King's College Hospital
NHS Foundation Trust

AGENDA

Meeting	**Public Board of Directors**
Time of meeting	**9am-11.30am**
Date of meeting	**3rd July 2019**
Meeting Room	**Dulwich Room, Hambleden Wing**
Site	**Denmark Hill**

			Encl.	Lead	Time
1.	**STANDING ITEMS**			**Chair**	**9am**
	1.1. Apologies				
	1.2. Declarations of Interest				
	1.3. Chair's Action				
	1.4. Minutes of Previous Meeting – 09/05/2019	**FA**	**Enc**		**9.00**
	1.5. Action Tracker & Matters Arising	**FA**	**Enc**		**9.05**
2.	**PATIENT FOCUS**				
	2.1. Patient Story	**FD**	**Oral**	**Dr S Dolan**	**9.05**
	2.2. A Dementia Friendly Hospital	**FD**	**Enc**	**Dr S Dolan**	**9.25**
	2.3. Adult Safeguarding Annual Report 2018/19	**FD**	**Enc**	**Dr S Dolan**	**9.40**
3.	**PRODUCTIVITY**				
	3.1. Chief Executive's Report	**FD**	**Enc. 3.1**	**Dr C Kay**	**9.55**
4.	**Governance**				
	4.1 Nomination of the Responsible Officer	**FA**	**Enc**	**Prof J Wendon**	**11.00**
	4.2 Information Governance Policy	**FA**	**Enc**	**L Hollins**	**11.10**
	4.3 Update on changes to Trust Governance Structures	**FD**	**Enc**	**S Coldwell**	**11.15**
	4.4 Report from Governors	**FR**		**J Allberry**	**11.20**
7.	**ANY OTHER BUSINESS**			**Chair**	**11.25**
8.	**DATE OF NEXT MEETING**				
	TBC				

Key: ***FE****: For Endorsement;* ***FA****: For Approval;* ***FR****: For Report;* ***FI****: For Information*

King's College Hospital NHS
NHS Foundation Trust

Members:	
Sir Hugh Taylor	InterimTrust Chair *(Chair)*
Faith Boardman	Non-Executive Director (SID)
Prof. Ghulam Mufti	Non-Executive Director
Dr Alix Pryde	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Christopher Stooke	Non-Executive Director
Dr Clive Kay	Chief Executive
Lorcan Woods	Chief Finance Officer
Dr Shelley Dolan	Chief Nurse and Acting Deputy Chief Executive
Prof. Julia Wendon	Executive Medical Director
Bernie Bluhm – *Non-voting Director*	Interim Chief Operating Officer, Denmark Hill
Fiona Wheeler– *Non-voting Director*	Acting Executive Managing Director, PRUH
Steven Bannister – *Non-voting Director*	Interim Director of Capital, Estates and Facilities
Lisa Hollins– *Non-voting Director*	Executive Director of Improvement, Informatics & ICT
Abigail Stapleton– *Non-voting Director*	Director of Strategy
Attendees:	
Siobhan Coldwell	Trust Secretary and Head of Corporate Governance (Minutes)
Sao Bui-Van	Director of Communication
Jessica Bush	Head of Engagement and Patient Experience
Apologies:	
Sue Slipman	Non-Executive Director, Vice Chair
Dawn Brodrick	Executive Director of Workforce Development
Prof Richard Trembath	Non-Executive Director
Circulation List:	
Board of Directors & Attendees	

Enc. 1.4

King's College Hospital NHS
NHS Foundation Trust

King's College Hospital NHS Foundation Trust Board of Directors

Draft Minutes of the Meeting of the Board of Directors held at 3.30pm -5.30pm on 9th May 2019, at King's College Hospital, Demark Hill.

Members:

Sir Hugh Taylor	Trust Chair, Meeting Chair
Chris Stooke	Non-Executive Director
Faith Boardman	Non-Executive Director
Prof Jonathon Cohen	Non-Executive Director
Prof Ghulam Mufti	Non-Executive Director
Dr Alix Pryde	Non-Executive Director
Dr Clive Kay	Chief Executive
Dr Shelley Dolan	Chief Nurse and Acting Deputy Chief Executive
Prof Julia Wendon	Executive Medical Director
Lorcan Woods	Chief Finance Officer
Lisa Hollins – Non-voting Director	Director of Improvement, Informatics and ICT
Abigail Stapleton - Non-voting Director	Director of Strategy
Steven Bannister – Non-voting Director	Interim Director of Capital Estates and Facilities
Bernie Bluhm – Non-voting Director	Interim Chief Operating Officer (DH)
Fiona Wheeler – Non-voting Director	Acting Executive Managing Director (PRUH)

In attendance:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance (minutes)
Sao Bui-Van	Director of Communications
Louise Clark	Deputy Director of Workforce
Jo Haworth	Deputy Chief Nurse
Chris North	Lead Governor
Ms Helen Cherry	Patient
Jane Allberry	Public Governor
Jane Clark	Public Governor
Victoria Silvester	Public Governor
Paul Cosh	Patient Governor
Andrea Towers	Patient Governor
Lorna Gibson	NHSI Observer
Catherine McLoughlin	Member of the Public
Nathaniel Appiyach	Member of the Public
Hilary Sears	Chair King's Charity
Gail Scott-Spicer	CEO, King's Charity
Dominique Allwood	NEXT Director
Sola Afuape	NED SWLSGMHT

Apologies:

Sue Slipman	Non-Executive Director
Prof. Richard Trembath	Non-Executive Director
Dawn Brodrick	Executive Workforce Director

Enc. 1.4

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/33 Apologies

Apologies for absence were noted.

019/34 Declarations of Interest

None.

019/35 Chair's Actions

No Chair's actions were reported.

019/36 Minutes of the last meeting

The minutes were agreed as an accurate record of the meeting held on 6th March 2019.

019/37 Action Tracker and Matters arising

The content of the action tracker was noted.

019/38 Patient Story

Ms Helen Cherry attended the Board to outline her experiences of being a patient at King's College Hospital. Ms Cherry is profoundly deaf and has been working with the Trust to improve the accessibility of information to patients. She noted the importance of being able to communicate complex information and the need to take account of individual need.

Ms Cherry recounted her experience of emergency in patient care and her concerns about communicating with relevant staff as she received treatment. She noted that she was extremely grateful that she was not required to remove her hearing aids during her operation and the communication by surgical staff was excellent. Her experience on the ward was not quite as positive, staff were less understanding her communication needs e.g. eye contact and lip reading. The wards were also very noisy at night.

Ms Cherry is also a patient at the Ophthalmology Department, where she is awaiting an operation for cataracts. She noted that she is experiencing additional anxiety due to her reliance on lip reading. Her experience of the eye clinic has been less positive. Clinics are very busy and waiting times are long. Administrative processes are ineffective (e.g. phone messages being left without a return number) and staff do not use her preferred method of communication (email).

Ms Haworth (Deputy Chief Nurse) updated the Board on the work the Trust is doing to improve the accessibility of Trust communication to patients. A programme is in place and will take some time to deliver. However, it is clear that some actions can be implemented quickly.

The Chair thanked Ms Cherry for attending the Board and sharing her insights on how patient experience can be improved.

Enc. 1.4

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/39 **Chief Executive Report**

Dr Kay provided the board with a summary of his report, noting that he had been well supported in his first few weeks in the Trust, and that staff had been very welcoming. Whilst noting the challenges the Trust faces, it is clear that the Trust does some excellent work in difficult circumstances. The Board welcomed Dr Kay to the Trust and noted his report.

019/40 **Integrated Performance Report (M12)**

Bernie Bluhm introduced the M12 Integrated Performance Report. In respect of the emergency care standard (ECS) the Trust ended the year on 77.86%. This is below where the Trust should be and significant improvement programmes are in place in both emergency departments.

During March, attendances at both sites were higher than in the previous year although admissions were static. The urgent care pathway is being reviewed so that Emergency Nurse Practitioners (EPNs) can deal with more patients. Discharge, length of stay and capacity are also being addressed. At the PRUH the improvement programme also includes working with partners to avoid admissions and support patients in the community. The Trust is also working with primary care to provide enhanced out-of-hours care. Twilight services are less robust so work is ongoing to ensure that junior doctor rotas are fit for purpose and there is appropriate cover to ensure decision making is timely. Finally, the improvement programme is looking at patient flow, so that patient movement is 'designed' and that discharge is properly planned.

In respect of Referral to Treatment (RTT), the Trust achieved its trajectory to reduce the number of 52 week breaches. The trajectory was also met in April. Nevertheless significant challenges remain and the Trust is working very closely with partners, clinicians, private sector and other NHS providers to reduce the number of patients waiting more than 52 weeks to zero.

In respect of cancer targets, the PRUH was completely compliant on 2 week and 62 day targets, but the Trust missed the target because of a deterioration of performance at Denmark Hill, specifically in urology and coleorectal cancers. Inter-Trust Transfer (ITT) performance is marginally better (40% in Feb, now 60%), but should be 80%, so there is some way to go to get this right.

In respect of the ECS, the Board noted that whilst there have been some discussions with the regulator about how 'type 2' emergency visits (e.g. dental and ophthalmology) are counted, this would not make a significant difference to the overall figures. The Board discussed capacity. It was noted that access to beds can take time – in part due to overall numbers but also as a result discharge processes. Readmission rates are low. Delayed transfer of care is not considered to be a significant issue.

The Board welcomed the focus on reducing the number of patients that have waited more than 52 weeks for treatment and was reassured that there is a separate workstream aimed at managing down waiting times overall, so that this situation does not re occur. The Board noted the improvements to process as well as recognising that capacity cannot be resolved without support from the STP.

Enc. 1.4

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/40 cont The endoscopy backlog has at the PRUH has impacted on compliance with the Diagnostics target. The Board noted that a range of mitigation issues were being implemented to address the endoscopy backlog, a recovery plan is in place and it is being treated as a priority in terms of investment. There are fewer issues at Demark Hill although the cardio-echo service has been extended to cover weekends in order to meet demand.

The Board received an update on quality issues from the Chief Nurse and Executive Medical Director. It was noted that in spite of assiduous monitoring, infection targets including MRSA and c-difficile were missed. The fabric of the Denmark Hill site creates challenges. The Board were assured that Prof Bernal had led a review of SHMI data at the PRUH and no concerns were raised as a result.

The Board noted the report.

019/41 **Monthly Safer Staffing Levels (Nursing)**

Dr Dolan presented the monthly safer staffing levels, that provides the Board with assurance that nurse staffing levels are regularly monitored across the Trust. She noted that an analysis of 'red' shifts has been undertaken and the trend was in the right direction. Staffing levels are reviewed every six hours. Although the vacancy rate has increased slightly, it remains low. Dr Dolan confirmed that all the nursing establishment reviews have now been completed.

The Board noted the report.

019/42 **M12 Finance Report**

Lorcan Woods confirmed that the Trust had submitted its draft accounts on time. He noted that the Trust received some PSF funding which means the Trust will report an adjusted deficit of £180m, this is £2m better than predicted. The Board noted that this was achieved in part because of better budgetary control (the divisions met their M8 forecasts), less depreciation as a result of CCU delays, commissioner challenges being satisfactorily resolved and a larger than anticipated contribution from KFM. Nevertheless, there were areas of underperformance including BMT and liver and the cost improvement programme fell slightly short.

In respect of the 19/20 budget, considerable effort has been made to ensure that budgets and contracts are widely understood. A formal budget holder survey will be carried out later in the year in order to identify what information and training is needed to be an effective budget holder. The Trust has received a fair settlement from commissioners and the overall budget is deliverable but the message to staff is clear that costs need to be reduced, the cost improvement programme must be delivered and the Trust must regain some financial credibility.

In respect of the finance team restructure, the Board noted that a number of senior appointments had been made.

Mr Woods went on to outline the capital position, noting the need to ensure careful prioritisation given the limited resources available. The Trust is making a case for additional capital funding, but the national position is difficult and the Trust's financial reputation is weak.

Enc. 1.4

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

019/43 Report from the Governors

Chris North updated that the Board that the Governors met with NHSI in March and had received comparative data from that demonstrated the scale of the operational challenge facing the Trust. The governors are concerned about operational and clinical performance and welcome the efforts being made to address the endoscopy backlog at the PRUH. However, longer term plans are needed to ensure patient experience improves.

The Governors held a joint KHP governors session in early May, focused on mental health and how to bring all partners in the local health economy to work more effectively together.

019/44 Any Other Business

The Chair noted that the Trust had received a draft CQC inspection report. Once the factual accuracy check has been completed, the report will be published. It is likely this will be in early June.

The Chair noted that the Trust meeting structure was being reviewed with a view to reducing the burden of meetings. The Board would next meet in July (3rd) and the Boar would meet in private in June to discuss what further governance changes were needed.

019/45 Date of the next Meeting

9am 3rd July 2019, Denmark Hill site.

BOARD OF DIRECTORS (PUBLIC MEETING) ACTION TRACKER

Date	Item	Action	Who	Due	Update
05/12/18	18/136	**Integrated Performance Report** Dr Sharpe to be invited to a future Board meeting to discuss how support for mentally unwell patients in ED are being improved.		Asap	Dates to be agreed.

Action Status as at: 31/10/2018

King's College Hospital NHS
NHS Foundation Trust

Report to:	King's Board
Date of meeting:	3rd July 2019
Subject:	Dementia Friendly Hospital Charter – King's progress
Author(s):	Lucy Hamer, Dr Catherine Bryant, Margaret Medlyn, Petula Storey, Meryem Shrimpton, Dr Belinda Kessel
Presented by:	Dr Catherine Bryant
Sponsor:	Dr Shelley Dolan
History:	Previously considered by Dementia Steering Group April 2019
Status:	Discussion and Decision

1. Background/Purpose

The accompanying paper updates the Board on King's progress towards achieving the Dementia Friendly Hospital Charter. It provides an overview of progress against the Charter requirements and identifies achievements and further actions required across our sites. The paper has been compiled with evidence from:

- Dementia and delirium teams at Denmark Hill and the PRUH
- Estates and facilities teams across both sites
- King's Patient engagement and experience team
- King's Volunteering Service

2. Action required

The Board is asked to:

- Discuss the progress made by the Trust towards the Dementia Friendly Hospital Charter and the actions required to meet the Charter
- Confirm an Executive and Non-Executive lead for dementia care
- Endorse the development, delivery and monitoring of a Trust-wide dementia strategy based on this Charter and the Dementia Standards for patients and carers and linked to King's 5 year strategy
- Ensure King's estates strategy incorporates dementia friendly environmental standards and these are included in commercial contracts
- Support King's active involvement in local Dementia Action Alliances to improve coordinated care for dementia patients/carers with health, care and other local stakeholders – in line with the NHS Long Term Plan
- Agree to undertake Board training on dementia to meet this aspect of the Charter

3. Key implications

Legal:	No specific legal implications to delivering the Dementia Friendly Hospital Charter
Financial:	There are financial implications particularly in relation to developing dementia-friendly estates, staff training and increasing the numbers of staff across a range of disciplines with specialist dementia training. However ensuring staff have the right skills to look after patients with dementia may result in improved health outcomes including shorter hospital stay.
Assurance:	The development of a King's dementia strategy, monitored and progressed with Executive and non-Executive support will strengthen the Board's assurances around delivery of the national Charter.
Clinical:	An estimated 25 per cent of hospital beds are occupied by people with dementia. People admitted to hospital who also have dementia stay in hospital for longer, are more likely to be readmitted and more likely to die than patients without dementia who are admitted for the same reason. Patients with dementia are at increased risk of developing delirium in hospital which also adversely affects health outcomes but can be prevented in up to a third of cases with good multicomponent intervention which also reduces in-patient falls (which are more likely to happen in patients with dementia and/or delirium). National dementia strategies and standards support early diagnosis of dementia to ensure patients receive appropriate treatment and support.
Equality & Diversity:	850,000 people are estimated to be living with dementia in the UK. One in 14 people over 65 and one in 79 of the whole population have dementia in the UK. People with dementia and carers should be treated with dignity and receive care and support that is based on individual need, rather than assumptions about the condition. Patients and their carers must not be discriminated against because of their condition, age or reduced mental capacity. Nationally patients from BAME backgrounds are less likely to receive a diagnosis of dementia and post diagnosis support.
Performance:	The quality of our dementia care is benchmarked through the National Dementia Audit (presented to Trust's Executive Quality Board) and through local quality assurance and governance. The Dementia Steering Group reports to the Trust Older person's Committee. We are required to report our performance on dementia and delirium screening for older patients admitted to the Trust to the Department of Health through UNIFY-2. We report back to the local CQRGs annually. The recent CQC report also highlights outstanding practice in relation to our frailty pathways and volunteering service which also impact on our dementia care.
	The NHS Long Term Plan sets out the expectation that dementia

Strategy:	care will improve through a range of approaches including more integrated health and care services and better support for carers. The development of the 5 year King's strategy and vision provides an opportunity to embed a corporate approach to dementia care. It is recommended that a dementia strategy is one of the supporting strategies in the 5 year strategic framework and recognises the system partnerships required with statutory and voluntary sector.
Workforce:	We need staff to have the right knowledge and skills to deliver high quality, person-centred care for people living with dementia as well as their families/carers.
Estates:	Dementia friendly hospital environment is an area for significant development at King's across all clinical areas. Requirements are set out in: • The Dementia Friendly Hospital Charter • Patient Led Assessments of the Care Environment (PLACE) includes specific dementia standards, which all Trusts are required to assess, with results reported nationally by NHS Digital (King's dementia scores have declined year on year for the last 3 years)
Reputation:	King's College Hospital at both Denmark Hill and PRUH sites has demonstrated areas of excellence on dementia and delirium practice. However we are requesting board support to ensure that we deliver excellence in care for all patients with dementia and delirium in all departments of the hospital.
Other:(please specify)	

4. Appendices

Dementia Friendly Hospital Charter – King's progress July 2019

King's College Hospital
NHS Foundation Trust

Dementia Friendly Hospital Charter – King's Progress, Board update July 2019

1. Purpose

This paper provides the Board with an update on King's work to achieve Dementia Friendly Hospital status. It uses the Dementia Friendly Hospital Charter (revised October 2018) as the basis for self-assessment and sets out further actions required and recommendations for the Board. The paper has been compiled with evidence from the Dementia and delirium teams at Denmark Hill and the PRUH, Estates and facilities team, patient experience and engagement team and King's Volunteering Service.

2. Background

The Dementia Friendly Hospital Charter was launched in 2015 and has been revised and updated in October 2018. It provides a minimum set of standards that focus on the needs of people with dementia and their families/carers and what they can rely on when they access a dementia-friendly hospital. The latest revision includes a new section on the important role of hospital volunteers and takes account of the latest national guidance, including NICE guidance updated in June 2018, and the National Dementia Action Alliance Dementia Statements. The 7 areas of the Charter covers staffing, partnership, assessments, care, environment, governance and volunteering.

3. Overview of achievements

King's has made considerable progress towards becoming a Dementia Friendly Hospital since the national Charter was introduced. This has been largely driven by the specialist dementia teams at both sites, estates teams and volunteering services. Highlights include:

- An integrated approach to dementia training across King's and the establishment of dementia champions at the PRUH
- 95-100% of over 75s screened for dementia and delirium at Denmark Hill and the comprehensive geriatric assessment (CGA) completed on admission at the PRUH
- Denmark Hill site rated top in the UK for the discharge of patients in the National Dementia Audit published in 2018

- Over 820 volunteers trained as dementia Friends in the last 3 years
- The introduction of some dementia friendly environments in parts of our health and ageing unit at Denmark Hill and on Darwin wards at the PRUH (largely through charitable funding)
- The successful introduction of a specialist dementia nursing team at the PRUH
- King's membership of local dementia action alliances in Lambeth, Southwark and Bromley resulting in some improved partnership working with voluntary sector providers of dementia and carers' support.

However there remain considerable challenges to achieving the Charter. In particular:

- Lack of a Trust-wide strategy for dementia care and a Trust-wide carers policy
- Cost pressures impacting on the development of dementia-friendly environments, evidenced by declining scores for dementia-friendly ward/clinic environments measured through annual PLACE assessments across our sites
- Increasing demands on dementia specialist teams
- Lack of staff capacity to enable King's to benefit from partnership working through borough and London wide dementia friendly initiatives

4. Board recommendations

- Discuss the progress made by the Trust towards the Dementia Friendly Hospital Charter and the actions required to meet the Charter
- Confirm an Executive and Non-Executive lead for dementia care
- Endorse the development, delivery and monitoring of a Trust-wide dementia strategy based on this Charter and the Dementia Standards for patients and carers and linked to King's 5 year strategy
- Ensure King's estates strategy incorporates dementia friendly environmental standards and these are included in commercial contracts
- Support King's active involvement in local Dementia Action Alliances to improve coordinated care for dementia patients/carers with health, care and other local stakeholders – in line with the NHS Long Term Plan
- Agree to undertake Board training on dementia to meet this aspect of the Charter.

4. King's progress towards achieving the Dementia Friendly Hospital Charter

The table below sets out progress and achievements across our sites against each area of the Charter standards.

Area of the Charter	Standards	Progress and Achievements
Staffing	Care is provided by staff who are appropriately trained in dementia care. Staff demonstrate a proactive approach to caring for people and are knowledgeable and skilled in identifying and addressing need	• Dementia training is an integral part of King's training and development strategy. The dementia team at Denmark Hill are running dementia and delirium simulation training days at both sites in 2019, including Dementia Friends training at the Postgraduate Medical and Dental Education Department • King's reports on the provision of dementia education to HEE and targets training to specific groups, including undergraduate medical students (dementia specialist nurse at Denmark Hill has received a letter of commendation from the Dean of Medical Education February 2019 for excellence in teaching) and nursing students • All staff receive dementia awareness training on induction and all Health Care Assistants receive Tier 1 dementia training • Junior doctors receive dementia awareness training on induction and through regular teaching sessions throughout the year • Most staff on Darwin 1 and 2 have received Tier 2 training and a further 20 PRUH staff received Tier 2 training in March 2019. A network of dementia link workers is in place across PRUH (25 across all wards and the Darwin staff) and have received Tier 2 training • Denmark Hill dementia team provide Dementia friends training to Medirest staff, which is particularly important for porters and ward hostesses. • Dementia Friends sessions are run at PRUH for all staff and the general public • A pilot project was completed on the Denmark Hill ortho-geriatric ward to provide a short enhanced training programme for staff on dementia and delirium • Several staff on PRUH wards (D1, S7 and AMU are completing a module at Greenwich on dementia) • Two dementia CNS were appointed at the PRUH in February 2018. They review patients and support them and their families on referral. 363 patients were referred to the CNS in the last 12 months • At Denmark Hill the dementia and delirium team see patients referred to them by staff through EPR or by phone and they also take referrals directly from carers/families. On

		average the team deals with 5 referrals daily (Mon-Friday) that come via EPR/telephone (we take referrals from any staff group) and also 5 patients to be screened for dementia and delirium (screening is shared with other liaison staff in geriatric medicine). • Information leaflets on dementia and delirium are available • Advocates can be arranged when necessary • Marjory Warren and Darwin wards are dementia and delirium friendly ward and have generally higher staffing ratios to meet the additional needs of patients. Nurse to patient ratios are displayed on King's Way for Wards at the ward entrances
Partnership	People with dementia and their family/carers are recognised as partners in their care. This includes: Choice and control in decisions affecting their care Support whilst in hospital and on discharge	• The Triangle of Care principles are explained on training days and informally on the wards • Carers and families are enabled to assist during mealtimes if requested at both sites • John's campaign was launched in 2016 at Denmark Hill. An audit in February 2018 found only 10% compliance and the scheme was relaunched in May 2018. John's Campaign was launched in 2018 at PRUH to promote carers' involvement and opportunities to stay with the person with dementia. • A Trust-wide carers policy working group has now been established to deliver a carers policy, including for carers of patients with dementia – recognising continued challenges on many wards • A new monthly carers support group started in January 2019 for families/carers of people with dementia run by Carer's Hub Lambeth and Southwark Carers on Marjory Warren ward. Bromley Carers have agreed to introduce a similar drop-in programme at the PRUH • Denmark Hill site was rated top in the UK for the discharge of patients in the National Dementia Audit published in 2018 • Information is shared between King's and discharge providers and efforts are made to involve patients and families in discharge arrangements • PRUH dementia CNS refer patients and families to the Bromley Dementia Hub and signpost to appropriate agencies • The Trust discharge policy covers patients with cognitive impairment including dementia and covers when patient's lack capacity to make a decision about discharge arrangements.

