AGENDA

Title of Meeting	Trust Board Meeting (Public)
Date	26th January 2023
Time	9.30 to 11.30
Venue	Lifesize

Agenda Item	DL	Description	FOR	Format	Lead	Time
TB/22-23/112	1.	Welcome, Introductions & Apologies		Verbal	Chair	9.30
TB/22-23/113	2.	Declaration of Interests		Verbal	Chair	
BOARD REFLECTION ITEMS						
TB/22-23/114	3.	Personal Story – Specialist Personality Disorder Service – The Brenchley Unit		Verbal	DHS	9.35
TB/22-23/115	4.	Quality Improvement – Promoting Physical Health and Well-being through Accessible Information		Verbal	AQ	9.45
STANDING ITEMS						
TB/22-23/116	5.	Minutes of the previous meeting	FA	Paper	Chair	9.55
TB/22-23/117	6.	Action Log & Matters Arising	FN	Paper	Chair	
TB/22-23/118	7.	Chair's Report	FN	Paper	JC	10.00
TB/22-23/119	8.	Chief Executive's Report	FN	Paper	HG	10.05
TB/22-23/120	9.	Board Assurance Framework	FA	Paper	AC	10.10
STRATEGY, DEVELOPMENT AND PARTNERSHIP						
TB/22-23/121	10.	MHLDA Provider Collaborative Board Update	FD	Paper	SS	10.20
TB/22-23/122	11.	Community Mental Health Framework Transformation – Quarterly update and timeline	FD	Paper	DHS	10.30
OPERATIONAL ASSURANCE						
TB/22-23/123	12.	Integrated Quality and Performance Report – Month 9	FD	Paper	HG	10.40
TB/22-23/124	13.	Finance Report: Month 9	FD	Paper	SS	10.50
TB/22-23/125	14.	Workforce Deep Dive – Staff Safety	FD	Paper	SG	11.00
TB/22-23/126	15.	Freedom to Speak Up Six-Monthly Report	FD	Paper	SG	11.10
TB/22-23/127	16.	Safer Staffing Report	FD	Paper	AC	11.20
CONSENT ITEMS						
TB/22-23/128	17.	Quality Committee Chair Report (incl mortality report Q3)	FN	Paper	CW	11.25
TB/22-23/129	18.	Workforce and Organisational Development Committee Chair Report (incl equality and diversity report)	FN	Paper	VB	
TB/22-23/130	19.	Mental Health Act Committee Chair Report	FN	Paper	KL	
TB/22-23/131	20.	Finance and Performance Committee Chair Report	FN	Paper	MW	
CLOSING ITEMS						
TB/22-23/132	21.	Any Other Business			Chair	11.30
TB/22-23/133	22.	Questions from Public			Chair	
	Date of Next Meeting: 30th March 2023					

Members:		
Dr Jackie Craissati	JC	Trust Chair
Venu Branch	VB	Deputy Trust Chair
Sean Bone-Knell	SB-K	Non-Executive Director
Kim Lowe	KL	Non-Executive Director
Peter Conway	PC	Non-Executive Director
Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
Mickola Wilson	MW	Non-Executive Director
Stephen Waring	SW	Non-Executive Director
Asif Bachlani	AB	Associate Non-Executive Director
Helen Greatorex	CE	Chief Executive
Dr Afifa Qazi	AQ	Chief Medical Officer
Andy Cruickshank	AC	Chief Nurse
Donna Hayward-Sussex	DHS	Chief Operating Officer
Sheila Stenson	SS	Chief Finance and Resources Officer/ Deputy Chief Executive
Sandra Goatley	SG	Chief People Officer
Adrian Richardson	AR	Director of Partnerships and Transformation
In attendance:		
Tony Saroy	TS	Trust Secretary
Hannah Puttock	HP	Deputy Trust Secretary
Kindra Hyttner	KH	Director of Communications and Engagement
Apologies:		

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

Kent and Medway NHS and Social Care Partnership Trust Board of Directors (Public)
Minutes of the Public Board Meeting held at 09.30 to 12.15hrs on Thursday 24th November 2022
Via Videoconferencing

Members:			
	Dr Jackie Craissati	JC	Trust Chair
	Venu Branch	VB	Deputy Trust Chair
	Catherine Walker	CW	Non-Executive Director (Senior Independent Director)
	Peter Conway	PC	Non-Executive Director
	Kim Lowe	KL	Non-Executive Director
	Mickola Wilson	MW	Non-Executive Director
	Sean Bone-Knell	SBK	Non-Executive Director
	Martin Carpenter	MC	NExT Director Scheme
	Dr Asif Bachlani	AB	Associate Non-Executive Director
	Helen Greatorex	HG	Chief Executive
	Dr Afifa Qazi	AQ	Chief Medical Officer
	Andy Cruickshank	AC	Chief Nurse
	Donna Hayward-Sussex	DHS	Chief Operating Officer
	Sandra Goatley	SG	Chief People Officer
	Sheila Stenson	SS	Chief Resources and Finance Officer and Deputy Chief Executive
Attendees:			
	Tony Saroy	TS	Trust Secretary (Minutes)
	Hannah Puttock	HP	Deputy Trust Secretary
	Kindra Hyttner	KH	Director of Communications and Engagement
	Paul Roberts	PR	Clinical Lead, Open Dialogue Services
	Lisa Bryce	LB	Nurse, Ruby Ward
	Abigail Hussein	AH	Quality Improvement Facilitator
Apologies:			
Observers:			

Item	Subject	Action
TB/22-23/85	**Welcome, Introduction and Apologies** The Chair welcomed all to the meeting. All written reports were taken as read.	
TB/22-23/86	**Declarations of Interest** There were no declarations of interest.	
TB/22-23/87	**Personal Story – Open Dialogue Services** The Board welcomed Paul Roberts, Clinical Lead for Open Dialogue Services, and Ember, a patient under the Open Dialogue Services.	

Item	Subject	Action
	The Open Dialogue service is a new form of counselling and the Trust is one of the national pioneers. Ember highlighted how her time with Open Dialogue services had led to improvements in her mental health and her relationship with family members, with the Open Dialogue services providing a safe space to communicate. The Board noted that the Trust is rolling out Open Dialogue services across the Trust with the intention to replicate its success in different services that the Trust provides. The Board thanked PR and Ember for the presentation and **noted** the Personal Story – Open Dialogue Services.	
TB/22-23/88	**Quality Improvement – Improving Diabetes Care** The Board welcomed LB and AH to the Board who presented a recent quality improvement project focussed on improving diabetes care. The Trust had devised the project so as to achieve consistency in the monitoring of patients' blood glucose in a timely way. The standardised process was supported by a training package, with the project pilot being run in the Trust's Ruby Ward. LB, a nurse on the Ruby Ward, explained the implementation process and the benefits of the standardised monitoring procedure for staff and patients. The project achieved a reduction in misdiagnosis and a reduction in delayed physical health treatment for diabetes-related matters. The Board reflected on the success of the pilot, which also encouraged patients' independence in blood-glucose monitoring. The Trust will be rolling out the standardised process across the Trust, with digital technology supporting patients and staff. The Board **noted** the Quality Improvement – Improving Diabetes Care.	
TB/22-23/89	**Minutes of the previous meetings** The Board **approved** the minutes of the meeting held on 29th September 2022.	
TB/22-23/90	**Action Log & Matters Arising** The Board **approved** the Action Log, noting that the action related to Operation Cavell is to be re-assigned to HG.	
TB/22-23/91	**Chair's Report** The Board received the Chair's Report. In response to comments detailed in the report, HG confirmed that staff members continue to be able to dine with patients, and staff will be reminded that they should feel free to sit with patients whilst patients are dining.	

Item	Subject	Action
	In response to concerns raised that a few mental health patients were in acute trust beds, the meeting was assured that the Trust aims to prevent patients from needing to present at acute hospitals. The Trust is using two different workstreams to achieve this: work on Delayed Transfers of Care (DTOC) and the winter initiative. The Board **noted** the Chair's Report.	
TB/22-23/92	**Chief Executive's Report** The Board received the Chief Executive's Report. HG highlighted the following matters to the Board: • The Trust's Review and Resettlement Team was one of the finalists in this year's Health Service Journal Patient Safety Awards. The team has been performing really well and has brought a number of patients back into the county. This is better for patients as they are closer to home and it also leads to a reduction in costs. There has been some recent national media interest in Out of Area bed use and KMPT is one of the better performing Trusts with only five people in non-KMPT beds. • The Trusts work with the third sector in creating Safe Havens is working well. • Congratulations to AQ for winning Psychiatrist of the Year from the Royal College of Psychiatrists. The Board **noted** the Chief Executive's Report.	
TB/22-23/93	**Board Assurance Framework** The Board received the Board Assurance Framework (BAF) for approval, with the Board complimenting the Trust for the good introductory summary. The Board was updated regarding the two risks that changed their score, and the two risks that were recommended for removal. The Board was informed about an emerging risk related to potential disruption of power supplies, with the Trust having completed a deep dive into the issue. The risk will remain under review but is considered well controlled at this time. PC highlighted that there is a trend developing that that Board will need to consider, namely the increasing financial pressures for the NHS; this will be a challenge for all NHS trusts, including KMPT. The Board reflected on the forthcoming industrial action and noted that a number of unions are still balloting their members. The Board will be updated in due course and is working with NHS England and the Integrated Care System on the issue. The Board discussed Risk ID 6881 – Organisational inability to meet Memory Assessment Demand. The Board noted that the Integrated Care Board (ICB) had decided not to replace the ICB Clinical Lead for Dementia and expressed its	

Item	Subject	Action
	disappointment. The Trust is working with the ICB regarding the matter and early indicators are that the ICB may reinstate the role. This will assist in the delivery of system-wide actions. The Board **approved** the BAF.	
TB/22-23/94	**Strategic Delivery Plan Priorities Update** The Board received the Strategic Delivery Plan Priorities Update. The Board reflected on a number of areas that had progressed well. However, there was disappointment regarding the slow progress made to date regarding production of a clinically led RiO streamlining and improvement plan, and its implementation. The Board heard that clinicians are struggling to engage with the RiO design team. Thus far, engagement has occurred through surveys and a total of 43 recommendations for RiO improvement have been identified. A workshop will be run in December to finalise the improvement plan. Such improvements will include changes in the way staff interact with RiO, including the reduction of document uploading. The Board also emphasised that progress in partnership working has been limited, as half the objectives for building relationships were off target. With finances likely to be difficult in 2023/24, it was suggested that next year's priorities should include 'tackling the financial deficit' as a standalone priority. The Board agreed that this will be discussed at its forthcoming Board Development Day. The Board thanked Nigel Lowther and his team for the production of the Strategic Delivery Plan Priorities Update. The Board **noted** the Strategic Delivery Plan Priorities Update.	
TB/22-23/95	**Anchor Institutions and Health Inequalities** The Board received the Anchor Institutions and Health Inequalities paper. The Board reflected on the opportunities available to KMPT as an Anchor Institution, this work being led by the Trust's new Director of Partnership and Transformation. The Board agreed that becoming an Anchor Institution should not be considered to be an additional task, but rather as a different way of thinking of service delivery. The Board noted the important role that the Trust's procurement team will have in ensuring local businesses are supported. The Board **noted** the Anchor Institutions and Health Inequalities.	
TB/22-23/96	**KMPT-KCHFT Memorandum of Understanding**	

Item	Subject	Action
	The Board received an update on the Memorandum of Understanding (MOU) between the Trust and Kent Community Health Foundation Trust (KCHFT). The Board noted the changes that have occurred in the Integrated Care System and the impact it has had on the MOU. For example, the HR directors from across the system are now working together and there is potential for joint recruitment hubs. The Board reflected on the priorities areas for joint working with KCHFT: • Opportunities regarding estate optimisation with a possible reduction of 25% to 30% of corporate (i.e. non-clinical) estate • Integrated dementia teams between the two Trusts, with a pilot being run in the east of Kent. The funding for the joint posts has been made recurrent. • The Trust is working with KCHFT to support that trust with RiO. The two Trusts may look to a single RiO system going forward. **Action: HG to provide the Board with a high-level 2023/24 action plan for areas of joint working under the MOU, by March 2023.** The Board **noted** the KMPT-KCHFT Memorandum of Understanding.	
TB/22-23/97	**Integrated Quality and Performance Report (IQPR) – Month 7** The Board received the IQPR for Month 7. The Board reflected on the Delayed Transfers of Care (DTOC), noting that the rate had reduced from 12.2% in September to 11.1% in October. This equates to abut 35 to 40 patients who are in a Trust bed but are ready to be discharged. To tackle the issue, the Trust is rolling out its winter initiatives which includes a new triage system. This is being delivered within the current cash envelope. The triage system has been in operation at Queen Elizabeth Queen Mother Hospital, William Harvey Hospital and Medway Hospital. There has been significant success in Thanet, with 50% of patients diverted to more appropriate care. DHS confirmed that the intention is to update the current system that will allow for quicker triage and beds for those who need to be admitted. This will ensure that patients are seen by the right service in a timely manner. The Board noted that the Trust is reviewing the PALS data metrics, so that local teams may benefit from real time data with a focus on outcomes and experiences. With the financial pressures likely to worsen over the next few financial years, the Board noted that performance is likely to be adversely affected. With that in mind, the Board shall be focussing on the strategic direction of the Trust at its Board Development Day in December, with that strategy supported by the IQPR, The Board **noted** the IQPR – Month 7.	

Item	Subject	Action
TB/22-23/98	**Finance Report: Month 7** The Board received the Finance Report: Month 5. • **Income and Expenditure**: KMPT is continuing to use temporary staffing due to vacancies and staff absence. Agency spend remains high and the in month spend is higher than that reported last year. Agency caps have been reintroduced which is likely to result in an increase in external scrutiny over the coming months. Executive-led meetings continue and will review agency spend. Check and challenge meetings are taking place in November with further deep dive into Care Group positions, Cost Improvement Programme achievement and agency spend. In other expenditure areas, month 7 saw higher levels of spend continue in external placement with 435 bed days being utilised in month due to complex care requirements and the Fern Ward decant due to Capital works taking place. • **Capital Programme**: In October, the Trust over spent by £0.46m against the plan. However, Year To Date the position remains underspent by £3.06m. The underspend relates to the delayed start and completion dates for Estates schemes, delays in recruitment to new digital staffing posts and slippage in the Improving Mental Health Services (IMHS) Programme due to issues found during groundworks. The forecast is still that we will spend the full £22.09m plan. This relies upon continued progress being made on IMHS and schemes being progressed quickly. • **Cash**: The cash position increased in month and remains strong at £27.41m. The actual cash position is £11.44m higher than the original plan. The forecast of £13.09m is reliant upon achievement of break even and meeting the capital plan. • **Agency:** Agency spend has exceeded plan in month 6 and on a year to date basis are over plan by £0.1m and this is forecast to continue - due to both vacancies and operational pressures. There will be continued focus and scrutiny on all agency spend as the new financial year progresses to ensure spend remains within budget. Agency caps have been reintroduced for the Kent and Medway system and are currently being worked through therefore it is vital to have clear plans in place to enable the reduction in spend currently the Trust is forecasting £538k over the system cap target. • **Cost improvement programme:** The Long-Term Sustainability Programme (CIPs) for 22/23 continues to make progress with a focus on the identified plans delivering as per plan. Further work has continued in order to identify further CIP schemes in order to close the current gap of £1.0m, this represents a £0.1m improvement in month. This will enable the annual target to be achieved and support the eradication of the underlying deficit by March 2023. Executive led check and challenge meetings are taking place in November to ensure focus remains on CIPs and efficiency plans. Work continues on addressing the underlying deficit, with two key pieces of work around rota review and Mental Health LD services to be completed during Quarter 4. These are expected to support the trust in addressing its recurrent deficit in year.	

Item	Subject	Action
	The Board noted the work on the transformation work being undertaken through the Community Mental Health Framework and through the Mental Health Optimal Staffing Tool work, which evaluates efficiencies in staffing. The Board **noted** the Finance Report: Month 7.	
TB/22-23/99	**Workforce Deep Dive – Recruitment and Retention** The Trust received the Workforce Deep Dive Paper. The Board reflected on the workstreams that were making the biggest difference to the Trust. Discussions centred on establishing and reinforcing the nursing pipeline, with student nurses being slowly brought into the Trust. The intention is to have 130 nurses join the Trust by year 4 and providing them with wraparound support. The Trust is looking at capacity issues and reassigning work to administrative support staff which will allow clinicians, across the multi-disciplinary team, to have more time to deal with patient care. The Board also noted that the greatest proportion of staff on long-term sickness are suffering from musculoskeletal issues. Those staff may benefit from increasing the number of Physiotherapists who work within the Trust and providing a service to staff as well as patients. The Board **noted** the Workforce Deep Dive – Recruitment and Retention.	
TB/22-23/100	**Freedom to Speak Up Report** The Board received the Freedom to Speak Up Report and reflected on the good performance of the new Freedom to Speak Up Guardian provider. The Board noted that it had received a seminar on Freedom to Speak Up in October. The report highlighted that the most prevalent themes were: • Efficacy of systems and processes; • Safety of staff; and • Relationships with managers. The Board will be receiving a full report in January 2023. The Board **noted** the Freedom to Speak Up Report.	
TB/22-23/101	**Medical Revalidation Report** The Board received and **approved** Medical Revalidation Report.	
TB/22-23/102	**Review of Standing Orders** The Board received the paper on the Review of Standing Orders and **approved** the amendments to the Standing Orders.	

Item	Subject	Action
TB/22-23/103	**Register of interests** The Board received and **noted** the Register of Interests. The Chair confirmed the Trust's stance on the Register of Interests, which is that all appointments (remunerated or non-remunerated) must be declared by Board members.	
TB/22-23/104	**Quality Committee Chair Report (incl. Mortality Report Q2)** The Board received and **noted** the Quality Committee Chair's Report including the Quarter 2 Mortality Report.	
TB/22-23/105	**Workforce and Organisational Development Committee Chair Report** The Board received and **noted** the Workforce and Organisational Development Committee Chair's Report.	
TB/22-23/106	**Mental Health Act Committee Chair's Report** The Board received and **noted** the Mental Health Act Committee Chair's Report.	
TB/22-23/107	**Audit and Risk Committee Chair's Report** The Board received and **noted** the Audit and Risk Committee Chair's Report. The Board expressed its disappointment that the Trust's External Auditors had failed to attend the recent meeting of the Audit and Risk Committee. PC confirmed that the non-attendance was not material as there was little to report this time of the financial year. PC will remind the External Auditors of the unacceptability of their non-attendance.	
TB/22-23/108	**Charitable Funds Committee Chair Report** The Board received and **noted** the Charitable Funds Committee Chair's Report.	
TB/22-23/109	**Finance and Performance Committee Chair's Report** The Board received and **noted** the Finance and Performance Committee Chair's Report.	
TB/22-23/110	**Any Other Business** The Board thanked MC for his work with the Trust Board.	
TB/22-23/111	**Questions from Public** The Board received no questions from the Public.	
	Date of Next Meeting The next meeting of the Board would be held on Thursday 26th January 2023.	

Item	Subject	Action

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

Date …………………………………………………………..

BOARD OF DIRECTORS ACTION LOG
UPDATED AS AT: 18/01/2023

Kent and Medway NHS and Social Care Partnership Trust

Key	DUE	IN PROGRESS	NOT DUE	CLOSED

Meeting Date	Minute Reference	Agenda Item	Action Point	Lead	Date	Revised Date	Comments	Status
ACTIONS DUE IN JANUARY 2023								
29.09.2022	TB/22-23/68	MHLDA Provider Collaborative Update	SS to provide an update paper on the MHDLA Provider Collaborative workstreams and their outcomes. Update to be provided at November Board meeting.	SS	November 2022	January 2023	On agenda	COMPLETE
29.09.2022	TB/22-23/72	Workforce Deep Dive – Leadership Development Strategy	In January 2023, SG to update the Board if the Trust is able to develop a formal in-house leadership development programme.	SG	January 2023		This will be progressed in 2023/24 in conjunction with KCHFT (Mandatory management training programme)	COMPLETE
29.09.2022	TB/22-22/73	Community Mental Health Framework Transformation	DHS to include implementation timeline and financial milestones in the next Community Mental Health Framework, which is due in January 2023.	DHS	January 2023		On agenda	COMPLETE
ACTIONS NOT DUE OR IN PROGRESS								
29.09.2022	TB/22-23/74	Closed cultures and professional boundaries	AC to provide an update on closed cultures and professional boundaries in March 2023.	AC	March 2023			NOT DUE
29.07.2022	TB/22-23/46	Operation Cavell Annual Progress Report	VB2 to provide an Operation Cavell update report to the Board in January 2023.	HG	January 2023	March 2023		NOT DUE
24.11.2022	TB/22-23/96	KMPT-KCHFT Memorandum of Understanding	HG to provide the Board with a high-level 2023/24 action plan for areas of joint working under the MOU, by March 2023.	HG	March 2023			NOT DUE
CLOSED AT LAST MEETING OR COMPLETED BETWEEN MEETINGS								
29.09.2022	TB/22-23/74	Register of interests	TS to present the Board with the up-to-date Register of Interests at the November Board meeting.	TS	November 2022		Discussed on the agenda	COMPLETE

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**Thursday 26th January 2023**
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 six matters:

- Kent & Medway System
- Chief Executive
- Changes to Non-Executive Directors
- Changes at Board
- Board Development Day and Trust Strategy
- Approval of business cases
- Trust Chair and Non-Executive Director visits

2. Kent & Medway system

It has been a busy period for the integrated system. I have attended a meeting for K & M chairs and CEOs to develop the provider collaboratives in the county. I have also chaired a workshop for the North Kent Health & Care Partnership board, as well as chairing the January HCP board meeting.

Cedi Frederick, Chair of Kent and Medway Integrated Care Board (K&M ICB), and Paul Bentley, Chief Executive Officer for K&M ICB will join a Board seminar later today to discuss the K&M ICB's strategy for the next few years.

3. Chief Executive

Helen Greatorex, our Chief Executive announced on 16th January 2022 that she is intending to take her retirement from KMPT and the NHS in the autumn. I know that there will be great feelings of sadness regarding her departure, as well as gratitude for the compassion and commitment that she has shown to our service users, carers and KMPT staff. Helen has led the organisation most ably for seven years, and we will ensure that there is plenty of opportunity over the course of this year to express our thanks to her.

4. Changes to Non-Executive Directors

The Board is pleased to welcome Stephen Waring as a Non-Executive Director. Stephen brings with him executive level experience in the NHS and local and central government. Stephen currently works at the Greater London Authority as the Head of Health and Care Policy and Partnerships.

5. Changes at Board

The Board is pleased to welcome Dr Adrian Richardson as the Trust's new Director of Partnerships and Transformation. Adrian joins us from Frimley Health and has over 20 years' experience working within the NHS. He qualified as a doctor in 2001 and transitioned

from clinical work as a Geriatrician into leadership roles in successful organisations across the South of England. He has extensive experience in transformation, partnership working, strategy, improvement and engagement.

6. Board Development Day and Trust Strategy

On the 16th December 2020, the Board met in person for its bi-annual Development Day. The session was externally facilitated and focussed on developing the trust's strategy. There was considerable unanimity between executive and non-executive board members regarding the broad areas that we need to focus on for the period 2023-26. We have agreed a timetable for discussion and development of the strategy and the next year's delivery plan, with a view to approval in March 2023. Key discussions include the leaders' event and our forthcoming meeting with the Engagement Council in February.

7. Approval of business cases

In accordance with the Trust's Standing Orders and advice from the Trust Secretary, the Chief Executive and I approved three business cases in December following consultation with two Non-Executive Directors. The Board will be sighted on the business cases later today.

8. Trust Chair and NED visits

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

Where	Who
December 2022	
BAME staff network meeting	Jackie Craissati
PALs and Complaints Team	Jackie Craissati
Fern Ward	Sean Bone-Knell
Communications Team	Catherine Walker
January 2023	
Thanet CMHT	Sean Bone-Knell
Folkestone community mental health team	Jackie Craissati
Folkestone Safe Haven	Jackie Craissati
Canterbury community mental health team	Jackie Craissati
Canterbury Safe Haven	Jackie Craissati

Jackie Craissati - visits

The two December meetings with staff were enormously helpful. With the PALs and Complaints team I was able to drill down into the detail of service user concerns in relation to 'communication' or 'staff attitude', and it was lovely to be assured that so many compliments relate to staff listening, patience and feeling understood. I have shared with the executive management team how complaint investigators might assist with quality and speed of investigations, improvements in communication regarding triage, and developing clinician skills in complaint responses.

My visit to the BAME staff network was a sobering experience as we went through the results of some interesting research in relation to racist verbal abuse experienced by staff. Although I know this is a problem, it was shocking to hear the detail of their experiences.

The network is recommending that the trust develops a consistent policy for dealing with racist verbal abuse, as currently responses are varied. I have asked for the research to come to the March board, and we are developing the next steps in our goal to becoming an anti-discriminatory and anti-racist organisation.

I was inspired by my visit to the community mental health team (CMHT) in Folkestone which was followed by an evening tour of the Folkestone Safe Haven run by the charity, Hestia. The CMHT faces similar challenges to our other community services, but has made impressive progress in addressing areas of risk such as Active Review. There was very encouraging feedback regarding the new multi-agency approach to screening referrals, particularly in relation to the patient experience. The Safe Haven service for those in crisis seems to me to be an invaluable resource, and I have asked our executive team to take action to see if we can improve its current underutilisation.

My visit to Canterbury is taking place after this report has to be finalised, and I will report on the highlights in my March Chair's report.

Sean Bone-Knell – Fern Ward
A really enjoyable visit to this busy Acute Ward for female patients. At the time of the visit, the first phase of refurbishment work for six bedrooms is taking place which is experiencing some delays. Staff members were very pleased to see this estates work taking place and look forward to the project end in 2023.

Positive comments were made about the recent change of food provider on this ward with a clear menu of choices.

Staffing levels and short-term sickness were seen by many as one of the key issues for the Trust at this time. Staff and Managers were all in good spirits and very welcoming and positive about the Trust and the patients they care for.

Catherine Walker – Communications Team
I joined the reformed Communications and Engagement Team's catch-up meeting. Thanks to all for making me welcome. Much is happening to enhance and refine KMPT communications both internally and externally. Matters discussed widely ranged from press coverage, community transformation consultation and staff survey to how to get more targeted staff information. Lived experience is embedded at key project points.

Sean Bone-Knell – Thanet Community Mental Health Team (CMHT)
The Beacon building in Thanet provides good accommodation for the CMHT alongside many other services with flexible working and bookable rooms. It is a well-kept and welcoming building, and staff seemed happy and content in their working environment. The Thanet CMHT serves a challenging area however IQPR performance in comparison with other CMHTs was very good.

The new Freedom To Speak Up approach within KMPT was seen as effective and the new Quality Improvement team had already been attending team meetings in Thanet to seek out opportunities for improvement.

The relationship between actuate and CMHT teams around discharge meetings was an area for improved communication to ensure more effective working.

An enjoyable visit to a well-managed and effective team.

Chief Executive's Board Report

Date of Meeting: 26 January 2023

Introduction

Since the last Chief Executive's report in November the pressure on our services has remained significant. In common with the rest of the county's health providers, we are experiencing difficulty in moving patients who are ready to leave our wards, on to their next appropriate placement. The causes of delay are multifactorial and require focused clinical and management partnerships to resolve.

We have strong and well-established working relationships with our system partners in other agencies, and work together to ensure that we do not allow inter-agency boundaries to slow our work to make sure that people receive the right care, in the right place, at the right time. But, that challenge is markedly more difficult at present and members of the board will be aware from national media coverage that KMPT is not alone in needing to retain a laser focus on patient and staff safety whilst we manage the pressures we are experiencing.

Against this backdrop, it has never been more important that we focus on the right things, and drive for results. The development of our new three-year strategy and its underpinning annual delivery plan will ensure that everyone can easily see how we are doing against the goals we have all agreed will make the biggest positive impact on achieving our simple mission; to provide brilliant care through brilliant people.

Veteran Aware Accreditation Award

We were pleased to hear at the end of 2022 that the Veterans Covenant Healthcare Alliance board had approved KMPT to become a Veteran Aware Trust in recognition of our commitment to the Armed Forces Covenant. They have recognised our work in identifying and sharing best practice across the NHS as an exemplar of the best standards of care for the Armed Forces community.

KMPT Joins the Purpose Health Coalition

In November 2022, KMPT joined the Purpose Coalition and signed up to a new framework for measuring social impact.

Members of the wider Coalition include both public and private sector organisations including universities, councils, Amazon and the BBC.

Chaired by Rt Hon Justine Greening former Secretary of State for Education, Transport and International Development, the Coalition was established in 2021 and brings together 21 NHS trusts covering over 120,000 NHS employees.

There is a strong link between the work of the Coalition and KMPT's aspiration to become an Anchor Institution. Further updates will be provided to the board later this year when the focus of our work is agreed.

The Integrated Care Board (ICB) and Hewitt Review

The first draft of the Hewitt review is expected to have been completed by the end of January, with a final report to be published by March 15th. Commissioned by Chancellor Jeremy Hunt and Secretary of State for Health Steve Barclay the review's Terms of Reference state that it will;

'Consider how the oversight and governance of Integrated Care Systems can best enable them to succeed, balancing greater autonomy and robust accountability with a particular focus on real time data shared digitally with the Department of Health and Social care and on the availability and use of data across the health and care system of transparency and improvement'

As the Hewitt Review continues, the ICB has finalised its Strategy, setting out its aims and ambitions. The board will be joined in seminar today by both the ICB's Accountable Officer and Chair for further conversation about this and other areas of interest.

KMPT strategy 2023-26

As outlined in the Chair's report, the board met in December to refine its thinking about KMPT's strategy 2023-26. Subsequent to that facilitated whole day, board event the executive and their teams have been working to create value-adding, easy to understand and measurable key performance indicators focused on three overarching strategic aims. A series of opportunities to engage and involve others in our thinking is planned including a dedicated leaders' event and conversations with our Engagement Pool. The board and its sub-committees will be updated as this work continues, leading to the launch of our new strategy at the end of March.

Working With Days

The Chief Executive and her team continue to commit to regularly spending time working alongside colleagues from across the organisation. Recently these have included the Chief Operating Officer spending time with physiotherapists in Canterbury; Chief People Officer with the teams on Jasmine and Ruby Wards and is with Chartwell ward in early February and the Chief Nurse spending a day with Community Mental Health Teams in Ashford and Canterbury. Since the last board meeting the Chief Executive has worked an early shift with the West Kent Crisis Resolution Home Treatment Team and is scheduled in early February to work in one of our acute hospital Emergency Departments with our Liaison Psychiatry Team.

Memorandum of Understanding

As part of a programme of joint working linked to our organisation's Memorandum of Understanding, the Chief Executives and Chairs from KMPT and Kent Community Health Foundation Trust met in January. It was agreed that a single update paper co written by both Chief Executives will be presented to both boards in the Spring. The paper will provide an overview and update along with mutually agreed areas of focus for the forthcoming year.

The board will receive an update from the Chief Finance Officer today, reflecting the new guidance which was issued on December 23rd 2022

Welcoming New Colleagues to KMPT

January saw the highest ever number of new starters for KMPT. Sixty-three new colleagues joined us in taking up posts in a wide range of clinical and non-clinical roles. This volume of new joiners represents an enormous amount of very detailed, person focused work on the part of the recruitment and learning and development team who work tirelessly to ensure that every single new starter has a positive

experience of joining us. I know that the board will want to join me in congratulating both teams on a job well done.

Changes in the Executive

Finally, I am pleased to welcome Dr Adrian Richardson to his first KMPT Board meeting having joined us as Director of Partnerships and Transformation.

Helen Greatorex
Chief Executive

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 26 January 2023

Title of Paper: Board Assurance Framework

Author: Louisa Mace, Risk Manager

Executive Director: Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose: Approval

Submission to Board: Regulatory Requirement

Overview of Paper

The Board are asked to receive and review the Board Assurance Framework (BAF) and to ensure that any risks which may impact on achieving the strategic objectives have been identified and actions put in place to mitigate them.

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

Issues to bring to the Board's attention

The BAF was last presented to the Board in November 2022.

- No new risks have been added to the BAF since November
- 1 risk has changed their risk score since November
  - Risk ID 6848 – Staff Turnover (Reduced from 20 (Extreme) to 15 (Extreme))
- 1 risk is recommended for removal
  - Risk ID 6052 – Improving and Sustaining Quality and Safety (Rating of 12 – High)
- Work continues to review risks included on the BAF. Where risk scores reduce or the risk is considered stable and well managed, these will be recommended for removal from the BAF.
- Where significant risks remain, but they are considered well managed and stable, these will be included on the TRR to retain oversight.

Governance

Implications/Impact: Ability to deliver Trust Strategy.

Assurance: Reasonable Assurance

Oversight: Oversight by the Audit and Risk Committee and Board level risk Owners (EMT)

Version Control: 01

The Board Assurance Framework

The BAF was last presented to the Board on 24th November 2022.

The Top Risks are

- Risk ID 3164 – Capital Projects – Availability of Capital (Rating of 16 – Extreme)
- Risk ID 6847 – Organisational Sickness Absence (Rating of 16 – Extreme)
- Risk ID 6881 - Organisational inability to meet Memory Assessment Service Demand (Rating of 16 – Extreme)
- Risk ID 6848 – Staff Turnover (Rating of 15 – Extreme)

Risk Movement

One risk has changed their risk score since the Board Assurance Framework presented to Board on 24 November

- **Risk ID 6848 – Staff Turnover (Reduced from 20 (Extreme) to 15 (Extreme))**
  Vacancy rate discussions have been undertaken since this was last presented to Board. The target vacancy rate has been updated to 16% (from 10%). This has affected the current likelihood score for the risk and reduced it from 4 likely to 3 possible, reducing the risk score. The confidence assessment for this risk is still under review, so remains red at this time.

Risks Recommended for Removal

One risk is recommended for removal

- **Risk ID 6052 – Improving and Sustaining Quality and Safety (Rating of 12 – High)**
  This risk has been reviewed. It is recommended for removal from the BAF as it is a mature risk which is well understood and well controlled. The intention is to move to looking at all risks through a quality and safety lens, so it may be that this risk is closed in time, but it will remain open for now so that focus on this is not lost during the change to the new landscape.

New Risks

No new risks have been added to the BAF this time.

Emerging Risks

Two new risks for the financial revenue and capital positions for 2023/24 are being considered. Finance will look to review the current risks with a view to recommending risks for closure where necessary. The new risks will take into consideration the impact of current inflationary pressures and factors outside of the Trusts control.

Version Control: 01

Other Notable Updates

- Consideration continues to be given as to the use of the Board Assurance Framework and Trust Risk Register to ensure the right risks are presented to Board and executive level oversight continues on the more stable significant risks. Work continues to ensure that all risks, at every level in the Trust, are focussed on key issues and interdependencies are identified.

- **Risk ID 7050 – Increased level of Delayed Transfers of Care**
  The position around Delayed Transfers of Care within the Trust remains very fluid. There has been a delay to the action regarding a dedicated local authority commissioner to solely work on DToC reduction. While there is a good level of engagement in the agenda, there seems to be some difficulty progressing the solutions.

- **Risk ID 6573 – Demand and Capacity for Adult and Older Adult CMHTs compared to pre pandemic levels**
  A further update on this risk is included in a separate paper to Board.
  It is planned that a pilot of the community mental health framework will be commencing in April 2023, with a full county roll out over the following 18 months. This action will be included in the March BAF.

- **Risk ID 6881 – Organisational inability to meet Memory Assessment Service Demand**
  There has been little change to this risk. There are some signs of this risk moving in the right direction from the trust perspective, with an improvement in the dementia diagnosis rate, but there remains concern around County Level engagement.

- **Risk ID 5991 – Organisational Risk – Industrial Action (Rating of 6 (Moderate))**
  This risk remains under review and is updated as the outcome of each Union's ballots are announced. Currently all Industrial Action is being mapped on a master spreadsheet and being assessed to see if there are any implications for KMPT. To date there are no ballots inside the trust that have an impact. Externally, for SECAMB Industrial Action, KMPT have enhanced the Psychiatric Liaison Service in each ED.

- **Risk ID 7084 – New Landscape (New Operating Model) (Rating of 9 – High)**
  No change to risk score for this risk. Work continues to progress with the move to the new landscape. Engagement levels with staff remain high and recruitment to key leadership posts is underway.

- **Risk ID 6966 – 2022/23 Financial Planning**
  This risk is coming to the end of its cycle as the 2022/23 financial year comes to an end. It is intended to open a new risk for the Financial Planning for 2023/24. This will be worked through for inclusion in the March BAF report.

Recommendations

The Board is asked to receive and review the BAF and to confirm that they are satisfied with the progress against these risks and that sufficient assurance has been received.
The Board are requested to note that work continues to ensure that all actions are identified and attention to detail within the recording of actions and their management is the primary focus of the named board level risk owners.

