
| **TB/21-22/35** | 14. | Eradicating dormitory wards in mental health facilities in Kent and Medway | FD | Paper | VB2 | 11.00 |
| **GOVERNANCE** | | | | | | |
| **TB/21-22/36** | 15. | NHSI Self-Certification Declaration | FA | Paper | TS | 11.10 |
| **CONSENT ITEMS** | | | | | | |
| **TB/21-22/37** | 16. | Audit and Risk Committee Chair Report | FN | Paper | PC | 11.15 |
| **TB/21-22/38** | 17. | Quality Committee Chair Report<br>• Infection, Prevention and Control Board Assurance Framework<br>• Annual Safeguarding Report<br>• Mortality Report | FN | Paper | FC | |
| **TB/21-22/39** | 18. | Workforce and Organisational Development Committee Chair Report | FN | Paper | VB | |
| **TB/21-22/40** | 19. | Finance and Performance Committee Chair Report | FN | Paper | MW | |
| **TB/21-22/41** | 20. | Mental Health Act Committee Chair Report | FN | Paper | KL | |
| **TB/21-22/42** | 21. | Use of the Trust Seal | FN | Paper | TS | |
| **CLOSING ITEMS** | | | | | | |

***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

| TB/21-22/43 | 22. | Any Other Business | | Verbal | Chair | 11.20 |
|---|---|---|---|---|---|---|
| **TB/21-22/44** | 23. | Questions from Public | | Verbal | Chair | 11.25 |
| | **Date of Next Meeting:** 30th September 2021 | | | | | |

| **Members:** | | |
|---|---|---|
| Dr Jackie Craissati | JC | Trust Chair |
| Venu Branch | VB | Deputy Trust Chair |
| Fiona Carragher | FC | Non-Executive Director |
| Peter Conway | PC | Non-Executive Director |
| Anne-Marie Dean | AMD | Non-Executive Director |
| Catherine Walker | CW | Non-Executive Director (Senior Independent Director) |
| Sean Bone-Knell | SB-K | Associate Non-Executive Director |
| Helen Greatorex | HG | Chief Executive |
| Vincent Badu | VB2 | Executive Director of Partnership and Strategy/(Deputy CEO) |
| Dr Afifa Qazi | AQ | Executive Medical Director |
| Jacquie Mowbray-Gould | JMG | Chief Operating Officer (COO) |
| Mary Mumvuri | MM | Executive Director of Nursing & Quality |
| Sheila Stenson | SS | Executive Director of Finance & Performance |
| Sandra Goatley | SG | Director of Workforce & Communication |
| **In attendance:** | | |
| Tony Saroy | TS | Trust Secretary (Minutes) |
| Hannah Puttock | HP | Deputy Trust Secretary |
| Tumi Banda | TB | Deputy Director of Nursing and Quality |
| Dr Efiong Ephraim | EE | Clinical Director for Older Adults Care Group |
| Clare Lux | CL | Locality Manager |
| **Apologies:** | | |
| Kim Lowe | KL | Non-Executive Director |
| Mickola Wilson | MW | Associate 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 meeting held at 0930 to 1150hrs on Thursday 27th May 2021**
**Via Videoconferencing**

| **Members:** | | |
|---|---|---|
| Dr Jackie Craissati | JC | Trust Chair |
| Venu Branch | VB | Deputy Trust Chair |
| Anne-Marie Dean | A-MD | Non-Executive Director |
| Catherine Walker | CW | Non-Executive Director (Senior Independent Director) |
| Sean Bone-Knell | SB-K | Associate Non-Executive Director |
| Fiona Carragher | FC | Non-Executive Director |
| Peter Conway | PC | Non-Executive Director |
| Kim Lowe | KL | Non-Executive Director |
| Mickola Wilson | MW | Associate Non-Executive Director |
| Helen Greatorex | HG | Chief Executive (CE) |
| Vincent Badu | VB2 | Executive Director Partnerships & Strategy/Deputy CE |
| Mary Mumvuri | MM | Executive Director of Nursing and Quality |
| Dr Afifa Qazi | AQ | Executive Medical Director |
| Jacquie Mowbray-Gould | JMG | Chief Operating Officer (COO) |
| Sandra Goatley | SG | Director of Workforce and Communications |
| Sheila Stenson | SS | Executive Director of Finance and Performance |
| | | |
| **Attendees:** | | |
| Tony Saroy | TS | Trust Secretary (Minutes) |
| Martine McMahon | MMc | Assistant Director of Transformation and Improvement |
| **Observers:** | | |
| Sarah Dickens | SD | Head of Research & Innovation |
| Dean Lewington | DL | Service Manager, Criminal Justice and Liaison Diversion Service |
| Julia Wilson | JW | Strategic Lead for Allied Health Professions |
| Victoria Nystrom-Marshall | VNM | Mental Health, Learning Disability and Autism Programme Lead |
| **Apologies** | | |
| Peter Conway | PC | Non-Executive Director |

| Item | Subject | Action |
|---|---|---|
| **TB/21-22/01** | **Welcome, Introduction and Apologies**<br><br>The Chair welcomed all to the meeting, which was livestreamed and had several senior members of staff in attendance as a development opportunity.<br><br>Apologies were received from PC. | |
| **TB/21-22/02** | **Declarations of Interest**<br><br>MM declared an interest as she is currently seconded one day a week to the Care Quality Commission as National Professional Advisor. | |



DRAFT

Kent and Medway
NHS and Social Care Partnership Trust

| Item | Subject | Action |
|---|---|---|
| TB/21-22/03 | **Supporting Service Users through Lockdown**<br><br>The Board welcomed Justine Norris MBE, Occupational Therapist, Amy Daniels, Acute Care Group Allied Health Professional Lead and Madeline Naick, service user, to the Board meeting.<br><br>Justine spoke to how, at the start of the first national lockdown due to Covid-19, she had created a resource pack for the Trust's service users that would help them deal with many aspects of their life during the lockdown. The pack contained a variety of activities including mood diaries, interactive charts and recommended activities in outdoor environments. The pack has been well received by service users and also by occupational therapists across the world – with KMPT building networks with those individuals. Justine felt that she was well supported within her team and encouraged to develop her skills.<br><br>Madeline explained to the Board how her mental health began to deteriorate to the point of feeling suicidal following changes in her physical health and her working role. Madeline described the support she received from Canterbury and Coastal Community Mental Health Team and how the use of the occupational therapy resource pack was a very important component of her recovery.<br><br>Amy Daniels highlighted to the Board Justine's ongoing work including the potential development of an app.<br><br>The Board reflected on the personal story noting the need for the Trust to improve its promotion of the research and innovation work it undertakes.<br><br>The Board thanked Justine Norris, Amy Daniels and Madeline Naick for attending the Board meeting. | |
| TB/21-22/04 | **Minutes of Previous Meeting**<br><br>The Board **approved** the previous minutes save for the following changes:<br><br>• For item TB/20-21/187 – Finance Report - Planning – the words "The first draft of the Capital Plan…" is to be replaced with "The final draft of the Capital Plan…"<br>• For item TB/20-21/185 – Strategy Delivery Plan 2021/22 - | |
| TB/21-22/05 | **Action Log & Matters Arising**<br><br>The Board **agreed** the Action Log.<br><br>**Action: By June 2021, VB2 to send TS a copy of the accessible three-page summary of the Organisational Strategy for circulation to the Non-Executive Directors (NEDs).** | |
| TB/21-22/06 | **Chair's Report**<br><br>The Board received the Chair's Report. | |





DRAFT

| Item | Subject | Action |
|---|---|---|
| | The Trust Secretary is collating all NED site-visit feedback, which will then be themed according to the issues that are raised. The Executive Management Team will be responsible for ensuring any themes are addressed. The Board will receive an update on a either a quarterly or bi-annual basis.<br><br>The Board **noted** the Chair's Report. | |
| **TB/21-22/07** | **Chief Executive's Report**<br><br>The Chief Executive's Report was received by the Board, which was taken as read.<br><br>The Chief Executive highlighted:<br><br>• The Trust's mission to deliver Brilliant Care through Brilliant People and noted that the Board will receive a statutory Establishment Review report and a paper on Tackling the Vacancy Challenge. These papers set out how the Trust is moving in the right direction.<br><br>The Board reflected on the Trust's Healthy Ward initiative, which focuses on food, nutrition and exercise. Although the Healthy Ward initiative is being overseen by the Strategic Lead for Allied Health Professions and the Deputy Director of Nursing and Practice, it is very much a co-produced initiative.<br><br>**Action: MM to produce a paper detailing the Terms of Reference for the Healthy Ward initiative. The paper will be submitted to the Quality Committee by July 2021.**<br><br>Suggestions and comments from the Board included:<br><br>• The Healthy Ward initiative should reflect the work that is taking place in terms of Health and Wellbeing of staff. This coincides with the work on staff rest areas, which staff are looking forward to seeing being implemented. The Trust will ensure staff are kept up to date regarding the creation of those staff rest areas.<br>• A recommendation that volunteers be included as they may be able to facilitate patient activities, including off-ward activities.<br><br>The Board **noted** the Chief Executive's Report. | |
| **TB/21-22/08** | **Integrated Quality and Performance Report (IQPR) – Month 1**<br><br>The Board received the IQPR, which now includes an 'IQPR Exceptions Reporting' section. This sets out the areas of concern and focus as identified by the Trust's Executive Management Team. SS and AQ took the Board through the areas so far as they relate to the effectiveness and responsive domain, highlighting in particular:<br><br>• There has been an increase in demand across the system, with the Trust's Patient Flow team working with the Trust's partners to ensure appropriate and timely patient discharge can occur. | |



DRAFT

| Item | Subject | Action |
|---|---|---|
| | • The number of out of area placements has increased from 310 bed days in March to 375 in April. This is made up of 303 PICU bed days and 72 Younger Adult Acute bed days. The Deputy Chief Operating Officer for Patient Flow is completing an overarching bed stock review.<br>• There has been an increase in the average Length of Stay for younger adults in the last three months, April saw a reduction to 25.9 days; this continues to be well within the national benchmarked average length of stay.<br>• There has been a general improvement in achieving the 4-week wait target in the Trust's Community Mental Health Teams. There has been a change in the skills mix within the teams and this is helping with meeting the target. The Trust is anticipating additional resource from its commissioners this month.<br><br>The Board discussed the following:<br>• The Trust's Patient Flow team has discharge co-ordinators and the Trust is considering changing the skills mix of the team to include social workers;<br>• Where there are Delayed Transfers of Care, this has been due to the complexity of the patient's needs and sourcing of accommodation for patients with complex needs.<br>• Although Length of Stay data is higher, there are no indications that this is affecting patient safety. The Trust reviews a number of different parameters to maintain patient safety including re-admission rates.<br>• The Trust recognises that unlike other areas nationally, the Trust holds all responsibility for Memory Assessment. The Trust will be working with its partners through the Mental Health, Learning Disability and Autism Improvement Board to change this so that, in the medium term, the Trust will be working with GPs and Neuropsychiatrists to carry out Memory Assessment. However, work is ongoing to resolve the memory assessment delays in the short-term.<br><br>**Action: JMG to produce a paper setting out the Trust's plans for the Memory Assessment Service for the short term. Paper to be presented to the Board by September 2021.**<br><br><u>Safe</u><br>• There has been a moderate harm ligature incident. No gaps in practise were identified in the immediate review of the care provided. Immediate action was taken to strengthen the contributory environmental factor. Work is ongoing nationally in collaboration with the Care Quality Commission and National Mental Health Nurse Directors Forums to improve patient safety related to ligature risks in wards. The outcomes will see the consolidation and development of national best practise guidance.<br>• With respect to the rate of physical health checks within 72 hours, an improvement from 92.9% in February to 96.2% in April has been seen and it is anticipated performance will continue to improve.<br>• The number of restrictive interventions has reduced, with 103 in April compared to a high of 159 incidents in August 2020. | |

DRAFT

| Item | Subject | Action |
|---|---|---|
| | Workforce<br>• There has been an increase in staff turnover and the Trust is working on the reasons raised for leaving. Most leave due to relocation and work-life balance but there are some who leave due to incompatible work relationships.<br>• Most staff leave within the first year of qualifying and the Trust is putting in place some actions, such as a work-buddying system, to help improve staff retention.<br><br>Finance<br>• Dealt with in Finance Report item.<br><br>Caring<br>• Patient Reported Experience Measure (PREM) average response rate (2.4%) remains lower than the local target of 10%. The only exception is Acute Care group who are exceeding this at (18.6%). The Quality Performance Reviews with Care Groups will discuss this and agree some trajectories for improving feedback.<br>• For inpatient services, there are four acute wards that have had lower scores over a few months. The areas contributing to a poor experience are related to the environment which is being addressed, feeling safe, food, involvement of friends and families as much as one wishes, and checking progress with medication all of which are being addressed.<br>• The Trust will be relaunching its 15-steps challenge and its mystery shopper work within the next few months.<br><br>The Board **noted** the Integrated Quality and Performance Report – Month 1. | |
| **TB/21-22/09** | **Finance Report: Month 1**<br><br>The Board received the Finance Report (Month 1), with the following matters highlighted:<br><br>• **Income and Expenditure:** Patient Care Income is reported as agreed with key commissioning organisations. This involved block payments based on historic contractual arrangements in line with planning guidance. Additional costs for COVID-19 is down by £148k and now stands at £211k.<br>• **Agency:** Agency spend for April is consistent with the last four months at £699k in month. Spend was high throughout the last financial year and the pressure is continuing into this financial year. Of this, £41k is directly related to COVID-19. Agency spend cap is set at £2million.<br>• **Cost Improvement Plan:** The Trust is currently working through a new long-term sustainability programme which will support delivery of the savings programme for 2021/22. There are schemes already underway which continue to progress and will bring cash releasing savings whilst the proposed "pillars" approach is embedded within the organisation. The Cost Improvement Plan target will be 4%, which is £7million.<br>• **Capital Programme:** Capital plans were submitted in April in line with the system control total. There is reduced funding available for 2021/22, | |



DRAFT

<table>
<tr><th>Item</th><th>Subject</th><th>Action</th></tr>
<tr><td></td><td>which has resulted in a prioritisation exercise led by the Executive Director of Nursing via the Trust Capital Group. The control total for the coming year is £15.5m for capital, including £4.6m for the nationally funded Eradicating Dormitories project. In April capital spend was £1.4m against a plan of £1.6m with underspends on IT and the Maidstone Mental Health Transformation project.<br>
• Cash: The cash regime in 2020/21 resulted in the monthly block income being paid one month in advance. This in no longer the case for 2021/22 and block income is received in the month it is due. The cash position remains strong at £14.4m, but has reduced by £2.8m, with lower receipts from NHS England and payments against year-end capital creditors.<br><br>
SS highlighted the following areas of concern for the Board’s attention:<br><br>
• There are risks related to the capital programme due to the current allocation of funding. Some of the capital projects may be suspended, although it is hoped that there will be progress on the data centre.<br><br>
Action: For July’s Board meeting, SS to produce a finance report detailing Finance and Performance Committee risks including details of capital control targets and agency spend.<br><br>
Action: TS to invite clinical directors to July’s Board.<br><br>
The Board reflected on the impact that delayed capital projects can have from a patient’s perspective. With the Trust having fewer freehold buildings, there is a risk that the Trust’s underlying deficit will not reduce as there are less buildings to sell.<br><br>
Action: MM to produce a capital projects update regarding those projects that have been agreed, the timescale for completion and the risk ratings connected to each capital project. Paper to be presented to Quality Committee in July 2021.<br><br>
The Board noted the Finance Report (Month 1).</td><td></td></tr>
<tr><td>TB/21-22/10</td><td>MHLDA Improvement Board<br><br>
The Board received the update paper on the Mental Health Learning, Disability and Autism Improvement Board (‘MHLDA Improvement Board’), which set out the headline workplan for each of the 6 priorities as well as progress/performance against defined Key Performance Indicators (KPIs).<br><br>
The MHLD&A Improvement Board is well embedded and progress is being achieved across all the workstreams, outcomes, aims and clear KPIs have been established for all workstreams. Lead organisations have been assigned within the system to provide leadership to ensuring appropriate resources and effective leadership around performance and improvement can be achieved.</td><td></td></tr>
</table>

| Item | Subject | Action |
|---|---|---|
| | The Board noted that the performance results are currently in month results, whereas the targets set are over longer periods, with some targets being over a 3-year period.<br><br>There has also been an increase in mental health service demand across the system, particularly in terms of eating disorders and child & adolescents. The Trust is working with the system to take the workplan forward.<br><br>The Board reflected on the MHLD&A Improvement Board paper. The Board noted that there will be a system-wide dementia strategy that will look at the wider care and support provided to dementia patients. That work is supported by clinical input, but there is also value in using FC's skill and experience from her role within the Alzheimer's Society.<br><br>**Action: HG & AQ to provide a copy of MHLD&A Improvement Board's dementia plan to FC for feedback by July 2021.**<br><br>The Board **noted** the update paper on the MHLDA Improvement Board. The Board will receive a bi-annual update paper on the MHLDA Improvement Board. | |
| **TB/21-22/11** | **In-Patient Establishment Review**<br><br>The Board received the In-Patient Establishment Review ('the Review'), which was taken as read.<br><br>The establishments were reviewed using the Mental Health Optimal Staffing Tool (MHOST), which enables ward-based clinicians to assess patient acuity and dependency, incorporating a staffing multiplier to ensure that ward establishments reflect patient needs in acuity and dependency terms. MHOST also provides the opportunity to benchmark against other trusts.<br><br>The Board noted:<br>• KMPT Safer Staffing fill rates from May 2020 to March 2021 ranged from 106% to 114%, which is within the set standard not to fall below 80% and not above 130%.<br>• Most wards apart from one had high Care Hours per Patient Day (CHPPD) which was influenced by the increased use of therapeutic observation in response to high acuity levels.<br>• Most wards, apart from Mother and Baby Unit and rehabilitation units, had high levels of acuity compared to national benchmarks. Resources deployed reflected the levels of complexity.<br>• There have been significant improvements to the management of the duty rosters, ensuring they are published twelve weeks in advance in line with the People Plan.<br>• The Trust is to have Allied Health Professionals supporting the work on the wards.<br><br>The Board reflected on the Establishment Review, noting that the Trust has a higher level of acuity on the wards when compared with the national picture. This is likely to be linked to the higher proportion of detained patients that the Trust has. | |



DRAFT

| Item | Subject | Action |
|---|---|---|
| | The Establishment Review is informing the Trust regarding the staff roster planning, allowing the Trust to plan at an earlier stage. The Trust is using agency staff to support observations of patients when necessary.<br><br>With a change in the skills mix of staff on the ward, such as more Allied Health Professionals, it may be possible to change the workforce model from two Registered Mental Health Nurses on the ward to just one. This would reflect the wider national picture of a shortage of available Registered Mental Health Nurses.<br><br>To help further, it was recommended that the Trust considers the use of social workers within the Crisis Resolution and Home Treatment Team, which may help reduce the number of patient detentions.<br><br>The Board **noted** the In-Patient Establishment Review. | |
| **TB/21-22/12** | **Tackling the vacancy challenge**<br><br>The Board received a paper on tackling the vacancy challenge, which was taken as read.<br><br>The Board reflected on the national shortage of Specialty Doctors and the impact that is having on the wider Child and Adolescent Mental Health Services, younger adults and older persons services.<br><br>The paper was complimented as presenting a clear picture of the issues and the Board was satisfied with the proposed attempts to tackle the vacancy challenge, many of which are reflected in our 2021/22 Strategy Operational Delivery Plan.<br><br>The Board **noted** the tackling the vacancy challenge paper. | |
| **TB/21-22/13** | **Mental Health Act Committee (MHAC) Chair Report**<br><br>The Board received and **noted** the content of the MHAC Chair report. | |
| **TB/21-22/14** | **Workforce and Organisational Development Committee (WFODC) Chair Report**<br><br>The Board received and **noted** the content of the WFODC Chair report. | |
| **TB/21-22/15** | **Quality Committee (QC) Chair Report (including Q4 Mortality Report)**<br><br>The Board received and **noted** the content of the QC Chair report, which include the Q4 Mortality Report. | |
| **TB/21-22/16** | **Audit and Risk Committee (ARC) Chair Report**<br><br>The Board received and **noted** the content of the ARC Chair report. | |
| **TB/21-22/17** | **Finance and Performance Committee (FPC) Chair Report** | |



DRAFT

| Item | Subject | Action |
|---|---|---|
| | The Board received and **noted** the content of the FPC Chair report. | |
| **TB/21-22/18** | **Board Assurance Framework**<br><br>The Board received the Board Assurance Framework, which was taken as read.<br><br>The Board reflected on the four additional risks:<br>• Risk ID 6623 – Easing of Lockdown National Roadmap - Agile working (Rating 8)<br>• Risk ID 6626 – Development of a Crisis Line (Rating 16)<br>• Risk ID 6628 – Financial Sustainability (Rating 16)<br>• Risk ID 6630 – Implementation of Trust Strategy 2020-2024 (Rating 8)<br><br>**Action: TS to place Board Assurance Framework higher on the Board agenda on the occasions it comes to the Board.**<br><br>The Board **approved** the Board Assurance Framework, including the removal of Risk IDs 6274, 6098, 6428 and 6431. | |
| **TB/21-22/19** | **Any Other Business**<br><br>There was no Any Other Business. | |
| **TB/21-22/20** | **Questions from Public**<br><br>There were no questions from the Public, but feedback on the meeting was given by five senior staff members. | |
| | **Date of Next Meeting**<br><br>The next meeting of the Board would be held on Thursday 24th June 2021. | |

Signed ………………………………………………………….. (Chair)

Date …………………………………………………………..

DRAFT

**Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)**
**Minutes of the Extraordinary Meeting held at 1345 to 1405hrs on Thursday 24th June 2021**
**Via Videoconferencing**

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

| Item | Subject | Action |
|---|---|---|
| **TB/21-22/21** | **Welcome, Introduction and Apologies**<br><br>The Chair welcomed all to the Extraordinary Board meeting, which had been called to allow for the review and approval of the Trust's Year-End Documentation.<br><br>Apologies were received from PC.<br><br>The Extraordinary Board meeting was livestreamed to allow members of the public to join. | |
| **TB/21-22/22** | **Declarations of Interest**<br><br>There were no declarations of interest. | |



DRAFT

| Item | Subject | Action |
|---|---|---|
| TB/21-22/23 | **Year End Documentation**<br><br>The Board received the Year End Documentation:<br>• Annual Report (including Annual Governance Statement)<br>• Annual Accounts<br>• External Auditors report<br>• Letter of Representation<br><br>The Board noted that the Trust had delivered its statutory obligations and a break-even position. The auditing process had gone well and although there were some further minor disclosures required by the Trust's External Auditors, these were not material.<br><br>The Trust's Audit and Risk Committee had reviewed the Year-End documentation on two occasions and on the final review of the documentation, the Committee agreed to recommend approval of the Year-End Documentation.<br><br>The Board **approved:**<br>• Annual Report (including Annual Governance Statement),<br>• Annual Accounts,<br>• External Auditors; and<br>• Letter of Representation.<br><br>Following approval, signatories will sign the Year-End documentation as required.<br><br>The Board complimented the Trust for its work that led to a smooth auditing process and approval of the Trust's year end documentation. The Board also thanked service users and carers who have helped KMPT improve its services.<br><br>As a matter arising, the Chair reminded Board members that the governance process continues with Annual Board and Committee effectiveness surveys to be circulated by the Trust Secretariat within the next few days. | |
| | **Date of Next Meeting**<br><br>The next meeting of the Board would be held on Thursday 29th July 2021. | |

Signed ………………………………………………………….. (Chair)

Date ……………………………………………………………..



DRAFT

NHS
Kent and Medway
NHS and Social Care Partnership Trust

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 22/072021**

| Key | DUE | IN PROGRESS | NOT DUE | CLOSED |
|---|---|---|---|---|

| Meeting Date | Minute Reference | Agenda Item | Action Point | Lead | Date | Revised Date | Comments | Status |
|---|---|---|---|---|---|---|---|---|
| **ACTIONS DUE IN JULY 2021** | | | | | | | | |
| 27.05.2021 | TB/21-22/05 | Action Log and Matters Arising | By June 2021, VB2 to send TS a copy of the accessible three-page summary of the Organisational Strategy for circulation to the Non-Executive Directors (NEDs). | TS | June 2021 | | | CLOSED |
| 27.05.2021 | TB/21-22/07 | Chief Executive's Report | MM to produce a paper detailing the Terms of Reference for the Healthy Ward initiative. The paper will be submitted to the Quality Committee by July 2021. | MM | July 2021 | September 2021 | MM has discussed item with AMD, with an agreed plan on how the initiative will be taken forward. The plan will be taken to QC in September. | In Progress |
| 27.05.2021 | TB/21-22/09 | Finance Report: Month 1 | For July's Board meeting, SS to produce a finance report detailing Finance and Performance Committee risks including details of capital control targets and agency spend. | SS | July 2021 | | | Complete |
| 27.05.2021 | TB/21-22/09 | Finance Report: Month 1 | TS to invite clinical directors to July's Board. | TS | July 2021 | | | Complete |
| 27.05.2021 | TB/21-22/09 | Finance Report: Month 1 | MM to produce a capital projects update regarding those projects that have been agreed, the timescale for completion and the risk ratings connected to each capital project. Paper to be presented to Quality Committee in July 2021. | MM | July 2021 | September 2021 | As of July 2021, indications are that there will not be any additional capital funding from the Kent and Medway Board ICS. MM and Director Estates are reviewing the capital projects plan in light of that information. | In Progress |
| 27.05.2021 | TB/21-22/10 | MHLDA Improvement Board | HG & AQ to provide a copy of MHLD&A Improvement Board's dementia plan to FC for feedback by July 2021. | HG | July 2021 | | Sent on 22.07.2021 to FC | Complete |
| **ACTIONS NOT DUE OR IN PROGRESS** | | | | | | | | |
| 27.05.2021 | TB/21-22/08 | Integrated Quality and Performance Report (IQPR) – Month 1 | JMG to produce a paper setting out the Trust's plans for the Memory Assessment Service for the short term. Paper to be presented to the Board by September 2021. | JMG | September 2021 | | | Not due |
| **CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS** | | | | | | | | |

**BOARD OF DIRECTORS ACTION LOG**
**UPDATED AS AT: 22/072021**

| Key | DUE | IN PROGRESS | NOT DUE | CLOSED |
|---|---|---|---|---|

| Meeting Date | Minute Reference | Agenda Item | Action Point | Lead | Date | Revised Date | Comments | Status |
|---|---|---|---|---|---|---|---|---|
| 28.01.2021 | TB/20-21/148 | Chief Executive's Report | TS to invite Justine Norris MBE, Occupational Therapist, to present her Personal Story at a Board meeting in Spring 2021. | TS | April 2021 | | Justine Norris has confirmed attendance | Closed |
| 25.03.2021 | TB/20-21/185 | Strategy Delivery Plan 2021/22 | The Executive Management Team will adjust Strategy Delivery Priorities 3a to 3c (as detailed within the Strategy Delivery Plan) by end of April 2021 for the Trust Chair's approval. Approval to be received outside of the meeting. | EMT | April 2021 | | EMT action is complete and the updated document has been signed off by the Chair/ CEO and circulated to the board . | Closed |
| 25.03.2021 | TB/20-21/188 | Recovery and Transform Update | TS to schedule a Board Seminar on Crisis Services by April 2021. The Board Seminar is to take place before the end of July 2021. | TS | April 2021 | | Seminar to take place in June 2021 | Closed |

| Title of Meeting | **Board of Directors (Public)** |
|---|---|
| Meeting Date | **Thursday 29th July 2021** |
| Title | **Chair's Report** |
| Author | **Dr Jackie Craissati, Trust Chair** |
| Presenter | **Dr Jackie Craissati, Trust Chair** |
| Purpose | **For Noting** |

## 1. Introduction

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

- Board meetings
- System-wide Meetings
- Staff Mental Health and Wellbeing Hubs
- NED visits
- Congratulations

## 2. Board Meetings

We have agreed as a Board to move to bimonthly Board meetings, as from May 2021, and we will review this change in 2022. The aim is to allow more time for the Executive team to embed actions from previous meetings, as well as scope to ensure that papers can draw on the latest data, test its accuracy and provide good quality analysis. Some of the Board committees are adopting the same strategy.

We have also agreed – once infection control guidelines for Covid have been relaxed – that we will alternate virtual and in person Board meetings, the latter taking place around the county on a rotational basis.

## 3. System-wide meetings

In addition to the usual meetings across the Integrated Care System (ICS), there have been two issues of particular note over the past two months. On 10th June I attended the first of several workshops for ICS and Health and Wellbeing Board leaders on Health Inequalities. This is a hugely important issue for all the people of Kent and Medway and a priority for the ICS.

For those of us working in mental health, it is an area of key concern given the impact of social factors on population well-being and resilience generally, but more specifically, the impact of social adversity on the health outcomes for people with a serious mental illness. I anticipate this becoming a very regular focus of our Board work over the next one to two years.

The second issue of note is that on 28th June we signed of the Kent and Medway system development and transition plan, for submission to NHS England. This sets the vision and blueprint for ICS working over the next few years.

## 4. Staff Mental Health and Wellbeing Hubs

The staff mental health and wellbeing hubs have been set up by NHSE/I to provide health and social care colleagues rapid access to assessment and local evidence-based mental health services and support where needed. The hub offer is confidential and free of charge for all health and social care staff and we have established a Kent & Medway hub.

The hubs can offer a clinical assessment and referral to local services enabling access to support where needed, such as talking therapy or counselling. It is separate and confidential from a staff member's own organisation. It is open to all health and social care staff, from all services and settings regardless of whether staff are dealing directly with COVID-19 patients or not. Staff can self-refer or refer a colleague (with their consent).

## 5. Trust Chair and NED visits

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

| Where | Who |
|---|---|
| **June 2021** | |
| Maidstone Hospital Psychiatric Liaison Team | Trust Chair |
| Quality and Performance meetings for the Older Adult care group and Forensic & Specialties care group. | Trust Chair |
| Senior Psychology Team | Trust Chair |
| Senior Allied Health Professional Team | Trust Chair |
| **July 2021** | |
| Swale Community Mental Health Team | Catherine Walker |
| Medway CMHT | Mickola Wilson |
| Spoke at the Leaders Event | Trust Chair |
| Ashford (William Harvey) Psychiatric Liaison Team | Trust Chair |
| Patient safety Team | Trust Chair |
| Ashford 111 Call Centre | Trust Chair |
| Folkestone Community Mental Health Team | Trust Chair |
| Spoke at the Big Conversation | Trust Chair |

**Chair visits**

I undertook a number of visits over the past two months, some of which were virtual, but others in person. I will summarise some of the themes that emerged for me as a result of these visits.

- I was universally welcomed with warmth and openness, and we had frank and informative discussions. This is greatly to the credit of staff, and I thank them for their generosity at a time of great pressure.
- It is very noticeable how a specialised role – such as liaison psychiatry – fosters good morale and excellent staff retention.
- I cannot emphasise enough what a strong impression is given by friendly and helpful reception staff, and I had a good experience of this on more than once occasion, despite a rather shabby physical environment.
- There seem to be strong allegiances within teams, although this brings the risk of operating as a bit of a bubble and separate from the rest of the Trust. Where services are co-located, then relationships and the pathway between them appear to be excellent. However, overall there was a sense that we could build stronger links horizontally (across similar teams throughout the trust), and along clinical pathways, as well as vertically (with senior management), particularly in communicating key concerns held by the board, and also learning from incidents.
- We continue to burden staff with well-intentioned but onerous bureaucracy, often as a result of actions that are undertaken in response to serious incidents. Different teams noted the extent to which they are drawn away from clinical work for extended periods of time.

**July 2021**

**Mickola Wilson's visit to Medway CMHT on 13th July 2021**

The team comprised 2 consultants and a psychotherapist, 2 team leaders and nurses observing the meeting.

The meeting was reviewing individual patients and their treatment pathways, in most cases this was to agree the initial intervention and 4-week referral plan.

The meeting was very efficient, each patients' notes were reviewed and a decision on the pathway made in 5 to 10 minutes.

The team were, as always very sympathetic and concerned about the patient wellbeing, although the review process seemed a little impersonal.

As a side issue the room was very noisy because of the building works outside and it was also very cold so I will raise this with the Estates Team.

**Catherine Walker's visit to Swale CMHT on 14th July 2021**

Staff shortages and departure were discussed. The high volume of referrals and acuity of some of these was in part counterbalanced by the number of referrals from SPOA and other sources which were thought to be more suited to primary care.

## 6 Congratulations

KMPT's Procurement Team has been shortlisted in two finalist categories in the UK National GO Awards (for COVID-19 outstanding response, and for team of the year). We wish them the very best with this competition.

Congratulations to James Osborne, Consultant Psychologist, who has been appointed by NHS England for one day a week in a clinical leadership role to support the delivery of the Community Mental Health Framework transformation across the South East England region. This is a great achievement of James' and very helpful for KMPT.

# Chief Executive Board Report

**Date of Meeting:** 29 July 2021

## Introduction

In common with other similar NHS trusts nationally, activity and acuity has remained high across the organisation. Our community teams and inpatient wards continue to experience an increase in demand for their services making it imperative that we use every single resource available to us to the very best effect.

## Covid-19

Whilst the easing of restrictions nationally is welcomed, in KMPT we remain focused on not only protecting our service users and staff, but protecting the benefits realised through new ways of working as a result of the pandemic. Key amongst them is increased access for patients, and improved flexible working for our staff. We have also seen significant cost savings through reduced travel.

Our Agile Working Group, led by the Deputy Chief Executive is ensuring that we retain the improvements, hone our approach and create new opportunities to work even more efficiently and effectively.

## Tackling the Vacancy Challenge

This new task and finish group established by the Chief Executive in May, has now met three times. Its focus is to support the significant work already in train, aimed at ensuring that we attract and retain the very best people, improving the quality of what we do, and making KMPT a great place to work and to receive care. The group's work is reported to the Workforce and Organisational Development Committee and detail of the improving picture will be shared with the board towards the end of this calendar year.

## Visiting Services in Person

The executive team has been increasing visits in person over recent weeks and the opportunity to meet colleagues and those who use our services face to face once again has been warmly welcomed by everyone.

Visits in person made by the Chief Executive since the last board meeting include an evening visit to Ashford Psychiatry Liaison at William Harvey Hospital, a Working With Day with Swale Community Mental Health Team, an all day visit to our services on the Medway Maritime Hospital (Ruby Ward, Newhaven Lodge and the Disablement Services) Our services at Highlands House were also visited as was The Beacon in Ramsgate, our services in Thanet on the Queen Elizabeth the Queen Mother Hospital site (Thanet Community Mental Health Team, Liaison Psychiatry and Woodchurch ward).

Our Crisis Response Home Treatment Teams have asked that the executive team visit them over coming weeks and a programme is in development. Demands for their services have been consistently high during the pandemic and an opportunity to hear directly from them about the remarkable and often lifesaving work that they do will be invaluable.

**The Year of the Community Mental Health Team**

As part of the Chief Executive's commitment to sponsor a focus on our community services and their transformation, a programme that will ensure that every team is visited at least once by the Chief Executive in the coming months is well underway. This programme of visits ensures that there is time to meet as many colleagues as possible, across all team roles, helping to shape and inform the improvement programme (the three Ss launched earlier in the year). The Chief Executive's open letter to the teams is attached for the board's information.

**KMPT Sponsored Medical Student**

Executive Medical Director Dr Afifa Qazi and the Chief Executive were delighted to meet for the first time, KMPT's own sponsored medical student. Mimoza Osmani, is nearing the end of her first year and shared some of her experience and reflections on what has been a truly remarkable experience. Mimoza will be invited to join the board for a future meeting.

**Appointment of Clinical Directors**

After a rigorous selection process, KMPT's first five Care Group Clinical Directors have been appointed. These important appointments mark a significant step up in ensuring that clinical leadership is front and centre of the organisation. Working in partnership with their Head of Service, the Clinical Directors will be setting the pace and agenda in their areas, ensuring that the high standards we all ascribe to, are consistently met or exceeded.

Dr Vijay Delaffon – Acute
Dr Efiong Ephraim – Older Adults
Dr Sohail Tariq – Forensic
Dr Mo Eyeoyibo – Community Specialist
Dr Kirsten Lawson – Community Mental Health Teams

**Clinical Lead Community Mental Health - NHS-E/I**

We were pleased to learn that KMPT's Dr James Osborne had been appointed to a newly established regional NHSE/I role. The role will involve James working with the South East NHS-E/I team to deliver the Community Mental Health Framework transformation across the South East region's six Integrated Care Systems. He will be providing clinical leadership and support to systems and providers, as well as making strong national links. This is an important appointment for James and for KMPT. We offer him our congratulations and an invitation to share his work with the board at a later date.

**Annual Accounts and Annual Governance Statement**

All documents were submitted on time and to plan in June, following scrutiny by both our auditors and the Audit and Risk Committee.

**Urgent and Emergency Care – June Board Seminar**

As part of its rolling programme of conversations with frontline staff from a wide range of disciplines, the June Board Seminar took the form of a workshop focusing on the successes and challenges in our Urgent and Emergency care services. A series of actions were agreed as a result of the workshop, and an update on progress and changes made as a result, will be shared with the board in six months' time.

**Healthy Wards Initiative**

A number of issues have been shared with board members on visits to some wards. The quality, choice and portion size of food served as well as the consistent availability of enjoyable and engaging activity programmes for patients seven days a week stand out as themes. In order to address these at pace, the Chief Executive asked the Executive Director of Nursing to lead a piece of work to deliver improvements. To this end, the Healthy Wards initiative has been established. Supported by a sponsoring Non-Executive Director it is anticipated that the group will drive speedy improvements where they are needed, and report to the Quality Committee.

**Integrated Care System (ICS) Design Framework**

This long-awaited document was published in early July and sets out the expectations of the Integrated Care System infrastructure. The Board will be joined today in its seminar to explore this further with the Kent and Medway ICS Accountable Officer Wilf Williams.

**KMPT Innovations Fund Launch**

The executive team has identified £50k which will be used to create an innovations fund. The fund will be open for individual members of staff or teams to apply for up to £5k at a time in order to support an innovation or idea that they can demonstrate might improve quality and reduce cost. The first bids will be considered in October with a panel which will include a Non-Executive Director.

Chief Executives Office
Trust Headquarters
Farm Villa
Hermitage Lane
Maidstone
Kent
ME16 9PH

Tel: 01622 724126
Website: www.kmpt.nhs.uk

An Open Letter for all CMHT & CMHSOP Colleagues. Please Share it Widely

Our Ref: HG

30 June 2021

Dear Everyone

**Re Making This The Year of CMHTs and CMHSOPs – An Update and Next Steps**

I think you all know that a number of colleagues from CMHSOPs and CMHTs joined the board at the end of April for a seminar discussion about the challenges and opportunities that our community teams across KMPT face.

Attached as an appendix is the list of those who joined the meeting so that you can see who was with us.

As a result of that seminar, the board agreed that making the community mental health teams (adult and older adult) a top priority for the next twelve months, will make sure we change things for the better and sustain the improvement

Since the seminar, I and my team have had many conversations with community team colleagues and I wanted to share with you our thoughts, and importantly, ask for your feedback.