Assessments	People with dementia and their family/carers have access to an accurate assessment of their needs and care is delivered accordingly	• At Denmark Hill all older people over 75 years are screened for dementia and delirium (with some targeted screening of other patient groups). The 4 AT screening tool is used and compliance is reported to Dept of Health monthly via UNIFY. Denmark Hill has 95-100% compliance. • At the PRUH, the comprehensive Geriatric Assessment (CGA) is completed by doctors on admission and can be included in the discharge summary. There is no formalised standard assessment by the dementia CNS but they see the patient and family where possible. The psychiatric liaison team can also be involved • The dementia team and some staff support carers and explore their needs and sign post to services • Nursing risk assessment includes falls/waterlow/MUST and appropriate care plans put in place post assessment • Palliative care team are involved in end of life care discussions
Care	People with dementia and their family/carers receive care that is person centred and meets specific individual needs	• 'This is Me' documents have been introduced across sites – and should be kept in the patient's folder at the end of their bed or displayed about their bed. • Patients from care homes should come with Red Bags including information about their personal profiles and any advance care plans • An advanced dementia leaflet is being introduced at Denmark Hill to provide information and start conversations. This is being tested with families/patients and staff. • Resuscitation is discussed with patients/families in line with Trust policy. PEACE documents (advanced care planning) are in use where appropriate and discussed with family members before completion. They can also be taken in the community. • At PRUH, evidence of distress is assessed and investigated on the dementia units most comprehensively. ABC charts are only partially used on the wards • Denmark Hill dementia team use specific assessment scales for pain with people with dementia. Abbey tool for pain assessment is used occasionally. A possible trial of a pain tool is being considered on the dementia unit • PRUH wards are part of the NHSI Nutrition Research Project and eating and drinking is monitored. At Denmark Hill, ongoing work with NHS Improvement Collaborative Project, Medirest and Health and Ageing units aims to increase protein intake for older patients and use of finger food.

		• Independence, mobility and activity is encouraged. A few activities take place with patients at PRUH. Physio and OT staff support some patient activity on the PRUH wards • Activity coordinators work across Denmark Hill Health and Ageing Unit to provide meaningful activities for all patients • The identification of dementia and delirium is part of King's falls assessment and a mandatory part of the adverse incident reporting process. The Denmark Hill dementia team are part of the Trust's falls steering group. • The dementia service has leaflets on joint dementia research and these are displayed on information stands. However there are limited opportunities to get involved in research at PRUH. Patients at Denmark Hill attending memory clinic are asked if they would like to be involved or hear more about research (with no obligation). They can choose to register their interest locally or nationally.
Environment	The care environment is comfortable and supportive, promoting patient safety, well being and independence and people with dementia are enabled to find their way around the hospital	• PLACE (Patient Led Assessment of the Care Environment) audits are carried out annually and the results are reported to the patient experience committee. King's scores on dementia-friendly environments have declined at Denmark Hill, PRUH and Orpington sites year on year since 2016. Annual action plans are drawn up following publication of the results these are shared with relevant parties for action and escalation. In 2018, compliance rates for dementia were 70.46% (Denmark Hill) and 72.53 % (PRUH). • The 2018 PLACE results identified improvements required in relation to signage, flooring, furniture. There are cost implications for a number of the improvements required • 20 flag signs have been installed around the site and 75 additional signs are on order for Denmark Hill that are dementia friendly. • PRUH currently has dementia signage on Darwin 1 and 2 and AMU 1 and 2 • The Darwin ward has colour coded bays. All bathrooms have new signage installed and colour coding around door frames. • New dementia friendly clocks have been ordered for all clinical areas at the PRUH • Darwin 1 and M3 have a small day room • At Denmark Hill work is starting to refurbish Donne Ward day room and the Frailty Unit day room to become dementia friendly (the latter from a Friends grant of £6500) • Patients with dementia/delirium should not be moved between 8pm-8am unless clinically indicated. Sometimes this happens for infection control/patients waiting in ED and is monitored in real time through safety huddles. Denmark Hill scored better than the national

		average for wards saying moves were avoided always/most of the time (59% compared to national 49%) in National Dementia Audit 2018 There are currently no policies in place to minimise moves within the PRUH hospital • Side rooms are used where possible to minimise noise and distractions – but limited space available to do this. The Trust Dignity policy is used to guide staff on minimising noise and distraction. • At Denmark Hill there is a carers hub on Marjory Warren ward – a room has been converted to provide carer access to tea/coffee making facilities and a microwave
Governance	Systems are in place to support continuous improvement of quality of care for people with dementia and their carers whilst in hospital, including resources and governance structures that support staff to deliver care that is dementia friendly.	• King's is signed up to the Dementia Friendly Hospital Charter • In 2018. King's joined local Dementia Action Alliances in Bromley, Lambeth and Southwark • Dementia Strategy Group in place at Denmark Hill and at PRUH with Oxleas representation • Dementia and delirium team reports to the Older Person's committee (with Executive chair) • Elderly medicine governance meeting at PRUH • Local Healthwatch (Lambeth and Southwark) have been involved in promoting King's work on dementia and encouraging feedback **Human resources** • King's staff leave policy addresses carers leave but is not specific to dementia • The dementia teams provide information and signposting to staff who are carers of people with dementia. **Feedback** • King's participates in the National Audit for Dementia • A compliments and complaints policy is available on the wards • How are We Doing surveys are collected from patients or relatives on all wards and reported internally monthly including patient comments • Carers questionnaires were completed as part of the National Dementia Audit • In 2018, talk back sessions were held at both sites with King's members and local groups to gather feedback about dementia services

Volunteering	Volunteers with specific dementia training are available to assist people with dementia where appropriate. They can provide additional support for activities and pastoral care, complementing those of paid staff and are not a substitute for them.	• All volunteers for the past 3 years have dementia training as part of their volunteer training day, and have become Dementia Friends. Dementia Friends training has been delivered to 824 hospital volunteers across both sites. • There are currently 33 volunteers on the Denmark Hill Health and Ageing Unit wards • All volunteers work to clearly defined role descriptions which have been co-designed with staff • Trained volunteers provide hand massage to patients on Marjory Warren ward and this will be extended to other Health and Ageing Unit wards • A volunteer visits the Health and Ageing Unit wards weekly with her Pets as Therapy dog • Patients referred to the palliative care team have access to an End of Life Companion Volunteer if needed. • A new Pears funded youth volunteering pilot started in March 2019 which will introduce mealtime support and engagement in activities for patients on Darwin 1 and 2.

5. Further actions required to achieve the Dementia Friendly Hospital Charter

Staffing

Trust- wide

- All staff regularly working with or assessing people with dementia should receive Tier 2 training
- Staff training records should identify whether and how many staff have received Tier 1, 2 , 3 teaching

PRUH

- All clinical staff should complete all seven models of The Open Dementia Programme on LEAP and this is made mandatory
- Introduce training for non-clinical staff at PRUH
- Specialist staff should all receive Tier 3 training

DH

- Develop a network of dementia champions at Denmark Hill
- Consolidate undergraduate nursing and medical student training
- Roll out the enhanced ward training programme on dementia and delirium to geriatric and general medicine wards

Partnership

Trust-wide:

- Embed John's Campaign across all wards and audit compliance
- Introduce a Trust-wide carers' policy to ensure a consistent approach to identifying, involving and signposting carers to support

PRUH

- Improve the active involvement of patients/families in discharge arrangements at PRUH
- Provide all families/carers at PRUH with information about Bromley Well and the Dementia Support Hub

DH

- Complete the NHS England Project "Identifying factors contributing to acute hospital delayed discharge for people living with dementia"

Assessments

- Improve the identification and referral for carers needs assessment

Care

Trust-wide:

- Ensure 'This is Me' forms are completed routinely and are accessible to all staff during care of the patient
- Ensure return of Red Bags with patients to care homes with updated documentation
- Improve information for families about advanced dementia and the impact on carers
- Increase use of ABC charts need to be used to identify triggers for distress. Eg pain, constipation, boredom
- Ensure routine pain assessment for all dementia patients
- Extend activity boxes across all wards using the dementia link nurses and new volunteer project

PRUH

- Extend opportunities for involvement in research at the PRUH

Environment

- The estates strategy to incorporate dementia friendly design principles and procurement standards and improved signage/orientation cues (including King's Fund and Virtual Hospital Ward tools)
- All changes to estates to embed dementia friendly environments using above standards
- Reduce the need to move dementia patients between wards between 8pm and 8am and avoid late evening discharges

PRUH

- Identify options for additional day room/social spaces at the PRUH as part of the estates strategy

Governance

- Introduce a King's dementia strategy based on this Charter and the Dementia Statements reporting to the Executive Quality Board
- Agree an Executive champion/Board lead
- Ensure active involvement in the borough Dementia Action Alliances to improve coordinated care for dementia patients/families
- Introduce the involvement of lay people/carers in dementia strategy groups
- Annual updates to the Board following this paper
- Review approach to ensuring contractors and agency staff uphold the Dementia Charter principles
- Clarify HR work to date on combating stigma of dementia amongst employees/introducing reasonable adjustments for staff with dementia
- PALS staff to receive dementia training, beginning with Dementia Friends training and then Tier 1 Dementia Training
- Deliver an engagement plan to support the delivery of King's dementia friendly Charter – increasing involvement of patients/carers and local groups
- Increase the response rates for patient surveys on older people's wards, making greater use of relatives/volunteer support

Volunteering

- Volunteer policy to be amended to include the role of volunteers in supporting dementia patients and carers

King's College Hospital NHS
NHS Foundation Trust

Report to:	Trust Board
Date of meeting:	03/07/2019
Subject:	Safeguarding Adults Annual Report
Author:	Heather Payne, Head of Adult Safeguarding
Presented by:	Jo Haworth, Deputy Chief Nurse / Heather Payne, Head of Adult Safeguarding
Sponsor:	Dr. Shelley Dolan
History:	N/A
Status:	Information and Assurance

Executive Summary

2018/19 has been another busy year for the Kings Safeguarding Adults Service. There has been a 94% increase in DoLS applications and Learning disability notifications continue to rise each quarter. There has been a focus on service development; including the Learning Disability service provision and alignment with the Child Safeguarding service as part of the 'Think Family' ethos.

The Mental Capacity has been a focus for 2018/2019. MCA 'big talks' have been held, giving staff the opportunity to hear from guest speakers from 39 Essex Street on new judgements on MCA and DoLS. KCH hosted the Lambeth Together MCA awareness day which focussed on Best Interests and Advanced decisions.

The service has continued to engage with the local Safeguarding Adults Boards and actively participates in the sub-groups of these boards contributing to the wider safeguarding agenda.

KCH is committed to ensuring its workforce is sufficiently skilled in safeguarding training. Over the last year training compliance figures have seen a quarter on quarter improvement for adult safeguarding training and it has been acknowledged by the Prevent Regional Lead that the Trust has made one of the best improvements nationally for its Prevent training compliance. However the CQC noted that the Trust is not compliant with the 85% target for Prevent, Safeguarding Adults Level2 and MCA across all staff groups and the service will be taking steps to address these gaps.

The CQC inspection has highlighted the risk to the Trust in terms of not receiving timely outcomes for Section 42 safeguarding enquiries from the Local Authorities. The Safeguarding service are taking steps to address these concerns.

Recommendation to the Board:
The Board is asked to note the findings of the Safeguarding Annual Report.

1. Introduction

Safeguarding Adults remains a key priority for KCH under the leadership of the Deputy and Chief Nurse. KCH is committed to working in partnership with key stakeholders to ensure that adults at risk in our Boroughs are identified early and protected from harm.

Safeguarding adults is the process of supporting adults with care and support needs and who may be at risk of abuse and neglect. The Local Authority is the lead agency and NHS Trusts have a statutory duty to work alongside them in the multi-agency setting to support those adults identified as being at risk.

The Safeguarding Adults (SGA) Service for 2018/2019 included Specialists for Safeguarding Adults, Learning Disabilities and a Deprivation of Liberty Safeguards (DoLS) Coordinator. A priority for 2019/20 is to increase capacity within the service, specifically in Learning Disability; this has been a key risk for the service and documented on the risk register (see appendix 1 for service organogram). Affiliated with the service is the Independent Domestic Abuse Advocates who are employed by Victim Support. The service works across all KCH sites.

2018/2019 has seen the Adult and Child Safeguarding service actively aligning both services to promote the 'Think Family' approach. A key change has been to combine the Adult and Child Safeguarding quarterly committee meetings in February 2019; this approach has improved learning across services. The Committee advises the Executive Quality Board, the Quality Assurance and Research Committee, the Clinical Quality Review Group and the Trust Board on how its statutory obligations are met.

The purpose of this report is to:

- Provide an overview of the Trust's safeguarding activity during 2018/2019,
- Provide assurance that the organisation is compliant with its safeguarding duties and,
- Outline the safeguarding risks and priorities for 2019/2020.

2. Safeguarding Adults Activity

During the reporting period, the Safeguarding Adults Service received 2,464 safeguarding concerns from services across the Trust. 778 were triaged as level 2[1] and referred on to the relevant local authority to be considered for a Section 42 enquiry. 1686 were categorised as level 1[2] concerns. The 2464 figure of concerns received show a slight decrease when compared with the 2658 concerns received in the previous year. However while the level 1 referrals show a decrease from 2017/18 the level 2 referrals show an increase from 662 to 778. This increase indicates that more referrals meet the section 42 threshold and shows increasing awareness and better quality referrals. Please refer to appendix 2 for a breakdown of the data.

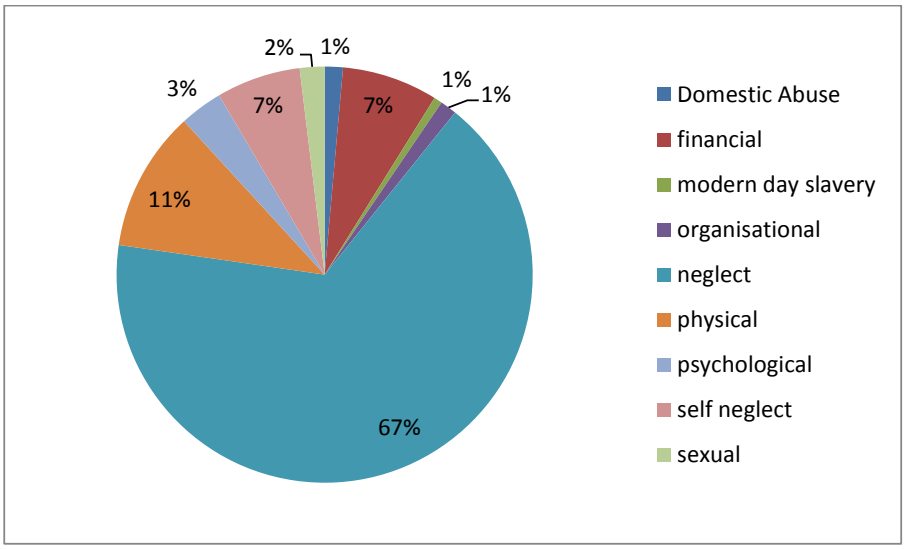
As with previous years the highest categories of abuse for the L2 referrals are neglect, physical and financial and this is in line with the national picture. However self-neglect cases are now also the third highest group alongside financial abuse, see figure 1:1. Additionally within the L1 concerns neglect remains the highest group but self-neglect and domestic

[1] A level 2 referral is where the SGA service determines that the adult with care and support needs have been potentially subjected to neglect and abuse and pass this on to the relevant Local Authority for consideration of a section 42 enquiry under the Care Act 2014 (a s.42 is the statutory duty to make enquiries into a safeguarding concern by the Local Authority).

[2] A level 1 referral is where staff have concerns for an 'at risk' adult. The SGA service provide advice and support and often sign posting on to supportive services for example Social Services for an assessment of support needs.

abuse concerns now are the second and third highest categories. Domestic abuse and self-neglect were included within the categories of adult abuse when The Care Act 2014 was implemented. These are considered 'new' areas of work within the field of adult safeguarding and there is a lack of national guidance on how these cases are managed. It is left to local policy to determine the management of these cases. A better understanding of our local picture will support on-going work in the multi-agency setting. Similarly the service has managed 8 cases where modern day slavery (MDS) was suspected which is an increase from 4 cases in 2017/18. MDS is another 'new' area of work for adult safeguarding so it is important the SGA service supports/ promotes multi-agency working.

Figure 1:1 L2 referrals showing categories of abuse



KCH implicated safeguarding referrals

The Trust receives limited information regarding the outcomes of section 42 enquiries from the respective local authorities; which potentially impacts on organisational learning and is a key risk that was raised by the CQC in February 2019. This has been escalated to the Lambeth and Southwark Safeguarding Boards, and Directors of Adult Social Care will be requested to support addressing this**.** The service has re-instated regular 6 weekly meetings with the senior practitioners in Lambeth, Southwark and Bromley social services for the purpose of facilitating timely outcomes. This risk has also been added to the corporate risk register.

Within the reporting period there were 76 KCH implicated S42 cases which were referred to the local authority from other organisations or self-referred through KCH. 72 cases have been concluded; 63 cases were not substantiated and 9 cases of abuse/ neglect were identified following the S42 enquiry. The 9 cases related to pressure ulcers and poor discharges (see appendix 2 figure 1:5). 4 cases from the reporting period are awaiting outcomes from the Local Authority, 2 of which are waiting for KCH internal investigation reports.

The SGA service supports the KCH/ GSTT Transfer of Care meetings held at the DH site which aims to improve the quality of discharges. This has also been made a Trust wide quality priority this year.

The SGA service is linked in with the Tissue Viability (TVN) service. On-going work to reduce pressure ulcers by the TVN service includes a variety of training programmes.

Improved governance procedures within the SGA service now ensure that Directors of Nursing and Heads of Nursing are made aware of KCH implicated cases at time of initial referral and similarly they are now informed of the outcomes of the safeguarding enquiry. Lessons learned from s42 enquiries are reported on at the Safeguarding Committee meetings.

In 2018/19 the SGA service has strengthened its operating framework with the Patient Safety and Risk Management team in order to support investigations where safeguarding may be a concern.

Domestic Abuse

The Independent Domestic Abuse Advocates (IDVAs) are part of the SGA Service. They are employed by Victim Support and collocated at both the DH and PRUH sites.
Frontline staff are able to access support for domestic abuse (DA) through training and on line resources. Referrals are made through the adult safeguarding team or directly to the IDVA service. The service offers support to both service users and KCH employees who may be experiencing domestic abuse. A total of 368 referrals for service users for the reporting period have been recorded. There was a total of 45 MARAC[3] referrals for the reporting period as set out in the table below. Please refer to appendix 2 figures 1:6 and 1:7 for more detail.

Table 1:1 MARAC referrals across sites

Q1	Q2	Q3	Q4
20	11	2	12

2018/2019 is the first full year that referral data has been collated. In line with data collected within the wider safeguarding update the service can clarify that domestic abuse concerns are making up a significant portion of total safeguarding concerns. This local picture aligns itself with the national picture of increasing awareness of domestic abuse.

Learning from Safeguarding Adult (SARs) and Domestic Homicide (DHRs) Reviews

During 2018/2019 the SGA service participated in 4 SARs and 9 DHRS within the boroughs of Lambeth, Southwark, Bromley, Lewisham, Greenwich and Bexley. One DHR (Sophia) was signed off by the Home Office in early 2019. The remaining 8 are in progress. One SAR (Miss A) has been concluded but recommendations are still being finalised. The remaining 3 are in progress.

Recommendations from DHR Sophia

KCH contributed to this review from a health service and an employer perspective. There were a total of 27 recommendations for agencies involved. KCH specific recommendations are;

- Drive/ promotion within Kings to raise awareness on domestic abuse with a focus on DA in the work place.
- Standalone policy/ guidelines for supporting staff experiencing DA.

In September 2019 KCH will host a DA awareness event with the support of Lambeth CCG. The focus of the day will be DA in the work place as well as general DA awareness. A DA policy task and finish group has been established to complete the DA policy for KCH employees.

[3] A Multi Agency Risk Assessment Conference (MARAC) is a victim focused information sharing and risk management meeting attended by all key agencies, where high risk cases are discussed.

Findings from SA Miss A

- Even when key case details are recorded on a case file, the nature of electronic databases do not always support frontline staff to be able to effectively access key information, leaving them with only a partial picture of an adult's needs.
- In circumstances where the consequences of an apparently capacitous adult's decisions over time may be life-threatening, practitioners need to be well supported to understand which practice, legal and ethical approach to take.
- The commissioning of care and support for adults who self-neglect, is not making full use of the potential for care workers to work alongside those adults.
- If a complex case is not being managed using an existing multi-agency process, no individual professional is responsible for drawing agencies together so there is a risk that an adults changing needs and risks will not be responded to quickly.

3. Prevent

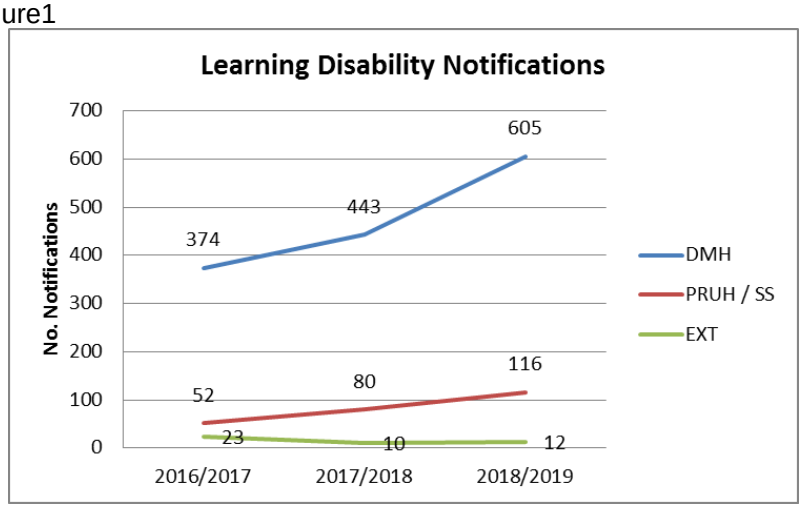
Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial.

The SGA service has managed less than 5 cases in 2018/19 and has had 1 request for information to support a case going through Channel panel[4]. Please see Appendix 5 for the full Prevent update. Please see the training section for the update on Prevent training.

4. Learning Disability Activity

Throughout 2018/2019 there were 733 notifications sent to the Clinical Nurse Specialist in Learning Disabilities (CNS-LD). These notifications can be sent either to request advice or support from the CNS- LD or notify the team that someone with a learning disability has been seen in the emergency department or been admitted to hospital as an inpatient. This is an increase of 37.5% from 2017/2018. Please see Figure 1 below.