Version Control: 01

Updated: 18 January 2023

NHS
Kent and Medway
NHS and Social Care Partnership Trust

Board Assurance Framework

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

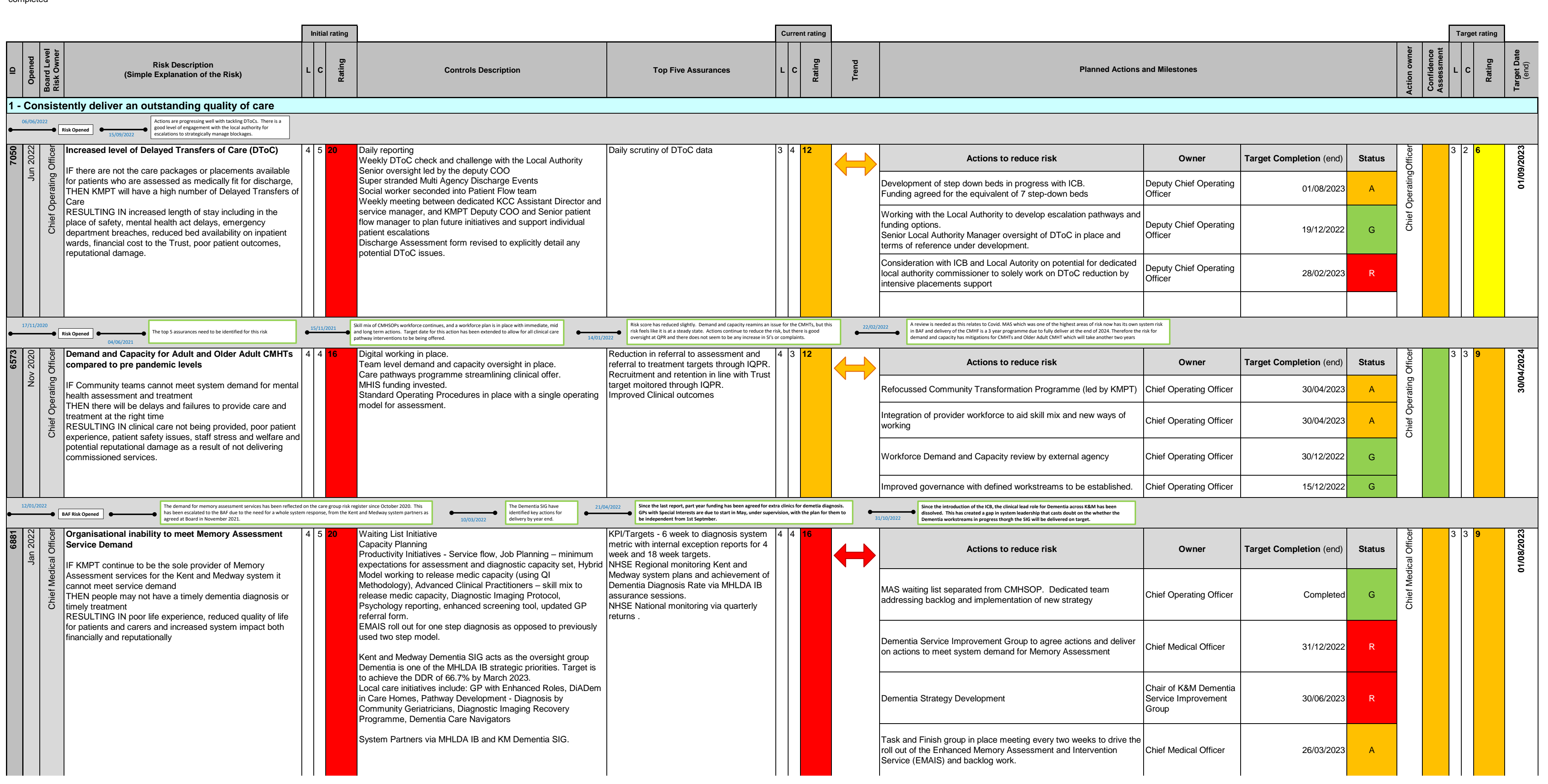
Definitions:
Initial Rating = The risk rating at the time of identification

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

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

Action status key:

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



1 - Consistently deliver an outstanding quality of care

06/06/2022 Risk Opened — 15/09/2022: Actions are progressing well with tackling DToCs. There is a good level of engagement with the local authority for escalations to strategically manage blockages.

17/11/2020 Risk Opened — 04/06/2021: The top 5 assurances need to be identified for this risk — 15/11/2021: Skill mix of CMHSOPs workforce continues, and a workforce plan is in place with immediate, mid and long term actions. Target date for this action has been extended to allow for all clinical care pathway interventions to be being offered. — 14/01/2022: Risk score has reduced slightly. Demand and capacity reamins an issue for the CMHTs, but this risk feels like it is at a steady state. Actions continue to reduce the risk, but there is good oversight at QPR and there does not seem to be any increase in SI's or complaints. — 22/02/2022: A review is needed as this relates to Covid. MAS which was one of the highest areas of risk now has its own system risk in BAF and delivery of the CMHF is a 3 year programme due to fully deliver at the end of 2024. Therefore the risk for demand and capacity has mitigations for CMHTs and Older Adult CMHT which will take another two years

12/01/2022 BAF Risk Opened — The demand for memory assessment services has been reflected on the care group risk register since October 2020. This has been escalated to the BAF due to the need for a whole system response, from the Kent and Medway system partners as agreed at Board in November 2021. — 10/03/2022: The Dementia SIG have identified key actions for delivery by year end. — 21/04/2022: Since the last report, part year funding has been agreed for extra clinics for demetia diagnosis. GPs with Special Interests are due to start in May, under supervision, with the plan for them to be independent from 1st Septmber. — 31/10/2022: Since the introduction of the ICB, the clinical lead role for Dementia across K&M has been dissolved. This has created a gap in system leadership that casts doubt on the whether the Dementia workstreams in progress thorgh the SIG will be delivered on target.

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current Rating	Trend	Action owner	Confidence Assessment	Target rating L	Target rating C	Target Rating	Target Date (end)
7050	Jun 2022	Chief Operating Officer	**Increased level of Delayed Transfers of Care (DToC)** IF there are not the care packages or placements available for patients who are assessed as medically fit for discharge, THEN KMPT will have a high number of Delayed Transfers of Care RESULTING IN increased length of stay including in the place of safety, mental health act delays, emergency department breaches, reduced bed availability on inpatient wards, financial cost to the Trust, poor patient outcomes, reputational damage.	4	5	20	Daily reporting Weekly DToC check and challenge with the Local Authority Senior oversight led by the deputy COO Super stranded Multi Agency Discharge Events Social worker seconded into Patient Flow team Weekly meeting between dedicated KCC Assistant Director and service manager, and KMPT Deputy COO and Senior patient flow manager to plan future initiatives and support individual patient escalations Discharge Assessment form revised to explicitly detail any potential DToC issues.	Daily scrutiny of DToC data	3	4	12	↔	Chief Operating Officer		3	2	6	01/09/2023
6573	Nov 2020	Chief Operating Officer	**Demand and Capacity for Adult and Older Adult CMHTs compared to pre pandemic levels** IF Community teams cannot meet system demand for mental health assessment and treatment THEN there will be delays and failures to provide care and treatment at the right time RESULTING IN clinical care not being provided, poor patient experience, patient safety issues, staff stress and welfare and potential reputational damage as a result of not delivering commissioned services.	4	4	16	Digital working in place. Team level demand and capacity oversight in place. Care pathways programme streamlining clinical offer. MHIS funding invested. Standard Operating Procedures in place with a single operating model for assessment.	Reduction in referral to assessment and referral to treatment targets through IQPR. Recruitment and retention in line with Trust target moitored through IQPR. Improved Clinical outcomes	4	3	12	↔	Chief Operating Officer		3	3	9	30/04/2024
6881	Jan 2022	Chief Medical Officer	**Organisational inability to meet Memory Assessment Service Demand** IF KMPT continue to be the sole provider of Memory Assessment services for the Kent and Medway system it cannot meet service demand THEN people may not have a timely dementia diagnosis or timely treatment RESULTING IN poor life experience, reduced quality of life for patients and carers and increased system impact both financially and reputationally	4	5	20	Waiting List Initiative Capacity Planning Productivity Initiatives - Service flow, Job Planning – minimum expectations for assessment and diagnostic capacity set, Hybrid Model working to release medic capacity (using QI Methodology), Advanced Clinical Practitioners – skill mix to release medic capacity, Diagnostic Imaging Protocol, Psychology reporting, enhanced screening tool, updated GP referral form. EMAIS roll out for one step diagnosis as opposed to previously used two step model. Kent and Medway Dementia SIG acts as the oversight group Dementia is one of the MHLDA IB strategic priorities. Target is to achieve the DDR of 66.7% by March 2023. Local care initiatives include: GP with Enhanced Roles, DiADem in Care Homes, Pathway Development - Diagnosis by Community Geriatricians, Diagnostic Imaging Recovery Programme, Dementia Care Navigators System Partners via MHLDA IB and KM Dementia SIG.	KPI/Targets - 6 week to diagnosis system metric with internal exception reports for 4 week and 18 week targets. NHSE Regional monitoring Kent and Medway system plans and achievement of Dementia Diagnosis Rate via MHLDA IB assurance sessions. NHSE National monitoring via quarterly returns .	4	4	16	↔	Chief Medical Officer		3	3	9	01/08/2023

Planned Actions and Milestones — 7050

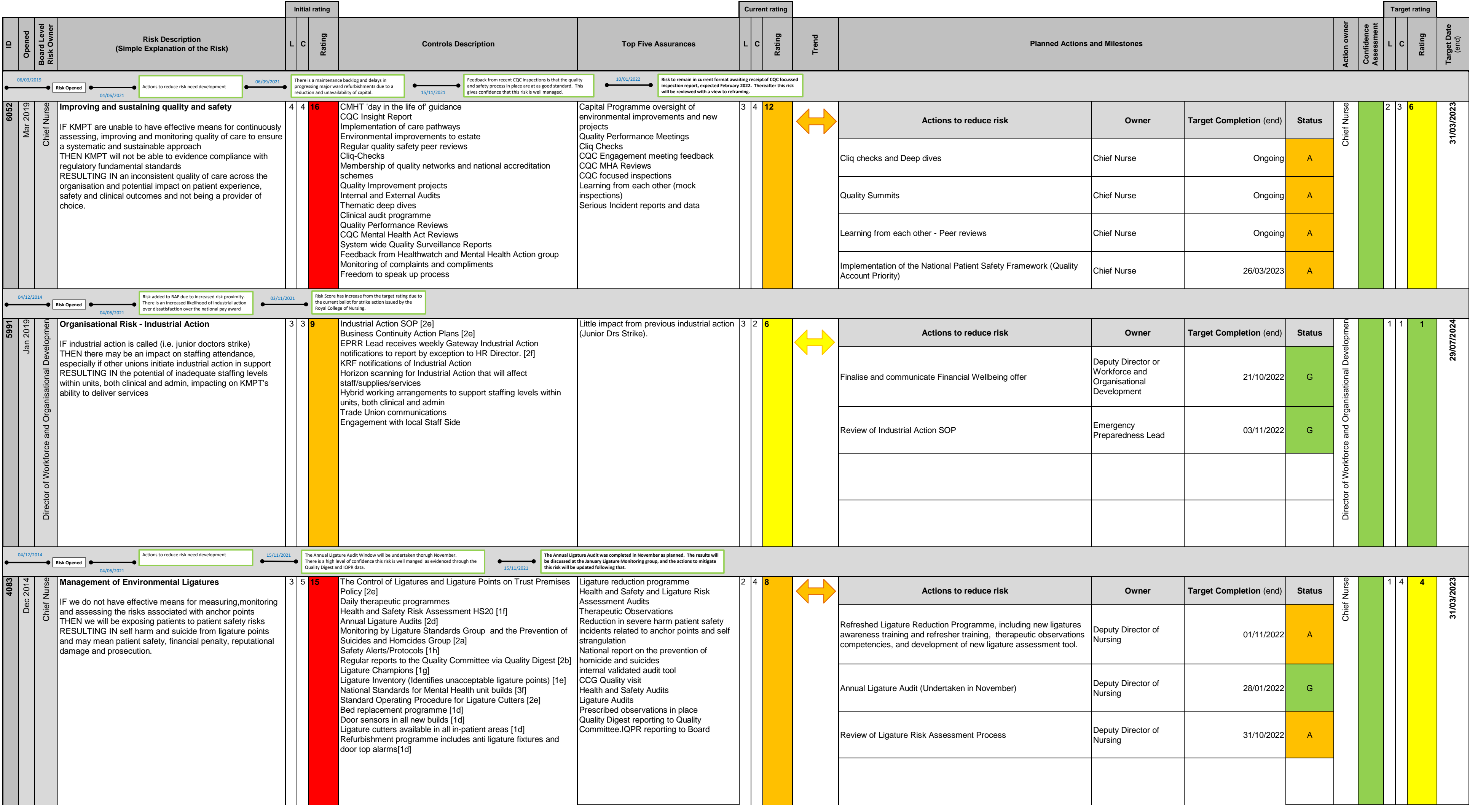
Actions to reduce risk	Owner	Target Completion (end)	Status
Development of step down beds in progress with ICB. Funding agreed for the equivalent of 7 step-down beds	Deputy Chief Operating Officer	01/08/2023	A
Working with the Local Authority to develop escalation pathways and funding options. Senior Local Authority Manager oversight of DToC in place and terms of reference under development.	Deputy Chief Operating Officer	19/12/2022	G
Consideration with ICB and Local Autority on potential for dedicated local authority commissioner to solely work on DToC reduction by intensive placements support	Deputy Chief Operating Officer	28/02/2023	R

Planned Actions and Milestones — 6573

Actions to reduce risk	Owner	Target Completion (end)	Status
Refocussed Community Transformation Programme (led by KMPT)	Chief Operating Officer	30/04/2023	A
Integration of provider workforce to aid skill mix and new ways of working	Chief Operating Officer	30/04/2023	A
Workforce Demand and Capacity review by external agency	Chief Operating Officer	30/12/2022	G
Improved governance with defined workstreams to be established.	Chief Operating Officer	15/12/2022	G

Planned Actions and Milestones — 6881

Actions to reduce risk	Owner	Target Completion (end)	Status
MAS waiting list separated from CMHSOP. Dedicated team addressing backlog and implementation of new strategy	Chief Operating Officer	Completed	G
Dementia Service Improvement Group to agree actions and deliver on actions to meet system demand for Memory Assessment	Chief Medical Officer	31/12/2022	R
Dementia Strategy Development	Chair of K&M Dementia Service Improvement Group	30/06/2023	R
Task and Finish group in place meeting every two weeks to drive the roll out of the Enhanced Memory Assessment and Intervention Service (EMAIS) and backlog work.	Chief Medical Officer	26/03/2023	A



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
6052	Mar 2019	Chief Nurse	**Improving and sustaining quality and safety** IF KMPT are unable to have effective means for continuously assessing, improving and monitoring quality of care to ensure a systematic and sustainable approach THEN KMPT will not be able to evidence compliance with regulatory fundamental standards RESULTING IN an inconsistent quality of care across the organisation and potential impact on patient experience, safety and clinical outcomes and not being a provider of choice.	4	4	16	CMHT 'day in the life of' guidance CQC Insight Report Implementation of care pathways Environmental improvements to estate Regular quality safety peer reviews Cliq-Checks Membership of quality networks and national accreditation schemes Quality Improvement projects Internal and External Audits Thematic deep dives Clinical audit programme Quality Performance Reviews CQC Mental Health Act Reviews System wide Quality Surveillance Reports Feedback from Healthwatch and Mental Health Action group Monitoring of complaints and compliments Freedom to speak up process	Capital Programme oversight of environmental improvements and new projects Quality Performance Meetings Cliq Checks CQC Engagement meeting feedback CQC MHA Reviews CQC focused inspections Learning from each other (mock inspections) Serious Incident reports and data	3	4	12		Chief Nurse		2	3	6	31/03/2023
5991	Jan 2019	Director of Workforce and Organisational Developmen	**Organisational Risk - Industrial Action** IF industrial action is called (i.e. junior doctors strike) THEN there may be an impact on staffing attendance, especially if other unions initiate industrial action in support RESULTING IN the potential of inadequate staffing levels within units, both clinical and admin, impacting on KMPT's ability to deliver services	3	3	9	Industrial Action SOP [2e] Business Continuity Action Plans [2e] EPRR Lead receives weekly Gateway Industrial Action notifications to report by exception to HR Director. [2f] KRF notifications of Industrial Action Horizon scanning for Industrial Action that will affect staff/supplies/services Hybrid working arrangements to support staffing levels within units, both clinical and admin Trade Union communications Engagement with local Staff Side	Little impact from previous industrial action (Junior Drs Strike).	3	2	6		Director of Workforce and Organisational Developmen		1	1	1	29/07/2024
4083	Dec 2014	Chief Nurse	**Management of Environmental Ligatures** IF we do not have effective means for measuring,monitoring and assessing the risks associated with anchor points THEN we will be exposing patients to patient safety risks RESULTING IN self harm and suicide from ligature points and may mean patient safety, financial penalty, reputational damage and prosecution.	3	5	15	The Control of Ligatures and Ligature Points on Trust Premises Policy [2e] Daily therapeutic programmes Health and Safety Risk Assessment HS20 [1f] Annual Ligature Audits [2d] Monitoring by Ligature Standards Group and the Prevention of Suicides and Homcides Group [2a] Safety Alerts/Protocols [1h] Regular reports to the Quality Committee via Quality Digest [2b] Ligature Champions [1g] Ligature Inventory (Identifies unacceptable ligature points) [1e] National Standards for Mental Health unit builds [3f] Standard Operating Procedure for Ligature Cutters [2e] Bed replacement programme [1d] Door sensors in all new builds [1d] Ligature cutters available in all in-patient areas [1d] Refurbishment programme includes anti ligature fixtures and door top alarms[1d]	Ligature reduction programme Health and Safety and Ligature Risk Assessment Audits Therapeutic Observations Reduction in severe harm patient safety incidents related to anchor points and self strangulation National report on the prevention of homicide and suicides internal validated audit tool CCG Quality visit Health and Safety Audits Ligature Audits Prescribed observations in place Quality Digest reporting to Quality Committee.IQPR reporting to Board	2	4	8		Chief Nurse		1	4	4	31/03/2023

Risk 6052 – timeline: 06/03/2019 Risk Opened; 04/06/2021 Actions to reduce risk need development; 06/09/2021 There is a maintenance backlog and delays in progressing major ward refurbishments due to a reduction and unavailability of capital.; 15/11/2021 Feedback from recent CQC inspections is that the quality and safety process in place are at as good standard. This gives confidence that this risk is well managed.; 10/01/2022 **Risk to remain in current format awaiting receipt of CQC focussed inspection report, expected February 2022. Thereafter this risk will be reviewed with a view to reframing.**

Risk 6052 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Cliq checks and Deep dives	Chief Nurse	Ongoing	A
Quality Summits	Chief Nurse	Ongoing	A
Learning from each other - Peer reviews	Chief Nurse	Ongoing	A
Implementation of the National Patient Safety Framework (Quality Account Priority)	Chief Nurse	26/03/2023	A

Risk 5991 – timeline: 04/12/2014 Risk Opened; 04/06/2021 Risk added to BAF due to increased risk proximity. There is an increased likelihood of industrial action over dissatisfaction over the national pay award; 03/11/2021 Risk Score has increase from the target rating due to the current ballot for strike action issued by the Royal College of Nursing.

Risk 5991 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Finalise and communicate Financial Wellbeing offer	Deputy Director or Workforce and Organisational Development	21/10/2022	G
Review of Industrial Action SOP	Emergency Preparedness Lead	03/11/2022	G

Risk 4083 – timeline: 04/12/2014 Risk Opened; 04/06/2021 Actions to reduce risk need development; 15/11/2021 The Annual Ligature Audit Window will be undertaken thorugh November. There is a high level of confidence this risk is well manged as evidenced through the Quality Digest and IQPR data.; 15/11/2021 **The Annual Ligature Audit was completed in November as planned. The results will be discussed at the January Ligature Monitoring group, and the actions to mitigate this risk will be updated following that.**

Risk 4083 – Planned Actions and Milestones

Actions to reduce risk	Owner	Target Completion (end)	Status
Refreshed Ligature Reduction Programme, including new ligatures awareness training and refresher training, therapeutic observations competencies, and development of new ligature assessment tool.	Deputy Director of Nursing	01/11/2022	A
Annual Ligature Audit (Undertaken in November)	Deputy Director of Nursing	28/01/2022	G
Review of Ligature Risk Assessment Process	Deputy Director of Nursing	31/10/2022	A

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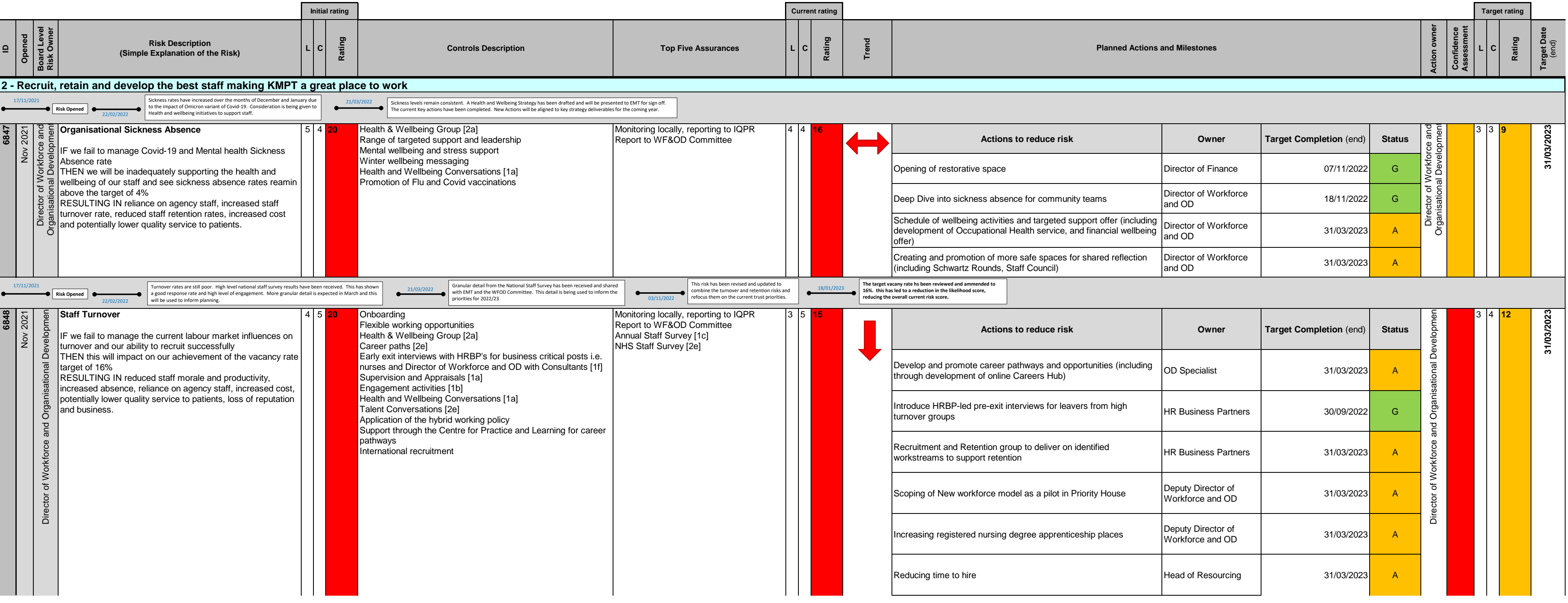

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
2 - Recruit, retain and develop the best staff making KMPT a great place to work																			
6847	Nov 2021	Director of Workforce and Organisational Development	**Organisational Sickness Absence** IF we fail to manage Covid-19 and Mental health Sickness Absence rate THEN we will be inadequately supporting the health and wellbeing of our staff and see sickness absence rates reamin above the target of 4% RESULTING IN reliance on agency staff, increased staff turnover rate, reduced staff retention rates, increased cost and potentially lower quality service to patients.	5	4	20	Health & Wellbeing Group [2a] Range of targeted support and leadership Mental wellbeing and stress support Winter wellbeing messaging Health and Wellbeing Conversations [1a] Promotion of Flu and Covid vaccinations	Monitoring locally, reporting to IQPR Report to WF&OD Committee	4	4	16	↔	See actions below	Director of Workforce and Organisational Development		3	3	9	31/03/2023
6848	Nov 2021	Director of Workforce and Organisational Development	**Staff Turnover** IF we fail to manage the current labour market influences on turnover and our ability to recruit successfully THEN this will impact on our achievement of the vacancy rate target of 16% RESULTING IN reduced staff morale and productivity, increased absence, reliance on agency staff, increased cost, potentially lower quality service to patients, loss of reputation and business.	4	5	20	Onboarding Flexible working opportunities Health & Wellbeing Group [2a] Career paths [2e] Early exit interviews with HRBP's for business critical posts i.e. nurses and Director of Workforce and OD with Consultants [1f] Supervision and Appraisals [1a] Engagement activities [1b] Health and Wellbeing Conversations [1a] Talent Conversations [2e] Application of the hybrid working policy Support through the Centre for Practice and Learning for career pathways International recruitment	Monitoring locally, reporting to IQPR Report to WF&OD Committee Annual Staff Survey [1c] NHS Staff Survey [2e]	3	5	15	↓	See actions below	Director of Workforce and Organisational Development		3	4	12	31/03/2023

Risk 6847 timeline:
- 17/11/2021 — Risk Opened
- 22/02/2022 — Sickness rates have increased over the months of December and January due to the impact of Omicron variant of Covid-19. Consideration is being given to Health and wellbeing initiatives to support staff.
- 21/03/2022 — Sickness levels remain consistent. A Health and Welbeing Strategy has been drafted and will be presented to EMT for sign off. The current Key actions have been completed. New Actions will be aligned to key strategy deliverables for the coming year.

Risk 6847 – Actions to reduce risk:

Actions to reduce risk	Owner	Target Completion (end)	Status
Opening of restorative space	Director of Finance	07/11/2022	G
Deep Dive into sickness absence for community teams	Director of Workforce and OD	18/11/2022	G
Schedule of wellbeing activities and targeted support offer (including development of Occupational Health service, and financial wellbeing offer)	Director of Workforce and OD	31/03/2023	A
Creating and promotion of more safe spaces for shared reflection (including Schwartz Rounds, Staff Council)	Director of Workforce and OD	31/03/2023	A

Risk 6848 timeline:
- 17/11/2021 — Risk Opened
- 22/02/2022 — Turnover rates are still poor. High level national staff survey results have been received. This has shown a good response rate and high level of engagement. More granular detail is expected in March and this will be used to inform planning.
- 21/03/2022 — Granular detail from the National Staff Survey has been received and shared with EMT and the WFOD Committee. This detail is being used to inform the priorities for 2022/23
- 03/11/2022 — This risk has been revised and updated to combine the turnover and retention risks and refocus them on the current trust priorities.
- 18/01/2023 — **The target vacany rate hs been reviewed and ammended to 16%. this has led to a reduction in the likelihood score, reducing the overall current risk score.**

Risk 6848 – Actions to reduce risk:

Actions to reduce risk	Owner	Target Completion (end)	Status
Develop and promote career pathways and opportunities (including through development of online Careers Hub)	OD Specialist	31/03/2023	A
Introduce HRBP-led pre-exit interviews for leavers from high turnover groups	HR Business Partners	30/09/2022	G
Recruitment and Retention group to deliver on identified workstreams to support retention	HR Business Partners	31/03/2023	A
Scoping of New workforce model as a pilot in Priority House	Deputy Director of Workforce and OD	31/03/2023	A
Increasing registered nursing degree apprenticeship places	Deputy Director of Workforce and OD	31/03/2023	A
Reducing time to hire	Head of Resourcing	31/03/2023	A

ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
3 - Put continuous improvement at the heart of what we do																			
20/09/2022 Risk Opened																			
7084	Sep 2022	Chief Operating Officer	**New Landscape (New Operating Model)** IF KMPT move to a new operating model with revised leadership structure without proper planning and formal consultation THEN there will be high levels of disruption to service delivery and concern amongst staff RESULTING IN disconnected systems and reporting structures, reduced staff retention, disruption to service delivery, poor patient experience and outcomes, reputational damage, potential litigation	4	4	16	Portfolio Plan Executive Director Oversight Support services involved in the programme Detailed Project plan outlining milestones and required steps to ensure smooth transition HR engagement with consultation and support to the workforce Regular communication strategy in place	Project oversight group minutes Learning and action logs Executive oversight	3	3	9	⟷	See actions below	Chief Operating Officer		3	2	6	**14/04/2023**
02/03/2021 Risk Opened																			
6861	Nov 2021	Executive Director of Finance	**Estates and Facilities Resources** IF adequate resources are not available to deliver the required services THEN non-delivery of all or some contracted services would occur RESULTING in backlogs, complaints, reputational damage, statutory non-compliances including CDM Regulations, potential harm to life and property, inability to respond to or avoid emergencies	5	4	20	Adequate staffing levels to carry out critical tasks to ensure compliance. Regular updates from Contractors regarding availability of staff / resources. Possible restructure of Estates and Facilities. Interim appointments of staff where required use of external specialist advisors	Project management support and reporting Interim recruitment to posts Vacancy reporting and recruitment	3	4	12	⟷	See actions below	Executive Director of Finance		3	3	9	**01/04/2023**
4 - Develop and extend our research and innovation work																			
			No Risks Identified against this Strategic Objective																

Planned Actions and Milestones – 7084

Actions to reduce risk	Owner	Target Completion (end)	Status
Ammendment of proposed plan following staff feedback	Chief Operating Officer	30/11/2022	G
Align clincial services to new Directorate structures, detailed plan underway	Chief Operating Officer	28/02/2023	A
Align support services and systems with proposed change	Chief Operating Officer	15/03/2023	A
Recruitment to vacant leadership posts	Chief Operating Officer	01/04/2023	A

Planned Actions and Milestones – 6861

Actions to reduce risk	Owner	Target Completion (end)	Status
Recruitment of interim Head of Capital Development and substantive staff to key management roles within the approved Structure	Strategic Director of Estates and Facilities	31/12/2022	A
Monitor staff workloads	Acting Lead for Estates	20/06/2022	G
New structure being drafted and approved at EMT w/c 21st March	Strategic Director of Estates and Facilities	31/03/2022	G
Full review of JDs and Person Specifications underway to draft develoment programmes where required for staff	Strategic Director of Estates and Facilities	20/06/2022	G

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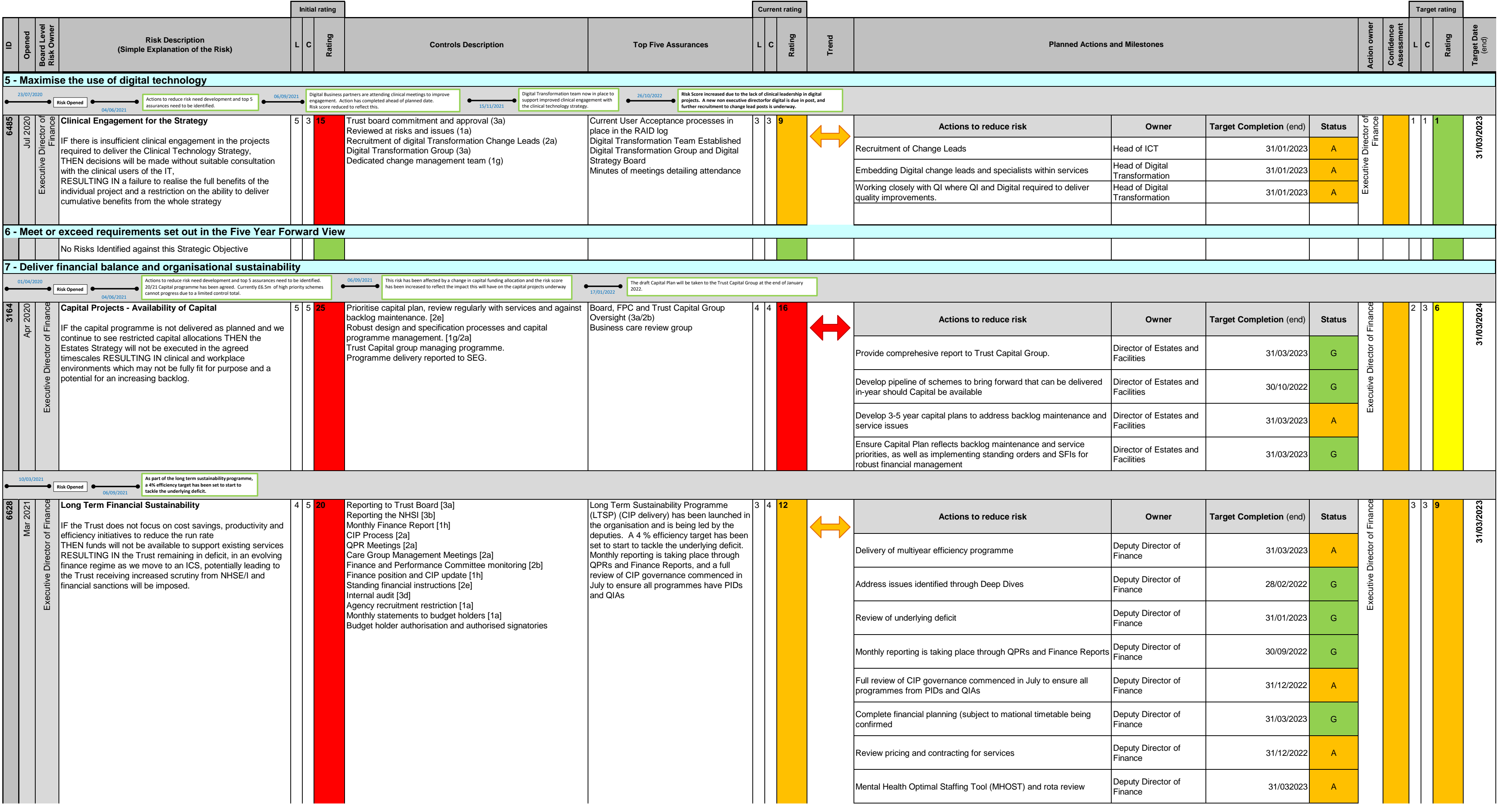


ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
5 - Maximise the use of digital technology																			
23/07/2020 Risk Opened 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. 06/09/2021 Digital Business partners are attending clinical meetings to improve engagement. Action has completed ahead of planned date. Risk score reduced to reflect this. 15/11/2021 Digital Transformation team now in place to support improved clinical engagement with the clinical technology strategy. 26/10/2022 RIsk Score increased due to the lack of clinical leadership in digital projects. A new non executive directorfor digital is due in post, and further recruitment to change lead posts is underway.																			
6485	Jul 2020	Executive Director of Finance	**Clinical Engagement for the Strategy** IF there is insufficient clinical engagement in the projects required to deliver the Clinical Technology Strategy, THEN decisions will be made without suitable consultation with the clinical users of the IT, RESULTING IN a failure to realise the full benefits of the individual project and a restriction on the ability to deliver cumulative benefits from the whole strategy	5	3	15	Trust board commitment and approval (3a) Reviewed at risks and issues (1a) Recruitment of digital Transformation Change Leads (2a) Digital Transformation Group (3a) Dedicated change management team (1g)	Current User Acceptance processes in place in the RAID log Digital Transformation Team Established Digital Transformation Group and Digital Strategy Board Minutes of meetings detailing attendance	3	3	9	↔	See actions below	Executive Director of Finance		1	1	1	**31/03/2023**
6 - Meet or exceed requirements set out in the Five Year Forward View																			
			No Risks Identified against this Strategic Objective																
7 - Deliver financial balance and organisational sustainability																			
01/04/2020 Risk Opened 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. 20/21 Capital programme has been agreed. Currently £6.5m of high priority schemes cannot progress due to a limited control total. 06/09/2021 This risk has been affected by a change in capital funding allocation and the risk score has been increased to reflect the impact this will have on the capital projects underway 17/01/2022 The draft Capital Plan will be taken to the Trust Capital Group at the end of January 2022.																			
3164	Apr 2020	Executive Director of Finance	**Capital Projects - Availability of Capital** IF the capital programme is not delivered as planned and we continue to see restricted capital allocations THEN the Estates Strategy will not be executed in the agreed timescales RESULTING IN clinical and workplace environments which may not be fully fit for purpose and a potential for an increasing backlog.	5	5	25	Prioritise capital plan, review regularly with services and against backlog maintenance. [2e] Robust design and specification processes and capital programme management. [1g/2a] Trust Capital group managing programme. Programme delivery reported to SEG.	Board, FPC and Trust Capital Group Oversight (3a/2b) Business care review group	4	4	16	↔	See actions below	Executive Director of Finance		2	3	6	**31/03/2024**
10/03/2021 Risk Opened 06/09/2021 As part of the long term sustainability programme, a 4% efficiency target has been set to start to tackle the underlying deficit.																			
6628	Mar 2021	Executive Director of Finance	**Long Term Financial Sustainability** IF the Trust does not focus on cost savings, productivity and efficiency initiatives to reduce the run rate THEN funds will not be available to support existing services RESULTING IN the Trust remaining in deficit, in an evolving finance regime as we move to an ICS, potentially leading to the Trust receiving increased scrutiny from NHSE/I and financial sanctions will be imposed.	4	5	20	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Long Term Sustainability Programme (LTSP) (CIP delivery) has been launched in the organisation and is being led by the deputies. A 4 % efficiency target has been set to start to tackle the underlying deficit. Monthly reporting is taking place through QPRs and Finance Reports, and a full review of CIP governance commenced in July to ensure all programmes have PIDs and QIAs	3	4	12	↔	See actions below	Executive Director of Finance		3	3	9	**31/03/2023**

Planned Actions and Milestones – Risk 6485

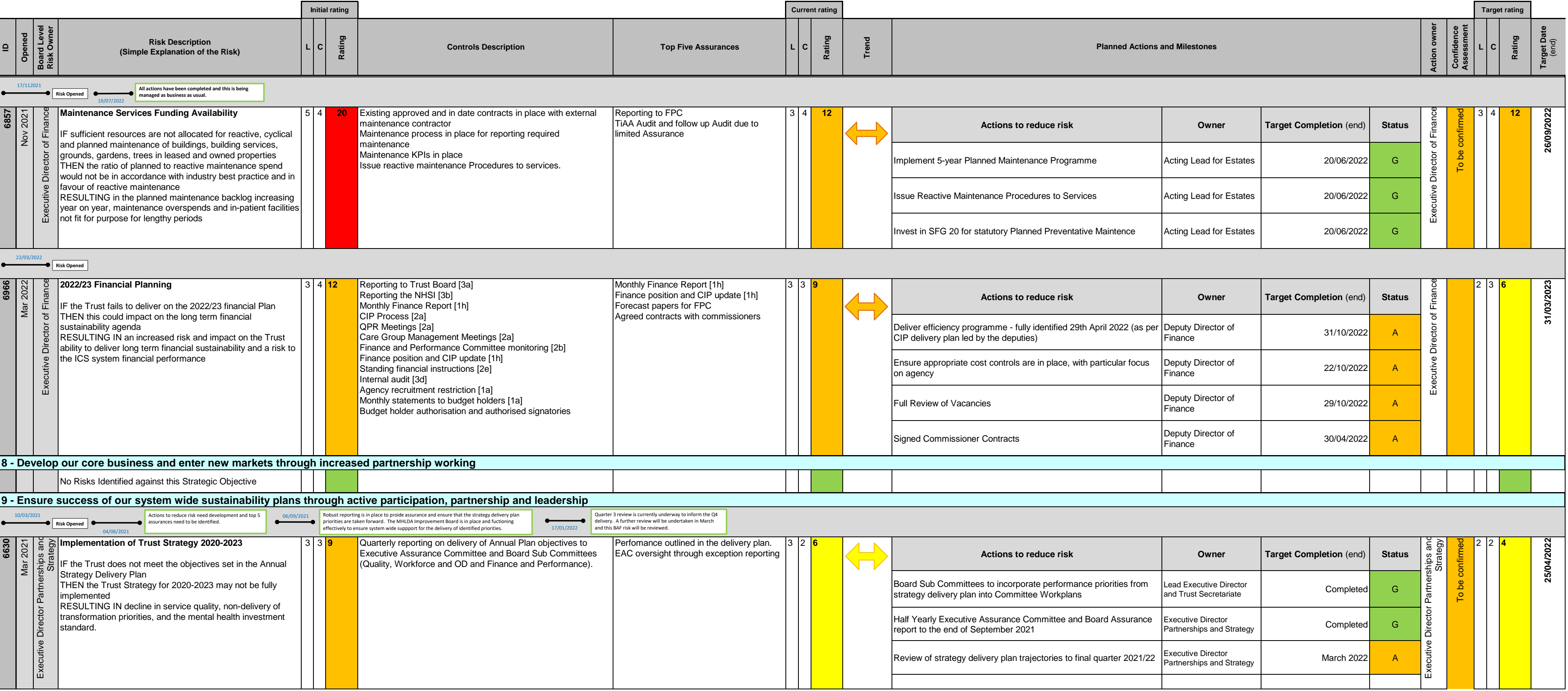
Actions to reduce risk	Owner	Target Completion (end)	Status
Recruitment of Change Leads	Head of ICT	31/01/2023	A
Embedding Digital change leads and specialists within services	Head of Digital Transformation	31/01/2023	A
Working closely with QI where QI and Digital required to deliver quality improvements.	Head of Digital Transformation	31/01/2023	A