I think that there are three headings that will help us agree what needs to happen next and then to get on with it. I've set out the three headings below, along with examples (not an exhaustive list, just a few examples) of the sort of thing we need to work on.

1. Staffing
    - Reviewing our establishments and making sure that we have the right posts in the right place
    - Sharpening our recruitment, being more creative, finding people in new places
      Creating new roles

2. Streamlining
    - Stopping things that don't add value
    - Streamlining our systems making it quick and easy to get things done
    - Removing the additional layers that slow us down in some of our processes

3. Specialism
    - Making it clear that community work is a specialism in its own right
    - Establishing a network of good practice sharing at local and national level
    - Making sure that all community staff have access to the training and development that they need

Some of this work has already started, but there is much more to come. I firmly believe that with your ideas, feedback, commitment and creativity we can make the community teams the place to be; the specialist service that everyone wants to join.

Over the next twelve months I will be coming to spend time with every single community team. I want to hear directly from you all about whether the things that we are changing, are making a positive difference to you, your colleagues and your clients. If they're not then we will think again and change what we are doing.

Finally, we will be sharing with you all soon, details of a special event taking place in May next year, marking twelve months from the start of this, our year of focus. Our first ever Community Mental Health Day of Celebration will be an all day, in person event for as many community mental health staff as we can gather together. The day will showcase and celebrate the brilliant specialist service that you, our community colleagues provide.

With Best Wishes

Yours sincerely

**Helen Greatorex**

**Chief Executive**

**Attendees :**

Teresa Barker – Head of Service for Older Adult Care Group

Alex Court – Senior Clinical Psychologist

Dr Sheeba Hakeem – Consultant Old Age Psychiatrist

Dr Efiong Ephraim – Consultant Psychiatrist

Louise Coppin – Consultant Psychotherapist

Dr Lola Osoba – Consultant

Amanda Hatfield-Tugwell – Locality Manager

Louise Gascoyne – Lead AHP (CRSL)

Clare Lux – Service Manager

Dr Kirsten Lawson – Consultant Psychiatrist

Mark Kitchenham – Trainee Advanced Clinical Practitioner

Sarah Trainor – Specialist Practitioner / Team Leader

# TRUST BOARD MEETING – PUBLIC

## Meeting details

**Date of Meeting:** 29th July 2021

**Title of Paper:** Integrated Quality and Performance Report (IQPR)

**Author:** All Executive Directors

**Executive Director:** Helen Greatorex, Chief Executive

## Purpose of Paper

**Purpose:** Discussion

**Submission to Board:** Standing Order

## Overview of Paper

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

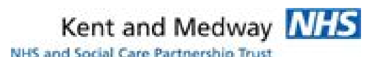
## Issues to bring to the Board's attention

The Trust's Business Intelligence System allows it to capture against a range of national and/or local targets that fall within the CQC's five domains. In April 2021 (the period covered by this report) it can be seen that bed usage remains under pressure. There was an increase in the number of patients presenting with very high acuity, which in turn caused an increase in the use of inappropriate out of area bed days, an increase in Lengths of Stay and Delayed Transfers of Care.

The Trust is carrying out an overarching bed stock review, which will be completed in October 2021. In the interim, clinical leadership across the Trust has been strengthened through the appointment of five Clinical Directors to ensure that care pathways work effectively.

Strengthened clinical leadership will also mitigate performance issues within the Trust's Community Mental Health Teams and the Community Mental Health Services for Older Persons where demand continues to exceed capacity. Older Adult 4 week wait for assessment has consistently been below target for five successive months impacted by the Memory Assessment Service. The system work on dementia is beginning to consider options to improve this standard with KMPT older adults' services engaging fully.

The Trust continues to work with its system partners to improve performance and is working consistently to improve capacity. Short to medium-term, this includes the use of agency staff which will continue until the Trust's work on recruitment and retention begins to take effect. In April staff turnover increased from 9.4% to 10.1%. The continued commitment of KMPT staff as evidenced by the Trust's overall staff




sickness rate remaining below target for the third successive month at 3.7% - is borne out by the majority of patients continuing to rate the Trust as delivering “very good” experience in the quality of their care.

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

## Governance

| | |
|---|---|
| **Implications/Impact:** | Regulatory oversight by CQC and NHSE/I |
| **Assurance:** | reasonable |
| **Oversight:** | Oversight by Trust Board and all Committees |

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

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

| Issues of Concern |
|---|
| **Lower rate of incident reporting, including near misses**<br>There has been variation in incident reporting, some of which may be linked to impact of COVID - 19 with a downward trend over the last year which has been noted in national benchmarking. The aim would always be to have an upward trajectory and to ensure that all incidents regardless of level of harm are reported, which signifies a positive safety culture. Work is underway to support teams with increasing incident reporting. This will be further facilitated by changes to the incident reporting system due to be implemented in the autumn. Approaches used to drive up incident reporting as part of a previous quality account priority where we saw significant improvement will also be reinforced and monitored through our governance processes to ensure positive impact. |

**Executive Commentary**

**Restrictive interventions** (011-013.S)
There has been a decrease in restrictive interventions, including use of seclusion, rapid tranquilisation and all restraints, the latter is lowest year to date (88 incidents compared to 159 in August 2020). All restrictive interventions are used as a last resort and are carefully monitored to ensure they are used for a minimum period possible. The work on the 2021/22 Quality Account priority focused on assessing risks of violence and aggression using the Broset Violence Checklist and implementing Safe Wards initiative has shown positive outcomes related to reduction in restrictive interventions on some participating wards. The Trust wide roll out continues with the aim of implementing this across all wards by the end of the financial year.

**Prone restraints** - all prone restraint incidents (4) occurred in the acute care group and involved different patients. No physical harm was reported following the restraints however some minor staff injuries were reported following use of seclusion. Post incident debriefs and support were offered and were facilitated in line with policy.

# IQPR Dashboard: Safe

| Ref | Measure | SoF | Target | Local / National Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 001.S | Occurrence Of Any Never Event | ✓ | 0 | N | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 002.S | CPA Patients Receiving Formal 12 Month Review | | 95% | N | 95.9% | 96.0% | 95.6% | 95.9% | 97.1% | 97.1% | 96.4% | 96.4% | 95.5% | 95.8% | 94.7% | 94.5% |
| 003.S | % Inpatients With A Physical Health Check Within 72 Hours | | 90% | L | 95.8% | 97.0% | 95.4% | 97.5% | 94.3% | 95.2% | 95.8% | 92.9% | 96.4% | 96.2% | 96.5% | 98.8% |
| 005.S | Number Of Unplanned Absences (AWOL and Absconds on MHA) | | - | - | 19 | 16 | 17 | 21 | 13 | 15 | 26 | 8 | 22 | 17 | 18 | 20 |
| 006.S | Serious Incidents Declared To STEIS | | - | - | 20 | 24 | 15 | 17 | 11 | 23 | 23 | 15 | 21 | 24 | 16 | 13 |
| 007.S | % Serious Incidents Declared To STEIS within 48 hours | | - | - | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| 008.S | Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days | | 0 | L | 3 | 8 | 17 | 12 | 20 | 14 | 5 | 0 | 5 | 2 | 4 | 5 |
| 010.S | All Deaths Reported On Datix And Suspected Suicide | | - | - | 232 | 218 | 140 | 134 | 232 | 225 | 275 | 178 | 155 | 150 | 77 | 146 |
| 011.S | Restrictive Practice - All Restraints | | - | - | 129 | 159 | 132 | 146 | 105 | 96 | 114 | 106 | 146 | 103 | 145 | 88 |
| 012.S | Restrictive Practice - No. Of Prone Incidents | | 0 | L | 1 | 10 | 13 | 11 | 6 | 3 | 10 | 3 | 6 | 4 | 8 | 4 |
| 013.S | Restrictive Practice - No. Of Seclusions | | - | - | 22 | 32 | 22 | 29 | 32 | 17 | 16 | 8 | 24 | 12 | 21 | 21 |
| 015.S | Ligature Incidents - Ligature With Fixed Points (moderate to severe harm) | | 0 | L | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | |
| 016.S | Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm) | | - | - | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 017.S | RIDDOR Incidents | | - | - | 2 | 2 | 4 | 4 | 1 | 1 | 2 | 0 | 3 | 2 | 6 | 0 |
| 018.Sa | Infection Control - MRSA bacteraemia | | 0 | N | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 018.Sb | Infection Control - Clostridium difficile | | | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 019.S | Safer staffing fill rates | | 80% | L | 114.7% | 114.5% | 111.9% | 111.2% | 109.4% | 106.5% | 106.0% | 104.3% | 108.8% | 108.9% | 110.1% | 110.7% |
| 020.S | Unplanned Readmissions within 30 days | | 8.8% | L | 7.0% | 14.1% | 11.6% | 8.2% | 8.5% | 6.3% | 8.1% | 7.7% | 5.2% | 6.3% | 4.2% | 3.8% |

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

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

| Issues of Concern |
|---|
| DTOC - This is an area of continued focus and is being addressed by joint work with KCC and Commissioners led by the KMPT Chief Operating Officer. |

**Executive Commentary**

The highlight of this month is the successful appointment of Clinical Directors (CDs) in all Care groups. The Clinical Directors started in their posts on 15 July 2021 and working collaboratively with the Heads of Service they will provide robust Clinical Leadership across the organisation. They will take charge of driving up quality and safety at care group level and will drive the implementation of the Care Pathways in all Care Groups.

June saw a significant increase in acute in patient bed usage through increased admissions and patient acuity; this is being robustly monitored by the patient flow team and despite additional measures put in place such as consultant ward rounds over weekends our out of area bed usage for adult patients saw a surge. Positively as of the 20th of July there are zero adult patient in an out of area acute bed (except female PICU). In order to look at a holistic picture of bed usage and identify sustainable solutions the Deputy Chief Operating Officer for Patient Flow is completing an overarching bed stock review, which will be completed in October 2021. This work has three work streams: demand and capacity, discharge process and alternatives to admissions. A detailed bed paper is being reviewed at Finance and Performance Committee this month.

Older Adult wards have seen a reduction in the previous very high length of stay with additional clinical support via the Clinical Director for Older Adults and Head of Service. This is monitored by the Executive Medical Director.

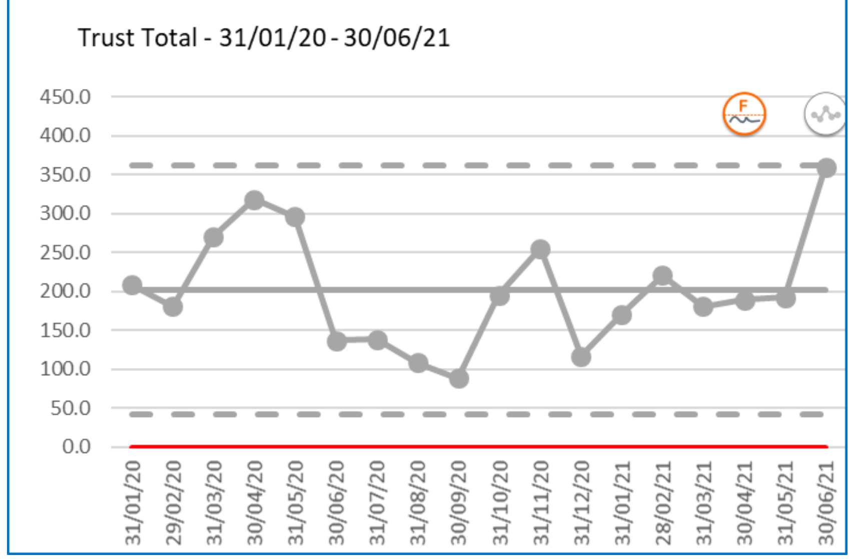
Delayed Transfers of Care (DToC) across all wards remains static, however on review they are on par with the national average for Mental Health trusts which on average is about 8%, in June KMPT DToC was 8.4%. This is an area of continued focus and is being addressed by joint work with KCC and Commissioners led by the KMPT Chief Operating Officer.

We have been successful in recruiting Dr Mudasir Firdosi, Consultant Psychiatrist and Senior Lecturer from St George's as our Clinical Director for Quality Improvement (QI). He will be joining KMPT on the 15th of Sept; he will provide robust clinical oversight to our QI ambition and will embark on a journey of engaging clinicians from all professional backgrounds into our QI programme. This appointment marks the commitment of the organisation to embed QI from ward to board and to enable us to deliver high quality evidence-based care to our population.

| | 005.E: Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Acute | | | 136.0 | 0.0 | -17.8 | 71.4 | 26.8 |
| 2 | OPMH | | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| 3 | PICU | | | 224.0 | 0.0 | 24.9 | 330.3 | 177.6 |
| 4 | **Trust Total** | | | 360.0 | 0.0 | 41.2 | 361.7 | 201.4 |

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

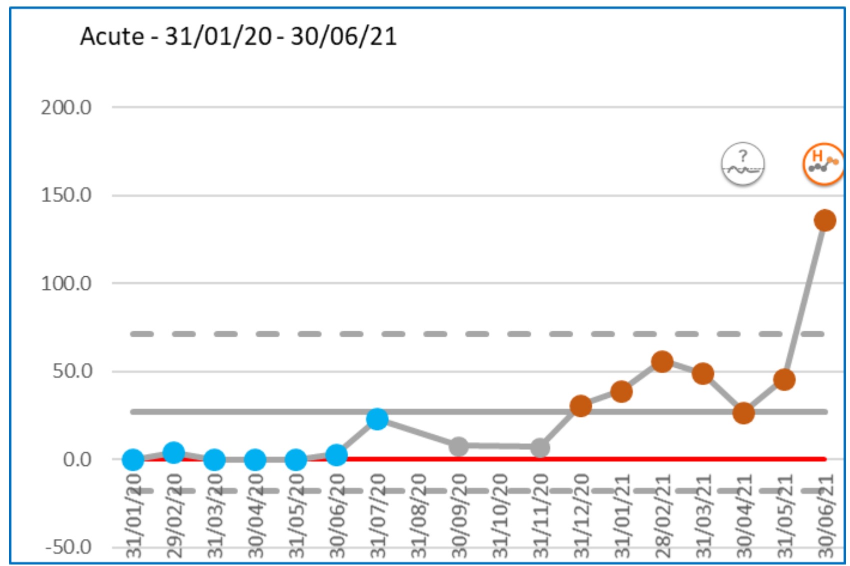
The total out of area placement bed usage was very high at 360 bed days in June. This is a mix of 224 PICU bed days and 136 Younger Adult Acute bed days. It remains female PICU driving the PICU rates with a review in place to consider if this is a likely onward trend post Covid. This only slightly falls short of the upper control limit following a consistent level for the previous 3 months as shown in the SPC chart below.




There was a marked increase in Adult acute out of area placements in June which saw increased demand for admission with patients presenting with very high acuity, impacting also on length of

stay. The patient flow team put in additional measures to ensure effective discharge planning is in place despite which we had to rely on a small number of out of are beds (an average of 5 at any given time). The bed challenge is consistent with a national picture of high acuity with increased demand for admissions and bed shortages.

The increase is partly a result of the previous contract for additional capacity expiring for this patient group, despite this Acute external bed days *(regardless of if counted as an external placement)* in June were at the highest position since January 2017.




| | 015.E: % Of Patients on CPA With Valid Care Plan | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Acute | | | 71.9% | 95.0% | 72.0% | 85.2% | 78.6% |
| 2 | CRCG | | | 88.6% | 95.0% | 88.9% | 93.0% | 91.0% |
| 3 | FSS | | | 94.8% | 95.0% | 92.4% | 98.1% | 95.3% |
| 4 | OPMH | | | 97.3% | 95.0% | 94.7% | 99.2% | 97.0% |
| 5 | Trust Total | | | 89.9% | 95.0% | 90.2% | 93.8% | 92.0% |

| | 017.E: % Non CPA Patients with a Care Plan or PSP | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | CRCG | | | 68.4% | 95.0% | 67.7% | 73.7% | 70.7% |
| 2 | FSS | | | 82.3% | 95.0% | 57.2% | 73.5% | 65.4% |
| 3 | OPMH | | | 68.2% | 95.0% | 64.1% | 73.6% | 68.8% |
| 4 | Trust Total | | | 74.4% | 95.0% | 64.3% | 71.8% | 68.0% |

| Interpretation of results (Trust wide) | |
|---|---|
| **Variation** | Special cause of **concerning** nature or higher pressure due to **lower** values<br>Special cause of **Improving** nature or higher pressure due to **higher** values |
| **Assurance** | Variation indicates consistently **failing short of target** |

| Narrative |
|---|
| New care planning measures were introduced into the IQPR for 2021/22. As an output of the Data Quality Group new measures 015.E and 017.E have split the CPA care planning out from the Non CPA which is inclusive of the new Personal Support Plan (PSP) in use across the CMHTs for patients not subject to CPA.<br><br>Over the new measures we are seeing incremental upward trends in both metrics with 12 month consecutive improvement for PSP standards moving from 55% in July 2020 to 74.4% in June 2021.<br><br>Of note over the coming year CPA will be designed out of Mental Health care and the Trust Care Planning Group is reviewing options for a single care planning process for all patients requiring KMPT care. The Trust will continue to report on CPA until new metrics are agreed locally with the health system.<br><br>Distribution of care plans remains a major challenge and whilst very small month on month improvement it does not have the traction needed. The care planning group has tasked the clinical leads for the Care Groups to review the reason for the gaps, which appears to be mostly a recording issue rather than people not being given their plan.<br><br>Ongoing performance monitoring is in place at team and care group level. |

| | 012.E: Average Length Of Stay (Younger Adults) | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Amberwood Ward | | | 56.0 | 25.0 | -9.7 | 57.7 | 24.0 |
| 2 | Bluebell Ward | | | 18.2 | 25.0 | 2.7 | 69.4 | 36.1 |
| 3 | Boughton Ward | | | 51.3 | 25.0 | -6.4 | 68.2 | 30.9 |
| 4 | Chartwell Ward | | | 20.4 | 25.0 | -10.8 | 65.4 | 27.3 |
| 5 | Cherrywood Ward | | | 21.6 | 25.0 | 4.5 | 45.7 | 25.1 |
| 6 | Fern Ward | | | 45.6 | 25.0 | -4.4 | 71.2 | 33.4 |
| 7 | Foxglove Ward | | | 25.0 | 25.0 | -6.0 | 66.2 | 30.1 |
| 8 | Pinewood Ward | | | 56.4 | 25.0 | -4.5 | 63.3 | 29.4 |
| 9 | Upnor Ward | | | 25.1 | 25.0 | 4.0 | 48.2 | 26.1 |
| 10 | YA Acute | | | 33.9 | 25.0 | 17.1 | 39.7 | 28.4 |

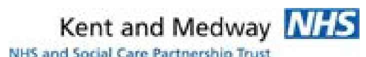
| Interpretation of results (Trust wide) | |
|---|---|
| Variation | Common Cause - no significant change |
| Assurance | Variation indicates **inconsistently** hitting or failing short of target |
| Narrative | |

Historically this target has consistently been met by the Acute Care Group for Younger Adult (YA) bed days. Following three months below 28 days in line with historic levels of LoS, the position for June 2021 increased to 33.9 days. Variation continues to exist across the younger adult wards, and is easily skewed by a few patients who are on the ward for excessive periods of time being discharged as numbers are small for each ward. Amberwood and Pinewood wards both had a LoS of 56 days in month, there were 4 discharges with a LoS in excess of 200 days between these two wards. Many of those who stay for long periods of time will be those who are delayed transfers. The lack of suitable onward care is generally the main issue and there are a number of actions in place to try to improve this position.

Whilst the Trust operates a needs led approach to in-patient admissions we continue to report against older and younger adult wards. The Older Adult Wards LoS had been increasing and peaked 102 days for April rather than the required 52 days. May and June saw a decrease to 61.6 and 65.8 days respectively bringing the 12 months average to 69.3 days. This impacts on bed availability for older adults who need in-patient care. Due to the low number of discharges per month OPMH LoS needs to be viewed over a longer period of time, e.g. 3-month average.

# IQPR Dashboard: Effective

| Ref | Measure | SoF | Target | Local / National Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 001a.E | Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days | ✓ | 95% | N | 97.6% | 95.5% | 98.2% | 98.0% | 97.8% | 98.7% | 96.5% | 98.9% | 98.3% | 98.9% | 97.3% | 97.8% |
| 001b.E | CPA patients receiving follow-up within 72hours of discharge | | | | 87.1% | 83.1% | 88.8% | 90.3% | 89.3% | 87.5% | 88.8% | 90.9% | 88.4% | 86.7% | 84.0% | 82.7% |
| 004.E | Data Quality Maturity Index (DQMI) – MHSDS Dataset Score | ✓ | 95% | - | 95.0% | 95.4% | 95.2% | 95.4% | 95.4% | 95.6% | 95.6% | 95.7% | 95.8% | 95.8% | 96.0% | 95.9% |
| 005.E | Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) | ✓ | - | - | 138 | 108 | 88 | 195 | 255 | 117 | 171 | 221 | 181 | 189 | 192 | 360 |
| 006.E | Delayed Transfers Of Care | | 7.5% | L | 6.8% | 6.4% | 8.1% | 10.7% | 12.7% | 11.9% | 10.5% | 9.2% | 8.5% | 8.7% | 8.6% | 8.4% |
| 011.E | Number Of Home Treatment Episodes | | 224 | L | 204 | 219 | 225 | 248 | 234 | 192 | 189 | 220 | 250 | 241 | 270 | 291 |
| 012.E | Average Length Of Stay(Younger Adults) | | 25 | L | 24.74 | 18.30 | 26.25 | 25.29 | 33.11 | 35.75 | 36.25 | 31.78 | 27.75 | 25.94 | 26.42 | 33.92 |
| 013a.E | Average Length Of Stay(Older Adults - Acute) | | 52 | L | 57.98 | 49.32 | 66.31 | 64.35 | 64.90 | 92.21 | 69.97 | 76.09 | 70.97 | 101.79 | 61.63 | 65.75 |
| 015.E | %Patients with a CPA Care Plan | | 95% | L | 93.3% | 92.8% | 93.1% | 93.0% | 92.5% | 93.0% | 91.8% | 91.0% | 89.4% | 89.9% | 88.7% | 89.5% |
| 016.E | % Patients with a CPA Care Plan which is Distributed to Client | | 75% | L | 16.2% | 16.1% | 17.7% | 19.6% | 22.6% | 24.3% | 26.1% | 29.9% | 39.3% | 50.9% | 52.3% | 53.8% |
| 017.E | %Patients with Non CPA Care Plans or Personal Support Plans | | 95% | L | 55.9% | 53.4% | 53.5% | 56.1% | 59.6% | 60.8% | 62.0% | 66.2% | 70.2% | 72.0% | 73.6% | 74.4% |



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

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

| Issues of Concern |
|---|
| Turnover has decreased by 1% since the previous month, it is still 0.5% above the target for 2021/22 (9%). The decrease is in all Care Groups, except Corporate Services:<br>All care group areas are developing their workforce plans, which include approaches to retention as part of the 'Growing for the Future' People strategy pillar. KMPT is also attending best practice sharing national events and is joining an Integrated Care System (ICS) task and finish group for retention across Kent and Medway. |

**Executive Commentary**

**Staff Sickness** (001.W-W)
Sickness for the month is 4.6% and this is a 0.6% increase on the month before.
If we remove the Covid sickness which is 0.31% the sickness for the month is 4.31%
Year to date (April, May and June) our sickness figure is 4.1%, 0.2% of this relates to Covid, therefore 3.9% without Covid. Short term sickness increased to 1.9% compared to 1.6% last month. Long term sickness is 2.6% an increase from 2% the previous month.

Activities in place to reduce sickness absence include:

- Successfully closed 24 long term sickness absence cases in June 2021.
    - 20 employees are returning to same post
    - 4 employees are no longer employed at KMPT
    - We are currently actively supporting managers with 71 cases of sickness absence.

    - The pilot of a health and wellbeing advisor recruited in the Acute Care Group has been extended and continues to work on a range of health and wellbeing initiatives. The plan to implement Schwarz rounds is in place, in September 2021. The musculo-skeletal provision for employees business case has also been approved. We are working with Occupational Health provider to implement.

- We have put in place many support offers for our staff to improve their health and wellbeing, most recently the Menopause group, which has had lots of positive feedback from staff. This forms part of our People Strategy and people recovery plan
- Staff continue to be offered the COVID vaccination (81% front line staff and 77% all staff 1st vaccination completed and 61% front line staff and 66% all staff 2nd vaccination completed), with a particular focus on supporting front line staff to access this, on-line support sessions, 121's with managers and staff, ensuring risk assessments completed when vaccinations not been undertaken and requesting lateral flow testing to be completed regularly
- A deep dive with the team on cases will be undertaken in July 2021

**Staff Turnover** (004.W-W)

Turnover has decreased by 1% since previous month, but is still 0.5% above the new set target for 2021/22 (9%).

Activities to reduce turnover:

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

**Staff Retention** (004.W-W)

This is a new KPI for 21/22. The June 2021 data shows a retention rate of 87%, against a target set for 21/22 of 90%. We will be reporting for future months progress against specific staff groups:

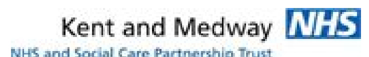
- Additional Clinical services from 86% to 90%
- Nursing from 88% to 91%
- Medical from 91% to 92%

Activities to support retention are reflected in turnover, but also include approach to recognising and celebrating long service.

## IQPR Dashboard: Well Led (Workforce)

| Ref | Measure | SoF | Target | Local / National Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 001.W-W | Staff Sickness - Overall | ✓ | 4.22% | L | 3.6% | 4.1% | 3.7% | 4.4% | 4.4% | 5.1% | 4.2% | 3.8% | 3.5% | 3.7% | 4.0% | 4.6% |
| 005.W-W | Appraisals And Personal Development Plans | | 95% | L | | | | 96.4% | 98.0% | 98.1% | 98.1% | 98.1% | 98.1% | 98.1% | | |
| 012.W-W | Essential Training For Role | | 90% | L | 90.7% | 91.0% | 90.4% | 90.0% | 89.4% | 89.5% | 91.3% | 90.4% | 91.2% | 91.8% | 92.4% | 90.4% |
| 015.W-W | Staff Retention (overall) | | 90% | | | | | | | | | | | | | 87.3% |
| 016.W-W | Staff Retention (Additional Clinical Services) | | | | | | | | | | | | | | | 85.1% |
| 017.W-W | Staff Retention (Nursing) | | | | | | | | | | | | | | | 87.0% |
| 018.W-W | Staff Retention (Medical) | | | | | | | | | | | | | | | 89.2% |
| 019.W-W | Staff Turnover (Overall) | | 4.00% | | 9.3% | 10.2% | 10.1% | 9.6% | 9.4% | 9.4% | 9.4% | 9.6% | 9.4% | 10.1% | 10.5% | 9.5% |
| 020.W-W | Staff Turnover (Additional Clinical Services) | | | | | | | | | | | | | | | 11.9% |
| 021.W-W | Staff Turnover (Nursing) | | | | | | | | | | | | | | | 9.1% |
| 022.W-W | Staff Turnover (Medical) | | | | | | | | | | | | | | | 8.1% |

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




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

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

**Issues of Concern**

Agency spend continues to be over budget. The new style finance report highlights four areas of exception this month. These include:

1. Agency spend
2. Private Placement spend
3. Planned and Reactive maintenance
4. Patient travel

**Executive Commentary**

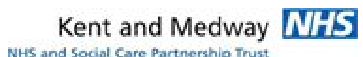
Please see the financial performance report included as a separate agenda item for the detailed financial performance narrative.

Kent and Medway

# IQPR Dashboard: Well Led (Finance)

| Ref | Measure | SoF | Target | Local / National Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 004.W-F | In Month Budget (£000) | | 0.0 | N | 0 | 0 | 0 | 0 | (0) | (0) | (0) | 0 | 0 | (0) | (0) | (0) |
| 005.W-F | In Month Actual (£000) | | - | - | (0) | 0 | 0 | 0 | (0) | 800 | 0 | 0 | 3 | 0 | 0 | (0) |
| 006.W-F | In Month Variance (£000) | | - | - | (0) | 0 | 0 | 0 | 0 | 800 | 0 | 0 | 3 | 0 | 0 | (0) |
| 006a.W-F | Distance From Financial Plan YTD (%) | ✓ | 0.0% | N | | | | | | | | | | 0.00% | 0.00% | 0.00% |
| 007.W-F | Agency - In Month Budget (£000) | | - | N | 427 | 427 | 427 | 427 | 427 | 427 | 427 | 427 | 427 | 427 | 427 | 427 |
| 008.W-F | Agency - In Month Actual (£000) | | - | - | 823 | 743 | 804 | 825 | 824 | 761 | 638 | 596 | 767 | 699 | 661 | 520 |
| 009.W-F | Agency - In Month Variance from budget (£000) | | - | - | 396 | 316 | 377 | 398 | 397 | 334 | 211 | 169 | 340 | 272 | 234 | 93 |
| 010.W-F | Agency Spend Against Cap YTD (%) | ✓ | 0.0% | N | 62.84% | 65.08% | 68.95% | 72.41% | 74.97% | 75.34% | 72.74% | 69.73% | 75.78% | 74.68% | 73.02% | 69.04% |

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




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

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

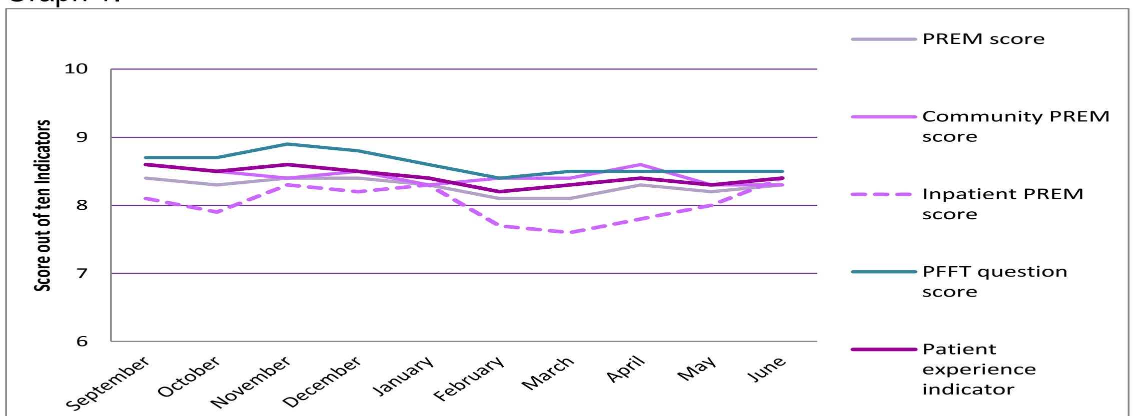
| Issues of Concern |
|---|
| |

**Executive Commentary**

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

The response rate is slowly increasing from 207 in September 2020 when it was relaunched, to 591 in June 2021. The aim is to achieve over 1000 responses a month. The acute care group consistently exceeds the 10% response rate set for each care group. Analysis of the PREM results indicates the majority of patients continue to report a “very good” experience in the quality of their care (above 8 out of 10) despite the impact of COVID-19 restrictions.

Graph 1.




In June, the inpatient PREM score has increased to 8.4 out of 10 from 7.7 out of 10 in February 2021. The provision of seven days a week therapeutic programmes across all inpatient services is contributing to the positive experience reported. The new partnership with the music therapy charity, Nordoff -Robbins is providing patients with access to music therapy at St Martins hospital wards once a week and has been well received by patients and staff. These music sessions have now been extended to the Psychiatric intensive Care Unit (Willow Suite). There are plans underway to introduce Sports and Exercise Technician roles across the three main hospital bases. This is innovative for the

acute mental health wards and will provide evidence -based sports and exercise activities that promote healthy living for patients and support the reduction of restrictive practice. When in post, the staff will be running groups, providing 1:1 session, facilitating gym use and supporting patients to access community sports resources in preparation for their discharge. All these therapeutic and engagement approaches are fundamental to our Healthy Wards initiative.

We have focused on creating various accessible methods to receive feedback from the diverse range of service users, including a new text service to be launched at the end of July 2021. This additional method of gathering feedback will help reach out to people who are not being seen face to face. In addition, a new Easy Read PREM for the Mental Health Learning Disability team (MHLD) is now operational and has started to see an increase in the responses provided which will in turn, inform areas for improvement.

For community services, an area of concern related to "being given help and support with finding advice for financial advice and benefits". The Debt Respite Scheme (Breathing Space Moratorium and Mental Health Crisis Moratorium) (England and Wales) Regulations 2020 enable eligible individuals who are experiencing mental distress to have a breathing space. A breathing space affords protections which includes pausing enforcement action and contact from creditors, freezing interest and charges on debts whilst the mental health crisis lasts plus thirty days after the crisis has ended.

For service users and clients not in crisis, a pilot project between KMPT and Citizens Advice has this year already helped nearly 130 people with their debt struggles and the dedicated advisors are encouraging more referrals. The project, which is being funded as part of suicide prevention work in Kent and Medway, provides a rapid referral pathway with the three specialist advisors able to offer immediate help. Feedback has been positive, both in terms of the ease of the referral process and the impact of this work. The team also want to step in and stop service users from reaching this point with preventative strategies. This project has been successful for people who found themselves in difficulty as a result of the pandemic. A communications message has gone out to staff to enable more patients to be helped.

# IQPR Dashboard: Caring

| Ref | Measure | SoF | Target | Local / National Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 002.C | Mental Health Scores From Friends And Family Test – % Positive | ✓ | 93% | N | | | | | | | 86.4% | 81.8% | 82.6% | 84.4% | 82.4% | |
| 003.C | Complaints - actuals | | - | - | 38 | 36 | 39 | 29 | 31 | 23 | 33 | 29 | 29 | 36 | 48 | 45 |
| 004.C | Complaints - per 10,000 contacts | | - | - | 9.92 | 11.00 | 10.63 | 7.79 | 8.04 | 6.45 | 8.97 | 7.90 | 6.88 | 9.29 | 12.84 | 11.27 |
| 005.C | Complaints acknowledged within 3 days (or agreed timeframe) | | 100% | L | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% | 100.0% |
| 006.C | Complaints responded to within 25 days (or agreed timeframe) | | 100% | L | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | 98.0% |
| 007.C | Compliments - actuals | | - | - | 128 | 89 | 111 | 132 | 120 | 99 | 97 | 96 | 122 | 111 | 100 | 120 |
| 008.C | Compliments - per 10,000 contacts | | - | - | 33.42 | 27.20 | 30.26 | 35.46 | 31.14 | 27.76 | 26.36 | 26.15 | 28.93 | 28.65 | 26.74 | 30.06 |
| 010.C | PALS acknowledged within 3 days (or agreed timeframe) | | - | - | 99% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| 011.C | PALS responded to within 25 days (or agreed timeframe) | | - | - | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 99% |
| 012.C | PALS - actuals | | - | - | 90 | 84 | 128 | 117 | 105 | 53 | 86 | 81 | 110 | 97 | 75 | 94 |
| 013.C | Patient Reported Experience Measures (PREM): Response count | | - | - | | | 207 | 394 | 348 | 357 | 249 | 391 | 447 | 372 | 550 | 591 |
| 014.C | Patient Reported Experience Measure (PREM): Response rate | | - | - | | | | 2.6 | 2.1 | 2.3 | 1.6 | 2.6 | 2.8 | 2.4 | 3.5 | 3.7 |
| 015.C | Patient Reported Experience Measure (PREM): Achieving Regularly % | | - | - | | | 840.0% | 830.0% | 8.4 | 8.4 | 8.3 | 8.1 | 8.1 | 8.3 | 8.2 | 8.3 |

*Note: 015.C measure construction changed from September 2020 to be a score out of 10*

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

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

| Issues of Concern |
|---|
| 4 week wait for assessment – in particular Maidstone CMHT.<br><br>Older Adult 4 week wait for assessment has consistently been within 59-65% for five successive months |

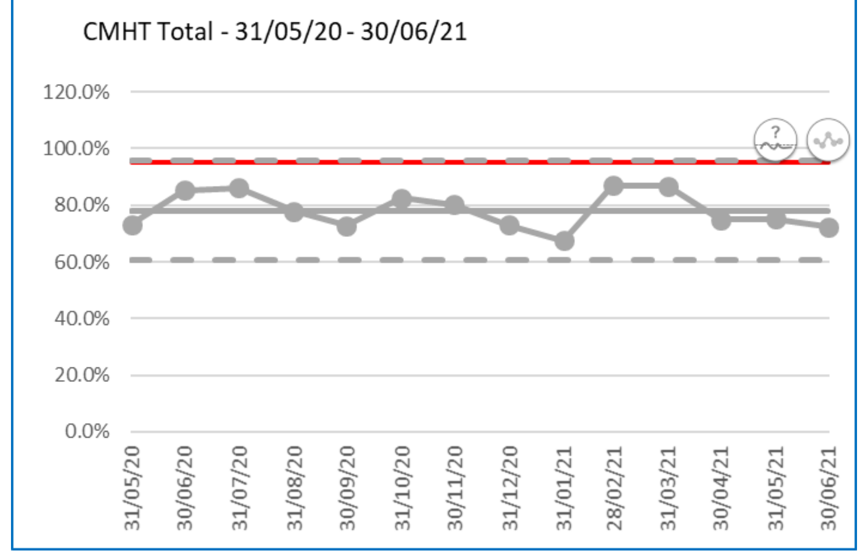
### Executive Commentary

| | 016.R: Routine Referral To Assessment Within 4 Weeks | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | CRCG | | | 72.6% | 95.0% | 61.1% | 95.2% | 78.2% |
| 2 | OPMH | | | 58.9% | 95.0% | 31.7% | 71.4% | 51.5% |
| 3 | Trust Total | | | 63.6% | 95.0% | 45.6% | 76.6% | 61.1% |

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

**Narrative**

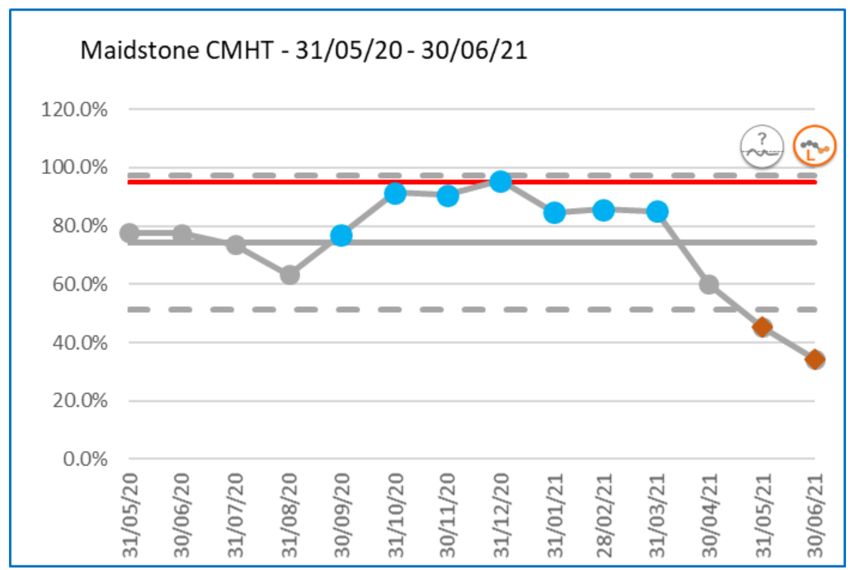
Overall the CMHT performance for the 4 week wait standard from referral to assessment continues to be below the average position of the last 16 months, achieving 72.4% in month.