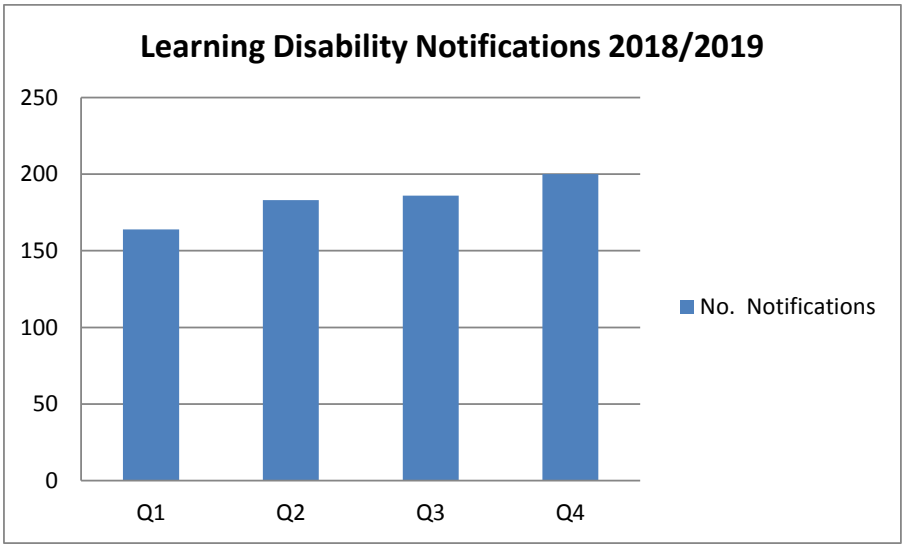
Figure1



4 Channel is an early intervention multi-agency panel designed to safeguard vulnerable individuals from being drawn into extremist or terrorist behaviour. Channel works in a similar way to existing multi-agency partnerships for vulnerable individuals. It is a voluntary process allowing the individual to withdraw from the programme at any time.

Figure 2 shows the referral rates by quarter. The continual increase in notifications demonstrates improved awareness of staff understanding their responsibilities for patients with a learning disability.

Figure 2



The LD service works with KCH frontline staff, community colleagues and patient families/ advocates to coordinate reasonable adjustments to allow services to be accessible to this patient group. Please see Appendix 3 for case example.

In 2018/19 he learning disability flag was developed. This is an electronic identifier which records that the patient has a learning disability and any reasonable adjustments required. This will be completed on admission to hospital. It will also be completed for people who have been referred to the CNS-LD within the last year. An easy read reasonable adjustments questionnaire has been developed to ensure service users can complete this information. This was developed in partnership with services users from Orchard Hill College.

KCH and the LD service recognise the importance of service user and carer engagement. Bromley, Lambeth and Southwark Mencap, Thinking Autism and Bromley XbyX are all now associate members of KCH. The patient experience team continue to work with the Lambeth learning disability assembly and Orchard Hill Specialist College. The team are currently liaising with a service user and the CNS-LD has engaged with Astley Carers Group to capture their experience of using KCH services.

Lambeth Learning Disability Alliance carried out a review of Trust signage. Recommendations included; more consistent terminology to describe departments, increased signage to ensure people know they are going the right way, more eye level signage, colour coded lines or paths to guide people to certain buildings or departments, external signage guiding people to the nearest toilets and more seating availability in the corridor areas.

KCH recognises the importance of providing learning disability awareness training. As a result this is a component of the safeguarding adults level 2 training. The team have also contributed to the recent Department of Health and Social Care's Consultation on Learning Disability and Autism Training.

Learning Disability Mortality Review (LeDeR)
KCH have reported 11 deaths of patients with Learning Disabilities to LeDeR for the reporting period. Three of these have been signed off by Local Area Coordinator as completed. Two referrals are currently in process.

Two of the reported 11 deaths have been investigated as serious incidents by the Trust.
Learning themes from LeDeR Reviews / Serious Incidents reviews completed to date are the discharge planning process, understanding and documentation relating to the MCA and understanding of the needs of patients with learning disabilities.

Actions taken as a result of LeDeR reviews:

- Review of Learning Disability service provision with the outcome of an additional LD Liaison role.
- Additional learning disability training sessions provided on the PRUH site, carried out in partnership with service user, family carers and Oxleas community learning disability service.
- Drive to improve understanding of the Mental Capacity Act.
- Mental Capacity Act conference hosted in March 2019.

The Trust has 3 trained LeDeR reviewers who are currently supporting the review of 5 cases relating to care and treatment in KCH.

5. Mental Capacity Act and Deprivation of liberty Safeguards Activity

Mental Capacity Act
The SGA Service provides support to frontline staff through training, consultations, intranet resources, MCA Policy and practical support for complex cases.

As part of SGA services objectives to increase awareness of the MCA the service has teamed with legal services to provide MCA/DoLS "big talks" from November 2018. This involves guest speakers from 39 Essex Street who provide guidance on latest case law judgements.

In addition KCH hosted the 'Lambeth Together' awareness day in March 2019. This event was attended by both professionals and service users and focussed on best interests and advanced care planning.

The SGA service provided support for 3 complex cases that went to the Court of Protection (COP) in the reporting period. Nationally the COP sees approximately 60 cases per annum. Involving the COP is evidence of good practice.

Deprivation of Liberty Safeguards (DoLS)
The SGA Service continues to coordinate and monitor the DoLS applications for the Trust. The Service has worked with 17 local authority DoLS offices in 2018/2019. The DoLS Coordinator and the wider service assist frontline staff with the practical application of the legislation. In 2018/2019 the application rate shows a 94% increase from 270 in 2017/2018 to 524 in 2018/2019. Please see figure 1 for the yearly comparison. This significant increase demonstrates an increased awareness of the safeguards amongst front line staff.

Figure 1: DoLS applications per year

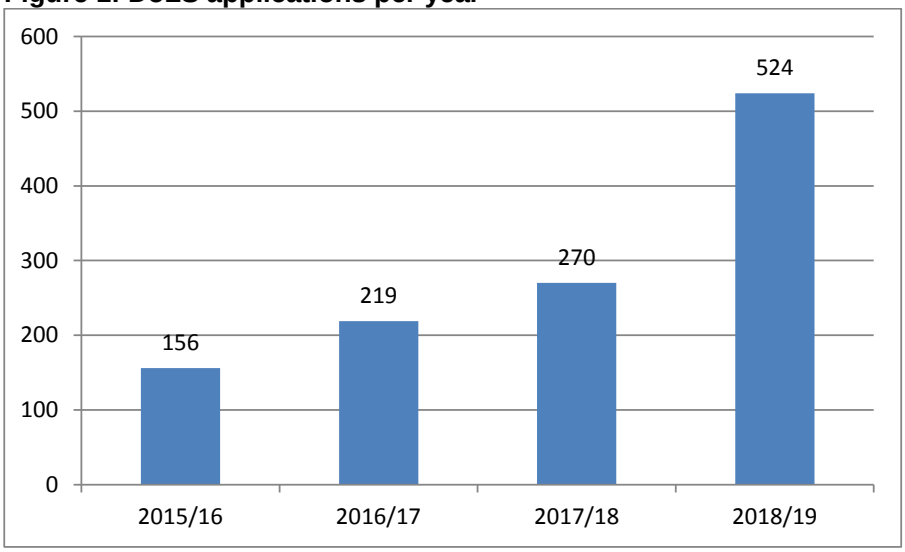
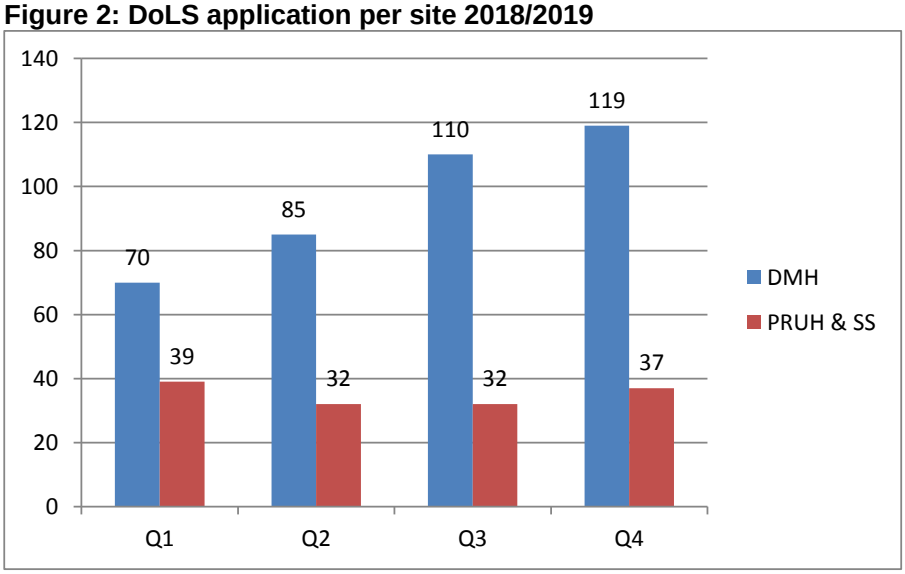


Figure 2: DoLS application per site 2018/2019



In the reporting year quarterly data has tracked application rate per site. (See figure 2.) The PRUH application rate has remained consistent between 30 and 40 referrals per quarter. The DH site has seen a quarter on quarter increase of 70 in Q1 to 119 in Q4. DH data demonstrates an increasing awareness/ understanding of the legislation. The application rate from the PRUH site has remained static. In 2019/2020 the SGA service will be concentrate on supporting PRUH staff in this area.

Out of the 524 applications 80 cases were 'not granted'. This means that the DoLS assessors deemed the application did not meet one of 6 criteria. These are;

1. Age requirement not met
2. Mental Health requirement not met
3. Mental Capacity requirement not met
4. No refusals requirement not met
5. Eligibility requirement not met
6. Best interest requirement not met

The remaining 444 cases were appropriate applications however many had the outcome suspended or withdrawn due to either the patient regaining capacity or being discharged/ transferred out of KCH. 78% resulted in a 'breach'. [5] During breach periods and in line with national guidance staff are advised to return to the MCA and treat patients in their best interests. This situation reflects the national picture of DoLS and is the key reason for the change in legislation.

Liberty Protection Safeguards

The Mental Capacity (Amendment) Act received Royal Assent in May 2019. The Deprivation of Liberty Safeguards will be replaced with the Liberty Protection Safeguards (LPS) system from October 2020. A new Code of Practice that will provide guidance / instruction for the LPS is expected in Spring 2020. Please see Appendix 4 for key features of the LPS legislation.

The new legislation means a significant change for NHS Trusts for the way a patient's liberty is protected during an in-patient admission, where they are unable to consent to their hospital stay. Currently the relevant local authority over sees the authorisation process for the safeguards. From October 2020 the Trust will take over this responsibility. The applicable age will also drop from 18 years to 16 years, meaning children services will also be involved in the change. The SGA service will be working closely with key internal and external services in 2019/2020 to ensure the change in responsibility is effectively resourced and implemented.

6. Training

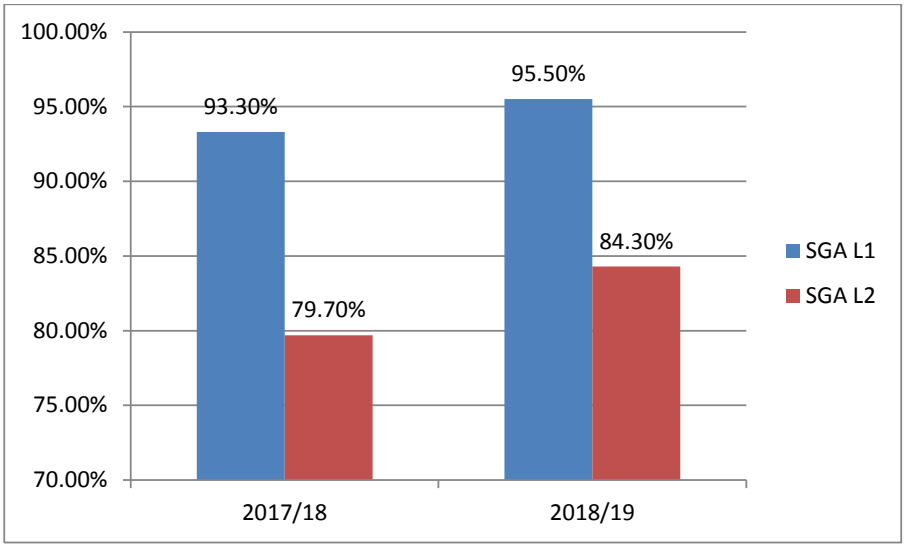
Kings is committed to ensuring its workforce is sufficiently skilled in safeguarding training. Over the last year training compliance figures have seen a quarter on quarter improvement for adult safeguarding training. It has been acknowledged by the Prevent Regional Lead that the Trust has made one of the best improvements nationally for its Prevent training compliance. However the CQC observed that our compliance percentages fall below the 85% target in Safeguarding Adults level 2, Prevent and MCA.

The Trust introduced mandatory standalone MCA and Consent training in October 2018, this is in addition to the MCA/DoLS training incorporated into the SGA L2 training.

Training percentages at 2018/2019 year end were:

- Preventing Radicalisation Level 1 & 2: **80.5%**
- Preventing Radicalisation Level 3: **74.1%**
- Safeguarding Adults Level 1: **95.9%**
- Safeguarding Adults Level 2: **84.3%**
- Mental Capacity & Consent: **65.9%**
- Please see figure 1 below to see the comparison with SGA training for 2017/18.
- Figure 1

[5] This is where there is a gap from the time our self-authorisation timeframe ends and before the DoLS assessors have completed their work to either uphold or disallow the application.



In August 2018 the Intercollegiate Document which sets out best practice for safeguarding adult training for the first time, was published. The SGA Service is working alongside the Learning and Development Service to support the integration of the intercollegiate document requirements with existing training to KCH to meet the training obligations by March 2021.

7. External Partners/ Assurance

The SGA Service works closely and is well supported by the Designated Nurses from Bromley, Southwark and Lambeth CCGs. The SGA service submits quarterly datasets to Southwark and Bromley CCG's and provides an annual assurance report to Lambeth SAB. The SGA service reports biannually to the CQRG.

Maintaining engagement with the Safeguarding Adults Boards and associated sub-groups was a priority for the SGA service in 2018/19. KCH has membership of Bromley, Southwark and Lambeth SABs and the SGA service has active membership of their associated subgroups

8. CQC June 2019

The CQC reported that staff continued to have a good understanding of the responsibilities to safeguard vulnerable people. It was acknowledged that staff understood MCA and consent how and when to assess whether a patient had the capacity to make decisions about their care.

The CQC had concerns about the service's governance arrangements in terms of delays in updates to the Trust Board. This relates to historical delays in concluding section 42 safeguarding referrals by the Local Authority. Since the inspection this has been escalated to Lambeth Safeguarding Adults Board and verbally to the Director of Adult Social Care for Lambeth, this was similarly raised with the Southwark Safeguarding Adults Board. The Deputy Chief Nurse will be formally notifying the LA directors of this concern.

The CQC had a concern that combining the adult and children's Safeguarding Committees meant reduced time for the discussion of adult services. As the learning and integration between services has improved significantly following integration the length and frequency of the meetings will be increased in 2019/20.to meet the concern.

Training percentage compliance was noted to be below 85% for Prevent and SGA L2. While overall figures are just below the target percentage, divisional breakdown show certain staff groups fall below expected compliance. The medical and dental staff group will need support in this area. This gap will be clearly reported on and monitored going forward.

The CQC reported noncompliance with MCA training. Standalone MCA and Consent training was introduced in October 2018, in addition to the MCA and DoLS already included in safeguarding adults level 2 training. The CQC did not make a reference to the MCA/ DoLS training within the level 2 training.

9. Risks

In 2018/19 the Risk Register has been a standing item on the Safeguarding Committee meeting agenda. Existing risks registered are for:

- **Prevent training - noncompliance with the 85% target**
  Please see Appendix 5 for actions taken to support compliance

- **LD service provision - as a result of a LeDeR review**
  The LD service provision has been reviewed and as a result we are recruiting into a post for a B7 LD Liaison Nurse

New risks to be added to the Corporate Risk Register post CQC inspection are;

- **Lack of outcomes for section 42 enquiries**

- **Safeguarding Adults Level 2 training and MCA Training – noncompliance with 85% target**

10. Priorities for 2019/2020

- **Addressing CQC concerns –** Training compliance for all safeguarding training to reach 85% target and to work with our external colleagues to support the timely outcomes of section 42 safeguarding enquiries
- **Focus on Internal engagement and supporting safeguarding activity at the PRUH site**
- **Dissemination of lessons learned**
- **Development of a Safeguarding strategy**
- **Focus on Service user feedback**

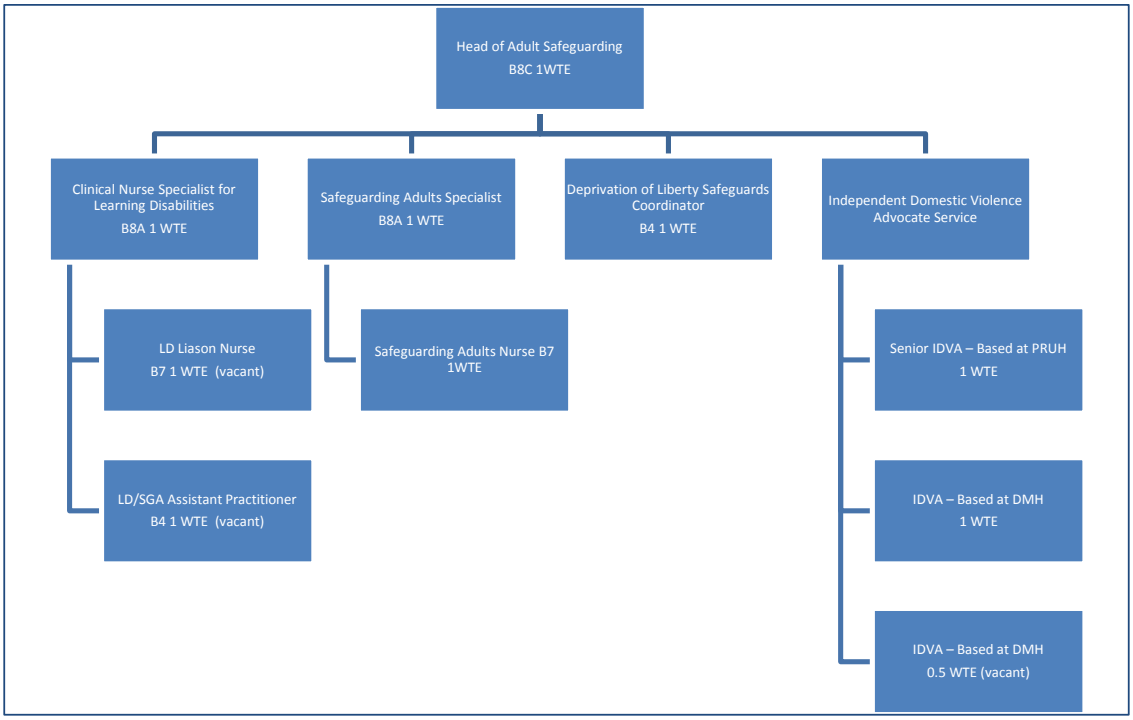
11. Conclusion

The Safeguarding Adults Service has concluded another extremely busy year. The SGA The service has clear priorities for 2019/20 and in addition will be working towards the changes to training proposed by the Intercollegiate Document and the Liberty Protection Safeguards legislation.

The SGA service faces the challenge of increasing areas of work as the speciality continues to develop nationally at a fast moving pace.

The SGA service continues to work to support all staff to up hold their responsibilities to safeguard at risk adults.