Planned Actions and Milestones – Risk 3164

Actions to reduce risk	Owner	Target Completion (end)	Status
Provide comprehesive report to Trust Capital Group.	Director of Estates and Facilities	31/03/2023	G
Develop pipeline of schemes to bring forward that can be delivered in-year should Capital be available	Director of Estates and Facilities	30/10/2022	G
Develop 3-5 year capital plans to address backlog maintenance and service issues	Director of Estates and Facilities	31/03/2023	A
Ensure Capital Plan reflects backlog maintenance and service priorities, as well as implementing standing orders and SFIs for robust financial management	Director of Estates and Facilities	31/03/2023	G

Planned Actions and Milestones – Risk 6628

Actions to reduce risk	Owner	Target Completion (end)	Status
Delivery of multiyear efficiency programme	Deputy Director of Finance	31/03/2023	A
Address issues identified through Deep Dives	Deputy Director of Finance	28/02/2022	G
Review of underlying deficit	Deputy Director of Finance	31/01/2023	G
Monthly reporting is taking place through QPRs and Finance Reports	Deputy Director of Finance	30/09/2022	G
Full review of CIP governance commenced in July to ensure all programmes from PIDs and QIAs	Deputy Director of Finance	31/12/2022	A
Complete financial planning (subject to mational timetable being confirmed	Deputy Director of Finance	31/03/2023	G
Review pricing and contracting for services	Deputy Director of Finance	31/12/2022	A
Mental Health Optimal Staffing Tool (MHOST) and rota review	Deputy Director of Finance	31/032023	A



ID	Opened	Board Level Risk Owner	Risk Description (Simple Explanation of the Risk)	Initial rating L	Initial rating C	Initial rating Rating	Controls Description	Top Five Assurances	Current rating L	Current rating C	Current rating Rating	Trend	Planned Actions and Milestones	Action owner	Confidence Assessment	Target rating L	Target rating C	Target rating Rating	Target Date (end)
17/112021 Risk Opened — 19/07/2022 All actions have been completed and this is being managed as business as usual.																			
6857	Nov 2021	Executive Director of Finance	**Maintenance Services Funding Availability** IF sufficient resources are not allocated for reactive, cyclical and planned maintenance of buildings, building services, grounds, gardens, trees in leased and owned properties THEN the ratio of planned to reactive maintenance spend would not be in accordance with industry best practice and in favour of reactive maintenance RESULTING in the planned maintenance backlog increasing year on year, maintenance overspends and in-patient facilities not fit for purpose for lengthy periods	5	4	20	Existing approved and in date contracts in place with external maintenance contractor Maintenance process in place for reporting required maintenance Maintenance KPIs in place Issue reactive maintenance Procedures to services.	Reporting to FPC TiAA Audit and follow up Audit due to limited Assurance	3	4	12		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Implement 5-year Planned Maintenance Programme / Acting Lead for Estates / 20/06/2022 / G Issue Reactive Maintenance Procedures to Services / Acting Lead for Estates / 20/06/2022 / G Invest in SFG 20 for statutory Planned Preventative Maintence / Acting Lead for Estates / 20/06/2022 / G	Executive Director of Finance	To be confirmed	3	4	12	26/09/2022
22/03/2022 Risk Opened																			
6966	Mar 2022	Executive Director of Finance	**2022/23 Financial Planning** IF the Trust fails to deliver on the 2022/23 financial Plan THEN this could impact on the long term financial sustainability agenda RESULTING IN an increased risk and impact on the Trust ability to deliver long term financial sustainability and a risk to the ICS system financial performance	3	4	12	Reporting to Trust Board [3a] Reporting the NHSI [3b] Monthly Finance Report [1h] CIP Process [2a] QPR Meetings [2a] Care Group Management Meetings [2a] Finance and Performance Committee monitoring [2b] Finance position and CIP update [1h] Standing financial instructions [2e] Internal audit [3d] Agency recruitment restriction [1a] Monthly statements to budget holders [1a] Budget holder authorisation and authorised signatories	Monthly Finance Report [1h] Finance position and CIP update [1h] Forecast papers for FPC Agreed contracts with commissioners	3	3	9		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Deliver efficiency programme - fully identified 29th April 2022 (as per CIP delivery plan led by the deputies) / Deputy Director of Finance / 31/10/2022 / A Ensure appropriate cost controls are in place, with particular focus on agency / Deputy Director of Finance / 22/10/2022 / A Full Review of Vacancies / Deputy Director of Finance / 29/10/2022 / A Signed Commissioner Contracts / Deputy Director of Finance / 30/04/2022 / A	Executive Director of Finance		2	3	6	31/03/2023
8 - Develop our core business and enter new markets through increased partnership working																			
			No Risks Identified against this Strategic Objective																
9 - Ensure success of our system wide sustainability plans through active participation, partnership and leadership																			
10/03/2021 Risk Opened — 04/06/2021 Actions to reduce risk need development and top 5 assurances need to be identified. — 06/09/2021 Robust reporting is in place to proide assurance and ensure that the strategy delivery plan priorities are taken forward. The MHLDA Improvement Board is in place and fuctioning effectively to ensure system wide suppport for the delivery of identified priorities. — 17/01/2022 Quarter 3 review is currently underway to inform the Q4 delivery. A further review will be undertaken in March and this BAF risk will be reviewed.																			
6630	Mar 2021	Executive Director Partnerships and Strategy	**Implementation of Trust Strategy 2020-2023** IF the Trust does not meet the objectives set in the Annual Strategy Delivery Plan THEN the Trust Strategy for 2020-2023 may not be fully implemented RESULTING IN decline in service quality, non-delivery of transformation priorities, and the mental health investment standard.	3	3	9	Quarterly reporting on delivery of Annual Plan objectives to Executive Assurance Committee and Board Sub Committees (Quality, Workforce and OD and Finance and Performance).	Perfomance outlined in the delivery plan. EAC oversight through exception reporting	3	2	6		**Actions to reduce risk** / **Owner** / **Target Completion** (end) / **Status** Board Sub Committees to incorporate performance priorities from strategy delivery plan into Committee Workplans / Lead Executive Director and Trust Secretariate / Completed / G Half Yearly Executive Assurance Committee and Board Assurance report to the end of September 2021 / Executive Director Partnerships and Strategy / Completed / G Review of strategy delivery plan trajectories to final quarter 2021/22 / Executive Director Partnerships and Strategy / March 2022 / A	Executive Director Partnerships and Strategy	To be confirmed	2	2	4	25/04/2022

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th January 2023
Title of Paper:	MHLDA Provider Collaborative Board Update
Author:	Attain
Executive Director:	Sheila Stenson, Chief Finance and Resources Officer/ Deputy Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Requested

Overview of Paper

The purpose of this paper is to provide a summary overview of the recently completed MHLDA Programme Stocktake.

The MHLDA Programme Stocktake provides an overarching summary of the status of the nine key MHLDA Programmes across Kent and Medway, a forward view of the planned activities to 2025/26, and makes recommendations about the potential strategic and organisational impact of the programmes of work.

Appendices: Programme status summaries – A one-page summary of the status, milestones, risks, and issues in each programme can be found in the Board Reading Room.

Issues to bring to the Board's attention

During December 2022 and January 2023, a stocktake was undertaken to provide a summary overview of the status of the MHLDA programmes with the intention of helping key partners to understand the cumulative impact, deliverability, and manageability of the MHLDA portfolio.

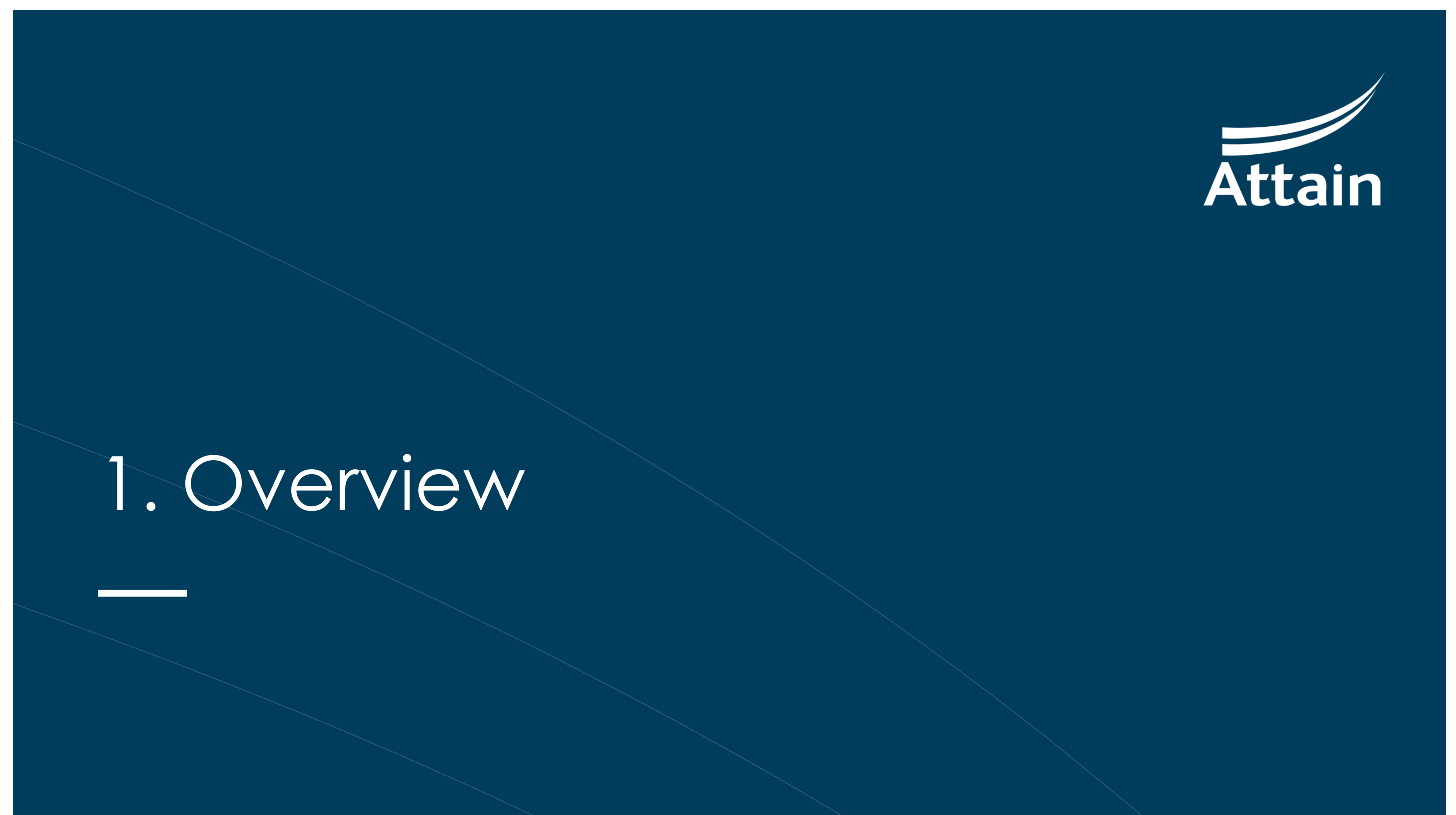
There are two work streams that are currently Red RAG rated and deemed to behind their plan. These are the Learning, Disability and Autism workstream and Wellbeing, Community and Prevention workstream.

Slide 11 sets out the MHLDA programmes and their objectives over the next two years. Slide 13 in the paper is to be brought to KMPT's Board attention for consideration.

Governance

Implications/Impact:	Regulatory oversight by MHLDA Provider Collaborative Board
Assurance:	Reasonable
Oversight:	Oversight by Trust Board

Attain
Improving health and wellbeing
Attachment One:
Kent & Medway
MHLDA Programme Stocktake
KMPT Board
January 2023


Attain
1. Overview

Purpose and scope

Across Kent and Medway there are currently nine key programmes of work that make up the Mental Health, Learning Disability, and Autism (MHLDA) Portfolio as follows:

Out of Area Placements	Urgent and Emergency Care	Dementia	Wellbeing, Community, and Prevention	Mental Health Investment Standard	Learning Disability & Autism	Children & Young People	Psychological Wellbeing (IAPT)	Community Mental Health Framework

The purpose of the MHLDA programme stocktake is to provide a summary overview of the current status of the MHLDA programmes of work and a forward view of the planned activities. The stocktake is intended as a resource that can be utilised by the Kent and Medway MHLDA Provider Collaborative Board, the Kent and Medway Partnership Trust (KMPT) Board, and wider partners, to help understand the cumulative impact, deliverability and manageability of the MHLDA portfolio.

The following areas were included for assessment as part of the stocktake across all nine programmes:

- Overarching objectives
- Expected outcomes and any identified associated monitoring and evaluation criteria
- Key milestones and critical path
- High-level assessment of the system and structure maturity of each programme
- High-level map of resourcing of each workstream
- Identification of major risks for each programme

The assessment of these in scope areas has enabled a thematic analysis of issues common to all eight programmes, alongside a suite of recommendations and a roadmap that highlights key milestones across the MHLDA portfolio.

Methodology

1. Stakeholder Interviews

One to one stakeholder interviews have been conducted with the lead for each of the MHLDA programmes of work, excluding CMHF. These interviews provided qualitative feedback that enabled the development of a programme overview and identification of a set of objectives for each. A key component of the stakeholder interviews was to understand the forward plan for each programme and identify planned activity where possible.

2. Desktop Review of Programme Documentation

A suite of programme documentation was supplied by programme leads for review. The document review helped to define quantitative elements of the stocktake report, including programme status and current resource dedicated to each programme. All RAG ratings documented within these sections of the report are based on self assessment indicated by programme leads during stakeholder interviews

3. Report Development

The assessment and analysis of stakeholder interview feedback, and desktop review, has provided us with an insight into the overview and objectives, current status, risks, key milestones and resourcing for each programme. These elements have brought together in this programme stocktake report.

The methodology deployed has helped to ensure a balance of programme specific analysis and portfolio-wide assessment.

Programme Specific Analysis

- OVERVIEW & OBJECTIVES
- PROGRAMME STATUS
- KEY MILESTONES
- RISKS
- PROGRAMME RESOURCING

Portfolio Wide Assessment

- KEY INSIGHTS & RECCOMENDATIONS
- MILESTONE ROADMAP

4

Long Term Plan for Mental Health

The Kent and Medway Provider Collaborative Board has made a commitment to deliver compliance against the Long Term Plan for Mental Health (LTP MH) and the Mental Heath Investment Standard (MHIS). The diagram below sets out the key objectives of the LTP for Mental Health, and where activity across the Kent and Medway MHLDA portfolio aligns to it.

Theme: Long Term Plan for Mental Health

LTP MH objective	Kent and Medway Programme Alignment
Grow investment in mental health services faster than the NHS budget	MHIS Programme
Improving services for people with common disorders	Psychological Wellbeing (IAPT)
Improving services for people with Severe Mental Illness	Community Mental Health Framework Transformation
Emergency Mental Health Support	Urgent & Emergency Care
Inpatient Care	Out of Area Placements
Suicide Prevention	Wellbeing, Community and Prevention
Improve Children & Young People's Mental Health Services	Children & Young People

Learning Disability and Autism

2. Assessment of programme processes

Defining maturity of programme processes

To help assess the maturity of each programme we have explored a number of lines of enquiry against six key elements of effective programme management. This table defines the key lines of enquiry within each domain.

Domain	Line of Enquiry
Programme Objectives	Does the programme have clearly defined long–term deliverables (up to 2025 / 2026 financial year) with associated milestones, timelines and project plans?
Programme Design, Controls and Documentation	Does the programme have established PMO processes and structures in place to monitor and assure effective delivery against objectives?
Outcomes Management	Is the programme delivering against objectives within expected timelines and producing expected outcomes?
Programme Workforce Resource	Does the programme have sufficient workforce capacity to deliver against short-term and long – term objectives?
Reporting	Does the programme provide reports on a regular basis to PCB/KMPT Board?
Risk and Issue Management	Does the programme have the ability to independently resolve risk and issues identified?

Programme process maturity assessment

Maturity Assessment

RAG has been undertaken based on Attain assessment of programme.

- 🟢 Mature with ongoing development plans in place
- 🟡 Emerging
- 🔴 Development required

	OOA	UEC	Dementia	W, C, P	MHIS	LDA	CYP	Psych. Wellbeing	CMHF
Programme Objectives	Amber	Amber	Green	Red	Green	Red	Green	Amber	Amber
Programme Design, Controls and Documentation	Green	Amber	Green	Amber	Amber	Amber	Green	Green	Amber
Outcome Management	Green	Amber	Amber	Green	Green	Red	Green	Amber	Red
Programme Workforce Resource	Green	Red	Amber	Green	Green	Red	Amber	Amber	Green
Reporting	Green	Green	Green	Green	Green	Green	Green	Green	Green
Risk and Issue Management	Amber	Amber	Amber	Red	Amber	Amber	Amber	Amber	Amber

8

Identified strengths and areas to explore

	Programme Strengths & Areas of confidence	Areas to Explore
Out Of Area Placements (OOA)	▪ Strong project design and control ▪ Project impact evidenced ▪ System cost saving evidenced	▪ KMPT lead OOA provider decision ▪ Ability to support dementia patient cohort ▪ Formation of standardise OOA provider contracts
Urgent Emergency Care (UEC)	▪ Met Liaison 24 standard targets ▪ Complete utilisation of year 1 funding	▪ Strategic guidance to support 2023 -2025 planning ▪ Programme workforce resource requirements
Dementia	▪ Progress against majority of programme objectives ▪ Clear 2023 – 2025 strategic direction ▪ Evaluations clearly embedded within programme informing future strategic decision	▪ Investment requirements for programme workforce team to support delivery against strategic plans ▪ Workstream workforce requirement to progress objectives and to meet service demands
Well Being Community & Prevention Oversight (WCP)	▪ Strong progress against programme objective evidence ▪ Project impact evidenced ▪ Agile programme delivery design ▪ Successful pilot outcomes that can be used to support future expansion plans	▪ Funding allocation to support programme continuation post March 2023
Mental Health Investment Standard (MHIS)	▪ National MHIS standard target met ▪ Robust governance structure	▪ Workstream workforce recruitment challenges ▪ Understanding the underlying MHIS position
Learning Disability and Autism (LDA)	▪ Strong stakeholder partnerships established	▪ Setting clearer system objectives for the LDA programme ▪ Funding allocation ▪ Programme Workforce Needs
Children and Young People (CYP)	▪ Successful workforce recruitment to vacant positions within transition programme ▪ Evidence based Transitions pathway design in place ▪ Strong collaborative working from all project leads within programme	▪ Workstream workforce resource requirement to meet service demand and capacity ▪ Isolated focus on projects undertaken by CYP programme
Psychological Well Being (IAPT)	▪ Robust governance and programme structure in place ▪ Effective collaborative working across 8 IAPT providers ▪ Workstream bottlenecks uncovered with mitigating actions in place	▪ Workstream workforce recruitment
Community Mental Health Framework	▪ Whole system approach to co-development of the Mental Health Together model	▪ The 'how' needs to be set out underpinned by a service specification and robust implementation plan

3. MHLDA Portfolio: Milestone Roadmap

Milestone roadmap: 2022/23 - 2025/26

	2022/23	2023/24	2024/25	2025/26
OOA	Reduce annual system cost by 10%; Reduce number of SMI patient cohort	KMPT lead provider OOA provider Bus. Case; Confirm reinvestment options	Reduce average length of stay; Standardise OOA Provider contracts; Potential to expand services to Surrey and Sussex	
UEC	Crisis House Implementation & Review; Urgent response service implementation	Y2 and Y3 investment decision to be decided following restructure; Implementation of complementary and alternative crisis services to ED and admission	MH Response Vehicles deployment	
Dementia	Dementia Coordinator Expansion & Evaluation; Diagnostic Pathway Redesign & Service Enhancements; Enhanced Care Model Review; Increase K&M DDR Rate to 66.7% by Q4	Young Onset Dementia Session implementation; DiADem Care Home Pilot; Crisis Pilots; West Kent Dementia Crisis pilot launch; DGS bridging service re-procurement	Admiral Nursing resource development and inclusion within pathway; Development and mobilisation of GpwER services; ACP Functional service developments; Ongoing plans to improve the Kent & Medway dementia diagnosis rate (DDR)	
W, C, P	Development subject to programme funding confirmation			
MHIS	2023-2024 MHIS Planning Undertaken via monthly/ bi-monthly meetings held by mental health planning group			
LDA	Development subject to programme funding confirmation			
CYP	Delivery of general transition communications video; Increase access to evidence based interventions	Delivery of bespoke interventions to support transition pathways; Delivery of bespoke staff training surrounding transition		
Psychological Wellbeing (IAPT)	We Listen Website Launch; IAPT Service Lead Procurement	Interface Pilot completion; GP Education training Hub session; Equity Audit roll out		
CMHF	Finalise Core Model Design; Governance Refresh inc. Prog Board; Demand & Capacity Model Build; Trailblazer Spec & Operating Policy Dev.	Medway & Swale Trailblazer: Phased Implementation; Lead Provider – KMPT; Scale Mental Health Together to other HCPs; Monitoring & Evaluation		

RAG Rating

RAG has been undertaken based on programme lead self-assessment.

- 🟢 On plan
- 🟡 Late to plan, manageable risk
- 🔴 Late to plan, at risk
- ⚪ Planned activity

4. Key Insights and Recommendations

Operational View: KMPT Board

The following insights focus on the operational impact of planned activity across the MHLDA portfolio, and are for consideration by the KMPT Board.

Key Insight	Recommendation
Planned change initiatives across the MHLDA portfolio will have a significant operational Impact.	A change management function should horizon scan for potential impacts on performance, quality and finance and proactively manage them.
Planned change initiatives across the MHLDA portfolio will have an impact on frontline staff.	A comprehensive organisational development programme should be put in place to support KMPT staff to navigate planned changes and to support staff wellbeing, recruitment and retention.
There is a significant opportunity for KMPT to continue developing their leadership role across the system by supporting partnerships between a broader range of MHLDA providers.	Consideration should be given as to how KMPT can continue to influence decisions at a system level about the direction of MHLDA in Kent and Medway in a way that encourages collaboration.
There is an opportunity for KMPT to develop a 'commercial function' in order to strengthen their ability to assume Lead Provider status across MHLDA programmes.	KMPT should explore the opportunity to develop a commercial function that can effectively discharge the transactional functions (planning and purchasing) of a Lead Provider.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th January 2023
Title of Paper:	Community Mental Health Framework – Quarterly Update
Author:	Donna Hayward-Sussex, Chief Operating Officer
Executive Director:	Donna Hayward-Sussex, Chief Operating Officer

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Board requested

Overview of Paper

This paper outlines the current position on the development and progress regarding new models of care within the Community Mental Health Framework Programme.

Issues to bring to the Board's attention

A revised governance process has been implemented following the stocktake review and findings. The new arrangements have provided clarity and enabled clear workstreams and workstream leaders to be identified.

The new clinical model has been agreed across all provider partners and stakeholders.

It is recognised that due to the scale and ambition of the programme there have been significant delays in piloting the new model. Kent and Medway are one of nine ICS' nationally reporting 'zero' against the number of PCNs that have been transformed through the Community Mental Health Framework. A sharp focus on moving from planning to implementation is key in the first half of 2023.

Governance

Implications/Impact:	There needs to be an agreed 'in scope' set of interventions for the Medway & Swale Trailblazer with associated costs and workforce requirements that can be implemented via the programme workstreams, subject to specification development and monitoring and evaluation framework sign off. If this cannot be agreed as a system position by CMHF Programme Board then mobilisation of the trailblazer will be delayed.
Assurance:	Reasonable
Oversight:	Executive Management Team

Community Mental Health Framework – Quarterly Update (January 2023)

Introduction

The plans to transform community mental health services across Kent and Medway commenced in early 2021. In September 2022, following a stocktake of the programme, it was noted that whilst the programme been successful in engaging extensively across the Kent system more rigor was required in essential areas for delivery including enabler functions to be established, systems to be agreed for data collection and monitoring along with demand and capacity analysis to inform workforce planning. Furthermore, the stocktake identified that the governance process needed to be reviewed to support financial approvals along with a necessity for a single coherent plan.

There has been extensive work to address the gaps identified in September 2022 with key milestones referenced below.

- Programme Director commenced post in November 2022. The Director has revised the team structure of the Programme Management Office with clear roles and responsibilities agreed and implemented.
- A review of Community Mental Health Framework (CMHF) governance structure has been undertaken with the Senior Responsible Officers agreeing the establishment of a CMHF Programme Board an Implementation Group along with a CMHF Partnership Group.
- Lead provider agreed with the Integrated Care Board (ICB) to enable the trailblazer to progress.
- Workstream leads have been identified and agreed for the following key areas:
  Model of Care and Outcomes Framework – Dr Afifa Qazi (KMPT) and Dr James Osborne (ICB)
  Workforce & Organisational Development – Jill Lane (ICB) and Lisa Barclay (Invicta)
  Finance and Contracting – Kevin Tupper (ICB) and Nicola George (KMPT)
  Data and Digital – Michelle Curtis (KMPT) and Nigel Lowther (KMPT)
  Estates – To be confirmed
  Communications and Engagement – Katie Newton (CMHF PMO) and KMPT Comms

The first Programme Board will take place in late January 2023 by which time it is expected that the leads for the estates workstream will have been identified. It is recognised that transformation of community services provides opportunities for new ways of working including shared estates.

In addition to the new governance arrangements being confirmed and workstreams established effort has continued in the development of the new model of care. This includes the preparation required to ensure the new model has the best chance of success and where appropriate commencement of initiatives that have been identified as essential within the planned community offer. These are described in detail in the following sections.

Mental Health Together

The community mental health transformation seeks to deliver the Community Mental Health Framework as one key deliverable of the NHS Long Term Plan. Specifically, the model should:

- Dissolve the boundaries between primary and secondary care
- Have a ‘no wrong door’ approach

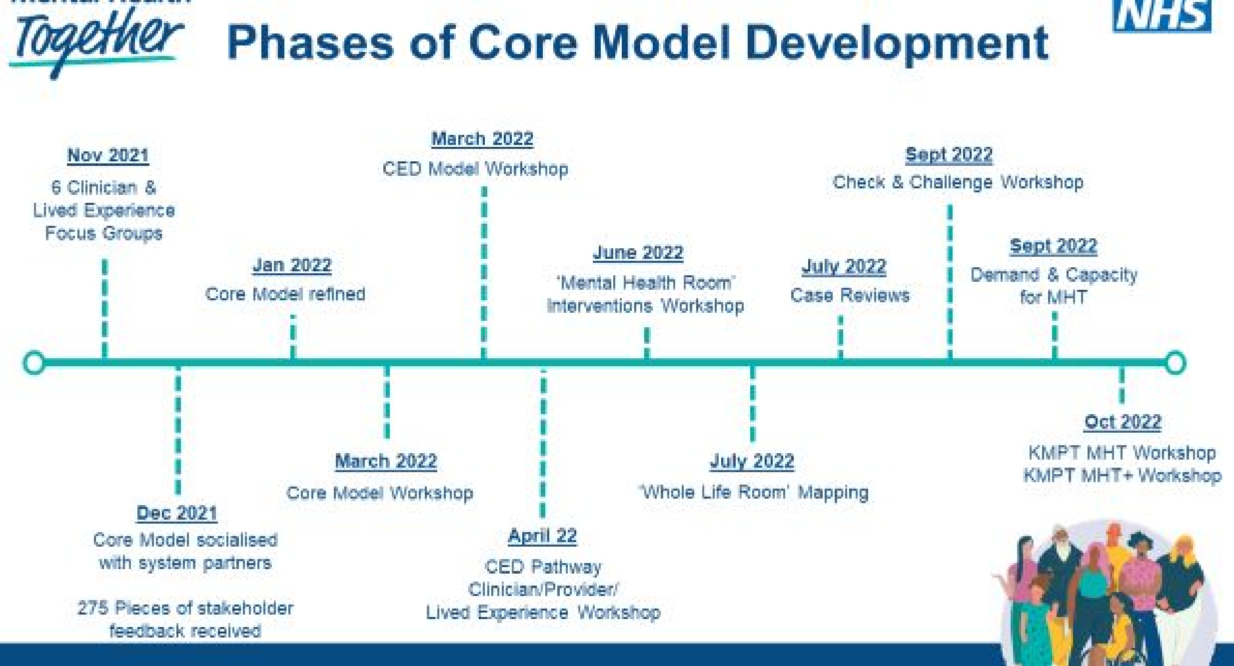
- Needs Led (as opposed to diagnosis led)
- Improve access to psychological therapies
- Achieve much closer integration with the Voluntary Care and Social Enterprise Sector
- Significant improvement in timely access

To achieve these providers must develop a core community model, ensure robust pathways of care for people with complex emotional difficulties and adults with eating disorders along with providing a community rehabilitation offer.

Whilst the Framework stipulates these areas as a priority the transformation provides an opportunity to address areas of learning from serious incidents. In particular for community services there is an urgent need to adopt a different approach to patients being 'signposted' to services. Transitions are crucial points in a person's care, particularly in mental health. These can both be a point of clinical risk as well as a trigger for people whose history of trauma has involved breaks or severance of relationships. An integrated and 'no wrong door' approach seeks to address this and is described further below.

Phases of Core Model Development

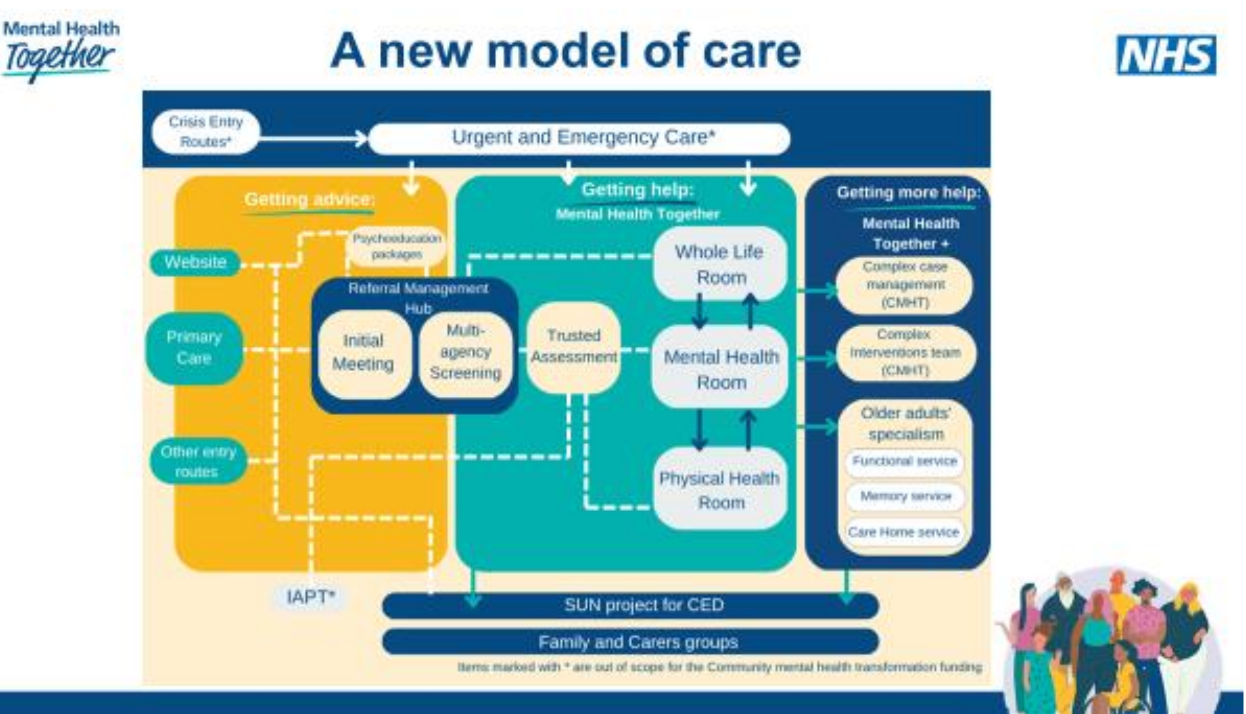
Clinical model development began in November 2021 with agreement of the final model reached in January 2023. It should be noted that whilst agreement has been reached for the clinical model the purpose of the trailblazer will be 'test and learn' and make amendments before implementing across Kent and Medway. Further to note, whilst the model of care has been developed with people with lived experience the pilot provides additional opportunities for feedback and co-development with our service users before the final model is adopted across the county.



Demand and capacity planning will be finalised in early February 2023.

Summary of New Model of Care

The new model of care will provide a range of entry routes into mental health services. These include Additional Roles Reimbursement Scheme (ARRS) Practitioners who are embedded in primary care, self-referrals and access via the Urgent and Emergency Care pathway.

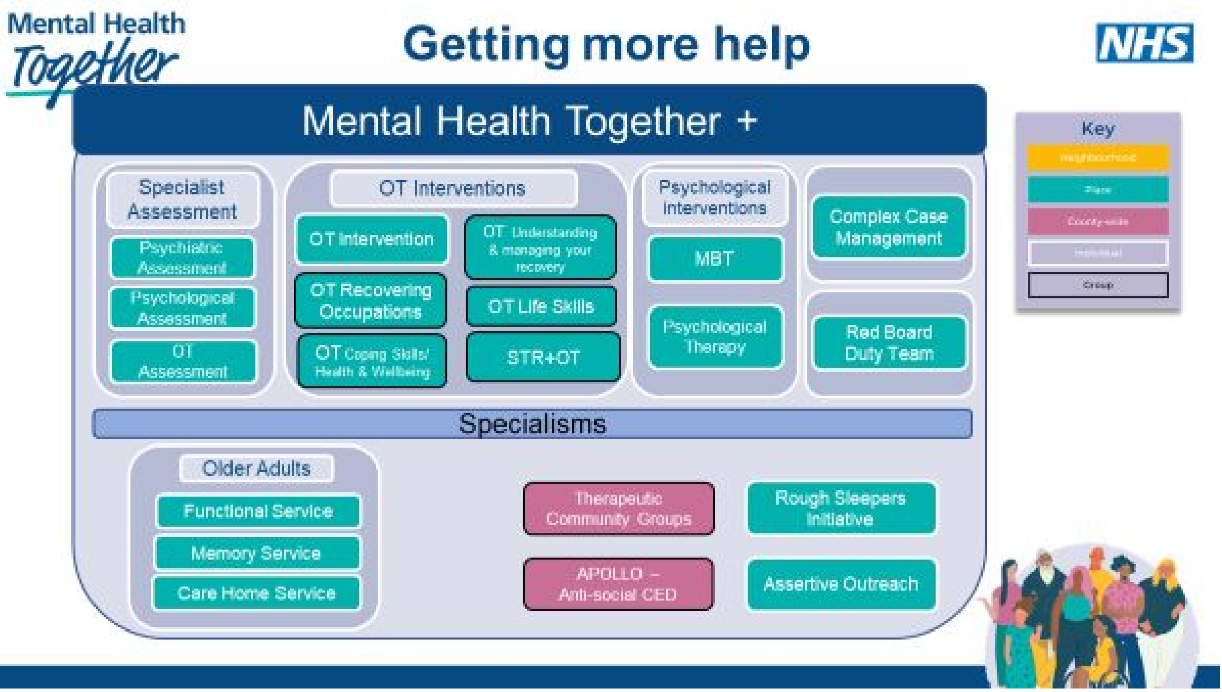


The Referral Management Hub will bring together all agencies delivering care together in a daily meeting with the central objective of identifying and supporting access to the most appropriate care. As a result, the person is no longer 'signposted' back to their GP or to another partner agency for their care, but instead is allocated to a partner based on the most suitable care offer. In addition to support patients in accessing their care a new Community Mental Health Connector role is being introduced. These new roles will offer focused support to individuals with the aim of building knowledge, skills, confidence and resilience in people, as well as encouraging people to access local activities and services.

The Mental Health Together Service replaces Primary Care Mental Health Services with a new integrated partner model. The three defined pathways (rooms) are depicted below.

It should be noted that access to the rooms as defined above is not restricted to any one room at a given time.

Mental Health Together + is a direct replacement of the current Community Mental Health model. The agreed model recognises the ambition for 'all age' whilst retaining the specialism of older adult services.



Overall the new model of community care seeks to provide an integrated 'needs' led approach which offers a broader range of interventions with opportunities for a diversity of roles. This increased focus on understanding individuals' needs is reinforced by the expectation of a consistent approach nationally in the collection of Patient Reported Outcomes Measures (PROMs) as routine. Specifically, all patients should have PROMs scores recorded using three outcomes tools, as a minimum. These are Goals Based Outcomes (GBOs), Recovering Quality of Life (ReQoL-10), and DIALOG.