Analysis by SPC shows that all CMHT's are subject to common cause variation with the exception of Maidstone which has breached the lower control limit for the second successive month at

34.3%. This is due to Maidstone taking all referrals and allocations for both Maidstone and Highlands House CMHTs from April 2021. This change has been made due to on-going nursing post vacancies at Highlands House and is a continuation of the the plan to centralise the assessment function across West Kent to utilise staffing in the most effective way.

Since May there has been a temporary locality manager leading these two teams who along with the Head of Service and the new Clinical Director are taking proactive action to resolve the particular issues across these two teams.

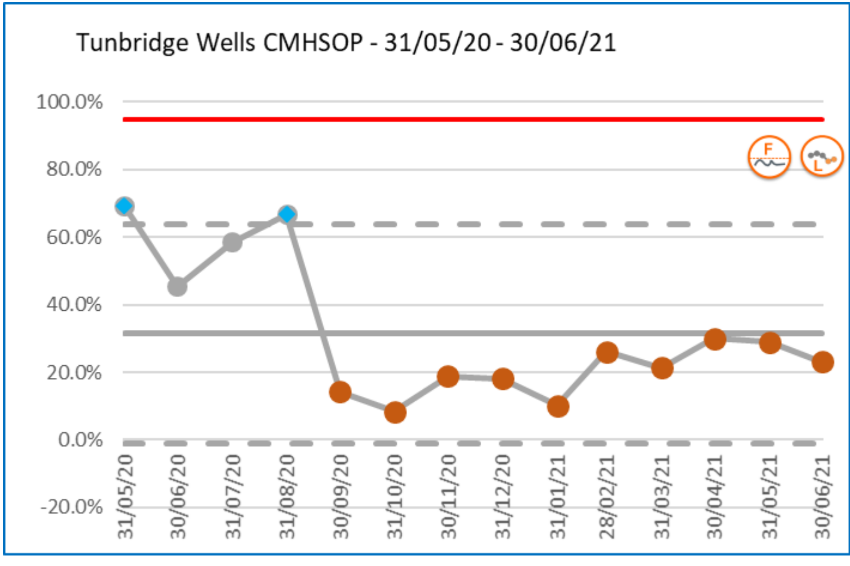



Recruitment plans, presented to Workforce Committee in July, evidence significant review and skill mix changes with the impact monitored through the QPR process.

Older Adult 4 week wait for assessment has consistently been within 59-65% for five successive months; as previously noted the impact of Memory Assessment Service and the fact demand far outstrips capacity remains the key issue. The system work on dementia is beginning to consider options to improve this standard with KMPT older adults services engaging fully.

| | | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Ashford CMHSOP | | | 94.7% | 95.0% | 40.0% | 101.1% | 70.6% |
| 2 | Canterbury CMHSOP | | | 71.9% | 95.0% | 29.8% | 92.0% | 60.9% |
| 3 | DGS CMHSOP | | | 84.5% | 95.0% | -3.4% | 104.6% | 50.6% |
| 4 | Dover & Deal CMHSOP | | | 17.9% | 95.0% | -2.2% | 81.8% | 39.8% |
| 5 | Maidstone CMHSOP | | | 34.7% | 95.0% | 2.2% | 86.1% | 44.1% |
| 6 | Medway CMHSOP | | | 70.6% | 95.0% | 0.1% | 90.2% | 45.1% |
| 7 | Sevenoaks CMHSOP | | | 36.4% | 95.0% | 3.0% | 81.7% | 42.3% |
| 8 | Shepway CMHSOP | | | 69.8% | 95.0% | 35.9% | 96.6% | 66.3% |
| 9 | Swale CMHSOP | | | 82.9% | 95.0% | 39.1% | 111.1% | 75.1% |
| 10 | Thanet CMHSOP | | | 28.8% | 95.0% | 4.8% | 85.9% | 45.3% |
| 11 | Tunbridge Wells CMHSOP | | | 23.1% | 95.0% | -1.1% | 63.8% | 31.4% |
| 12 | CMHSOP Total | | | 58.9% | 95.0% | 31.7% | 71.4% | 51.5% |

Significant variation exists across the teams, Tunbridge Wells CMHSOP is showing negative special cause variation and achieved 23.1% in month, compared to Ashford, Shepway and Swale CMHSOPs who are showing positive special cause variation demonstrating and improving position. A SWK remedial plan that has been established focussing on challenges including: variation in clinical / medical practice (currently being addressed), vacancies and potential increase in acute demand. Importantly there has been some positive recruitment into this team in the last month.

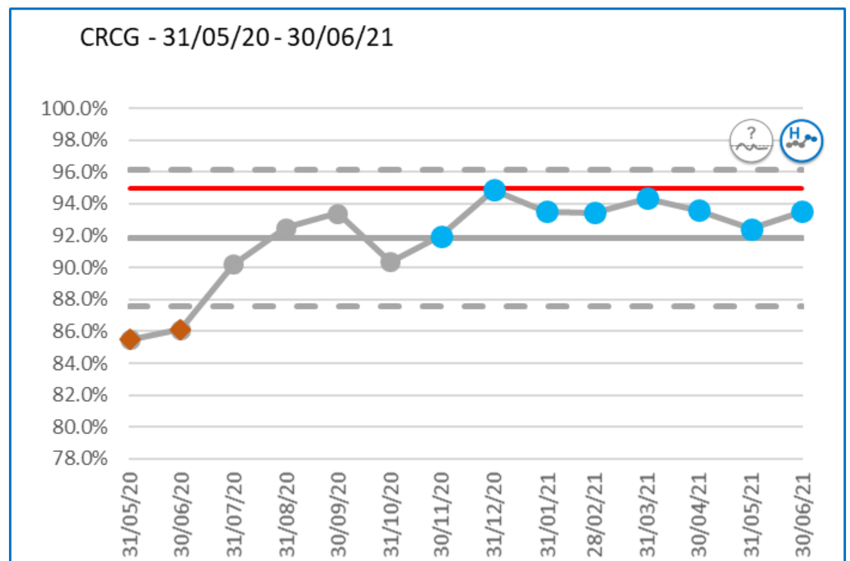


| 017.R: 18 Weeks Referral To Treatment | | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | CRCG | | | 93.5% | 95.0% | 87.6% | 96.1% | 91.8% |
| 2 | OPMH | | | 86.8% | 95.0% | 44.0% | 74.9% | 59.4% |
| 3 | Trust Total | | | 90.0% | 95.0% | 65.2% | 83.0% | 74.1% |

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

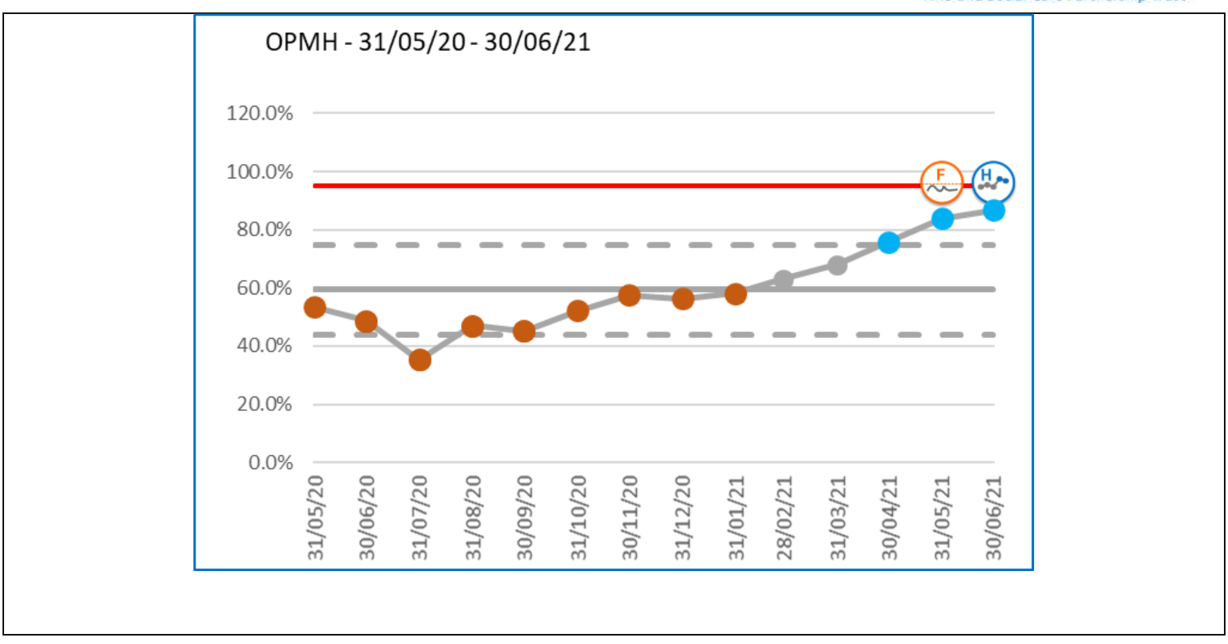
**Narrative**

The CMHT performance for the 18 week wait standard from referral to commencement of treatment continues to perform well and shows special cause variation of an improving nature. All CMHT's achieved in excess of 95% with the exception of DGS and Maidstone who achieved 85.3% and 84.1% accordingly – an improvement for DGS and a reduced level of performance for Maidstone.




The Care Group has recently skill mixed the staff to provide increased numbers of Support Time and Recovery workers and Psychology Assistant staff, in order to deliver the Initial Interventions programme which is the first treatment for most newly referred patients. The recently recruited staff are undertaking the training to deliver Initial Interventions and job planning has taken place. The positive impact on the 18 week wait and the Active Review programme will be monitored through the care group QPR.

It is also positive to note special cause variation of an improving nature within CMHSOPs, the table below shows this is driven by improvements in 5 teams, with three teams achieving the 95% target – an increase from two in May.




| | 007.R: DNAs - 1st Appointments | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Acute | | | 13.5% | | 2.8% | 10.4% | 6.6% |
| 2 | CRCG | | | 10.2% | | 4.6% | 15.2% | 9.9% |
| 3 | FSS | | | 10.7% | | 8.1% | 18.1% | 13.1% |
| 4 | OPMH | | | 4.7% | | 1.0% | 6.9% | 3.9% |
| 5 | Trust Total | | | 9.8% | | 6.2% | 12.1% | 9.1% |

| | 008.R: DNAs - Follow Up Appointments | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Acute | | | 23.8% | | 3.2% | 12.1% | 7.7% |
| 2 | CRCG | | | 10.5% | | 6.7% | 13.4% | 10.1% |
| 3 | FSS | | | 6.6% | | 3.7% | 12.5% | 8.1% |
| 4 | OPMH | | | 3.1% | | 1.2% | 4.4% | 2.8% |
| 5 | Trust Total | | | 10.7% | | 5.3% | 10.9% | 8.1% |

| Interpretation of results (Trust wide) | |
|---|---|
| **Variation** | Common Cause - no significant change<br>Special cause of **Improving** nature or higher pressure due to **lower** values |
| **Assurance** | N/A – not set target |

**Narrative**

A high level of variation continues to exist in DNA rates across care groups, in order to better understand reasons for this the options on RiO were rationalised in April 2021.

The Acute Care Group has seen an increase in DNA recording in recent months, this is down to new processes implemented from April within the OT service. Previously this staff group did not enter appointments into the RiO diary, the performance team is working with the service to address some data quality issues and ensure clear local processes exist for diary use.

DNAs and Cancellation continue to be scrutinised by the Trust Wide Data Quality Group and any future recommendations for changes to these indicators will be highlighted if required.

| | 013.R - 0.15R: Referrals | Performance | Assurance | Latest Value | Target | Lower process limit | Upper Process limit | Mean |
|---|---|---|---|---|---|---|---|---|
| 1 | Acute | | | 1,862 | | 1,787.9 | 3,101.3 | 2,444.6 |
| 2 | CRCG | | | 5,637 | | 3,295.8 | 6,429.9 | 4,862.9 |
| 3 | FSS | | | 1,989 | | 1,523.3 | 2,363.5 | 1,943.4 |
| 4 | OPMH | | | 1,672 | | 817.7 | 1,798.4 | 1,308.1 |
| 5 | Trust Total | | | 11,160 | | 7,948.7 | 13,170.1 | 10,559.4 |

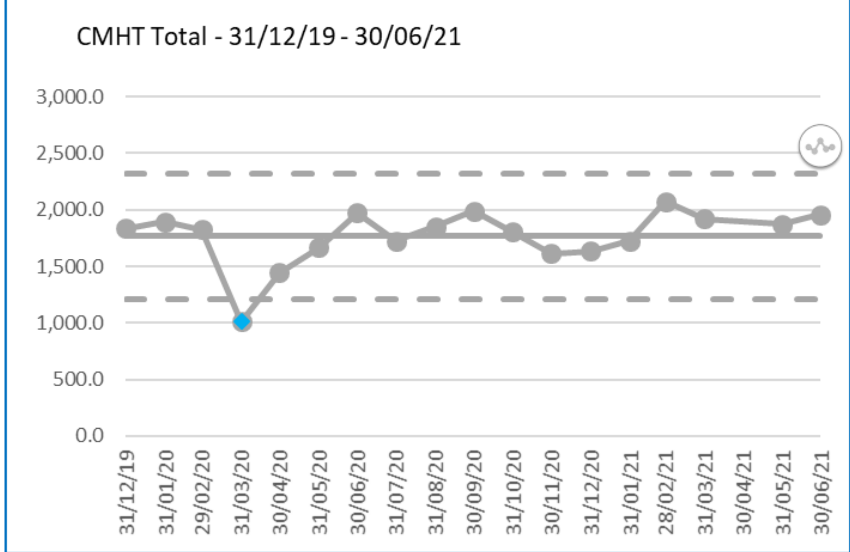
| Interpretation of results (Trust wide) | |
|---|---|
| **Variation** | Common Cause - no significant change |
| **Assurance** | N/A – not set target |

**Narrative**

SPC analysis has highlighted ongoing increased pressure in month driving increases in the Community Recovery Care Group (CRCG). The increased pressure on CRCG and reduction in Acute is impacted on by the movement of Liaison Psychiatry to CRCG within the management structure for reporting purposes in December 2020.

Whilst not significant the chart below shows an above average number of CMHT referrals in the last four months.

Kent and Medway NHS
NHS and Social Care Partnership Trust

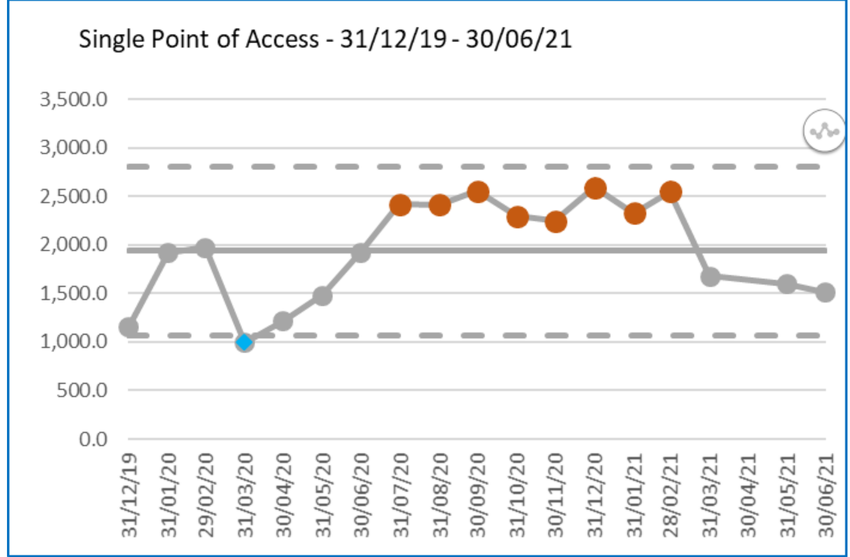



The majority of the CRCG pressure historically had been due to Single Point of Access (SPoA), as shown below; June saw a second third successive reduction in referrals received. This does not mean a reduction in calls to the service however we are unable to report telephony data at this point in time.

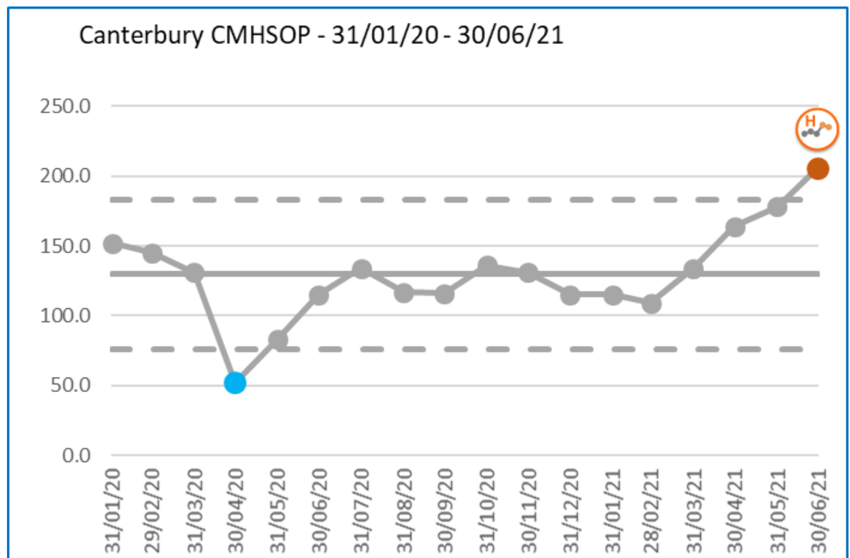
A reduction of approximately 400 referrals in April and May was expected due to a change in how routine referrals are processed by the service. This is the lowest number of referrals received by the service since it moved to function as a public facing Crisis Line and saw a significant increase in referral demand due to the pandemic.

Whilst a core element of the service is referrals the current reporting does not allow for other telephony activity to be reported on, this will improve with the new telephony option procured in June 2021. The new system will be rolled out to SPOA first as part of the Trust wide implementation.

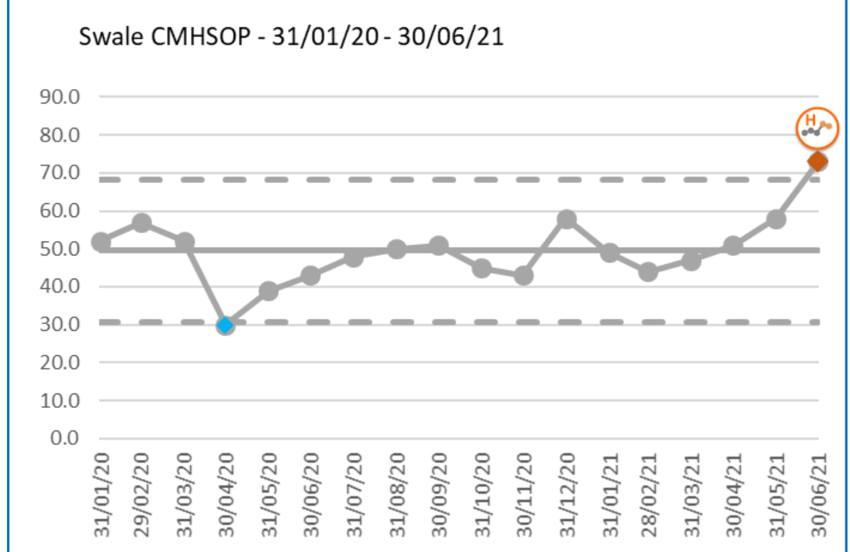
Kent and Medway NHS
NHS and Social Care Partnership Trust




Within OPMH services SPC analysis has highlighted special cause variation within Canterbury CMHSOP and Swale CMHSOP. As shown below there have been 4 successive months of increased referral levels with June 2021 breaching the upper confidence limit in both cases.



Kent and Medway NHS
NHS and Social Care Partnership Trust




0:19R Is a new metric added in month to split out CMHT referrals, usually made by GPs and local services against those referred into the CMHTs by SPOA that are deemed urgent. This has not been a metric previously noted and therefore the fact the teams had not met this metric consistently was not a known entity. Separating this data has enabled the service supported by the Executive Team to make a number of key changes. The findings conclude the need to pull urgent 24/7 assessment out of the CMHTs and into its own pathway aligned to our crisis line and crisis services. The two relevant Clinical Directors with the Heads of Service have been asked to review options to progress a standardised 24/7 crisis assessment as a matter of priority. This action is aligned to the required delivery of the long term plan.

# IQPR Dashboard: Responsive

| Ref | Measure | SoF | Target | Local / National Target | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 001.R | People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral | ✓ | 60% | N | 66.7% | 85.7% | 81.3% | 78.3% | 78.3% | 69.6% | 78.9% | 63.6% | 80.0% | 71.4% | 69.2% | 75.0% |
| 005.R | % of Liaison (urgent) referrals seen within 1 hour | | - | - | 84.0% | 89.3% | 93.6% | 87.1% | 92.4% | 90.9% | 88.3% | 83.2% | 82.5% | 93.1% | 88.3% | 87.5% |
| 006.R | % of Liaison (urgent) referrals seen within 2 hours | | - | - | 92.1% | 93.9% | 96.0% | 95.5% | 94.9% | 93.5% | 94.4% | 90.7% | 90.7% | 88.2% | 93.9% | 89.1% |
| 007.R | DNAs - 1st Appointments | | - | - | 6.2% | 6.5% | 8.4% | 11.7% | 13.0% | 13.5% | 12.6% | 12.9% | 11.3% | 8.3% | 8.7% | 9.8% |
| 008.R | DNAs - Follow Up Appointments | | - | - | 5.6% | 5.9% | 7.7% | 11.4% | 11.3% | 11.1% | 11.0% | 9.9% | 9.4% | 8.1% | 8.2% | 10.7% |
| 009.R | Patient cancellations- 1st Appointments | | - | - | 0.5% | 0.6% | 1.1% | 1.0% | 1.1% | 1.3% | 0.9% | 1.0% | 0.8% | 0.1% | 0.0% | 0.1% |
| 010.R | Patient cancellations- Follow Up Appointments | | - | - | 2.7% | 2.9% | 3.1% | 3.1% | 2.8% | 3.2% | 2.9% | 2.6% | 2.6% | 0.4% | 0.3% | 0.2% |
| 011.R | Trust cancellations- 1st Appointments | | - | - | 14.5% | 19.9% | 17.7% | 18.6% | 11.6% | 3.7% | 4.4% | 3.9% | 3.4% | 4.2% | 4.8% | 6.0% |
| 012.R | Trust cancellations- Follow Up Appointments | | - | - | 9.5% | 10.8% | 10.9% | 9.8% | 9.5% | 8.9% | 9.2% | 9.2% | 9.0% | 11.2% | 12.6% | 12.7% |
| 013.R | Referrals Received (ave per calendar day) | | - | - | 367.6 | 361.7 | 377.2 | 382.3 | 359.4 | 331.4 | 342.5 | 363.4 | 399.0 | 360.0 | 361.6 | 372.0 |
| 014.R | Referrals Received (ave per working day) | | - | - | 424.0 | 433.1 | 436.1 | 449.2 | 426.0 | 400.1 | 419.1 | 433.8 | 459.6 | 427.4 | 458.7 | 434.8 |
| 015.R | Referrals Received (per 10,000 Kent and Medway Registered GP population)) | | - | - | 717.9 | 641.9 | 715.6 | 718.9 | 667.5 | 622.3 | 625.2 | 627.7 | 743.3 | 641.6 | 631.4 | 692.5 |
| 016.R | Referral to Assessment with 4 weeks Care Spell | | 95% | - | 68.2% | 55.2% | 44.3% | 44.1% | 52.8% | 53.0% | 52.2% | 68.7% | 70.4% | 68.9% | 67.7% | 63.6% |
| 017.R | Referral to Treatment within 18 weeks Care Spell | | 95% | - | 59.8% | 68.4% | 67.8% | 70.3% | 71.8% | 72.5% | 72.7% | 74.0% | 78.6% | 84.1% | 87.7% | 90.0% |
| 018.R | % Patients waiting over 28 days from referral | | - | - | 55.7% | 58.2% | 54.9% | 50.5% | 44.9% | 45.6% | 39.0% | 30.9% | 23.1% | 28.0% | 30.4% | 28.5% |
| 019.R | Urgent referrals seen within 72 Hours | | 95% | - | 54.5% | 59.1% | 52.6% | 53.7% | 55.6% | 57.6% | 54.2% | 61.6% | 63.1% | 59.6% | 62.3% | 62.4% |

## Appendix A: Single Oversight Framework

### Overview

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

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

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

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

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

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

# IQPR Dashboard: Single Oversight Framework

| Ref | Measure | Target | Mar-21 | Apr-21 | Trend (Last 12 months where available, left to right) |
|---|---|---|---|---|---|
| 001a.E | Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days | 95% | 98.3% | 98.9% | |
| 001b.E | CPA patients receiving follow-up within 72hours of discharge | 95% | 88.4% | 86.7% | |
| 005.E | Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days) | | 310 | 375 | |
| 001.R | People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral | 60% | 80% | 71% | |
| 004.E | Data Quality Maturity Index (DQMI) – MHSDS Dataset Score | 95.0% | 95.7% | 95.7% | |
| 001.S | Occurrence Of Any Never Event | 0.0% | 0.0% | 0.0% | |
| 001.W-W | Staff Sickness - Overall | 4.2% | 3.5% | 3.7% | |
| 002.W-W | Staff Sickness - Short term | 1.7% | 1.6% | 1.6% | |
| 002.C | Mental Health Scores From Friends And Family Test – % Positive | 93% | 82.6% | 84.4% | |

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

**Appendix B: IQPR Overview and Guides**

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

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

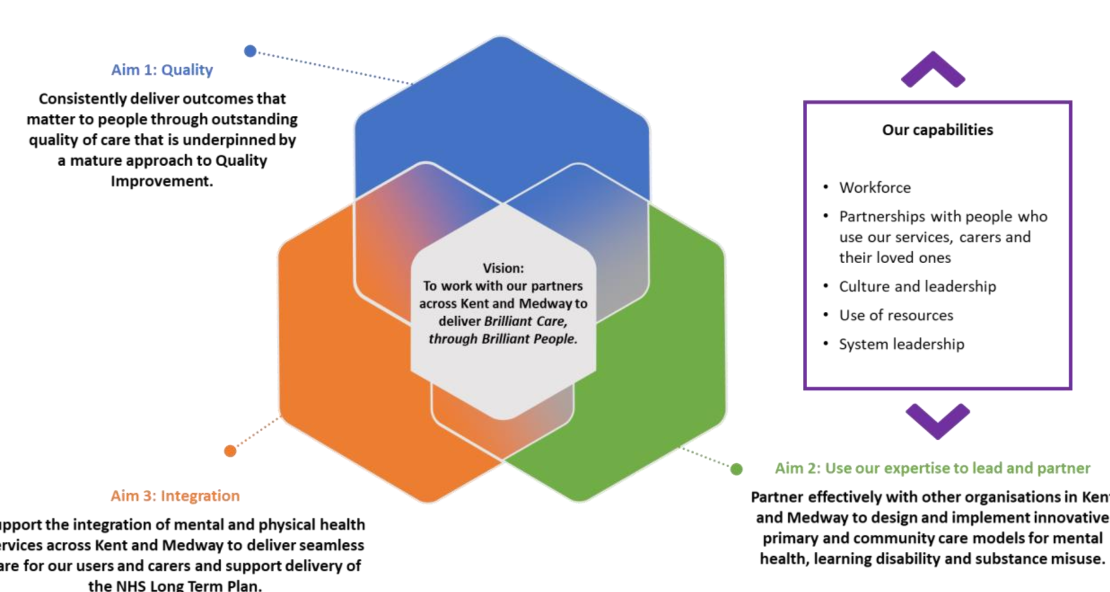
The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally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

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

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

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

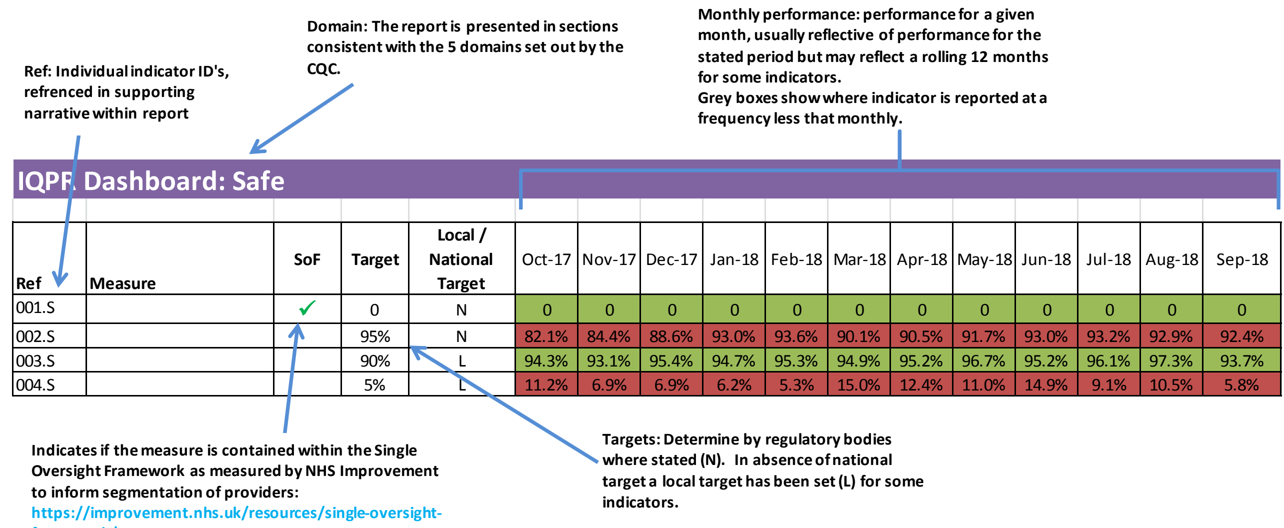
NHS
Kent and Medway
NHS and Social Care Partnership Trust


Aim 1: Quality
Consistently deliver outcomes that matter to people through outstanding quality of care that is underpinned by a mature approach to Quality Improvement.
Vision:
To work with our partners across Kent and Medway to deliver Brilliant Care, through Brilliant People.
Our capabilities
Workforce
Partnerships with people who use our services, carers and their loved ones
Culture and leadership
Use of resources
System leadership
Aim 3: Integration
Support the integration of mental and physical health services across Kent and Medway to deliver seamless care for our users and carers and support delivery of the NHS Long Term Plan.
Aim 2: Use our expertise to lead and partner
Partner effectively with other organisations in Kent and Medway to design and implement innovative primary and community care models for mental health, learning disability and substance misuse.

# IQPR Dashboard Guide

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

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




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

## IQPR Exception Reporting

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

**SPC Key:**

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

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

# IQPR Change Tracker

| Date | Change | Report Reference |
|---|---|---|
| December 2020 | Latest Trust Strategic Objectives applied to domains throughout report<br><br>Liaison removed from 4 & 18 week wait measures and Liaison measures redefined as follows:<br><br>% of Liaison (urgent) referrals seen within 1 hour<br>Numerator – Of the Denominator who has had a face to face contact of any duration within 1 hour<br>Denominator – Urgent or Emergency Referrals starting in the month that are in hours for the teams, Medway and Thanet teams only. Referrals ending with a discharge reason of 'Dropped Out' or 'Patient Non Attendance' are excluded.<br><br>% of Liaison (urgent) referrals seen within 2 hours<br>Numerator – Of the Denominator who has had a face to face contact of any duration within 2 hours<br>Denominator - Urgent or Emergency Referrals starting in the month that are in hours for the teams, Ashford, Canterbury, Dartford, East Team, Maidstone and SW Kent, Maidstone, Tunbridge Wells teams only. Referrals ending with a discharge reason of 'Dropped Out' or 'Patient Non Attendance' are excluded. | All Domains<br><br>002.R & 003.R<br>005.R & 006.R |
| January 2021 | Statistical Process Control Charts implemented for exception report within a new section within the report. Previous areas of focus within individual domains removed. | |
| Februray 2021 | Indicator removed: Freedom to speak up issues<br><br>IQPR Overview and Guide moved to appendicles | 013.W-W |
| May 2021 | New/amended indicators for 2021/22:<br>Unplanned Readmissions within 30 days (020.S)<br>Replaces 28 day readmission indicator<br>CPA patients receiving follow-up within 72hours of discharge (001b.E)<br>New inclusion in IQPR<br>Care Planning / Crisis Planning / Distribution<br>Previous indicators retired, new measures introduced to include PSP reporting. (015.E – 017.E)<br>Waited time measures<br>Previous indicators retired, new measures introduced to include PSP reporting. (016.R – 018.R)<br>Workforce metrics<br>Vacancy metrics retired, replaced with retention measure (015.W-W)<br>New absence and turnover targets | |

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

# TRUST BOARD MEETING - PUBLIC

## Meeting details

**Date of Meeting:** 29th July 2021

**Title of Paper:** Finance Report for month 3 (June 2021)

**Author:** Victoria French, Deputy Director of Finance

**Executive Director:** Sheila Stenson, Executive Director of Finance

## Purpose of Paper

**Purpose:** Noting

**Submission to Board:** Regulatory Requirement

## Overview of Paper

The attached report provides an overview of the financial position for month 3 (June 2021). This is consistent with the position submitted to NHS Improvement in the Month 3 Financial Performance Return.

## Issues to bring to the Committee's attention

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

The cash position remains strong at £15m in line with projections. Supporting the Trust's ability to deliver a breakeven position by year-end is the Long-Term Sustainability Programme, which has identified savings of £3.1m to date as part of the overall £7m target. That Programme remains on track.

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

1. Temporary staffing – deep dive on agency spend has been completed and included in this month's Board report
2. Private Placement Spend – a bed paper has been taken to FPC this month which presents three scenarios in regards to bed capacity
3. Planned and Reactive maintenance – TIAA Trust internal auditors are currently undertaking a review of the Trust processes
4. Patient Travel Spend – relates to the use of patient transport. A task and finish group are being set up to review our processes.

Version control: 1

## Governance

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

Version control: 1

# Finance Report

## Trust Board

## June 2021

# Contents


| | |
|---|---|
| **Executive Summary** | **3** |
| **Income and Expenditure and Long Term Sustainability Plan** | **4** |
| **Exception Reports** | **5** |
| **Appendices** | |
| **Balance Sheet and Cash** | **6** |
| **Capital Programme** | **7** |

# Executive Summary

## Key Messages for June 2021

In June, the Trust has reported a breakeven position both in month and year to date. This is in line with the plan submitted for H1.

The Trust is awaiting confirmation of both guidance and timings for the H2 Planning Round. There have been indications it is likely to be similar to H1 with a higher efficiency target being required which is why focus remains within the Trust on the efficiency programme.

The Trust is continuing to progress with the new approach, called the Long Term Sustainability Programme, which is being led by Deputy Directors. Of the £7m target set for the organisation, £3.1m has been identified at the end of June, an improvement of £0.9m since the last report.

## Income and Expenditure

Within the breakeven position reported, there are several key drivers. There is continued pressures in temporary staffing and private placements above budget. Agency spend at the end of Q1 was £1.9m, only £77k lower than this time last year, however spend in June was lower than previous months. This is being mitigated currently by vacancies due to challenges recruiting into substantive roles.

| | Year to Date | | |
|---|---|---|---|
| | *Plan* | *Actual* | *Variance* |
| | **£000** | **£000** | **£000** |
| Income | (55,080) | (54,183) | 898 |
| Employee Expenses | 42,645 | 41,066 | (1,578) |
| Operating Expenses | 11,192 | 11,896 | 704 |
| **Operating (Surplus) / Deficit** | **(1,243)** | **(1,221)** | **23** |
| Finance Costs | 1,243 | 1,221 | (23) |
| **(Surplus) / Deficit** | **0** | **0** | **0** |

## At a Glance

| | |
|---|---|
| Income and Expenditure | Green |
| Efficiency Programme | Green |
| Agency Spend | Red |
| Capital Programme | Red |
| Cash | Green |

## Key

On or above target

Below target, between 0 and 10%

More than 10% below target

## Capital Programme

The YTD position is underspent by £2m. The main reasons for the underspend are delays on the Closed Protocol schemes, more detailed specifications required for Emmetts and Walmer heating, VAT reclaims and retention adjustments, and Strategic IT schemes not yet proceeding.

## Cash

The cash balance at the end of June was £15.1m. No cash plan was required for the national plan submission, but the Finance team continue to monitor internally. This cash balance has increased in month with receipts for the Provider Collaborative and block contract income for Q1 from the CCG.

# Income and Expenditure and Long Term Sustainability Programme

## Statement of Comprehensive Income

| | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|
| | *Plan* £000 | *Actual* £000 | *Variance* £000 | *Plan* £000 | *Actual* £000 | *Variance* £000 |
| **Income** | (18,549) | (18,167) | 382 | (55,080) | (54,183) | 898 |
| **Employee Expenses** | 14,238 | 13,648 | (590) | 42,645 | 41,066 | (1,578) |
| **Operating Expenses** | 3,896 | 4,135 | 239 | 11,192 | 11,896 | 704 |
| **Operating (Surplus) / Deficit** | **(415)** | **(385)** | **30** | **(1,243)** | **(1,221)** | **23** |
| **Finance Costs** | 415 | 385 | (30) | 1,243 | 1,221 | (23) |
| **(Surplus) / Deficit** | **0** | **0** | **0** | **0** | **0** | **0** |

### Commentary

Pay continues to underspend and is underspent by £1.5m on a YTD basis. This is largely driven by vacancies particular within MHIS initiatives with substantive pay underspent by £4.9m to month 3 which has partly been offset by bank and agency costs.

Operating expenses is overspent by £704k. The key area contributing to the overspend is Private Placements with a greater number of bed days being utilised than planned.

## Long Term Sustainability Programme (Efficiency Programme)

| | Annual | Current Month | | | Year to Date | | |
|---|---|---|---|---|---|---|---|
| **Pillar** | *Plan* £000 | *Plan* £000 | *Actual* £000 | *Variance* £000 | *Plan* £000 | *Actual* £000 | *Variance* £000 |
| Back Office | (2,000) | (167) | (110) | 57 | (500) | (354) | 146 |
| Workforce | (1,000) | (100) | (15) | 85 | (100) | (45) | 55 |
| Service Line Reporting | (1,000) | 0 | 0 | 0 | 0 | 0 | 0 |
| Patient Pathways | (1,500) | (100) | (80) | 20 | (100) | (241) | (141) |
| Procurement and Purchasing | (1,000) | (100) | (44) | 56 | (100) | (107) | (7) |
| Commercial Development | (500) | 0 | (15) | (15) | 0 | (45) | (45) |
| **Total** | **(7,000)** | **(467)** | **(264)** | **203** | **(800)** | **(792)** | **8** |

### Commentary

The Long term Sustainability Prgoramme is on plan for the first quarter with savings targets phased more towards H2 in line with national expectations. So far of the £7m target, £3.1m has been developed, leaving a gap of £3.9m to be found. There are ideas coming forward via the pillars to be costed over the coming months to close this gap.