Appendices
Appendix 1: Safeguarding Adults Service Organogram 2019/2020



Appendix 2: Safeguarding activity data

Figure 1:1 2018/2019 L2 referrals

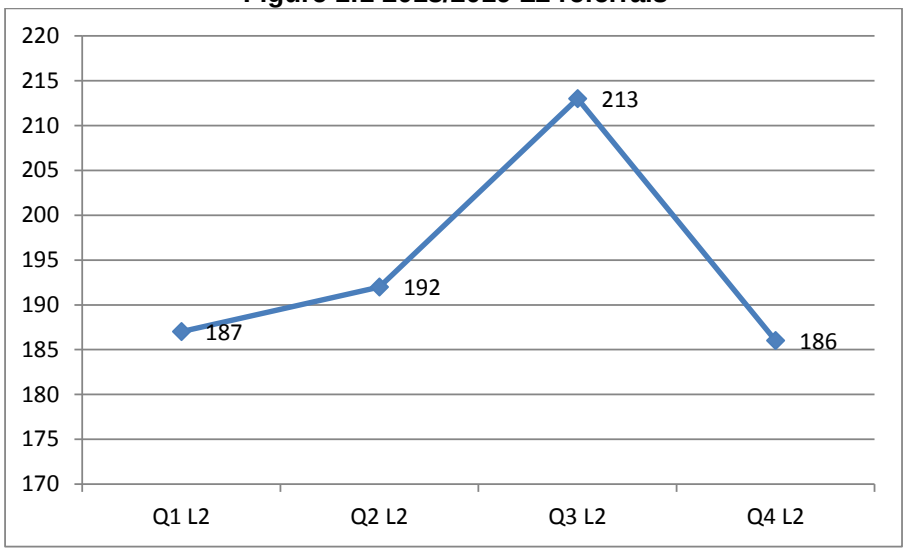


Figure1:2 2018/2019 L1 referrals

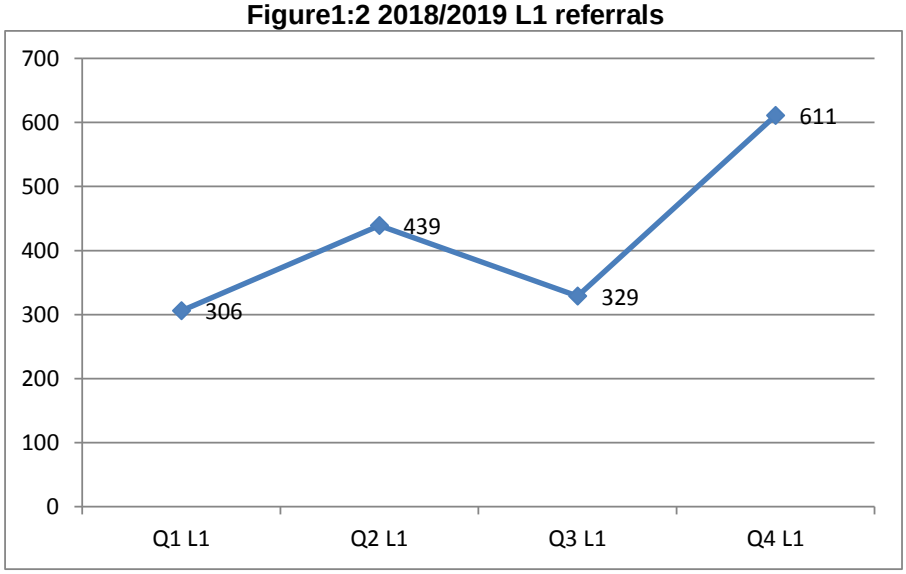


Figure 1:3 Total referrals for 2017/2018 and 2018/2019

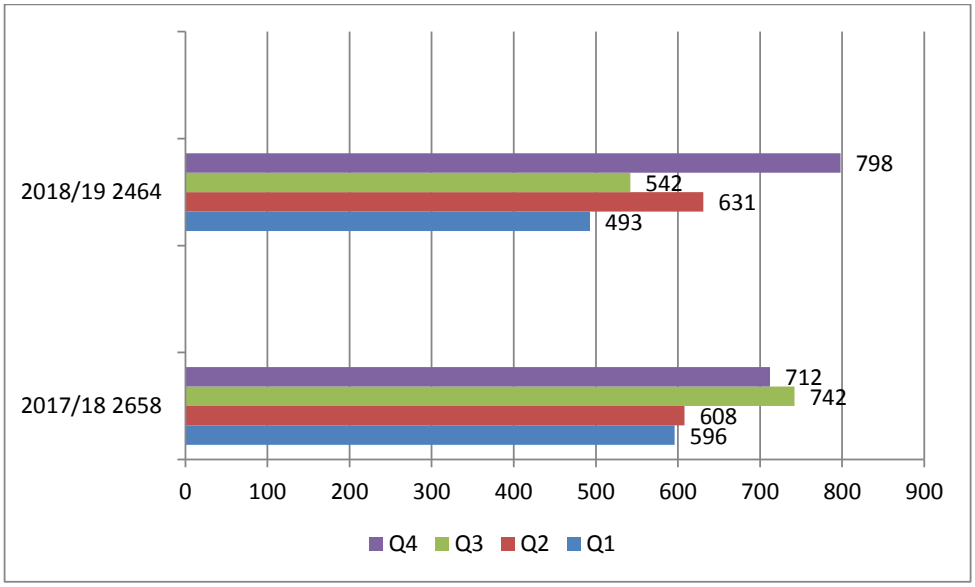


Figure 1:4 L1 and L2 referrals for 2017/18 1nd 2018/19

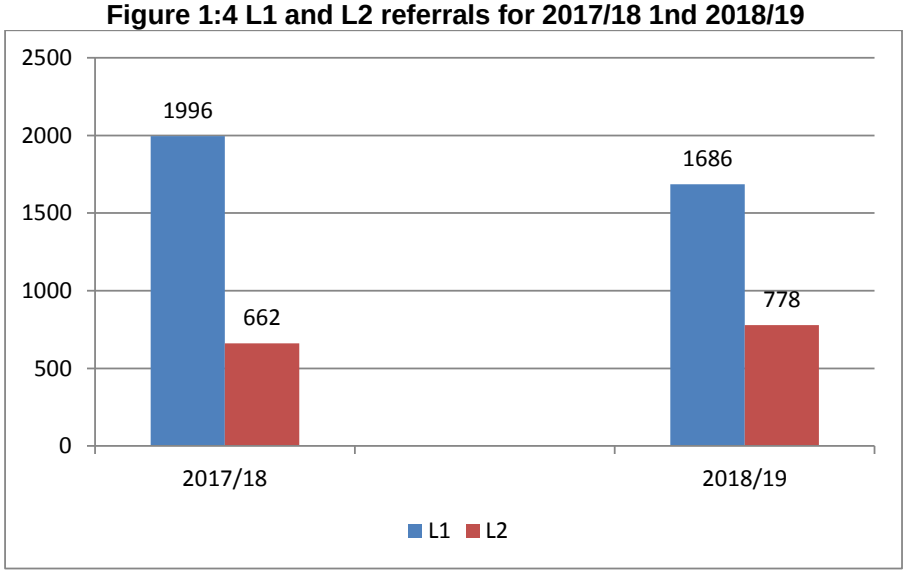


Figure 1:5 KCH implicated S42s concluded as abuse/neglect confirmed

No of cases	Category of abuse	Details
4	Neglect- pressure ulcers	Poor documentation/sharing of information with external professionals
3	Neglect- medication errors	Incorrect medication on discharge and poor communication with community pharmacy
2	Neglect- poor discharge	No district nurse referral/ lack of information with nursing home/ cannula left in place

Figure 1:6 Domestic Abuse referrals per quarter per site 2018/2019

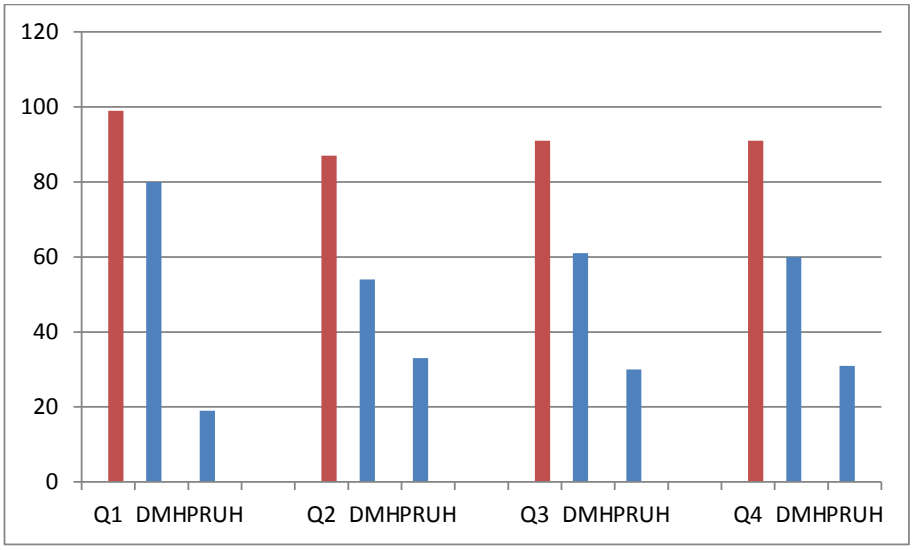
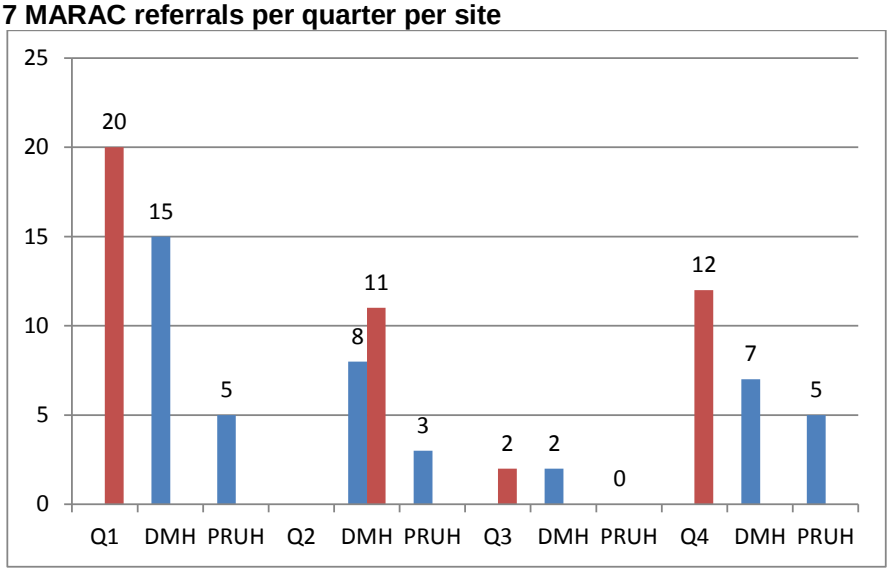


Figure 1:7 MARAC referrals per quarter per site



Appendix 3: Learning Disability Case example highlighting good practice

In 2019, the CNS-LD has worked with community learning disability colleagues in GSTT, Transport services and internal colleagues spanning special care dentistry, gastroenterology, radiology and day surgery to ensure a patient with Learning disabilities, Autism and a severe phobia of hospital/ health interventions had the required investigations following significant unexplained weight loss in the community.

The reasonable adjustments made included:

- Team briefed on patient's needs prior to admission
- Planning meetings held
- Co-ordinating investigations under one General Anaesthetic
- Working outside usual working protocols i.e. Community Learning Disability Nurse worked adapted hours, Anaesthetist visited the patient at home to administer sedation and anaesthetic support on route to hospital
- Recovery process adapted, family supported to be present, alternative recovery environment in order to reduce risks presented
- High dependency ambulance booked to wait for patient's duration of attendance at hospital
- Clinic booked out for the morning
- Team waiting to receive patient on arrival.

Appendix 4: Key features of the Liberty Protection Safeguards (LPS)

- In line with the Law Commission's suggestion they start at 16 years old. There is no statutory definition of a deprivation of liberty beyond that in the Cheshire West and Surrey Supreme Court judgement of March 2014 – the 'acid test' [i]
- Deprivations of liberty have to be authorised in advance by the 'responsible body'.
- For NHS hospitals, the responsible body will be the 'hospital manager'.
- For arrangements under Continuing Health Care outside of a hospital, the 'responsible body' will be their local CCG (or Health Board in Wales).
- In all other cases – such as in care homes, supported living schemes etc. (including for self-funders), and private hospitals, the responsible body will be the local authority.
- For the responsible body to authorise any deprivation of liberty, it needs to be clear that:
  1. **The person lacks the capacity to consent to the care arrangements**
  2. **The person has a mental disorder**
  3. **The arrangements are necessary to prevent harm to the cared-for person, and proportionate to the likelihood and seriousness of that harm.**
- In order to determine this, the responsible body must consult with the person and others, to understand what the person's wishes and feelings about the arrangements are.
- An individual from the responsible body, but not someone directly involved in the care and support of the person subject to the care arrangements, must conclude if the arrangements meet the three criteria above (lack of capacity; mental disorder; necessity and proportionality).
- Where it is clear, or reasonably suspected, that the person objects to the care arrangements, then a more thorough review of the case must be carried out by an Approved Mental Capacity Professional.
- Safeguards once a deprivation is authorised include regular reviews by the responsible body and the right to an appropriate person or an IMCA to represent a person and protect their interests.
- As under DoLS, a deprivation can be for a maximum of one year initially. Under LPS, this can be renewed initially for one year, but subsequent to that for up to three years.
- Again, as under DoLS, the Court of Protection will oversee any disputes or appeals.
- The new Act also broadens the scope to treat people, and deprive them of their liberty, in a medical emergency, without gaining prior authorisation.

[1] Is the person subject to continuous supervision and control and is the person free to leave? (Supreme Court Judgement 2014)

Appendix 5: Prevent Report March 2019

Prevent Update March 2019

Background

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. CONTEST focuses on all forms of terrorism.

The aim of Prevent is to ensure that there are preventative strategies in place across all agencies to support and divert people who may be susceptible to radicalisation, before they become directly involved in any illegal activity relating to acts of violence or terrorism. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial.

In April 2015, the Prevent Statutory Duty under Section 26 of the Counter-Terrorism and Security Act 2015 was made a statutory responsibility for the health sector. The Duty stated that the health sector needed to demonstrate "*due regard to the need to prevent people from being drawn into terrorism*".

Within health, NHS Trusts and Foundation Trusts are specifically mentioned in the Duty. However, Prevent is part of mainstream safeguarding and therefore all health staff must ensure vulnerable people are safeguarded.

The NHS Standards Contract requires all NHS funded providers to demonstrate they comply with the requirements of the Prevent Duty. This includes ensuring that there is a named Prevent Lead and that there is access to quality training for staff in their organisation.

In 2015 NHS Trusts were required to commence Prevent training for all staff, with a target date of March 31st 2018 to achieve 85% compliance.

KCH Prevent background

- In September 2017 the Trust commenced its Prevent roll out program, which coincided with the current Head of Adult Safeguarding commencing their post in August 2017. It should be acknowledged that the Trust was unfortunately late to implement the Prevent Training program.
- The current Head of Adult Safeguarding has worked closely with the NHS E Regional Prevent Lead to address the training need for the Trust.
- The Trust's position in regards to Prevent has been reported at each Quarterly Safeguarding Committee meeting
- The Trust's non-compliance to the March 2018 government target date was recognized and added to the Trust Risk Register in May 2018
- The Trust complies with the National Prevent Duty Data Sets Submission on a quarterly basis
- The Trust has a standalone Prevent Policy
- Training compliance and Trust position has been reported at each safeguarding committee meeting which is held on a quarterly basis.
- Commissioning colleagues (Southwark, Lambeth and Bromley) all noted the Trust's progress with Prevent in the Adult Safeguarding Annual Report 2017/2018.

Progress Mapping

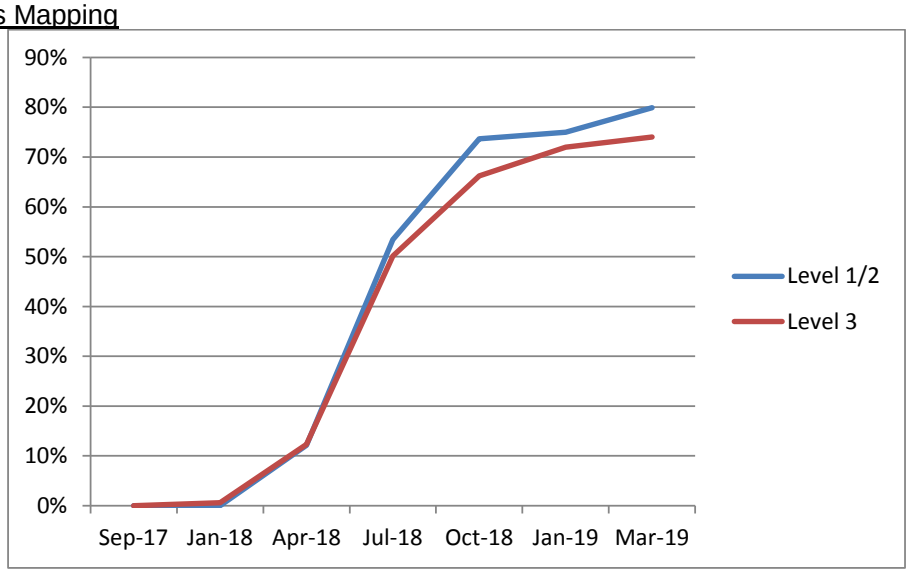


Figure 1: Prevent Training Compliance from September 2017 to March 2019

Work to support Trust compliance has included;

- 31 KCH staff members trained across sites to facilitate Prevent delivery
- L3 (WRAP) Intensive roll out programme; added to Induction sessions, added to bi-weekly Core Skills Update Session, additional stand-alone Prevent rolling sessions, added onto to existing planned meetings/ services day
- Safeguarding Administration supported the Learning and Development team with uploading Prevent registers onto LEAP.
- NHS E released an approved ELearning package for L3 (WRAP) in mid-February 2018, the SGA service worked alongside the Learning and Development team to align staff groups to either package, role dependent and this now appeared as part of Trust staff mandatory training.
- Prevent was added to new starters induction requirement
- The SGA Service and Learning and Development were supported by Coms Team to drive Trust awareness

NHS E Regional Prevent Lead Feedback in terms of KCH assurance and performance (based on January 2019 data submission)

"In terms of the Trust performance, Kings has historically been a poor performer in terms of Prevent training at Level 1-3 up until August 2017, when the current Head of Adult Safeguarding came into post. By way of context, (and at that point) the Trust was at 0% compliance for Level 3 Prevent training.

However capacity building training was undertaken including training for trainers and the new Prevent eLearning products were placed on the Trust's learning platform. The Trust is now at 72% for level 3 Prevent training which is one of the best improvements nationally- and the organisation is now on trajectory to meet full compliance of 85% trained at levels 1-3 in the next two quarters."

Paul Mccann

KCH Prevent current position

The Head of Adult Safeguarding recognises that as a Trust we have not reached 85% compliance and more work is required. The following plans are in place.

- Weekly communication to Managers whose staff show non-compliance with their Prevent training (with the support of the Learning and Development Team)

- Awareness Day, currently in discussions with Southwark CCG and Head of Safeguarding Adults at GSTT to co-host a morning at each Hospital to help drive up compliance
- Update reports will reported into the quarterly Safeguarding Committee meetings.

King's College Hospital NHS
NHS Foundation Trust

Report to: Board of Directors
Date of meeting: 3rd July 2019
Author: Siobhan Coldwell
Presented by: Dr Clive Kay
Sponsor: Dr Clive Kay
Subject: Chief Executive's Report
Status: For discussion and assurance

4.1

SUMMARY

This paper outlines the key developments and occurrences from May to July 2019 that the Chief Executive wishes to discuss with the Board of Directors.

ACTION REQUIRED

The Board is asked to:

1) note the:
   - key issues arising in respect of operational performance against the Trust's four main constitutional targets
   - M2 financial performance
   - key workforce developments including consultant appointments and safer staffing levels
   - findings of the CQC report and the action being taken to ensure the recommendations are fully addressed.
   - developments in respect of integrated care in south east London
   - summary of the NHS interim workforce plan.

2) ratify the Trust Workforce plan 2019/20, following endorsement of the Education and Workforce Committee.

REPORT FROM THE CHIEF EXECUTIVE

KING'S PERFORMANCE

Performance in the Trust remains challenged in all four access targets and the Trust missed its planned trajectories for the Emergency Care Standard (ECS) and for reducing the number of patients waiting more than 52 weeks for treatment.

RTT - 52 weeks Recovery
The May trajectory was missed by c30. There are a number of reasons for this, principally related to under-utilisation of available outsourced provision (e.g. South West London Elective Orthopaedic Centre [SWLEOC]). The majority of the backlog are trauma and orthopaedics cases (T&O). If performance continues on the current trajectory, June's target is also at risk. Consequently, a number of mitigations have been put in place:

- A secondee from NHSi, with significant expertise in elective care transformation has joined the Trust to provide additional support.
- New processes have been put in place for identifying and transferring patients to outsourced providers, particularly SWLEOC.
- Consultants will ensure that relevant patients are being prioritised.

The Trust fully appreciates the importance to patients of us meeting the trajectories we have laid out in the operational plan and it is hoped the mitigations described above, will ensure this commitment is delivered.

Emergency Care Standard
The overall performance for May 2019 was an improvement on the previous month, but below trajectory.

Denmark Hill
ECS performance improved at Denmark Hill during May to 70.10%, although this was below the target of 75%. The Trust has worked hard, with the support of Hunters, to improve the effectiveness of the UCC and this showed improvement in May. Bed availability remains a concern, weekend discharge is significantly better and there are a number of programmes are underway to reduce average lengths of stay. Other initiatives being developed include:

- reviewing demand and capacity across all care groups to ensure that the Trust's bed base is being used in the most effective way.
- reviewing the medical staffing model (job planning) to ensure the most effective use of the resources available.
- opening an interim same day Ambulatory Emergency Care Unit to reduce pressure on ED.

PRUH
ECS performance also improved at the PRUH in May to 77.6% but below the target of 82.5%. A detailed improvement plan is in place and there is support from NHSI. There is also a weekly CCG-led out of hospital group. There has been a renewed focus on clinical leadership and decision making as well as more consistent weekend discharge practices. Whilst UCC performance is generally better than DH, there is scope to improve.

Cancer
Both sites are compliant with the 2 week wait target. Inter-Trust Transfer performance has shown some improvement but the Trust is an outlier in London on meeting the 62 day target. The Trust is reviewing admin processes to ensure that any delays are minimised.

Diagnostics
The Board will be aware that there is a significant endoscopy capacity gap at the PRUH. A recovery plan is being implemented in order to improve capacity to recover the short-term position as well as develop a medium solution. A harm review is also underway. The backlog has reduced for patients on the activity diagnostic list (DMO1) as well as for surveillance patients. At the current trajectory, the backlog will be cleared by the end of September 2019.

A full Integrated Performance Report can be found at appendix 1 of this paper.

KING'S FINANCIAL POSITION M2

At month 2 the Trust is reporting a year to date deficit of £31.7m, £0.2m favourable to plan. A £5.2m adverse income variance is offset by favourable variances in pay £3.4m and non-pay £1.9m. However, it should be noted that the Trust has benefited from non-recurrent £2.1m positive variance relating to receipt of monies from NHS England which had previously been written off.

Pay is £3.4m favourable to plan, with favourable variances across all staff categories. Maintaining this positive variance will be essential in coming months to offset the ramping up of the CIP target phased to deliver in the latter part of the year. Non Pay is £1.9m favourable to plan. This is driven by the inclusion of a £0.9m positive variance on the KFM position and

the £2.1m positive variance as a result of NHS England paying debt which the Trust had previously written off.

Clinical Income is £1.8m adverse YTD, this includes an adjustment at Trust level of £2.8m for over performance on the block contract, a provision for challenges (£1.4m) and RTT 52 week fines (£0.9m). Excluding fines and challenges clinical income would show a £0.5m favourable variance. Private patient income is £0.5m adverse due to under-delivery against the Car-T plan. The annual plan was for 9 patients. There are potentially 2 currently in the work up stage so month 3 position should improve. Overseas visitor income is adverse by £0.8m due to a drop in the number of overseas patients being identified (47% less than at this time last year). Other operating income is £2.7m adverse predominantly due to a £1.9m difference in the phasing the NHSI plan and the final budget. This will come back into line throughout the year.

The capital position remains consistent with the briefing the Board received in May. However, the prioritisation list will inevitably need to be reconsidered in light of the CQC report recommendations.

The full finance report can be found at appendix 2.

KING'S QUALITY GOVERANCE

King's continues to have a positive reporting culture The overall trust reporting of no harm /near miss incidents against total incidents reported for May is 80% which remains above the national average of 73% of all incidents reported that cause no harm. This is an indicator of a good reporting culture for the organisation.

Incidences of violence and aggression towards staff remain high; the workforce team are working with the KCH Charity to provide a health and wellbeing program to support staff.

The Summary Hospital-Level Mortality (SHMI) for (1/11/17 to 31/10/18) is 96, below the expected of 100 (95% CI 92, 99) and. Our Trust wide Standard Readmissions Ratio (SRR) remains below expected (100) at 90 (95% CI 88, 92; 1/02/18 to 1/01/19).

Our King's Way for Wards Accreditation continues to progress with 78 clinical areas on the scheme. There are currently 50 wards on the scheme at Denmark Hill of which 9 are rated as green and 41 are rated as Amber of the 28 wards on the scheme at PRUH and South Sites 2 are rated as green and 26 are rated as Amber.

Complaints response rates are continuing to improve in terms of reducing the number of open complaints in the system and the total number of overdue complaints. In December 2018, we had over 80 complaints that were overdue and 180 open complaints, as of the end of May this had reduced to 44 overdue and 102 open complaints. The main themes for May related to communication and staff attitude. Overall patient experience feedback from the Friends and Family Test and how are we doing questionnaire remains good with scores for being treated with respect, dignity, and kindness and understanding both with 96% as good. Our overall NHS stars score is unchanged from previously.

CARE QUALITY COMMISSION (CQC) INSPECTION

The Trust's latest CQC report was published on 12th June. Whilst the overall rating "requires improvement" did not change, there were a number of changes in the scoring that sits underneath.. However the Trust was found to be 'inadequate' in the way it uses its resources and the ED service at the PRUH was also rated inadequate. The Trust takes this extremely seriously and has been developing and implementing an improvement plan in recent months and the Trust is working with partners to ensure there is proper oversight of the recovery plan.

The full CQC report is attached at appendix 3.

KING'S PEOPLE

Resourcing

The Trust vacancy rate remained at 10.90% in May 2019.

The Trust were finalists in the recent HPMA Awards with their 2018 Nurse Recruitment initiative. The ceremony was held in Manchester in June. Only 3 Trusts were shortlisted as finalists from 23 entries in the recruitment category.
The following Consultants have joined the Trust since April 2019;

- Dr Uday Kumar (Honorary Consultant in Paediatric Allergy Clinics) joined 1 April 2019
- Mr Iain Parsons (Honorary Consultant in Cardiology) joined 1 April 2019
- Dr Jun Liong Chin (Honorary Consultant in Hepatology) joined 1 April 2019.