The measures are recommended because DIALOG focuses on the person's wider social needs to support the development and review of a holistic care plan. Goals Based Outcomes (GBO) pays attention to measuring progress towards personal meaningful goals and ReQoL-10 provides a better understanding of the factors contributing to the patient's personal recovery.

In summary, the new community model seeks to lessen the current system of complicated referrals and transition processes to the most appropriate support. This includes transfers (not signposting) to specialist services which include Mental Health Learning Disabilities and Autism, Forensic and Perinatal services. Moreover, patients accessing community mental health services should receive timely interventions based on a needs led approach with Patient Reported Outcomes Measures shaping the care they receive.

Next Steps and Timeline

It has been agreed that the trailblazer will go ahead in Medway and Swale with preparation underway.

To afford the model the best potential for success several actions have been taken ahead of the planned launch in April 2023.

There is agreement that funds from the CMHF investment will be utilised to establish the Low Intensity Support Team. This will allow for patients that no longer require a service from the Community Mental Health Team to be transferred to this new dedicated physical health room.

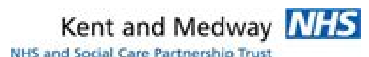
In recognition that the Community Mental Health Team caseload remains high and that planned future clinical interventions could be implemented at pace and ahead of the trailblazer it has been agreed that funds from the CMHF investment monies will be released to enable the commencement of developments within the Complex Emotional Disorder pathway. These include the new Service User Network (SUN) service which is an open access peer support model and Managing Emotions Programme.

In addition, Initial Interventions offered by Porchlight, with supervision and training from psychological therapies staff within KMPT will commence in Medway & Swale.

Summary

Good progress has been made regarding the new governance arrangements for the Community Mental Health Programme. The new enabler workstreams with identified leads will support the programme to gain the momentum needed for such an ambitious transformation.

An agreed set of interventions for the Medway & Swale Trailblazer is required with associated costs and workforce requirements to permit the pilot commencement in April. This is achievable as all parties are aligned with the need for pace. In the meantime, incremental changes are taking place with discreet clinical interventions being introduced ahead of the launch.



TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th January 2023
Title of Paper:	Integrated Quality and Performance Report (IQPR)
Author:	All Executive Directors
Executive Director:	Helen Greatorex, Chief Executive

Purpose of Paper

Purpose:	Discussion
Submission to Board:	Standing Order

Overview of Paper

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

Issues to bring to the Board's attention

Whilst this report (which presents December's activity) includes targets met and some areas of improvement, it also clearly sets out areas of challenge where targets have been missed, helping to inform future priorities.

The Board's attention will naturally focus on those areas below target, seeking assurance that measures are in place to rectify the situation. The report shows continued pressure in some of our key workforce metrics along with examples of the work in train to improve the situation.

Sickness Absence increased by a further 0.9% in month to 6.8% compared to the 4% target. Particularly escalated levels have been observed in a number of Community teams as well as increased levels in the Older Adults Care Group. This increase is considered to be driven largely by an increase in Covid-19 related absence in December.

Additionally, the Vacancy Gap and turnover continue to exceed target. A broad range of interventions are in train to address these challenges, the detail of which can be found within this report under the Well-Led domain. It should be noted that the vacancy target was revised from 10% to 16% in November 2022 as agreed by Workforce and Organisational Development committee.

Bed pressures is an area of focus for the Executive Team, levels of Delayed Transfers of Care (DToC) have increased in recent months with December seeing 13% of bed days lost to DToC compared to 11.5% in November. This equates to 1,622 bed days in month, 52 beds per day on average.

Out of Area placements which exceed contracted beds remains a challenge. 150 bed days were used in December 2022, a reduction to annual average following a peak of 322 days in September. This remains an area of focus with robust processes overseeing all placements.

Plans to address winter pressures were previously detail in Novembers IQPR, these continue to aim to reduce bed pressures.

It has previously been highlighted that our community teams require an increased focus, this includes; care planning and waiting times for assessment and treatment. Despite ongoing challenges, it is positive to note that the access measure for assessment within 4 weeks for Community Mental Health Team and functional Community Mental Health Service for Older Persons routine referrals continues to maintain its position in excess of 80%. Further improvement is being managed at a team level supported by exception reporting, the impact of factors such as vacancy rates, sickness and referral rates continue to result in variation across teams. Work is underway on an implementation plan for the new national waiting time measurement: Measuring waiting times in non-urgent community mental health services for adults and older adults.

Governance

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

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

Executive Lead(s): Chief Nurse
Lead Board Committee: Quality Committee

Issues of Concern
No areas of concern to raise this month.

Executive Commentary

Restrictive Practice

The Trust's approach to the use of restraint is carefully monitored and reviewed in line with national best practice. The use of restraint is always a last resort and staff are trained in de-escalation techniques and other preventative measures which are always considered before restraint is implemented. Please note that this reporting period is 01/12/2022 – 31/12/2022.

There were 74 reported incidents of restraint needing to be used in December 2022, a slight increase of seven from the previous month. The Acute Care Group (ACG) reflected an increase of six incidents; the Forensic and Specialist care group (FSCG) reporting an increase of one incident and the Older Adult care group (OACG) maintaining at fifteen restraints for the month. The majority of restraints occurred in the Acute Care Group (ACG) with 55 reported in December 2022. All use of restrictive interventions is monitored in line with Trust policy with strategic oversight by the Promoting Safe Care group which has membership from all care groups and subject matter experts.

In December 2022, there were three prone restraints reported involving two different patients. All occurred in the Acute Care Group. No harm was reported with any use of prone restraint.

The use of seclusion continues to fluctuate monthly with twelve episodes reported in December 2022; nine within the Acute Care group and three occurred in the Forensic & Specialist Care Group. These involved eight different patients throughout the Trust. It is worth noting that KMPT continue to see an overall decrease in the last 12 months from the reported 19 seclusion episodes in December 2021. All instances of seclusion are reviewed and an overview retained in order to identify outliers or patterns.

IQPR Dashboard: Safe

Ref	Measure	SoF	Target	Local / National Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
001.S	Occurrence Of Any Never Event	✓	0	N	0	0	1	0	0	0	0	0	0	0	0	0
002.S	CPA Patients Receiving Formal 12 Month Review		95%	N	93.2%	93.5%	93.8%	93.4%	92.7%	93.0%	93.2%	91.3%	90.0%	90.2%	93.2%	93.5%
011.S	Restrictive Practice - All Restraints		-	-	88	83	105	82	121	97	120	103	71	87	67	74
020.S	Unplanned Readmissions within 30 days		8.8%	L	5.3%	4.5%	7.7%	6.7%	6.4%	6.3%	5.5%	3.6%	4.5%	4.4%	5.1%	8.7%

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

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

Issues of Concern

- **Care planning continues to be an area of concern and increased focus.**
- **Delayed transfers of care (DToC) continue to have an impact on bed availability, it is positive to note the reduction in external placements despite the ongoing DToC pressure**

Executive Commentary

Within the effective domain Delayed Transfers of Care increased to 13% in December from 11.5% in November, despite the increase the position for Q3 was overall lower than that seen in Q2. Work continues with partners to explore every opportunity to reduce the impact of delays for our patients including the use of winter funds by social care colleagues. It is positive to note that despite the increase in month the total number of patients delayed for more than 100 days at the end of December was three, compared to eight at the end of October.

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. A key focus for both older and younger adult mental health teams is the required reduction in caseloads. This can only be achieved with support from all agencies supporting a step-down model for patients whose mental state is stable. This important aspect of improving care will be achievable with the implementation of Mental Health Together going live in 2023. In the meantime, the community services continue to seek improvement through regular scrutiny of caseloads. It is recognised that the Older Adult Care Group have a number of areas that they need to focus on to achieve improvement. These areas and the plans in place to support the improvements, are highlighted below.

Average Length Of Stay, Older Adults – Acute (013a.E) Length of Stay increased to 125 days in December, the highest reported position of the last 12 months. There were 31 discharges in December compared to an average of 26 over the last 12 months. There was one discharge in excess of 1,000 days which has skewed this month’s average.

	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			72.0	0.0	-34.6	109.5	37.4
2	OPMH			0.0	0.0	0.0	0.0	0.0
3	PICU			78.0	0.0	16.3	273.5	144.9
4	**Trust Total**			150.0	0.0	11.3	353.4	182.3

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

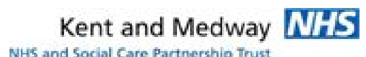
December 2022 saw a reduction in the use of out of area beds not procured in advance by KMPT, 150 bed days were used (72 YA Acute and 78 PICU), compared to 167 in November (77 YA Acute and 90 PICU). This is the lowest position since June 2022. A contract is in place for 5 Acute beds whilst the required estates works are undertaken on Fern ward, however only three of which are in Kent and therefore usage of the remaining two beds contribute to this indicator. This contract is in place until the end of February 2023.

	015.E: % Of Patients on CPA With Valid Care Plan	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	**Acute**			87.5%	95.0%	59.5%	94.6%	77.0%
2	**CRCG**			87.3%	95.0%	84.9%	91.5%	88.2%
3	**FSCG**			95.1%	95.0%	90.6%	97.6%	94.1%
4	**OPMH**			97.6%	95.0%	92.9%	99.1%	96.0%
5	**Trust Total**			89.6%	95.0%	87.3%	92.1%	89.7%

	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**			66.3%	80.0%	64.8%	70.0%	67.4%
2	**FSCG**			69.7%	80.0%	66.8%	77.0%	71.9%
3	**OPMH**			72.1%	80.0%	69.5%	81.4%	75.4%
4	**Trust Total**			69.0%	80.0%	68.6%	73.9%	71.3%

Interpretation of results (Trust wide)	
Variation	*CPA Care Plans:* Common Cause - no significant change *Non CPA PSP & Care Plans:* Special Cause Variation of a **Concerning nature**
Assurance	Variation indicates consistently **failing short of target**
Narrative	

CPA Care Planning



CRCG remains the biggest contributor to this indicator, the care group position reduced by 2% in month to 87.3%. This equates to 221 patients on CPA with an overdue Care Plan across CRCG, an increase from 187 at the end of November.
OPMH and FSS are exceeding 95%, the Acute Care Group Figure reflects a low number of patients (16).

Non CPA Care Plans and Personal Support Plans (PSP):
Trust wide performance remains stable with only minor variation in recent months, although continues to be short of target and is 5% lower than September 2021.

The CMHTs were at 67.7% compliance (-1.3% in month) with this Target in November 2022. Thanet CMHT were the only team surpassing the 80% target. Medway CMHT is subject to special cause variation, breaching the lower confidence limit. Medway CMHT have high vacancy and staff sickness levels. Substantive staff continue to be offered additional hours to support with getting this work completed. Additionally, a number of new starters have commenced post in January 2023, 2 band 6 staff and 2 band 3 staff. Post staff induction it is expected that compliance will improve.

Similarly, the West Kent and Swale CMHTs are also experiencing staffing challenges. The West Kent teams have had 5 STR workers start and are currently being inducted.

Swale have experienced high sickness rates, which places significant pressure on a small team. However, the early January 2023 data is demonstrating an improving position. The team has also allocated staff to focus on Care Plan and PSP compliance. With this focus, we are expecting to see an increase in compliance in the next two months.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford & Canterbury CMHT			73.0%	80.0%	67.8%	79.3%	73.6%
2	DGS CMHT			73.3%	80.0%	57.8%	71.8%	64.8%
3	Dover & Deal CMHT			72.8%	80.0%	66.4%	86.0%	76.2%
4	Maidstone CMHT			58.7%	80.0%	47.4%	66.4%	56.9%
5	Medway CMHT			55.3%	80.0%	56.6%	71.0%	63.8%
6	Shepway CMHT			70.6%	80.0%	72.8%	92.2%	82.5%
7	Swale CMHT			60.6%	80.0%	55.6%	74.3%	64.9%
8	SWK CMHT			62.0%	80.0%	42.9%	67.0%	54.9%
9	Thanet CMHT			91.5%	80.0%	75.6%	93.8%	84.7%
10	**CMHT Total**			67.7%	80.0%	65.4%	70.9%	68.2%

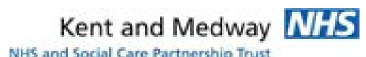
CMHSOPs are subject to special cause variation overall, driven by five CMHSOPs who are showing special cause variation.

Instances of PSP's not being correctly recorded on RiO were identified, work to rectify previous errors and processes have been reviewed to ensure accurate data collection. An improvement of 3.7% was shown in December and is expected to continue throughout January 2023 with planned compliance by the end of February 2023.

	017.E: % Non CPA Patients with a Care Plan or PSP	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			83.3%	80.0%	66.0%	88.0%	77.0%
2	Canterbury CMHSOP			74.4%	80.0%	63.8%	87.1%	75.4%
3	DGS CMHSOP			77.2%	80.0%	72.5%	88.1%	80.3%
4	Dover & Deal CMHSOP			83.3%	80.0%	79.5%	92.0%	85.7%
5	Maidstone CMHSOP			59.0%	80.0%	58.0%	81.1%	69.5%
6	Medway CMHSOP			69.2%	80.0%	65.5%	83.4%	74.5%
7	Sevenoaks CMHSOP			67.9%	80.0%	60.2%	79.4%	69.8%
8	Shepway CMHSOP			67.2%	80.0%	75.5%	84.9%	80.2%
9	Swale CMHSOP			72.7%	80.0%	63.0%	81.3%	72.1%
10	Thanet CMHSOP			77.8%	80.0%	71.9%	86.1%	79.0%
11	Tunbridge Wells CMHSOP			69.8%	80.0%	51.2%	73.5%	62.4%
12	**CMHSOP Total**			72.1%	80.0%	71.1%	80.5%	75.8%

IQPR Dashboard: Effective

Ref	Measure	SoF	Target	Local / National Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	✓	95%	N	98.5%	98.6%	93.8%	95.6%	95.8%	95.2%	97.0%	98.4%	100.0%	98.5%	97.2%	96.4%
001b.E	CPA patients receiving follow-up within 72hours of discharge				78.6%	85.0%	84.4%	84.1%	83.9%	85.7%	85.1%	85.3%	78.9%	90.7%	81.1%	80.4%
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	✓	95%	-	96.1%	95.9%	95.7%	95.7%	95.7%	95.6%	95.6%	95.5%	95.3%	95.2%	95.3%	95.4%
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)	✓	-	-	120	69	176	283	255	141	117	176	270	152	167	150
006.E	Delayed Transfers Of Care		7.5%	L	13.1%	12.8%	12.4%	10.9%	9.9%	10.7%	12.2%	13.3%	12.2%	11.1%	11.5%	13.0%
012.E	Average Length Of Stay(Younger Adults)		34	L	35.99	33.63	36.23	38.84	37.11	36.38	35.88	37.30	34.76	36.14	36.33	34.49
013a.E	Average Length Of Stay(Older Adults - Acute)		77	L	53.88	57.41	72.63	81.88	85.15	69.11	64.40	117.17	98.88	78.42	89.65	125.16
015.E	%Patients with a CPA Care Plan		95%	L	90.6%	90.2%	89.3%	87.9%	87.7%	88.9%	89.0%	88.3%	88.2%	88.4%	90.5%	89.6%
016.E	% Patients with a CPA Care Plan which is Distributed to Client		75%	L	74.2%	73.3%	72.5%	71.5%	72.2%	75.3%	75.2%	71.8%	73.9%	76.1%	74.4%	74.9%
017.E	%Patients with Non CPA Care Plans or Personal Support Plans		80%	L	73.5%	73.4%	70.9%	69.2%	68.7%	71.1%	69.9%	68.8%	68.2%	68.5%	68.5%	69.0%
018.E	Bed Occupancy (Net)				95.0%	93.7%	94.4%	94.4%	96.1%	96.5%	95.6%	97.8%	96.1%	96.4%	96.4%	95.0%



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

Executive Lead(s): Chief People Officer
Lead Board Committee: Workforce Committee

Issues of Concern
No areas of concern to raise this month.

Executive Commentary

KMPT has continued to see an increase in sickness absence, resulting in absence in December which was significantly above target. These high levels of sickness absence affected most Care Groups in December, with particularly escalated levels in a number of Community teams and increased levels in the Older Adults Care Group.

This increase is considered to be driven largely by an increase in Covid-19 related absence (which had been separated out from normal sickness absence reporting prior to September) during the final months of 2022.

Although it hasn't materially increased, the most prevalent reason for sickness absence at KMPT continues to be poor mental health, representing in excess of 30% of all sickness absence. National trends indicate that mental health is consistently the most frequently cited reason for sickness absence across most employers. Furthermore, KMPT intelligence suggests that the majority of mental health related absences stem from challenges at home rather than work, but with a growing prevalence of work-related factors. A deep dive on this topic was presented to this month's Workforce and OD Committee.

Interventions planned and in train relating to sickness absence include:

- Maintenance and enhancement of health and wellbeing offer, including offer relating to financial wellbeing (ongoing)
- Additionally, where work-related reasons are cited for poor mental health amongst our workforce, managers and HR staff are being encouraged to be curious as to the underlying cause of these (ongoing)
- Robust absence management, which focuses on early identification of triggers for absence (Q4).

KMPT has also paid particularly close attention to vacancy rates over recent months. The change in KPI agreed at the previous Board meeting (to reflect changes in the national and global context not foreseen at the time of setting these KPIs) means that vacancy levels now appear to be closer to target than previously, however this does not detract from the focus in this area. Vacancy levels continue to be a particular concern amongst our Band 5 and Band 6 nursing workforce, middle grade doctor workforce, and occupational therapist workforce, and particularly in the Dover and Dartford geographies.

It is considered that poor workforce supply and some delays in securing new starters (owing largely to candidates having a significantly greater choice of vacancies currently than is typical for the UK market) are the main factors driving our vacancy rate, rather than turnover. However, given those challenges, it is critical that turnover levels are contained. A deep dive into turnover and retention is planned for March's Workforce and OD Committee meeting.

As part of the ongoing cleanse of data and improvement in reporting, turnover figures from November onwards were corrected. Although this gives the appearance of an increased turnover rate compared with reporting prior to that point, in real terms, there was a decrease in turnover between October and November and a gradual further reduction is predicted during Q4, albeit that the market remains unstable.

Interventions planned and in train relating to vacancy rates, retention and turnover include:

- Longstanding vacancies to be considered for conversion to new roles as appropriate (establishment to be adjusted in Q3);
- Increase in Registered Nurse Degree Apprenticeship places (increase in identified placements by the end of Q4);
- Reduction of time to hire and implementation of enhanced candidate experience programme (by the end of Q4)
- Expansion of the Centre for Learning and Practice (currently offers key retention opportunities for B2/3 HCAs/HCSWs) (ongoing and by end of Q4)
- Roll out of Band 5 nurse development programme (by end of Q4);
- Continued development of the Centre for Learning and Practice to enhance career opportunities and development and improve retention (ongoing);
- Flexible Working Campaign to improve retention (Q4).

IQPR Dashboard: Well Led (Workforce)

Ref	Measure	SoF	Target	Local / National Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
001.W-W	Staff Sickness - Overall	✓	4.00%	L	4.3%	4.3%	4.3%	4.3%	4.5%	4.5%	4.2%	4.8%	5.1%	6.3%	5.9%	6.8%
005.W-W	Appraisals And Personal Development Plans		95%	L	99.0%	99.0%	99.0%	99.0%					71.6%	92.9%	94.7%	
006.W-W	Vacancy Gap - Overall		16.00%	L	15.1%	15.2%	15.7%	15.1%	15.3%	16.6%	17.8%	15.8%	16.0%	15.8%	16.3%	16.2%
012.W-W	Essential Training For Role		90%	L	92.5%	93.0%	92.0%	91.9%	92.5%	92.6%	92.8%	93.0%	92.8%	93.1%	93.1%	93.2%
015.W-W	Staff Retention (overall)		86%		85.9%	85.4%	83.2%	83.4%	84.0%	83.3%	84.2%	84.2%	83.7%	83.8%	84.2%	84.2%
019.W-W	Staff Turnover (Overall)		12.50%		13.1%	13.4%	12.7%	13.0%	13.1%	12.6%	14.9%	13.3%	13.3%	13.4%	14.6%	14.8%
023.W-W	Safer staffing fill rates		80.00%	L	102.5%	101.3%	101.5%	103.5%	103.6%	101.9%	100.5%	102.1%	102.5%	99.9%	100.4%	99.1%

- *New targets were introduced November 2022; historic data RAG rated against the new targets however may have previously been compliant against old targets.*

Note:
The measure: '***005.W-W: Appraisals And Personal Development Plans'*** is not reported this month, due to a technical issue on iLearn that is awaiting a fix by the developers at the time of reporting.

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

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

Issues of Concern
The Trust has a challenging efficiency target for this financial year (£7m). The gap is currently £0.8m, which is to be identified, there are clear areas of focus for all care groups and support services, final delivery plans are now required. The Trust is also focussed on eliminating the underlying financial deficit and has a clear plan for the remaining quarters of this financial year on how this will be delivered.

Executive Commentary

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

IQPR Dashboard: Well Led (Finance)

Ref	Measure	SoF	Target	Local / National Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
004.W-F	In Month Budget (£000)		0.0	N	0	0	0	0	0	0	0	0	0	0	0	0
005.W-F	In Month Actual (£000)		-	-	0	0	0	0	0	0	0			0	0	0
006.W-F	In Month Variance (£000)		-	-	0		0	(0)	0	0	0			0	0	0
006a.W-F	Distance From Financial Plan YTD (%)	✓	0.0%	N	0.00%	0.00%	0.00%	-0.32%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
007.W-F	Agency - In Month Budget (£000)		-	N	427	427	427	565	565	565	565	565	565	565	565	565
008.W-F	Agency - In Month Actual (£000)		-	-	595	516	698	533	572	612	708	544	709	631	766	728
009.W-F	Agency - In Month Variance from budget (£000)		-	-	168	89	271	(32)	7	46	143	(22)	143	65	201	163
010.W-F	Agency Spend Against Cap YTD (%)	✓	0.0%	N	48.08%	45.60%	47.08%	-5.69%	-2.27%	1.23%	7.24%	5.03%	8.42%	8.87%	12.20%	14.05%

- *Some targets are variable in year; historic data RAG rated against the new targets however may have previously been compliant against old targets.*
- Agency target has been amended in December 2022 to reflect system caps.
- Figures for 007/008/009.W-F have been upadted back to April 2022

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

Executive Lead(s): Chief Nurse & Chief Operating Officer
Lead Board Committee: Quality Committee

Issues of Concern
No areas of concern to raise this month.

Executive Commentary

Friends and Family Test (002.C)

The latest data reflects Family, friends and carer survey activity during the period 1st October 2022 to 30th November 2022. There are 177 responses, up from 113 in the previous period (August and September 2022). Assurance can be given as the carer reported experience measures remain in the top range. There are no trust wide concerns.

PALS, complaints and compliments (005-008.C)

There were 124 PALS and complaint contacts in the period 1 November to 15 December 2022 consisting of 47 complaints and 77 PALS type contacts. All localities and wards are receiving a similar level of contact and no particular locality is reported as an outlier.

Re-opened complaints have decreased in this period with just one case re-opened.

98% of PALS and complaints were acknowledged within three days. 97% of PALS and complaints were responded to within the agreed timeframe.

Patient Reported Experience Measures (PREM) (013-015.C)

The trust wide patient experience indicator is 8.5 out of 10 which is in the top range where patients ‘strongly agree’ that they experience our services positively. Assurance can be given as the target for the experience scores is being consistently met.

KPI	Latest month	Measure	Target	Assurance	Variation	Mean	Lower process limit	Upper process limit
Patient experience indicator	Nov 22	8.4	6.0			8.3	8.0	8.6
Overall PREM score	Nov 22	8.3	6.0			8.3	7.9	8.6
Satisfaction indicator	Nov 22	8.6	6.0			8.5	8.0	9.0
Community PREM score	Nov 22	8.3	6.0			8.3	8.0	8.7
Inpatient PREM score	Nov 22	8.4	6.0			8.1	7.3	8.9
PREM Response rate	Nov 22	5%	10%			4%	2%	5%

IQPR Dashboard: Caring

Ref	Measure	SoF	Target	Local / National Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
002.C	Mental Health Scores From Friends And Family Test – % Positive	✓	93%	N	84.5%	84.9%	84.5%	84.5%	79.5%	84.9%	83.8%	86.6%	84.8%	83.7%	87.1%	88.1%
005.C	Complaints acknowledged within 3 days (or agreed timeframe)		100%	L	99.0%	99.0%	98.0%	98.0%	97.0%	98.0%	99.0%	97.0%	98.0%	99.0%	98.0%	98.0%
006.C	Complaints responded to within 25 days (or agreed timeframe)		100%	L	98.0%	98.0%	97.0%	98.0%	98.0%	98.0%	98.0%	97.0%	97.0%	98.0%	97.0%	98.0%
007.C	Compliments - actuals		-	-	187	131	162	113	115	89	174	184	145	123	120	143
008.C	Compliments - per 10,000 contacts		-	-	52.16	38.93	43.68	34.90	30.79	25.70	50.87	52.97	42.11	36.78	33.34	48.20
013.C	Patient Reported Experience Measures (PREM): Response count		-	-	651	634	698	511	738	691	740	686	698	729	681	522
014.C	Patient Reported Experience Measure (PREM): Response rate		-	-	4.2	4.1	4.6	3.6	4.8	4.7	5.1	4.6	4.8	5.2	4.6	4.1
015.C	Patient Reported Experience Measure (PREM): Achieving Regularly %		-	-	8.1	8.2	8.3	8.2	8.0	8.3	8.2	8.3	8.3	8.2	8.3	8.4

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

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

Issues of Concern
Memory Assessment Services, demand continues to outstrip capacity. Actions include the role out of a new model (see below)

Executive Commentary

There is recognition of continued challenges in meeting performance targets consistently across CMHTs and CMHSOPs with a high degree of variability between teams. Work is being undertaken to address the waiting list for the Memory Assessment Service which includes implementing a new model. Addressing the backlog of patients will require a refreshed approach which will be established following further scrutiny of data and assurance that the new model will achieve the outcomes expected.

Work is underway to review access times in future service transformation, some of which will be driven by national guidance, such as access times for non-urgent referrals. Work on the urgent referral pathway will also look to redefine how measures can best be applied.

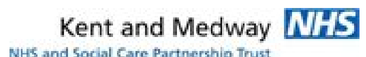
	016.R: Routine Referral To Assessment Within 4 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			82.5%	75.0%	58.3%	87.5%	72.9%
2	OPMH			85.9%	75.0%	46.0%	90.0%	68.0%
3	Trust Total			83.3%	75.0%	58.6%	84.0%	71.3%

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

Narrative

This indicator has been amended for 2022/23: Older Adult activity related to organic presentations is now reported within a separate measure against a 6-week target (reported below). The activity reported against CMHSOPs for the 4-week target reflected Functional and Complex Dementia presentations until 14th July 2022 when changes were made to RiO to give the ability to split the two pathways.

Following recent increases CMHT performance reduced slightly by 3.2% to 82.5%, this maintains an improved position of the last five months compared to performance of early 2022.



CMHSOP carried out 71 assessments in period, which whilst less than the 246 by CMHTs, saw a significant increase in the percenatge seen in 4 weeks. Increasing from 66.3% in November to 85.9% in December. Performance in future months will identify if this is a significant change in consistent levels of achievement.

The following table shows the performance of CMHSOP teams against the 6-week target for Routine Memory Assessments and Complex Dementia, highlighting two teams continuing to show special cause variation: DGS and Shepway CMHSOPs.

	016.R: Care Spell start to Memory Assessment (Routine) Assessment Within 6 Weeks	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			77.8%	75.0%	71.6%	110.2%	90.9%
2	Canterbury CMHSOP			28.1%	75.0%	2.0%	74.0%	38.0%
3	DGS CMHSOP			16.1%	75.0%	13.4%	95.0%	54.2%
4	Dover & Deal CMHSOP			76.0%	75.0%	20.2%	89.0%	54.6%
5	Maidstone CMHSOP			72.9%	75.0%	52.2%	101.1%	76.7%
6	Medway CMHSOP			40.0%	75.0%	8.9%	53.8%	31.3%
7	Sevenoaks CMHSOP			17.6%	75.0%	-11.1%	61.1%	25.0%
8	Shepway CMHSOP			43.8%	75.0%	40.8%	95.6%	68.2%
9	Swale CMHSOP			57.1%	75.0%	54.7%	103.4%	79.1%
10	Thanet CMHSOP			46.9%	75.0%	22.8%	88.3%	55.6%
11	Tunbridge Wells CMHSOP			0.0%	75.0%	-15.1%	55.6%	20.3%
12	CMHSOP Total			44.1%	75.0%	36.2%	74.6%	55.4%

Overall there remains a large variance across teams in performance against the 6-week to assessment measure with a range in month of 0% (7 patients) to 77.8%. The implementation of the new service model Enhanced Memory Assessment and Intervention Service (EMAIS) has commenced across all CMHSOP teams; however, the stage of implementation varies significantly as historic waiting lists are addressed.

The Standard Operating Policy/ Day in the Life Pack is being updated with clear flow charts for staff to follow for the Functional and Memory Service pathways to ensure a consistent approach to the new service and reduce variation.

Work has commenced with the Transformation team to set up RIO Clinic streams for all appointments. This will initially be piloted in Medway CMHSOP, and once evaluated and confirmed an effective approach will quickly be rolled out across all the teams. This will support a consistent approach in the teams and also highlight capacity, and any cancellation of appointments.

There is also a project underway in the Medway CMHSOP to determine if patients need to be seen by a doctor or can be reviewed by a nurse. It is recognised that approximately 30% of patients waiting to be reviewed have already got a diagnosis and do not need to be seen by a doctor.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	CRCG			94.5%	75.0%	85.7%	97.5%	91.6%
2	OPMH			62.5%	75.0%	62.1%	80.8%	71.5%
3	Trust Total			75.4%	75.0%	74.0%	86.0%	80.0%

Interpretation of results (Trust wide)	
Variation	Special Cause Variation of a **Concerning nature**
Assurance	Variation indicates **inconsistently hitting or failing target**
Narrative	

Overall performance (75.4%) continues to show special cause variation of a concerning nature, this is driven by performance in the CMHSOPs as CMHTs achieved 94.5% in month.

The table below highlights four CMHSOPs (Canterbury, Medway, Sevenoaks and Shepway) showing special cause variation. A number of teams however are achieving significantly lower levels mainly due to the impact of the acute medical shortages within the care group and that longer wait patients are now being seen. It is positive to note three teams were able to achieve in excess of 85% in month.

This metric includes MAS patients, as the implementation of EMAIS develops there will be a positive impact on this indicator although as previously highlighted the implementation varies across teams due to differing caseload and waiting list sizes.

	017.R: 18 Weeks Referral To Treatment	Performance	Assurance	Latest Value	Target	Lower process limit	Upper Process limit	Mean
1	Ashford CMHSOP			88.9%	95.0%	75.0%	108.2%	91.6%
2	Canterbury CMHSOP			49.2%	95.0%	46.6%	86.0%	66.3%
3	DGS CMHSOP			93.0%	95.0%	66.4%	101.8%	84.1%
4	Dover & Deal CMHSOP			82.6%	95.0%	48.4%	98.2%	73.3%
5	Maidstone CMHSOP			64.9%	95.0%	36.7%	87.7%	62.2%
6	Medway CMHSOP			48.3%	95.0%	47.1%	92.1%	69.6%
7	Sevenoaks CMHSOP			15.4%	95.0%	32.4%	79.5%	55.9%
8	Shepway CMHSOP			33.3%	95.0%	56.5%	98.6%	77.5%
9	Swale CMHSOP			96.2%	95.0%	63.7%	107.3%	85.5%
10	Thanet CMHSOP			75.5%	95.0%	46.2%	96.9%	71.5%
11	Tunbridge Wells CMHSOP			41.7%	95.0%	16.7%	83.9%	50.3%
12	**CMHSOP Total**			62.5%	95.0%	62.1%	80.8%	71.5%

IQPR Dashboard: Responsive

Ref	Measure	SoF	Target	Local / National Target	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	✓	60%	N	81.3%	86.4%	75.0%	76.5%	77.4%	75.0%	45.8%	69.6%	76.2%	87.0%	87.5%	70.4%
007.R	DNAs - 1st Appointments		-	-	10.0%	10.7%	10.7%	11.0%	12.4%	11.4%	13.4%	13.4%	12.9%	13.2%	14.3%	13.8%
008.R	DNAs - Follow Up Appointments		-	-	8.5%	7.8%	7.9%	8.4%	8.3%	8.4%	9.1%	8.2%	8.5%	8.7%	8.6%	8.4%
009.R	Patient cancellations- 1st Appointments		-	-	2.2%	1.9%	2.7%	2.3%	2.3%	2.5%	2.5%	2.1%	2.4%	2.4%	2.4%	2.4%
010.R	Patient cancellations- Follow Up Appointments		-	-	4.7%	4.9%	5.2%	5.4%	5.4%	5.2%	5.6%	5.1%	5.6%	6.2%	6.2%	6.3%
011.R	Trust cancellations- 1st Appointments		-	-	4.0%	3.9%	4.5%	4.9%	5.0%	4.2%	4.6%	4.0%	4.9%	4.5%	4.3%	4.7%
012.R	Trust cancellations- Follow Up Appointments		-	-	10.4%	11.4%	12.0%	11.6%	9.9%	11.4%	11.1%	10.4%	11.5%	10.5%	10.3%	11.2%
016a.R	Care spell start to Assessment within 4 weeks (Excl. MAS)		75%	-	57.2%	70.8%	68.3%	67.0%	63.8%	67.2%	71.4%	81.6%	80.8%	84.4%	81.3%	83.3%
016b.R	Care spell start to Assessment within 6 weeks (MAS only)		75%	-	53.1%	59.9%	55.6%	58.2%	61.1%	52.6%	59.0%	61.5%	50.7%	41.6%	46.4%	44.1%
017.R	Care spell start to Treatment within 18 weeks		95%	-	76.8%	81.7%	78.3%	77.5%	76.1%	76.5%	78.2%	78.7%	75.8%	75.5%	73.3%	75.4%
018.R	% Patients waiting over 28 days from referral (Excl. MAS)		-	-	37.2%	30.3%	32.2%	36.5%	26.5%	26.1%	22.7%	24.1%	25.5%	24.3%	28.8%	44.7%
019.R	Urgent referrals seen within 72 Hours		95%	-	62.3%	60.2%	58.4%	62.6%	63.4%	61.5%	62.8%	65.1%	60.0%	65.5%	62.6%	63.2%

Appendix A: Single Oversight Framework

Overview

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

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

The first version of the SOF was published in September 2016 with amendments made annually.
The Framework aims to help NHSI to identify NHS providers' support needs across six themes:

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

NHSI monitor providers' performance under each of these themes and consider whether they require support to meet the standards required in each area. Individual trusts are segmented into four categories according to the level of support each trust needs. KMPT's current segmentation is 2 as highlighted below, this is the default segment that all ICBs and trusts will be allocated to unless the criteria for moving into another segment are met:

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

IQPR Dashboard: Single Oversight Framework

Ref	Measure	Target	Nov-22	Dec-22	Trend (Last 12 months where available, left to right)
001a.E	Care Programme Approach (CPA) Follow-Up – Proportion Of Discharges From Hospital Followed Up Within Seven Days	95%	97.2%	96.4%	
001b.E	CPA patients receiving follow-up within 72hours of discharge		81.1%	80.4%	
005.E	Inappropriate Out-Of-Area Placements For Adult Mental Health Services. (bed days)		167	150	
001.R	People With A First Episode Of Psychosis Begin Treatment With A Nice-Recommended Care Package Within Two Weeks Of Referral	60%	87.5%	70.4%	
004.E	Data Quality Maturity Index (DQMI) – MHSDS Dataset Score	95%	95.3%	95.4%	
001.S	Occurrence Of Any Never Event	0	0	0	
001.W-W	Staff Sickness - Overall	4.0%	5.9%	6.8%	
002.C	Mental Health Scores From Friends And Family Test – % Positive		87.1%	88.1%	

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

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.