Regular meetings are taking place with deputy directors. Each pillar is mapping out the impact over the next three years. This will support recurrent delivery of savings and ensure a rolling programme focused on KMPT for the future.

# Exception Report

## Top 4 Variances

| | Plan £000 | Actual £000 | Variance £000 | Proportionate Overspend |
|---|---|---|---|---|
| Agency | 1,083 | 1,880 | 797 | **74%** |
| Private Placements | 854 | 1,550 | 696 | **81%** |
| Planned and reactive maintenance | 626 | 962 | 336 | **54%** |
| Patient travel | 145 | 255 | 110 | **76%** |

## 1. Temporary Staffing Spend: Agency £797k

Agency spend last year was reported at the highest levels in over 4 years. That trend has continued into 2021-22 with particular pressure areas within the Medical and Nursing staff groups.
The high level of agency spend presents a budgetary pressure because is at levels higher than expected. There is a separate deep dive paper being presented to Trust Board on agency spend that outlines key actions.

| | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 YTD |
|---|---|---|---|---|---|
| Bank | 11,131 | 11,390 | 13,560 | 16,968 | 4,189 |
| Agency | 6,924 | 6,459 | 6,395 | 8,740 | 1,880 |
| Total | 18,055 | 17,849 | 19,955 | 25,708 | 6,068 |

## 2. Private placement Spend £696k

As part of the Trust's block contract a level of private placement spend is commissioned due to the lack of female PICU facility within existing bed base. However the year to date position to June shows an elevated usage of external beds. For the period of June, 511 bed days were utilised, representing an average of 17 placements.

The increase is due to three main factors:

1. Refurbishment work on Willow Suite resulting in closed beds
2. An increase in acute bed days purchased to cope with acute inpatient pressures
3. Three "non core" placements.

## 3. Planned and reactive maintenance £336k

The budget for Planned and Reactive maintenance charges is based on trend analysis from previous financial years with input from Estates in order to horizon scan what works are planned.
At the end of the first quarter spend is over and above these levels by £336k. A full analysis of this spend is currently being undertaken by the Estates department to manage works for the remainder of the financial year. Our newly appointed Estates Director is also putting in place new processes with our supplier for maintenance to better manage spend.

## 4. Patient Travel £110k

Between April and June the Trust has seen spend levels above budget, a lot of which aligns to the increase in private placements and associated travel costs. To date the budgetary pressure for all of patient travel totals £110k.

# Appendices

# Statement of Financial Position Overview

| Statement of Financial Position | Opening 31st March 2021 *Actual* £000 | Prior Month 31st May 2021 *Actual* £000 | Current Month 30th June 2021 *Actual* £000 |
|---|---|---|---|
| Non-current assets | 130,002 | 131,179 | 130,784 |
| Current assets | 22,682 | 21,207 | 20,777 |
| Current liabilities | (24,777) | (24,649) | (23,929) |
| Non current liabilities | (11,976) | (11,806) | (11,701) |
| **Net Assets Employed** | **115,931** | **115,931** | **115,931** |
| | | | |
| **Total Taxpayers Equity** | **115,931** | **115,931** | **115,931** |

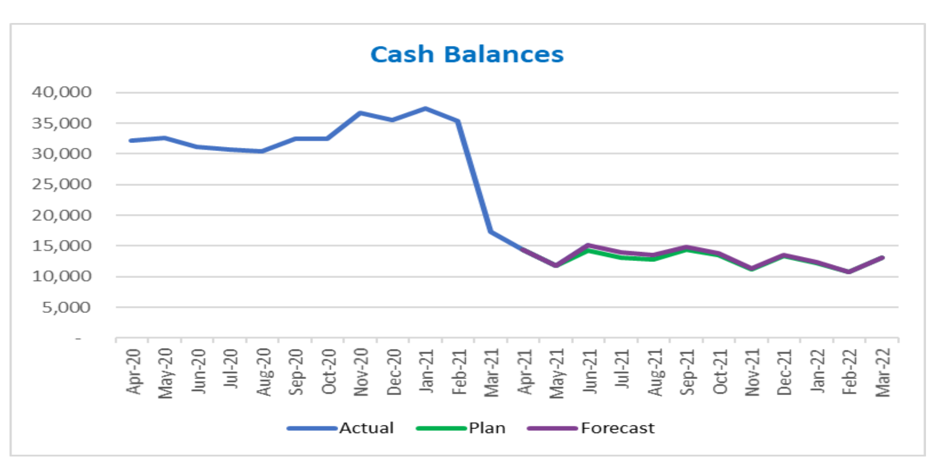
## Commentary

Non current assets has decreased by £0.4m in month, due to depreciation charges exceeding the capital expenditure in month.

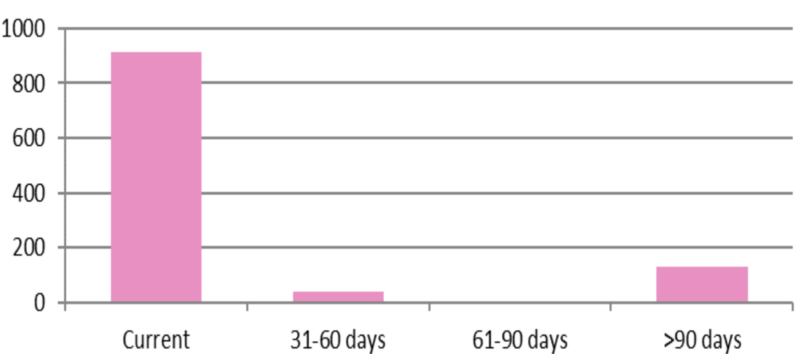
The cash position within current assets remains strong with an increase in month of £3.2m primarily made up of receipts from Provider Collaborative, additional block contract receipts for Q1 from the CCG and VAT recovery relating to April and May received in June.

Current liabilities has reduced by £0.7m with a £0.9m decrease in capital creditors partly offset by a £0.3m increase in the PDC dividend accrual as a result of national advice on COVID capital treatment.

Our total invoiced debt is £1.1m, of which £0.9m is within 30 days. Debt over 90 days has remained at £0.1m.



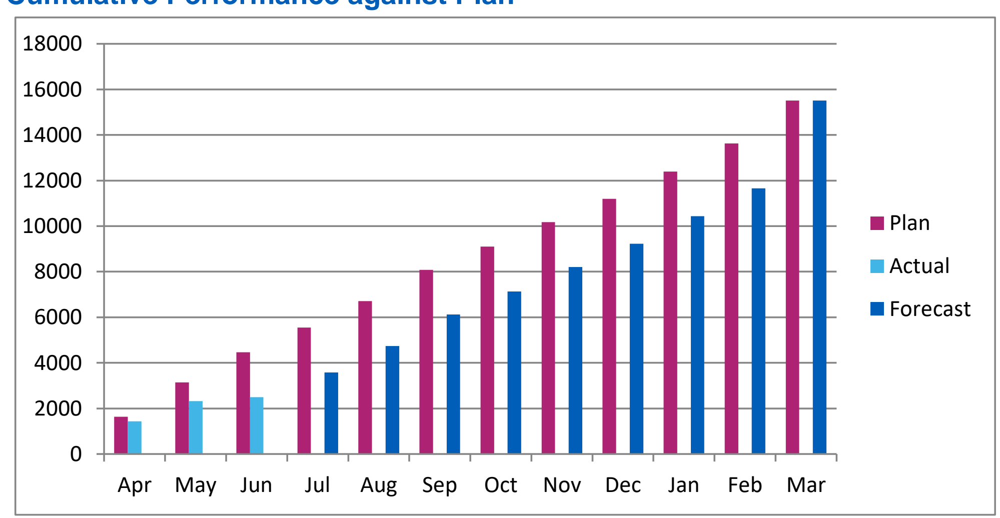

## Aged Debt Analysis



# Capital Expenditure

| | Current Month | | | Year to Date | | | Full Year |
|---|---|---|---|---|---|---|---|
| | *Plan* £000 | *Actual* £000 | *Variance* £000 | *Plan* £000 | *Actual* £000 | *Variance* £000 | *Plan* £000 |
| Information Management and Technology | 217 | (15) | (232) | 668 | 242 | (426) | 2,856 |
| Capital Maintenance & Minor Schemes 2021/22 | 237 | 0 | (237) | 587 | 0 | (587) | 2,142 |
| Capital Maintenance & Minor Schemes from 2020/21 | 619 | (4) | (623) | 2,426 | 1,585 | (841) | 3,635 |
| Capital Maintenance & Minor Schemes Prior Year Adj | 0 | (1) | (1) | 0 | (58) | (58) | 0 |
| Strategic Schemes - Orchards Ward | 174 | 120 | (55) | 523 | 452 | (70) | 1,045 |
| Improving Mental Health Services (Maidstone) | 66 | 71 | 6 | 250 | 264 | 14 | 5,787 |
| PFI 2020/21 | 3 | 3 | 0 | 10 | 10 | 0 | 40 |
| **Total Capital Expenditure** | **1,316** | **174** | **(1,142)** | **4,463** | **2,496** | **(1,967)** | **15,505** |

## Cumulative Performance against Plan




## Commentary

In June, the Trust has spent £0.2m against the initial plan of £1.3m, this is predominantly due to slippage on estates schemes and staff not yet being in post for the IT capital projects.

The YTD position is underspent by £2m, £0.4m on IMT schemes and £1.6m estates schemes. The main reasons for the underspend are delays on the Closed Protocol schemes, an increased specification requirement for Emmetts and Walmer heating, VAT reclaims and retention adjustments, and Strategic IT schemes not yet proceeding.

The forecast position for 2021/22 remains at £15.5m. Further detail on capital risks is being provided separately to the Finance and Performance Committee, and is being closely monitored by the Trust Capital Group.



Trust Board - Public-29/07/21

# TRUST BOARD

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | 29th July 2021 |
| **Title of Paper:** | Finance Exception Report - Agency |
| **Author:** | Victoria French, Deputy Director of Finance |
| **Executive Director:** | Sheila Stenson, Executive Director of Finance |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussing |
| **Submission to Board:** | Board requested |

## Overview of Paper

This report provides a deep dive into agency spend within the Trust, focusing on analysis by staff group as well as Care Group, highlighting case study examples to increase awareness of the key drivers for agency use at KMPT.

## Items of focus

Agency spend had been reducing year on year since 2016/17 from a peak of £9.5m, down to £6.4m in 2019/20. However, in 2020/21, levels have risen considerably, partly due to the pandemic but also due to increasing challenges regarding recruitment into existing roles as well new roles arising from the investment Mental Health services have received. Retention remains an area of focus within the organisation and is improving with staff turnover being the lowest it has been for a number of years.

Areas of high spend are medical and nursing staff groups, the Acute and Community Recovery Care Groups, in particular Community Mental Heath Teams (CMHT), and Inpatient units. Tests for change have been undertaken in these areas to assess whether higher bank rates can reduce the reliance on agency workers at premium rates.

Agency cap rates are set nationally and are around 23% above substantive staffing costs. Cap rates are not always adhered to, particularly with the medical workforce, where it can be challenging to source and retain agency doctors. This results in an increased pressure financially and potentially impacts on quality of service.

Agency spend is being picked up this year within the Long-Term Sustainability Programme under the Workforce Pillar, led by the Deputy Director of Workforce and Deputy Medical Director.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Impact on ability to deliver financial balance if high premium costs continue. Impact on patient safety and quality of service delivery if consistent safe staffing levels cannot be maintained. |

| | |
|---|---|
| **Assurance:** | To be assigned |
| **Oversight:** | Care Groups, Quality and Performance Review Meetings, EMT, Workforce Committee, Finance and Performance Committee |

# Finance Exception Report – Agency Spend

## 1. Introduction

Agency spend has had significant focus within the NHS for the last six years following the introduction of cap rates in 2015 to limit the amount that organisations should be spending via third party agencies for temporary workers. Cap rates currently sit at 55% above substantive pay scales, which equates to a premium charge of around 23% once employers on costs are taken into account for substantive workers.

Following a rise in agency use at KMPT, the Trust Board requested a deep dive review into spend to better understand key drivers and actions and mitigations to reduce spend in future.

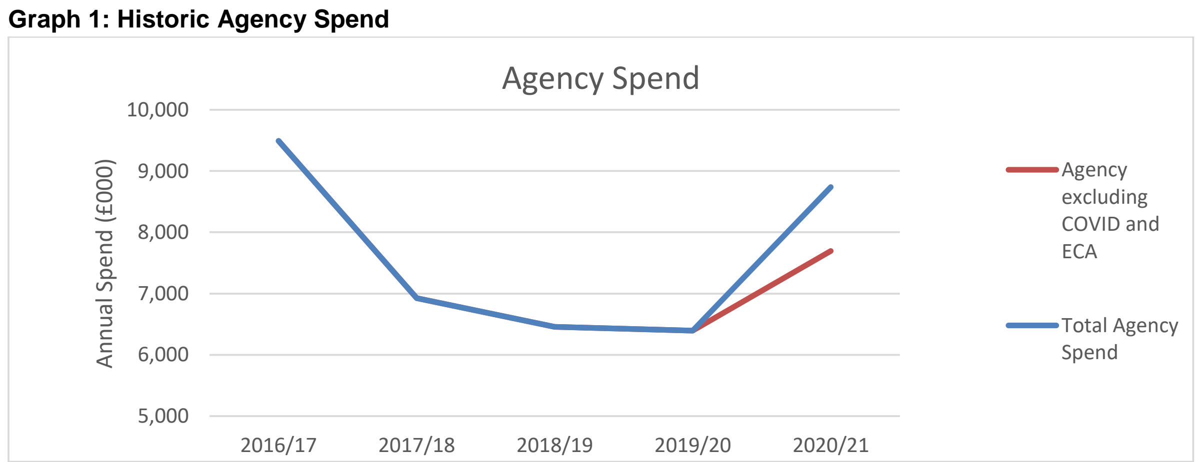
This report sets out the historic position on agency; highlights case studies over the last year where spend has been targeted and controls introduced; and outlines the key measures in place currently to manage spend.

## 2. Context

Agency spend at KMPT had been reducing consistently over a four-year period, following an increased focus and control on spend introduced in 2016/17. Spend in 2016/17 peaked at £9.5m, but quickly reduced to an average of between £6.5m and £7m for the proceeding three years, with marginal reductions year on year.

In 2020/21 during the pandemic, there was a significant rise in spend, as shown in the graph below. It also illustrates the level of pressure presented by agency spend specific to Covid and the Extra Care Area (ECA) both of which were externally funded as exceptional items. This increase has remained into 2021/22, and agency use in the first quarter has been consistent with levels of spend in 2020/21.

**Graph 1: Historic Agency Spend**



Within this the majority of spend is within the Medical and Nursing staff groups as indicated in Table 1 below. These are the areas with high vacancies and clinical risks need to be fully considered if posts are not covered. As a result, there is a reliance on temporary workers to maintain safe services and the agreed safer staffing rotas.

**Table 1: Overall Agency Spend by Staff Group**

| Staff group | 2016-17 £'000 | 2017-18 £'000 | 2018-19 £'000 | 2019-20 £'000 | 2020-21 £'000 | 2021-22 to June £'000 |
|---|---|---|---|---|---|---|
| Admin, Clerical & Management | 563 | 138 | 165 | 75 | 96 | 16 |
| Healthcare Assistants | 831 | 822 | 353 | 92 | 45 | 5 |
| Medical | 3,903 | 2,670 | 3,111 | 3,019 | 3,598 | 785 |
| Nursing | 3,376 | 2,669 | 2,442 | 3,097 | 4,550 | 993 |
| Other Non-Clinical | 518 | 511 | 323 | 87 | 289 | 48 |
| Scientific, Therapeutic & Technical | 302 | 114 | 65 | 25 | 161 | 32 |
| **Total spend** | **9,492** | **6,924** | **6,459** | **6,395** | **8,740** | **1,878** |

## 2.1 Registered Nursing

Currently within the Trust, registered nursing vacancies are 137 WTE[1]. The number of registered nurses employed has increased year on year, from 829 WTE on average in Q1 2020/21, to 860 WTE on average in Q1 2021/22[2], however there is still a significant gap to close to recruit fully to all posts, which results in continued reliance on bank and agency workers.

Particularly highest levels of spend are in the Community Recovery and Acute Care Groups. Table 2 shows the Care Group level spend trend for Agency Registered Nursing spend.

**Table 2: Registered Nursing Agency Spend by Care Group**

| Financial Year ><br>Care Group | 2016-17 £'000 | 2017-18 £'000 | 2018-19 £'000 | 2019-20 £'000 | 2020-21 £'000 | 2021-22 Q1 £'000 |
|---|---|---|---|---|---|---|
| Acute | 2,169 | 1,807 | 1,499 | 1,217 | 1,149 | 332 |
| Community Recovery | 742 | 629 | 505 | 1,214 | 2,244 | 425 |
| Forensics | 3 | 13 | 83 | 63 | 73 | 18 |
| Older Adults | 493 | 236 | 355 | 560 | 419 | 108 |
| Support Services | (31) | (16) | | | | |
| Covid 19 | | | | 43 | 389 | 52 |
| Extra Care Area | | | | | 276 | 59 |
| **Total Spend** | **3,376** | **2,669** | **2,442** | **3,097** | **4,550** | **993** |

Agency usage and spend within the Acute Care group has consistently reduced over the last five years. During this time, there have been changes in the bed base and the introduction of Support and Signposting, and expansion of Crisis Resolution Home

[1] Based on current budgets, as reported to NHSE/I in June 2021, for band 5 and above nurses trust wide
[2] Based on worked WTE for band 5 and above nurses trust wide as reported to Finance and Performance Committee and NHSE/I between April and June 2020, and April and June 2021

Treatment Services as part of the Mental Health Investment Standard. The Care Group reported higher levels of acuity and complexity within the inpatient wards which increased the level of staff require for which analysis is on-going. Due to some of the difficulties in filling shifts with NHSP bank staff, agency was utilised. However overall this has been managed to reduce spend.

Conversely, for Community Recovery, spend has increased considerably. The majority is within the Community Mental Health Teams (CMHTs) and is driven by the high levels of vacancies. There has been significant investment in these teams in the past 18 months as part of the Mental Health Investment Standard (MHIS). The Trust has not been able to recruit to the posts to match the level of investment however over the past 6 months as we come out of Covid the Care Group has done a significant amount of skill mixing which will not only improves CMHT recruitment and retention offer but aligns to the ambition to reduce agency spend. The cost has been increasing due to the above but also the rates paid for temporary workers. Difficulties in sourcing workers has resulted in a higher cost per WTE.

### 2.2 Medical staff

Difficulties recruiting substantive medical staff has led to a continued and consistently high level of medical agency. This was particularly prevalent in the Community Recovery, Forensics and Acute Care Groups. Table 3 demonstrates the spend trend.

**Table 3: Medical Agency Spend by Care Group**

| Financial Year ><br>Care Group | 2016-17<br>£'000 | 2017-18<br>£'000 | 2018-19<br>£'000 | 2019-20<br>£'000 | 2020-21<br>£'000 | 2021-22 Q1<br>£'000 |
|---|---|---|---|---|---|---|
| Acute | 698 | 665 | 1,144 | 1,027 | 918 | 184 |
| Community Recovery | 1,989 | 1,374 | 1,283 | 1,201 | 1,567 | 313 |
| Forensics | 311 | 81 | 332 | 600 | 758 | 193 |
| Older Adults | 925 | 550 | 353 | 191 | 316 | 95 |
| Support Services | (20) | | | | | |
| Covid 19 | | | | | 39 | |
| **Total Spend** | **3,903** | **2,670** | **3,111** | **3,019** | **3,598** | **785** |

While it has been difficult to successfully recruit to medical posts, it has meant that there has been a continued use of the same agency doctors, often with a high agency premium and exceeding the NHSE/I cap pay levels.

To add further pressure, it would appear that there is a limited number of agency doctors available too, which drives up the hourly rate for the staff available.

Table 4 demonstrates that whilst medical agency spend is high, volume is much lower but due to the high levels of premium and charges above the NHSE/I cap rates, still presents a significant cost pressure.

**Table 4: Adherence to Cap Rates for Medical Staff**

| Care Group | Time since first placement | % of rate above NHSE/I Cap | No. of PAs. | No of agency workers |
|---|---|---|---|---|
| Acute | Less than 6 months | 35.57% | 10 | 1 |
| | Over 1 year | 5.08% | 10 | 1 |
| | Over 2 years | 16.32% | 10 | 1 |
| CRCG CMHT | Less than 6 months | 17.85% | 10 | 1 |
| | Over 1 year | 5.52% | 10 | 1 |
| | Over 2 years | No breach | 10 | 1 |
| | 3 years or more | No breach | 10 | 1 |
| CRCG Specialist | Over 1 year | 21.57% | 10 | 1 |
| Forensics | Less than 6 months | 34.67% | 8 | 1 |
| | Over 1 year | 17.85% | 10 | 1 |
| | Over 2 years | 20.61% | 10 | 1 |
| Older Adults | Less than 6 months | 11.23% | 2 | 1 |
| | Less than 12 months | 24.04% | 10 | 1 |
| | 3 years or more | No breach | 10 | 1 |
| **TOTAL** | | | **190** | **20** |

## 3. Long Term Sustainability Plan – Workforce Pillar

As part of the recently launched Long Term Sustainability plan there is a target set for the Workforce pillar to achieve £1.0m cash releasing savings.

The workstream consists of various schemes, one of which is a reduction in agency usage. The target is to reduce overall agency spend by £2.0m. This will be achieved by other enabling programmes such as the case studies below and the upcoming Student Nurse intake and International recruitment. Increasing the Trust's recruitment into posts on a substantive basis will deliver an anticipated net saving of £0.5m.

## 4. Case Study – Band 5 Bank Rates Acute Inpatient

One initiative to reduce agency use in inpatient settings has been the pilot period of an increased bank rate for band 5 nurses. The pilot was introduced because it was becoming increasingly difficult to attract bank workers to fill vital shifts, with feedback that a key factor was low pay rates.

Benchmarking was undertaken across local provider organisations in Kent and Medway, as well as other mental health trusts in the region, to understand the approach to setting bank rates. KMPT was the lowest paying trust from this exercise.

Following a paper in December 2020 EMT agreed for a test of change of 3 months from January 2021 initially to increase the pay rate for Band 5 nurses to top of scale. This was subsequently increased to 6 months to allow for better data and trial. The objective was to:

1. Listen to feedback from our staff
2. Reduce Agency costs
3. Attract more RMNs (Band 5) to NHSP
4. Increase the number of shifts being filled by bank

The 6-month pilot concluded on 30th June. It was extended for a month to allow for the review of findings from the pilot, and for ultimate decision regarding the future of this change. There has been minimal financial impact during the pilot, but considerable impact in terms of higher bank hours worked and new workers being recruited to NHSP. This led to the recommendation that the higher bank rate is made permanent which has now been approved.

## 5. Case Study – Band 6 Bank Rates CMHTs

As mentioned above, there has been a continued and increasing trend in agency spend and a key area of pressure has been within the Community Mental Health Teams (CMHTs).

The CMHTs have sourced a high level of their agency workers from Recruitment agencies directly which has led to higher rates being agreed than may otherwise have been procured and difficulties in processing invoices for payment. CMHT teams now source their agency staff via NHS Professionals rather than the agencies directly and rates have since been renegotiated which resulted in a marginal cost reduction for the Care Group. The main focus has now turned to usage and demand.

In late May 2021 a test for change initiative was put in place to pay NHSP band 6 nurse shifts at the top point of scale for a period of six months. This was on the basis that it would test whether financial incentive attracts staff to bank alongside delivering the associated quality benefits from a more stable and consistent workforce via NHSP.

Whilst this is still in the early stages of implementation, the below identifies at this early stage a small increase in the Bank Nursing staff working within the CMHTs in June, compared to April and May.

**Table 5: Community Mental Health Teams Bank Use**

| Department | Type | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 |
|---|---|---|---|---|---|---|---|---|
| CMHT | Spend £ | 27,772 | 19,058 | 21,676 | 38,810 | 23,575 | 27,860 | 34,828 |
| | Wte | 7.42 | 5.45 | 6.08 | 11.18 | 5.30 | 7.84 | 9.12 |

## 6. Case Study – Ancillary workers

Whilst spend is relatively low when compared to the above two case studies, the ancillary workforce is one area where it has been a challenge to fill shifts via NHSP bank. This has resulted in shifts being filled with agency workers. Whilst there has been a decrease in spend as at the end of the first quarter this financial year the challenge continues. It can be seen in table 6 below, that particular pressure was experienced during the Covid Pandemic and the level of cleaning staff required.

**Table 6: Ancillary Worker Agency Spend**

| Financial Year > | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21 | 2021-22 to June |
|---|---|---|---|---|---|---|
| Care Group | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Support Services | 471 | 492 | 324 | 85 | 80 | 37 |
| Care Groups | 44 | 19 | (1) | 2 | (0) | 0 |
| Covid | | | | | 209 | 10 |
| **Total Spend** | **515** | **511** | **323** | **87** | **289** | **48** |

## 7. Conclusion

It is expected that 2022/23 planning will bring a renewed focus on agency nationally, as we transition away from the pandemic finance regime and back towards a more normal planning cycle. Whilst we await confirmation of national initiatives the Trust needs to continue and extend the work already in progress with the focus on the continued use of agency and actions that are being taken to eradicate as much as possible.

The following actions are in progress:

1. Medical agency and the placements above NHSI cap are being explored with Procurement and Medical Staffing teams to ensure the lowest rates are negotiated but also to explore if different employment models can be introduced.

2. Skill mix the medical workforce to fill long terms gaps in medical workforce with alternative models in development. A test of change for Acute Care Group is now in progress led by the newly appointed Clinical Director

3. With Clinical Directors now in post this enables delivery of clinical pathways at pace; this will support broader opportunities to skill mix at a multidisciplinary level to reduce overreliance on Nurse and Medical recruitment.

4. Contributing to this will be work that has commenced on reviewing observations using QI methodology which will be linked to a national project and from which outputs should improve not only quality and safety but also result in financial efficiencies.

5. To continue the improvements made to the rostering processes which has resulted in rosters being published 12 weeks in advance to enhance planning and enabling oversight through monitoring of unused hours and ensuring an even spread of resources.

6. To continue to the good work with NHS Professionals to increase more ancillary workers to sign up to NHSP to reduce the reliance on agency.

7. An element of bank use is inevitable; building on current work which has seen an increase in NHSP Band 5 pay rates translate to an increase in staff signing up to NHSP and has been received very positively by Care Groups. To continue with the payment review for other Bands of staff to encourage the same move from agency to NHSP

# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | 29 July 2021 |
| **Title of Paper:** | CQC Quality Improvement - Update Report |
| **Author:** | Rachel Town, Compliance and Assurance Manager |
| **Executive Director:** | Mary Mumvuri, Executive Director of Nursing, AHPs and Quality |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion and noting |
| **Submission to Committee:** | Standing Order |

## Overview of Paper

This report provides an update on progress made on the Quality Improvement Plans (QIPs) put in place following the two unannounced focussed inspections that KMPT received in November and December 2020. It includes update on the key actions underway and overseen by the CQC Oversight Group in order to ensure that the trust is prepared for future CQC inspection activity. The report was presented and discussed at the Quality Committee meeting on 20 July 2021.

### Issues to bring to the Board's attention

- Progress has been made against the two QIPs since their implementation in March/April 2021. There are no delayed or overdue actions. Progress is shared with CQC through quarterly engagement meetings.
- A further unannounced focussed inspection was undertaken by the CQC on 09 June 2021. The inspection took place as concerns had been raised about patient care on the wards at Little Brook Hospital. The inspection team looked at 2 Key Lines Of Enquiry (KLOEs) within the safe and well-led domains and the Extra Care Area. No concerns were escalated during or shortly after the meeting.
- The Boughton Ward Quality Improvement Plan (QIP) continues to be reviewed on a monthly basis via a quality summit meeting. The CQC Inspection Manager and the Relationship Owner both attended the Quality Summit on 21 July and heard first hand feedback from the ward and Care Group leadership team.
- A self-assessment on a CQC report Out of sight, who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition (Oct 2020) has identified some areas for improvement which are being worked on
- A programme of peer mock inspections, that are risk based, are underway across all inpatient services and due to conclude by beginning of August, with community-based services following shortly after. Overarching themes will inform a strategic improvement plan.

**Governance**

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

## 1. Introduction

This report provides an update on the Quality Improvement Plans (QIPs) put in place following the two unannounced focussed inspections that KMPT received in November and December 2020 in addition to Little Brook Hospital unannounced focussed inspection to all acute wards in June 2021 and the self-assessment on the CQC report- *Out of sight, who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition (Oct 2020)*

## 2. CQC Unannounced Focused Inspections and associated Quality Improvement Plans (QIPs)

### 2.1 Quality Improvement Plans (QIPs) Q1 Update

Following the two unannounced focused inspections undertaken by the CQC in November and December 2020, quality improvement plans were produced identifying the key action that would be undertaken for the must and should do's identified. The CQC Oversight Group receives assurance updates on the implementation of these plans monthly from the care groups At the end of Q1 (June 2021), the following progress has been made:

| **Acute wards and PICU inspection (Littlebrook Hospital)** | |
|---|---|
| **Must do** | |
| The trust must take action to ensure that patient's nutritional needs are assessed and provide food to meet their dietary needs including cultural and religious needs (Regulation 14). | • Referral details have been produced by the dieticians and the information page on iConnect has been updated.<br>• An audit to check compliance with nutrition policy standards was conducted in June, report will be available in Q2.<br>• CliQ checks now include a review of service user nutritional requirements in order for the associated care plan and information transfer during handover to be checked.<br>• Meal related incidents are being reported as there is heightened awareness amongst staff. Data is now available on Datix incident reporting system.<br>• Malnutrition Universal Screening Tool (MUST) training has been made essential training for all |

| | |
|---|---|
| | inpatient nursing staff which should help with assessments |
| The trust must take action to remedy all outstanding maintenance issues and ensure the facilities and equipment is well-maintained and fit for purpose (Regulation 15). | • Willowsuite works continue and are due for completion before September 2021.<br>• The new Director of Estates has reviewed processes for the monitoring of outstanding maintenance issues. A maintenance team has been setup to ensure that all estates issues identified for improvement following inspections are carried out in a timely manner with support from the finance team. |
| **Should do** | |
| The service should consider reviewing ward restrictions including use of mobile phones on an individual basis and also ensure consistency for how patients would meet with their visitors. | • Mobile phone protocol is in place and restrictions are put in place based on level of risk.<br>• An audit was conducted in May; data is currently being analysed with a plan to repeat again in July. |
| The trust should consider a robust mechanism of capturing informal complaints, feedback and concerns raised by patients and how they would address them. | • 90% of wards across the acute care group were found to be displaying their community meeting minutes in May (CliQ check data).<br>• The PALs and complaints team are providing monthly reports of informal complaints (PALs concerns) to the acute care group. |
| The service should take steps to address the mandatory training compliance to ensure the trust targets are met. | • This is being monitored by the acute care group on a monthly basis and plans are in place to ensure ongoing improvements<br>• Compliance in June was as follows for the wards at Littlebrook Hospital:<br>  ○ Willow Suite – 94.91%<br>  ○ Cherrywood Ward – 90.71%<br>  ○ Pinewood Ward – 89.02%<br>  ○ Amberwood Ward – 87.25% |
| The service should ensure patient records are thorough and complete, and there is coordination between patient records on different systems. | • CliQ checks continue to monitor the quality of documentation.<br>• The results for May for the 4 wards identified the following RAG ratings:<br>  ○ 4 x Green<br>  ○ 4 x Amber<br>  ○ 2 x Red<br>• For the 2 teams RAG rated as red, conference calls were conducted with relevant ward managers, Heads of Nursing and Senior Practitioners to check, challenge and support improvements |

| **CMHT inspection (DGS, Dover/Deal, Medway and SWK)** | |
|---|---|
| **Must do** | **Should do** |
| The trust must ensure that patients' risk assessments contain complete and good quality information, are updated, reviewed and reflective of identified risks, and that all patients have risk management plans (Regulation 12). | • As at the end of June, 84.8% of people on a CPA pathway have a risk summary and 90% of people on a Non-CPA pathway have a risk summary.<br>• The average quality of risk summaries across all CMHTs is recorded at 68% via CliQ Checks. However, three teams achieved results under 50% and are receiving support to improve. Excluding |

| CMHT inspection (DGS, Dover/Deal, Medway and SWK) | |
|---|---|
| **Must do** | **Should do** |
| | these exceptions, the average result across the remaining teams is at 80%. This is an improvement from 64% at the previous round.<br>• Risk summary guidance sessions have been provided to each CMHT and the Team Leader forum. In total, 172 staff have received this training and additional sessions will be provided in July for any staff who have missed these sessions. This is part of a QI project led by Clinical Director. |
| The trust must ensure that, where necessary, patients have a crisis plan that has been developed with the patient, and where relevant their carer. Plans must contain complete and good quality information, identify the patient's triggers and any support available for the patient and carer (Regulation 12). | • At the end of June, 84.6% had a crisis care plan.<br>• The average quality of crisis care plans across all CMHTs is recorded at 79% via CliQ Checks. However, one team achieved a result under 50% and they are receiving support to improve. Excluding this exception, the average result across the remaining teams is at 84%. The results at the previous round were at 83% which demonstrates that this improvement is being sustained. |
| The trust must ensure that patients receive assessment and treatment that they need without extended delay and within trust targets (Regulation 17). | • At the end of June, the 4 week wait was measured at 76% and the 18 week wait is measured at 90.7%.<br>• The exceptions with the 4 week wait was mainly the West Kent CMHTs, in particular the South West Kent CMHT. This team has historically struggled to appoint Band 6 Nursing staff. There are a number of agency nurses covering these vacancies but are mainly carrying caseloads. As a result of this, all new referrals and first assessment appointments are being conducted by the Maidstone team. By doing this, capacity in the WK team has increased and they are now able to offer more assessment slots, increasing the number of appointments.<br>• The total number of people waiting 18 weeks or longer for psychology input in March 2021 was at 96. Total number of people waiting 18 weeks or longer for psychology input in May 2021 was at 87. An action plan is in place to monitor this. |
| **Should do** | |
| The trust should ensure that they deliver on their plans to improve telephone access for patients and staff to all teams as per their plan. | • A new telephony provider has been appointed and are working on a delivery plan which should functionality and provide a greater variety of options to ensure that calls are answered timely and efficiently.<br>• Post call surveys will also be available for both staff and patients alike, so for the first time, KMPT will have a standardised way of gaining immediate feedback on the telephony service.<br>• Healthwatch will be visiting CMHTs later this year and will obtain feedback from patients about the telephone service to identify if improvements have been noted. |

| CMHT inspection (DGS, Dover/Deal, Medway and SWK) | |
|---|---|
| **Must do** | **Should do** |
| | • The Mystery Shopper exercise started in July whereby an expert by experience will be calling 46 services. A report outlining the findings will be shared at TWPCEG and the CQC Oversight Group. |
| The trust should consider improving the process for 'Red Board' meetings to ensure consistency across the teams, capture patients who present with emerging risks to prevent deterioration and record decisions for removing patients. | • The Red Board Protocol has been updated and shared with staff and will be subject to ongoing reviews for effectiveness.<br>• SMT/Executive attendance at RED Board meetings continues across all teams. The latest feedback from these is that some teams have increased what is covered which is burdensome. Teams have been asked to identify areas that can be monitored elsewhere so the meetings remain as a safety huddle. |
| The trust should continue to regularly review the numbers of staff needed in each of the teams to be able to deliver safe and efficient care to patients. | • Vacancy rates have been increasing from 13.39% in March to 17.59% in May. These are being addressed via Tackling the vacancy challenge, skill mixing and some of the recruitment drives.<br>• Turnover rate was at 8.5% in March, 11.1% in April and 9.43% in May.<br>• Each CMHT has a bespoke recruitment action plan which includes skill mixing. |
| The trust should ensure governance systems are effective and they respond to managing risk promptly. | • Actions are not due until Q2.<br>• Trust's performance management framework is under review with the aim of relaunching QPRs from September with greater focus on exceptions and evidence of appropriate scrutiny of metrics at care group meetings.<br>• Care groups exception reporting to be supported by performance team using appropriate tools (e.g. SPC). |
| The trust senior leaders should ensure they improve relationships, support and communication within the community mental health teams. | • Actions are not due until Q3.<br>• Training around creating psychologically safe teams is to be piloted in one team per care group including CRCG. Executive Team have spent time with teams across the Trust. |

### 2.2 Focussed inspection to Little brook Hospital

A further unannounced focussed inspection was undertaken by the CQC on 09 June 2021. The inspection took place as concerns had been raised about patient care on the wards at Little Brook Hospital. The inspection team looked at 2 KLOEs within the safe and well-led domains and the ECA was reviewed by the MHA reviewer who accompanied the inspection team.

The positive feedback included observation of connected leadership that was visible on the wards. Staff were supported by the matrons and inpatient senior practitioner. Medicines management was good as was safeguarding processes. There was positive patient feedback from both Amberwood and Willow Suite.

Areas for improvement related to provision of activities on some wards, access to psychology, poor décor, restrictive interventions understanding and use of blanket restrictions on some wards and induction of NHSP staff. Work is underway to address these areas. The inspection report has not yet been received however any additional must or should do's identified will be added to the existing QIP. The service will not be re-rated as a result of this inspection.

## 3. CQC Oversight Group

The CQC Oversight Group had a refresh and refocus in May 2021 and moved to a monthly meeting schedule. The membership has been strengthened to include the Chief Operating Officer, Deputy Chief Operating Officers, Heads of Service, and recently appointed Clinical Directors. The group continues to have input from quality managers, corporate services functions and professional leads. This group has oversight of all QIPs, internally established quality summits, self-assessments from national publications and CQC bi-monthly Insight reports which provides benchmarking data.

4. **CQC report – Out of sight, who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition** - A review of the recommendations made in the CQC report that was published in October 2020 was conducted to identify gaps within KMPT and the wider health economy. There were 6 recommendations made in the report that were for NHS providers to address. KMPT was compliant with 1 of these with recommendations being partially complaint for 2 of the recommendations and for the remaining recommendations gaps were identified. An improvement plan is in place to address the gaps. These gaps included:
    - Human rights – patients do not receive information relating to this on admission and so a poster is in development which will be displayed across inpatient settings.
    - Training needs – need to provide training to tier 1 of autism and LD competency framework. Also need to include trauma informed care in PSS training. Trauma informed approach is used in Promoting Safe Services training. There is also trial of Tier 1 and 2 Autism Training that is currently in place due to report in September/October 2021, with the learning being utilised for Trust wide role out. National initiatives on training standards on Autism and LD have been delayed due to the Covid19 Pandemic.
    - Care pathway – admission and discharge processes for both inpatient and community pathways, the support that is offered and having stand-alone specialist units for those with a Learning Disability and autism all need to be considered. A new SOP is in development which will focus on LD and autism pathways. Standalone units are also being reviewed as part of the MHLD Programme Board which KMPT are part of.

# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | 29th July 2021 |
| **Title of Paper:** | Progress on Turning the Tide; Tackling Racism |
| **Author:** | Helen Greatorex, Chief Executive |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Board requested |

## Overview of Paper

This paper provides an update on the progress KMPT has made across a number of areas including the seven challenges presented to the Board by Simon Cook, the Chair of the KMPT Black Asian and Minority Ethnic Staff Network in June 2020.

## Issues to bring to the Board's attention

At its June 2020 meeting, the Trust Board recognised that in order for the Trust to tackle racism it needed to address those seven challenges. Workstreams were created for each of those challenges, some of which involved working with statutory partners and the Kent & Medway Integrated Care System (ICS).

With the support of KMPT's Black, Asian and Minority Ethnic (BAME) Staff Network, progress has been made in each of the seven workstreams and key successes include the launch with Kent Police of Operation Cavell – tackling hate crime in February 2021, creation of a dedicated Diversity and Inclusion Lead post in the ICS, a programme of training and development for mentees and mentors through the first BAME reverse mentoring programme and the appointment of 160 BAME allies.

The systems available for staff to report racism are robust, and include Freedom to Speak Up, the Trust's Green Button and Datix. Any reports of racism, however intermittent, is a very serious concern for the Trust.

The growing confidence of staff to tackle racism appears to be reflected in the improvement in KMPT's BAME staff engagement score in the annual NHS Staff Survey. With the ongoing backing from KMPT's BAME Network, the Trust's staff, partners and service users can be assured that the Trust remains committed to tackling racism in all its forms.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Increased staff turnover, reduced patient safety and poor-quality care are all risks if racism goes unaddressed |
| **Assurance:** | Not applicable |
| **Oversight:** | Workforce and Organisational Development Committee |

Version Control: 01

## Background and Introduction

This paper provides the board with an update on progress made in relation to our aim of becoming a proactively diverse and inclusive organisation whose stance on tackling racism of any kind is clear for all to see.

In June 2020, Simon Cook as Chair of the Trust's Black, Asian and Minority Ethnic (BAME) Staff Network shared an open letter with the board. Simon's letter was written in the days following the murder in the United States of George Floyd and was set against the backdrop of the emerging recognition of the increased risk that Covid-19 posed to people from a BAME background.

Simon and colleagues from the Trust's BAME Network were invited to address the Board and Simon shared his personal story and insights. They also set out a series of specific challenges; challenges that they believed if met by the Trust, would make a significant difference to the experience of existing KMPT BAME staff, and to potential employees too.

That powerful and open discussion led to the development of an action plan, sponsored by the Chief Executive and monitored by the Workforce and Organisational Development Committee.

The work sponsored by the Chief Executive, whilst starting with the challenges, has broadened over the last year and includes working at system level to drive the required changes across the county as a whole.

This short paper describes the emphasis of that work, noting that whilst much has been achieved in twelve months there is much more to do. We cannot and will not be complacent about how far we have come and today we will reiterate as a board, our commitment to driving this work faster and further than ever before.

## Feedback from Staff Following the June 2020 Board Meeting

### KMPT's BAME Staff Network

The response from staff to the board's clear signal that its intention is to step up our ambition and tackle racism in all its forms clearly and decisively has been welcomed.

Feedback from our own BAME Network was positive, with an emphasis on wanting to see changes made in response to commitments given. This paper brings an outline of the changes and feedback from the independent, anonymous Annual Staff Survey, undertaken in late 2020 showed that the changes were making an impact.

### Annual Staff Survey

The national staff survey results for KMPT reported a high overall engagement score of 7.4 for BAME staff. This was in comparison to an average overall score of 7.1 and a score of 7 for white staff. Importantly, our BAME respondents scored highly in the domains of Advocacy and Motivation; a reflection we believe that relates to the carefully tailored support and communication with BAME staff throughout the pandemic. The executive team made a commitment to ensure that they understood more about how it feels to be a member of BAME staff in KMPT and a reverse mentoring programme was established as a result.

### BAME Reverse Mentorship Programme

The establishment of a group of BAME volunteer mentors, who have each taken on a mentee from a senior role, has been an important step in sharing experiences and reflecting across different levels in the organisation. The mentors all underwent accredited training in mentorship, and the mentees were trained

in how to be mentored. The opportunity to think with and listen to a mentor colleague whose experience, role and ethnicity is different from theirs is invaluable. In KMPT, a number of initiatives and actions were well underway by mid- Summer 2020. Our thinking then moved to how we could help lead the system to a bolder statement about tackling racism.

### Working at System Level

KMPT led the system in establishing in July 2020 a county-wide network of the six provider trusts' BAME Network chairs. This pre-dated by months, the groups that NHSI/E required Integrated Care Systems (ICSs) to establish and it created a firm foundation for further work to be delivered across the system as a whole.

Examples include training and development opportunities for BAME leaders in all the trusts, and importantly the creation of a dedicated Diversity and Inclusion Lead post in the ICS. This is a newly created post, established at the behest of the county-wide network.

### Progress on Meeting the Challenges

The original seven challenges are set out below with progress shown against each.

| Challenge | | Progress |
|---|---|---|
| 1 | Increase the number of non BAME colleagues involved in the BAME Network and joining the October 2020 Black History Month conference. | • Membership of the network has increased from 100 - 140. Non BAME staff account for the majority of that increase.<br>• The Black History Month Celebration was attended by over 70 staff from all backgrounds. |
| 2 | Elevate training around race, ethnicity and respect to a more prominent position. | • Coaching course established and run. Now undergoing evaluation.<br>• Health Inequalities Group working with BAME advisors.<br>• Reverse mentoring programme established. 16 trained mentors matched to their mentees in April 2021. |
| 3 | Actively support staff to feel sure that we will support them to report racist incidents to the police. | • KMPT Chief Executive and Chief Constable launched Operation Cavell in February 2021.<br>• Programme of regular meetings between Trust Security Manager with staff and Kent Police. |
| 4 | Actively support all staff to challenge any racial incident whether it was directed at them or not | • 160 BAME Allies have been through 4 training sessions covering:<br>1) Being an active ally<br>2) Why it's a micro-aggression<br>3) Understanding white privilege and fragility<br>4) Becoming anti-racist<br>• The Freedom to Speak Up Guardian (FtSUG) sits on the BAME staff network and works closely with NHS Professionals (NHSP) to ensure BAME NHSP staff are also able to speak up.<br>• Survey sent out to 655 NHSP staff working in KMPT. Although less than 10% responded to the survey (the first of its kind) 60% of those respondents said they felt safe to speak up about anything that concerns them when working for NHSP at KMPT. |

Version Control: 01

| | | |
|---|---|---|
| 5 | To insist that Race and Diversity is included on all meeting and supervision agendas | • A specific question was added to the Trust's supervision form in January 2021 |
| 6 | To consider developing a champion/ally network for BAME staff | • BAME champion funding of £3k per Care Group has been allocated. The funding pot will be held centrally for 2021 with the BAME staff network advising Care Groups on how best to use the funding. |
| 7 | For members of the board, to educate themselves in particular, in order to understand how we can be part of the solutions for change. | • NED induction package has been reviewed and updated in the light of feedback.<br>• The Chair and Chief Executive will include in the board's development programme, a focus on this issue in the next six months. |

## Future work

In addition to action already taken, the following additional work is planned for each challenge:

| Actions planned | | Delivered By |
|---|---|---|
| 1 | • Staff network roadshows are booked throughout 2021 to continue encouraging non BAME staff to become involved in the network. | Ongoing |
| 2 | • A pilot survey with BAME services users will be carried out in June 2021<br>• Review of current Equality Diversity and Inclusion training and consideration of additional in-house course looking at equality, compassion and human rights. | Completed<br>December 2021 |
| 3 | • KMPT's Hate Crime Strategy and Policy to be reviewed and updated taking into account Operation Cavell | September 2021 |
| 4 | • Further analysis of the KMPT/NHSP survey will inform actions.<br>• FtSU Guardian will refresh the promotion of FtSU Ambassadors across KMPT and encourage more staff to become Ambassadors. Target figure to be set. | September 2021<br>December 2021 |
| 5 | • Diversity and Inclusion questions to be strengthened in the interview process for leadership roles, including Medical Staffing. Asking applicants to give examples of how they personally have moved the D&I agenda forward.<br>• Diversity and Inclusion requirements to be included in the Appraisal process this year. Staff will be asked to set an objective on what they will do to move the D&I agenda forward at KMPT. | Completed<br>November2021 |
| 6 | • BAME Allies to be invited to a catch-up meeting to find out how they are utilising their skills and if they need any further support. It will be proposed that a regular Allies meeting is set up. | September 2021 |
| 7 | • A more formal induction offer for new board members, including opportunities for learning from best practice. This will include the focus on diversity and inclusion; provide information about the workforce and those who use our services. | November 2021 |

Version Control: 01

## Summary and Conclusion

The Summer of 2020 marked a step change in the nature of conversations about the experience of KMPT staff whose background is BAME. The murder of George Floyd and the risks faced by BAME colleagues from Covid-19 provided a catalyst for a different sort of discussion, with an openness across the NHS not previously seen.

KMPT has a well-established history of being an inclusive, creative and diverse organisation with a multitude of talents drawn from a wide range of backgrounds. But, we know that we are still not free of racism. We know too that this inevitably effects lives in ways that are unimaginable to those who have never experienced it.

The Board is invited today to restate its commitment to tackle head on, racism in all its forms, wherever and whenever it occurs, making it absolutely clear that we are working hard to meet our BAME Network's overarching challenge, to become an anti-racist organisation.

The Chief Executive will continue to personally sponsor this work both in KMPT and at system level.

The Board is asked to endorse the direction of travel, noting the challenges that lie ahead and to agree the frequency with which updates are provided.

Version Control: 01

# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | 29 July 2021 |
| **Title of Paper:** | Eradicating dormitory wards in mental health facilities in Kent and Medway |
| **Author:** | Vincent Badu, Deputy Chief Executive/ Executive/ Executive Director Partnerships & Strategy |
| **Executive Director:** | Vincent Badu, Deputy Chief Executive/ Executive Director Partnership & Strategy |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Discussion |
| **Submission to Board:** | Board requested |

## Overview of Paper

A paper setting out next stage in the eradication of dormitory wards, including the pre-consultation business case (PCBC), which has been developed by the commissioners (Kent and Medway Clinical Commissioning Group (KMCCG).

## Issues to bring to the Board's attention

Following the Trust's successful bid for £12.65m of government funding for the eradication of dormitory wards in mental heath facilities in Kent and Medway, the Trust is required to commencing building works by December 2021. The works would need to be completed by November 2022 in order to meet the nationally agreed deadline.

In support of dormitory wards eradication, KMCCG has developed the PCBC following input from KMPT and other stakeholders. The KMCCG Governing Body are meeting on 29 July to discuss the PCBC, with the recommendation to approve the business case on the single preferred option and agree to proceed to public consultation. If agreed, public consultation, led by commissioners, will start on 3 August 2021 and run for seven weeks until midnight on 21 September 2021. Following consultation, KMCCG will reflect on the consultation responses and make its decision in November 2021.

This programme of work has been led by the Improving Mental Health Services Capital Project Board within the Trust, and across the system is overseen by the Kent and Medway Mental Health, Learning Disability and Autism Improvement Board.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Risk of impact on Government funding |
| **Assurance:** | Reasonable |
| **Oversight:** | Trust Board and Finance and Performance Committee |

**Background**

The NHS in Kent and Medway is committed to improving mental health services. Part of this improvement includes delivering on the Government's commitment to eradicate outdated dormitory style mental health inpatient wards. There is one remaining mental health dormitory ward in Kent and Medway, Ruby Ward, based at Medway Maritime Hospital, run by Kent and Medway NHS and Social Care Partnership Trust (KMPT).

Following a national bidding process, we were delighted to be awarded £12.65m of government funding to replace Ruby Ward with a new fit-for-purpose unit that will provide single en-suite rooms and a modern therapeutic environment for 16 older adult patients with functional mental illness (rising from 14), at our Hermitage Lane, Maidstone site. To access this government funding, we need to draw down the money in financial year 2021/22. Work must begin in December 2021, to be scheduled for completion in November 2022, to meet the nationally agreed deadline for eradicating dormitory wards for mental health patients in Kent and Medway. This is part of the national policy to eradicate mental health dormitory wards across the country by 2024.

A pre-consultation business case (PCBC) has been developed by the commissioners (Kent and Medway Clinical Commissioning Group (KMCCG)) which sets out a single preferred option proposal to vacate the current Ruby Ward at Medway Maritime Hospital and build a new older adults' mental health inpatient unit that would house Ruby Ward at our Hermitage Lane Maidstone site. The PCBC explains why, working in partnership with the CCG, we want to make the change, describes the proposals for the new unit in more detail and sets out the expected benefits. The PCBC has been developed with input from a wide range of groups and stakeholders and is based on sound clinical evidence and best practice. It has been subject to the national assurance process with NHS England and Improvement including two formal panel 'gateway' sessions including clinical review. The full PCBC is available on diligent in the Board reading room.

The KMCCG Governing Body are meeting on 29 July to discuss the PCBC, with the recommendation to approve the business case on the single preferred option and agree to proceed to public consultation. If agreed, public consultation, led by commissioners, will start on 3 August 2021 and run for seven weeks until midnight on 21 September 2021.

Board members are asked to note and discuss the information included in this paper (and in the full PCBC) and add their support to the formal recommendations to the CCG Governing Body.

**Situation**

Kent and Medway NHS and Social Care Partnership Trust and Kent and Medway CCG are working together to improve the quality of care for people who need admission to a mental health bed. Following KMPT's successful bid for £12.65m of government funding, this includes planning for a new facility for older adults with functional mental illness, as part of the national policy to eradicate dormitory wards for mental health patients.

The PCBC is available in the board reading room and details the case for change and describes proposals to build a new facility for older adults, including single en-suite bedrooms for 16 patients (rising from 14) at KMPT's Hermitage Lane Maidstone site. The new, purpose-built facility will be available to any older adult with functional mental illness, as appropriate for their needs, wherever they live in Kent and Medway. It will replace the single last remaining mental health dormitory ward, Ruby Ward, which is currently operating at Medway Maritime Hospital in Gillingham.

The new Ruby Ward would be one of several wards for older adults across Kent and Medway that provide specialist inpatient mental health care for those who need it.

Replacing multi-bed bay accommodation, the proposed new unit will offer greater privacy, access to outside space and dedicated therapeutic areas, and improved safety and infection control measures. This latter point is an increasingly important concern in light of the Covid-19 pandemic. This proposal is part of local ambitions to provide high-quality and safe accommodation and the support of multi-disciplinary specialist teams for patients who need it, within the context of a programme of wider mental health transformation and services delivered in the community as well as in a hospital setting.

**Implications/Impact:**

There is a comprehensive Integrated Impact Assessment (IIA), described in chapter 9 of the PCBC. Overall, we believe that the proposal for consultation has many more advantages than disadvantages, compared to now. The integrated impact assessment looked at the impact on:

- health outcomes
- health and care services and staff
- the groups of people who are protected by equalities law
- deprived communities
- travel and access for local people
- sustainability and the environment.

The IIA concluded that the proposal to relocate Ruby Ward to the Maidstone KMPT site would have a significant beneficial impact on quality, safety, and patient outcomes. This is because the new ward will improve privacy and dignity of care, reduce length of stay, reduce adverse incidents, ensure accommodation meets best practice for same sex accommodation within a mixed gender setting, improve facilities for visitors, improve access to therapeutic support, improve patient safety, provide flexible accommodation to meet the needs of patients, provide two additional beds to meet the needs of a growing and ageing population, and locate the ward near to other inpatient mental health services improving safety and quality.

The proposed new location for Ruby Ward is approximately 12 miles from where it currently is based at Medway Maritime Hospital. This means there could be some impact on travel times for people who are admitted to Ruby Ward, as well as for staff, visitors and the organisations providing patient transport to the ward. The travel analysis also identified that people living in the most deprived areas of Kent and Medway were more likely to be impacted by increased journey times.

We have already started thinking about how we can reduce the impact of increased travel times that some people would experience if Ruby Ward relocated to Maidstone. Patients are usually transported to the ward by ambulance or other types of patient transport; therefore, we have focused primarily on reducing the impact on visitors and also on staff.

It has already been agreed that there would be dedicated car parking for patients and visitors at the Maidstone site. There would also be benches for people to rest whilst walking from the car park to Ruby Ward, based on feedback we have already received from patients and carers. The new ward would be better set up for visitors (who may also be elderly or have a disability) with ground-floor access, dedicated visiting space and disabled facilities.

In addition, we will make sure we continue to identify visitors who may need support to get to Ruby Ward to see a loved one and continue to make best use of volunteer transport services to provide free or subsidised transport where needed.

For those staff who may have longer journey times, we will work with them on a case-by-case basis to look at how we can help to reduce the impact on them

**Assurance:**

As with all service reconfigurations, the proposals are subject to the national assurance process with NHS England/Improvement. This includes demonstrating robust evidence for how the ‘five tests’ for service change have been met as well as additional scrutiny, check, and challenge on this work programme and the development of this business case. NHSEI have approved this programme of work through its stage one and stage two gateway assurance process for service change.

**Oversight:**

This programme of work has been led by the Improving Mental Health Services Capital Project Board within the trust, and across the system is overseen by the Kent and Medway Mental Health, Learning Disability and Autism Improvement Board.

The proposals are being discussed and considered by Kent and Medway CCG, who will lead the consultation process and make a final decision on the proposals following consultation. The CCG’s decision-making meeting is planned for November 2021.

**Recommendations:**

Board members are asked to:

- Note the development of a single preferred option for the proposed relocation of Ruby Ward from Medway Maritime Hospital in Gillingham to a new purpose-built facility at KMPT’s Hermitage Lane site in Maidstone
- Note that this proposal aligns with KMPT’s wider plans for the redevelopment of the Maidstone site
- Note that KMCCG’s Governing Body is being asked to approve the pre-consultation business case for a single preferred option for the future provision of Ruby Ward services as the basis for a public consultation, and that following consultation a final decision will be made by the CCG in November 2021
- Note that, if approved, this will mean that a formal public consultation with the public will start on 3 August 2021 and finish at midnight on 21 September 2021, and that the CCG will also directly consult with HASC as per its legal duties
- Agree to support and endorse the single preferred option as set out in the business case
- Agree to support a decision for the CCG to consult, and for KMPT to engage with the consultation process as appropriate

**PUBLIC BOARD – 29 July 2021**

**Eradicating dormitory wards in mental health facilities in Kent and Medway – the proposed relocation of Ruby Ward from Medway Maritime Hospital to the Hermitage Lane site in Maidstone**

## Background – national policy context

There is a compelling body of national evidence to show that good quality buildings improve patient care and patient experience, as well as providing a better environment for staff to work in.

The Independent Review of the Mental Health Act 1983[1], the *NHS Long Term Plan*[2] and the *Care Quality Commission*[3] are all clear that dormitory wards compromise mental health patients' privacy, dignity, and safety, and increase the risk of infection (particularly in Covid-19 times).

In October 2020, the government allocated £400m over four years to remove dormitories[4] from all mental health inpatient accommodation in England and to replace the dormitory wards with single ensuite bedrooms to help improve the safety, privacy, and dignity of patients with mental illness.

The eradication of dormitories for mental health patients is expected to improve the individual care that can be given to patients, allowing them to get better more quickly and reduce the length of their inpatient stay in hospital. It is also expected to have patient safety benefits including through better infection control and by reducing the risk of incidents involving patients or staff. The investment is also expected to provide a better environment for our staff.

## Our local 'case for change'

Across Kent and Medway, we have been making good progress in improving the safety and quality of our mental health sites and facilities. Ruby Ward is the single remaining mental health dormitory ward in the area, catering for older people with acute, functional, mental health difficulties.

The investment in a new purpose-built building for these inpatient mental health services provides the opportunity to vacate the current Ruby Ward, meaning that older adult patients with mental health problems would no longer need to be cared for in a ward which is not suited to their specific needs, and which – in terms of mental health care best practice - compromises their privacy, dignity, and safety.

The unit was not designed as a mental health ward and the environment has long been recognised as not fit for purpose in terms of supporting the care of mental health patients. It does not deliver the safety, privacy, and dignity that our mental health patients have every right to expect. It has limited space for the additional therapeutic activities that can significantly contribute to the successful recovery and rehabilitation of patients. Ruby Ward is a first floor ward and does not offer easy access to outdoor space and fresh air.

Developing a new, purpose-built facility for inpatient mental health services to the new agreed specification will improve patient care, quality, and experience.

---

[1] https://www.gov.uk/government/publications/modernising-the-mental-health-act-final-report-from-the-independent-review

[2] https://www.longtermplan.nhs.uk/

[3] https://www.cqc.org.uk/sites/default/files/Brief_guide_Shared_sleeping_arrangements_on_mental_health_wards_dormitories.pdf

[4] https://www.gov.uk/government/news/over-400-million-pledged-to-remove-dormitories-from-mental-health-facilities

## Additional benefits to the wider health and care system

Vacating the current Ruby Ward would also allow Medway NHS Foundation Trust (MFT) to use the space for general and acute medicine. It will provide much needed additional physical health ward space for treating Medway residents who are currently waiting for planned treatments and procedures. Additional general hospital capacity is crucial to support the reduction in waiting times and waiting lists that have been exacerbated by the Covid-19 pandemic.

**Assessment:**

## Clinical model of care

There is national and local clinical support to eradicate dormitory wards in mental health facilities. The clinical model has been informed by a wide range of clinical evidence including national standards and clinical guidelines and the expert knowledge of clinicians locally and nationally. It has been overseen and endorsed by the Clinical and Professional Board, chaired by Dr Jihad Malasi, which sits as part of the Kent and Medway Mental Health, Learning Disability and Autism Improvement Board. In addition, the development of the proposals has been led by the trust's Deputy Medical Director and reviewed and endorsed by our Medical Director, and by the Clinical Chair of Kent and Medway CCG.

As well as ensuring effective community provision is available for people with mental illness, when a psychiatric admission is needed the ward the person is admitted to must be fit for purpose, Wards must provide a safe, high quality therapeutic environment. Board members will be aware that the proposals to relocate Ruby Ward are one part of a much wider mental health strategy for Kent and Medway and a focus on ensuring the provision of 'end-to-end' care along the patient pathway through a combination of community-based and specialist inpatient services.

We are not proposing to significantly change the clinical model of care with the relocation of services currently provided on Ruby Ward, but our proposals do enhance it. The proposed site of the new facility, at the trust's Hermitage Lane Maidstone site, will allow better co-location of the ward with other mental health services that will enable the admission of patients with a higher level of acuity as specialist staff will be close by to help support patient care and recovery. Two additional beds will be available, helping to future proof demand and capacity for services which has seen a 10-15% increase over the last 12 months. The proposed new purpose-built facility will also offer significantly more space for the therapeutic activities that support and speed up rehabilitation and recovery and are an integral part of best practice clinical standards for the care and treatment of older adults with serious mental health conditions. We expect that the proposed new facility, with the benefits of the therapeutic space it would bring, to reduce the average length of stay for patients. This is currently 66 days on Ruby Ward and higher than our other older adult mental health inpatient wards across Kent and Medway.

## A needs-led service – responding to the requirements of the patient cohort

The patient cohort currently affected by these proposals is older female adults with acute mental health difficulties who require admission to a hospital bed for a limited period. In the future, the service will cater to all older adults with acute functional mental illness as the proposed new facility will be able to accommodate patients of different genders.

Older adults are more likely to have physical health conditions and requirements. A purpose-built unit will provide an environment that is supportive to their recovery, maintains their dignity and privacy and ensures that their physical needs (medical and nursing) are met.

## Demand for services

The national and local strategic priority is to continue to enhance mental health community services, support people in their own homes and avoid hospital admission wherever possible, however, admission to an inpatient ward will be necessary for some people.

Our modelling confirms anecdotal evidence that capacity is being stretched as a result of more complex needs and staff availability – backing the case for a move to a new facility co-located nearer to other mental health services. Bed modelling work is supported by Kent and Medway's local clinicians.

## Relocation of Ruby Ward – our proposal

A modern, purpose-built facility will address the challenges currently experienced by patients and staff on Ruby Ward and bring about significant benefits in the way that care, and support are provided.

Board members will be aware that KMPT provides inpatient beds on a Kent and Medway-wide basis, with different specialist facilities and different specialist teams caring for patients in different places. There is not a concept of 'local' specialist inpatient beds designated for geographical communities – all inpatient services are provided for all Kent and Medway residents on a needs-led basis first. Admission to all our units are managed through our clinically led patient flow team who consider presenting needs of patients and how these needs can best be met by our different wards. Considerations will include the availability of appropriate care support and availability of an appropriate admission bed to meet someone's needs. The new purpose-built facility will be available to anyone who needs it wherever they live in Kent and Medway.

## Options development

Taking Ruby Ward's current location in Gillingham into account, we have worked with health and care system partners to comprehensively assess and re-assess the potential for local Medway site solutions. Five criteria have guided this assessment, based on the specific requirements of the capital bid process and the national policy relating to the eradication of dormitory wards.

- **Scale**: Sufficient suitable space, whether existing buildings for adaptation or for a new build including external space for a garden, parking etc. KMPT also prefers ground floor options for all inpatient services as it better suits patients' physical needs.
- **Availability:** Given the urgency of the national timetable, driven by both Covid-19 related concerns and the unacceptability of mental health dormitory accommodation in terms of patient safety, privacy and dignity, the building or land must be available in the short term. The timescale set by regulators for awarding capital funds to the trust is for commencement of construction of a new-build or major conversion in December 2021 to meet a November 2022 deadline for eradicating dormitory mental health wards in Kent and Medway.
- **Location alongside other acute mental health services:** our strategy for locating new acute mental health inpatient units, in common with all other mental health trusts, is to co-locate with other inpatient services to ensure the support of a wider team of mental health medical, psychological, therapeutic, and nursing staff to the ward team. Co-location offers greater workforce resilience and access to a wider range of specialist expertise. It is easier to deliver this if acute inpatient mental health services are located together. An additional benefit is that co-located services are a more attractive offer for staff and can aid recruitment, training and development, and retention.
- **Location alongside general acute hospitals:** Mental health inpatient facilities should be located close to general hospitals so that medical emergencies are more easily managed. This is significantly more important for older people with mental health problems, whose physical health care needs are usually higher, as in the general population, but further exacerbated by

their mental health problems, which can make diagnosis of serious physical health problems more difficult.

- **Site ownership:** The capital investment that the trust will receive needs to be invested in KMPT estate, owned by the trust, and declared as an asset on the trust's balance sheet. If the relocation is to be within Medway this would require the trust having to acquire a site there. We have had this position confirmed by our regulator. NHS England and Improvement also confirmed there is no additional funding available from the national programme to support acquisition of assets.

The application of the hurdle criteria against potential options led to the identification of a single preferred option for the proposed relocation of Ruby Ward including the construction of a new purpose-built facility. As there was no shortlist of options, it has not been necessary to develop or apply evaluation criteria. However, we have agreed that any additional options that may be identified during the consultation process have to address our case for change and will be assessed against the hurdle criteria above and three specific evaluation criteria:

- access
- implementability
- cost.

This assessment has resulted in a single preferred option of a new purpose-built facility on the Hermitage Lane Maidstone site. However, the CCG and trust remain open-minded to other potential solutions that may arise through consultation that meet the case for change, pass the hurdle criteria and assess well against the evaluation criteria.

### Engaging with stakeholders

Kent and Medway CCG and KMPT have worked together to engage with local stakeholders. Pre-consultation engagement activity with key stakeholders and audiences includes:

- ongoing work with patients, families, and carers on the design of the proposed new purpose-built older adults' unit
- engagement and communication with staff across KMPT through trust-wide internal communications.
- review of engagement work undertaken by KMPT and Kent and Medway CCG with relevant patient cohorts to gather and review existing insights
- initial contact with and planning for further briefing and engagement sessions with stakeholders including voluntary and community sector organisations, local MPs, and councillors, Healthwatch Medway and Healthwatch Kent, local patient representative groups linked to KMPT and Kent and Medway CCG
- ongoing engagement and liaison with Kent Health Overview and Scrutiny Committee (HOSC) and Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) (updates and attendances at formal meetings and informal meetings, briefings and working groups)
- targeted engagement in the form of focus groups and 1-1 interviews with current and previous users of Ruby Ward services and their loved ones and carers
- planning for a seven-week period of public consultation that will take place with local people including staff, patients, families, and carers who have used the Ruby Ward service. The CCG will also directly consult with HASC as per its legal duties.

### Scrutiny committees

The case for change and emerging proposal was presented to Medway Health and Adult Social Care Overview and Scrutiny Committee (HASC) at its meeting on Wednesday 17 March 2021. At that meeting, members agreed the proposal was a significant variation of service and requested formal consultation for a proportionate period of six weeks. The CCG is planning to hold a seven-week consultation for extra rigour of approach and to give an additional week during September for all those with an interest in the proposals to have their say.

The Kent Health Overview and Scrutiny Committee (HOSC) received an informal briefing in spring 2021 and a formal update at their meeting on 10 June 2021. Members agreed that the proposal did not constitute a substantial variation to service. We are committed to ongoing engagement with members and, in partnership with the CCG, will keep them updated on this programme's progress as formal public consultation will include Kent residents as Ruby Ward patients are drawn from across the entire Kent and Medway area.

### Benefits framework

An initial benefits framework is set out clearly the PCBC and will be further developed for the decision-making business case. It describes the clinical, patient experience, staff, estate, and environmental benefits the proposal would bring.

### Impact assessments

An Integrated Impact Assessment (IIA) has been undertaken as part of the proposal to re-locate Ruby Ward. It has concluded that the proposal would have a significant beneficial impact on quality, safety, and patient outcomes. Groups with protected characteristics (particularly people with disability, older people, men, transgender people and BAME communities) and deprived communities are likely to disproportionally benefit from the proposals as they are more likely to use the service or need to be able to access the service in future.

Travel analysis has been undertaken that looks at the impact of the proposal on people travelling to their nearest ward and for patients travelling to Ruby Ward from across the north and west of Kent and Medway, as 80% of Ruby Ward patients are from this area. The proposals would result in minimal change in travel times by car at peak and off-peak times (and a reduction in travel times for some), but a potential increase for some who would use public transport. This latter category would mean an impact for visitors and staff who travel to work on public transport rather than patients. Patients would not travel to Ruby Ward for admission by public transport, they would not be well enough so would typically arrive by ambulance, patient transport, taxi, or driven by a loved one or friend. In addition, whilst the changes will result in some patients, staff and visitors having to travel slightly further to access Ruby Ward in its proposed new location, it is considered that this is more than offset by the quality, safety and clinical patient outcomes benefits of the proposals.

### Financials – affordability

The PCBC demonstrates that the proposals are affordable and supported by appropriate capital and revenue modelling, including a review of workforce requirements. The analysis concludes that redevelopment on the Maidstone site is affordable and sustainable to the local health and care system and the plans are supported by the wider Integrated Care System. Further details can be seen in Chapter 13 of the PCBC

### Implementation planning

A robust and comprehensive implementation planning process is underway to support the delivery of the programme. Implementation planning work covers the design and development of the proposed new

facility, ensuring that clinical best practice and patient and staff insight is at the heart of the proposal. The work has progressed at pace in line with the project and funding timescales agreed at the time of the award with the Department of Health and Social Care. It is preparatory work and subject to the final outcome for the future location of Ruby Ward which will be decided by Kent and Medway CCG Governing Body after the period of public and HASC consultation.

Significant focus is given to not just the building and fitting out of the new facility but also how it would get up and running and how the transition would be managed from the current Ruby Ward to the new. The KMPT older adults' service lead and HR business partners are working closely with the programme's leadership to plan and deliver staff engagement and the necessary formal HR consultation with all staff who would be impacted by the proposed move. To note, no jobs would be at risk although some members of staff may choose not to relocate to Maidstone. For those staff we have plans in place to support them each individually to find an alternative suitable role either within other KMPT services based in Medway or with other NHS partners based in Medway.

## Consulting – planning and approach

A comprehensive and proportionate public consultation is being planned, with an emphasis on how the proposals will impact on the current, recent, and potential future users of Ruby Ward services, their families and loved ones. The consultation plan is well-developed and has been reviewed and scrutinised by a range of stakeholders and partners, including Medway HASC, Medway Healthwatch, Kent Healthwatch and NHS England/Improvement.

Our approach to consultation has been informed by best practice principles, complies with legal and statutory duties, and reflects the current coronavirus context. The consultation plan is proportionate and takes account of people having varying levels of interest and prior involvement in the proposals. Consultation activities have been designed to reach and collect feedback from a broad range of audiences, including the seldom heard, those with protected characteristics and the digitally excluded, through a mixture of channels. How people want to participate in public consultations varies widely, and different ways to receive information and participate are offered. Once consultation is underway, the CCG will maintain a flexible approach to assessing the effectiveness of the activities identified in the plan, especially in light of the easing of Covid-19 restrictions (or further restrictions being put in place) and will amend their approach as appropriate. The consultation plan is an appendix of the pre-consultation business case.

## Feedback from the assurance process with NHS England/Improvement

The PCBC has been developed in line with the legal and statutory duties that the NHS must discharge, and guidance it must adhere to, for substantive service change. This includes the assurance process undertaken by the regulator, NHS England/ Improvement, as additional scrutiny, check, and challenge on this work programme and the development of the pre-consultation business case.

The proposal is in line with *Five Year Forward View for Mental Health*[5] and the *Mental Health Long Term Plan*[**Error! Bookmark not defined.**] and supports the delivery of national policy to eradicate mental health dormitory wards for improved privacy, dignity, and safety for patients.

## Conclusion

We are grateful to staff, patients, and stakeholders for their input in developing these proposals. The single preferred option outlined in the PCBC describes a significant opportunity to make a tangible difference to the experiences of patients and their loved ones who require inpatient admission during a period of serious mental ill health, and will ensure that they have the privacy, dignity, and safety that they need and deserve. Staff, too, will benefit from being able to care for patients in an environment that

[5] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

supports more effective therapeutic activity, offers greater opportunities for professional support and development, and helps manage the infection control considerations that are more important than ever in light of Covid-19.

# TRUST BOARD MEETING – PUBLIC

## Meeting details

**Date of Meeting:** 29th July 2021

**Title of Paper:** NHSE/I Board Self-Certification Declaration

**Author:** Tony Saroy, Trust Secretary

**Executive Director:** Helen Greatorex, Chief Executive

## Purpose of Paper

**Purpose:** Approval

**Submission to Board:** Statutory

## Overview of Paper

A paper setting out assurance to the Board that the Trust is in a position to self-certify that it can meet the obligations set out in the NHS provider licence and that it has complied with governance requirements.

## Issues to bring to the Board's attention

On an annual basis, the NHS Provider Licence regime requires two declarations:

- Providers must certify that their board has taken all precautions necessary to comply with the licence, NHS acts and NHS Constitution.
- Providers must certify compliance with required governance standards and objectives.

The Trust has a robust governance structure which supports the Trust's position that it is able to self-certify against those two declarations. The governance structure itself is subject to a number of checks and balances by way of regular oversight externally by the Trust's External and Internal Auditors, and internally by way of the Audit & Risk Committee and the Board itself.

Current assurances include year-end documentation, together with the Annual Governance Statement, which was audited by Grant Thornton in June 2021 and approved by the Trust Board in the same month.

## Governance

**Implications/Impact:** Impact on legal compliance - NHS trusts are subject to the equivalent of certain provider licence conditions (including Condition G6 and Condition FT4) and must self-certify under these licence provisions.

**Assurance:** Significant

**Oversight:** Oversight by Trust Board

Version Control: 01

# NHSE/I Board Self-Certification Declaration

## Introduction

This is the fifth year NHS Trusts must self-certify. NHS Trusts are exempt from needing a provider licence however, directions from the Secretary of State requires NHSE/I to ensure that all NHS Trusts comply with specific conditions that are equivalent to the provider licence.

NHS Trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements. The self-certification requirement set out in CoS7 (3) does not apply to NHS Trusts and therefore we are not required to comply with this condition. The Trust has to self-certify that it is compliant with the following conditions:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)).
- The provider had complied with required governance arrangements (Condition FT4(8)).

## KMPT Approach and Assurance

The aim of self-certification is for providers to be assured that they are compliant with the relevant conditions. The templates supplied by NHSE/I have been completed to prove compliance, with the necessary and recommend governance processes followed which are summarised below.

- Internal and External Audit Assurance.
- Externally audited year end documentation including the Annual Governance Statement.
- Standing Financial Instructions.
- Standing Orders for the Board of Directors.
- Annual Decelerations of Interests, Fit and Proper Person Test and Corporate Governance queries.
- Managing Conflicts – Interests, Gifts, Hospitality and Sponsorship Policy and Procedure.
- Terms of Reference and Workplans for each of the Board Sub-Committees.
- Board and Board Sub-Committee Self-Assessments.
- Regular review of the IQPR, Finance Performance Report and Financial Plan by Board and its Sub-Committees.
- Regulatory inspection compliance.
- Board Assurance Framework.
- Non-Executive and Executive visits to services.

**Recommendation**

It is recommended that the Trust Board approves the compliant self-certification declaration for 2020-21 as per the NHSE/I requirement.