Safer Staffing (Nursing)

The Trust continues to monitor safer staffing levels in line with the Francis recommendations. The aggregate nursing and midwifery staff vacancy for May 2019 has increased slightly this month to 8.41%. This has steadily increased since October 2018 when the overall vacancy was 6.0%.

The registered nursing recruitment hotspots are outlined below. Various successful recruitment campaigns have decreased the vacancies, but some areas still remain with an above 10% vacancy rate.

- **DH:** Acute and Emergency Care (13.26%), Theatres and Anaesthetics (15.17%), Children's (18.23%), Cardiovascular (12.77%), Cancer (13.98%)
- **PRUH:** Acute and Emergency Care (18.20%),

Please note: Paediatric Services at the PRUH have a vacancy of 9.08% during May 2019. This is a decrease of 3.29%, since December 2018, the Children's Care Group across both sites have been working closely with HR to address this and have a pipeline due to start during October 2019, from the Newly Qualified Nurse deployment. A full report can be found at Appendix 4 and it includes a summary of action being taken to address nursing and midwifery recruitment and retention.

The King's Workforce Plan 2019-20
The Trust develops a workforce plan each year. The current plan, attached for agreement at appendix 5, has been discussed in detail at the Education and Workforce Committee and is presented here for ratification.

King's Stars Annual Awards 2019 – 3rd July
In partnership with King's Charity and their generosity the Trust will be launching its second annual King's Stars Awards Ceremony on the 14th November 2019 at the Kia Oval. The process for nominations is currently open and will enable staff and patients the opportunity to nominate individuals and teams who have gone above and beyond in a variety of different categories. At the annual event, the Trust will also take the opportunity to recognise staff that have reached their 25 years and 40 years' anniversary of working for King's. A robust communications plan will support the launch of the event.

King's Diversity Festival
The Trust to mark its continued commitment to Equality Diversity and Inclusion will be hosting its first Diversity Festival during the first two weeks of July. The festival will incorporate events across Denmark Hill and the PRUH on mental health and the accessibility information standard as well as the BAME Annual conference and the PRIDE march. The event is open to all staff working at King's.

KING'S RESEARCH AND INNOVATION

Following the success launch of the R&I Strategy on 11th April 2019, the focus of R&I is now directed to increasing recruitment to research studies, particularly at the PRUH (cutting edge commercial and non-commercial studies), experimental medicine, patient public interaction (PPI) as well as artificial intelligence and digital big data collection. The R&I department are also putting in place an advanced therapy medicinal product (ATMP) academy to underpin the increasing national activity in the experimental medicine arena.

KCH is also one of the key Trusts participating in the successful INNOVATE award - "Creating a network of digital pathology, imaging and AI centres" and COGSTACK, an information retrieval and extraction platform, will underpin this initiative.

National Clinical Trials Day was recently celebrated at both the Denmark Hill and PRUH sites – with many research areas participating. This day promoted the diverse range of studies that are open to KCH patients to participate in, as well as raising awareness of the research carried out within these sites to patients, public and staff members.

STP DEVELOPMENTS

The Trust received the letter below from Andrew Bland, the South East London STP lead:

South east London is the first area in London to join NHS England and Improvement's third wave of Integrated Care Systems

Simon Stevens, Chief Executive of NHS England and NHS Improvement has today announced that Our Healthier South East London is the first area of London to join the third wave of the national Integrated Care System (ICS) programme.

ICSs bring together local health and care organisations and local councils to re-design care and improve population health, through shared leadership and action. South East London ICS will build on the collaboration of the partners to date through Our Healthier South East London, to help people stay well for longer by supporting them to lead healthier lives,

manage their own health conditions and provide easier access to care when they need it, often closer to where they live.

The organisations that form the south-east London ICS are:

NHS Bexley CCG
NHS Bromley CCG
NHS Greenwich CCG
NHS Lambeth CCG
NHS Lewisham CCG
NHS Southwark CCG
London Borough of Bexley
London Borough of Bromley
Royal Borough of Greenwich
London Borough of Lambeth
London Borough of Lewisham
London Borough of Southwark
Guys and St Thomas' NHS Foundation Trust
Kings College Hospital NHS Foundation Trust
Lewisham and Greenwich NHS Trust
Oxleas NHS Foundation Trust
South London and Maudsley NHS Foundation Trust

The leaders of all these organisations have committed to collaboratively leading the health and care system in south east London to address financial, performance and quality challenges and break down barriers to working more effectively across organisations. There are many examples of how we are doing some this now, for example:

1. In Bromley, health and social care organisations are working together in the *One Bromley* alliance. GPs, community matrons, geriatricians, mental health services, social care and the voluntary and community sector have worked together to identify patients who may need extra support and have so far improved the quality of care of 3,400 patients with complex and long-term health conditions. This has reduced A&E admissions by 34% for this cohort in the first six months.

2. For Mental Health services, Oxleas NHS Foundation Trust and South London and Maudsley NHS Foundation Trust have been working as the South London Partnership with South West London and St George's NHS Trust. Together they have delivered care closer to home for children and young people - with a 75% reduction in out of area placements.

3. Working together as the South east London Cancer Alliance, our partnership has ensured patients who see their GP with vague but worrying symptoms are now able to see a consultant and have several diagnostic tests on the same day at Rapid Access Diagnostic Clinics at Guy's and Queen Mary's Hospitals. The clinics have seen over 1,000 patients.

4. As a system, sharing records helps clinicians to make informed decisions faster both improving productivity and outcomes for patients. Our partnership work means there are now over 1.7 million shared electronic patient records that have been viewed over 5.3 million times by clinicians in south east London.

5. Lambeth Together brings together health, care and communities to make it easy for people to connect to the right services and support and improve services for people. Through its Living Well Network Alliance, over 500 people a month access a multi-agency front door, for example get help with employment and housing; factors that have a huge impact on health and wellbeing. About 10 people each evening access it's out of hours crisis support service, provided by voluntary and community sector organisations.

There are many other excellent examples and we want to be able to do more of this kind of joined up work more quickly. We cannot do any of it without your support and hard work and I'd like to take this opportunity to thank you for your contribution, which has helped us to get to this point.

Yours faithfully

Andrew Bland
Our Healthier South East London - STP Lead

NHS Interim People Plan

NHS Improvement has published its interim NHS people plan which sets the national strategic framework for the workforce over the next five years.

The plan was ordered as part of the NHS Long Term Plan and drawn up under NHSI Chair Dido Harding, and Senior Responsible Officer Julian Hartley, CEO of Leeds Teaching Hospitals NHS Trust. A national steering group engaged extensively with stakeholders, including NHS Providers, to ensure a wide range of views fed into the document.

NHS Providers have produced an "on the day" briefing which provides a full analysis of the interim people plan. It discusses key initiatives including consultations on a "new offer" to NHS staff; a pensions policy proposal; and a new "leadership compact". It also proposes measures to significantly grow the nursing workforce; review HR/OD best practice in NHS trusts; and devolve workforce planning to regions, systems and local NHS organisations. The full 'on-the-day" briefing is attached at Appendix 6.

Integrated Performance Report

Month 2 (May) 2019/20

Board Committee
3 July 2019

Contents

King's College Hospital NHS Foundation Trust

Executive Summary 2019/20 Month 2

King's College Hospital NHS Foundation Trust

Best Quality Of Care – Safety, Effectiveness & Experience

- The national Summary Hospital Mortality Index (SHMI) is 94.64 based on the latest data available, and performance on all Trust sites is better than the expected index of 100.
- HCAI – No MRSA bacteraemia cases reported to May; 10 new VRE bacteraemia cases reported in May which is above the target of 3 cases; E-Coli bacteraemia: 8 new cases reported in May which equals the target of 8 cases; 9 new C-difficile cases which equals the monthly quota of 9 cases.
- Friends & Family (FFT) Inpatient survey recommendation score improved from 93.1% in April to 94.7% in May. FFT score for ED at Denmark Hill reduced from 74% to 73% for May, and reduced at PRUH from 68^ to 66% in May.

Best Quality Of Care – Patient Access

- Trust A&E compliance improved from 71.73% in April to 73.50% in May, but remained below the recovery trajectory of 78.5%.
- Latest data available shows that treatment within 62 days of post-GP referral is not compliant with the 85% target at 78.7% for May 2019. Treatment within 62 days following screening service referral is compliant with the 90% target at 94.0%
- The national target of 1% patients waiting above 6 weeks for diagnostic test was not achieved in May at 8.91% but exceeds the planned trajectory of 11.1%.
- RTT incomplete performance improved further from 77.53% for April to 78.80% in May. The number of patients waiting >52 weeks increased by 6 to 177 cases in May, of which 174 cases are admitted incomplete pathways and 3 cases are non-admitted.

Excellent Teaching and Research

- The Number of Studies figures (132 in total) show the number of active studies by study-type (which indicates complexity and funding allocation) from the first month of this year. There have been 2733 patients recruited into active studies for this financial year.
- There are zero open incidents which are currently under investigation/review (this is reported quarterly).
- There have been zero serious events that have been subject to in-depth investigation, reporting and remedial action planning.

Skilled, Motivated, Can Do Teams

- Appraisal rates: decreased by 9.75% from April to 64.32% in May, below the 90% target. This was due to decrease in the non-medical appraisal rate to 59.67% for May.
- Statutory & Mandatory training: compliance increased from 82.07% in April to 83.39% in May, and remains above the 80% target.
- Sickness rates: shows a decrease for the fourth consecutive month from 3.35% in April to 3.20% in May. Of the 1,922 occurrences reported in May, 1,689 are classified as short-term and 233 as long-term instances.
- Vacancy rates: remained at 10.90% in May. The vacancy rates for the divisions are PRUH/South Sites at 9.52%, Networked Services at 11.47% and UPACs at 9.21%.

Top Productivity

- **Outpatients**: Digital Outpatients strategy paper circulated for feedback and completed.
- **Kings Way for Wards (KWfW)**: 45 wards completed out of the 79 wards across all sites, and ten wards have achieved green accreditation with a score of 90% or more.
- **Theatres**: Average Cases Per Session productivity has been above baseline twice over the previous 5 weeks.
- **Flow**: 9-month trial of Acute Surgical Pathway nurse commenced to facilitate early assessment and streaming from ED at the DH site. ED internal professional standards continue to embed and the 20% increase in specialty response within 60 minutes continues to sustain at PRUH.

Firm Foundations – Finance

- At Month 2 the Trust is reporting a year to date deficit of £31.7m, which is £0.2m favourable to plan.
- Income: reporting an adverse variance of £1.8m YTD which includes provision for challenges and 52-week penalties.
- Pay: reporting a favourable variance of £3.4m YTD with favourable variances across all staff categories.
- Non-Pay: reporting a favourable variance of £1.9m YTD to plan.
- CIP: Trust programme has delivered against internal plan of £49m, and The in-implementation value is split as 18% non pay, 71% income, and 11% pay with no significant variances in M2.

DOMAIN 1:
Best Quality Of Care - Safety, Effectiveness & Experience

- Healthcare Associated Infection
- Mortality
- Friends and Family Test

Domain 1: Key Delivery Metrics
Healthcare Associated Infection

King's College Hospital NHS Foundation Trust

OPERATIONAL CONTEXT

Denmark Hill

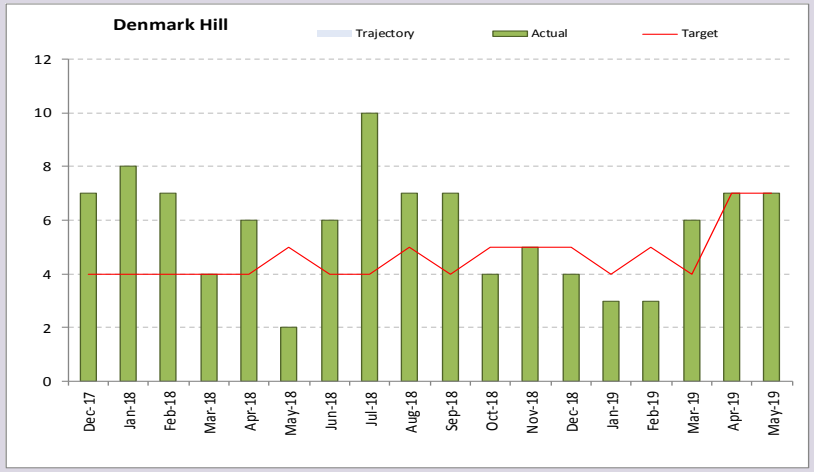
- **MRSA**: Zero cases reported in May, with the last case reported in March 2019.
- **C-difficile**: 7 cases reported in May which equals the target for the month of 7 cases. YTD there have been 17 cases reported.
- **e-Coli**: 8 cases reported in May which is above the target for the month of 6 cases. YTD there have been 16 cases reported.
- **VRE**: 10 cases reported in May which is above the target for the month of 3 cases. YTD there have been 17 cases reported.

PRUH

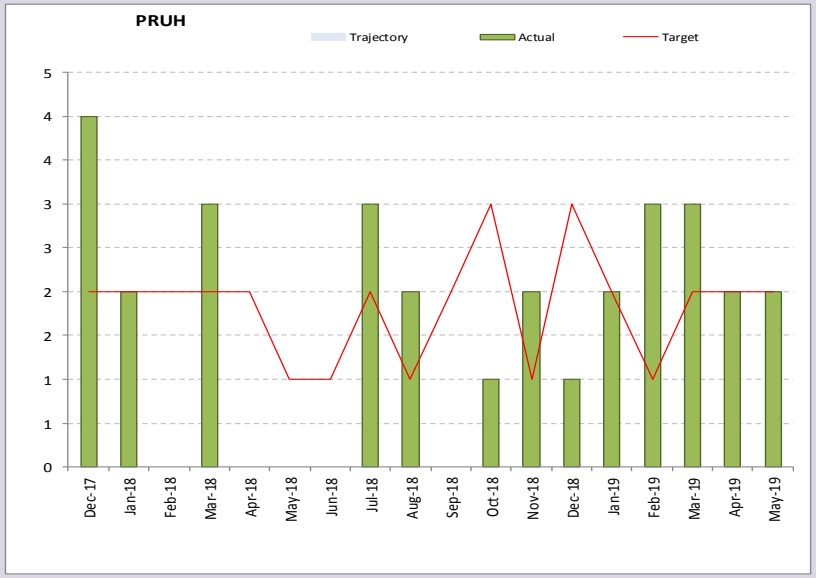
- **MRSA**: Zero cases reported in May, with the last case reported in March 2019.
- **C-difficile**: Two cases reported in May which equals the target for the month of 2 cases. YTD there have been 2 cases reported.
- **e-Coli**: Zero cases reported in May which is below the target for the month of 2 cases. YTD there have been 4 cases reported.

MAY DELIVERY

- **C-Difficile: Denmark Hill reported cases**



C-Difficile: PRUH reported cases



HCAI DELIVERY PLAN ACTIONS

Denmark Hill

- **MRSA**: There were no MRSA bacteraemias reported during the month of April and May 2019.
- **C.difficile (CDI):** The CDI cases also now include the community onset HCAIs. there were 4 cases reported in Haematology and 3 cases in critical care. The cases are all being reviewed and learning identified. Work remains on-going to address sampling whilst patients are on laxatives, and isolation on onset of symptoms which remains a challenge due to the lack of isolation facilities. The CDI Task and Finish Group meeting to agree further strategies is planned.
- **E.Coli :** The Gram Negative Blood Stream Infection Task and Finish Group meeting was held on the 18th June 2019. A number of actions/work streams remain on-going to reduce all GNBSIs, both at the PRUH site and DH.
- **VRE Cases:** The highest incidence of VRE remains in Haematology and Critical Care. The source in most cases has been identified as gut translocation. Some IV related cases have been seen, and the clinical teams are working with the IV team to improve practice.

PRUH:

- **MRSA**: There were no MRSA bacteraemias reported during the month of April and May 2019.
- **C.difficile (CDI):** The CDI cases also now include the community onset HCAIs. There were 2 cases reported for May, both within Post-Acute Medicine. The cases are all being reviewed and learning identified. Work remains on-going to address sampling whilst patients are on laxatives, and isolation on onset of symptoms which remains a challenge due to the lack of isolation facilities. The CDI Task and Finish Group meeting to agree further strategies is planned.
- **E.Coli :** The Gram Negative Blood Stream Infection Task and Finish Group meeting was held on the 18th June 2019. A number of actions/work streams remains ongoing to reduce all GNBSIs both at the PRUH site and DH. All GNBSIs are now being reviewed at the PRUH by the Surgical site infection surveillance nurse.

Domain 1: Key Delivery Metrics
Mortality

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

SHMI (Summary Hospital-level Mortality Indicator)

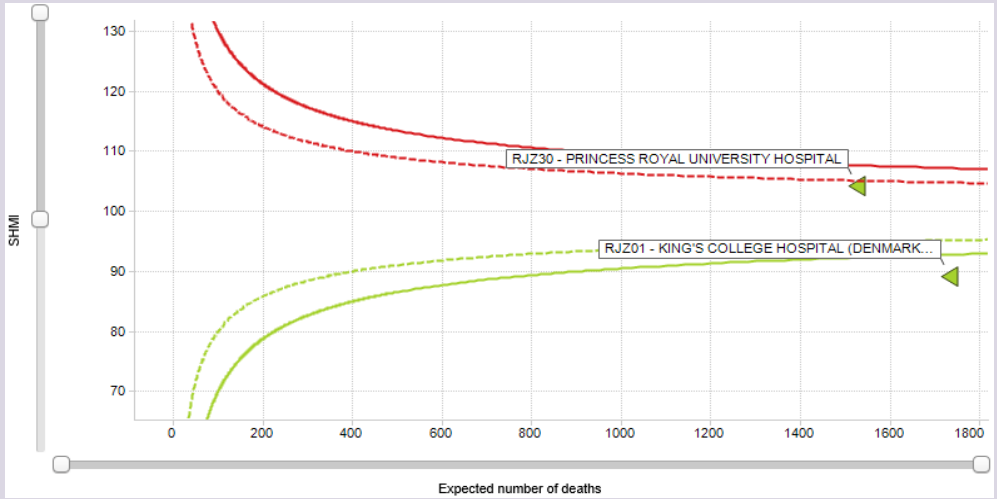
- King's SHMI (January 2018 to December 2018) is 94.64 (95% CI 91.40, 98.00), based on latest Hospital Episode Statistics data available via the HED system.
- The national Summary Hospital-level Mortality Indicator (SHMI) is a risk-adjusted mortality indicator expressed as an index based on the actual number of patients discharged who died in hospital or within 30 days compared to the expected number of deaths. A SHMI of below 100 indicates fewer deaths than expected.

HSMR (Hospital Standardised Mortality Rate)

- King's Hospital Standardised Mortality Ratio (HSMR) for HSMR for April 2018 to March 2019 is 85.50 (95% CI 81.71, 89.43), based on latest Hospital Episode Statistics data available via the HED system.
- HSMR is a similar model to SHMI but includes just 56 diagnostic groups, includes only in-hospital deaths and excludes patients identified as receiving palliative care.

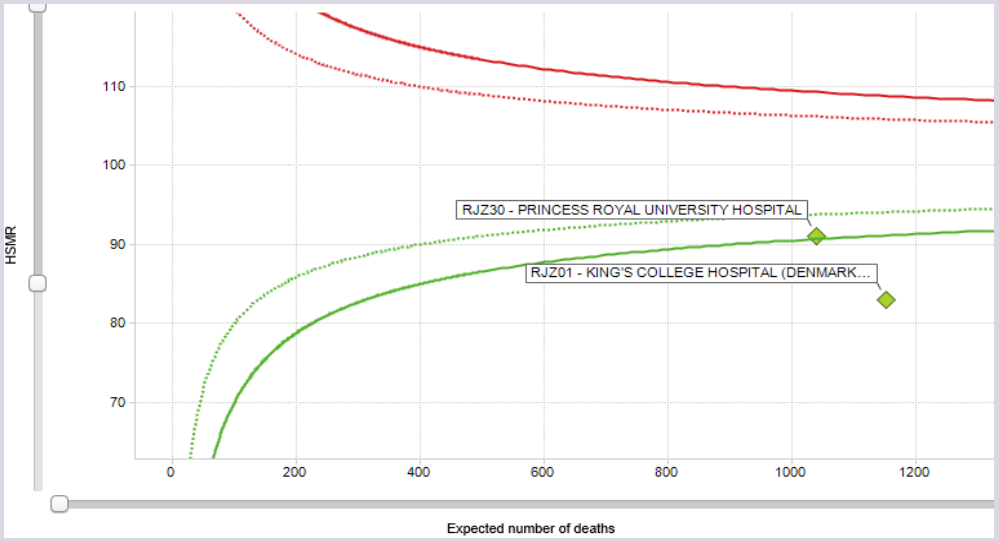
MORTALITY - HSMR and SHMI measures

- SHMI: Denmark Hill and PRUH



Data Source: HED

- HSMR: Denmark Hill and PRUH



MORTALITY : DENMARK HILL

- SHMI for January 2018 to December 2018 is 89.19 (95% CI 84.80, 93.70), representing a risk-adjusted mortality rate below expected.

As a result of ongoing issues with NHS Digital's external data supplier, HED are unable to update the monthly SHMI with the mortality outcomes after discharge. As a result data is only available up to December 2018.

- HSMR for April 2018 to March 2019 is 82.68 (95% CI 77.51, 88.10).

MORTALITY : PRUH

- SHMI for January 2018 to December 2018 is 104.30 (95% CI 99.20, 109.60), representing a risk-adjusted mortality rate within expected range.

As a result of ongoing issues with NHS Digital's external data supplier, HED are unable to update the monthly SHMI with the mortality outcomes after discharge. As a result data is only available up to December 2018.

- HSMR for April 2018 to March 2019 is 91.11 (95% CI 85.40, 97.11).

Domain 1: Key Delivery Metrics
Friends & Family Test

King's College Hospital NHS Foundation Trust

FFT - A&E

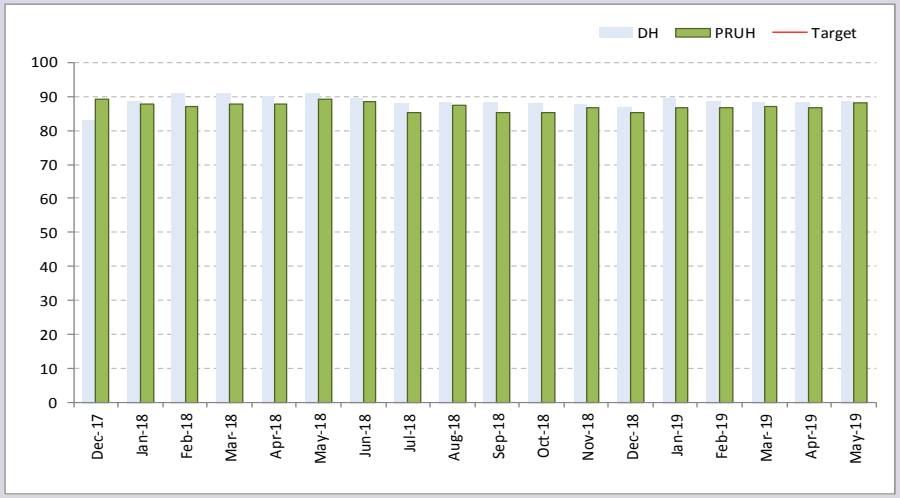
- Overall Trust FFT score dropped one point in May to 71% of patients recommending, with an increase of 3% for those patients not recommending - to 17% in May.
- The Denmark Hill FFT score dropped from 74% to 73%, and PRUH also decreasing again from 68% to 66% of patients recommending - the not recommending rate for May was 20%.
- Kings overall remains well below scores achieved by other London Trusts, and by Trusts nationally and the Shelford Group.
- CQC 2018 National Acute and Emergency Survey results - internal management report indicates drop in performance since last survey with a significant number of indicators red-rated. Overall patient experience rating similar for both sites with DH at 7.9 and PRUH at 7.8. Report for internal use only - CQC will publish in September 2019.