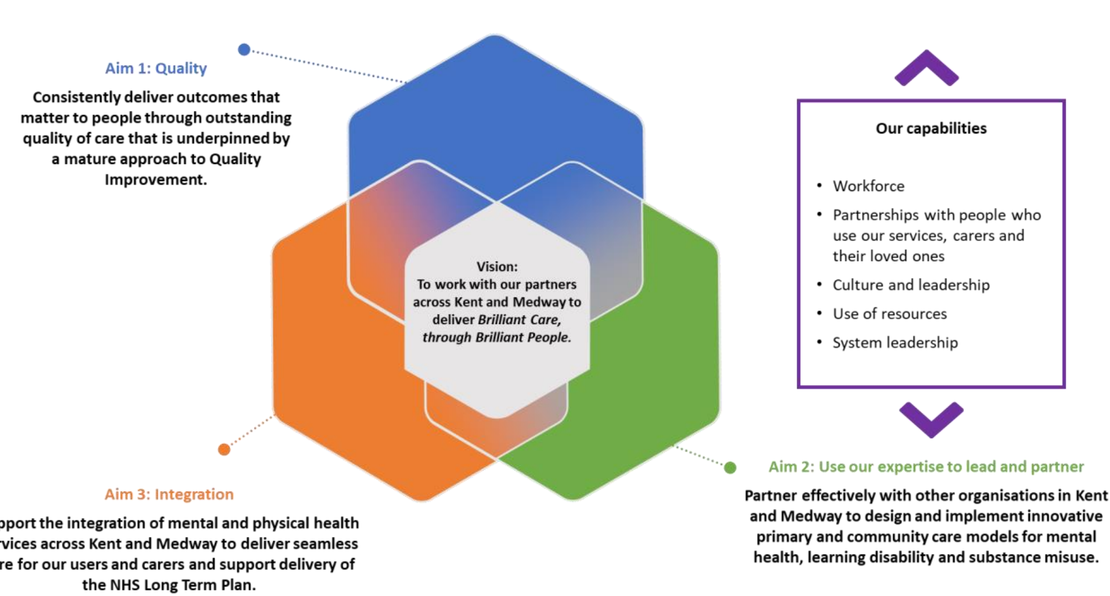
The report contains exceptions driven by Statistical Process Control (SPC) which draw conclusions about whether the process variation is consistent (in control) or is unpredictable (out of control, affected by special causes of variation). This is focussed on a selection of key indicators and is additionally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

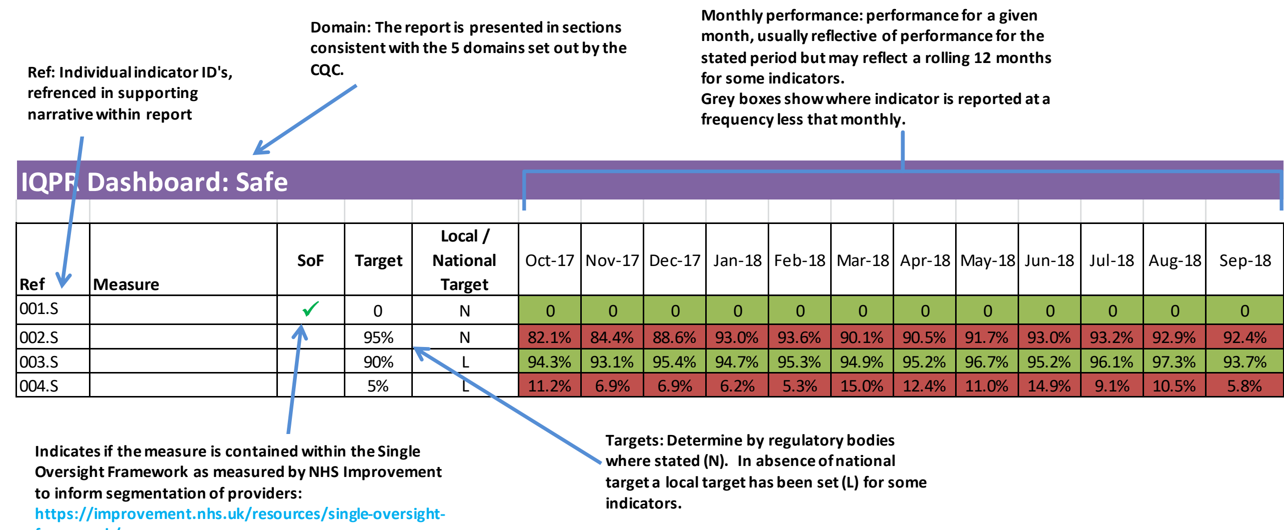
NHS
Kent and Medway
NHS and Social Care Partnership Trust


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
April 2022	Removals: • 003.S % Inpatients With A Physical Health Check Within 72 Hours • 007.S % Serious Incidents Declared To STEIS within 48 hours • 008.S Number Of Grade 1&2 Sis Confirmed Breached Over 60 Days • 010.S All Deaths Reported On Datix And Suspected Suicide • 015.S Ligature Incidents - Ligature With Fixed Points (moderate to severe harm) • 016.S Ligature Incidents - Ligature With No Fixed Points (moderate to severe harm) • 018.Sa Infection Control - MRSA bacteraemia • 018.Sb Infection Control - Clostridium difficile • 011.E Number Of Home Treatment Episodes • 005.R % of Liaison (urgent) referrals seen within 1 hour • 006.R % of Liaison (urgent) referrals seen within 2 hours • 013.R. 014.R, 015.R Referral counts *All removals are subject to appropriate internal governance despite no longer being reported in the IQPR with routes of escalation if required.* Amendments and Additions: • 019.S. Safer staffing fill rates – moved to workforce section with new reference • Acute bed occupancy introduced • Amendments to inclusions for 4 week wait and additional 6 week wait metric for Dementia waits introduced	023.W-W 018.E 016.R (a,b)
September 2022	Removals: • 006.S Serious Incidents Declared To STEIS • 012.S Restrictive Practice - No. Of Prone Incidents • 013.S Restrictive Practice - No. Of Seclusions • 017.S RIDDOR Incidents • 003.C Complaints - actuals • 004.C Complaints - per 10,000 contacts • 010.C PALS acknowledged within 3 days (or agreed timeframe) • 011.C PALS responded to within 25 days (or agreed timeframe) • 012.C PALS - actuals Target Changes: • 012.E Average Length of Stay (Younger Adults) • 013a.E Average Length of Stay (Older Adults - Acute) • 017.E %Patients with Non-CPA Care Plans or Personal Support Plans • 016a.R Care spell start to Assessment within 4 weeks (Excl. MAS) • 016b.R Care spell start to Assessment within 6 weeks (MAS only)	

Changes made prior to 2022/23 reports removed from table, these can be viewed in earlier IQPRs

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26 March 2023
Title of Paper:	Finance Report for month 9 (December 2022)
Author:	Nicola George, Associate Director of Finance
Executive Director:	Sheila Stenson, Chief Finance and Resources Officer

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 9 (December 2022). This is consistent with the position submitted to NHS Improvement in the Month 9 Financial Performance Return.

Items of focus

As at the end of December 2022 Kent and Medway NHS and Social Care Partnership Trust (KMPT) is reporting a breakeven even position in line with plan.

For this financial year it is imperative focus continues on ensuring a breakeven position is delivered. It is important to note the following:

1. Focus needs to continue on minimalising agency spend as much as possible. Agency caps have been reintroduced this financial year and the Trust ‘s cap has been set at £6.78m. The Trust is presently forecasting to exceed this cap by £1.10m. This position is consistent with trusts across the country but is likely to attract additional external scrutiny as per the pre-Covid regime.

2. Focus needs to continue on ensuring the progress on the sustainability programme continues. Progress has been made but it is vital that any gaps and delays in planned savings plans are mitigated. This is in line with the Trust objective to eradicate the Financial deficit by March 2023.

3. Capital spend remains under plan, with a year to date underspend of £4.41m. The detailed forecast for the year is being developed with Estates and IT and will be shared in month

4. The cash position remains strong at £26.74m at the end of December 22.

Governance

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

Finance Report

Trust Board

December 2022

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Executive Summary

Key Messages for December 2022

For the period ending 31 December, the Trust has reported a break even position. This position is expected to continue in year with the Trust delivering a break even position against plan.

Key financial challenges for the Trust continue to be:
- The demand pressures on the Trust's bed base, presenting the risk of utilising further external beds.
- Continued high agency usage with particular pressures within Nursing and Medical staff groups. This area is subject to external scrutiny through an agency cap.
- The delayed start dates for the capital plan, with the year to date position £4.41m behind plan, bringing pressure to utilise the annual allocation by the end of March 23. This position is expected to deliver in year.
- Cash balances remain high predominantly due to the delay in the capital plan

Draft annual planning guidance has now been released and the impacts are being worked through internally and with Commissioners. The first draft of budgets have been provided to care groups with Executive led check and challenge sessions to take place in January.

Income and Expenditure

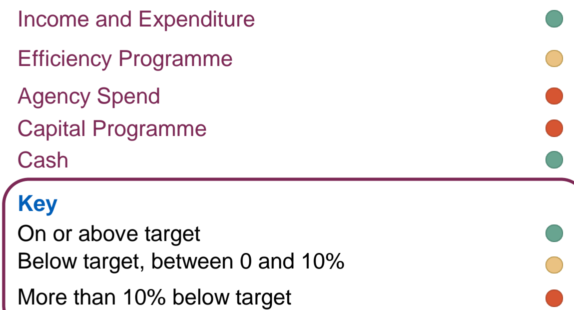
KMPT is continuing to use temporary staffing due to vacancies and staff absence. Agency spend remains high, with the in month position representing a £0.73m spend compared to a year to date average of £0.64m, Pressure areas continue to be Medical and Nursing staff groups with highest levels of spend seen in the Community Recovery and Acute Care Groups. Agency caps have been reintroduced which is resulting increased external scrutiny. Executive led meetings continue to review agency spend.

Check and challenge meetings continue to take place with further meetings in January as part of planning with focus on Care Group positions, CIP achievement and agency spend.

In other expenditure areas, month 9 saw higher levels of spend continue in external placements with 382 bed days being utilised in month. 5 beds relate to the Fern Decant, 5 to Female PICU. In addtion to the block spend, a further two beds are being used to accommodate a complex patient. These additional charges, plus all additional observations for the patient, are being recharged to the ICB whilst a permanent placement is sought.

	Year to date		
	Plan	*Actual*	*Variance*
	£000	**£000**	**£000**
Income	(174,472)	(177,863)	(3,392)
Employee Expenses	135,236	135,020	(216)
Operating Expenses	34,894	38,757	3,863
Operating (Surplus) / Deficit	**(4,341)**	**(4,085)**	**256**
Finance Costs	4,341	4,085	(256)
(Surplus) / Deficit	**0**	**(0)**	**(0)**

At a Glance - Year to Date



Capital Programme

In December, the Trust underspent by £0.83m against the plan. YTD the position remains underspent by £4.41m.

The underspend relates to the delayed start and completion dates for Estates schemes, delays in recruitment to new digital staffing posts and slippage in the Improving Mental Health Services (IMHS) Programme due to issues found during groundworks and delays with the mechnical, electrical and plumping packages (MEP).

The forecast is still that we will spend the full £22.09m plan. This relies upon continued progress being made on IMHS and schemes being progressed quickly.

The contracts/SLAs have now been signed for the new year schemes and works have commenced. The forecast also includes the Data Centre refresh being completed in 22/23. Monthly meetings are being held to review and update the forecast.

Cash

Whilst the cash position reduced in month due to capital payments it remains strong at £26.74m. The actual cash position is £10.88m higher than the original plan. Receipts are £4.92m higher, the main factors being additional funding in relation to the pay award and acute inpatient ward pressure and higher funding from HEE. Payments are £5.95m lower than plan predominantly due to lower creditor and capital payments (due to slippage), partially offset by the impact of the pay award on payroll costs.

The year-end forecast has been increased by £3.49m to £16.57m, largely to reflect the slippage in the capital programme which will lead to higher capital creditors in March.

Income and Expenditure and Long Term Sustainability Programme

Statement of Comprehensive Income

	Current Month			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000	£000	£000	£000	£000	£000
Income	(19,441)	(20,162)	(721)	(174,472)	(177,863)	(3,392)
Employee Expenses	14,969	15,098	129	135,236	135,020	(216)
Operating Expenses	3,990	4,649	659	34,894	38,757	3,863
Operating (Surplus) / Deficit	**(481)**	**(415)**	**66**	**(4,341)**	**(4,085)**	**256**
Finance Costs	481	415	(66)	4,341	4,085	(256)
(Surplus) / Deficit	**0**	**(0)**	**(0)**	**0**	**(0)**	**(0)**

Commentary

Year to date pay is under plan at the end of December by £0.22m. Substantive pay is underspent by £4.02m at the end of December due to vacancies. This is partly offset by bank and agency costs of £3.81m.
The underspend is largely driven by vacancies and in particular within Mental Health Investment Standard initiatives. For these areas, the corresponding income has also been deferred to match and performance is being closely monitored between the Trust and ICS colleagues.

Agency spend remains high with a year to date spend of £5.8m. Agency caps have been reintroduced to support the reduction of agency expenditure at a system level with KMPT having an agency limit of £6.8m. The forecast outturn has increased to £7.9m which if spend materialises as expected will mean we will exceed the cap by £1.1m - presenting a worsening position as the financial year has progressed.

Other non pay at year end includes a high level of spend on External placements compared to previous months spend levels with year to date spend £3.58m against a plan of £2.87m contributed to by the Fern Ward decant due to capital works and a patient admitted with complex needs which impacted the usage of the external placement beds for which the cost has been recharged to the Commissioner.

Long Term Sustainability Programme (Efficiency Programme)

	Annual	Current Month			Year to Date			22/23
	Plan	Plan	Actual	Variance	Plan	Actual	Variance	Forecast
Pillar	£000	£000	£000	£000	£000	£000	£000	£000
Back Office	(816)	(90)	(335)	(245)	(542)	(1,108)	(566)	(1,435)
Workforce	(938)	(110)	(20)	90	(631)	(139)	492	(216)
Service Line Reporting	(2,905)	(322)	(73)	250	(1,962)	(608)	1,354	(794)
Patient Pathways	(905)	(99)	(43)	56	(600)	(565)	35	(694)
Procurement and Purchasing	(300)	(30)	(20)	10	(195)	(78)	117	(137)
Commercial Development	(1,130)	(95)	(174)	(79)	(808)	(2,115)	(1,307)	(2,840)
Non-recurrent slippage	0	(746)	0	746	0	0	0	0
Total	**(6,995)**	**(746)**	**(664)**	**828**	**(4,738)**	**(4,614)**	**124**	**(6,116)**

Commentary

The Long Term Sustainability Programme (CIPs) for 22/23 continues to make progress with a focus on the identified plans delivering as per plan.

Work has continued to identify further CIP schemes to close the gap which is currently £0.88m, a favourable movement of £0.4m since the last report. The focus will remain on identifying further schemes which will enable the annual target to be achieved and support the eradication of the underlying deficit by March 2023. Executive led check and challenge meetings continue as part of planning to ensure focus remains on CIPs and efficiency plans for this year but also to develop a pipeline of schemes for 23/24.

Work continues on the rota review initiative which is expected to generate significant savings. Work is on-going to mobilise in quarter 4 and support the trust in delivering a balanced underlying position

Exception Report

Top Variances

	Plan £000	Actual £000	Year to date Variance £000	Proportionate Overspend	Reported Last report
Agency	5,045	5,785	740	15%	12%
Bank	11,445	14,513	3,068	27%	26%
External Placements	2,676	3,752	1,076	40%	37%

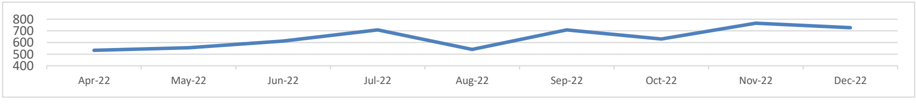
1. Temporary Staffing Spend: Agency £0.74m

Agency spend has exceeded plan in month 9 and on a year to date basis are over plan by £0.74m and this is forecast to continue - due to both vacancies and operational pressures particular within Medical and Nursing staffing groups.

There will be continued focus and scrutiny on all agency spend as the financial year progresses to ensure spend remains within budget. Agency spend remains high with a year to date spend of £5.8m. Agency caps have been reintroduced to support the reduction of agency expenditure at a system level with KMPT having an agency limit of £6.8m. If spend continues as forecast we will exceed the cap by £1.1m - presenting a worsening position as the financial year has progressed.

ANNUAL	2018/19	2019/20	2020/21	2021/22	2022/23 (YTD)
Agency	6,459	6,395	8,740	7,537	5,785

MONTHLY TREND



2. Temporary Staffing Spend: Bank £3.068m

The financial plan for bank has been based on trend analysis from previous financial years, and is predominantly planned to cover annual leave and short term sickness.

There has been an decrease in the run rate in month 9 and is more in line with trend when compared to 22/23 average spend - with £0.79m being spent in month against a year to date average of £0.86m.

The Acute and Forensic Care Groups continue to report higher levels of bank due to the clinical requirements and the high level of observations of a specialist patients. There is a Quality Improvement project underway with focus on clinical observations which will provide further insight into the cost drivers for bank spend.

MONTHLY TREND

	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
Nursing	577	595	625	591	617	683	608	586	572
Healthcare As	733	814	757	835	933	952	1,039	790	856
Other	55	123	150	145	140	166	130	150	135
Total	**1,364**	**1,532**	**1,532**	**1,571**	**1,691**	**1,801**	**1,777**	**1,526**	**1,563**

3. External placements £1.076m

As at month 9 the year to date spend remains high with 382 bed days reported in month.

The main driver for movement away from plan relates to 5 additional acute beds being utilised due to the planned Fern Ward decant. This relates to the refurbishment work being undertaken and is in line with the expected impact.

In addition 2 additional beds have been required due to a complex patient. These beds have been held empty to enable the patient's needs to be meet.

The external placement utilisation will continue to be closely monitored particular as we approach autumn and winter.

External placements - bed days summary:

Type	*Actual* Apr-22	*Actual* May-22	*Actual* Jun-22	*Actual* Jul-22	*Actual* Aug-22	*Actual* Sep-22	*Actual* Oct-22	*Actual* Nov-22	*Actual* Dec-22
PICU	379	361	257	201	274	377	311	228	217
Younger Adult	115	120	96	15	6	115	114	165	165
Total	**494**	**481**	**353**	**216**	**280**	**492**	**425**	**393**	**382**

Structural Deficit

Current Annual Underlying Deficit	£6.4m

Key Drivers

Driver	Value
Forensic Community Service	£0.8m
Forensic Inpatients	£0.4m
External placements	£1.2m
Brookfield	£0.7m
Mental Health Learning Disability Services	£1.1m
Neurology Services	£0.3m
Bridge House Detox Service	£0.3m
Agency Spend (premium element)	£1.5m
Total	**£6.4m**

M9 Summary

The Trust has undertaken a review of its underlying position as part of the 2023/24 planning. This has allowed it to identify a further £0.75m improvement to the underlying position. This is predominantly through a recosting of the Trust's staffing budgets.

The remaining £3m is expected to be delivered through the MHOST and rota review (£2m), and contract pricing review predominantly in MHLD (£1m). These positions are expected to be confirmed in Quarter 4.

Key Actions currently being implemented

These schemes have been reviewed with Care Groups. Any schemes still in development are not included in this section but mapped out in the "Bridging the Gap" section below. As schemes are signed off they will transfer to this section.

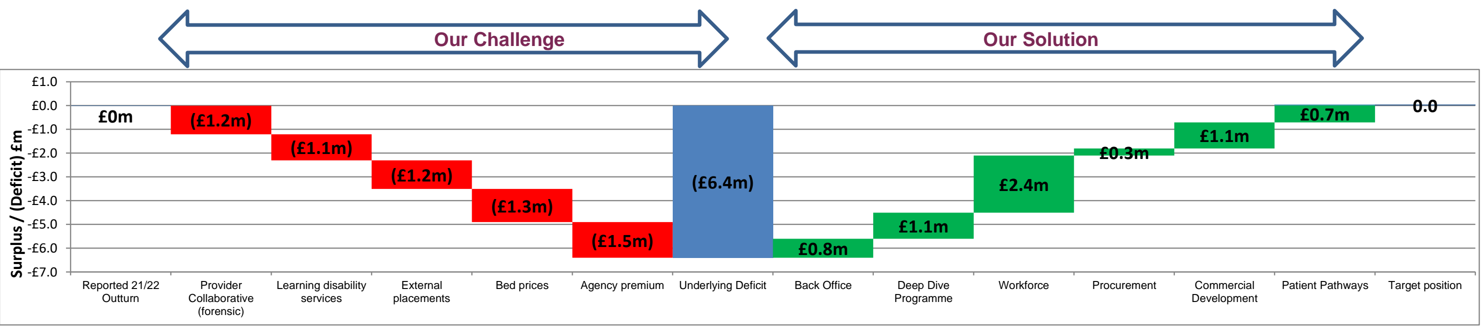
Action	Value
Psychology review*	£0.4m
Agency controls	£0.6m
Bridge House price increases	£0.3m
Forensic service establishment review	£0.7m
MHOST (Mental Health Optimal Staffing Tool) and ward establishment reviews	£0.3m
Brookfield price increase	£0.1m
FOLS contracted prices	£0.25m
Planning review	£0.75m
Total	**£3.4m**

*this is the recurrent value, £0.7m will be realised in 22/23, of which £0.3m is non recurrent

Residual Annual Underlying Deficit	**£3.0m**
Target position for 31st March 2023	**£0m**
Remaining Gap	**£3.0m**

100% 90% 80% 70% 60% 50% 40% 30% 20% 10% 0%

Bridging the Gap



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Appendices

Statement of Financial Position

	31st March 2022	30th November 2022	31st December 2022
	Opening	*Actual*	*Actual*
	£000	£000	£000
Non-current assets			
Property Plant and Equipment	135,978	156,304	156,776
Intangible Assets	3,185	2,408	2,465
Other non-current receivables	538	447	450
Total non-current assets	**139,701**	**159,159**	**159,690**
Current Assets			
Trade and other receivables	6,522	5,552	5,444
Cash and cash equivalents	20,077	27,754	26,474
Assets held for sale	0	0	0
Total current assets	**26,599**	**33,305**	**31,918**
Current Liabilities			
Trade and other payables	(23,365)	(31,180)	(29,630)
Provisions	(1,629)	(1,639)	(1,629)
Borrowings	(914)	(2,745)	(2,750)
Other Financial Liabilities	0	0	0
Total current liabilities	**(25,907)**	**(35,563)**	**(34,009)**
Non-current Liabilities			
Provisions	(3,716)	(3,595)	(3,587)
Borrowings	(13,786)	(28,704)	(28,444)
Total non current liabilities	**(17,502)**	**(32,299)**	**(32,031)**
Total Net Assets Employed	**122,891**	**124,602**	**125,569**
Total Taxpayers Equity	**122,891**	**124,602**	**125,569**

Commentary

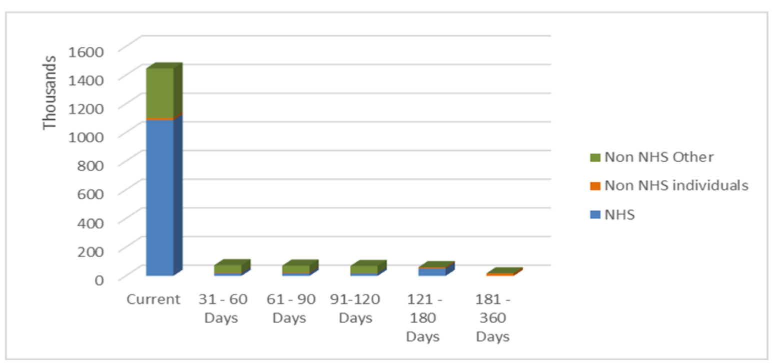
Non-current assets
Non current assets have increased by £0.53m in month, reflecting the increased capital expenditure in the month which offsets depreciation.

Current Assets
The cash position remains strong at £26.47m. However, there has been a decrease of £1.28m in the month, largely due to increased capital payments in line with reduced capital creditors.

Receivables have decreased by £0.11m. Accrued income reduced by £0.66m with invoices raised for SLAs. The increase this generated in invoiced receivables was more than offset by clearance of previously held invoices and payments from the provider collaborative. The net impact was a reduction in billed debt of £0.22. There was an increase in the VAT receivable of £0.71m as in November two months of claims were received in month.

Current Liabilities
Trade and other payables have decreased by £1.55m. This is mainly due to a decrease in capital creditors of £1.75m following higher cash payments to capital contractors in December, and a reduction in deferred income of £1.10m largely related to Health Education England and the ICB. Some of these decreases have been offset by increases in general accruals, the monthly PDC accrual and trade payables.

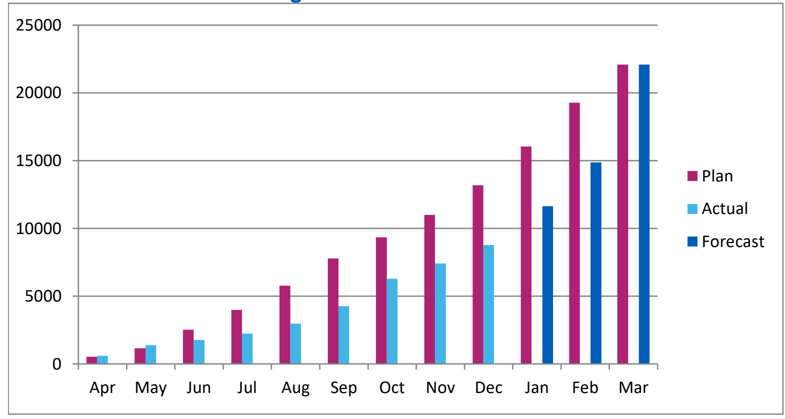
Aged Debt
Our total invoiced debt is £1.75m, of which £1.57m is within 30 days. Debt over 90 days stands at £0.16m.



Capital Expenditure

	Current Month			Year to Date			Full Year	
	Plan £000	*Actual* £000	*Variance* £000	*Plan* £000	*Actual* £000	*Variance* £000	*Forecast* £000	*Plan* £000
Information Management and Technology	186	204	18	1,811	1,142	(669)	3,604	2,350
Capital Maintenance & Minor Schemes 2022/23	443	169	(274)	2,169	946	(1,223)	5,346	4,154
Capital Maintenance & Minor Schemes from 2021/22	0	255	255	3,412	3,234	(177)	4,041	3,412
Strategic Schemes - Ward Refurbishment	300	11	(289)	300	84	(216)	354	1,988
Improving Mental Health Services (Maidstone)	1,255	722	(533)	5,469	3,347	(2,122)	8,704	10,145
PFI 2022/23	4	3	(1)	29	31	2	41	41
Total Capital Expenditure	**2,188**	**1,363**	**(825)**	**13,190**	**8,784**	**(4,406)**	**22,090**	**22,090**

Cumulative Performance against Plan



Commentary

April to December the Trust has underspent against its capital plan by £4.41m; the in month position is showing a £0.83m underspend.

- Prior Year Schemes £0.72m of the underspend relates to the delayed start and completion dates for the Fern Ward refurbishment and Emmetts/Walmer Heating, this underspend has been partially offset by an overspend on schemes such as sink holes, Comms Rooms and rest rooms £0.58m .
- New year estates schemes such as legionella works, BMS upgrades and fire alarm panels are underspent by £1.22m, works have now commenced in these areas.
- The underspend of £0.67m on IT schemes is as a result of delays in recruitment to new digital staffing posts.
- The Improving Mental Health Services Programme is £2.12m underspent due to issues found during groundworks and delays with the Mechanical, Electrical and Plumbing (MEP) packages.

The Trust is forecasting to spend its allocation in full, but this is reliant on schemes being progressed quickly. Monthly meetings are being held to review and update the forecast.

TRUST BOARD MEETING – PUBLIC

Date of Meeting:	26 January 2023
Title of Paper:	Workforce Deep Dive: Violence and Aggression, and Staff Safety
Author:	Rebecca Stroud-Matthews, Deputy Director of People
Executive Director:	Sandra Goatley, Chief People Officer, Andy Cruickshank, Chief Nurse

Purpose of Paper

Purpose:	For discussion
Submission to Committee:	Committee Request

Overview of Paper

One of KMPT's three strategic priorities for 2022-23 is Workforce, and set within that priority is a focus on improving staff wellbeing. Ensuring a safe working environment is a critical foundation to this work, and so this month the Trust Board has requested a deep dive into violence and aggression against staff. This paper sets out the current position, themes, and trends in relation to violence and aggression, as well as highlighting plans in place or in train to address these.

Issues to bring to the Board's attention

There were 1648 incidences of violence and aggression reported via Datix during the twelve month period between 1st December 2021 and 30th November 2022. These incidents were perpetrated against 1096 different members of staff, suggesting that over the past 12 months, almost 1 in 3 KMPT staff has experienced violence of aggression by patients or service users.

Additionally, BAME staff were the subjects of 57% of all incidents reported, meaning that at least 76% of BAME staff have experienced violence and aggression.

Significant efforts are already being made to address violence and aggression at KMPT, as well as to support staff affected by such incidents. However, this paper highlights a range of further activities which could be undertaken to further this agenda.

Governance

Implications/Impact:	Recruitment and retention; quality and safety and absence

Assurance:	Reasonable
Oversight:	Workforce and Organisational Development Committee

1. Introduction and context

1.1 Over recent years health and social care employees have had a consistently higher risk of experiencing violence at work than employees in other occupational groups. Although there has been significant emphasis placed on this at a national level, including through the national Violence Prevention and Reduction Standard introduced in 2020, there has been little reduction over the past decade. In 2021 (2022 data awaited) around 15% of staff reported via the National Staff Survey that they had experienced violence at work, and it is estimated that there are in excess of 300 assaults on average per Trust per year (HSJ Freedom of Information Request).

1.2 It is thought that most incidences of violence have a clinical cause, and as such, a considerably higher proportion of incidences of violence take place in Mental Health settings than in others. By way of illustration, some reports (RCN: Violence and Aggression in the NHS) suggest that such incidences are as much as three times more likely to take place in a mental health Trust than in an ambulance Trust and more than six times more likely to take place in a mental health Trust than in an acute Trust.

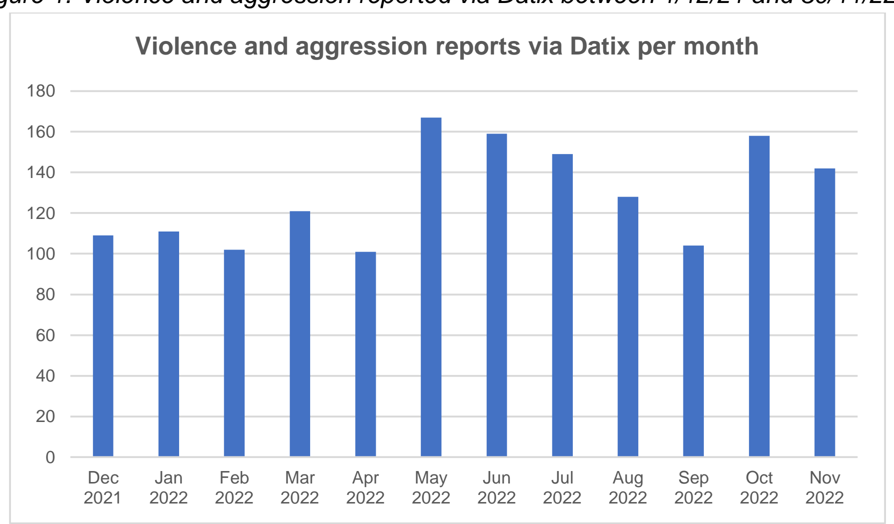
1.3 As well as a duty to comply with the Violence Prevention and Reduction Standard, NHS employers also have a duty under the Health and Safety at Work Act 1974 to protect the health, safety and welfare of staff. Additionally, failure to ensure safe working conditions will of course contribute materially to the critical staffing challenges health and social care are facing.

1.4 This paper aims to give an overview of KMPT's current position in relation to staff experiences of violence and aggression, as well as to provide some assurance in relation to interventions and support in place in this area.

2. Position within KMPT

2.1 Reports via the Datix system indicate that at KMPT over the past twelve months (between 1st December 2021 and 30th November 2022), there were a total of 1648 incidences of violence and aggression reported, as illustrated in Figure 1 below. These incidences were against 1096 different members staff, suggesting that over the past twelve months almost 1 in 3 KMPT staff has experienced violence or aggression by patients or service users.

Figure 1. Violence and aggression reported via Datix between 1/12/21 and 30/11/22



2.2 This tallies with intelligence obtained through the National Staff Survey. Encouragingly, the alignment of these data sets indicates sound levels of reporting of violence, and indeed 93% of staff tell us through the Staff Survey that they reported the last incident that they experienced.

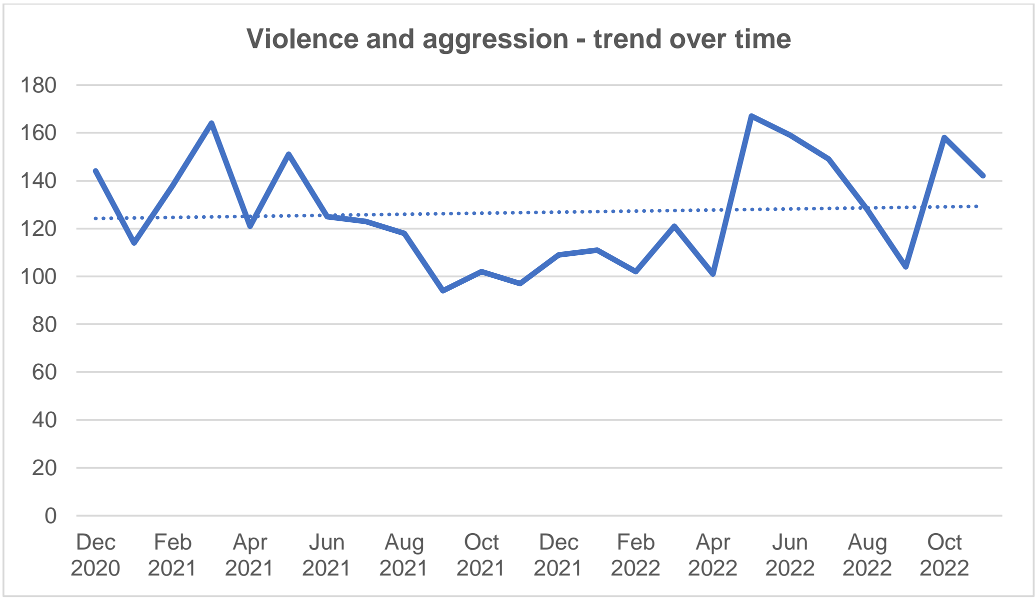
Figure 2. Proportion of staff responding positively in National Staff Survey on reporting violence

	2021	**2020**	**2019**
% of staff who reported last incident of violence at KMPT	93.3%	93.8%	95.4%
% of staff who reported last incident of violence - national average	89.3%	86.7%	87.7%

2.3 It is not currently possible to compare numbers reporting violence and aggression through Datix at KMPT with numbers reporting similar incidents through other organisations. However, the National Staff Survey indicates that marginally more staff experience violence and aggression at KMPT than the national average for mental health trusts (17.1% at KMPT compared with 14.9% average).

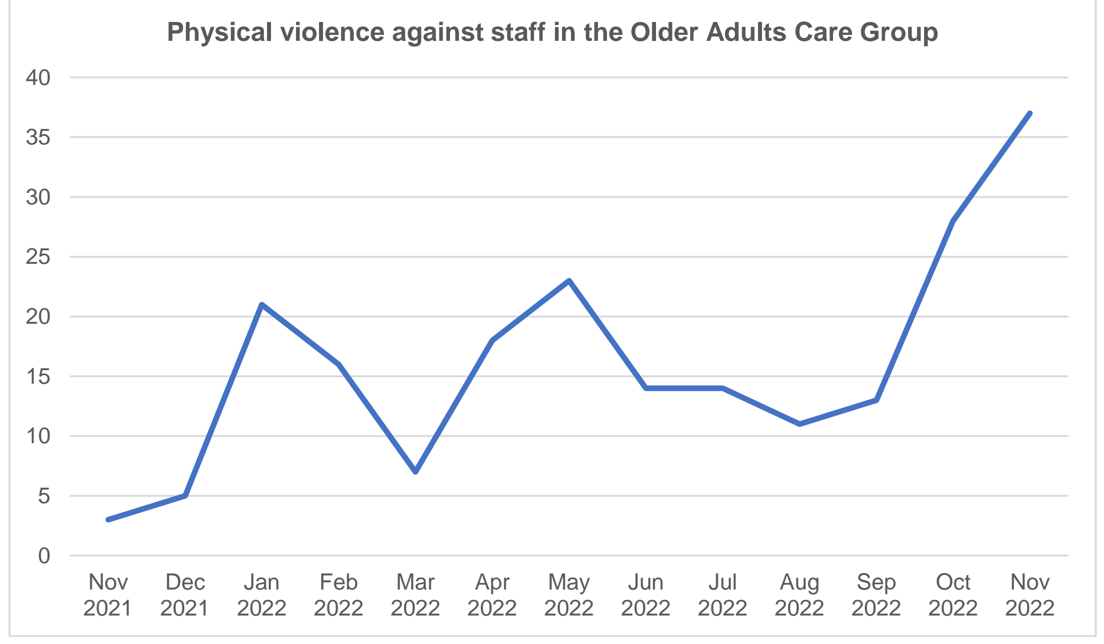
2.4 Additionally, in spite of numbers of reports fluctuating month by month, overall a slight upwards trend can be seen over the past 24 months (Figure 2). This is in line with the national picture.

Figure 3. Trends in violence and aggression over time, as reported via Datix.



2.5 The highest volume of incidences of violence and aggression are, perhaps unsurprisingly, seen in the Acute Care Group. However, there has been a particularly steep increase in these incidences in the Older Adults Care Group over the past twelve months (Figure 4).

Figure 4: Physical violence against staff in the Older Adults Care Group between 1/11/22 and 30/11/22



2.6 It is considered that there may be a range of factors which are contributing to these trends, although it should be caveated that this assessment is largely anecdotal. In the Older Adults services in particular, it is considered that a change in the patient/service

user cohort, whereby the services are treating more acutely unwell individuals, and increasingly younger individuals with greater capacity for violence and aggression than historically. It is likely that high levels of acuity are contributing to incidents of violence and aggression across the Trust, compounded by lower than desirable staffing levels in places.

2.7 The most frequently reported types of violence and aggression appear to be:

Category of violence and aggression	Proportion of all reports
Physical assault (actual contact)	50%
Physical threat (no contact)	16%
Verbal abuse	13%

2.8 It is possible that the prevalence of physical assault amongst reports does not reflect an actual prevalence of this type of violence and aggression, but rather reflects that staff are more likely to report incidents of physical violence than they are incidents of non-physical violence or aggression.

2.9 There is a clear racial disparity in relation to incidents of violence and aggression. 57% of all incidents of reported on Datix involved a BAME member of staff, which means that 76% of BAME staff have experienced violence and aggression, compared with 19% of white staff. It appears that although this disparity does exist in relation to physical violence, it is even more pronounced in relation to non-physical violence, which is perhaps due to the high proportion (70%) of verbal abuse which involves racial content.

3. Interventions and support in place

3.1 Violence and aggression against staff is an ongoing challenge for KMPT and a range of interventions have already been put in place.

3.2 In particular, over recent years, KMPT has benefitted from a close and proactive working partnership with the Kent Police Mental Health Team. The core premise or Operation Cavell has been to instil into the Trust a zero-tolerance approach to criminal violence and aggression, and to deal effectively with any crimes reported from KMPT.

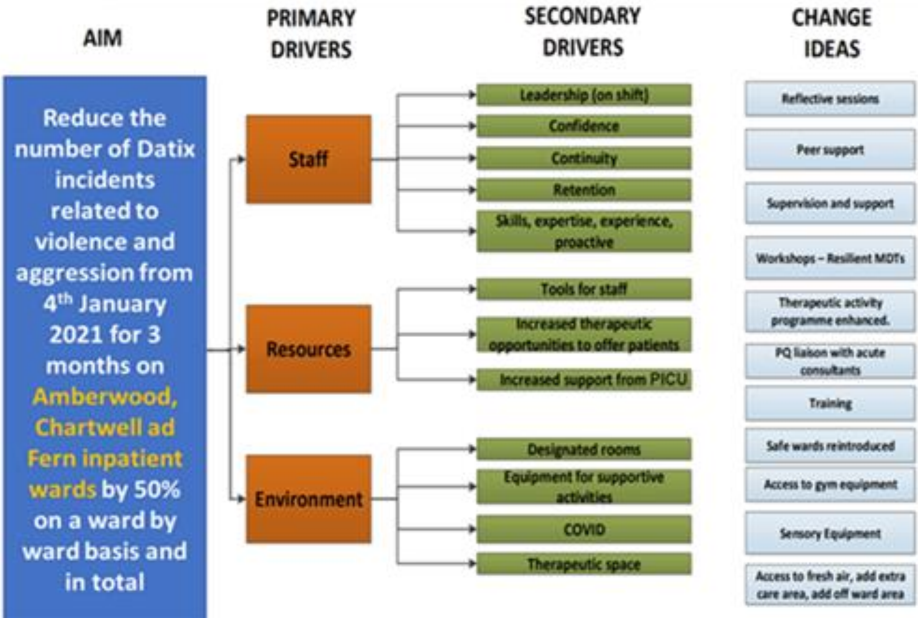
3.3 As part of this approach, the Kent Police Mental Health Team were the first operational policing team in the country to be embedded within a mental health trust, with three operational police officers having tactical responsibility for Littlebrook Hospital, Priority House, and St Martin's Hospital. The partnership has also provided an accredited detective for complex and/or protracted investigations.