**Worksheet "FT4 declaration"**

**Financial Year to which self-certification relates** | 2020-21 | Please Respond

## Corporate Governance Statement (FTs and NHS trusts)

*The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one*

| | Corporate Governance Statement | Response | Risks and Mitigating actions | |
|---|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 3 | The Board is satisfied that the Licensee has established and implements:<br>(a) Effective board and committee structures;<br>(b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and<br>(c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes:<br><br>(a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively;<br>(b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations;<br>(c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions;<br>(d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern);<br>(e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making;<br>(f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence;<br>(g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and<br>(h) To ensure compliance with all applicable legal requirements. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure:<br><br>(a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided;<br>(b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations;<br>(c) The collection of accurate, comprehensive, timely and up to date information on quality of care;<br>(d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care;<br>(e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and<br>(f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| **Signature** | **Signature** |
|---|---|
| **Name** Chairman | **Name** Chief Executive |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A | | Please Respond

## Worksheet "G6 & CoS7"

Financial Year to which self-certification relates: 2020-21 — Please complete the explanatory information in cell

# Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

*The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.*

### 1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

| | Statement | Response | |
|---|---|---|---|
| 1 | Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution. | Confirmed | OK |

### 3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

**EITHER:**

| | Statement | Response | |
|---|---|---|---|
| 3a | After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. | | Please Respond |

**OR**

| | Statement | Response | |
|---|---|---|---|
| 3b | After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services. | | Please Respond |

**OR**

| | Statement | Response | |
|---|---|---|---|
| 3c | In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate. | | Please Respond |

**Statement of main factors taken into account in making the above declaration**

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

| | | | |
|---|---|---|---|
| **Signature** | | **Signature** | |
| **Name** | | **Name** | |
| **Capacity** | Chairman | **Capacity** | Chief Executive |
| **Date** | 29 July 2021 | **Date** | 29 July 2021 |

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

| | Title of Meeting | **Board of Directors (Public)** |
|---|---|---|
| | Meeting Date | **29 July 2021** |
| | Title | **Audit and Risk Committee (ARC) Report** |
| | Author | **Peter Conway, Chair of ARC** |
| | Presenter | **Peter Conway, Chair of ARC** |
| | Executive Director Sponsor | **N/A** |
| | Purpose | **Assurance** |

## Summary

The Audit and Risk Committee (ARC) met on 15 June 2021 to consider:

- Annual Accounts (audited) 2020-21
- Annual Report (part audited) 2020-21
- Risk Management
- Single Point of Access Service
- Auditors' Progress Reports
- Finance Matters/Updates
- Gifts and Hospitality Registers
- Fire Safety Annual Review

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

| **Area** | **Assurance** | **Items for Board's Consideration and/or Next Steps** |
|---|---|---|
| Financial Reporting | Annual Accounts (audited): Subject to some final checks by Grant Thornton, an unqualified audit opinion will be given | ARC recommends that the Accounting Officer and Board approve the Annual Accounts at the meeting on 24 June. |
| Financial Reporting | Annual Report (part audited): included receiving positive FTSU assurance. Value for Money Audit not due until September. | 1)ARC recommends that the Accounting Officer and Board approve the Annual Accounts at the meeting on 24 June<br>2)FTSU reporting and scrutiny to be clarified across Board and its sub-committees |
| Risk Management | 1)Risk Registers: new formats received demonstrating good progress. Various comments and suggestions made<br>2)Single Point of Access Risk Deep Dive: risk mitigations underway which are appropriate but challenging to implement. Target dates of end July are likely to need extending. Alignment of service and Trust risk registers required | 1)Board to acknowledge progress and direction of travel<br>2)Interim clinical support to mitigate safety risks may need extending. It will take time to embed new arrangements for telephony, staffing, training, wellbeing, operational processes, 111 alignment and data. |

| | | |
|---|---|---|
| | | High risk service. Board may wish to receive interim progress reports |
| Auditors' Progress Reports | 1)Internal Audit: 2x reasonable assurance reports (Financial Systems and Risk Management) and 1 substantial assurance (Data Security and Protection Toolkit). Amendments to TIAA workplan agreed (timing delay of one audit and substitution of Maintenance Governance audit for Infrastructure Refresh Programme audit)<br>2)Counter Fraud: positive assurance | Auditors positive about Trust's cyber-security work which benchmarks well with other SE Region Trusts |
| Finance Matters | Single Tender Waivers: positive assurance | |
| Internal Controls | 1)Gifts and Hospitality Registers: positive assurance<br><br>2)Fire Safety: positive assurance | 1)Very few entries on the register. Policy compliance to be reviewed in September |

## 1 Recommendation

**The Board is asked to:**

1) **Note the content of this report**
2) **Provide direction regarding ''Items for Board's Consideration'' where appropriate and/or complete recommended next steps**

| Title of Meeting | **Board of Directors (Public)** |
|---|---|
| Meeting Date | **29 July 2021** |
| Title | **Quality Committee Report** |
| Author | **Fiona Carragher, Non-Executive Director and Committee Chair** |
| Presenter | **Fiona Carragher, Non-Executive Director and Committee Chair** |
| Executive Director Sponsor | **N/A** |
| Purpose | **For Noting** |

## Executive Summary

The Quality Committee was held on 20 July 2021. In line with the Committee work plan, the following items were discussed and scrutinised as part of the meeting:

1. Quality Digest
2. Quality Risk Register
3. CQC Report
4. Quality Impact Assessments
5. Infection Prevention and Control – Board Assurance Framework (July 2021)
6. Mortality Report Q1
7. Active Review Team
8. Acute Care Group - Physical Health Audit
9. Complaints annual report
10. Safeguarding Annual report
11. Medicines Management/ Controlled Drugs annual report
12. Psychological Therapies Waiting List

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

### 1. Risk Register

The Committee received and noted the report.

It was reported that 10 (2.4%) of the quality risks are rated as high but considered to be poorly controlled due to insufficient effective controls across the three lines of defence.

The Committee noted that most of the new risks added to the report in July relate to capacity and environmental factors, with a notable increase in risk score relate to staffing factors.

The Committee were provided with assurance around recruitment and new roles that are being developed as well as a significant increase in the recruitment of newly registered nurses filling all inpatient vacancies by September 2021. Confirmation was provided about the revised robust preceptorship programme in place and that

ongoing monitoring will be via the Workforce Committee, with assurance provided that all new multi-professional roles and new ways of working are subject to quality impact assessments and ongoing monitoring.

The Committee agreed to bring to the Board's attention, the TGU estate risk associated for which with the cost of refurbishment is potentially higher than a new build.

**2. Updated Infection Prevention and Control (IPC) Board Assurance Framework (BAF) July 2021**

The Committee were asked to note the NHS England updates in the BAF (v1.6) and the self-assessment completed by the Trust in July. Minor gaps in assurance and the mitigations in place were highlighted, noting that there are no uncontrolled risks identified. This report will be submitted to NHSE by end of July, in line with their requirements.

The Committee noted the ongoing hard work by the infection control team, and the cautious and risk-based approach to IPC and keeping everyone safe. The Committee agreed to endorse the paper before submission to the Board and NHSE, based on the detailed upfront analysis.

**3. Annual Complaints Report**

The Committee received and noted the report.

The Committee noted an overall steady state in terms of the delivery of a Patient Advice and Liaison and Complaints services.

Key themes for improvement were noted by the Committee:

- Lack of access and appropriate treatment
- Staff attitude and poor communication
- Concerns from carers about their inclusion, or lack of, in the care provided to their relative
- Increases in complaints from May – June for West Kent community Team (as noted in the Quality Digest)

It was noted that the majority of PALS and complaints are still raised by the patient directly, although a significant proportion of contacts are raised by carers or family members.

The Committee noted a positive reduction in the number of re-opened complaints due to dissatisfaction with the initial complaint outcome response, with 17% of cases re-opened in 2019-20, compared to 13% for 2020-21.

It was reported that the Acute Care Group has the highest percentage of overall complaints, but do also receive a high number of compliments.

The Committee were advised that self-assessment work is underway with the PHSO over the next 6 months, as well as Quality Improvement work and improvements to shared learning approaches.

The Committee noted that SMART actions are agreed to embed the learning and

disseminate across the care group(s) for improvements in care and delivery of services, remaining a key priority for this next year.

Committee endorsed the report.

4. **Customer service/Therapeutic engagement**

The new roles in inpatient to support healthy wards were noted as an innovative approach to providing a wider range of therapeutic activities. The Committee briefly discussed and agreed to pursue opportunities across each locality, particularly around sport and exercise (Big Sport England), and the possibility of partnering with customer service experts in the private sector in order to hear from the silent voices (people who might not provide direct feedback through compliments or complaints or PREM). The Committee were advised that a voluntary service review is underway, looking at how best to place volunteers in the future. The Committee wanted to escalate this good news and positive future working to the board.

5. **Annual Reports**

To note that all annual reports were reviewed and endorsed by the Committee; attached for noting by the board.

**The Board is asked to:**

1) **Note the content of this report.**
2) **Receive the attached Annual Reports:**
   a) **Infection, Prevention & Control Board Assurance Framework**
   b) **Safeguarding Annual Report**
   c) **Mortality Report Q1**

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Publications approval reference: 001559

# Infection prevention and control board assurance framework

June 30th, 2021. V1.6

Updates from V1.5 highlighted

## Foreword

NHS staff should be proud of the care being provided to patients and the way in which Foreword

NHS staff should be proud of the care being provided to patients and the way in which services have been rapidly adapted in response to the COVID-19 pandemic.

Effective infection prevention and control is fundamental to our efforts. We have developed this board assurance framework to support all healthcare providers to effectively self-assess their compliance with PHE and other COVID-19 related infection prevention and control guidance and to identify risks. The general principles can be applied across all settings; acute and specialist hospitals, community hospitals, mental health and learning disability, and locally adapted.

The framework can be used to assure directors of infection prevention and control, medical directors and directors of nursing by assessing the measures taken in line with current guidance. It can be used to provide evidence and as an improvement tool to optimise actions and interventions. The framework can also be used to assure trust boards.

Using this framework is not compulsory, however its use as a source of internal assurance will help support organisations to maintain quality standards.

Ruth May

Chief Nursing Officer for England

## 1. Introduction

As our understanding of COVID-19 has developed, PHE and related; guidance on required infection prevention and control measures has been published, updated and refined to reflect the learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, services users and staff.

We have developed this framework to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The tool therefore can also provide assurance to trust boards that organisational compliance has been systematically reviewed.

The framework is intended to be useful for directors of infection prevention and control, medical directors and directors of nursing rather than imposing an additional burden. This is a decision that will be taken locally although organisations must ensure they have alternative appropriate internal assurance mechanisms in place.

## 2. Legislative framework

The legislative framework is in place to protect service users and staff from avoidable harm in a healthcare setting. We have structured the framework around the existing 10 criteria set out in the Code of Practice on the prevention and control of infection which links directly to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Health and Safety at Work Act 1974 places wide-ranging duties on employers, who are required to protect the 'health, safety and welfare' at work of all their employees, as well as others on their premises, including temporary staff, casual workers, the self-employed, clients, visitors and the general public. The legislation also imposes a duty on staff to take reasonable care of health and safety at work for themselves and for others, and to co-operate with employers to ensure compliance with health and safety requirements.

Robust risk assessment processes are central to protecting the health, safety and welfare of patients, service users and staff under both pieces of legislation. Where it is not possible to eliminate risk, organisations must assess and mitigate risk and provide safe systems of work.

Local risk assessments should be based on the measures as prioritised in the hierarchy of controls. In the context of COVID-19, there is an inherent level of risk for NHS staff who are treating and caring for patients and service users and for the patients and service users themselves in a healthcare setting. All organisations must therefore ensure that risks are identified, managed and mitigated effective

# Infection Prevention and Control Board Assurance Framework

This Framework template is provided by NHSE/I. It has been populated as required by NHSI/E in January 2021 and will be reviewed in July 2021.

| 1. Systems are in place to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks posed by their environment and other service users. | | | |
|---|---|---|---|
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| | | | |
| Systems and processes are in place to ensure:<br>• local risk assessments are based on the measures as prioritised in the hierarchy of controls. The risk assessment needs to be documented and communicated to staff;<br>• the documented risk assessment includes:<br>○ a review of the effectiveness of the ventilation in the area;<br>○ operational capacity;<br>○ prevalence of infection/variants of concern in the local area. | • Suspected or positive patients are isolated<br>• Reduced staff working in areas to avoid overcrowding<br>• Virtual assessments offered<br>• PPE supplied<br><br>• Room capacities stipulated in all areas<br>• Regional meetings attended to be notified of variants of concern | NA | NA |

| | | | |
|---|---|---|---|
| • triaging and SARS-CoV-2 testing is undertaken for all patients either at point of admission or as soon as possible/practical following admission across all the pathways;<br>• when an unacceptable risk of transmission remains following the risk assessment, consideration to the extended use of Respiratory Protective Equipment RPE for patient care in specific situations should be given;<br>• there are pathways in place which support minimal or avoid patient bed/ward transfers for the duration of admission unless clinically imperative;<br>• that on occasions when it is necessary to cohort COVID-19 or non-COVID-19 patients, reliable application of IPC measures are implemented and that any vacated areas are cleaned as per national guidance;<br>• resources are in place to enable compliance and monitoring of IPC practice including:<br>  ○ staff adherence to hand hygiene;<br>  ○ patients, visitors and staff are able to maintain 2 metre | • All patients tested at admission<br>• Discussions with IPC team and Tactical to discuss use in specific situations<br>• Patients are admitted to a needs lead bed and are only transferred if clinically imperative<br>• Standard operating procedure developed and used to support IPC measures including decontamination of vacated areas | • Some patients refuse swabbing | • Patient isolated for 10 days if refuse to swab<br>• Enhanced observations<br>• Monitoring of vital signs |

| | | | |
|---|---|---|---|
| social & physical distancing in all patient care areas, unless staff are providing clinical/personal care and are wearing appropriate PPE;<br>○ staff adherence to wearing fluid resistant surgical facemasks (FRSM) in:<br>▪ a) clinical;<br>▪ b) non-clinical setting;<br>○ monitoring of staff compliance with wearing appropriate PPE, within the clinical setting;<br>• that the role of PPE guardians/safety champions to embed and encourage best practice has been considered;<br>• that twice weekly lateral flow antigen testing for NHS patient facing staff has been implemented and that organisational systems are in place to monitor results and staff test and trace;<br>• additional targeted testing of all NHS staff, if your location/site has a high nosocomial rate, as recommended by your local and regional Infection Prevention and Control/Public Health team; | • The Trust has a SOP in place and it is regularly reviewed in line with the latest guidance<br>• IPC continue with Hand Hygiene audits, IPC precautions are promoted and staff have access to iLearn<br>• Monthly hand hygiene audit<br>• Ward managers/team leaders monitor compliance with the over-arching guidance from Matrons and IPC team<br>• The Trust has set PPE guidance to be used in the services in line with national guidance.<br>• IPC team complete monthly Spotlight checks in all areas.<br>• There is a robust testing strategy in place. Staff test at home using the lateral flow tests twice per week and request a PCR swab test if positive. They are advised to isolate as per latest guidance. Outbreaks are declared for two or more people with a positive covid-19 PCR swab result and outbreak policies are followed including PCR testing for all staff. Staff report via Path-EKS. A weekly report is sent to NHSE. | | |

| | | | |
|---|---|---|---|
| • training in IPC standard infection control and transmission-based precautions is provided to all staff;<br>• IPC measures in relation to COVID-19 are included in all staff Induction and mandatory training;<br>• all staff (clinical and non-clinical) are trained in:<br>  ○ putting on and removing PPE;<br>  ○ what PPE they should wear for each setting and context;<br>• all staff (clinical and non-clinical) have access to the PPE that protects them for the appropriate setting and context as per national guidance;<br>• there are visual reminders displayed communicating the importance of wearing face masks, compliance with hand hygiene and maintaining physical distance both in and out of the workplace;<br>• IPC national guidance is regularly checked for updates and any changes are effectively communicated to staff in a timely way; | • Infection Prevention and Control e-Learning is available for all staff.<br>• Donning and doffing (putting on and taking off) of PPE training has been provided to staff on a train the trainer basis, including domestic teams. Additionally, a video showing the correct procedures is available via iLearn.<br>• PPE guidance available on intranet with each setting/context and on display in all areas<br>• IPC team check for new guidance daily and present at tactical groups | | |
| • changes to national guidance are brought to the attention of boards and any risks and mitigating actions are highlighted; | • Risk register on the pandemic is in operation. The Board is apprised on the pandemic by EMT and there is a framework of all the changes made, risk and | | |

| | | | |
|---|---|---|---|
| • risks are reflected in risk registers and the board assurance framework where appropriate;<br>• robust IPC risk assessment processes and practices are in place for non COVID-19 infections and pathogens;<br>• the Trust Chief Executive, the Medical Director or the Chief Nurse approves and personally signs off, all daily data submissions via the daily nosocomial sitrep;<br>• the IPC Board Assurance Framework is reviewed, and evidence of assessments are made available and discussed at Trust board;<br>• the Trust Board has oversight of ongoing outbreaks and action plans;<br>• there are check and challenge opportunities by the executive/senior leadership teams in both clinical and non-clinical areas. | mitigations in place with is aligned to the Recovery and Transformation Programme.<br>• IPC continue to monitor, record, and track other infections. The Physical Health Team monitors and supports the delivery of physical health care with the care teams.<br>• Covid SOP approval group, supported by 3 Executives (Chief Operating Officer, Executive Director of Nursing and Quality/DIPC and Executive Medical Director) and other clinical experts meet regularly to approve and review SOPs. All SOPs must be in line with national guidance. Updates are communicated by Communications Team and uploaded on iConnect (Trust Intranet).<br>• All Executives monitor their areas of responsibility and monitor the local, regional and national updates and feedback to Executive Management Team (EMT) daily, Tactical Teams three times a week and regular schedule of Trust meetings on risk and updates.<br>• Guidance is checked daily for any changes.<br>• CEO weekly briefings to the Board<br>• DIPC signs off sitreps<br>• IPC quarterly reports<br>• Monthly IPC Spotlight check<br>• Quality Digest report to Quality Committee | | |

| | | | |
|---|---|---|---|
| | • Integrated Quality and Performance Report to the Board | | |

| 2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections | | | |
|---|---|---|---|
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| | | | |
| Systems and processes are in place to ensure:<br><br>• designated nursing/medical teams with appropriate training are assigned to care for and treat patients in COVID-19 isolation or cohort areas;<br>• designated cleaning teams with appropriate training in required techniques and use of PPE, are assigned to COVID-19 isolation or cohort areas;<br>• decontamination and terminal decontamination of isolation rooms or cohort areas is carried out in line with PHE and other national guidance;<br>• assurance processes are in place for the monitoring and sign off following terminal cleans as part of outbreak management and actions are in place to mitigate any identified risk; | All staff caring for Covid-19 positive in isolation is appropriately trained.<br><br>• Robust cleaning procedures and trained staff are in place. Cleaning teams work closely with clinical staff to cleaning schedules and cleaning areas of suspected and confirmed cases. There are up to update SOPs on cleaning<br>• The cleaners have been trained in donning and doffing. Training is available on a continuous basis for temporary staff from matrons and clinical staff. The PPE to use has been designated by the Trust and it is available to cleaning staff at all times.<br>• Decontamination SOP details procedures, PPE and substances to be used and all are in line with national guidance.<br>• Cleaning schedules and resources have been reviewed to meet the cleaning requirements in pandemic response. This is detailed in the decontamination SOP. | NA | NA |

| | | | |
|---|---|---|---|
| • cleaning and decontamination is carried out with neutral detergent followed by a chlorine-based disinfectant, in the form of a solution at a minimum strength of 1,000ppm available chlorine as per national guidance. If an alternative disinfectant is used, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses;<br>• manufacturers' guidance and recommended product 'contact time' is followed for all cleaning/disinfectant solutions/products as per national guidance;<br>• a minimum of twice daily cleaning of:<br>○ areas that have higher environmental contamination rates as set out in the PHE and other national guidance;<br>○ 'frequently touched' surfaces e.g. door/toilet handles, patient call bells, over bed tables and bed rails;<br>○ electronic equipment e.g. mobile phones, desk phones, tablets, desktops & keyboards; | • SOP and posters have been put in place in line with National Guidance<br>• SOPs clearly demarcate what are reusable and how decontamination must be done in line with national guidance<br>• All Trust areas cleaned on a daily basis with Tristel/Chlorclean by facilities, staff are reminded to clean their own workspaces (such as desks etc.) as per the keeping everyone safe SOP<br>• Single use items are used where appropriate, cleaning regimes are in place for the devices that are not single use. | | |

| | | | |
|---|---|---|---|
| ◦ rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff;<br><br>• reusable non-invasive care equipment is decontaminated:<br>◦ between each use<br>◦ after blood and/or body fluid contamination<br>◦ at regular predefined intervals as part of an equipment cleaning protocol<br>◦ before inspection, servicing or repair equipment;<br><br>• linen from possible and confirmed COVID-19 patients is managed in line with PHE and other national guidance and the appropriate precautions are taken;<br>• single use items are used where possible and according to single use policy;<br>• reusable equipment is appropriately decontaminated in line with local and PHE and other national guidance and that actions in place to mitigate any identified risk; | • Decontamination checklist in annual audit | | |

| | | | |
|---|---|---|---|
| • cleaning standards and frequencies are monitored in non-clinical areas with actions in place to resolve issues in maintaining a clean environment;<br>• where possible ventilation is maximised by opening windows where possible to assist the dilution of air. | • Monthly IPC Spotlight audit | | |

| 3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance | | | |
|---|---|---|---|
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| | | | |
| Systems and process are in place to ensure:<br>• arrangements for antimicrobial stewardship are maintained<br>• mandatory reporting requirements is adhered to and boards continue to maintain oversight | • Pharmacists receive all information concerning antibiotic prescribing and challenge outside first line treatment.<br>• Infection control meeting and reporting schedules have been maintained<br>• Quarterly Board Committee Reports have been maintained<br>• Update reports have been presented to Quality Committee | **NA** | **NA** |

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | | | |
| Systems and processes are in place to ensure:<br>• national guidance on visiting patients in a care setting is implemented;<br>• areas where suspected or confirmed COVID-19 patients are being treated have appropriate signage and have restricted access;<br>information and guidance on COVID-19 is available on all trust websites with easy read versions;<br>• infection status is communicated to the receiving organisation or department when a possible or confirmed COVID-19 patient needs to be moved;<br>• there is clearly displayed, written information available to prompt patients' visitors and staff to comply with hands, face and space advice. | • Visiting reviewed regularly by Executive Management Team, Covid 19 Tactical Meeting, IPC and Care Groups.<br>• Clear signage on an all Trust buildings.<br>• Command and Control information cascade with logs of new guidance and briefings recorded.<br>• Performance, workforce and Covid status reports.<br>• There are dedicated pages on Covid-19 on the KMPT internet and Intranet. Easy reads and posters are available for staff, carers and patients.<br>• Transfers of patients are facilitated by clinicians with appropriate handover in place. | | |

| | | | |
|---|---|---|---|
| • Implementation of the Supporting excellence in infection prevention and control behaviours Implementation Toolkit has been considered C1116-supporting-excellence-in-ipc-behaviours-imp-toolkit.pdf (england.nhs.uk) | • PCR Swabs are performed prior to discharge or transfers to Care Homes, Rehab and other clinical settings. Transfers into KMPT and out of KMPT are coordinated by Patient Flow Team.<br>• Covid19 Page on iConnect with the latest guidance, SOPs and IPC contacts<br>• Posters and information distributed to services<br>• Toolkit sent out via communications | | |

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| | | | |
| Systems and processes are in place to ensure:<br>• screening and triaging of all patients as per IPC and NICE guidance within all health and other care facilities is | • All new admissions swabbed and isolated at day 1, re-swabbed at day 5 and 7 then weekly | Due to mental state, some patients may refuse to be swabbed | • Patient nursed on increased levels of observations to ensure boundaries are maintained during 10-day isolation. |

| | | | |
|---|---|---|---|
| undertaken to enable early recognition of COVID-19 cases;<br>• front door areas have appropriate triaging arrangements in place to cohort patients with possible or confirmed COVID-19 symptoms and to segregate from non Covid-19 cases to minimise the risk of cross-infection as per national guidance;<br>• staff are aware of agreed template for triage questions to ask;<br>• triage is undertaken by clinical staff who are trained and competent in the clinical case definition and patient is allocated appropriate pathway as soon as possible;<br>• face coverings are used by all outpatients and visitors;<br>• individuals who are clinically extremely vulnerable from COVID-19 receive protective IPC measures depending on their medical condition and treatment whilst receiving healthcare e.g. priority for single room isolation;<br>• clear advice on the use of face masks is provided to patients and all inpatients are encouraged and supported to use surgical facemasks (particularly when moving around the ward) providing it is tolerated and is | • Covid symptom check upon entry/admission<br>• Individuals placed in protective isolation if required<br>• Patients are risk assessed for the use of mask wearing and advised to wear when necessary | Not appropriate for all pts to wear masks due to metal strip. | • Daily Isolation notification to Patient flow team and Nursing Directorate from Clinical Leads |

| | | | |
|---|---|---|---|
| not detrimental to their (physical or mental) care needs;<br>• monitoring of Inpatients compliance with wearing face masks (particularly when moving around the ward) providing it is tolerated and is not detrimental to their (physical or mental) care needs;<br>• patients, visitors and staff are able to maintain 2 metre social & physical distancing in all patient care areas; ideally segregation should be with separate spaces, but there is potential to use screens, e.g. to protect reception staff.<br>• isolation, testing and instigation of contact tracing is achieved for patients with new-onset symptoms, until proven negative;<br>• patients that test negative but display or go on to develop symptoms of COVID-19 are segregated and promptly re-tested and contacts traced promptly;<br>• there is evidence of compliance with routine patient testing protocols in line with Key actions: infection prevention and control and testing document;<br>• patients that attend for routine appointments who display symptoms of COVID-19 are managed appropriately. | • If mask risk assessed as appropriate and patient not adhering - a Datix is submitted<br>• Swabbing SOP and Isolation guidance SOP | | |

NHS
Kent and Medway
NHS and Social Care Partnership Trust

| 6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection | | | |
|---|---|---|---|
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| Systems and processes are in place to ensure:<br><br>• separation of patient pathways and staff flow to minimise contact between pathways. For example, this could include provision of separate entrances/exits (if available) or use of one-way entrance/exit systems, clear signage, and restricted access to communal areas.<br><br>• all staff (clinical and non-clinical) have appropriate training, in line with latest PHE and other national guidance to ensure their personal safety and working environment is safe.<br><br>• all staff providing patient care and working within the clinical environment are trained in the selection and use of PPE appropriate for the clinical situation and on how to safely don and doff it.<br><br>• a record of staff training is maintained | • One- way systems are implemented where possible. Communal areas for staff are risk assessed for occupancy. Communal areas for patients are used for those in the medium risk pathway and an additional area is created where required for high risk pathway.<br><br>• Staff have had train the trainer approach in the use of PPE and the Trust with L&D have put in place e-learning courses for all staff to access.<br><br>• Training has been led by IPC team and the matrons. Student Employees have been trained by PPFs | Local training records for sessions such as donning and doffing may not be reflected in individual staff records on i-Learn. | Local Managers retain local records for team-based training. Trainers also keep a record of attendees. |

| | | | |
|---|---|---|---|
| • adherence to PHE national guidance on the use of PPE is regularly audited with actions in place to mitigate any identified risk.<br><br>• hygiene facilities (IPC measures) and messaging are available for all patients/individuals, staff and visitors to minimise COVID-19 transmission such as:<br><br>○ hand hygiene facilities including instructional posters<br><br>○ good respiratory hygiene measures<br><br>○ staff maintain physical distancing of 2 metres wherever possible in the workplace unless wearing PPE as part of direct care<br><br>○ staff maintain social distancing (2m+) when travelling to work (including avoiding car sharing) and remind staff to follow public health guidance outside of the workplace<br><br>○ frequent decontamination of | • Training records logged with L&D<br><br>• There is a weekly meeting with the matrons to support the use and procurement of PPE. Incidents are reported and recorded on Datix.<br><br>• Posters available on intranet, notice boards and hand hygiene facilities.<br><br>• Staff are regularly reminded on National guidance around distancing<br><br>• Don and doff training on iLearn<br>Posters on display in all areas. | | |

| | | | |
|---|---|---|---|
| equipment and environment in both clinical and non-clinical areas<br><br>○ clear visually displayed advice on use of face coverings and facemasks by patients/individuals, visitors and by staff in non-patient facing areas<br><br>• staff regularly undertake hand hygiene and observe standard infection control precautions.<br><br>• the use of hand air dryers should be avoided in all clinical areas. Hands should be dried with soft, absorbent, disposable paper towels from a dispenser which is located close to the sink but beyond the risk of splash contamination as per national guidance.<br><br>• guidance on hand hygiene, including drying should be clearly displayed in all public toilet areas as well as staff areas<br><br>• staff understand the requirements for uniform laundering where this is not provided for on site | • Hand hygiene facilities have posters on the | | |

| | | | |
|---|---|---|---|
| • all staff understand the symptoms of COVID-19 and take appropriate action (even if experiencing mild symptoms) in line with PHE and other national guidance if they or a member of their household display any of the symptoms<br><br>• a rapid and continued response through ongoing surveillance of rates of infection transmission within the local population and for hospital/organisation onset cases (staff and patients/individuals)<br><br>• robust policies and procedures are in place for the identification of and management of outbreaks of infection. This includes the documented recording of outbreak meetings. | correct method of hand washing.<br><br>• Uniform SOP has been developed for staff to use. Extra uniforms and new scrubs have been provided to staff<br><br>• IPC have worked with Comms and L&D to have information in training and communication. All SOPs provide up-to-date guidance in line with national guidance.<br><br>• Changes to guidance are monitored by the SOP Group and Tactical Meeting and reported to EMT.<br><br>• Incident reporting and investigation reports<br><br>Covid Outbreak plan published IMARCH reports to PHE | | |

| | | | |
|---|---|---|---|
| | | | |
| 7. Provide or secure adequate isolation facilities | | | |
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| Systems and processes are in place to ensure:<br>• restricted access between pathways if possible, (depending on size of the facility, prevalence/incidence rate low/high) by other patients/individuals, visitors or staff | • Inpatient settings are treating suspected and confirmed Covid19 have designated rooms for the treatment of patients. Self-isolation is done in rooms or cohorting if there are difficulties in self isolation e.g. patient refusing. | Inpatient rehabilitation services have shared washing facilities which may pose a challenge for isolation. | SOP in place to support staff with identifying isolation places in the units. |
| • areas/wards are clearly signposted, using physical barriers as appropriate to patients/individuals and staff understand the different risk areas | | | |
| • patients with suspected or confirmed COVID-19 are isolated in appropriate facilities or designated areas where appropriate | | | |
| • areas used to cohort patients with suspected or confirmed COVID-19 are compliant with the environmental requirements set out in the current PHE national guidance | | | |
| • patients with resistant/alert organisms are managed according to local IPC guidance, including ensuring | • IPC and Physical Health Team are monitoring all alerts and advise on care plans and placements. | | |

| • appropriate patient placement | | | |
|---|---|---|---|

| 8. Secure adequate access to laboratory support, as appropriate | | | |
|---|---|---|---|
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| There are systems and processes in place to ensure:<br>• testing is undertaken by competent and trained individuals;<br>• patient and staff COVID-19 testing is undertaken promptly and in line with PHE and other national guidance;<br>• regular monitoring and reporting of the testing turnaround times with focus on the time taken from the patient to time result is available;<br>• regular monitoring and reporting that identified cases have been tested and reported in line with the testing protocols (correctly recorded data);<br>• screening for other potential infections takes place;<br>• that all emergency patients are tested for COVID-19 on admission;<br>• that those inpatients who go on to develop symptoms of COVID-19 after admission are retested at the point symptoms arise; | • Appropriately trained staff are in place in care groups to conduct swabbing and SOPs and guidance are in place.<br>• Staff and Patient testing are in place and HR lead on staff testing and the clinical teams supported Infection Prevention and control team on patient testing. | There are no laboratory testing facilitate in Medway, therefore swabs have to transported and analysed via another Acute Trust in the North of the County. This has led to some delays in receiving patients results. | To mitigate this risk, swabs are now being sent to another Acute Trust in the system who is able to report within 24hrs.<br>IPC Team monitor response times reported by the services |

| | | | |
|---|---|---|---|
| • that emergency admissions who test negative on admission are retested on day 3 of admission, and again between 5-7 days post admission;<br>• that sites with high nosocomial rates should consider testing COVID negative patients daily;<br>• that those being discharged to a care home are tested for COVID-19 48 hours prior to discharge (unless they have tested positive within the previous 90 days) and result is communicated to receiving organisation prior to discharge;<br>• that patients being discharged to a care facility within their 14 day isolation period are discharged to a designated care setting, where they should complete their remaining isolation;<br>• that all Elective patients are tested 3 days prior to admission and are asked to self-isolate from the day of their test until the day of admission. | | | |

| 9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections | | | |
|---|---|---|---|
| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
| Systems and processes are in place to ensure: | | | |

| | | | |
|---|---|---|---|
| • staff are supported in adhering to all IPC policies, including those for other alert organisms;<br>• any changes to the PHE national guidance on PPE are quickly identified and effectively communicated to staff;<br>• all clinical waste and linen/laundry related to confirmed or suspected COVID-19 cases is handled, stored and managed in accordance with current national guidance;<br>• PPE stock is appropriately stored and accessible to staff who require it. | • IPC reporting has been maintained and is monitored and reported to IPC group.<br>• IPC and Tactical Team are monitoring changes and the implications on national guidance.<br>• SOP in place and additional collections are in place to ensure that there is no accumulation of waste.<br>• Procurement with IPC have developed PPE Stocks, the management and delivery of the PPE. There is a process in place on ordering and delivery of PPE available 7 days of the week, there are stocks in inpatient setting available 24 hrs of the day. | N/A | N/A |

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

| Key lines of enquiry | Evidence | Gaps in Assurance | Mitigating Actions |
|---|---|---|---|
| Appropriate systems and processes are in place to ensure:<br>• staff in 'at-risk' groups are identified using an appropriate risk assessment tool and managed appropriately including ensuring their physical and wellbeing is supported; | • Appropriate systems supported by Workforce, HR and Nursing Directorate are in place. | | |

| | | | |
|---|---|---|---|
| • that risk assessments are undertaken and documented for any staff members in an at risk or shielding groups, including Black, Asian and Minority Ethnic and pregnant staff;<br>• staff required to wear FFP reusable respirators undergo training that is compliant with PHE [national guidance] and a record of this training is maintained and held centrally;<br>• staff who carry out fit test training are trained and competent to do so;<br>• all staff required to wear an FFP respirator have been fit tested for the model being used and this should be repeated each time a different model is used;<br>• a record of the fit test and result is given to and kept by the trainee and centrally within the organisation;<br>• those who fail a fit test, there is a record given to and held by trainee and centrally within the organisation of repeated testing on alternative respirators and hoods;<br>• members of staff who fail to be adequately fit tested a discussion should be had, regarding re deployment opportunities and options commensurate with the staff members skills and experience and in line with nationally agreed algorithm;<br>• a documented record of this discussion should be available for the | • Managers utilise risk assessments to determine staff needs and appropriate action is taken which may include shielding, working from Home or redeployment during the pandemic.<br>• SOPs are in place in line with national guidance.<br>• The Trust has 63 Fit testers with 20 fit testing kits. Records of training are collated by L&D<br>• KMPT have been supported by the National Team<br>• Weekly reports FFP3 staff testing received from Learning and Development, shared with staff Teams, Bronze, Silver and Tactical | | |

| | | | |
|---|---|---|---|
| staff member and held centrally within the organisation, as part of employment record including Occupational health;<br>• following consideration of reasonable adjustments e.g. respiratory hoods, personal re-usable FFP3, staff who are unable to pass a fit test for an FFP respirator are redeployed using the nationally agreed algorithm and a record kept in staff members personal record and Occupational health service record;<br>• boards have a system in place that demonstrates how, regarding fit testing, the organisation maintains staff safety and provides safe care across all care settings. This system should include a centrally held record of results which is regularly reviewed by the board;<br>• consistency in staff allocation should be maintained, reducing movement of staff and the crossover of care pathways between planned/elective care pathways and urgent/emergency care pathways as per national guidance;<br>• all staff to adhere to national guidance and are able to maintain 2 metre social & physical distancing in all patient care areas if not wearing a facemask and in non-clinical areas;<br>• health and care settings are COVID-19 secure workplaces as far as practical, that is, that any workplace | • SOPs and processes are in place, the managers are supported by business partners.<br>• Processes are in place for testing, communicating results and follow up. | | |

| | | | |
|---|---|---|---|
| risk(s) are mitigated maximally for everyone;<br>• staff are aware of the need to wear facemask when moving through COVID-19 secure areas;<br>• staff absence and well-being are monitored and staff who are self-isolating are supported and able to access testing;<br>staff who test positive have adequate information and support to aid their recovery and return to work. | • Team rosters and staffing reviewed as part of Command and Control structures.<br><br>Posters and social distancing stickers displayed throughout buildings<br><br>Risk assessments conducted and room capacity displayed on rooms<br><br>Use of PPE is reiterated in SOPs, iConnect and | | |

| | | | |
|---|---|---|---|
| | PPE is available upon entry to buildings<br><br>Daily reports on staff absence including suspected Covid Cases<br><br>Wellbeing support provided by managers, HR and IPC as required<br><br>• New OH contract now in place. | | |

**Kent and Medway NHS Social Care Partnership**
**Annual Safeguarding Report 2020/2021**

## Purpose:

The purpose of this annual report is to inform Trust Board Members of the progress with regard to its statutory responsibilities for safeguarding children, young people and adults. The report identifies safeguarding activity for children, young people and adults within the Trust over 2020/2021. It provides assurance that Kent and Medway NHS Social Care Partnership has delivered its statutory responsibilities and undertaken activities appropriate in protecting patients, carers, children and their families. It further confirms that policies and procedures to guide practice are in place and accessible, raise awareness of key issues and identify key priorities for 2021/2022.

## Executive Summary:

**Safeguarding Children:**

Kent and Medway NHS Social Care Partnership has statutory responsibilities (Section 11 Children Act 1989, 2004) to promote the welfare of children and young people and ensure they are protected from harm.

The Trust has arrangements in place that reflect the importance of safeguarding and promoting the welfare of children, including:

- A clear line of accountability for safeguarding activity and deliverables.
- A Senior board level lead (Executive Director of Nursing, AHPs and Quality) and Deputy (Head of Safeguarding) with the required knowledge, skills and expertise to take leadership responsibility for the organisation's safeguarding arrangements;
- A culture of listening, learning and advocating for safeguarding children.
- Clear safeguarding referral procedures and policies.
- Clear whistleblowing procedures, which reflect the principles in Sir Robert Francis Enquiry related to "Freedom to Speak Up"
- National and local reviews are suitably referenced in staff training to enable timely and practice lead learning.

- Codes of conduct, staff expectation, NICE Guidance, and safeguarding being everybody's responsibility is embedded into safeguarding culture which is suitably referenced in training, policy, trust wide communications and actions plans to enable safeguarding and promoting the welfare of children to be recognised and addressed.
- Clear escalation policies for staff to follow when child safeguarding concerns are not being addressed by other agencies.
- Arrangements and training which set out clearly the processes for sharing information, with other practitioners and with safeguarding partners.
- Training which meets the 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' Intercollegiate Document (2019) requirements.

The Trust continues to meet its statutory obligations in terms of having the required Named Nurse for Safeguarding Children, Safeguarding Specialist Advisors and a Named Doctor for Safeguarding, all of whom contribute to the delivery of the safeguarding activity to ensure children, young people and families are support at the earliest opportunity and children and young people are protected from harm.

**Safeguarding Children Partnerships**

The Safeguarding Partners responsible for the functioning of the Safeguarding Children Partnerships are from three sectors: The Local Authority; the Clinical Commissioning Group; and the Chief Officer of Kent and Medway Police. Together, these Safeguarding Partners are in charge of agreeing on and implementing new safeguarding strategies to strengthen multi-agency working and, in turn, improve the provision of safeguarding and child protection arrangements in the local area. Safeguarding Partners must set out how they will work together with all relevant agencies and make clear their arrangements for conducting local reviews.

KMPT are active sub-group members of the Medway Safeguarding Children Partnership which replaced the Medway Safeguarding Children's Board (MSCB). The Kent Safeguarding Children Multi-Agency Partnership which replaced the Kent Safeguarding Children's Board in September 2019 has not effectivity engaged partner agencies in learning, or engagement, therefore KMPT have formally escalated this to the Health Reference Group, the Joint Exploitation Group and via the Section 11 Audit return. In mitigation, all national and KMPT learning has been embedded into KMPT safeguarding training to ensure the Trust addresses areas of development to improve safeguarding children and family outcomes.

KMPT actively participates in the Joint Partnership Health Reference Safeguarding Group, Health Liaison Meeting, the Medway Performance Management and Quality Assurance Subgroup, and Joint Exploitation Group and MASH Strategic Group to enable shared discussions, development and learning which then feed into KMPT's safeguarding development plans in the promotion of excellent safeguarding and client care. The engagement with theses groups has continued through the pandemic to ensure KMPT adhere

to their safeguarding statutory responsibilities, recognising the need to continue to advocate, promote and safeguard children at risk of harm during a period of reduced visibility and increased risk.