FFT - Inpatient

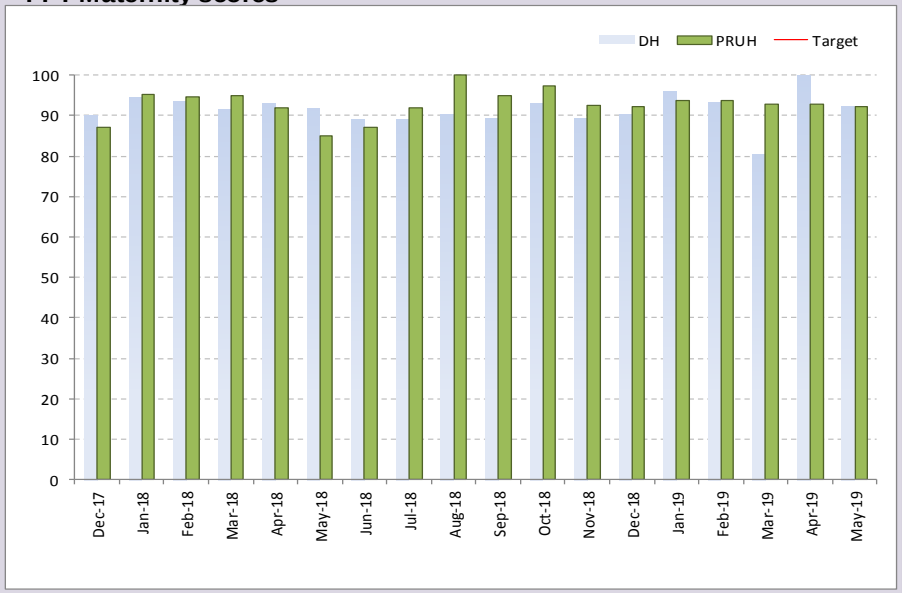
- Inpatient FFT increased slightly to 94.7% for May.
- The Denmark Hill score increased from 93% to 95% patients recommending, with PRUH recommendation rate slipping back 2 points to 92%.
- Response rates continue to remain steady but further work still needed to get all wards to the initial 25% target .
- The Trust remains generally in line with average FFT scores for the London region, and slightly below national average rate.

FRIENDS AND FAMILY TEST (FFT): MAY 2019

- **FFT Outpatient scores**



- **FFT Maternity scores**



FFT - OUTPATIENTS

- The overall Trust score remained at 88% for the third month in a row, with a 5% patients not recommending.
- Denmark Hill dropped one point to 88%, and PRUH increasing to 88.6% for May.
- A new Outpatient '*How are we doing*' survey will launch at the end of June to gather baseline information on outpatient experience. It will include questions to evaluate transformation work to-date, such as experience with receptionists to evaluate the new reception standards, gather feedback in clinics using the InTouch system and explore alternative options with patients for outpatient appointments in the future.

FFT - MATERNITY

- The overall combined FFT score increased by rose one point to 93%, with 2% patients not recommending.
- The Denmark Hill FFT score dropped from 100% recommendation in April to 92% in May, and PRUH remained at 92%.

DOMAIN 2:
Best Quality Of Care – Patient Access

- A&E – 4 Hour Waits
- Cancer Waiting Times
- Diagnostic Waiting Times
- Referral To Treatment (18 Weeks)

Domain 2: Key Delivery Metrics
A&E – 4 Hour Waits

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

Period: May 2019
Source: NHS England

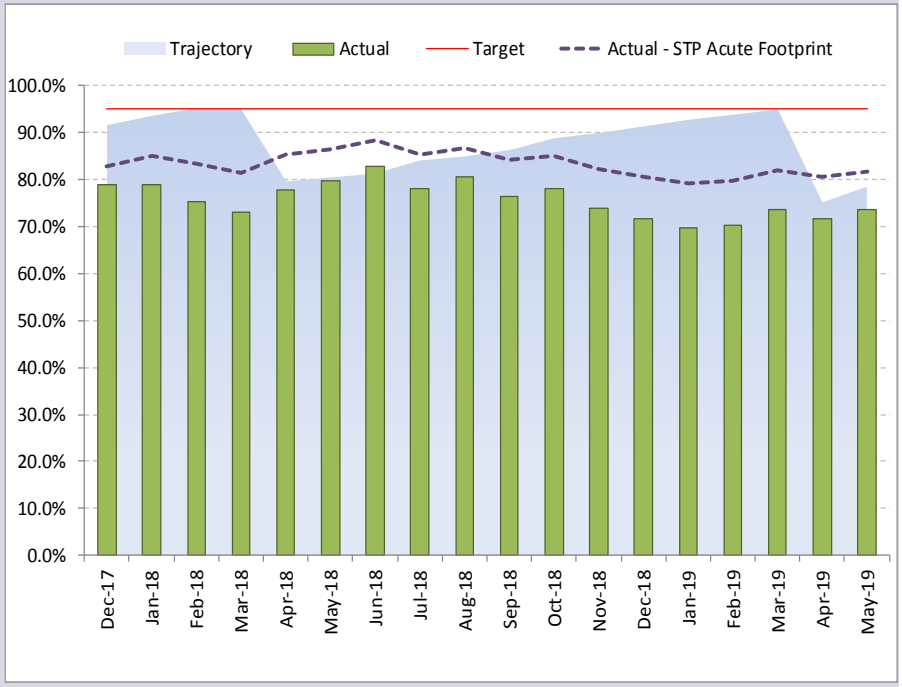
From December 2017 to June 2018, NHSI were including local Type 3 (urgent care centre) activity in published statistics. From July 2018 onwards, the figures below reflect provider level data which excludes non co-located type 3 activity:

- 20.2% of all ED/UCC providers (95) in England were compliant in May.
- Providers with less than 10,000 A&E attendances per month were compliant in 70.6% of cases, whereas only 8.5% of providers between 10,000 and 19,999 attendances per month were compliant.
- 25 providers have more than 20,000 attendances (including Kings) and none of the Trusts in this group were compliant in May.
- KCH had the 13th highest A&E Type 1 attendance volume in England (of 133 Acute Providers).
- KCH had the 14th highest volume of admissions via A&E (of 133 Acute Providers)

MAY DELIVERY

- Trust 4-hour performance improved from 71.73% in April to 73.50% in May. Compliance is below the recovery trajectory of 78.5% for the month.
- Aggregate STP acute footprint performance compliance improved from 80.64% in April to 81.73% in May, which includes non co-located Type 3 urgent care centre activity.
- Medical, surgical and specialist funded bed stock utilisation remained relatively static at 98.92% in May based on our daily Sitrep submissions.
- The proportion of formally reportable delayed transfers increased from 3.4% in April to 4.2% in May at an average of 3.4% of the 499 medical bed-base in April. This excludes patients who are medically fit for discharge but have not been classified as delayed transfers under national guidance as a multi-disciplinary case review had not taken place.

A&E: Maximum waiting time of 4 hours from arrival to admission, transfer or discharge



ACTIONS TO RECOVER

DH

- Joint weekly clinical meetings between Hurley and the Trust commenced as part of the UEC improvement programme.
- Increased GP cover provided to avoid the early morning gap.
- Pilot of primary care streaming taking place 18th and 19th June
- ADU opened beginning of June providing 12 -14 chair spaces
- Continue to support the ring fencing of 5 assessment trolley spaces on Brunel.

PRUH

- Recruitment issues have delayed appointment to the Patient Flow co-ordinator. The Assistant Service Manager is currently supported the role to support ED-acute flow.
- Approval to recruit to an Advanced Clinical Practitioner – role will support front door to deliver 'see and treat' model.
- Recruitment underway for senior doctor posts in ED to support early decision making and out of hours cover.
- AEC Business case to be discussed at June Investment Board to agree funding for substantive posts to continue extended operating hours.

ACTIONS TO SUSTAIN

- Culture change that achieves site-wide engagement recognised as a key enabler for both sites with targeted actions to deliver the recovery plan.
- At least weekly review of actions through groups on each site.
- Increased Board and Kings Executive (KE) oversight: Monthly Board reporting and fortnightly KE reporting on progress against recovery plan.

Domain 2: Key Delivery Metrics
A&E – 4 Hour Waits (2)

King's College Hospital NHS Foundation Trust

OPERATIONAL CONTEXT

Denmark Hill

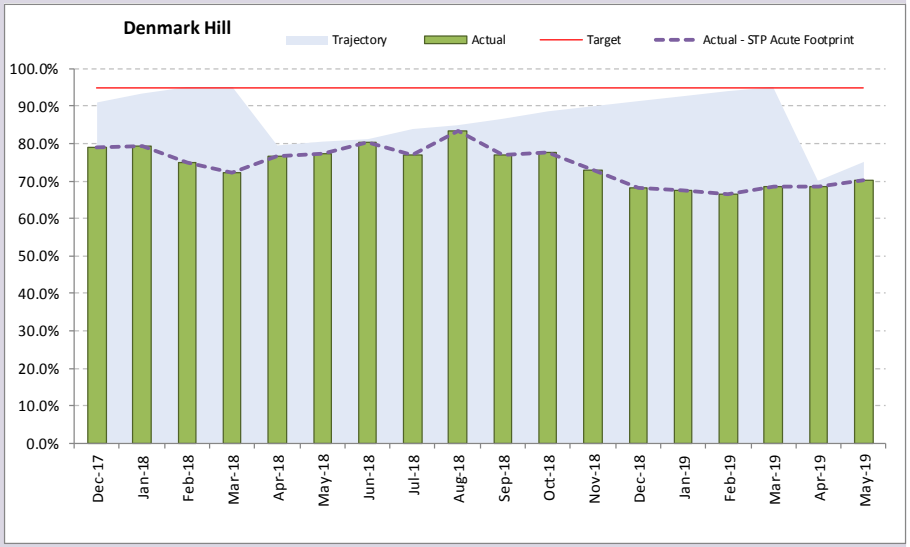
- 11,187 ED attendances in May-19 vs 10,834 in May-18, which represents a 3.3% increase in activity, with increased attendances in all age groups but particularly 279 additional attendances in the 0-64 age group.
- 2,838 emergency admissions in May-19 vs 2,655 in May-18 which represents a 6.9% increase, and a 13.4% increase in the 85+ age group.
- Daily average of 18 DToC in May19 compared to 13 DToC in May-18.
- 3,082 ambulance conveyances in May-19 vs 3,092 in May-18.
- 682 Red phone conveyances in May-19 vs 692 in May-18.
- 10 declared 12-hour breaches in May based on our daily Sitrep submissions.

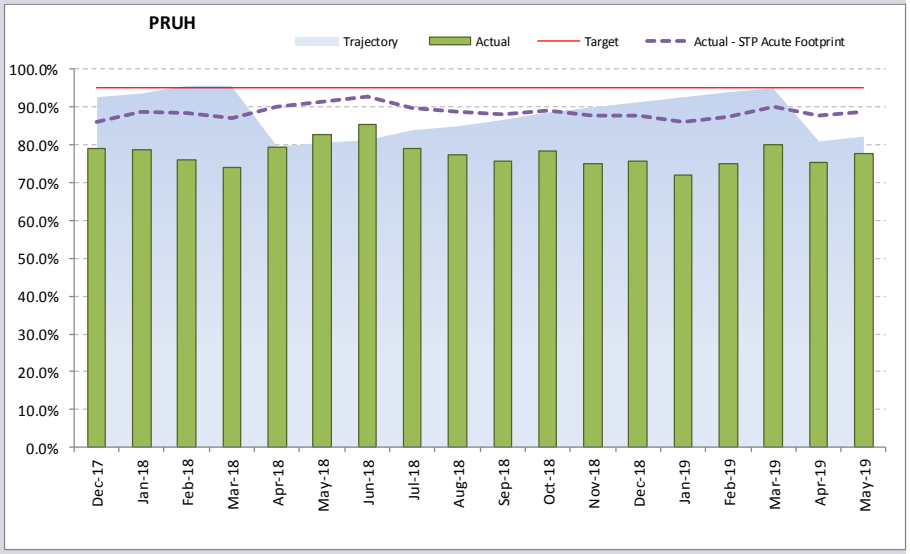
PRUH

- 5,569 ED type 1 attendances in May-19 vs 5,855 in May-18, which represents a -4.9% decrease in activity. There were reduced attendances in all age groups.
- 2,251 emergency admissions in May-19 vs 2,237 in May-18, with increased admissions seen in the 0-64 and 65-84 age groups.
- Daily average of 2 DToC in May-19 compared to 4 in May-19.
- 2,437 ambulance conveyances in May-19 vs 2,472 in May-19.
- 355 Red phone conveyances in May-19 vs 401 in May-18.
- 14 declared 12-hour breaches in May based on our daily Sitrep submissions.

MAY DELIVERY

- **A&E: Maximum waiting time of 4 hours from arrival to admission, transfer or discharge**





KEY RISKS TO DELIVERY: DENMARK HILL

- Further resignations in the ENP workforce within ED.
- Failure to secure appointments at 8a ENP level (only 1 of 7 posts filled).
- Reduced ED senior decision making out of hours, particularly at night.
- Short term medical staffing arrangements for Same Day Emergency Care unit not formalised.
- Activity through new ADU facility not yet embedded, and therefore providing limited support to performance improvement.

KEY RISKS TO DELIVERY: PRUH

- Senior operational and clinical leadership of ED processes and flow out of hours/weekends.
- Workforce gaps and recruitment – developing alternative workforce to include physicians assistants, ANPs.
- Physical capacity in ED and Business Case approval.
- Surgical ambulatory and assessment model and location.
- SAFER/ R2G length of time to embed on site.
- Sustainability and further improvements are dependent on a focused change programme requiring a system-wide approach to pathway redesign and organisational development.
- Community capacity and out of hospital pathways eg IVAB and other @home services.

Domain 2: Key Delivery Metrics
Cancer Waiting Times

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

Period: April 2019 (latest provisional data published)
Source: NHS England

- Compliance is assessed monthly; for the 62-day all cancers treatment target, only 11.9% of Trusts were compliant in all 12 months of 2018/19.
- Only 37.4% of Trusts were compliant with the 62-day time to first treatment target (85%) in April.
- Only 52 of 155 Trust's undertake =>100 treatments in month (including KCH), and 19.2% of Trust's in this peer group were compliant in April.

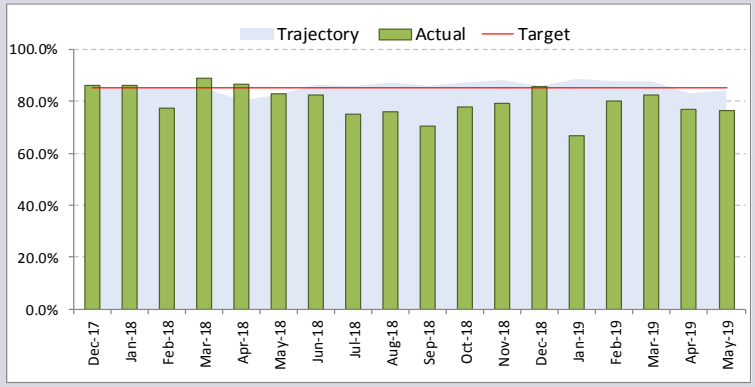
OPERATIONAL CONTEXT

- 2,424 2WW referrals seen in May 2019 vs 2,563 in April 2019, representing a -5.4% decrease.
- Based on the number of 2WW referrals received, the conversion rate to the cancer PTL was 4.4% in May-19, the same as Apr-19.
- There were no patients added to the PTL post day-38 in May 2019, consistent with the previous 6 months.
- There were 192 cancer 62-day treatments in May 2019 compared to 179 in April 2019.
- There were 185 total treatments (including non-cancer) in May 2019 compared to 192.5 in April 2019.

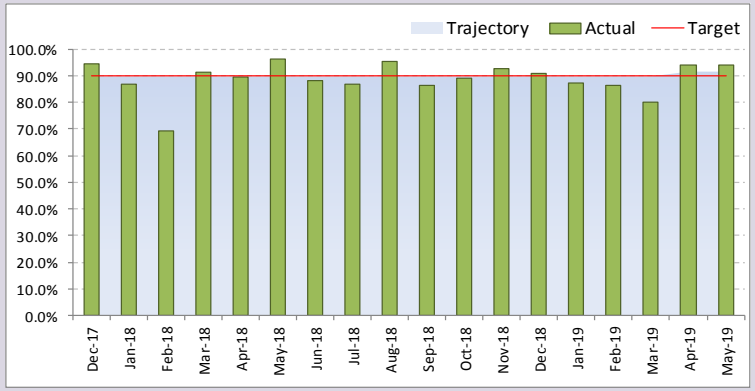
MAY DELIVERY

- Cancer compliance is subject to further ratification prior to national reporting, and is shown for indicative purposes only.
- Based on the latest month-end data for May, cancer treatment performance within 62 days following GP referral is not compliant with 78.7% of urgent GP referrals meeting standard (target 85%).
- Cancer treatment performance within 62 days following screening service referral is compliant with 96.3% of referrals meeting standard (target 90%).
- Two week waiting times performance following GP referral declined slightly from 93.5% in April to 93.% in May, but in line with the national target of 93%.

Cancer 62 days for first treatment: from urgent GP referral: all cancers



Cancer 62 days for first treatment: national screening service referral: all cancers



ACTIONS TO RECOVER

- In-month challenges include DH and PRUH prostate biopsy capacity issues, and PRUH colorectal radiology capacity issues.

Response actions include:

- Backlog clearance of un-reported PRUH 2WW radiology scans.
- Additional ad hoc prostate biopsy capacity.
- Review of PRUH colorectal radiology capacity to enable full coverage across Trust.

ACTIONS TO SUSTAIN

- HPB radiology workshop scheduled for mid-June.
- Reporting protocols to be complete by the end of June.
- Network HPB radiology buddying to commence in July (ACN initiatives that should reduce external referrals to Denmark Hill HPB service).
- PRUH colorectal radiologist to be recruited.
- Daily tracking hour in place targeting patients on pathway that need previous step reviewed.
- CNS-led colorectal referral triage and assessment model underway at PRUH.
- Trust approved diagnostic capacity fund in place for 2019/20.

Domain 2: Key Delivery Metrics
Cancer Waiting Times (2)

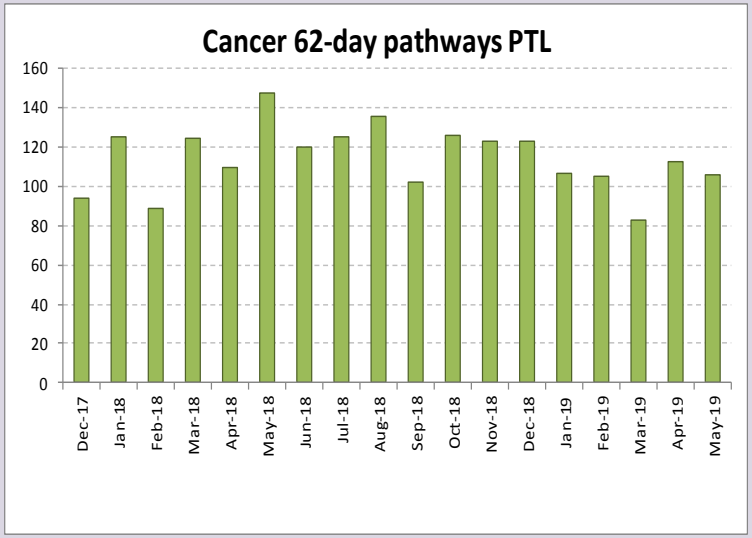
King's College Hospital NHS Foundation Trust

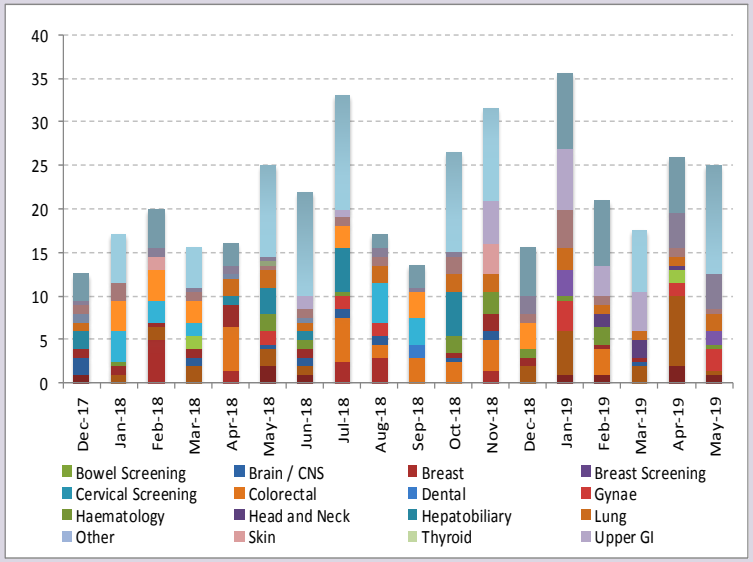
PATHWAY REDESIGN & IMPROVEMENT

- Process agreed for fast tracking first CT appointment on DH lung pathway. To be implemented when ACN funded navigators are in post - commenced in June 2019 at DH with initial training required. The same process will be developed for PRUH site.
- Molecular pathology turnaround times in place for lung pathways Trust wide (48 hours for processing, 24 hours for reporting) compliance.
- PRUH lung "cancer hour" in place to enable daily virtual pathway review (discussions in place for DH lung pathway).
- HCC pathway deep dive held - multiple capacity and demand reviews to be conducted.

MAY DELIVERY

Cancer 62-day PTL trend





IMPROVING >38 DAY TERIARY REFERRALS

- Revision of 2WW capacity and demand (for high volume, high impact specialities);
- ACN funded cancer pathway managers held in early June to provide further band-with for cancer pathway improvement and delivery. DH appointments made.
- Cross site consultant urology job plans being advertised to enable further elective capacity, particularly at the PRUH site.
- PRUH prostate pathway: ring-fenced prostate biopsy result slots to be devised.
- EBUS service being developed on PRUH site (to reduce diagnostic waits in lung pathway) - provisional go live date in July.
- PRUH endoscopy and radiology capacity reviews underway (with business case proposals to be submitted).

Domain 2: Key Delivery Metrics
Diagnostic Waiting Times

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

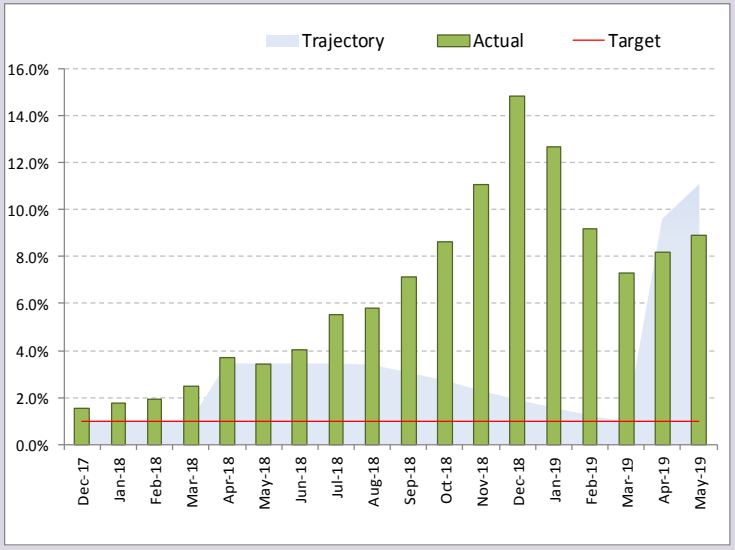
Period: April 2019 (latest published)
Source: NHS England

- Nationally 63.2% of Trusts were compliant in April 2019.
- KCH is in the 28 Trusts with the highest turnover (>13,000 tests per month). Within this peer group, 32.1% were compliant.
- 26.1% of providers with between 10,000 and 12,999 tests per month were compliant; 41.3% for providers with between 5000-9,999 tests per month.
- The majority of providers (283 of 367) deliver less than 5000 tests per month, with 79.2% of organisations in this group being compliant.