3.4 Additionally, recognising the prevalence of hate crime specifically, the Trust with its BAME Network continues to develop its Hate Crime Policy. This Policy clearly defines hate crime, and sets out the process for reporting hate crime incidents. It also provides guidance as to the support offered to a member of staff who has experienced hate crime,

including assessing early signs of distress, validating the direct impact of the incident, and understanding stress reaction. Kent Police and victims reporting hate crime at KMPT continue to experience challenges in addressing hate crime, owing to the volume of such incidents, as well as legislative restrictions due to the privacy of locations.

3.5 At a team level, reducing violence and aggression has recently been a particular focus of the Quality Improvement team, with a number of pilots evidencing noticeable improvements in the position on individual wards. The interventions through these pilots have focused on creating improved therapeutic environments through use of sensory equipment, as well as on installing safety pods, focusing on recruitment of substantive staff, and introducing safety huddles.

Figure 5. Violence and aggression driver diagram as designed by the Quality Improvement team in 2021



3.6 KMPT applies the Broset violence and aggression risk assessment tool wherever possible, although it should be noted that its application is variable depending on numbers of regular staff on shift.

3.7 Overall, KMPT strives to ensure that every patient and service user is receiving the right care in the right environment at the right time, recognising that often, failure to do so sits behind incidents of violence and aggression. Furthermore, close scrutiny is applied to the adequacy of staffing levels, and to the appropriate skill mix for the case load at any point in time. More recently, this is being done through regular roster "Check and Challenge" meetings, delivered by the clinical, HR and service management teams in conjunction.

3.8 Conflict management training is currently mandatory for all staff, and breakaway training is mandatory for all staff based in Clinical Care Groups and sites. Some staff (those working in inpatient settings) are also required to undertake physical interventions training. Training around reduction in use of restraint and seclusion is of a high standard and there is interest from NHS England in this training as delivered at KMPT.

3.9 Post-incident debriefing is understood to happen consistently with senior member of the teams on-shift, and counselling is available for staff requiring additional support.

3.10 Overall, KMPT's strategy, policies and training programmes are aligned around promoting safety, safely de-escalating situations, and reducing restrictive practices which are recognised to have the potential to generate violent and aggressive behaviours.

4. Interventions and support going forward

4.1 Notwithstanding the work already in train, further focus is needed going forwards in a number of areas. It is proposed that a multi-disciplinary Working Group is established to progress this work:

i. **Refresh of the profile of Operation Cavell, including expectations of the partnership**
Although initial internal communications around the Operation Cavell partnership were robust, it is considered that it would be timely now to refresh and strengthen these, taking into account the passage of time as well as staff turnover. It is also considered that some resetting of expectations may be beneficial – focusing on aims around restorative justice alongside or ahead of aims around criminal justice. Feedback on successful resolution should be part of these communications, and consideration will be given to incorporating stories from staff who have experienced violence or aggression into Schwartz Rounds.

ii. **Review of support to areas with higher incidence of violence and aggression;**
Areas with higher incidence of violence and aggression should be identified and targeted support offered. To do this most effectively, data quality improvements will be required and data from a range of sources will need to be triangulated. This should include across Datix (or its successor), police information and the National Staff Survey.

iii. **A review of management and leadership training;**
In Q1 of 2023-24, a review of leadership and management training will be undertaken. The refreshed offer will include improved content around managers' role

in creating safe environments, in de-escalating volatile situations, and in debriefing post-incident.

iv. **Adoption of technology**
Widening of use of CCTV and adoption of body warn cameras is currently being explored. It is considered that this sends a zero-tolerance message to patients, or service users with capacity, therefore “reboundarying” the therapeutic relationship, supports post-incident reflection and learning, and increases the likelihood of prosecution.

v. **Encouraging reporting**
Although reporting levels are good overall, there appears to have been a gradual deterioration in levels of reporting over the past few years (indicated through the National Staff Survey). Additionally, there is a belief that, although violent incidents are well reported, non-violent incidents may be under-reported. Further communications around the importance of reporting are being considered, and improved feedback as highlighted in the subsequent point will also encourage reporting.

vi. **Learning and feedback from incidents reported**
Most incidents of violence are rated as low harm and so are responded to clinically, but not routinely investigated. As such, trust-wide themes are difficult to obtain, although it is anticipated that the implementation of the successor system to Datix will support with improving this position. However, even in the absence of this data, significant learning and improvement opportunities are available on a more local basis, also serving to retain the involvement of those affected. Specifically, teams can sensitise to the factors that instigate violence, and opportunities to mitigate these collectively.

vii. **Strengthen quality and consistency of debriefing and response where violence or aggression have arisen;**
Although it is considered that there is reasonable discipline around post-incident debriefing, the quality of these debriefs is not understood. This process has recently been refined and strengthened to ensure it is responsive, supportive and thorough. These debriefs are critical, and independence can sometimes add considerable value. The revised process should be implemented and the opportunity of a debrief with the Trust Security Manager, as an impartial party, should be promoted.

viii. **Promote counselling and Trauma Risk Management (TRIM) and Trauma Informed Care for staff affected by violence or aggression**
Although it is understood that counselling is routinely offered to staff affected by physically violent incidents, it is not clear that this offer is regularly taken up, or that the same is true for staff affected by non-physical violence or aggression. This offer should be promoted. Additionally to psychological interventions however, an approach which recognises any such incidents as potential trauma is currently being explored. This would involve ongoing trauma-focused peer support from a trained TRIM practitioner.

ix. **Re-launch of the Safewards model**
Safewards is an approach to making environments safer by tackling route causes of conflict and containment. Although it requires strength and consistency of leadership, it is proven to deliver a reduction in conflict, violence and aggression on wards. A re-launch of the Safewards model is planned for later this year.

5. Conclusion

5.1 KMPT has an ongoing commitment to provide safe working environments for its staff, and it is recognised that a significant number of the workforce face violence and aggression in the course of their duties. Much work has been undertaken to manage and mitigate such incidents, and many of these efforts have, in isolation, seen very positive results. Over the course of the next twelve months, the reduction of violence and aggression, and support to staff who do experience such incidents, should receive particular attention. This must include a focus on the racial disparity in terms of staff who experience such incidents. Different strands of work in train should be consolidated in order to maximise their impact, and a holistic approach should be maintained. It is envisaged that the Safer Services Strategy, which will be introduced later this year, will be the ideal means of doing this.

5.2 With this approach, it is anticipated that over the coming 12 months, the experiences of staff after having been subject to violence or aggression will improve, levels of confidence in reporting all types of violence and aggression will increase, and as a result of greater transparency of these incidents, KMPT will gain an enhanced understanding of the factors which contribute to them and how to mitigate against them.

5.3 Ultimately, with this continued focus and approach, it is hoped that KMPT will become a safer place both for our staff to work, and for our patients and service users to be treated.

TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting: 26 January 2023

Title of Paper: Freedom to Speak Up Report – First six months

Author: Lincoln Murray, the Guardian Service

Executive Director: Sandra Goatley, Chief People Officer

Purpose of Paper

Purpose: Discussion

Submission to Board: Regulatory Requirement

Overview of Paper

A paper formally updating the Board on the new independent Guardian Service.

Issues to bring to the Board's attention

In summer 2022, the Trust's Freedom to Speak Up (FTSU) service moved from being internally provided to an externally provided company. This allows the FTSU to be resourced by way of a more robust model. Since June 2022, 65 cases were opened, with 27 of those cases remaining open at the time of this report.

The Trust has seen an improvement in the reporting it has received, with there being confidence in the data provided and recommendations received. These recommendations relate to:

- Investigations and Formal Processes,
- Management Issues,
- Neurodiversity Awareness, and
- The Guardian Service toolkits and National Guardian Office toolkits.

The Trust is reviewing those recommendations, with the Trust's HR Business Partners working with colleagues to address those issues that remain outstanding. Lessons learned from the issues raised is shared across the Trust.

Governance

Implications/Impact: Trust Strategy: Growing our capability to deliver

Assurance: Reasonable

Oversight: Oversight by Trust Board

Version Control: 01

Biannual Report
6 June 2022 to 30 November 2022

Circulation:

Executive Lead: Sandra Goatley
Chief People Officer

Prepared by: Rebecca Crosbie
Freedom to Speak Up Guardian

The Guardian Service Ltd.

December 2022

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1. Executive summary

Background to Freedom to Speak Up

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

The Guardian Service

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

This report details the progress of The Guardian Service (GSL) within Kent and Medway NHS and Social Care Partnership Trust (KMPT) during the period of 6th June to 30th November 2022. This period is the first 6 months of the service going live within the trust. Prior to that an internal guardian was in post and therefore this report shall contain no comparable data outside of 6th June to 30th November.

This report will provide an overview of the types of matters raised by staff to The Guardian Service and an analysis any issues which arose as a result of this. In total, 65 cases have been raised via The Guardian Service during this period. These cases are recorded by GSL against specific themes which are Management Issue, System & Process, Bullying & Harassment, Discrimination & Inequality, Behaviour & Relationship, Worker Safety and Patient Safety/Quality of Care.
This report should be presented biannually at a Board meeting by the Freedom to Speak Up Guardian. This is recommended by the National Guardian Office (NGO) to ensure the independence of the employee voice to the Trust's decision makers.

2. Purpose of the paper

The purpose of this paper is to provide an activity report with further insight and narrative around the concerns raised throughout the year, supplementary to the monthly numerical reports provided to the Trust.

The report also sets out key themes and makes recommendations for the Trust to consider.

3. Number of concerns raised

During the period of 6th June 2022 to 30th November 2022 there were 65 Freedom to Speak Up (FTSU) matters raised via The Guardian Service. At the end of this period 27 of these cases remained open under proactive weekly or fortnightly review and 38 had been closed. September and October saw an increase in FTSU matters being raised. This could have been down to increased promotional visits and communications around FTSU month.

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

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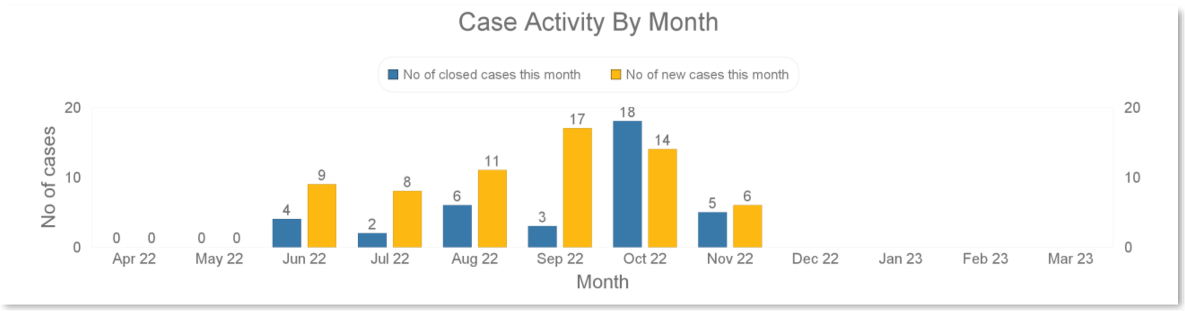

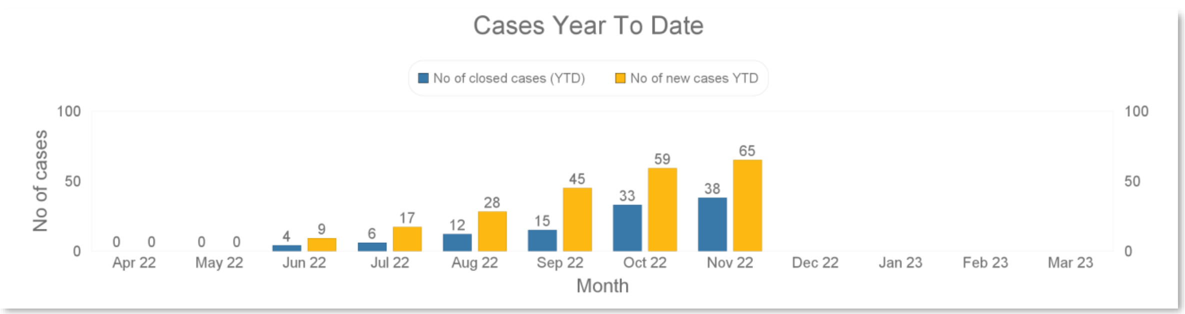

4. Confidentiality

Around half of individuals raising FTSU matters have done so giving permission to escalate with full disclosure *(49%)*. With a total of *75%* of cases being escalated into the trust either anonymously or with full disclosure. For those cases which have remained within the remit of The Guardian Service some have used the service for information and emotional support, some have explored fears and barriers with the Guardian and then escalated independently internally and others have reflected and decided they don't need to take matters further.

Confidentiality	No. of concerns	Percentage
Keep it confidential within Guardian Service remit	16	24.62%
Permission to escalate with names	32	49.23%
Permission to escalate anonymously	17	26.15%
Total	**65**	**100%**

5. Themes

Concerns raised are broken down into the following categories.

Theme	Total
A Patient and Service User Safety / Quality	7
B Management Issue	12
C System Process	21
D Bullying and Harassment	3
E Discrimination / Inequality	4
F Behavioural / Relationship	5
G Other (Describe)	1 (COVID)
H Worker Safety	12

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Grand Total	65

6. Trends in Cases

As this is the first period for The Guardian Service to be live within KMPT and so there is no comparable data from previous years.

7. Assessment of Themes

7.1. Management Issues

12 FTSU cases were categorised as Management Issues. Matters raised under this theme relate to staff perceptions on managerial practice, communication, or behaviour. 9 of these related to experiences of incivility and a management style which was perceived as aggressive or targeting the individual. There were also cases where individuals felt a lack of presence or support from management including examples of where individuals had tried to address their concerns with their manager internally but didn't feel listened to.

Communication from management has also been raised where individuals feel that matters relating to their role, ability to operate or changes have not been communicated to them or that the manager has a poor communication style. 5 of these cases confidentially remained within the remit of the Guardian Service through fear of reprisal or detriment. In all of these cases the Guardian explored these fears and barriers with the individual and the options they have to address the matter. 5 of these cases were escalated with full disclosure but in some cases a disclosure only to a more senior member of the trust and not their manager through fear of detriment. 2 cases were escalated anonymously.

Due to individuals sharing their fears of detriment the Guardian has been working with individuals and within briefings to emphasise that the trust has a zero-tolerance approach to this and cases of detriment would be taken seriously. Following reassurances some concerns have then been escalated at a later date and staff have shared that they feel supported knowing that the Guardian will be there for the duration of the journey of raising a concern until the case is closed.

Escalated cases were handled by the appropriate person within the trust and those which have been resolved were done so using discussions within supervision, one to one meetings and reflective conversations. Open cases remain under proactive review to resolve.

7.2. Patient Safety/Quality of Care

All staff who contact GSL are advised that patient and staff safety concerns with an immediate risk of harm are escalated immediately, with assurance being given to staff of their anonymity should they wish to remain anonymous.

7 FTSU cases were categorised as Patient Safety/Quality of Care. 2 of these related to staffing levels on the wards impacting delivery of care and 2 relating to clinical presence/process and availability of doctors within a service. 1 related to patient against patient violence. 1 related to staff treatment of patients due to a perceived training need around the understanding of the mental capacity act and deprivation of liberties. 1 related to access to space to see patients impacting the ability to deliver care effectively.

All cases were escalated to the trust and responded to within the agreed RAG protocol timeframe. In cases where staffing levels were questioned and there was deemed immediate risk measures were taken to ensure safe staffing levels and support to staff. In one case a positive open dialogue was created with the trust where an individual's experiences of the wards could be shared, and consideration taken to review

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some operational practice and implement support strategies. An establishment review was also shared with staff in order to communicate an awareness of the decisions made in regard to safe staffing levels.

The cases relating to clinical presence/practice were explored and addressed quickly with policy reinforced, improvements were seen by the individuals who raised the concerns. In one case and during site visits some staff were experiencing significant difficulty and pressures due to staffing levels, including impact to care delivery but felt supported by their managers and that nothing could be done as this was an NHS wide issue. It was emphasised by management that despite recruitment difficulties being widespread that staff should still be raising situations where low staffing is impacting quality of care, so the trust have an awareness of where teams are having difficulty. In some instances, there was a fear of raising concerns about staffing level situations as individuals did not want it to impact their managers who they felt were under additional pressures already.

Service managers have been responsive and open to developing lines of communication with any teams who are facing ongoing challenging situations with patients or staffing levels.

It is important to highlight that The Francis Report revealed that overall patient outcome was diminished as a result of cultures and practices which the themes other than Patient Safety can provide an insight into.

7.3. Behaviour/Relationship

FTSU cases about workplace behaviours and relationship issues amongst staff, their colleagues and/or their managers are addressed by this theme. 5 matters were reported during the period and were raised within the context of:

<u>Managers Behaviours</u>

-Incivility and Rudeness

-Treating different staff differently/favouritism

-Communication Styles or Use of Negative Language

-Unprofessional behaviour/conduct

<u>Colleagues Behaviours</u>

- Communication Styles or Use of Negative Language

-Deliberately impeding someone's ability to operate

-Professional standards and conduct

-Poor team culture

-Incivility

4 of these were escalated into the trust, 3 anonymously and 1 with full disclosure. 2 of the cases escalated remain open at the time of writing the report with ongoing internal informal investigations and emotional support being offered to the individuals from the Guardian. 1 remained within the remit of The Guardian Service with the individual receiving emotional support and information to help them to decide how to proceed internally themselves. The Guardian will offer a facilitated meeting where appropriate and try to support an informal process prior to engaging a formal one. Currently all cases have been managed via informal routes.

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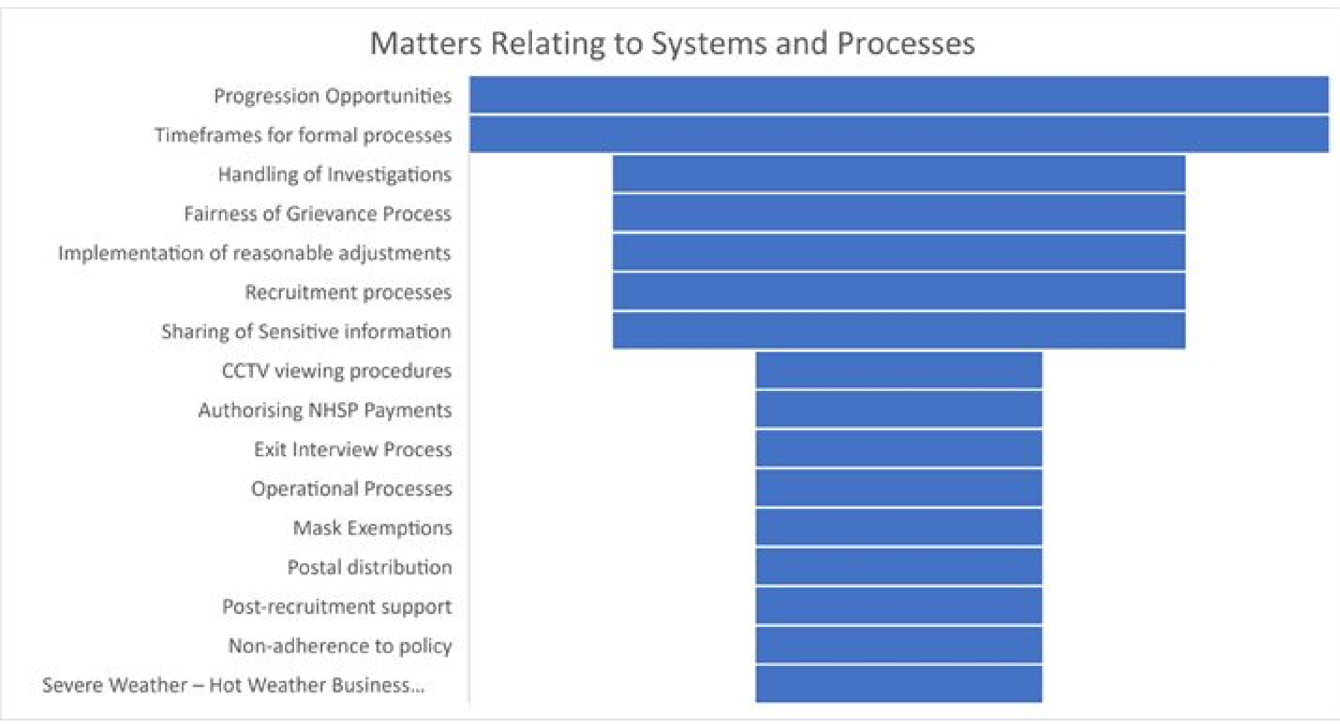
7.4. System/Process

System and Processes is the leading theme for FTSU matters raised with The Guardian Service year to date. This theme looks at staff feedback on their experience with the organisations systems as well as queries and concerns that relate to internal policies and procedures. From this theme there were 21 FTSU matters raised.

Of the 21 cases 17 were escalated to the appropriate person within the trust, 5 anonymously and 12 with full disclosure. 4 remained within GSL remit receiving emotional support and information. 11 cases closed and 10 remain open at the time of writing this report.

Matters reported for this theme related to:



Individuals in different roles felt that there was a lack of progression opportunity available for them and that discussions within supervisions and appraisals either weren't meaningful or were not followed up on. All of these cases remain open, and discussions are taking place internally on how to support the individuals.

When an individual is part of a formal process the Guardian does not get involved in the process itself. The Guardian can offer emotional support throughout or share feedback with the trust on individuals' experiences of the process. 5 cases shared their feedback on processes such as grievances, dignity at work complaints or formal investigations. In all cases individuals felt that there were no clear timelines and processes took longer than expected leading to additional negative impact on psychological wellbeing. Individuals also felt that communication was limited and that they were often left waiting for updates or correspondence for weeks or in one case months. Individuals also expressed a lack of pastoral support and felt the management of investigations was not robust or in some cases biased. Overall individuals felt those investigating was not experienced enough to do so.

The trust has shared considerations for a mechanism which would have a dedicated team to handle investigations within the trust which would mitigate some of the concerns raised about timeframes and

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overall handling of investigations. Discussions with Employee Relations suggested a review of some policies and the expectation of timeframes within them, but this is yet to be taken further.

In response to a FTSU matter raised about accidental sharing of personal information a system was reviewed and changed and in response to questions over appropriate viewing of CCTV an audit was put in place to monitor.

The Guardian Service was also used to support staff to understand policy relating to recruitment, mask wearing exemptions and implementation of reasonable adjustments. One concern was raised in relation to the adverse hot weather conditions and the Trust responded sharing a consideration to add hot weather within the business continuity plan for future occurrences.

7.5. Bullying & Harassment

For the theme of Bullying & Harassment 3 cases were raised during this period. In one case the individual had submitted their resignation and engaged a formal process as a result. Due to them leaving the trust they did not pursue further with the Guardian but did share feedback on the ongoing process which was shared with the trust.

The 2 remaining cases open at the time of writing the report and are both subject to an informal process including either mediation or facilitated discussions to explore the allegations and rebuild relationships.

It is worth noting that when discussions are raised around the terms Bullying & Harassment the guardian will always support an individual to identify if indeed, if they feel they are being bullied or if it may be a management style or form of incivility that is being experienced and may fall under a different theme such as ‘Management Issue’ or ‘Behaviour/Relationship’.

7.6. Discrimination/ Inequality

For the theme of Discrimination and inequality 4 cases were raised during this period. These cases looked at reports of ageism, racism, neurodiversity awareness and disability discrimination during recruitment. 2 of the four cases were escalated and both received a written or verbal response from the trust.

In the case of racism communications were created for a group of teams to raise awareness and understanding of racist behaviour, the implications of such behaviours and reinforced the trusts zero tolerance approach. In the case raising concerns around ageism an open discussion with the trust was able to take place and a process implemented with support of the Diversity and Inclusion Team.

Two cases were not escalated but the individuals were able to receive information and options relating to policy and legislation. One then chose not to take the matter further and one was able to proceed internally and resolve the matter themself whilst receiving emotional support from the Guardian.

7.7. Worker Safety

Worker Safety was in the top three themes for FTSU matters being raised with The Guardian Service. Under the theme of Worker Safety there were 12 cases for this period. Dependent on immediate risk these cases are rated as Red or Amber. Of the 12 cases 5 were recorded as Red and 7 Amber. All cases were responded to within the agreed initial RAG protocol timeframe. In any cases where there was an immediate risk to staff this was addressed, and measures put in place to mitigate any further risk.

5 of these cases related to a group of concerns that came in from one staffing team. This group of concerns related to a sudden change of office space (less than 7 days’ notice) without consultation or communication with the staff involved. The team felt that the new space would put them at high risk of

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potentially volatile behaviour from patients and that the room itself having no ventilation, windows, access to necessary facilities (toilet/kitchen) and only one exit. A consideration is consultation around change would be appropriate to mitigate the stress and anxiety; and staff not feeling valued as was the experience of staff in this situation.

2 of these concerns related to potential work-related injury and harm to health due to maintenance of equipment. As a result of raising the concern a piece of equipment was deemed not safe for use and further usage stopped, a full review of health and safety in this area is now taking place in consultation with the individuals who raised the concern.

1 case was raised where due to a repair not being carried out within a reasonable timeframe access could not be gained to an area to support staff during an incident which resulted in unnecessary staff injury. Raising the concern with The Guardian Service led to an escalation of the repair taking place, a review of the escalation of maintenance issues, pastoral support for those involved in the incident and additional staff put in place to support until the works could be carried out.

4 cases were raised in relation to increasing violent behaviour from patients towards staff. All of these cases were raised from Acute wards. Staff shared feedback that they felt the last two years had seen a sharp increase in the needs of the patients and with that came more violent behaviour against staff. In all cases individuals were fearful of how they would be perceived for raising the concerns and in some cases didn't feel they could be escalated. Close communication has taken place with the Service Manager to ensure staff feel comfortable sharing their experiences and that the Service Manager has an awareness of any challenges staff are facing or any additional support that staff may need.

Only 1 of these cases remains open pending further investigations, a second would have remained open but the individual has since left the trust, despite this the trust is still reviewing their concern.

7.8. Other

Under the theme of other the main choices are Fraud or COVID. 1 case was raised under this theme and it related to policies relating to COVID. As a result of this concern clarification and understanding of policy was provided to the individual and communication with the trust which considered an update on policy in relation to mandatory mask wearing and infection prevention control in relation to COVID.

8. Statistical Graphs

8.1. Concerns raised by Directorate

Acute Care Group	13
Community Recovery Care Group	13
Corporate/Support Services	9
Forensic Care Group	16
Older Adult Care Group	9
Not Disclosed	5
Total	**65**

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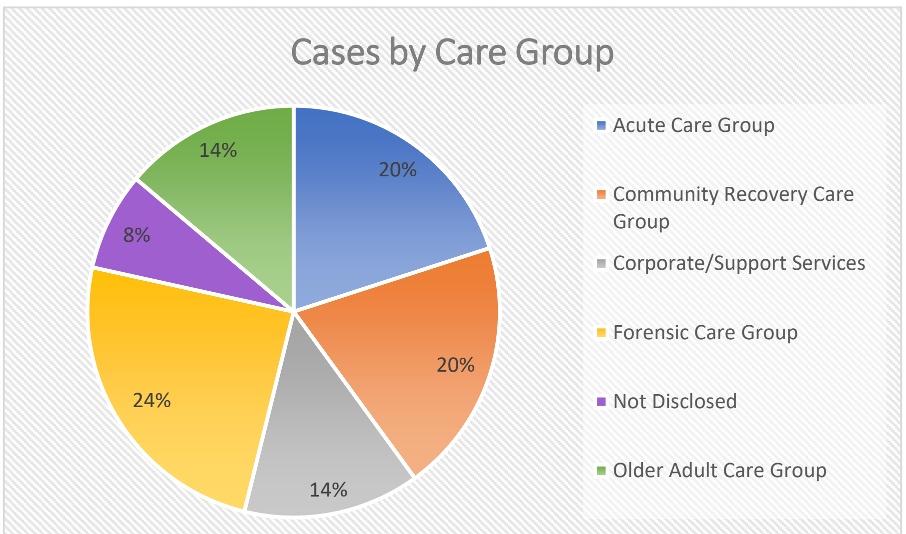

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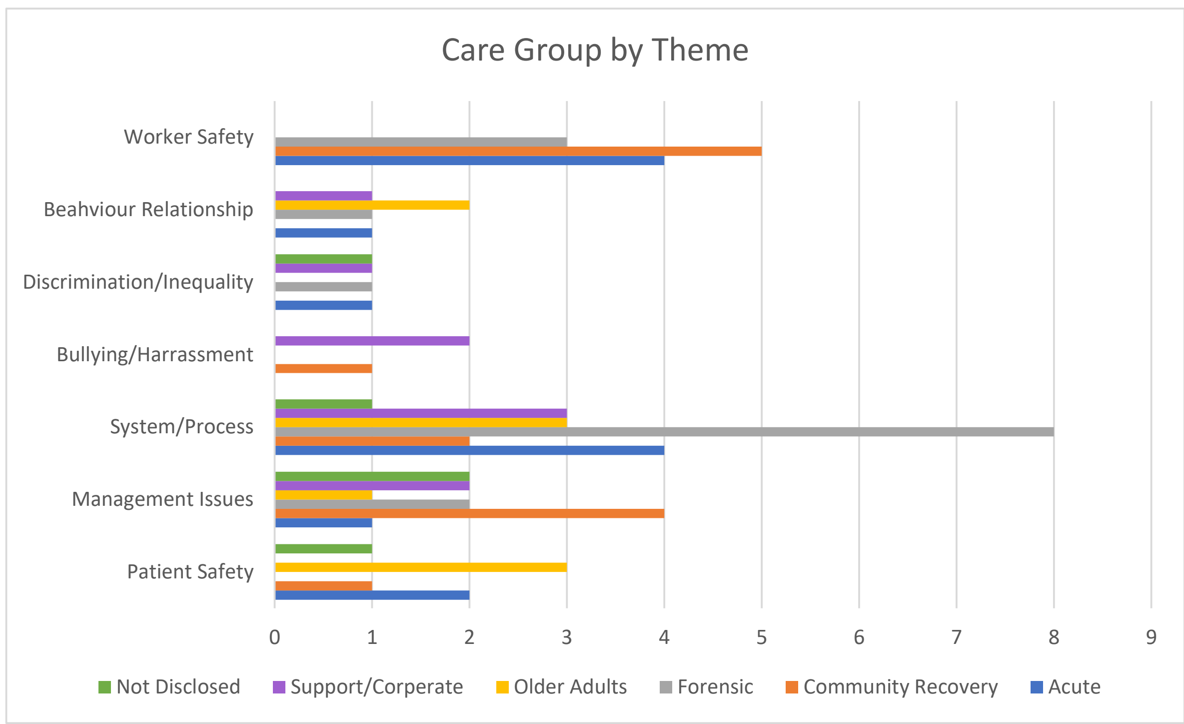
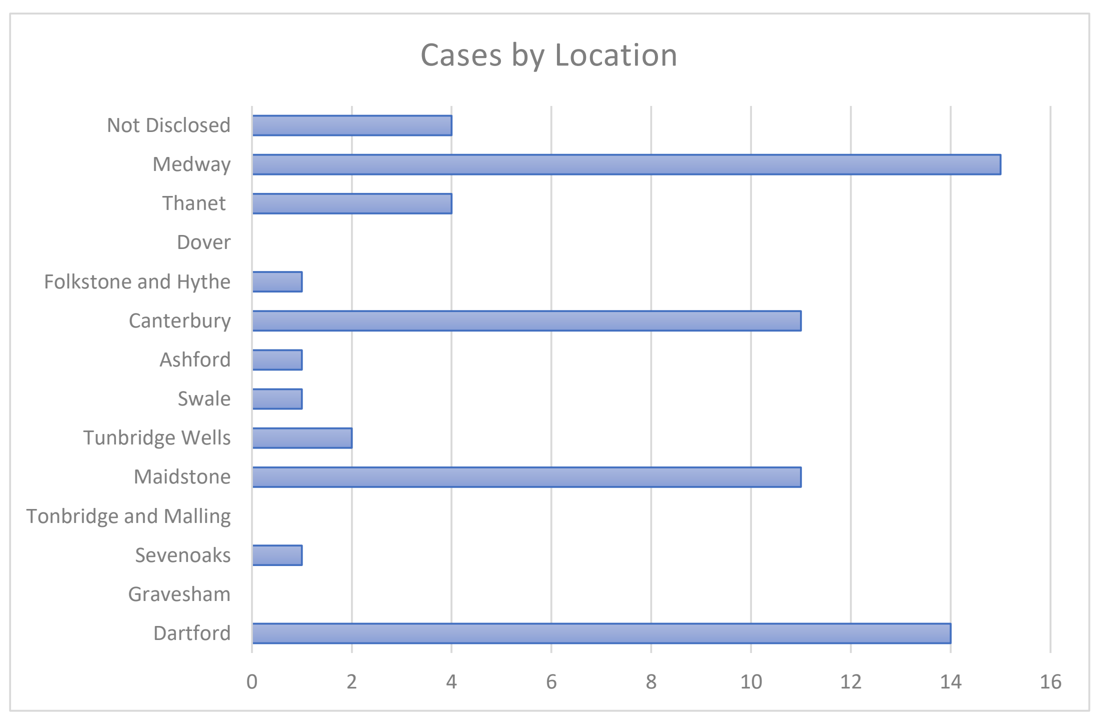


8.2. Concerns raised by Location



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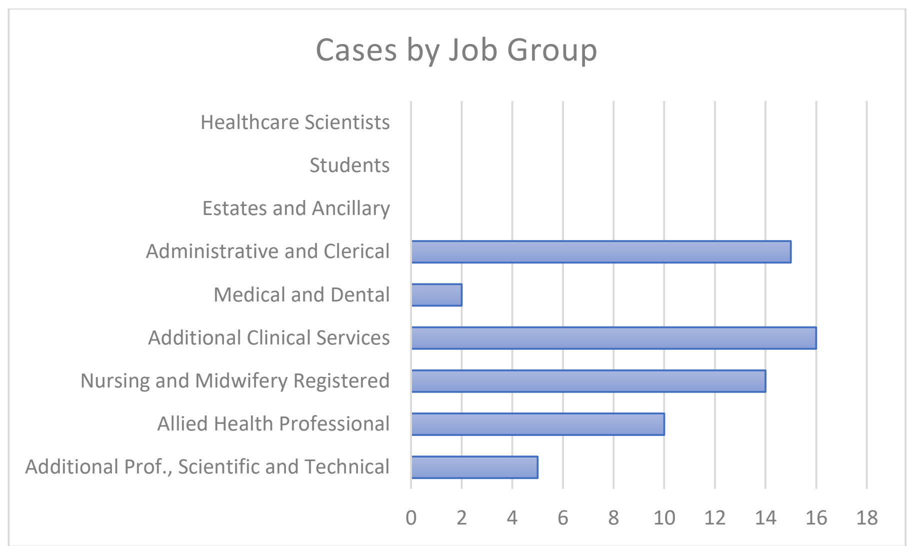
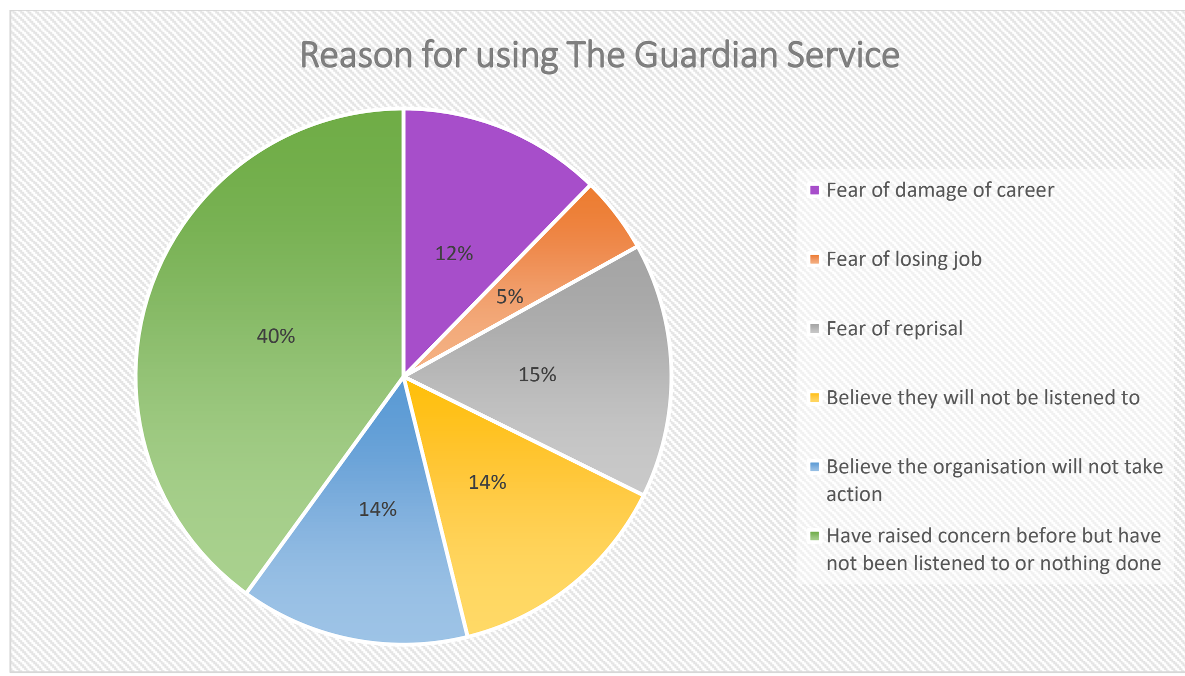
8.3. Concerns raised by Job Group

Cases have been raised by a range of professionals of different levels across different job groups with ***Additional Clinical Services, Nursing & Midwifery and Administrative and Clerical*** being the most prevalent.