**Section 11 of the Children Act 1989**

KMPT are fully compliant with Section 11 of the Children Act 1989 updated 2004; and are fully committed to fulfilling this duty. It requires Local Safeguarding Children Partnerships (LSCPs) to ensure that organisations have safeguarding arrangements in place. As part of the Section 11 audit, KMPT are asked to self-assess the extent to which we meet the safeguarding requirements and standards as set out in Section 11 of the Children Act 1989 (2004). The self-assessments are submitted with evidence of compliance, which are peer and board reviewed to ensure oversight and scrutiny. The assessments are formally adapted and developed by the LSCP (Medway and Kent) to include local themes and board priorities.

**Key outcomes of the KMPT Section 11 Audit:**

KMPT is compliant with Section 11 requirements, and is meeting all key expectations and deliverables to the highest standard. KMPT have a select few areas that require review and development which are discussed below. This is significant achievement for KMPT which reflects the volume of work and commitment the KMPT Safeguarding Team, Practitioners, managers and the Board have in ensuring children are safeguarded from harm.
The areas identified for consideration will be monitored internally by the Trust Wide safeguarding group.

**Audit Areas:**

1. Senior Management have a commitment to the importance of Safeguarding and Promoting the Welfare of Children (***Fully compliant in all areas***)

2. A Clear Statement of Agency's responsibility towards children is available to all staff (***partially compliant***, the introduction of the NHSP Matrix in July 2021 will enable full compliance)

3. A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children. (***Fully compliant in all areas***)

4. Service developments take account of the need to safeguarding and promote the welfare of children and is informed, where appropriate, by the views of children and families (***Fully Compliant in all areas***).

5. Staff supervision, awareness and training on safeguarding and promoting the welfare of children for all staff working with or in contact with children and families (***Fully Compliant in all areas).***

6. Safe recruitment, vetting procedures and allegations against staff (***Fully compliant***, however an area of consideration)

   *Area for consideration:*

   - The LSCP's expected standard for DBS (Disclosure and Baring Service) repeat checks is to be completed three yearly as standard, however KMPT reflects similarly to other NHS Trust which complete DBS checks on employment. KMPT Forensic Teams do however have yearly DBS checks.
     KMPT will reinforce the 'Good Character' statement and ensure this is completed as routine, however the KMPT Human Resources team will need to consider risk and cost as part of an assurance plan.
   - An Allegations against staff and People in a Position of Trust Stand alone policy is required. (***Fully compliant***)

7. Effective inter-agency working to safeguarding and promote the welfare of children (***Partial compliance***):

   *Area for development:*

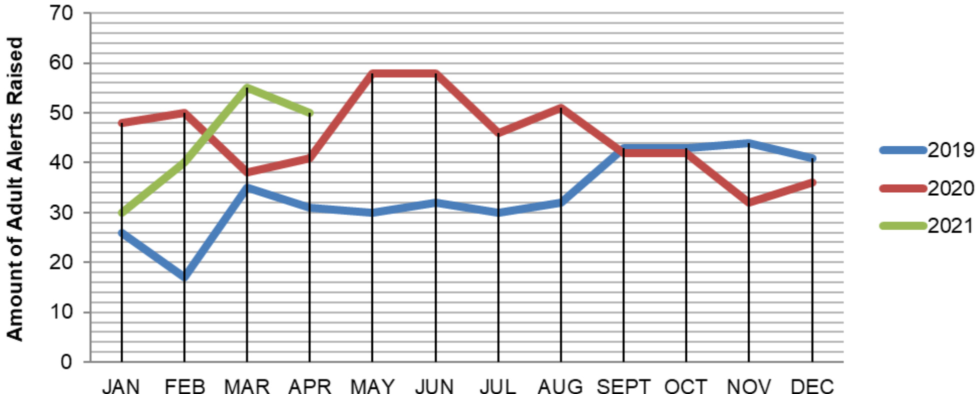
   - Improved Children Protection Conference attendance; to ensure staff are proactive in ensuring multi disciplinary and multi agency work is effective, staff participate in multi agency meetings and forums to consider individual children. Action is taken to address non-attendance.

8. Information Sharing (***Fully compliant***)

### KMPT Safeguarding Children Activity:

In response to the 'National Lock down' due to the Covid 19 Pandemic, the KMPT Safeguarding Team developed the Safeguarding Children and Young People Training package so that this could be delivered virtually, and adhered to the 'Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff' Intercollegiate Document (2019). The timely training adaption by the safeguarding team ensured that staff had access to safeguarding learning and development to ensure staff at all levels had the skills to respond safely and confidently to safeguarding concerns as part of an embedded safeguarding culture in a unique and high-risk period. Children were less visible during the pandemic, families had less support and resilient factors such as school, nursery and family support ceased. The early adaption also ensured that KMPT met its Key Performance Indicators delivering safeguarding training on average to over 95% of the staff. In addition to the above, the Safeguarding Team increased the volume of communications and newsletters to ensure the message of safeguarding was understood.

KMPT staff have continued to consider and respond to safeguarding children responsibilities during the pandemic and reduced visibility with referrals into Social Services and Early Help as evidenced below.




The KMPT safeguarding team have continued to strongly advocate the 'Think Family' approach. Think Family is within both safeguarding adults and children training sessions, and safeguarding policy. Think family and risk to children during the pandemic has been shared Trust Wide via Communications, Screen Savers and discussions with Champions to embed this approach in daily practice. This approach has been especially important during the pandemic in recognition of the stresses and strains families have been under due to the lack of educational, family and peer support.

Child information captured on the client RiO records has been identified as an area of improvement for a period of time. With support from the RiO team, the RiO children's information capture has been developed to be more user friendly, which includes an increase in options to capture the child's care arrangements reflecting unique family dynamics. Trust wide communications, Champion forums and sharing the RiO improvement has been disseminated at Trust Wide meetings. There has been a slight improvement in capture (0.7%) however for 2021/2022 this is an area that will be continually improved and monitored as part of the safeguarding agenda.

KMPT has met all of the Child Safeguarding statutory strategic objectives, and local audit requirements including evidencing of working in partnership with the safeguarding partners, protecting children from harm, responding to emerging themes such as isolations, reduced visibility, and Domestic Abuse. Evidencing training provision and compliance, evidence of safeguarding processes in place to support staff to respond safely and effectively; and current accessible policy with cohesion with the differing partnership processes and policy. The Safeguarding Team have supported the Trust in the delivery of key Safeguarding Children and Young People Policies such as Safeguarding Children and Young People Policy, Child Visiting Policy Guidelines for the Management of Pregnant Women cared for in the Acute Service

(2020) and responding to Allegations Against Staff and People in a Position of Trust (March 2021).

**Serious Case Reviews**

KMPT have contributed to one published Serious Case Review's (SCR) in 2020/2021, in Medway, with learning delivered in response to the SCR action plan for all agencies in developing the "think family" approach to generic or adult service practitioners. The recommendations required children and adult health (including mental health) providers to consider how it can make it easier for professionals in Medway to understand how and where to make referrals and gather/share information when concerns are identified about children. In response to these actions identified from practice in 2019, KMPT have 'think family' embedded into policy and training, and evidence of staff responding to the needs of children is evident in the referral rate data. The KMPT public facing webpage has clarity regarding who to contact if a person is experiencing a mental health crisis/need, in addition to the Single Point of Access developing the referral mechanism which will be in place during 2021. The KMPT safeguarding team are highly visible both externally and internally and accessible to Medway (and other authorities) social care to enable safeguarding information requests, which of know received into the team on a daily basis.

Similar to 2019/2020, in 2020/2021 there is a notable low level of involvement with local Serious Case Reviews' from KMPT in comparison to other agencies. This can provide assurance and evidence that KMPT front line staff are working with clients and families to prevent serious incidents of harm to children and are contributing to the early intervention.

Due to the Covid 19 pandemic, the areas for development in 2020/202021 had to be re-prioritised to ensure the best and safest safeguarding service, therefore have continued over to 2021/2022.

**Key priorities and development for Children and Young People Safeguarding:**

- The 'voice of the child' and 'lived experience' must to be evident in all client records, and risk assessments as appropriate. The impact on the child/ren of parental chronic and acute mental ill health must be evident and responded too. This will ensure the application of 'Think Family' principles whilst keeping children safe from harm.
- Children are identified on Rio records as standard practice, and that care plans reflect the needs and risk management of the children in the household or in the care of the client.
- Safeguarding children activity to continue with evidence captured in referral standards.

- Training to continue to reflect changing themes, trends and local learning as appropriate.
- KMPT to continue to contribute to the Local Safeguarding Children's Partnership agenda.
- Increase of KMPT staff attendance at Child Protection Conferences
- KMPT to continue to meet Section 11 requirements and make improvement as identified.
- Safeguarding referral audit, including 48 hours follow up adherence.

**Key Challenges going forward:**

- The impact of the Kent Safeguarding Children Board changing to a partnership has been very evident with non-engagement and a significant delay in shared learning. The partnership duty of delivery is held by the CCG, KCC and Police.
- KMPT Safeguarding staffing levels to be maintained with increase resource provision to support with deliverables and sustainability.
- The KMPT safeguarding team to develop practice whilst prioritising statutory functions within the confines of staffing levels.
- Increase need for safeguarding administration support to ensure support and capture of Child Protection Conference attendance.
- The introduction of Liberty Protection Safeguarding in 2022 impact and application on patients 16 years and over.

### Safeguarding Adults:

The Care Act (2014) and Adult Safeguarding: Roles and Competencies for Health Care Staff Statutory guidance (2018) provides the statutory frameworks that make provision to care and support adults at risk, including safeguarding adults from abuse or neglect are in place within health organisations. KMPT has a Lead Professional for Safeguarding Adults, Mental Capacity (MCA) & Deprivation of Liberty's (DoLS), in addition to an Adult Safeguarding and Domestic Abuse Lead, and Generic Safeguarding Specialist Advisor. These roles are necessary to ensure that safeguarding adults and the Mental Capacity Act (2005) are embedded into practice and that staff to access to support and mechanisms to respond to safeguarding concerns safely and confidently.

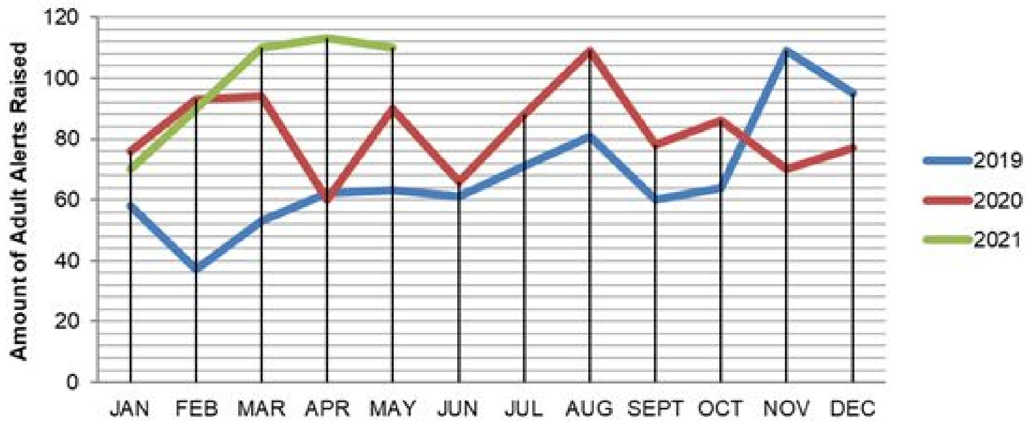
KMPT's Adult Safeguarding policies are up to date and accessible with clear guidance that is cohesive with the Kent and Medway Safeguarding Adults Board (KMASB) multiagency protocols and procedures to ensure a clear shared process for front line staff.

KMPT are key members of the Kent and Medway Safeguarding Adults Board, Safeguarding Subgroups, Domestic Homicide Steering Group, Safeguarding Adults Review Group and the Kent and Medway Channel Panel. Membership of these meetings enable shared learning,

contribution to the safeguarding agenda and for KMPT clients and families to be supported and protected with embedded safeguards to ensure excellent and responsive care. Membership of these groups supports the Kent and Medway Safeguarding Adults Board to capture safeguarding activity and compliance with the Care Act (2014) with the monitoring of actions and contribution.

Making Safeguarding Personnel is intrinsic to KMPT's adult safeguarding process to ensure that adults at risk are supported in a person-led and outcome focused approach. Making Safeguarding Personal is embedded within the safeguarding practice, policy and training throughout KMPT. The KMPT Safeguarding Team developed a Make Safeguarding Personal patient leaflet which is used in patient welcome packs. A 'Think Family' approach was introduced into all safeguarding training in 2019, and will continued to be embedded into training and practice to ensure that risks and resilience within the family unit are considered within care planning and assessment to ensure that KMPT clients and families have the right support and safeguards.

The impact of the 'National Lock Down' and data collection is still yet unknown, however isolation, lack of visibility, and potential reduced ability to ask for help has been of concern to safeguarding professionals. Reassuringly, there is evidence that safeguarding adults is embedded into KMPT culture, with alerts/referral rates evidencing commitment from KMPT staff to recognise and respond to safeguarding concerns during the pandemic, thus enabling a multiagency approach. Adult Alerts made by KMPT into the Local Authority have continued to increase evidencing proactive and systemic safeguarding and responsiveness:




KMPT have continued to contribute to Safeguarding Adult Reviews (SARs) and in the dissemination of learning. The SAR activity in Kent and Medway is increasing significantly year on year, in both making the referral and Independent Management Reports (IMR) contributions. In response to the pandemic, the SAR Working Group with support from the Kent and Medway Safeguarding board temporarily reduce the request for summary and IMR reports, however to ensure adherence to the Care Act and as virtual meetings became the

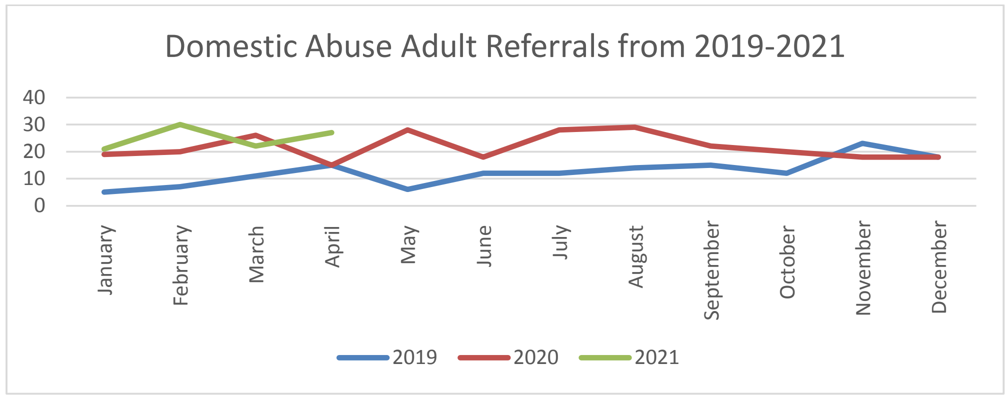
new ‘normal’, work continued to enable learning. This increase of work has supported learning and development through the delivery of action plans, which will be improved client care; however, the increase in activity has contributed to a significant increased work load within the safeguarding team which has been challenging.

Moving forward, support of the safeguarding team in the delivery of shared objectives to improve safeguarding and outcomes for patients and families will enable the continued contribution and learning that ensure KMPT are compliant with the Care Act (2014). The key themes and learning coming from SARs have been consistent, providers to ensure carers are supported in the prevention of harm. Professional curiosity is supported and enabled in practice, staff are supported in recognising and responding to domestic abuse.

Professionals need to continue working together to ensure adults at risks voices are evident; Self Neglect and Hoarding is responded too, and the Multi Agency Self Neglect and Hoarding Policy adhered too. In response to the above learning, the KMPT public facing webpage includes guidance, support and information available to carers. The safeguarding team have shared learning via the safeguarding champions, learning events, newsletters, bespoke team refresher training, safeguarding supervision and trust wide communications. The KMPT safeguarding team captured the assurance that these mechanisms for shared learning were effective by performing a carers awareness and resource audit following the dissemination of learning, this sample audit identified reasonable assurance that staff could respond to the needs of carers. Additionally, KMPT is part of the Triangle of Care in response to supporting carers, with work ongoing to further embed the principles.

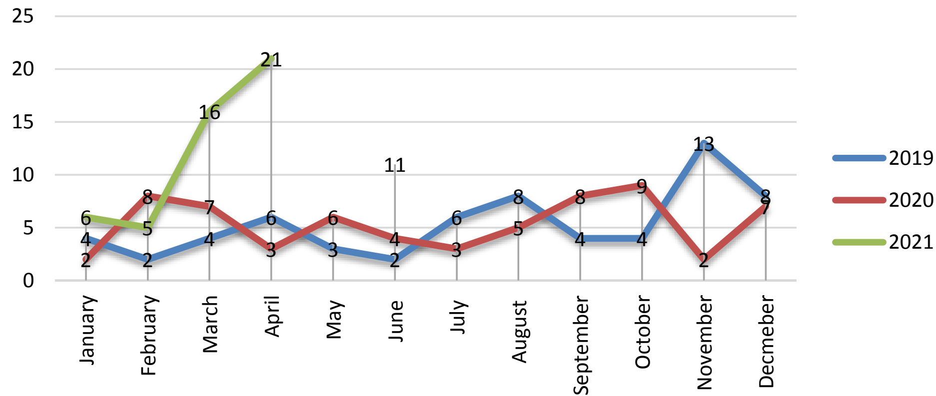
Professional Curiosity discussion are embedded into all safeguarding training packages and policy, referrals into social care from KMPT evidence that KMPT front line staff are being curious and are identifying safeguarding by working with their patients and families as evidenced in the volume of alert/ referral activity even during a pandemic. Domestic Abuse is discussed in all safeguarding training sessions to ensure confidence and identification, and the

Domestic Abuse safeguarding page on iconnect has a wealth of accessible resource for staff to use and consider. DASH RIC (Domestic Abuse Stalking and Harassment Risk Assessment Tool) training has been delivered and will continue to be delivered by the safeguarding team as supplementary training to enable the identification and capture of high-risk domestic abuse. The Domestic Abuse referral rate captured during the pandemic as evidenced below, reflects the diligence and professional curiosity of KMPT front line staff in identifying and responding to domestic abuse.




Self Neglect is discussed in adult safeguarding training and the multi-agency policy and protocol for managing self neglect and hoarding is accessible from the KMPT Safeguarding Intranet. Bite-size training, video and other self neglect resources have been added to the KMPT internal ''iconnect safeguarding adults page for easily accessible information. The referral rate identifying Self Neglect has increased, evidencing staff are responsive, thoughtful in their practice and are responding to the additional resources and the Self Neglect and Hoarding Multi Agency Policy.

**Self Neglect Social Care Alert/Referral Rate**:




The Safeguarding Team have and will continue to be available for safeguarding consultations to enable discussion and clear action plan development to safeguard patient and families.
To provide continued assurance that KMPT has embraced the lessons learnt into daily practice the following key audits will be completed in 2021/2022

- Self Neglect in practice audit.

**Domestic Homicide Reviews**

In March 2021 there had been a total of 39 Domestic Homicide Reviews (DHR) in Kent and Medway since the introduction on a statutory basis under Section 9 of the Domestic Violence, Crime and Victim Act 2004. In 2020/2021 there have been a total of 5 Domestic Homicide Reviews commissioned that KMPT will contributed to, this is in addition to continued 2019/2020 DHR activity. It is recognised that Kent and Medway have higher numbers of SAR's and DHR's activity compared to other authorities and are considered an outlier. KMPT have been committed to learning and reducing both SAR and DHR activity with shared learning, learning embedded into safeguarding training and multiagency working.

**Multi Agency Risk Assessment Conferences (MARACs)**

During 2020/2021, the KMPT safeguarding team fully committed to participating in the local Multi Agency Risk Assessment Conferences (MARACs) during the pandemic to enable working together to safeguarded clients and families exposed to high risk domestic abuse. This has been especially important due to reduced visibility and reduced ability for people to ask for help due to the 'National Lock Down'. The MARAC is a risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan. A number of MARACs are run throughout Kent on a bi-weekly rotation and weekly basis in Medway in 2020/2021 a total of 275 MARAC's were held. The graph below captures the number of cases referred into MARAC year on year, evidencing the increase volume of research and work professionals and agencies such as KMPT contribute to, in supporting a multiagency approach to keep people and families safe.

| Kent and Medway MARACs | Adults | Children |
|---|---|---|
| March 2019-2020 | 2419 | 3229 |
| March 2020-2021 | 2762 | 3581 |

The KMPT Safeguarding Team have provided 100% of research to the 275 MARACs held in 2020/2021, and when required have support with attending the virtual MARAC to represent the mental health opinion, provide advice and make suggestions that contribution to the safety plan of KMPT patient and families. The KMPT safeguarding team have continued to ensure that MARAC information is documented on the RiO records, and that the professional working with the client is notified to ensuring that clients exposed to high risk domestic abuse are supported and that their Care Plan can reflect the risk with information sharing. Due to the increase in MARAC activity in conjunction with other increases in safeguarding activity, the MARAC process going forward will need support in resource; this will enable improved MARAC information sharing, and responsiveness by attending the meetings to enable mental health expertise discussions. Recruitment is underway in order to increase the capacity to respond effectively to MARAC activity.

## Prevent:

KMPT have continued to commit to the Prevent Agenda and statutory duties of The Counter Terrorism & Security Act 2015. Prevent is about safeguarding people and communities from the threat of terrorism. Prevent is part of CONTEST, the Government's counter-terrorism strategy. It aims to stop people becoming terrorists or supporting terrorism and violent extremism. KMPT are core members of the Channel Panel, and have contributed to 8 Prevent referral's in 2020/2021. The referrals in reflection of the reduced visibility and isolation guidance is a credit to KMPT staff identifying and responding to safeguarding concerns relating to people at risk of being drawn in to terrorism. Prevent training is embedded into safeguarding training in addition to the stand-alone Home Office eLearning for a collective and systemic approach to embedding the Prevent safeguarding Agenda.

**Safeguarding Adults Key Achievements:**

- The continued delivery of high-quality training as evidenced with the increased referral rate
- Training compliance ensuring KMPT staff are given the tools to safeguarding adults.
- Increased Safeguarding Activity to protect clients and their families as evidenced in referrals.
- Engagement and responsiveness to SARs learning for improved adult safeguarding and care.
- Embedding the DATIX system as a mode to capture safeguarding activity and management oversight.
- Maintaining MARAC research activity whilst staffing levels have been impacted on sick leave and staff changes.
- Delivering DASH RIC training to staff
- The safeguarding team being accessible for consultations
- The delivery of safeguarding duties and KPI's during a pandemic.

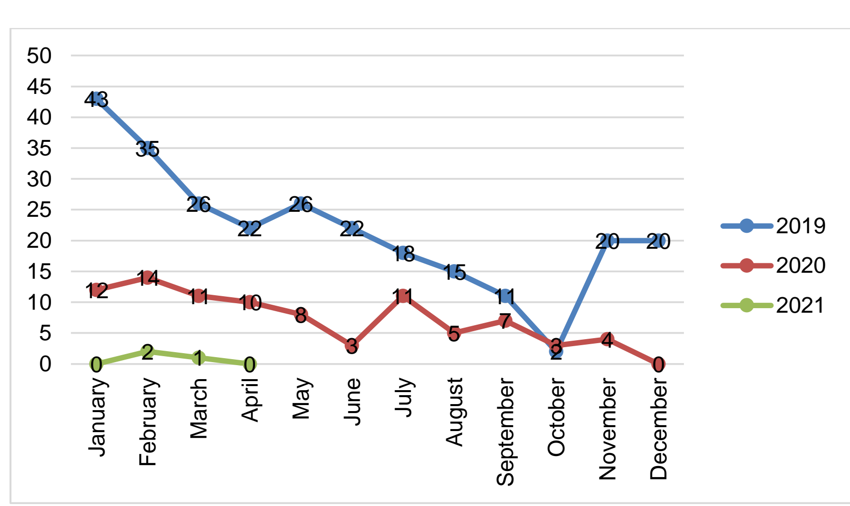
**Key Challenges:**

- Increase of SAR activity and work that contributes to the research and delivery of learning
- Maintaining training standard and Adults Safeguarding Priorities with competing demands.
- Increasing MARAC attendance.

**Mental Capacity Act and Deprivation of Liberties:**

KMPT has seen a decrease in the numbers of Deprivation of Liberty Safeguard (DoLS) applications in 2020/2021 with the reduction of long stay beds. DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and, in the person's, best interests. Representation and the right to challenge a deprivation and other safeguards that are part of DoLS. KMPT as the managing authority have strived to continually meet the application requirements in line with statutory responsibilities. As part of developing practice and safeguards for persons that have been in breach of the supervisor body authorisation held by the local authority the KMPT safeguarding team developed the DATIX system to capture all breached DoLS for oversight and the introduction of an openness letter sent to clients, families and advocates was developed to ensure that people are fully informed of their rights and the current situation as part of excellent client focused care.

**DoLS Recorded from 2019 – 2021**




KMPT will refer patients to the Independent Mental Capacity Advocates (IMCAs) who support people when they are assessed to lack capacity to make a best interest decision and they do not have family or friends appropriate to consult about the decision. The reduction of IMCA referrals is reflective in the reduction of DoLS applications since 2019 due to the reduction of long stay beds.

| IMCA 2019 | 2020 IMCA | 2021 IMCA2 |
|---|---|---|
| 12 | 4 | 2 |

KMPT have continued to attend the Kent and Medway Local Authority Network meetings formally known as Local Implementation Network to keep at the front of information sharing and joint learning. KMPT have separate Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards Policies to support staff with the MCA and DoLS process. In addition to this

staff can access trust MCA/DoLS leads for support and advice. The primary purpose of the Mental Capacity Act (2005) is to promote and safeguard decision-making within a legal framework. It does this in two ways; by empowering people to make decisions for themselves wherever possible, and by protecting people who lack capacity by providing a flexible framework that places individuals at the heart of the decision-making process. It allows people to plan ahead for a time in the future when they might lack the capacity, for any number.

**MCA assurance**

In 2019 the safeguarding team completed a 'Deep Dive' Audit of the application of MCA, following this Deep Dive, sample audits have been achieved to ensure that the actions put in place continued to enable assurance that MCA and the legal application and documentation is met. An MCA audit was conducted with support of the TIAA in January 2021 which identified the Trust continues to have reasonable assurance in the delivery and application of MCA, a key achievement in the delivery of the safeguarding agenda. This continued achievement has been due to the support and continued efforts from the Professional Lead of MCA and Safeguarding Adults and Safeguarding Specialist Advisors in raising the profile of MCA, improving resources, and developing and delivering training to meet the needs of staff.

**Key Achievements:**

- Completion of a review MCA and DoLS audit with assurance levels met.
- Improved training and resources accessible to staff.
- Improved MCA and DoLS documentation
- The introduction of DATIX to capture breach DoLS activity for Trust oversight
- Training compliance maintained to 87%
- Having two Best Interest Assessor's professionals in the team to support expertise

**Key Challenges:**

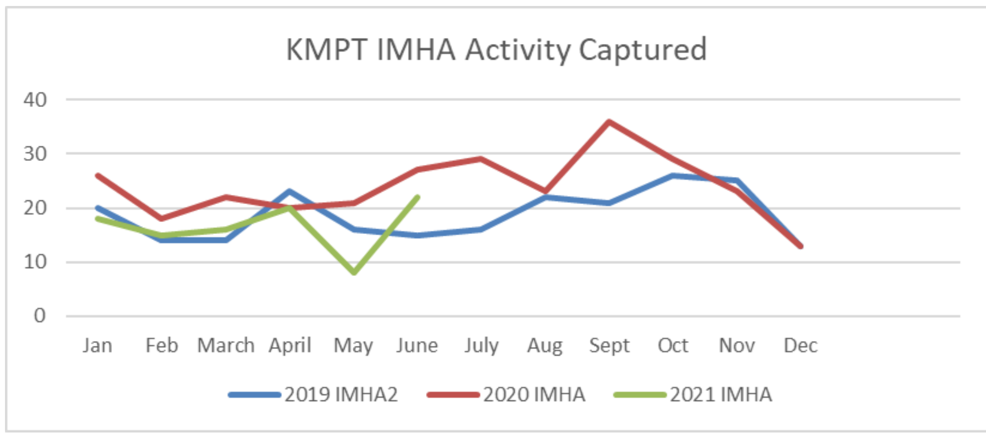
- The continuation of improved MCA and DoLS application and documentation
- The pending introduction of LPS (Liberty Protection Safeguards) Code of Practice in 2021; moving managing and supervisory functions to provider services**,** which will require more resource.
- Safeguarding Team resource in the preparation and delivery of LPS.

**Safeguarding and IMHA**

A safeguard to ensure the people with mental ill have support to voice their wants and opinion independently can be with the support from an Independent Mental Health Advocates (IMHAs). IMHAs support people with issues relating to their mental health care and treatment. They also help people understand their rights under the Mental Health Act.

Advocates can support people who are:

- detained under the Mental Health Act (except under short-term sections 4, 5, 135 and 136)
- conditionally discharged restricted patients
- subject to a Community Treatment Order
- subject to guardianship
- being considered for S57 or S58A treatment, or Electro-Convulsive Therapy




## Training, Knowledge and Shared Learning:

KMPT safeguarding training is reflective of both the Adults and Children's Intercollegiate Documents. These statutory frameworks are followed with the inclusion of local learning from Serious Case Reviews (SCR) Safeguarding Adult Reviews (SAR) and Domestic Homicide Reviews (DHR) to enable continued reflective learning and development.

**Training Compliance:**

| Safeguarding Training | KPI | Total Staff No: | Total Trained | Trust Compliance |
|---|---|---|---|---|
| Safeguarding Adults Level One | 90% | 810 | 798 | **99%** |
| Safeguarding Adults Level Two | 90% | 868 | 829 | **96%** |
| Safeguarding Adults Level Three | 90% | 1447 | 1390 | **96%** |
| Safeguarding Children Level One | 90% | 530 | 516 | **97%** |
| Safeguarding Children Level Two | 90% | 415 | 399 | **96%** |
| Safeguarding Children Level Three | 90% | 2276 | 2163 | **95%** |
| Preventing Radicalisation | 90% | 3365 | 3325 | **99%** |
| Mental Capacity Act/DoLS | 90% | 2236 | 1951 | **87%** |

KMPT's Safeguarding Training compliance has seen a significant achievement in the delivery of volume and quality to ensure KMPT staff are given the support and tools in identifying and responding to safeguarding activity. The mode of training delivery swiftly moved from face to face to the virtual conference forum, this was supported by the Learning and Development Team and utilisation of the Lifesize and Big Blue Button video conference programmes. This delivery has been achieved due to commitment from the safeguarding team, support from the learning and development team, support from IT teams providing the equipment for virtual learning and team managers supporting staff to attend.

The KMPT Safeguarding Team with support from the Learning and Development fund supported the training and accreditation of the KMPT Domestic Abuse Lead to become a fully accredited DASH RIC trainer. DASH RIC training has been delivered to key teams and will continue to form part of the training delivery plan to ensure staff have the skills to identify high risk domestic abuse requiring referral in to the MARAC (Multi Agency Risk Assessment Conference). Domestic Abuse has been a key theme coming out of DHR's, SARS and SCR's locally and nationally and as such KMPT are committed to increase the skills of the workforce to enable safe and timely support.

Training provided by the Local Children's Safeguarding Partnerships are shared via the trust intranet, internal communications, links to LSCP websites, and Champion forums to utilise the skills and learning opportunities for KMPT staff to provide excellent and safe care.

### Supervision:

The KMPT Safeguarding Team have been delivering targeted supervision to teams such as the Maternal Mental Health Service and the Rosewood Mother and Baby Unit to support with embedding safeguarding into practice; however, the safeguarding team plan to offer safeguarding supervision to other needs in need of additional support. The KMPT Learning and Development Team currently capture supervision activity of which safeguarding is a mandatory field of enquiry.

### Governance and Assurance

The Executive Lead for Safeguarding is the Executive Director of Nursing and Quality who sits on the Trust Board. The Executive Lead chairs the Trust Wide Safeguarding Group and also the Trust Wide Patient Safety and Mortality Review Group in the embedding of high quality systemic leadership. These feed into the Quality Committee where reports and activities related to safeguarding are discussed, therefore providing Board level oversight of safeguarding activities across KMPT. There are local safeguarding meetings for which the Care Quality Commission are invited and attend when possible. This provides an opportunity to hear first-hand, how patients are safeguarded in the Trust.

KMPT hold Trust Wide Safeguarding Group meetings held bi- monthly, in which the Executive Director and Nursing and Quality, the Trusts Named Safeguarding Doctor, Head of

Safeguarding, Head of Services, Care Group Leaders, the Police, Local Authority Senior Social Workers and Designated Nurses from the CCG attend to ensure safeguarding is intrinsic to practice, information and learning is shared systemically at all levels as part of the quality assurance process. KMPT senior management are committed to the importance of safeguarding and promoting welfare; as evidenced through the use of DATIX a reporting mechanism in which referrals into adult and children social services are reviewed by practitioner managers and when possible the safeguarding team. KMPT operates a risk forum meeting in which practitioners can request complex case review to ensure all the safeguarding elements and mental health needs have been considered. This forum is led by senior managers, doctors and experienced practitioners.

### CliQ Checks

The clinical quality team performed routine CliQ quality checks within KMPT. Safeguarding and MCA are areas of performance review within the quality check. The CLiQ quality check overall assurance level for safeguarding is below:

| Service | Assurance Percentage |
|---|---|
| Early Intervention and Psychosis | 92% |
| Inpatient Rehab | 96% |
| Community Rehab | 100% |
| PD | 94% |
| Liaison Psychiatry Service | 91% |

**Area of Development**

- KMPT to have an identified Non-Executive Director (NED) as Champion for the Safeguarding Agenda for continued and improved external board level scrutiny.

### Development and actions carried over from 2019/2020 to 2020/2021

- Continue with the delivery of DASH RIC training, to further increase the skills and knowledge of front line staff and embed routine enquiry and safe response into everyday practice.
- Ensure that all KMPT Care Groups have Champion representation
- Audit Safeguarding children and adult activity to identify quality and learning opportunities.
- Maintaining Safeguarding Training Compliance and Quality.
- Delivery of training in response to emerging themes, learning from Domestic Homicide Reviews, Serious Case Reviews and Safeguarding Adult Reviews.
- Increase Child capture on the RiO records reflecting risks and resilience.
- Support the Heads of Nursing, Operations in the reduction of patient on patient abuse a monthly theme from Safeguarding Alerts.

KMPT has achieved significant compliance and quality improvement in regard to safeguarding activity as evidenced above during a very challenging year with increased safeguarding risk exposed to adults and children. The impact of the National Lock Down on safeguarding cannot be underestimated and the outcome from this will be evident in the year forward. There are still areas for development however with the continued support and commitment of the safeguarding team, staff, managers and executives safeguarding will continue to be embedded as part of the delivery of excellent patient care. The actions identified for prioritisation in 2021 will be underpinned by a delivery plan, with progress monitored at Trust wide governance meetings.

# Quarterly Mortality Report (Q1)

## 1. INTRODUCTION

1.1 The expectations in relation to reporting, monitoring and Board's oversight of mortality incidents is set out in National Quality Board's 'Learning from Deaths' guidance (March 2017), and builds on the recommendations made by the MAZARS investigation into Southern Health (Dec 2015), the CQC report 'Learning, Candour and Accountability publication' (Dec 2016) and the Learning Disabilities Mortality Review (LeDeR) which is now managed by NHS England. This is further reflected in our local policies and procedures to ensure we discharge our duties effectively, and as such the Committee would be familiar with the report history and purpose.

## 2 MORTALITY SCRUTINY

2.1 The Trust Wide Serious Incident and Mortality Review Panel (TWSIMRP) continues to meet twice a week to review all mortality incidents reported on Datix. The membership has been consistent and includes Care Group SI leads, medical input and subject matter experts as necessary.

2.2 Mortality incidents are further scrutinised by the Mortality Review manager, to allow further analysis across the Trust and identification of themes and trends.

## 3 ANALYSIS OF INFORMATION

3.1 In Q1, a total of 370 mortality incidents were reported on Datix. The graph (1) below shows the figures relating to mortality that have been reported since April 2020. This includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality in Q1 have significantly decreased compared to 608 in Q4 2020/21. The reduction of mortality incidents has also impacted on the number of STEIS reported cases compared to the data provided in Q4 2020/21. The decrease in mortality figures is felt to be partially linked to the overall reduction in COVID-19 deaths, with 11 reported in Q1 compared to the larger sum of 116 in Q4 2020/21.

3.2 As previously highlighted to the Board, the figures will continue to fluctuate depending on the timing of updating patients' records on the national spine by General Practitioners. The vast majority of these incidents were reported by Older Adults community teams and would have been people who had previous contact with community teams and from areas in the County with a high proportion of older people and also with more nursing or residential homes.

3.3 Whilst the cases are reported as a death of the patient, it does not mean that the death was attributable to the organisation or that there were care or service delivery concerns. They are reported to enable a review by the SI and Mortality Panel to assure the organisation and external bodies, including families as necessary, that there were no contributory factors relating to the death of the patient. In the event that any additional learning points are identified, the individual incidents are reviewed and action is taken to prevent reoccurrence. This can include further review in the form of a Structured Judgement Review.

**Graph 1 Mortality reported cases**

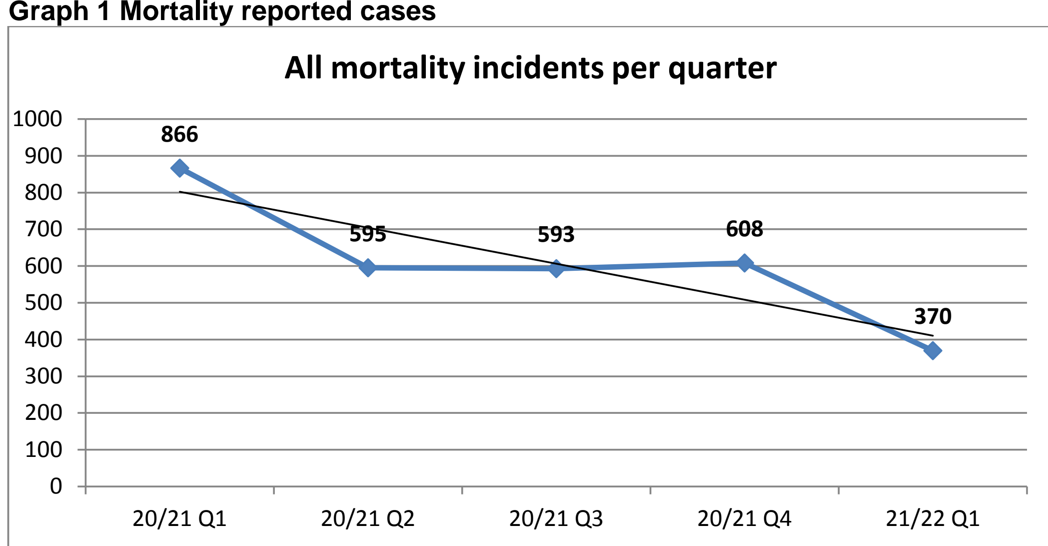



**Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide**

| | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Suicide (actual) | 7 | 4 | 5 | 6 | 0 | 2 | 1 | 3 | 1 | 0 | 2 | 5 | 4 | 39 |
| All Deaths reported on Datix | 287 | 238 | 216 | 140 | 135 | 232 | 226 | 275 | 178 | 155 | 150 | 74 | 146 | 2452 |

3.4 Graph (1) shows all mortality incidents reported on Datix while Table (1) indicates the number of all mortality incidents and suspected or confirmed suicides of patients reported by month. Of the total incidents for Q1, 2.9% of deaths of patients are suicide or suspected suicide related. This compares to 0.7% reported in the previous quarter. The average number of deaths for the 13 months above was 187 per month. For this quarter, there was an average of 123 per month. This is less than the previous quarter, where there was an average of 202 per month in Q4 2020/21.