MAY DELIVERY

- The national target of 1% patients waiting above 6 weeks for diagnostic test was not achieved in May with Trust performance declining further to 8.91%. This was though better than the trajectory of 11.1% for the month.
- At site level, the number of breaches for PRUH sites increased from 754 reported in April to 758 in May, which equated to 12.97% performance. The breaches at PRUH are mainly endoscopy tests (617 in total) including 326 colonoscopy, 186 gastroscopy and 105 sigmoidoscopy breaches. There were also 115 breaches in cardiology - echocardiography.
- Performance at Denmark Hill is not compliant reporting 5.34% for May with 354 breaches. There were 275 breaches in cardiology echocardiography, 28 breaches in cystoscopy and 16 breaches in colonoscopy.

Diagnostics: Maximum waiting time of 6 weeks for diagnostic test



ACTIONS TO SUSTAIN

- Following KCH Performance Meeting with Commissioners and NHSI/E in April, it was agreed that the Trust would adopt a cross-site equalising approach in relation to PRUH Endoscopy backlog clearance and to mitigate risk associated with PRUH longest waiting patients. 18 Weeks Support outsourcing provider has been retained as part of the plan, undertaking weekend lists for PRUH patients at DH, and BMI have committed to providing an additional 60 patients per week for next 6 months.
- Backlog clearance Echocardiography on the DH site has been problematic with number of breaches rising again due to the service unable to secure additional temporary staff required, despite offering longer placements. Recovery plan revised and as of 12th June, we are already seeing a downward trajectory for June, though this remains above the initial forecasted return to compliance as of Month 4.
- Radiology continues to utilise additional capacity including use of independent sector, mobile imaging scanners and providing additional sessions in-house out of hours. DH MRI capacity remains fragile due to both demand (particularly for Cardiac MR) and the age of MR scanners resulting in unplanned downtime.

KEY RISKS

- PRUH Endoscopy capacity continues to be challenged due to high demand especially for 2WW referrals. Outsourcing capacity - risk remains with patients unwilling to travel and accept appointments. Transport is being offered to mitigate.
- Patient Risk: A Harm Review led by the Medical Director has been undertaken as part of the response to the serious incident raised in respect to the PRUH backlog. All patients waiting have been reviewed and risk-assessed; as of 16th May, 5 AIs have been raised in relation to possible missed cancers. A letter is being drafted to patients and GP, and once reviewed by Corporate Comms/Medical Director, will be sent out to all patients affected. A new hot line number will be available. Senior booking team staff will start calling patients with the longest waiting times.
- PRUH Endoscopy backlog clearance plan – Business case has been submitted to Investment Board (IBG) for June, for procurement of additional scopes and a Vanguard decontamination facility.
- Both sites Cardiac echo capacity remain dependent on existing staff working additional weekend lists. Additional temporary staff has proven problematic to secure, and the situation remains under daily review. Service has had discussion with GSTT but they are also using agency staff to maintain diagnostic waits.

Domain 2: Key Delivery Metrics
Diagnostic Waiting Times (2)

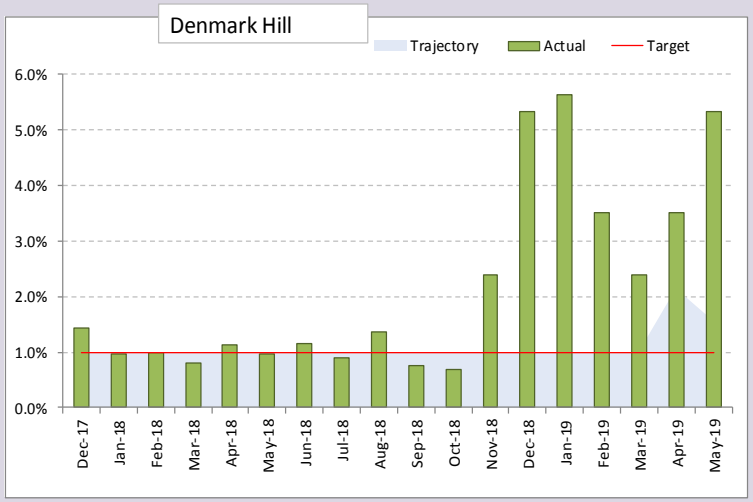
King's College Hospital NHS Foundation Trust

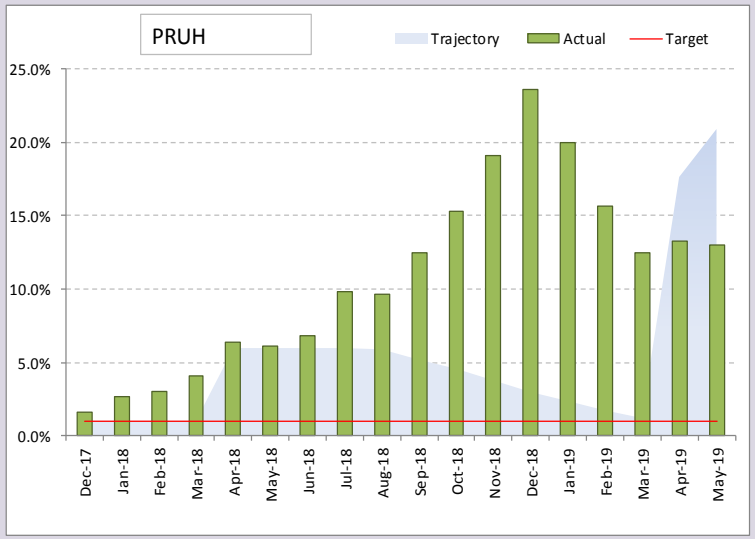
OPERATIONAL CONTEXT

- There has been a 247% decrease in the volume of tests undertaken in May 2019 (as reported on the DM01 return) compared to May 2018.
- For the same comparative period and 362 more cardiology echocardiography tests 337 more non-obstetric ultrasound tests, 190 more CT scans have been undertaken.
- We have however performed 1,243 fewer MRI scans, 435 fewer neurophysiology tests and 40 fewer audiology assessments.
- 12,475 patients waiting at the end of May-19 vs 11,574 in May-18, which represents an increase of 901 patients waiting.
- Over the same period 328 more cardiology echocardiography tests (1,921 patients waiting), 236 more colonoscopy tests waiting (779 total waiters), 181 more CT waiters (1,122 total waiters) and 121 more MRI test waiting (616 total waiters).
- In terms of waiting list reductions, there were 344 fewer patients waiting for DEXA scans.

MAY DELIVERY

Diagnostics: Maximum waiting time of 6 weeks for diagnostic test by Site





DELIVERY ACTIONS: DENMARK HILL

- Echocardiography – **271** breaches in May compared to the backlog clearance target of 59. Whilst the Care Group has permission to use 2 WTE additional temporary staff, it was unable to secure agency staff. Interim resource has now been secured, and further space has been identified in Radiology to undertake ECHOs, as Suite 6 is fully utilised. The latest capacity review anticipates that the backlog will reduce to 150 by June, and to 75 by July. This could reduce further if another agency member of staff becomes available.
- Endoscopy – **53** breaches in May as a direct result of the cross-site equalising approach in relation to PRUH Endoscopy backlog clearance; As a Trust overall the total diagnostic and surveillance breaches for May was 1,143 which is better than the 1,218 in the PRUH recovery trajectory plan.
- Gynae Cystoscopy – **27** breaches in May due to one of the three clinicians being off sick and the service unable to cover the lost sessions. Additional lists planned in June/July to catch-up. Care group looking to mitigate the fragility through reviewing the establishment and bolstering the team.
- MRI and CT - **10** breaches in May compared to 18 in April. Cardiac MRI and CT remains the area of greatest capacity pressures. Care group meeting with DDO weekly to review demand/capacity and outsourcing requirements.
- DH Dexa scanner – **4** breaches in May compared to 31 in April). Scanner replaced in March, with additional sessions ran across Saturdays in April and May ensuring return to compliance as of June.

DELIVERY ACTIONS: PRUH

- Endoscopy – 617 breaches in May, reduced from 701 in April). A full recovery programme is being managed on a daily basis and the size of the waiting list is reducing. PRUH referrals are being managed via activity to the DH site, 18 Weeks Support insourcing providing weekend lists at DH and PRUH, and outsourcing to BMI. It is hoped that additional capacity will be utilised at GSTT and Sidcup. Validation of the surveillance patients will be completed by the end of June and then, as agreed, waiting times will be equalised across the active waiting list and surveillance patients.
- Echocardiography – 115 breaches in May compared to 20 in April. Approval has been given for 21 additional lists at weekends, however, securing staff for this is challenging. Permanent recruitment is essential and DH and PRUH will be working together on this.
- Cystoscopy –11 breaches in May, which have been difficult to avoid with the number of Bank Holidays and school holidays . Close monitoring is in place to improve performance.
- CT – 8 breaches in May compared to 11 in April. Still a challenge due to the volume of tests, outsourcing is still being utilised.
- Non-Obstetrics Ultrasound – 4 breaches in May compared to 10 in April). A "spend to save" business case is to be submitted to IBG to resolve the capacity issues for Radiology modalities

Domain 2: Key Delivery Metrics
Referral to Treatment

King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

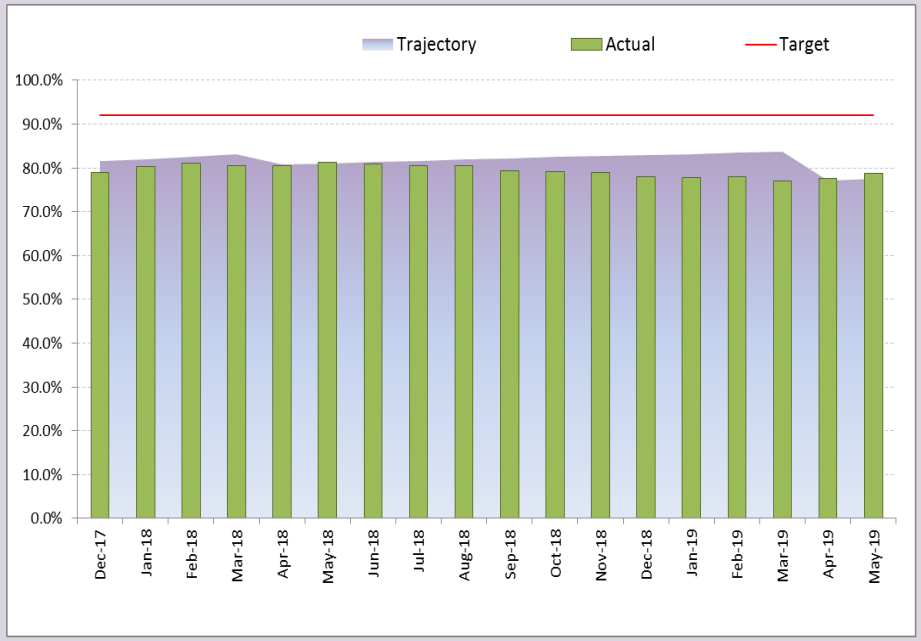
Period: April 2019 (latest published)
Source: NHS England

- Nationally 41.5% of Trusts compliant in April 2019.
- 68.1% of Trusts with a PTL (waiting list) of 20,000 or less were compliant, whereas only 15.2% of those with a PTL of greater than 20,000 were compliant.
- 15 Trusts have a PTL of >50,000 pathways, and only 1 Trust within this peer group is compliant.
- KCH has the fourth largest PTL in England (78,074) of those Trusts reporting RTT positions. Manchester University Trust (91,526), Barts Health (88,773), and University Hospital Birmingham (87,054) are reporting the largest PTL positions in England.
- The Trust had the 3rd highest GP referral demand in England (of 361 providers). In 2017-18 this demand reduced by -3.3% compared to 2016/17.
- The Trust was the 7th highest provider of elective admission in England (of 332 providers).

MAY DELIVERY

- Performance compliance improved from 77.53% for April to 78.80% for May (national target 92%). This reported position is better than the trajectory target of 77.6% for the month.
- Total PTL increased by 221 cases to 78,526 patients waiting for treatment at the end of May, with an increase of 1,168 pathways for patients waiting 0-17 weeks.
- The >18 week backlog decreased by 947 pathways to 16,649 in May compared to the April position of 17,596 - there were key backlog decreases in General Surgery (-168), Ophthalmology (-126), Dermatology (-122), T&O (-112) and Colorectal Surgery (-74). There were backlog increases reported in Oral Surgery (+58), Endocrinology (+26).
- >52 weeks breaches increased by 6 cases from 171 cases reported in April to 177 cases in May, which is above the trajectory of 144 cases. There were 174 admitted pathways (an increase of 8 patients) and 3 cases are non-admitted pathways. There was an additional 5 breaches reported in Colorectal Surgery, and 3 fewer breaches reported in each of Ophthalmology and Plastic Surgery.

RTT: Maximum waiting time of 18 weeks from referral to treatment



ACTIONS TO RECOVER

- Launch of new PTL performance dashboard from week commencing 10 June.
- Additional senior leadership support secured via NHSI to progress elective recovery programme.
- Care group PTL reviews in place supported by RTT Performance Manager.
- PTL meetings focus on 43-51 week wait patients to avoid further movement into the 52 week position.
- Weekly PTL meetings established and led by the COO at the DH site, and by the Deputy Director for Planned Care at the PRUH site.
- Capacity gap remains in Bariatric Surgery and discussions are on-going with commissioners regarding restrictions to bariatric referral acceptance. Existing capacity alerts have had no discernible impact to date.
- Following initial meetings held with the IST team for key challenged specialties including Ophthalmology, Orthopaedics, Colorectal Surgery and Bariatric Surgery) to review data requirements, IST launch and training scheduled for 6 June.

ACTIONS TO SUSTAIN

- Continued focus on management of long waiting patients.
- A new theatres productivity programme was launched on 3rd September 2018, using similar data, processes and principles to the national theatre productivity programme.
- An 8-4-2 booking process has commenced at PRUH.
- A new Trust-wide Governance system has been launched in March 2019. An interim RTT lead has been appointed to provide central leadership and co-ordination in support of the COO, and working daily across both divisions and linking into PRUH.
- Back to basics PTL management training for all service managers and outpatient staff being developed with roll-out in May.
- Transformation and development of alternative pathways underway, eg Advice & Guidance

Domain 2: Key Delivery Metrics
Referral to Treatment (2)

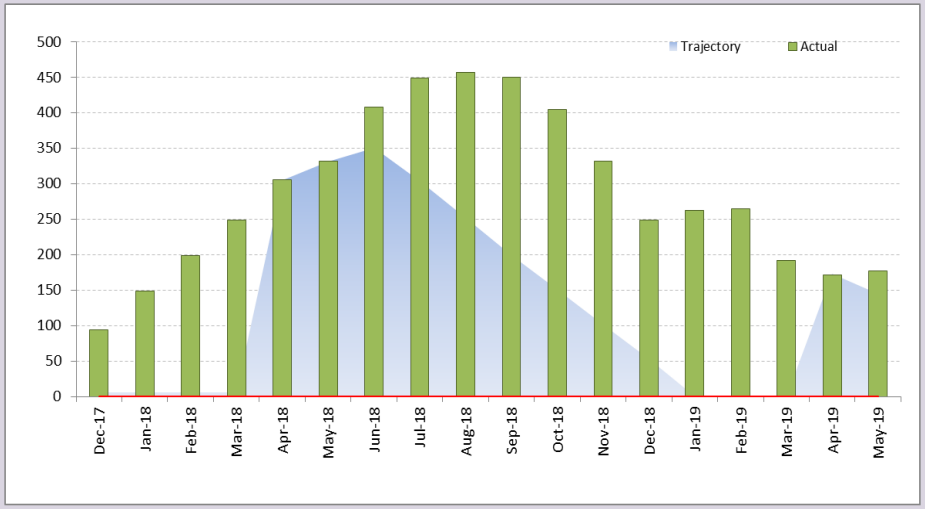
King's College Hospital NHS Foundation Trust

OPERATIONAL CONTEXT

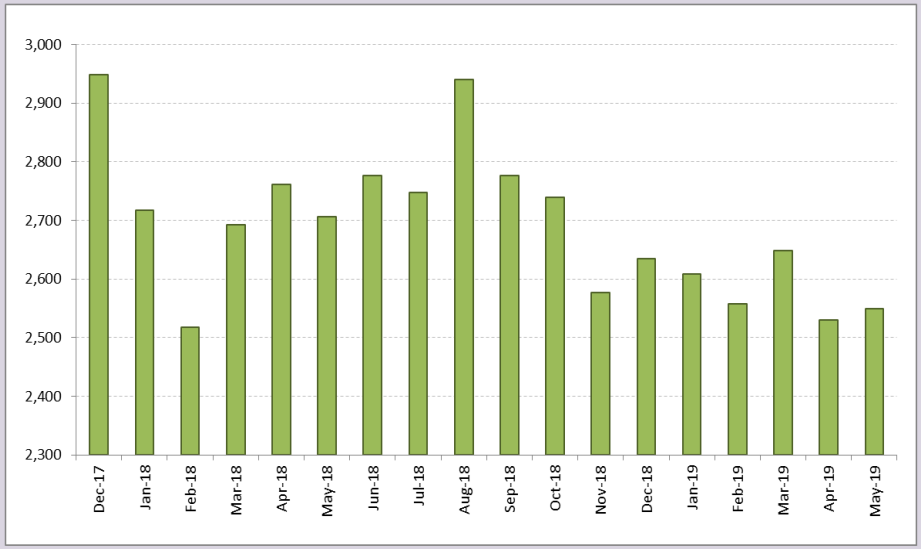
- 3,648 RTT admitted completed pathways in May-19 vs 4,028 in May-18, driven by a reduction of 273 pathways in Ophthalmology, 77 in Dermatology and 54 in T&O.
- 18,604 non-admitted competed pathways in May-19 vs 18,812 in May-18. There were reduced non-admitted completed pathways in Gynaecology (-420), Ophthalmology (-205) and General Medicine (-126). There were increased non-admitted completed pathways in Thoracic Medicine (+316), and General Surgery +100).
- 42,056 referrals received in May-19 vs 45,756 in May-18, an decrease of 3,700 referrals. There was a decrease of 3,025 GP and 756 Dentists referrals, as well as a decrease of 734 internal-consultant referrals. There was an increase in A&E referrals (+343) and self referrals (+616).
- 32,238 New attendances seen in May-19 vs 33,193 in May-18, a -2.9% decrease.
- 80,879 Follow-up attendances seen in May-19 vs 82,315 in May-18, a -1.74% decrease.
- 3,926 New DNA's in May-19 vs 4,571 in May-18.
- 9,379 Follow-Up DNA's in May-19 vs 10,146 in May-18.
- New:FU ratio worsened from to 2.48 in May-18 compared to 2.51 in May-19.

LONG WAITERS

RTT: Patients waiting >52 weeks from referral to treatment



RTT: Patients waiting >36 weeks (un-validated) from referral to treatment



INSOURCING

- No further outpatients are planned to be seen by 18 Weeks Support (18WS) in the 2019/20 financial year.
- The Trust has an operational recovery plan to increase capacity including outsourcing to Denmark Hill site, as well as using the private sector provider BMI, and insourcing using 18 Weeks Support.
- There were 171 endoscopy patients seen by 18WS during May 2019 compared to 216 in April.

OUTSOURCING

- We continue to secure additional off-site capacity via a number of outsourcing providers for General/Bariatric Surgery, T&O, Neurosurgery as well as ENT:

- *16 elective patients seen at BMI hospitals and 1 Colorectal Surgery patient seen at BMI in May.*
- *17 elective patients seen at Harley Street in Neurosurgery in May.*
- *3 T&O patients seen in BMI hospitals in May and 4 T&O patients seen at SWLEOC in May.*
- *5 Vascular Surgery patients seen at GSST in May.*
- *92 endoscopy patients see in BMI hospitals in May, compared to 35 seen in April.*

- A more robust process for outsourcing T&O patients to SWLEOC has been agreed – and this will take effect in July.

DOMAIN 3:
Excellent Teaching and Research

- Research

Domain 3: Education and Research

King's College Hospital NHS Foundation Trust

R&I GRANTS AND FUNDING

- The CRN funding YTD awarded metric shows the total income received via the annual allocation from the South London CRN based on research recruitment (£TBC) – and topped up by successful applications in year for contingency funding for extra research activity. This will increase further in-year.
- The KCH R&I Department supports investigators to apply for grants (research funding) to support clinical trials and research studies. Investigators apply for funding from NIHR, charities and pharmaceutical companies (industry).

R&I UPDATE

- The KCH R&I Department supports non-commercial clinical research which has been adopted into the NIHR Portfolio. The clinical research includes Clinical Trials, interventional and observational studies. The R&I Department and research staff within Kings College Hospital NHS Foundation Trust are funded by the local South London Clinical Research Network (CRN). The Number of Studies figures (132 in total) show the number of active studies by study-type (which indicates complexity and funding allocation) in the first month of this year. KCH also support commercial trials at KCH; these are supported by the KHP Commercial Trials Office (CTO).
- The Recruitment to NIHR Clinical Research Network portfolio studies (all) metric shows the number of patients (2733) that have been recruited into active studies for FY 2019-2020.
- There have been 0 research incidents raised to-date from April 2019. We monitor untoward incidents where research protocols are not properly observed or patients have been affected. These are managed, reviewed and reported via the DATIX system and reviewed by subject matter experts in the R&I governance framework.
- There have been 0 Serious events that have been subject to in-depth investigation, reporting and remedial action planning. There are 0 open incidents which are currently under investigation/review.

ACTIONS

- As part of the governance review of R&I, a comprehensive balanced scorecard for research is in development. Additional information will be included for the next reporting cycle.

DOMAIN 4:
Skilled, Motivated, Can Do Teams

- Appraisal Rates
- Training Rates
- Sickness Rates
- Vacancy Rates

Domain 4: Key Delivery Metrics
Appraisal Rates

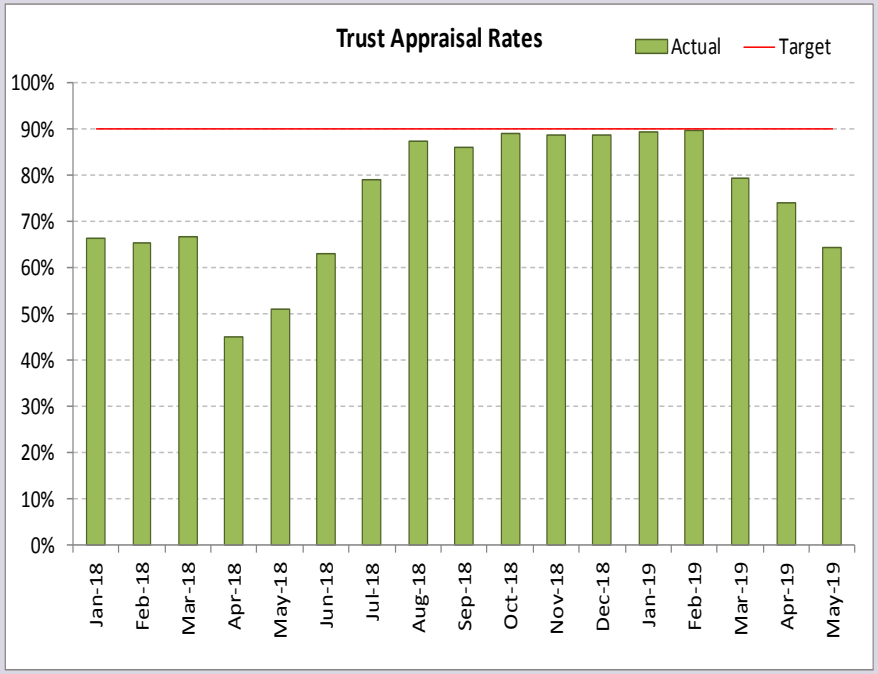
King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

- We are seeking to collect this data from similar sized Trusts, AUKUH (Association of UK University Hospitals) and Trusts who form part of the Shelford Group.