9. Why do staff use The Guardian Service?

The most common reason (40%) for employees to use The Guardian Service was because they felt they had raised the matter internally previously but felt that they have not been listened to of that nothing had been done in response. Additionally, 28% believed that they would not be listened to (14%) or that the organisation would not take action (14%).



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10. Detriment

Year to date one individual has shared that they feel they have suffered a detriment as a result of speaking up. This individual left the organisation as they felt they had no other option and didn't feel that matters could be resolved. Following this they met with one of the Executive Management Team for an exit interview and their concerns are being explored in detail by the trust.

11. Action taken to improve the Freedom to Speak Up culture

Implementation of The Guardian Service within KMPT has offered a confidential and anonymous route for employees to Speak Up. This was in response to the staff survey in 2021 where staff shared, they didn't always feel psychologically safe when raising concerns internally. Since the service went live the Guardian has been increasing visibility across the trust to raise awareness of how to raise concerns and the importance of speaking up.

Visits and Briefings

The Guardian carries out a mix of Promotional Site Visits, Briefings and Communication Meetings within the trust. Promotional site visits raise awareness of the service, offer engagement with staff within the workplace and share information on positive speaking up culture. These also offer insight into the working environment and any challenges that employees may be facing. Briefings are carried out at both managers and corporate inductions and within team meetings so that staff have an awareness of how to raise concerns and the importance of speaking up. Communications meetings are held with key people within the trust to ensure collaborative working and sharing of themes, this would include but is not limited to the Executive Lead, CEO and NED for FTSU.

During this period the following visits and briefings have taken place:

Promo	30
Comms	16
Briefing	45
Total	**91**

Contacts

When handling cases the Guardian may have many contacts with individuals to support resolving any FTSU matters raised. These may include face to face, telephone or email contacts. Where possible the Guardian will always offer a face-to-face meeting initially but there is often a preference for a phone call.

During this period the following number of contacts were made in relation to the 65 FTSU matters raised with the service:

Email	487
Telephone	270
Face to Face	48
Total	**805**

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- The Guardians listen and support staff to enable them to raise their own concerns. Exploring ideas and options for using existing tools, such as facilitated meetings, peer facilitation, formulating e-mails to managers, verbal communication and preparation for staff attending facilitated or one to one meeting. All of which can help an individual bring about a resolution, without instigating formal grievance procedures.

- Monthly meetings with the Chief People Officer to talk through the monthly activity reports which includes themes and outcome of cases. No individual can be identified by the discussion of themes therefore maintaining staff confidentiality where requested.

- Quarterly meetings held with CEO and NED for FTSU to discuss emerging themes and learning points.

- Quarterly one to one meetings are held with HR Business Partners to support understanding of any themes or data regarding each care group.

- The Guardians assist managers in identifying issues within a specific team by offering a one-to-one session with each staff member so that they could confidentially and anonymously raise their concerns. The Guardian Service produces a summary of themes and observations for management so that issues can be targeted and resolved.

- All corporate and managers inductions include The Guardian Service.

- Biannual reports to be presented to the board to share data and themes on Speaking Up.

- The trust has implemented NHSE Freedom to Speak Up training as mandatory to all staff within the trust.

- The trust is currently implementing the new national standard Freedom to Speak Up policy within the trust to offer more accessible language on speaking up and the procedures for doing so.

- A communications plan was implemented with information relating to The Guardian Service being on all trust computer screen savers, intranet, Vlog and posters/flyers distributed across all sites.

- A new role profile for Freedom to Speak Up Champions has been created in line with NGO guidance and a recruitment drive to develop a network of champions to support development of a positive speaking up culture is in place.

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

12. Obstacles to Speaking Up

32% of individuals who have raised FTSU matters with The Guardian Service have done so through fear of suffering a detriment, including fear of damage to career, loss of job or reprisal. When speaking with those who contact the service a common statement to hear is ‘I don’t want to get in trouble’ or ‘I don’t

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want to be seen as a problem'. There is still a stigma around Speaking Up and how Speaking Up is perceived within the organisation.

40% of individuals raising FTSU matters say they have done so as they have raised things internally but feel they have not been listened to or action has not been taken. Individuals will speak up less if they feel that themselves or colleagues have not been heard in the past. Sharing of positive experiences and case studies of speaking up can help this.

Despite acknowledgement of concerns meeting the agreed RAG protocol timeframe the follow up and actions to resolve has in some cases taken longer than what would be supporting of early resolution. Any cases that are taking longer to resolve are discussed in the monthly meeting with the Executive Lead for FTSU and if needed re-escalated into the Executive Management Team. Individual experiences of speaking up can impact the overall speaking up experience within the organisation. Considerations around the expectation for addressing concerns and the timeframes for doing so has been discussed with the Executive Lead and the Guardian will work with the organisation to develop and communicate an expectation around this to support early resolution.

13. Learning and Development

The Guardian routinely meets every week with other FTSU Guardians from across England, Scotland, and Wales. This contributes to continued learning of how to best address complex concerns and aids the sharing of best practice. It also represents an opportunity for Trusts to compare policy/procedure with other trusts to help to identify and share best practice.

FTSU Guardians attend the meetings and events organized by the National Guardian Office (NGO). This, in addition to the NGO Bulletins, enables Guardians to keep up to date with developments in the field which in turn support the effective handling of concerns.

The Guardian Service has clients across a number of NHS Trusts and are therefore in a position to compare and contrast best practice approaches in respect to policy, service implementation and organisational response.

All FTSU Guardians have minimum of two sessions per annum with a Psychotherapist and can have additional sessions when/if required.

All FTSU Guardians are trained Mental Health First Aiders, thereby providing an enhanced service to members of staff contacting the Service.

All FTSU Guardians are provided with resilience training.

14. Comments & Recommendations

- Investigations and Formal Processes - Within the cases for this period there was number of individuals who shared poor experiences whilst undergoing a formal process or investigation. This feedback related to timeframes being longer than expected, a lack of communication from the trust during this period and/or the investigation itself not being to an expected standard. The trust has shared considerations for a team to be in place dedicated to carrying out investigations and it would be a recommendation that this is followed up and implemented to mitigate further experiences similar to those of which feedback has been received via The Guardian Service.

- Management Issues – One of the leading themes for matters being raised with The Guardian Service it is important to reflect on the widespread impact this theme alongside incivility can have on employee engagement, employee motivation and staff retention. Leaders at every level need to role-model the speaking up principles but also have the tools to deliver effective

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leadership skills and communication that aligns with the trust's values. Mid-level managers may benefit from additional support in leadership and communication skills. Training could include listening, emotional intelligence, improving empathy, self-awareness, as well as skills to ensure supervisions and appraisals are meaningful for staff.

- Neurodiversity Awareness – There have been 5 cases where neurodiversity has been an element of matters raised. In all cases there was feedback given that described a lack of awareness from managers on how to support an individual or that the support needed was minimised or not implemented. The Guardian has been working closely with the Diversity and Inclusion Manager to ensure all individuals receive necessary support and to identify any support managers may need. The trust had previously started a workstream to look at creating a project group to develop best practice for supporting neurodivergent colleagues and training for managers supporting those colleagues. It is my recommendation that considerations be taken to look at how to develop and implement this to support both individuals and managers. Autism Spectrum Condition, Attention Deficit Hyperactivity Disorder and Dyslexia were included in the theme of these 5 concerns so it would be important to ensure the training covers all conditions which fall under the term Neurodiversity and not just that of Autism Spectrum Conditions.

- The Guardian Service toolkits and NGO toolkits – The Guardian Service and the NGO have developed respective toolkits (Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS services toolkit and The Power of Speaking Up) to support executive teams of NHS trusts to examine their practice and foster open cultures and behaviours that are responsive to feedback from workers. It is expected that the executive lead for Freedom to Speak Up (FTSU) will use the guidance available from the toolkits and NGO self-review tool to help the board reflect on its current position and the improvement needed to meet the expectations of NHS England and NHS Improvement and the National Guardian's Office.

15. Staff Feedback

'You really are supportive, I remember the first time I spoke to you, very valuable support and direction was given from day one. Thank you
In these senior roles it really can get difficult to talk and seek help, but you made this process so easy and a positive one'

'The Guardian was kind and caring'

'The response has been very quick and effective, thank you'

'I feel relieved to have someone to speak to and felt much better after speaking with The Guardian'

'I didn't feel this could be resolved as we had been trying internally for over 6 months but within 48 hours there was a plan in place so thank you'

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

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Appendix

- Agreed Escalation Timescales

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

Agreed Escalation Timescales		
Red	Includes patient and staff safety, safeguarding, danger to an individual including self-harm.	Response required within 12 hours
Amber	Includes bullying, harassment, and staff safety.	Response required within 48 hours
Green	General grievances e.g. a change in work conditions.	Response required within 72 hours

RAG timings relate to:

- The speed with which an issue is escalated to the appropriate person
- The Guardian reports back to a contact that it has been raised
- The individual receives confirmation that the issue is being dealt with
- RAG timings do not relate to resolution timing

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

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

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TRUST BOARD MEETING – PUBLIC

Meeting details

Date of Meeting:	26th January 2023
Title of Paper:	Safer Staffing Update
Author:	Teresa Barker: Interim Deputy Director of Nursing and Practice
Executive Director:	Andy Cruickshank: Chief Nurse

Purpose of Paper

Purpose:	Noting
Submission to Board:	Board requested

Overview of Paper

This is a further update on the progress made to address safe staffing since the Mental Health Optimal Staffing Tool (MHOST) Review from May 2022.

Issues to bring to the Board's attention

- The staffing fill rates in November 2022 were mostly within the range of 80%-130%, with the exception of unregistered staff on night shift at 133.98%
- The work completed to seek feedback on a review of shift patterns has culminated in a planned consultation to commence in February 2023.
- The roster check and challenge meetings are now established in the care groups, working to a consistent term of reference and demonstrating positive measurable outcomes
- The temporary staffing meetings with NHSp are resulting in positive improvements to fill rates and quality
- The QI project established to support practice improvements in therapeutic observations is ongoing but has shown a consistent reduction in 1:1 observations since October 22 in the Acute Care Group.

Governance

Implications/Impact:	Vacancies, roster management, shift patterns, therapeutic observations practice and associated QI projects impact on quality and safety, and financial viability.
Assurance:	Reasonable
Oversight:	Workforce and OD Committee

Version Control: 01

Introduction

The Board was presented with a full MHOST enabled establishment review in May 2021. The review fully considered a multi professional establishment to inpatient care settings across all care groups. The Board was updated on next steps in May 2022. This paper is a summary to appraise the Board on the current safe staffing fill rate, plus an update on four key workstreams linked to this agenda

- Shift Pattern review
- Roster check and challenge
- Temporary staffing management
- Therapeutic observations QI project

1. Staffing fill rates

Trust wide, safe staffing fill rates were as follows, most recently in November 2022. Previous months of July to October 2022 are shown as a comparison. Where RN availability is low, as evidenced by the data, wards are booking additional HCAs to enable safer staffing. Further work is required to pull the whole Multi-disciplinary team into the establishment, to include Allied Health, Psychology and Medical staffing.

Month	RNs Daytime %	HCAs Daytime %	RNs Night time %	HCAs Night time %	Overall %
July 2022	78.65	105.27	90.55	133.81	102.07
August 2022	76.25	109.13	89.78	137.56	101.57
September 2022	80.68	107.89	93.05	134.62	104.06
October 2022	83.14	101.58	92.47	133.20	102.59
November 2022	84.43	102.14	89.83	133.98	102.59

2. Shift Pattern Review

As reported in July 2022, a shift pattern review project was commissioned, led by the substantive Deputy Director of Nursing & Practice, and supported by the Transformation Team with all care groups represented. Focus Groups, a staff survey, shared email inbox for responses and the development of an iConnect page were all mobilised in order to take feedback from staff on their views and ideas related to shift patterns. The data gathered from these feedback mechanisms indicates that overall, staff were receptive to shorter long day shifts and a consistent shift pattern trust wide, however they were keen to ensure that flexible working opportunities would still be available to support those with responsibilities outside of the workplace, including in caring roles.

As a result, a paper was taken to the Joint Negotiation Forum (JNF) in December 2022. The Forum agreed that staff consultation will commence in February 2023 with a proposal to move towards consistent long day shift patterns (7am-7:30pm and 7pm-7:30am) with a one-hour break. This is the equivalent of 13 shifts per WTE per month, improving the work-life balance for staff as well as meeting the needs of the service. Long days will reduce to 12.5 hours, with potential for improving safety by reducing burnout and presenteeism. By removing shift overlap across services there will be financial efficiencies up to a value of circa £2m.

3. Roster Check and Challenge

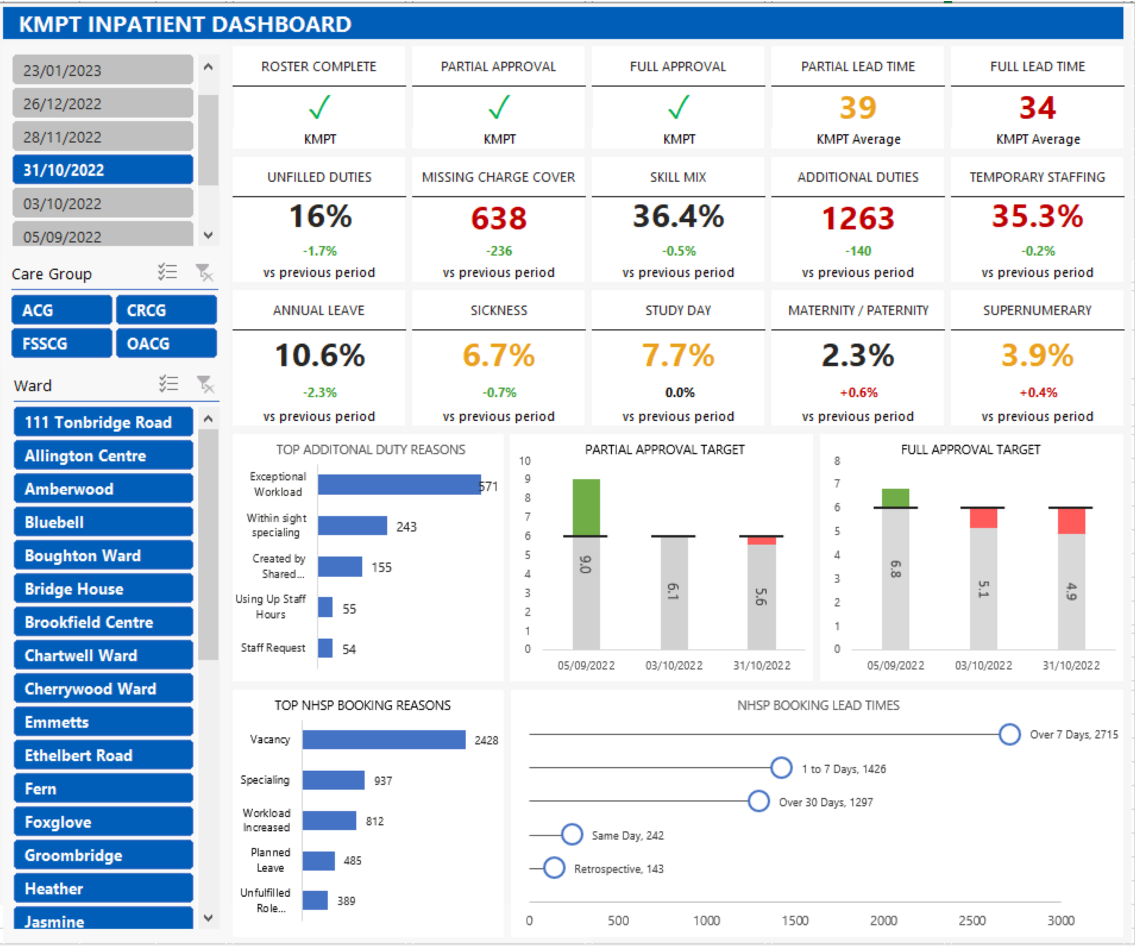
The roster concerns highlighted by the MHOST review are being addressed by care groups in routine Roster Check and Challenge (RCC) meetings. Terms of reference and a clear and consistent structure for these meetings was agreed with care group Heads of Nursing, who chair the meetings with each ward team, supported by Human Resources and Finance Business Partners, and the eRoster team. Meetings are held monthly.

Significant improvements are noted in the roster efficiencies related to working patterns, working restrictions, adjusted permissions for charge cover and the management of A/L thresholds. Improvements have been made regarding skill mixing and the removal of ancillary and admin staff onto the correct roster teams. Ongoing priorities being addressed include the timeliness of Service Managers approving rosters, ensuring that the correct NHSp booking behaviours are being practised, and ensuring that all vacancies are added to the TRAC system in a timely way. Data accuracy has been addressed and the process has supported care group workforce plans and allocation of resourcing.

Overall, the practices that had been observed by the original MHOST exercise (including disproportionate utilisation of supernumerary shifts, rosters being constructed by untrained junior staff, unreviewed flexible working agreements and poor long-term sickness absence management) have been addressed.

The e-Roster Lead for the trust reports that since roster check and challenge started, there has been a considerable drop in shifts that are missing charge cover and additional duties along with a smaller drop in unfilled duties. Since the check and challenge started, the missing charge cover has reduced by 300, additional duties by 500 and unfilled duties by 1.7%. It is recognised that data accuracy has also improved through this process, which will be a contributing factor to the improvements demonstrated in the table below.

NHS
Kent and Medway
NHS and Social Care Partnership Trust



4. Temporary staffing

Regular operational meetings are in situ with NHSp with a number of workstreams surrounding this. Of note from the January 2023 meeting is that the fill rate being achieved across KMPT is higher than national comparators when analysing December 2022 performance. This is contributing to the overall improvement in fill rates in clinical settings. Fill rates are a key indicator that wards are safely staffed – so good behaviours around this to mitigate gaps are essential to achieving this. You can see form the figures below that the struggle to fill Qualified Nursing shifts is reflected in the national picture.

NHSp are working closely with KMPT on a relaunched marketing campaign for 2023 and we have advised some specific geographical areas of focus, including Thanet.

December	National Bank Fill %	KMPT Bank Fill %
All Bank	62.6%	73.0%
A & C	78.2%	95.9%
AHP	46.0%	79.6%
Qualified Nursing	46.7%	53.8%
Unqualified Nursing	76.2%	82.6%
Estates & Facilities	70.1%	100.0%

5. Therapeutic Observation and Engagement Quality Improvement Project

Nationally, it is clear that a radical change in the practice and culture of observation is required. The Therapeutic observation and engagement project was set up to create an effective process to move away from observation to intervention; enabling the reducing restrictive practice agenda nationally, enhances patient safety and wellbeing, and supports recovery.

This project has been set up on 10 forensic, working age and older adult acute with support from the QI and Transformation Team. The QI group has been meeting to discuss the drivers including learning from incidents and need to evolve practise that is then supported by an updated policy guidance to support more creative ways of delivering observations that support the patient's recovery, and make best use of all of the embedded interventions and those in development across the wards. There is good multi-professional representation in the group, with a current focus on interventions and support that can enable effective and therapeutic observation.

Specific to Forensic Wards, the use of zonal observations is being explored and discussions with trusts nationally via the mental health nurse directors forum is live around this matter. The group have been invited and will be attending a national forum with NHSE and CQC in relation to therapeutic observations.

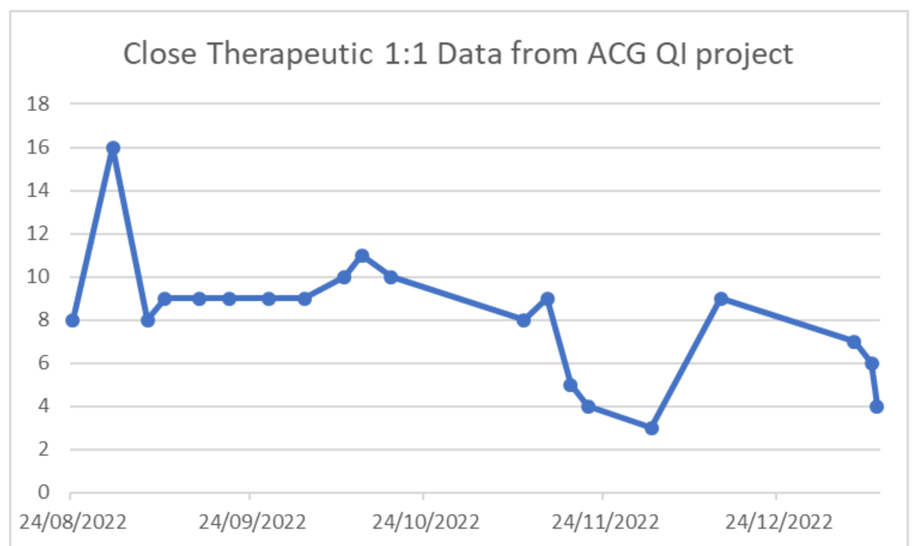
The project is now at the stage of collating change ideas, exploring multiple parameters and obtaining baseline data. Taking learning from Healthcare Improvement Scotland, the Chief Nursing Officer has challenged the group to ensure that the following principles are addressed as front and centre of the project

- Understanding the lived experience of patients and their families and engaging their participation, consent and choice about treatment and care.
- Creating physical environments which are fit for purpose, therapeutic and as far as possible hazardous free.
- Developing a model of care based on emerging evidence about trauma-informed care environments and the treatment of complex mental health issues and behaviours such as personality disorder, self-harm and violence.
- Creating ward systems that value anticipation, early recognition of deterioration and triggers for harm, personalised early response mechanisms and support for all patients.
- Introducing education, training and clinical supervision or action learning for staff to ensure they have the competencies and capabilities to respond to the demands of contemporary, complex, mental health care delivery.

Version Control: 01

- Supporting a relational-based approach to care and treatment in order to foster engagement with patients.
- Embedding a human rights based approach

The trust wide QI project has influenced the acute care group to initiate a care group specific QI project from 24th August 2022, with the objective to reduce the number of therapeutic observations on all acute care group wards. A number of change ideas were actioned and enhanced observations are reducing, as demonstrated in the table below.



The following steps were implemented as part of the change ideas:

1. A senior nurse was assigned to engage in leading clinical discussions with MDT to review the observation levels in a timely manner to maximise the therapeutic benefit and to enhance patient experience.

2. Psychiatric Intensive Care Unit [PICU] liaison staff were engaged in supporting the clinical discussions with Multi-disciplinary teams to develop Positive Behaviour Support Plan, as part of harm reduction strategy.

3. In some areas with high number of observations [Priority House], Increased therapeutic activities were offered in terms of 1:1, groups both on and off ward during evenings and weekends by rostering additional AHP staff.

4. Professionals meetings were convened to discuss and develop care plans that supports therapeutic risk taking.

5. MDT approach to undertake therapeutic observation by nursing and AHP staff members.

6. Staff from all levels were encouraged to discuss the therapeutic value of continuing with the observation during hand overs and safety huddles.

This initiative has started to show some encouraging results as the care group were able to reduce the number of therapeutic observations significantly. On the 7th of November 2022, St Martin Hospital site and Priority House did not have any close therapeutic observations. These change ideas and data will be shared with the Trust Wide QI project group for therapeutic observations.

Findings:
Version Control: 01

1. We were able to reduced 1:1 observation significantly and have evidenced that this is achievable [please refer to the graph & figures] and its sustainability depends on MDT approach that includes therapeutic interventions offered for service users.
2. We have seen a reduction in restrictive practices [restraints/seclusions/RT] which can be interpreted as the ability to have more staff availability to engage with patients and to attend for patient care in a timely manner.

Next Steps:

1. Change the notion from the '*number of observations*' to the '*duration of observations*' .
2. To consider having a dashboard for data input and quick reference
3. Review of clinical policy to restructure approach and choices for clinicians and service users/patients around observations.
4. Expansion of MDT interventions including calming room facilities etc.

Separate to the trust wide QI project, a localised QI project has been in progress since January 2022 on in-patient rehabilitation wards. This project was launched recognising that the observation needs of in-patient rehabilitation clients is different than that on acute or forensic wards and has resulted in consistent two hourly observations of all rehabilitation patients with updated training and documentation for both permanent and temporary staff. The burden of low value observation has been reduced and replaced with meaningful interactions that support a reduction in isolation, better engagement with patients and ongoing assessment of ADLs that enables the continual updating of care plans that support timely recovery.

In order to effectively measure enhanced therapeutic observations against staff fill rate and financial impact, further work is starting to address how this might best be supported through the systems currently available to us. Further results from forensics and rehabilitation services will follow in due course.

6. Conclusion

To conclude, a combination of the roster check and challenge, alongside the focus on temporary staffing and QI initiatives is contributing to improvements across a range of safe staffing metrics. It is recommended that next steps include the pooling of multi-disciplinary teams on one ward roster (including the medical workforce) as well as a system to monitor and calculate enhanced therapeutic observations against staffing fill rates and spend. It is predicted that the proposed two shift system will also support further improvements across all domains of safe staffing metrics.

Title of Meeting	**Board of Directors (Public)**
Meeting Date	**26th January 2023**
Title	**Quality Committee Chair's Report**
Author	**Catherine Walker, Senior Independent Director and Interim Committee Chair**
Presenter	**Catherine Walker, Senior Independent Director and Interim Committee Chair**
Executive Director Sponsor	**N/A**
Purpose	**For Noting**

Matters to be brought to the Board's attention

- The committee were informed of Risk ID 6646 – a concern related to Disablement Services Centre Infrastructure added to the Quality Risk Report in November 2022 and increasing in risk score relating to the building condition. A briefing will be provided to the Trust Board in the near future which will include recommendations regarding the Disablement Services.

- The committee noted improvements outlined in the Quality Digest report regarding communication between inpatient wards, estates services and security issues previously identified when patients were recorded as AWOL. It was noted that the Estates team now have a revised structure of support which is more effective and communication is improving.

- The committee were informed that due to increased workload within the Patient Safety Team and a lack of capacity within trained medics, there have been limited Structured Judgement Reviews completed for this quarter. A plan has been agreed to create two bespoke Structured Judgement Review jobs. An internal advertisement for two doctors to undertake structured judgement reviews as an additional part of their roles.

- The committee were presented with the Suicide Thematic Report which studied serious incidents relating to suspected or confirmed suicide that occurred between 1st April 2018 and 31st March 2022. The purpose of this review was to identify any trends and themes, focusing on patient demographics and contact with KMPT and external services in the eight weeks before a patient's death. A number of themes were identified and recommendations given.

  The Committee discussed the recommendations and agreed on the need for a holistic approach to assessing suicide risks in patients. The full report is available in the Diligent Board reading room for Board members.

Items referred to other Committees (incl. reasons why)

- It was noted that the action of receiving the outcome the Duty of Candour TIAA audit was overdue and the matter was therefore referring to Audit and Risk Committee to enquire as to the progress of this audit.

The Quality Committee was held on 17th January 2023. The following items were discussed and scrutinised as part of the meeting:

1. Quality Impact Assessments
2. Quality Risk Register Report & Review

3. Quality Digest
4. CQC Update Report
5. Strategic Delivery Plan Priorities
6. Quarterly Report from Guardian of Safe Working
7. Care Group Presentation – Liaison Psychiatry - ‘CORE24 Accreditation and Triage Model’
8. Safer Services Strategy Update
9. Mortality Report Q3 2022-23
10. Suicide Thematic Report

The Board is asked to:

1) Note the content of this report.

Mortality Report – Q3 of 2022/23

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 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, Information Governance, physical health, medical input and subject matter experts as necessary.

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

3 ANALYSIS OF INFORMATION

3.1 In Q3, a total of 282 mortality incidents were reported on Datix. The graph (1) below shows the figures relating to mortality that have been reported since October 2021. This includes natural causes, expected and unexpected deaths of patients. Incidents relating to mortality have marginally increased. When data is compared to the Q2 2022/23 Mortality Report, there has been a 2.5% increase in mortality reported incidents (275 reported in Q2 2022/23). The number of Datix Death notifications reported (as part of the data reconciliation work) have again decreased, with a total of 15, compared to 25 in Q2 2022/23.

3.2 The number of COVID–19 deaths has again remained low in Q3, with a total of seven reported. The number of STEIS reported mortality incidents in Q3 was 27. This compares to 23 in Q2 2022/23. STEIS reported mortality incidents have increased for both community recovery and acute services. There has been a noticeable increase in acute STEIS reported deaths, with numbers being their highest within the last year.

3.3 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. As shown in graph 7, the number of mortality in older adult patients is consistently higher than any other service.

3.4 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 Serious Incident 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 or a Root Cause Analysis/Learning Review.

Graph 1 Mortality reported cases

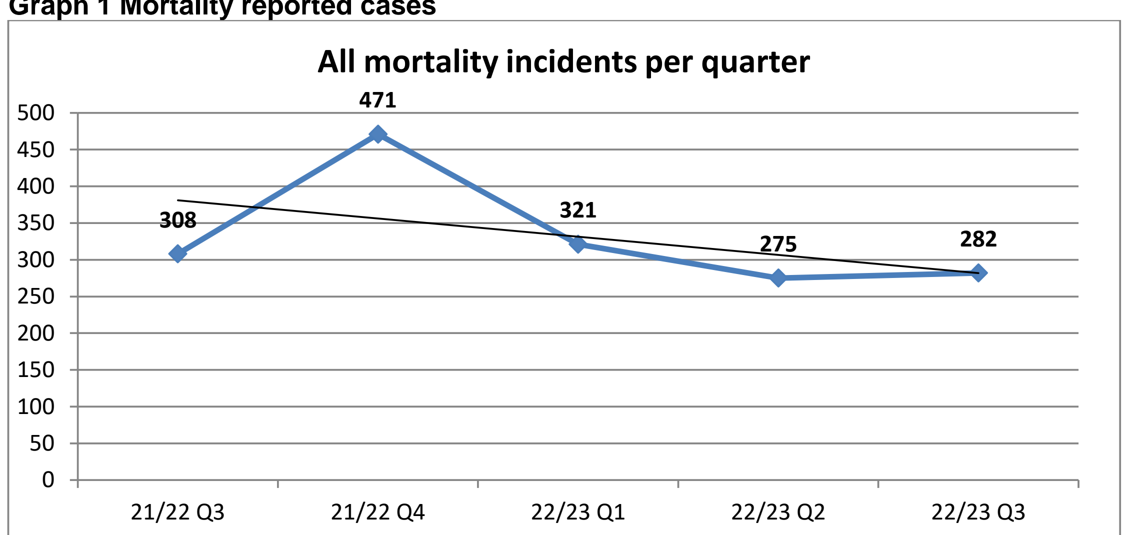


Table 1 Number of mortality incidents and serious incidents relating to suspected or confirmed suicide

	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Total
Suicide (actual)	0	1	3	2	4	0	2	4	2	3	4	4	2	31
All Deaths reported on Datix	120	174	152	144	123	107	91	88	90	97	99	93	90	1468

3.5 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 Q3, 3.5% of deaths of patients are suicide or suspected suicide related. This compares to 3.2% reported in the previous quarter. The average number of deaths for the 13 months above was 113 per month. For this quarter (Q3), there was an average of 94 per month. The numbers are similar to the previous quarter.

3.6 On review of the suspected suicide incidents, over the 13 months, Community Recovery Services are the highest reporters. In Q3 2022/23, the number of suspected suicide incidents has increased, with a total of 10, compared to nine in Q2. When compared to previous quarters, the rates of suicide are higher than historic reporting figures, with numbers previously sitting between five and seven each quarter.

3.7 Of the 10 suspected or confirmed suicide incidents reported in Q3 2022/23, seven patients were under Community Recovery services at the time of their death, and two patients were under Acute services. Suspected/confirmed suicides have increased for Acute services. There were no suspected suicides reported for this care group in Q2 2022/23.

3.8 Analysis by age and gender

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

Age Band	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	Total
100+	1	1	1	2	1	**6**
90 to 99	42	72	53	46	40	**253**
80 to 89	103	179	112	68	81	**543**
70 to 79	62	101	62	65	61	**351**
60 to 69	26	30	23	32	27	**138**
50 to 59	30	28	26	19	31	**134**
40 to 49	23	31	21	20	14	**109**
30 to 39	13	15	18	15	18	**79**
20 to 29	5	13	4	8	7	**37**
10 to 19	3	1	1	0	2	**7**
Unknown	0	0	0	0	0	**0**
Total	**308**	**471**	**321**	**275**	**282**	**1657**

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	0	6	36	35	14	18	4	10	5	2
Female	1	34	45	26	13	13	10	8	2	0

Table 4 COVID-19 deaths by gender

	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec -22	Total
Female	2	2	2	5	2	2	3	2	2	2	2	0	2	1	2	31
Male	3	1	1	1	1	4	1	1	0	2	4	3	2	0	0	24
Total	5	3	3	6	3	6	4	3	2	4	6	3	4	1	2	55

3.8.1 As stated in previous reports, the vast majority of incidents relate to older people living in the community, in particular, those over 70 years of age, residing in residential or nursing homes and presenting with co-morbidities. In Q3 there have been 11 incidents where the criteria for Structured Judgement Review (SJR) was met. Six for Community Recovery Services and four for the Older Adult Care Group. The majority of cases met the SJR criteria due to a diagnosis of psychosis during the patients last episode of care. Findings from completed reviews are detailed on page 14.

3.8.2 We continue to see low numbers of mortality from COVID-19. A total of seven COVID-19 deaths occurred in Q3 2022/23. These either relate to patients who died in the community or in an acute hospital. All patients were over the age of 65.

3.8.3 When data is analysed for reported deaths within KMPT according to gender, indications are that figures of mortality in men are usually higher than in women. However, deaths reported in Q3 2022/23 were higher in females (152) than males (130). This is not in

line with usual reporting figures, as shown in graph 3. Following review, the majority of female mortality incidents were of natural causes/expected deaths, where no care or service delivery issues have been noted and therefore further investigation is not required.

3.8.4 12 female deaths have been STEIS reported and are subject to a Root Cause Analysis investigation. Two female deaths are suspected suicides. The majority of serious incidents relating to females are unexpected deaths, where the cause of death is not currently known. One female patient sadly died on an older adult inpatient ward after she collapsed. The patient was detained under Section 2 of the Mental Health Act at the time of death and is subject to a Root Cause Analysis investigation. Initial gaps in care relate to the physical health monitoring of the patient, who spent just under 48 hours on the ward before she died.

3.8.5 Much like previous reports, the vast majority of patient deaths were due to natural causes, including deaths of patients living in a care home or nursing home, and of patients who died in an acute hospital, unrelated to their mental health condition. The overall figures of mortality are higher in older adults, with 70% of the total mortality incidents reported in Q3 2022/23 relating to patients over the age of 65.

3.8.6 There has been a slight increase in deaths of patients under the age of 20 in Q3, with a total of two reported, compared to zero in Q2. Both patients were male and died unexpectedly. One patient died after jumping in front of a train. The circumstances of death for one patient is currently unknown, as the patient died out of area. Cause of death has been established to be severe head injuries. He died in 2021, although KMPT were notified of the death in December 2022.

3.8.7 Deaths of patients aged 40 to 49 have slightly decreased this quarter. This is the lowest number over the course of the financial year. One noticeable difference for this age category is that the majority of deaths were of females (three of which have been STEIS reported). Previous reports have highlighted that mortality in males within this age category was higher.

3.8.8 Two patients died as a result of an incident involving a train in Q3 2022/23. One female patient was in her late fifties and open to a community mental health team at the time of death. Another patient was an 18 year old male, with a suspected diagnosis of autism, who died within 72 hours of discharge from a KMPT ward. Both incidents have been declared as a serious incident and are currently in the stages of investigation. Initial concerns noted for the two cases are as follows:

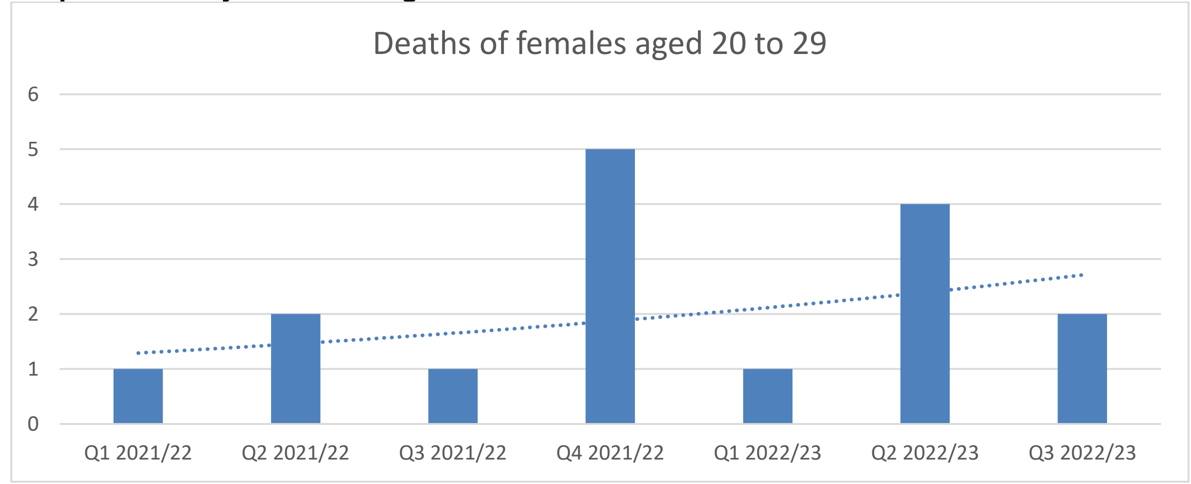
- Section 17 leave
- Possible premature discharge from the ward
- Queries around level of risk determined for both patients
- Lack of contact with the patient (ART)
- Possible lack of exploration for a carer’s assessment
- Long waiting times for consultant/outpatient appointment

3.8.9 There has been a noticeable increase in incidents involving trains within the past 12 months, not all relate to mortality. Since January 2022, there have been nine incidents reported: five have been declared as a serious incident. Overall, the incidents affected five males and four females and were self-harm/suspected suicide related.