3.5 On review of the suspected suicide incidents, over the 13 months, Community Recovery Services were the highest reporters. In Q1 2021/22, the number of suspected suicide incidents increased with a total of 11 compared to four in Q4 2020/21. As shown in Table 1, incidents relating to suicide was at it's highest in the summer of 2020. We then saw a reduction throughout Q3 and Q4 2020/21. The data for Q1 2021/21 indicates that numbers are again on the rise, with May 2021 being the highest reporter of suspected suicide deaths in Q1 2021/22. There were no suspected suicides reported by Forensic and Specialist Services or the Acute Care Group.

3.6 Eight of the 11 suspected or confirmed suicides were in the Community Recovery Care Group; one community team in particular being the outliers, with a total of five suspected suicide deaths occurring over the past three months. The Community Recovery Care Group has seen an overall increase in suicide related incidents in Q1 compared to Q4 where there were three suspected suicide deaths. Five Community

Recovery Care Group cases related to male patients, with ages ranging between 25 and 60 years. As identified in the National Confidential Inquiry into Suicide and Homicide (NCiSH) 2021 annual report which included a focussed piece of work around male suicide, suicide in males aged between 40 to 54 years old is higher than any other age category. When comparing this data to that of the data in Q1, two male patients were within this age category. The youngest male in Q1 to have died from suicide was 25 year old.

3.7 The 2021 annual NCiSH report highlighted that patients who live alone represent approximately half of all patient suicide. Their increased risk arises both from their mental and physical ill-health factors weakening their ties with society such as a lack of employment, recent relationship breakdowns and financial difficulties.

3.8 The data for KMPT shows that there has been an increase in older person suspected suicide in Q1 2021/22, with a total of three compared to one in Q4 2020/21; two patients were male and one female. The ages ranged between 71 and 86 years old. Any themes from suicide related deaths will be captured as part of the suicide thematic review, completed every six months with a focussed piece of work on older adult suicides to be included.

**3.9 Analysis by age and gender**

**Table 2 and 3, below, show all deaths recorded on Datix by age and gender**

| Age Band | 20/21 Q1 | 20/21 Q2 | 20/21 Q3 | 20/21 Q4 | 21/22 Q1 | Total |
|---|---|---|---|---|---|---|
| 100+ | 3 | 2 | 1 | 1 | 5 | **12** |
| 90-99 | 162 | 11 | 138 | 97 | 61 | **469** |
| 80-89 | 348 | 13 | 215 | 255 | 121 | **952** |
| 70 to 79 | 192 | 34 | 110 | 124 | 74 | **534** |
| 60 to 69 | 53 | 33 | 49 | 49 | 33 | **217** |
| 50 to 59 | 45 | 52 | 30 | 31 | 31 | **189** |
| 40 to 49 | 34 | 118 | 16 | 24 | 20 | **212** |
| 30 to 39 | 24 | 232 | 16 | 18 | 17 | **307** |
| 20 to 29 | 6 | 94 | 10 | 5 | 8 | **123** |
| 10 to 19 | 0 | 4 | 1 | 1 | 0 | **6** |
| Unknown | 1 | 0 | 0 | 3 | 0 | **5** |
| Total | **868** | **593** | **586** | **608** | **370** | **3025** |

**Table 3 Deaths reported on Datix by gender and age**

| | 100+ | 90-99 | 80-89 | 70-79 | 60-69 | 50-59 | 40-49 | 30-39 | 20-29 | 10-19 |
|---|---|---|---|---|---|---|---|---|---|---|
| Male | 2 | 23 | 62 | 35 | 21 | 18 | 13 | 13 | 7 | 0 |
| Female | 3 | 35 | 59 | 39 | 12 | 13 | 7 | 4 | 1 | 0 |

**Table 4 COVID-19 deaths by gender**

| | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Apr-21 | May-21 | Jun-21 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|

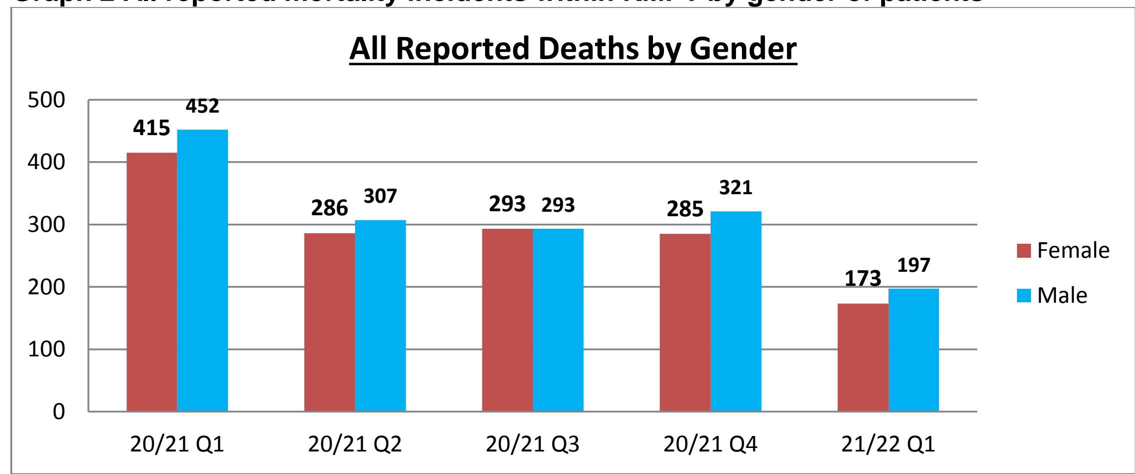
| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Female | 1 | 2 | 6 | 23 | 47 | 17 | 11 | 2 | 0 | 1 | 110 |
| Male | 2 | 2 | 7 | 27 | 45 | 17 | 14 | 2 | 5 | 1 | 122 |
| Total | 3 | 4 | 13 | 50 | 92 | 34 | 25 | 4 | 5 | 2 | 232 |

3.9.1 As in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age and residing in residential or nursing homes and presenting with co-morbidities. In Q1 there have been six older adult incidents that have been subject for an SJR, due to the patient having a diagnosis of psychosis during their last episode of care.

3.9.2 The figures relating to mortality have decreased significantly in Q1 2021/22 compared to Q4 2020/21. It is likely that the decrease is due the reduction of COVID-19 related deaths in Kent. Mortality incidents relating to COVID-19 are likely to fluctuate in the coming months. The roll out of the COVID-19 vaccination has possibly impacted on the reduction in mortality, with many people now having received their second vaccination.

3.9.3 When data is analysed of reported deaths within KMPT according to gender, indications are that figures of all mortality in men and women has fluctuated in each quarter (see graph 2). In Q1, the number of deaths in males was higher than in females, and has been higher in most quarters, with the exception of Q3 2020/21 where the figures were equal. From a review of patient deaths reported between Q1 2020/21 and Q1 2021/22, the figures relating to older patients are higher in comparison to younger patients (below the age of 60). Much like previous data, mortality in older patients is higher in females whereas mortality in younger adults is higher in males.

**Graph 2 All reported mortality incidents within KMPT by gender of patients**




3.9.4 In Q1, the 11 cases of suspected suicide by age and gender were as follows in table 5.

**Table 5 Suspected suicides by age and gender**

| Age | Male | Female |
|---|---|---|
| 10 – 19 years | - | - |
| 20 – 29 years | 1 | - |
| 30 – 39 years | 1 | 2 |
| 40 – 49 years | 1 | - |
| 50 – 59 years | 1 | 1 |

| 60 – 69 years | 1 | - |
|---|---|---|
| 70 – 79 years | 1 | 1 |
| 80 – 89 years | 1 | - |
| 90 – 99 years | - | - |

3.9.5 Nationally, middle-aged males (between the ages of 40 to 54 years) are at a higher risk of death by suicide although suicide occurs in all ages and genders (NCiSH data). It would be expected that figures for male suicide in this age group would be over-represented in this specific age range.

3.9.6 The numbers of suspected suicides reported in Q1 2021/22 has increased, with a total of 11 reported compared to four in Q4 2020/21. There were four female suspected suicides reported in Q1 compared to one in the previous quarter. Information provided in the 2021 annual NCiSH report relating to COVID-19, stated that there has been no significant rise in individual months after lockdown began. A comparison of rates in 2019 and 2020 showed no difference, despite evidence of greater distress for patients. NCiSH have stated the reason why there has been no identified rise is likely to be due to:

- Increased vigilance and support from family, friends and neighbours
- Reduced access to certain methods
- Increased social coherence

There are however some points that need to be considered:

- Early overall data
- The local impact may vary
- Variation between groups
- Real time surveillance (RTS) is new and further development is needed

3.9.7 KMPT is participating in a study for The National Confidential Inquiry into Suicide and Homicide (NCiSH), by providing real time data for patients who have died from suspected or confirmed suicide. The information provided is in the form of a questionnaire and will help to understand the rates of suicide nationally during the COVID-19 pandemic. The set criteria is as follows:

- Patients who have died by suspected suicide within 12 months of contact with KMPT services, for deaths occurring since 1 January 2020.

3.9.8 So far, KMPT have identified 66 patient deaths that meet the criteria of a NCiSH questionnaire. The NCiSH has confirmed with KMPT that the study has been extended to 31/03/2022.

**4 Mortality review by ethnicity**
**Table 6 Deaths by ethnicity**

| | 20/21 Q1 | 20/21 Q2 | 20/21/Q3 | 20/21 Q4 | 21/22 Q1 | Total |
|---|---|---|---|---|---|---|
| Bangladeshi | 0 | 1 | 0 | 1 | 0 | 2 |
| Black African | 3 | 1 | 0 | 1 | 2 | 7 |
| Black Caribbean | 2 | 2 | 2 | 0 | 0 | 6 |
| Chinese | 1 | 0 | 0 | 0 | 1 | 2 |
| Indian | 2 | 1 | 0 | 3 | 1 | 7 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Mixed white and Asian | 0 | 0 | 0 | 1 | 0 | 1 |
| Mixed white and black African | 2 | 0 | 0 | 1 | 0 | 3 |
| Mixed white and black Caribbean | 1 | 0 | 0 | 1 | 2 | 4 |
| Not stated | 76 | 65 | 42 | 49 | 33 | 265 |
| Other Asian | 3 | 4 | 1 | 3 | 1 | 12 |
| Other Mixed | 0 | 2 | 1 | 2 | 0 | 5 |
| Other ethnic category | 1 | 0 | 1 | 2 | 0 | 4 |
| Pakistani | 0 | 0 | 1 | 0 | 0 | 1 |
| White - British | 757 | 504 | 524 | 528 | 324 | 2638 |
| White - Irish | 7 | 3 | 3 | 4 | 1 | 18 |
| White - other white | 12 | 10 | 11 | 10 | 5 | 48 |
| Unknown | 1 | 0 | 0 | 2 | 0 | 3 |
| Total | 868 | 593 | 586 | 608 | 370 | 3026 |

4.1.1 The majority of the incidents relate to people who are from a white British background. This is consistent with the local population profile being predominantly white British. Reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were seven in Q1 2021/22 compared to 15 in Q4 2020/21. Of the BAME deaths in Q1 2021/22, two were Datix death notifications (this may have been related to GP practices completing administration work). Two incidents were reported to legal services by the Coroner. One of which was a suspected suicide incident relating to a chinse older female. This has been reported as a serious incident in line with national criteria.

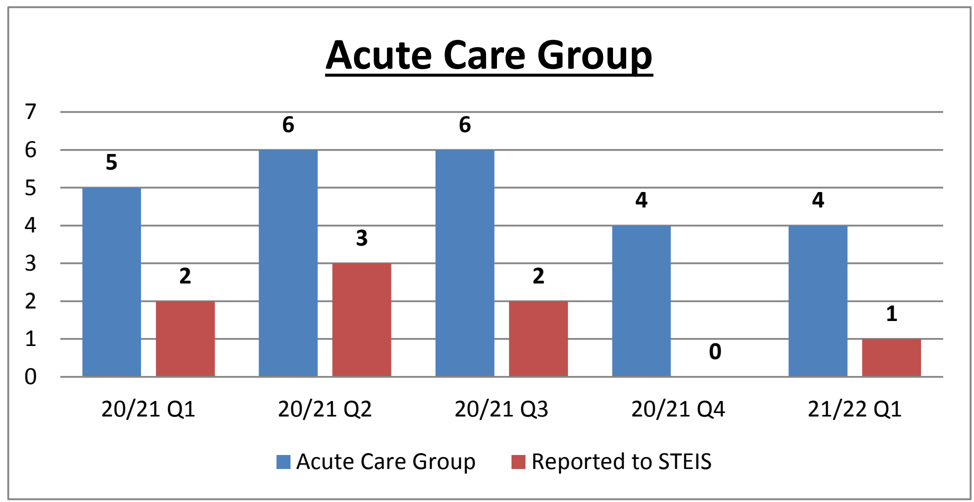
4.1.2 The 2021 annual National Confidential Inquiry into Suicide and Homicide stated that 7% (107) suicide related deaths were patients of ethnic minority groups. The report found that there were differences between ethnic groups in social and clinical characteristics that could be important to suicide prevention. For example, patients from a South Asian background were less likely to be unmarried or living alone and they had high rates of affective disorder. Black Caribbean and Black African patients were more likely to live alone and had the highest rates of schizophrenia and other delusional disorders. Black Caribbean patients also had a higher rate of drug and alcohol misuse. Chinese patients were more often female and had a short history of psychiatric illness. Patients from multiple/mixed ethnic background had higher rates of personality disorder, co-morbidity and previous self-harm and substance misuse.

4.1.3 Of the 370 incidents reported on Datix during Q1, 33 (8.9%) had no ethnicity recorded compared to 8% in Q4. Where ethnicity was not recorded, this could be due to some patients declining to provide their ethnicity, or were people under KMPT care for a number of years before the renewed focus on ethnicity reporting. Work is ongoing in operational and performance team to improve on ethnicity recording.

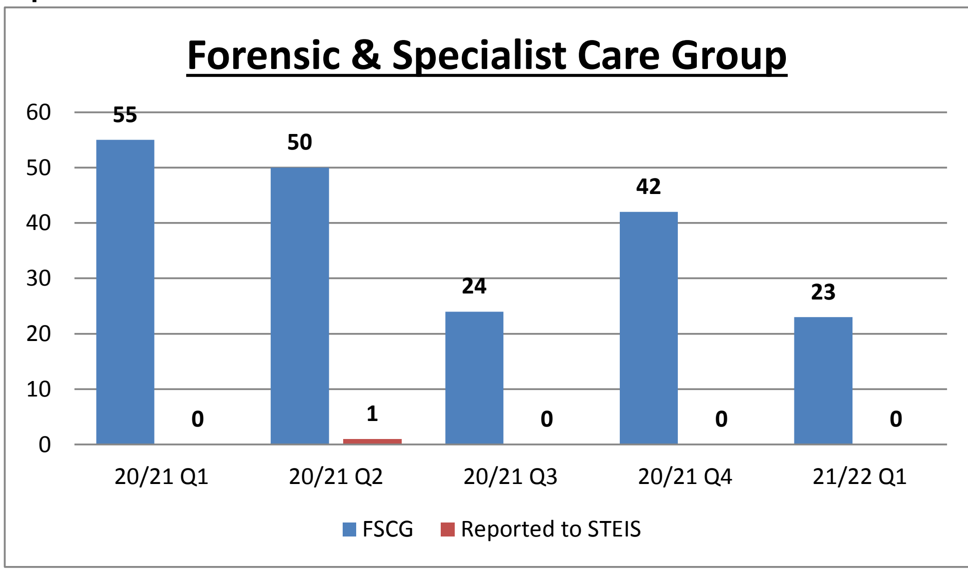
## 5 Serious Incidents and LeDeR cases

5.1 The following graphs (3 to 6) show the mortality incidents reported for the period 01/04/2020 to 30/06/2021 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

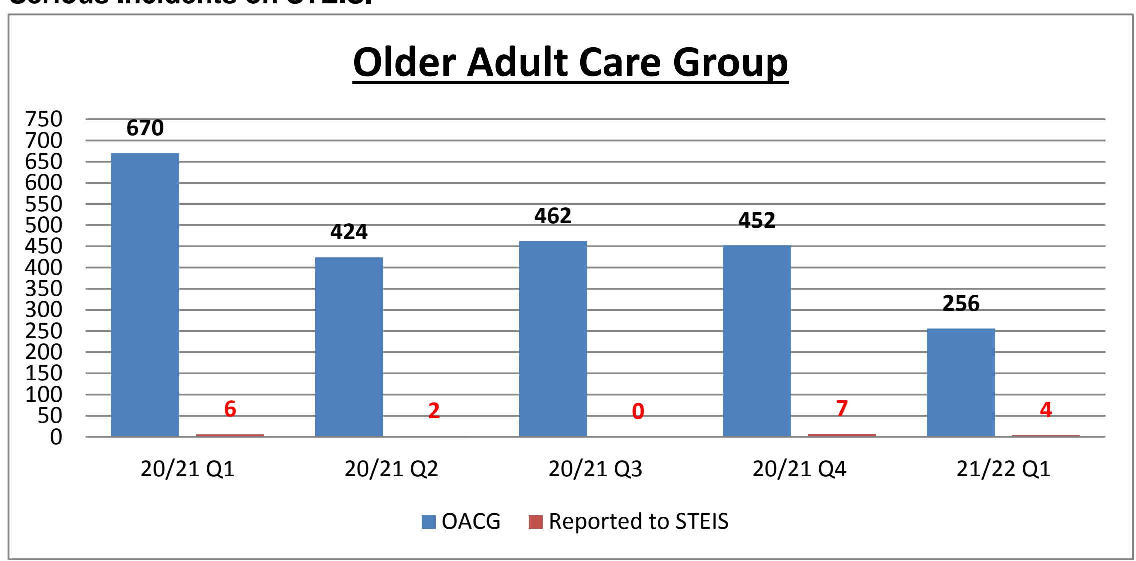
**Graph 3 Mortality by Acute Care Group and numbers of those reported as Serious Incidents on STEIS.**



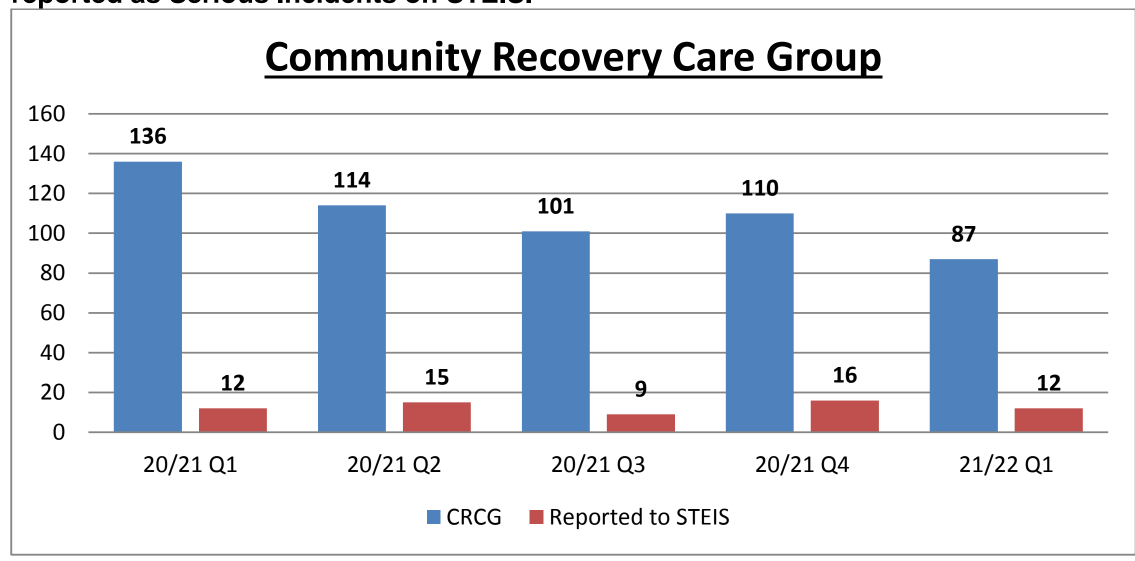

**Graph 4 Mortality by Forensic and Specialist Care Group and numbers of those reported as Serious Incidents on STEIS.**



**Graph 5 Mortality by Older Adult Care Group and numbers of those reported as Serious Incidents on STEIS.**




**Graph 6 Mortality by Community Recovery Care Group and numbers of those reported as Serious Incidents on STEIS.**




5.1.2 Figures relating to mortality have decreased in every care group with the exception of Acute Care Group where the figures remained the same in Q4 and Q1. Older Adult serious incidents have decreased, as shown in graph 5. This is likely to be related to there being no COVID-19 related inpatient deaths reported in this quarter. Overall, serious incidents reported across the Trust in Q1 decreased by six compared to Q4. The mortality figures relating to COVID-19 have seen a noticeable decrease in Q1, with a total of 11 deaths recorded, compared to 116 in Q4 2020/21.

5.1.3 On review of the 17 Serious Incidents relating to mortality that were reported on STEIS, 11 relate to suspected suicide. The remaining incidents relate to mortality where cause of death may not be known but care and service delivery problems have been identified. One incident relates to an inpatient death on a KMPT ward.

5.1.4 In Q1, there were seven mortality incidents where the service user had a diagnosis of a learning disability which was reported to LeDeR. All patients were of white-British ethnicity. Three patients were male and four female and ages ranged between 56 and 86 years.

5.1.5 The findings from the national annual LeDeR report for 2020 were that overall, males accounted for 57% of deaths and females of 43%. This is slightly different to the data for KMPT, where deaths in females with a learning disability were slightly higher than in males. The LeDeR report found that a large majority of adults with learning disabilities were White-British (89% in 2020). A review of deaths of KMPT patients with learning disabilities in 2020 found the figures to be the same, with a small proportion of patients being of other ethnic minorities. The LeDeR report showed that the median age for adult deaths in 2020 was 62. This is fitting with KMPT's data, with the average age of learning disability patients being 60 years old in 2020. The report found that in 2020, 58% (1120) of patients with a learning disability who died had mental health needs.

5.1.6 The report showed that several variables were significantly associated with a greater likelihood of dying between 18 to 49 years. These included the following:

- The likelihood for Asian/Asian British ethnicity was 9.2 times greater than a white British person of dying aged 18-49 years, further demonstrating the need to address health inequalities at every opportunity
- Those with profound and multiple learning disabilities were 6.4 times greater to die than someone with mild learning disabilities.
- Those subject to mental health or criminal justice restrictions in the five years prior to death were 4.3 times greater than someone no under such restrictions.
- Deaths of mixed/multiple ethnicities were 3.9 times greater than someone of white British ethnicity
- Deaths of Black/African/Caribbean/Black ethnic groups were 3.6 times greater than someone of white British ethnicity.
- Deaths of patients who had not had an annual health check in the previous year were 1.5 times greater than those who had regular health checks. This is an area of focus for the Kent and Medway health system

5.1.7 The report also showed the variable associated with the reduced likelihood of dying aged 18 49 years:

- Prescribed antipsychotic medication (0.7 times less than someone not).
- Prescribed antidepressant medication (0.9 times less than someone not).

5.1.8 The report found that there has been a steady increase in the proportion of reviewers who felt that a person's care met or exceeded good practice from 2018 to 2020. In 2018, the proportion of reviewers reporting this was 48%, which had risen to 58% in 2020. Although this is encouraging, it still means that in 2020, 42% of reviewers felt that the person's care had not met good practice.

5.1.9 The report focussed on the broader impacts of COVID-19 on the lives of people with learning disabilities. These were predominantly in relation to four key issues:

1. Restrictions on face to face visits or contact
2. Delays in the provision of clinical care, particularly hospital admissions for both routine and emergency care and closure of social care facilities

3. An impact on the physical and mental health of people with learning disabilities
4. Poor quality bereavement experiences.

5.2 The report found that the most frequently reported recommendations to local practice were categorised as training and development needs, and included general learning disability awareness, training about the Mental Capacity Act, about specific medical conditions and safeguarding protocols. Another recommendation made was for community learning disability teams to jointly work for a period to ensure that people with mild learning disability have the correct support from mental health services.

5.2.1 The leading underlying causes of death by geographical region and CCG for deaths from 2018 to 2020, where ICD-10 codes are available, was included in the report. In 2018 to 2019, the leading cause of death within Kent and Medway CCG was bacterial pneumonia, where as in 2020 this was COVID-19.

## 6. STRUCTURED JUDGEMENT REVIEW LEARNING

6.1 There have been a total of 13 SJRs completed since implementation of the process in October 2020, with some others in the stages of review. The reviews have identified a mixture of very good care and areas of care that could be improved. It is important to note that the SJR outcome has not changed the original decision where it was not deemed to be a serious incident. The care groups with the highest number of cases for SJR are Community Recovery and Older Adults. This is to be expected as the caseload is typically higher for both services. The Mortality Review Manager is working with the care groups to ensure that the learning from reviews is shared with the wider teams. Evidence of discussion is uploaded to Datix.

6.2 The most common “red flag” criteria that prompted the SJRs is:

- Diagnosis of psychosis during the patient’s last episode of care

6.3 A themed SJR review is currently underway and it is anticipated that this will be complete by the end of July 2021 and shared at Quality Committee in the autumn A review of ad-hoc cases has also started to slowly be introduced however is slower because of increased demand in mortality reviews. .

## 7. CONCLUSION AND NEXT STEPS

7.1 Mortality incidents recorded on Datix decreased in Q1 compared to Q4. STEIS reported mortality incidents have also reduced, although the percentage of overall incidents compared to STEIS reported for Q1 has increased. Incidents relating to suspected or confirmed suicide have increased in Q1 with a total of 11 reported, compared to four in Q4 2020/21. There has also been a noticed decline in older adult suicide deaths. It is unknown at this time why there has been such an increase. A detailed review will be undertaken outside of this report to identify any themes/ areas of concern. One community recovery team in particular is an outlier for suicide related deaths, with a total of five reported in Q1. From initial review, there is learning regarding the follow up of patients, particularly upon referral, and ensuring patients are cared for on the correct care pathway.

7.2 Themes of learning drawn from serious incidents will continue to be reviewed as part of the six-monthly suicide thematic review. The review has already been completed and will be presented to Quality Committee in September 2021.

8.3 The Trust will continue to review mortality incidents through the Structured Judgement review process and relevant thematic reports and share the learning as necessary.

| Title of Meeting | **Board of Directors (Public)** |
|---|---|
| Meeting Date | **Thursday 29th July 2021** |
| Title | **Workforce and Organisational Development Committee Report** |
| Author | **Venu Branch, Non-Executive Director & Committee Chair** |
| Presenter | **Venu Branch, Non-Executive Director & Committee Chair** |
| Executive Director Sponsor | **N/A** |
| Purpose | **For Information/Assurance/Approval** |

## Executive Summary

The Workforce & Organisational Development Committee (WFODC) met on Tuesday 20th July and discussed the following agenda:

- Presentation from the Community Care Group
- Workforce, OD and Communications Presentation
- Health & Wellbeing Recovery Plan
- Monthly Training Compliance Reporting in the QPR
- Feedback from Royal College of Nursing Bullying and Harassment Event
- New Ways of Working
- Exit Interview Process
- HR Risk Register

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

- Presentation from the Community Care Group
- New Ways of Working approach
- HR Policy – Travel and Miscellaneous Expenses – Final Ratification
- Health & Wellbeing and Recovery Plan
- HR Risk Register
- Items for information – Letter from Nursing of Colleges

**Community Care Group**

The Committee received a comprehensive presentation which captured a wide range of data and commentary relevant to Workforce and Organisational Development across the Community Mental Health Teams (CMHTs), Early Intervention Process (EIP), Rehabilitation Services, Liaison Psychiatry and Specialist Personality Disorder Services.

The Committee noted the following key priorities and concerns.

Operational Priorities:

- Recruitment of Band 7 Clinical Nurse Specialist. A pilot is taking place in Canterbury CMHT, which has now been extended across all 4 CMHT's.
- Skill mixing, is in progress to help recruit an Assistant Psychologists to support the initial Interventions Pathway.

- The Care Group are working closely with Celia Dunn, Lead Social Worker to review the Mental Health Social Job Description.
- Successful appointments of NMPs in all teams with the exception of West Kent, this post is out for recruitment.
- On-going Clinical Professional Development days for the EIP team continue to take place every 3 months and career progression workshops are taking place for band 5 nurses within Rehab Services. Reflective practice is being rolled across the Service.
- Further support for Thanet services, including drop in sessions to meet with staff to understand the challenges within the service.

The Care Group has a number of Development Away Days scheduled over the coming months to establish team building and assist with working relationships across Medway CMHT and Ashford CMHT

The main concerns outlined were:

- Recruitment and Retention of Band 6 nursing in South West Kent
- Relationship issues within Medway CMHT and Ashford CMHT.
- Impact on other teams CMHT/CMHSOP due to change of Leadership in the West Kent team
- Band 6 NHS Staff Pay, although it has increased, we are still not attracting staff to move from Agency.
- Staff morale due to the impact of COVID.

**Workforce, Organisational Development and Communication Presentation**

The Committee received a comprehensive presentation.

**Key Performance Indicators**.
The Trust's turnover year to date is 9.79 vs our target 10.5. Sickness is running at 3.85 vs 4.22, excluding COVID sickness. Figures for COVID Vaccinations for frontline staff is 81%, for 1st vaccination and for 2nd vaccination is 61%. There are Risk Assessments taking place for all staff that are not vaccinated to understand what the implications are.

The Director of Workforce and Organisational Development updated the Committee around the Nursing Associate, Nurse Degree and the OT Degrees. There are 21 successful for the Nursing Degree, 22 successful applicants for Nursing Associates there are 4 successful applicants for the OT Degree. We also have 21 International Nurses currently signed up. This will help with our future pipeline.

**Recruitment and Retention**

It was reported that the recruitment team processed 42.6% more offers in Q2 2021 compared to this time last year. (2021- 358 offers, 2020 – 251offers). In addition, 277 starters in various roles in the same period.

**Encourage and Belonging – Becoming and Anti-Racist Organisation**
After a conversation between the Chair of the WFOD Committee, the Head of Quality and Diversity and the Director of Workforce and OD, we will explore this further and work with a group to explicitly set out our aspirations and how we will get there so all employees understand

The Deputy Director of Nursing will bring an update on Operation Carvell to the next Workforce Committee meeting. This will include the number of incidents reported to the police and whether these are progressed

**Health & Wellbeing and Recovery Plan**

Eric Barrett, Health and Wellbeing Lead presented the draft KMPT Action plan to the Committee for discussion. It is reported that NHSEI have outlined 9 board principle that a wellbeing guardian should support. The action plan has been developed in response to the principles but there was some concern about the scale of the work packages in relation to resource for delivery. The draft plan will be shared again with action owners to ensure commitment and prioritisation to the work and then shared more widely for engagement with all staff. The final action plan will be brought back to the WFOD Committee for approval.

**New Ways of Working**

Jennie Cogger, Deputy of Workforce and Organisational Development presented the report to the Committee. The report is a continuation of the paper provided on the Tackling the Vacancy Challenge which was submitted to the Board in May 2021. The report describes how the teams have skill mixed the difficult to recruit roles to create innovative solutions to our workforce issues. In order to reduce the use of temporary staff and to recruit and retain staff we are developing new roles. These roles will support and attract new staff from within and externally from KMPT. Currently we are providing limited assurance to the vacancies being filled as these roles are still being embedded and we are still developing/recruiting to these roles. The Committee identified key questions for further discussion at the next WFOD.

**Risk Register – New Approach**

The Committee would like the Board to note that the risk around recruitment and retention will never be fully mitigated and that the Board needs to develop a level of tolerance for holding the risk. KPI's are in place for these risk areas and are also reported via Integrated Quality Performance (IQPR) Board on a monthly basis. There was some discussion around the achievement of target dates and their timeframe and it was agreed that the team should gather more details around the specific risks and issues, whereby we can then review and move forward with more sophisticated reporting in relation to very targeted risk areas. This work will build on the significant improvement in our data which has been achieved in the last 18 months.

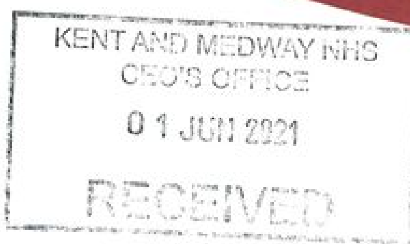
The Director of Workforce and OD shared that the staff turnover rate had significantly improved. In 2016 it was 17.8%. The Committee agreed there was limited assurance on the filing the vacancies and retention but recognised there was considerable good work going on in these areas. The target date on the risk register of March 2022 is the target date for meeting this year's KPIs.

**Item for Information**

Letter from Royal College of Nursing - Appendix A Recommendation

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

www.rcn.org.uk | 0345 772 6100




Adam Mapp
Flat 3, 15 Ethelbert Square
Westgate-On-Sea
CT8 8SR

Monday 24th May 2021

Helen Greatorex
Kent and Medway NHS and Social Care Partnership
Trust Headquarters
Farm Villa
Hermitage Lane
Maidstone
Kent ME16 9PH

Dear Helen,

**Feedback from a bullying and harassment event held by the East Kent branch of the Royal College of Nursing**

In April all members of the East Kent Branch of the Royal College of Nursing were invited to attend an event on bullying and harassment in the workplace. This was chaired by myself and was led by Ali Upton, the Chair of the RCN UK Safety Representative's Committee.

At this event, members who are employees of Kent and Medway NHS and Social Care Partnership shared with us that they did not experience bullying and harassment and found your trust a positive place to work.

I wanted to share this with you as the term bullying and harassment so often has negative connotations and I felt it important to celebrate your trust's example and good practice.

Yours sincerely

Adam Mapp
**Branch Chair**
**East Kent Branch**
**Royal College of Nursing**

Publication Code: 004 798

| | Title of Meeting | **Board of Directors (Public)** |
|---|---|---|
| | Meeting Date | **29 July 2021** |
| | Title | **Mental Health Act Committee (MHAC) Report** |
| | Author | **Kim Lowe, Chair of MHAC** |
| | Presenter | **Kim Lowe, Chair of MHAC** |
| | Executive Director Sponsor | **Dr Afifa Qazi, Executive Medical Director** |
| | Purpose | **Assurance** |

## Summary

The Mental Health Act Committee (MHAC) met on 12 July 2021 to consider:

- Executive Medical Director Report
- MHLOG Report
- Quarterly Reports of the MHA Activity Data
- MHA Compliance Report
- MHA/MCA Training Report
- Report from the Associate Hospital Managers
- Policy Report
- Updated MHAC Terms of Reference

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

| Area | Assurance | Items for Board's Consideration and/or Next Steps |
|---|---|---|
| Backlog of Hearings | Risk mitigations underway with required support from the Board. | There are 45 outstanding renewal appeals to be processed at the MHA office in Maidstone due to a vacancy. This vacancy has now been filled and training is underway for this new member of staff. The risk to the Trust is high, as given the period of delay, the service user may have recourse to bring legal action for being detained longer than was required.<br><br>A part time member of the MHA Team from another site, who is experienced in supporting with this work, is keen to increase their hours to help clear the backlog and implementation could be immediate if funding of these additional hours could be sourced. The MHA Compliance Manager will continue to monitor the numbers and report back to MHAC on the progress of this |

| | | |
|---|---|---|
| | | work.<br><br>***The Board to support in the additional funding required to bring the backlog of hearings up to date.*** |
| Section 12 App | Positive Assurance | The section 12 app contract is in place and the SOP is being finalised and the app is due to go live later this month. This will approve the way the crisis care pathway is delivered by making MHA assessments quicker to do and simpler to complete. |
| Associate Hospital Managers Training | Positive Assurance | The Associate Hospital Managers have received training on patients with autism and learning disabilities. The training was well received by the Managers and they agreed going forward to identify training requirements which sit alongside their mandatory training that they will undertake on a regular basis. |

## Recommendation

**The Board is asked to:**

1) **Note the content of this report**
2) **Provide direction regarding ''Items for Board's Consideration'' where appropriate and/or complete recommended next steps**

# TRUST BOARD MEETING – PUBLIC

## Meeting details

| | |
|---|---|
| **Date of Meeting:** | 29 July 2021 |
| **Title of Paper:** | Use of the Trust Seal |
| **Author:** | Kay Learmond, Head of Legal Services |
| **Executive Director:** | Helen Greatorex, Chief Executive |

## Purpose of Paper

| | |
|---|---|
| **Purpose:** | Noting |
| **Submission to Board:** | Statutory |

## Overview of Paper

Under Standing Order 12 (Custody of seal and sealing of documents) of the Trust's Standing Orders, the Trust Board is obliged to receive a quarterly report identifying the use of the Trust Seal and is asked to note this report.

## Issues to bring to the Board's attention

Within the Trust's Standing Orders, it identifies that the Trust is responsible for keeping a register of sealing, with every use of the Trust Seal being numbered consecutively and signed by the persons who approved and authorised the sealing of the document and attested the Seal.

The Seal of the Trust shall not be fixed to any documents unless the sealing has been authorised by either the Trust Board, a Committee of the Board, the Trust Chairman, the Chief Executive, or their designated acting replacement, in accordance with the Scheme of Delegation. Before any building, engineering, property or capital document is sealed it must be approved and signed by two members of the Board.

A report of all sealing is required to be made to the Trust Board at least quarterly as a means for the Board to assure itself that the Trust is in compliance with its Standing Orders.

## Governance

| | |
|---|---|
| **Implications/Impact:** | Non-compliance with the Trust's Standing Orders |
| **Assurance:** | Significant |
| **Oversight:** | Oversight by Trust Board |

Version Control: 01

## Use of the Trust Seal Q1

| Number | Date of Sealing | Description | Signatures | Comments |
|---|---|---|---|---|
| 142 | 27.05.2021 | Lease of the Flete Building at Thanet Mental Health Unit to Kent County Council | Helen Greatorex<br>Jack Craissati | Authorised by the Deputy Director of Finance |
| 143 | 29.05.2021 | Lease of Eureka Park from Stone Blue Holdings Limited | Helen Greatorex<br>Jackie Craissati | Authorised by the Deputy Director of Finance |
| 144 | 29.06.2021 | Deed of Surrender for Eureka Park | Helen Greatorex<br>Jackie Craissati | Authorised by the Deputy Director of Finance |

Version Control: 01