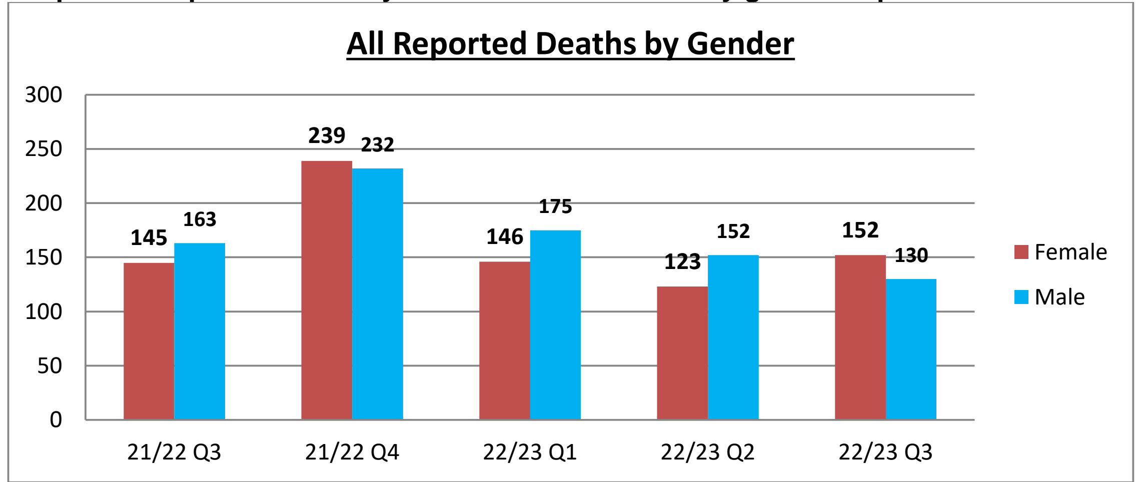
3.8.10 The number of deaths of patients aged 30 to 39 has fluctuated most quarters. In Q1 2022/23, the numbers appeared to have increased, with a noticeable decrease in Q2 2022/23. To ensure that this is being monitored adequately, the Q3 figures have been reviewed to identify any differences in the data. As shown in Table 3, mortality in females within this age category has slightly increased by three, compared to the previous quarter (Q2). The figures for males has remained the same. This mirrors the findings of the four year suicide thematic review (2018 to 2022), in that there seemed to be higher numbers of female mortality (suspected/confirmed suicide), than any other age category for females.
Of the eight mortality incidents for females between 30 to 39, all have been reviewed in the SI and Mortality Panel, where only one incident has been STEIS reported. This relates to a female patient who died unexpectedly, following what we believe to be as a result of self-harm. Six cases were reported to KMPT Legal services via HM Coroner as unexpected deaths. No gaps in care were identified into the care provided and further investigation is not required.

3.8.11 Mortality in females aged 20 to 29 has been reviewed in the previous mortality reports, due to the noticeable increase in incidents in Q4 2021/22. The figures have been monitored over the course of the financial year. As shown in Graph 2, there has been a decline in the numbers this quarter. For the two incidents reported in Q3, one has been STEIS reported due to gaps in care. Both patients are believed to have died unexpectedly, although circumstances around the death are unknown.

Graph 2 Mortality in females ages 20 to 29



Graph 3 All reported mortality incidents within KMPT by gender of patients



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3.8.12 In Q3, the 10 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	1	-
20 – 29 years	3	-
30 – 39 years	1	-
40 – 49 years	-	1
50 – 59 years	1	1
60 – 69 years	2	-
70 – 79 years	-	-
80 – 89 years	-	-
90 – 99 years	-	-

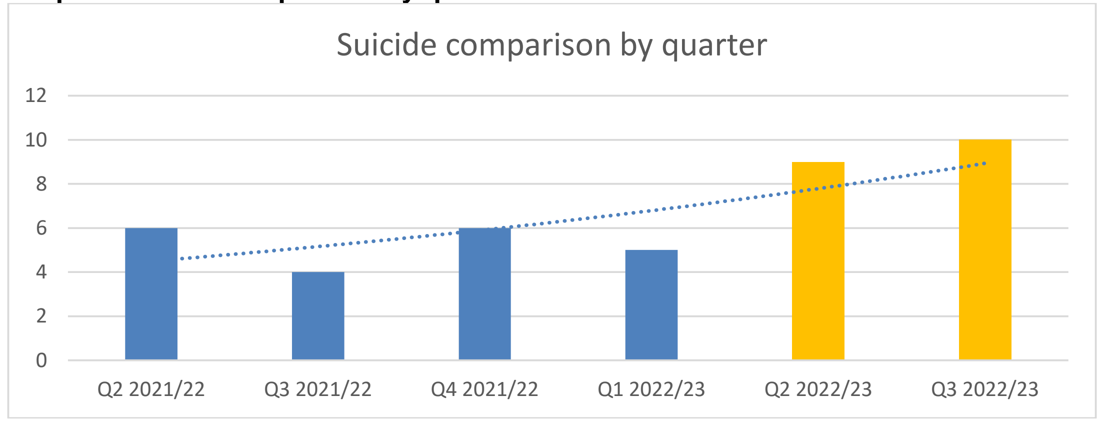
3.8.13 10 suspected suicides were reported in Q3 2022/23. This is an increase of one, since the previous quarter. There were more males who died from suspected suicide in Q3, which is to be expected, given that suicide rates are higher than in females. There are differences in the Q3 data to that of the National data, in that the rates of suicide in younger males were more common this quarter. This also differs from the Q2 2022/23 report findings, where most patients were middle aged or older adults. Previous mortality reports indicate that although there are some consistencies with regards to certain patient age groups, this does fluctuate most months. All 10 of the suspected/confirmed suicides reported this quarter were for working age patients, under the age of 65.

Table 6 common ages for suicide by quarter

	Q2 2021/22	Q3 2021/22	Q4 2021/22	Q1 2022/23	Q2 2022/23	Q3 2022/23
Male	20-29	20-29	20-29 60-69	N/A	40-49 50-59	20-29 60-69
Female	N/A	N/A	40-49	50-59	50-59	N/A

NB. Where N/A is stated, this either means that there were no suicides or there was no outlier for age in that particular quarter.

Graph 4 suicide comparison by quarter



3.8.14 Suspected/confirmed suicides declared as a serious incident has again increased this quarter. The graph shows that there was a rapid increase in suspected or confirmed suicide deaths from Q2 2022/23 onwards. The majority of suspected suicide incidents reported in Q3 related to a Community Mental Health Team, with a total of five, two for patients under

the care of Medway CMHT at the time of death. Unlike previous reports, two incidents were for patients who were discharged from a Liaison Psychiatry Service, prior to their death.

3.9 Mortality review by ethnicity

Table 7 Deaths by ethnicity

	21/22 Q3	21/22 Q4	22/23 Q1	22/23 Q2	22/23 Q3	Total
Bangladeshi	0	0	1	0	0	1
Black African	0	1	1	0	2	4
Black Caribbean	0	1	0	1	1	3
Chinese	0	0	0	0	0	0
Indian	1	2	1	0	0	4
Mixed white and Asian	1	1	1	0	2	5
Mixed white and black African	0	0	1	0	0	1
Mixed white and black Caribbean	0	1	1	0	0	2
Not stated	42	50	32	31	22	177
Other Asian	4	1	2	1	2	10
Other Mixed	0	1	2	0	0	3
Other ethnic category	2	1	2	0	1	6
Pakistani	0	0	0	0	0	0
White - British	248	404	271	238	249	1410
White - Irish	0	2	2	0	2	6
White - other white	10	6	4	4	1	25
Unknown	0	0	0	0	0	0
Total	308	471	321	275	282	1657

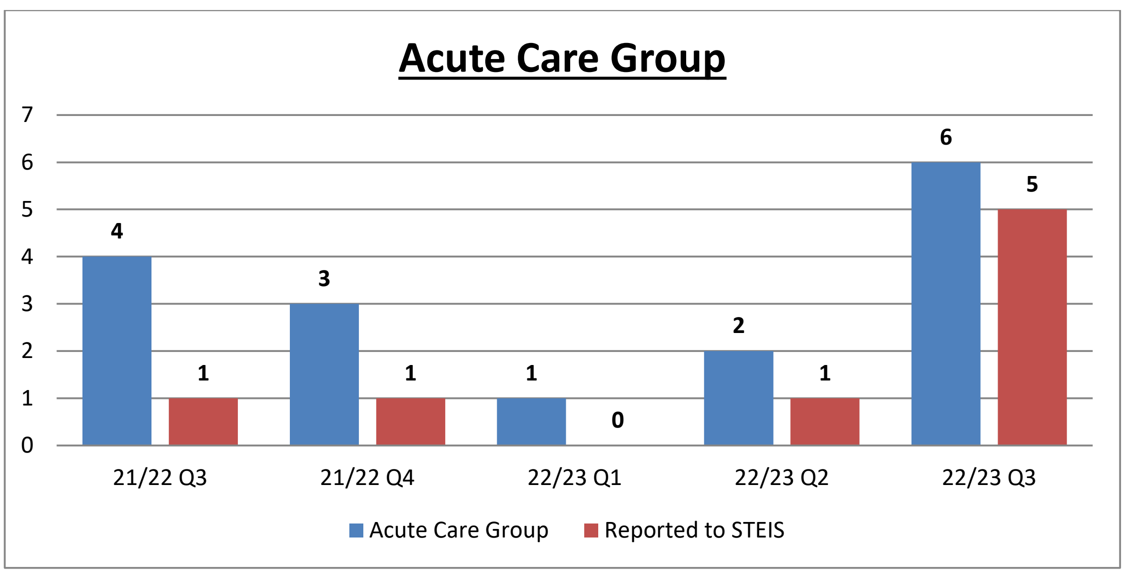
3.9.1 The majority of the incidents relate to people who are from a white–British background. This is consistent with the local population profile being predominantly white-British. On reviewing the Black Asian and Minority Ethnic (BAME) deaths, there were seven in Q3 2022/23, compared to two in Q2 2022/23. Of the BAME deaths in Q3 2022/23, five patients are believed to have died from natural causes. One unexpected death has been STEIS reported as a suspected suicide, due to gaps in care identified.

3.9.2 Of the 282 incidents reported on Datix during Q3 2022/23, 8% had no ethnicity recorded compared to 11% in Q2.

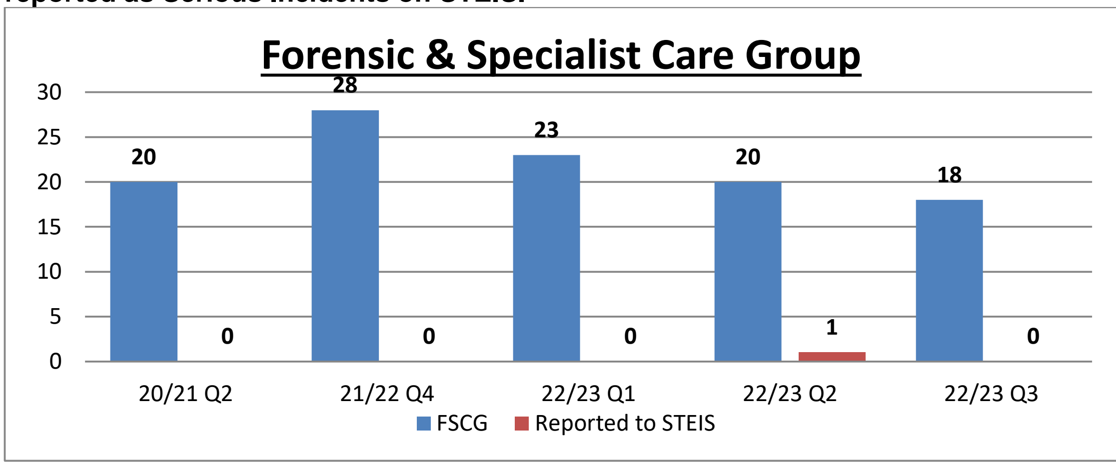
4 Serious Incidents and LeDeR cases

4.1 The following graphs (5 to 8) show the mortality incidents reported for the period 01/10/2021 to 31/12/2022 by Care Group. All mortality related serious incidents are subject to Root Cause Analysis investigation as per national framework and KMPT policy.

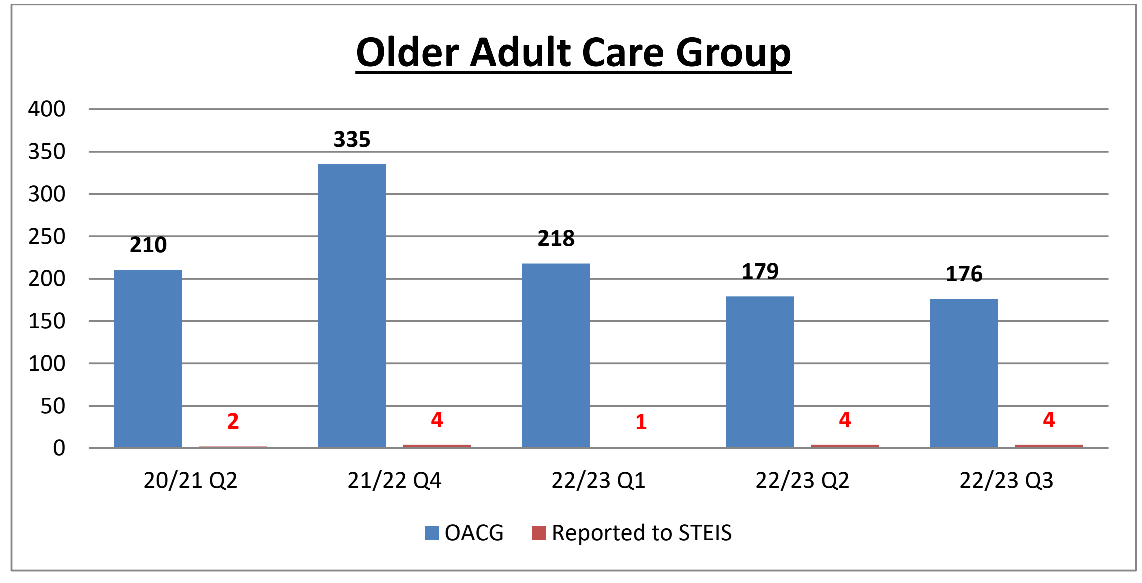
Graph 5 Mortality by Acute Care Group and numbers of those reported as Serious Incidents on STEIS.



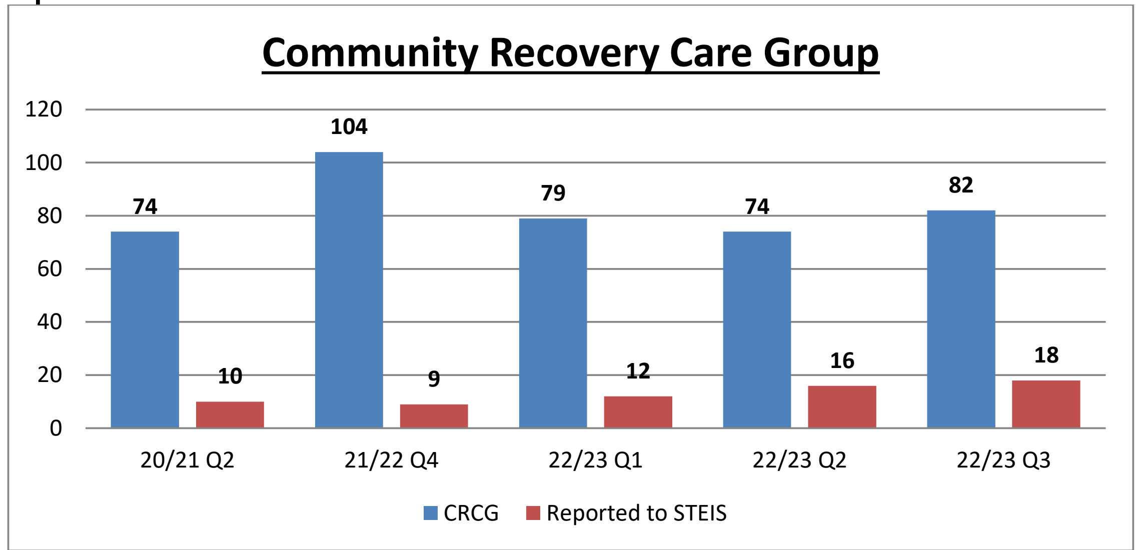
Graph 6 Mortality by Forensic and Specialist Care Group and numbers of those reported as Serious Incidents on STEIS.



Graph 7 Mortality by Older Adult Care Group and numbers of those reported as Serious Incidents on STEIS.

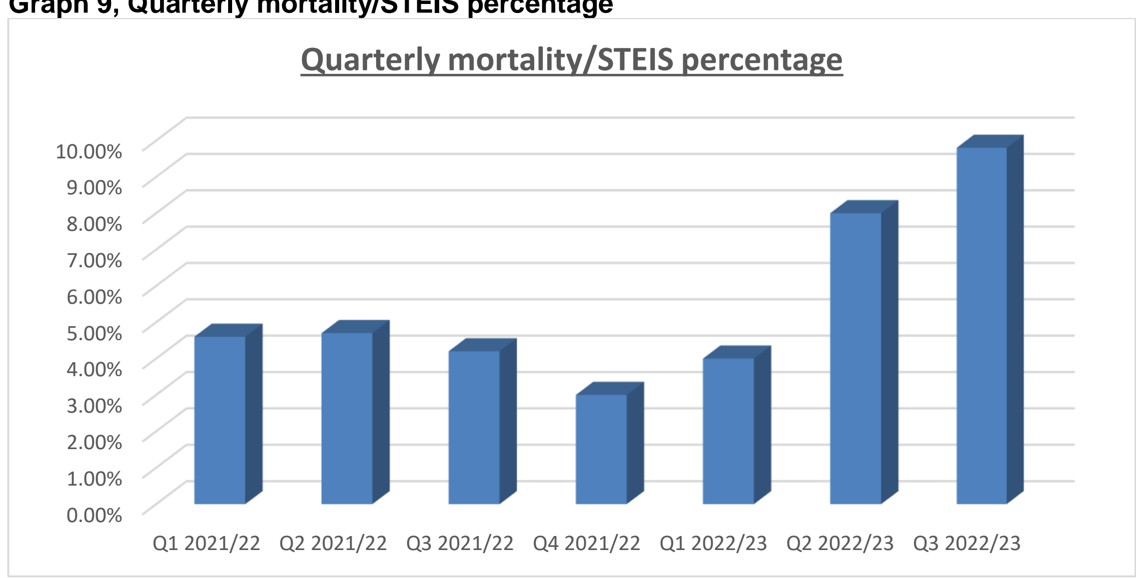


Graph 8 Mortality by Community Recovery Care Group and numbers of those reported as Serious Incidents on STEIS.



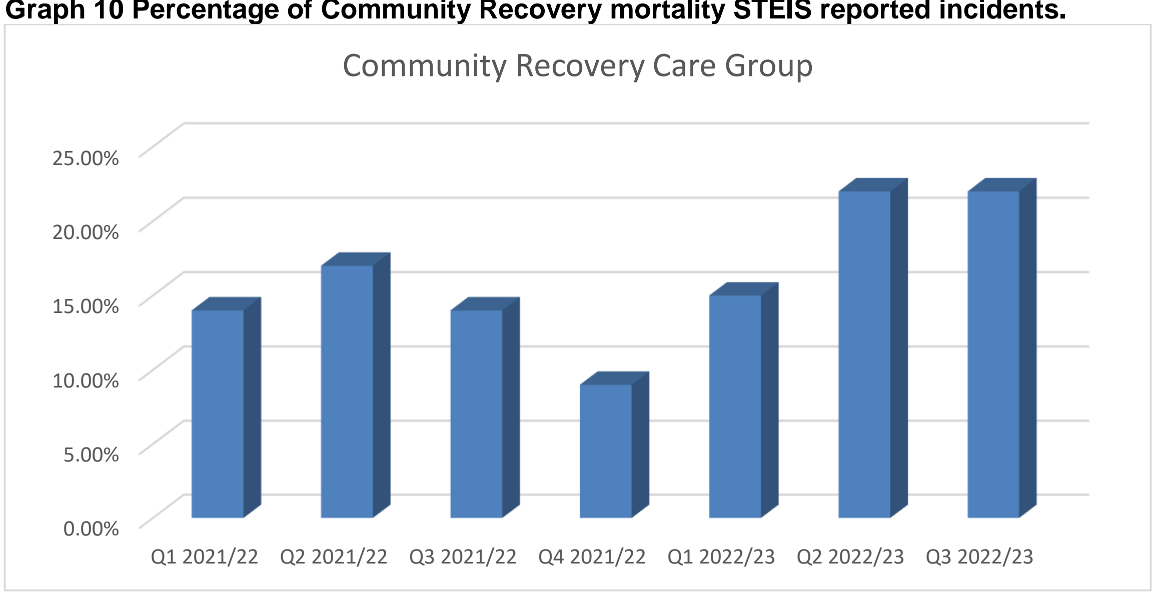
4.1.2 A total of 27 mortality serious incidents were reported in Q3, compared to 23 in Q2. The percentage of serious incidents compared to overall mortality in Q3 is 9.5%. This compares to 8% in Q2 2022/23. There has been a significant increase in mortality incidents reported on STEIS for the Acute Care Group. Mortality incidents overall for this care group have increased in Q3, compared to previous quarters.

Graph 9, Quarterly mortality/STEIS percentage



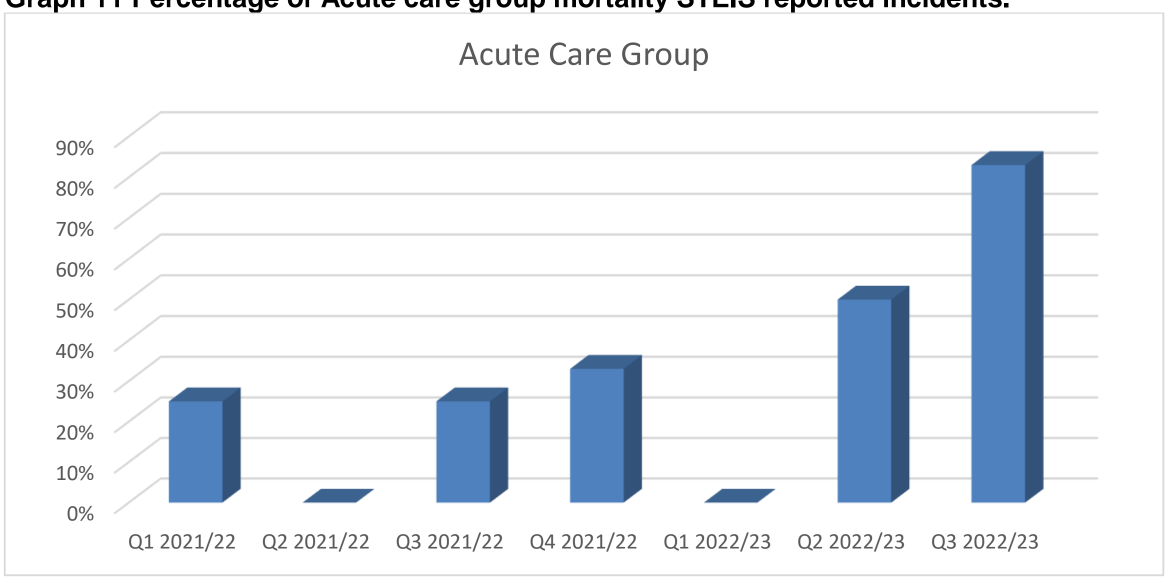
4.1.3 Graph 9 shows the percentage of STEIS reported mortality incidents each quarter. As demonstrated, the percentage of STEIS reported deaths has notably increased over the past six months.

Graph 10 Percentage of Community Recovery mortality STEIS reported incidents.



4.1.4 Graph 10 shows the percentage of STEIS reported mortality each quarter, when compared to the overall figures of mortality for the care group. As indicated, Q2 and Q3 have seen an increase in the amount of STEIS reported deaths, when compared to the overall mortality figures for that quarter.

Graph 11 Percentage of Acute care group mortality STEIS reported incidents.

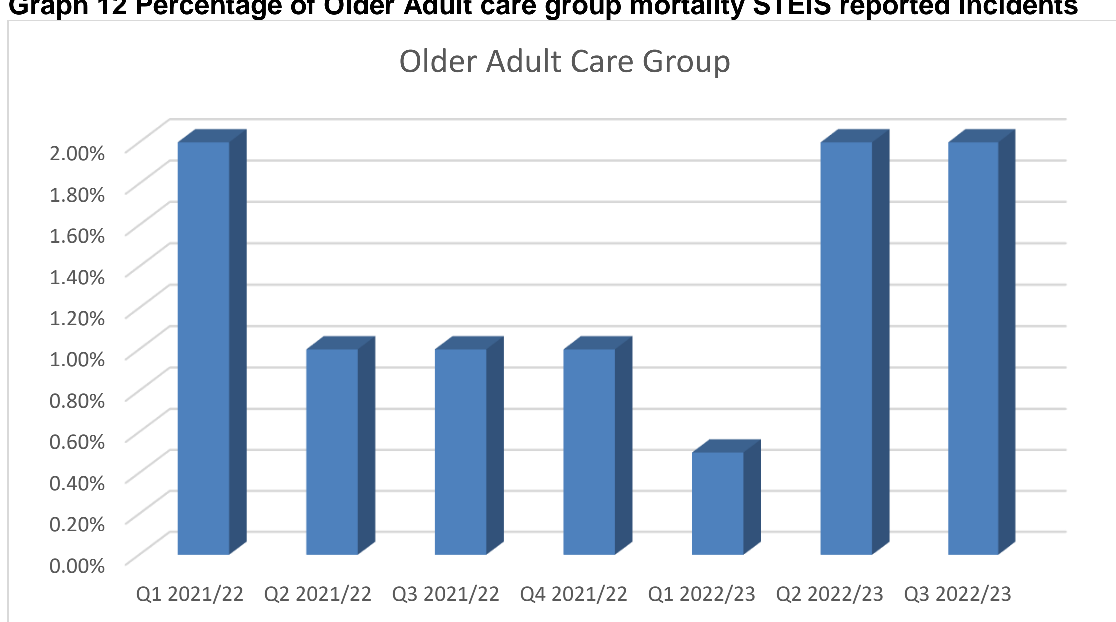


4.1.5 The number of mortality incidents within the Acute Care group are typically smaller than other care groups, such as community recovery and older adults. Acute services have reported their highest number of STEIS reported mortality incidents this quarter. There were six deaths within Acute services reported this quarter with an equally high number of STEIS reported (five). Mortality figures for this care group usually do not exceed three per quarter, with even smaller numbers of STEIS reported deaths (typically one per quarter).

4.1.6 When reviewed, three incidents have been reported as a suspected/confirmed suicide, with an additional case believed to be as a result of self-harm. One patient died from severe head injuries, the circumstances around the death are not yet clear. Four patients were

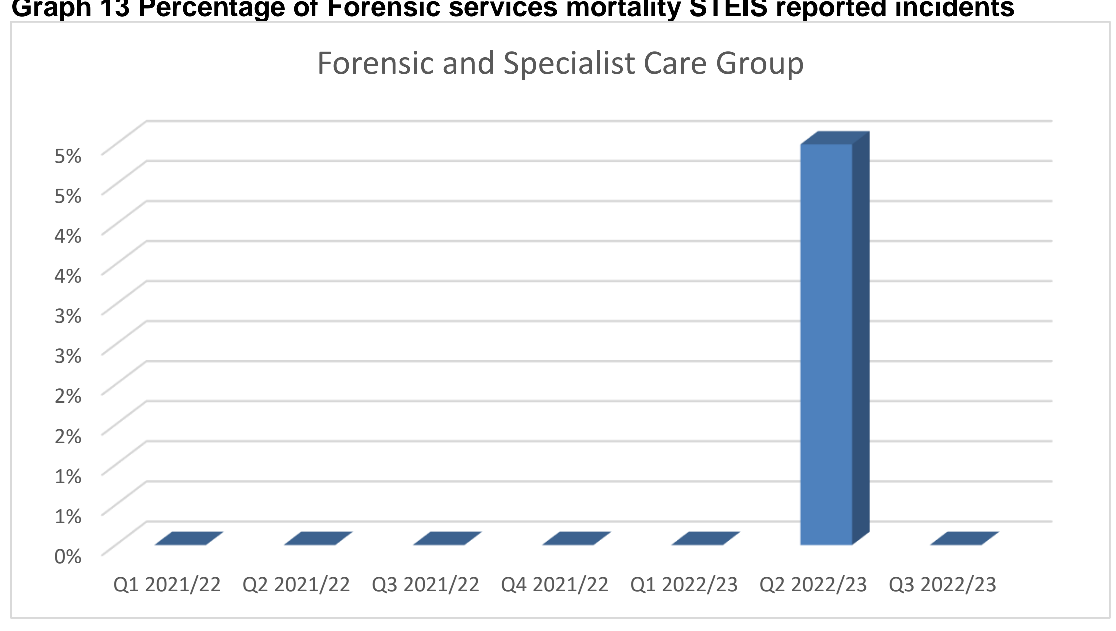
under the care of a crisis resolution home treatment team at the time of their death, with three different crisis teams involved.

Graph 12 Percentage of Older Adult care group mortality STEIS reported incidents



4.1.7 The percentage of STEIS reported mortality incidents, compared to overall deaths in each quarter remains small for the older adult care group. Although the graph shows some fluctuation, the percentage of STEIS reported incidents did not exceed 2%. Older Adult services typically see a higher number of mortality incidents, which mainly relate to natural causes deaths, where further review or investigation is not required.

Graph 13 Percentage of Forensic services mortality STEIS reported incidents



4.1.8 The forensic and specialist service usually report low numbers of mortality, with an equally low number of deaths reported on STIES. As shown, the care group reported one death as a serious incident in Q2 2022/23, equating to 5% of the overall mortality figures.

4.1.9 On review of the 27 Serious Incidents relating to mortality that were reported on STEIS in Q3, 10 relate to suspected/confirmed suicide. One patient died from suspected suicide shortly after discharge from a KMPT ward. Another patient sadly died unexpectedly on a KMPT older adult ward. One incident has been STEIS reported as a homicide. This is a complex case involving three males, two of which (perpetrator and victim) were known to KMPT services, with varying levels of contact.

4.1.10 The remaining STEIS reported incidents relate to patients who have died unexpectedly, where the cause of death has not been confirmed, but gaps in care meet the criteria for investigation. All serious incidents are in the stages of investigation; however, initial findings and concerns have been listed below:

4.2 Initial learning from the STEIS reported cases are as follows:

Concerns identified for cases relating to unexpected death:

- Physical health checks not completed as per policy (4)
- Referral to another organisation not considered/completed
- Level of risk/assessment (8)
- Lack of contact/referral for another organisation (3)
- Lack of/issues with documentation (4)
- Lack of contact with the patient (3)
- Delays in appointment timeframe/ appointments being booked
- Possible incorrect care pathway (2)
- Medication prescribing/monitoring (3)
- Carer/family views not sought
- DNA policy
- Carers assessment/ referral was not explored
- Safeguarding not considered

Concerns identified for cases relating to suicide incidents:

- Decision to discharge the patient (ward/community) (2)
- Level/ assessment of risk (7)
- Delays in appointment timeframe/ appointments being booked (4)
- Lack of documentation (2)
- Lack of joint working with another organisation (2)
- Lack of joint working with KMPT services (2)
- Unclear if referrals to specialist services were completed (2)
- Lack of contact with the patient (5)
- Possible that family views not considered (3)
- Carers assessment/ referral was not explored (2)
- Possible missed opportunity to gain collateral information from family

4.2.1 The gaps in care reviewed relate to all STEIS reported deaths reported in Q3. These include suspected/confirmed suicides, homicide and unexpected deaths (one relating to a patient who died on an older adult KMPT ward). Assessment of risk was considered to be one of the most common concern from initial review of the incident. This included possible lack of suicide inquiry with the patient, recording of level of risk, exploration of suicidal risk triggers and exploration of risk towards others. For the patients who died unexpectedly, and

not believed to be suicide related at this stage, physical health monitoring was noted as a concern for four cases. This included gaps in physical health checks. We continue to see gaps relating to carer's assessments and possible gaps around action taken following family concerns being raised. There were also some common areas of learning for both suicide and unexpected deaths relating to the joint working with external organisations. This included a lack of communication with the GP, and potential missed opportunities to refer patients to the appropriate services, such as drugs and alcohol, or requesting the GP complete a referral to ASD/ADHD services.

4.2.2 In Q3, four mortality incidents were reported to LeDeR, as per the national guidelines for reporting learning disability and autism deaths. Three cases were downgraded to a low level incident as no care or service delivery issues were identified. One case has been reported as a serious incident, and has been categorised as a suspected suicide. Of the overall deaths reported to LeDeR, two patients were male and two female. Two of white-British ethnicity, one of mixed white and Asian background and one of white-Irish ethnicity.

4.2.3 As previously stated, KMPT are continuing to work with LeDeR to improve engagement with families. This is working well so far and compliance is monitored via the Duty of Candour panel, held weekly. KMPT have received positive feedback on this work, which is improving the family engagement with the LeDeR team.

5. STRUCTURED JUDGEMENT REVIEW LEARNING

5.1 Unfortunately, due to increased workload within the patient safety team and a lack of capacity within our trained medics, there have been limited SJRs completed this quarter. The learning has been pulled from those completed in Q3 and detailed as follows:

Good care

- Timely assessments
- Evidence of carer involvement
- Risk assessment of the patient
- Physical health checks

Areas for improvement

- Lack of documented consideration for a dietician referral on a KMPT ward to support the patient when it was noted food and fluid intake had reduced. Dietician support was previously utilised with good effect.
- Additional social (external to KMPT) support that could have been offered to the patient. Social stressors present that did not seem to have resolved.
- Patient not followed up as per ART policy
- A medical review, to review medication, was not booked

5.2 Following discussion with the Trusts Chief Medical Officer in December 2022. A plan has been agreed to create a bespoke Structured Judgement Review job advertisement for two medics to undertake the SJR reviews. This is a positive step in improving current processes, and will allow for protected time for the reviews to be completed in a timelier fashion. The Mortality Review Manager is currently working on creating a job plan, which will be shared and published once complete.

6. THE MEDICAL EXAMINER

6.1 As stated in previous reports, NHS England and NHS Improvement submitted an application under Regulation 5 of the Health Service (Control of Patient Information) Regulations 2022 ('section 251 to support') to process confidential information without consent. The approved application can be found on the Health Research Authority's website. When the statutory medical examiner systems commences, it is expected that organisations will add medical examiners to the list of persons with a right to access to patient records in the Access to Health Records Act 1990. We understand that for KMPT the numbers will be small in comparison to the deaths reported.

6.2 A paper was presented at the Trust-wide Mortality Patient Safety and Mortality Review Group in October 2022 to provide an update on the current situation for KMPT. The Mortality Review Manager is working with the lead Medical Examiners and the Trusts Information Governance/Access team to ensure that KMPT health care records can be shared with the MEs when a death has been referred to them.

6.3 As previously stated the Medical Examiner is interested in non-coronial deaths and only when a the KMPT doctor is responsible for completing the Medical Certificate Cause of Death (MCCD). With this knowledge, the deaths KMPT will be required to refer to the medical examiner will be small in numbers. This is because of the small proportion of deaths that occur on a KMPT site (KMPT ward). This is further reduced as deaths referred to the Coroner do not require a referral to the Medical Examiner.

7. CONCLUSION AND NEXT STEPS

7.1 Mortality incidents recorded on Datix have slightly increased in Q3 2022/23

7.2 Suspected/confirmed suicides have risen in Q3, with a total of 10 reported, compared to nine in Q2 2022/23.

7.3 STEIS reported mortality incidents have significantly increased within the Acute Care Group. Community Recovery continue to be the highest reporters of STEIS reported deaths, whereas Older Adults continue to be the highest reporters of non STEIS/natural causes deaths.

7.4 The rate of mortality in the different age categories continue to vary each quarter. Mortality in patients between the ages of 18 to 19 have increased in Q3 with a total of two compared to none reported in Q2. Deaths of patients aged 40 to 49 have slightly decreased this quarter. This is the lowest number over the course of the financial year. One noticeable difference for this age category is that the majority of deaths were of females (three of which have been STEIS reported). Previous reports have highlighted that mortality in males within this age category was higher.

7.5 The Mortality Review Manager will continue to work with the Medical Examiners in Kent, in preparation for the roll out of the Medical Examiner process in Mental Health.

7.6 A bespoke job advertisement will soon be created, for two doctors to undertake Structured Judgement Reviews. This will improve current processes.

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

7.8 The Trust will continue with its work on suicide prevention. The suicide prevention strategy remains out of date.

Title of Meeting	Board of Directors (Public)
Meeting Date	26th January 2023
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, Chief Medical Officer
Purpose	Assurance

Matters to be brought to the Board's attention

- The S12 app is due to launch the week commencing the 16th January 2023. This has been a huge piece of work for the Trust and offer huge benefits in terms of sourcing doctors for assessments in a timely manner.
- The lapse in Community Treatment Orders (CTOs) is currently being looked into and a report is due back to the next Committee meeting, with the Chair of the Committee due to receive a verbal update before then.

Items referred to other Committees (incl. reasons why)

- None

MHAC met on 16th January 2023 to consider:

Significant assurance:

- Chief Medical Officer's Report
- MHLOG Report
- MHLOG Report Terms of Reference
- Mental Health Act Monitoring Report
- DoLS Audit Update
- Report from Associate Hospital Managers

Reasonable assurance:

- CLIQ Checks Audit
- DoLS/LPS Interim Update

Limited assurance:

- None

Launch of the S12 App

The S12 App is due to be launched the week commencing the 16th January 2023. The app has already launched in Medway and is used widely across the country. The S12 App was produced to assist with the amount of paperwork required for an S12 assessment, as well as showing the availability of a suitable doctor to carry out the assessment and processing the relevant doctors claim forms. S12 assessments are required to be completed within 24 hours and it is hoped that the by the app allowing quicker identification of a relevant S12 doctor, this will have a positive impact on compliance.

CTO Compliance

A deep dive into lapsed CTOs was due to take place and come to the Committee in January however, the deep dive is taking longer than expected. The Committee Chair has requested a verbal update ahead of the next Committee meeting, before the deep dive is presented to the Committee. A short update on CTOs was received at the last Committee meeting which showed an increase in CTOs and there being a clear geographical variation in the use of CTOs.