MAY 2019 DELIVERY

- The individual rates for medical and non-medical are reported as 87.09% and 59.67% respectively. While the medical rate is showing an increase of 1.16%, the non-medical rate has decreased by 11.84%. However, it should be noted that the new appraisal window for non-medical staff is still open until 31st of July. Reporting in August would provide us with a better reflection of the appraisal rate.
- The overall appraisal rate is 64.32% in May showing 9.75% decrease from last month.



ACTIONS TO RECOVER

- See below

ACTIONS TO SUSTAIN

- Workforce indicators are discussed at Divisional Board meetings each month.
- Area's which are not achieving the required target are highlighted in monthly reports, and progress is discussed as Divisional Boards.
- The Workforce Medical staffing team is reviewing all medical appraisals and are undertaking more focused work in Dentistry.
- Improved data management on the recording systems have supported improved analytics.
- Additional training has been provided so that any barriers to recording appraisal data are being overcome.

Domain 4: Key Delivery Metrics
Training Rates

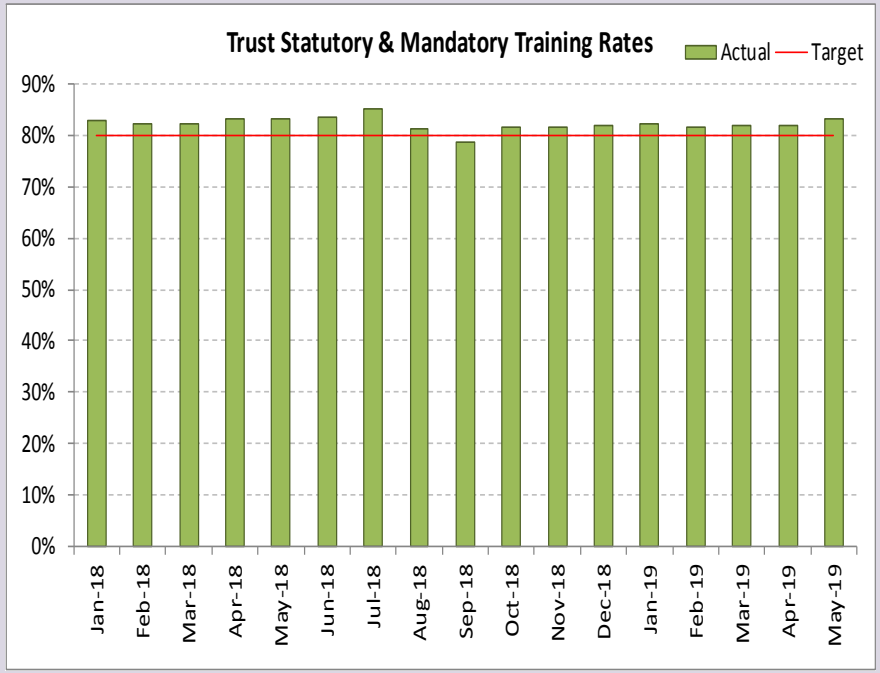
King's College Hospital NHS Foundation Trust

CONTEXT

- We are seeking to collect this data from similar sized Trusts, AUKUH (Association of UK University Hospitals) and from Trusts who form part of the Shelford Group.

MAY 2019 DELIVERY

- Statutory and Mandatory Training compliance has increased this month from 82.07% in April to 83.39% in May (the third consecutive increase) and continues to be better than the 80% target.



ACTIONS TO RECOVER

- See below.

ACTIONS TO SUSTAIN

- Continue to promote Core Skills Update Day as main route for clinical staff to refresh 5 Statutory & Mandatory topics in one day.
- Increase Induction capacity for non-medical staff to ensure that new starters can complete their statutory & mandatory training in a timely way.
- All statutory & mandatory topics are being reviewed via the Challenge Panel in terms of their target audience, frequency and delivery mode.
- Develop plan via new On boarding function on LEAP to roll out eLearning to new starters in advance of joining the Trust (this is already in place for medical staff).

Domain 4: Key Delivery Metrics
Sickness Rates

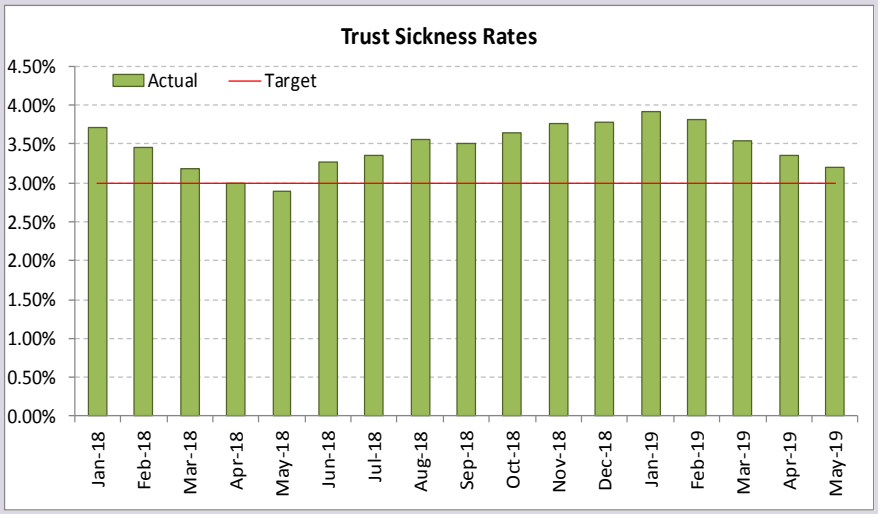
King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

- We are seeking to collect this data from similar sized Trusts, AUKUH (Association of UK University Hospitals) and Trusts who form part of the Shelford Group.

MAY 2019 DELIVERY

- The sickness rate for May is 3.20% showing a decrease for the fourth consecutive month of 0.15% from the previous month (3.35%). However, continuing the same trend as in previous months, the sickness rate is higher than the rate reported for the same period in 2018 (2.89%).
- Sickness rates for Networked and UPACs divisions have improved for the third consecutive month: Networked is 2.33% (within Trust target of 3%), PRUH is 3.83% and UPACs is 3.48%. Corporate areas show a combined sickness rate of 3.48%.
- The total number of occurrences reported in May were 1,922 - of which 1,689 are classified as short-term and 233 as long-term instances.
- The 2 highest reasons for short-term sickness remain the same as in previous reporting periods, "Gastrointestinal problems" (325 occurrences) and "Cold, Cough, Flu - Influenza" (318 occurrences).
- Trends for Long-term sickness also remain similar: "Anxiety/stress/depression/other psychiatric illnesses" (52 occurrences) and "Other musculoskeletal problems" (38 occurrences).



ACTIONS TO RECOVER

- The target of 3% is an aspirational Trust Target.

ACTIONS TO SUSTAIN

- There are a range of initiatives underway as part of the support to lowering sickness absence, and hence the Trust overall sickness rate.
- These include well-being initiatives such as Younger Lives and improved access to Occupational Health Services.
- Active management for both long and short term sickness cases across is happening with oversight from Directorate teams and Workforce.

Domain 4: Key Delivery Metrics
Vacancy Rates

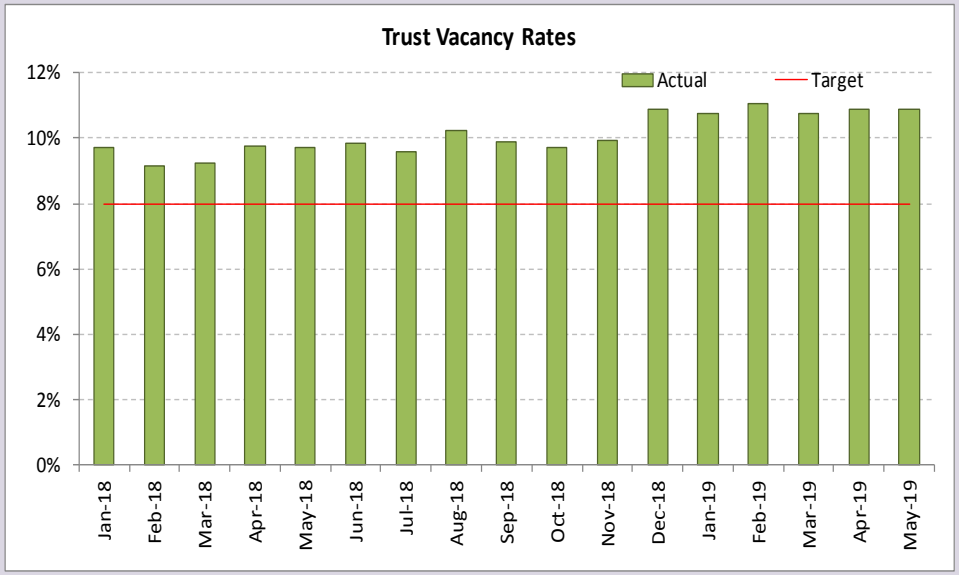
King's College Hospital NHS Foundation Trust

NATIONAL CONTEXT

- We are seeking to collect this data from similar sized Trusts, AUKUH (Association of UK University Hospitals) and from Trusts who form part of the Shelford Group.

MAY 2019 DELIVERY

- The reported vacancy for May is 10.90%, which is the same rate as the one reported in April. This equates to a vacancy FTE figure of 1,426.85 FTE.
- The vacancy rate for the main divisions are: 11.47% in Networked, 9.21% in PRUH and 9.52% in UPACs.
- Adding up the Bank & Agency FTE and substantive FTE shows a total actual FTE for May of 12,639.55 FTE.
- The starting position of the budgeted establishment for Month 2 (May) is 13,096.16. This shows an all employees (permanent and temporary) vacancy figure of 3.16%.



ACTIONS TO RECOVER

- The target of 8% is an aspirational Trust Target and not reflective of a local or national position.

ACTIONS TO SUSTAIN

- The Recruitment function is continuing with it's extensive programme of regional, national and international recruitment. Campaigns are regularly monitored and assessed to ensure they contain to deliver successful candidates.
- Work will continue on reducing voluntary turnover through a range of initiatives.
- Work will continue on managing the budgeted establishment of the Trust.

DOMAIN 5:
Top Productivity

- Transformation - Outpatients
- King's Way For Wards
- Theatre Productivity
- Transformation – Flow

Domain 5: Key Delivery Metrics
Transformation - Outpatients

King's College Hospital NHS Foundation Trust

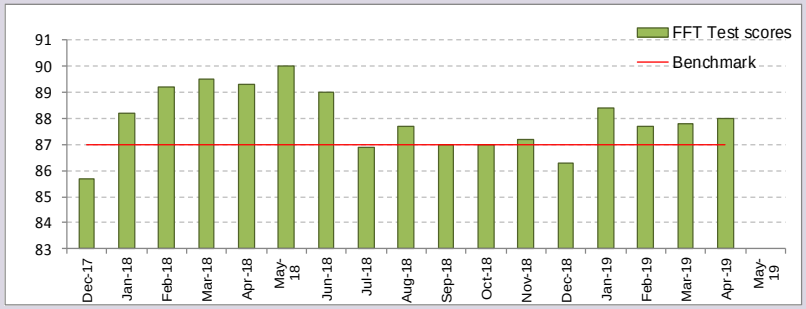
CURRENT PROGRESS

The outpatient programme covers the following areas:

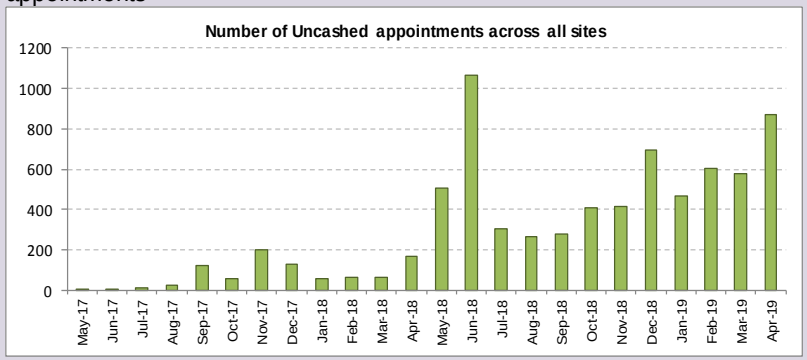
- a health check that has been rolled out to all outpatient areas to review aspects that impact on patient experience
- a review of outpatient demand and capacity, including bookings and referrals processes and a move to standardisation
- a financial improvement project that seeks to correctly charge for outpatient procedures, MDT clinics, and the provision of Advice & Guidance advice phone calls and virtual clinics
- an utilisation improvement programme to improve waits, reduce DNAs and the booking process for patients
- the design and roll out of King's Way for Outpatients, a programme that standardises processes and improves visual management for staff and patients.
- implementation of digital outpatient processes across each site including the testing of an end to end patient pathway and electronic referral systems
- joint partnership working across Southwark, Lambeth, and Bromley CCGs on Aspiring Integrated Care System work.

TRANSFORMATION - OUTPATIENTS

- Improving experience: Overall percentage of patients recommending Kings



- Improving processes: Reductions in lost income due to not cashing-up appointments



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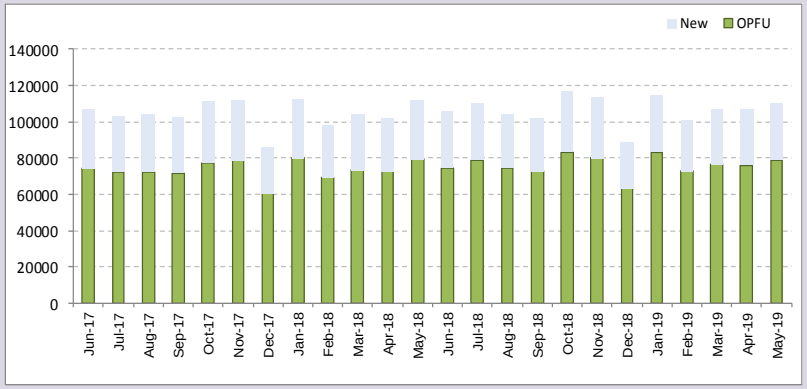


THIS MONTH'S IMPROVEMENT

- Feedback on collaborative tools to be used for Innovation Procurement (PiPPi) working group.
- Planned for PiPPi London event, including developing content/workstream focus.
- Inducted new project manager to support InTouch outpatient check-in expansion rollout, including meeting with relevant specialty leads.
- Digital Outpatients strategy paper circulated for feedback and completed.
- Reviewed governance structure for digital outpatients and pathways programme and amended to make more robust.
- Attended value-based healthcare meeting in Paris to progress programme workstreams with consortia partners.
- Amended patient survey to include questions on forthcoming InTouch features.
- Met with KCH Charity to explore partnership working to develop of an app to see patients in the right time, right place.

NEXT STEPS

- Meet with palliative care clinical leads to discuss value-based healthcare pathways and scope opportunities at King's to implement in a cross-cutting manner.
- Hold inaugural PiPPi steering group to present project aims and needs, and engage with key stakeholders.
- Agree date for the value-based healthcare training course.
- Commence procurement and pathway mapping for InTouch expansion.
- Meet with KCH Charity, vendor and clinicians to discuss next stages of an app to reduce un-necessary face-to-face follow ups.
- Assess viability of VBHC pathway work in pancreatic cancer alongside European partners.
- Progress PiPPi work on KCH-relevant projects and arrange virtual catch up with project lead.

Domain 5: Key Delivery Metrics
King's Way For Wards

King's College Hospital NHS Foundation Trust

KWfW PROGRAMME UPDATE

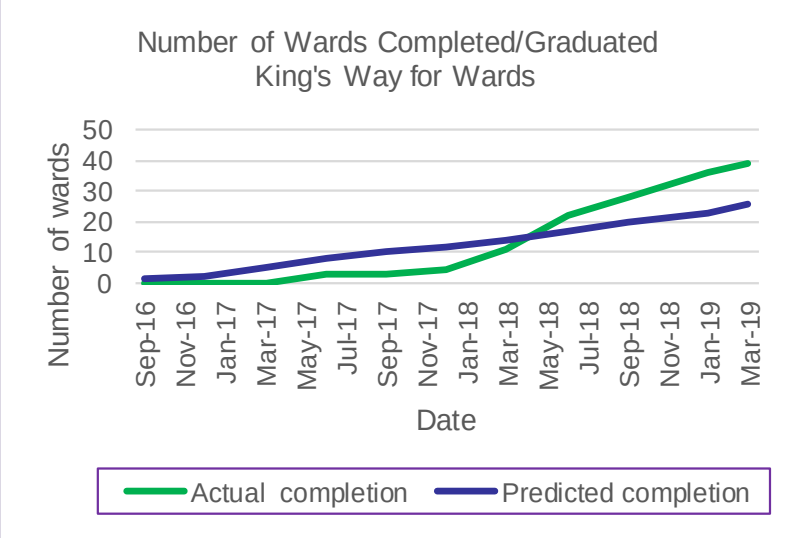
- King's Way for Wards Quality Improvement Programme helps all wards to use the same processes and systems, so that we provide consistently excellent care across all sites.
- 45 areas out of 79 have now graduated from King's Way for Wards:
- 28 wards at Denmark Hill and 17 wards at PRUH and South Sites.
- Within the King's Way for Wards Quality Improvement Team, Sara Herridge-Lewer has returned to the PRUH as the Associate Director of Nursing.
- A new Lead Nurse has been appointed and will join the team in July.

CURRENT WARDS ON PRGRAMME

DENMARK HILL: Fisk & Cheere, Lister Ward Howard, Todd, Twining, Kinnier Wilson HDU, Guthrie

PRUH/South Sites: Medical 1 and Medical 2, Farnborough ward and Discharge Lounge.

ACTUAL PROGRESS EXCEEDING PREDICTED PROGRESS



Added White Belt Sessions

- Following feedback from the survey monkey the team have been delivering bespoke white belt sessions to teams on away days/staff meetings where possible so staff are not having to be released from the wards again to attend training.

Month	Area	Staff trained
March	Network care Critical Care	23 7
April	Maternity	36
May	Maternity	6

WARD ACCREDITATION UPDATE

- All inpatient areas have now had an accreditation via the perfect ward application. We have started cycle 1 again.

Highlights of the last year:

- Maternity and Critical Care units were amber in their first accreditation.
- All other inpatient areas have improved their scores, and there are no longer any wards scoring 'Red'.
- Scores range from 73% to 93% across the Trust with an average increase in scores of 11% for all sites.
- Ten wards turned green including Rays of Sunshine, Thomas Cook Critical Care, Dawson, V&A HDU, DMU, David Marsden, Brunel, Coptcoat, Bodington and Surgical 4.
- Waddington Ward became the first ward to maintain their green accreditation, and Rays of Sunshine became the second ward to maintain green in May.

Going forward:

- To attempt to get back on track to a 4-month cycle, we are looking at how we can utilise the team to best undertake the audit. This will include a team approach to accreditation audits.

Domain 5: Key Delivery Metrics
Theatre Productivity

King's College Hospital NHS Foundation Trust

CURRENT PROGRESS

The King's Theatre Productivity Programme incorporates a number of the elements of the national theatre programme, and focuses on four key workstreams:

- **6:4:2 and Session Management** - Maximising the number of theatre sessions used through better governance and cross-cover
- .
- **Scheduling** – Ensuring lists are filled productively and booked at least four weeks out.
- **Pre-assessment** – Maximising throughput and reliability of pre-assessment clinics.
- **Theatre Processes** – Starting on time, minimising inter-case downtime and avoiding cancellations.
- The theatre productivity programme commenced on 3rd September 2018, and initial progress has ben encouraging.

The overall aims of the theatre productivity programme are to:

- Increase the in-session productivity of theatre lists, as measured by Average Cases Per Session (ACPS).
- Ensure as many theatre lists are used as possible.
- Ensure theatre sessions as allocated to the specialties who need them most.
- Support chronological booking to clear the Trust's 52-week backlog as swiftly as possible.

TRANSFORMATION - THEATRES PRODUCTIVITY

- **Average Cases per Session (APCS)**

Specialty	Target Average ACPS	Baseline Average ACPS 2017/2018	01/04/2019	08/04/2019	15/04/2019	22/04/2019	29/04/2019
General Surgery	1.60	1.47	1.98	1.18	1.77	1.64	1.70
Liver HPB	0.80	0.73	0.88	0.67	0.67	0.88	1.00
Neurosurgery	1.10	1.01	0.99	0.84	0.59	1.00	1.06
Ophthalmology	4.40	3.96	3.94	3.78	4.17	3.59	3.73
Cardiothoracic	0.79	0.72	0.77	0.81	0.76	0.81	0.73
Max Fax	2.01	1.81	2.20	1.83	1.45	1.73	1.67
Overall Average	**1.78**	**1.62**	**1.79**	**1.52**	**1.57**	**1.61**	**1.65**
% Utilisation	84.7%	76.5%	83.3%	77.0%	83.4%	82.8%	82.8%

- **Number of Cases per Week**

Specialty	Target Cases Per Week	Baseline Cases Per Week 2017/2018	01/04/2019	08/04/2019	15/04/2019	22/04/2019	29/04/2019
General Surgery	42	39	57	21	35	37	43
Liver HPB	19	17	16	9	9	16	18
Neurosurgery	35	32	33	25	16	27	35
Ophthalmology	120	108	127	103	87	88	112
Cardiothoracic	15	13	20	17	17	14	19
Max Fax	11	10	22	21	17	13	15
Overall	**242**	**219**	**275**	**196**	**181**	**195**	**242**
Difference to Baseline			**56**	**-23**	**-38**	**-24**	**23**
Running Total			**56**	**33**	**-5**	**-29**	**-6**

- **Cancellations**

Specialty	Target Reduction	Baseline OTD Cancellations Per Week 2017/2018	01/04/2019	08/04/2019	15/04/2019	22/04/2019	29/04/2019
General Surgery	**1**	3	4	7	1	3	3
Liver HPB	**0**	1	2	1	0	2	1
Neurosurgery	**1**	3	5	6	4	1	3
Ophthalmology	**5**	10	12	7	12	6	10
Cardiothoracic	**1**	3	5	2	2	2	2
Max Fax	**1**	2	1	1	2	1	0
Overall	**9**	**22**	**29**	**24**	**21**	**15**	**19**
Difference to Baseline			**7**	**2**	**-1**	**-7**	**-3**
Running Total			**29**	**53**	**74**	**89**	**108**

- **Financials**

Specialty	Target Income per week	Baseline Income Per Week 02/04/18 to 02/09/18	01/04/2019	08/04/2019	15/04/2019	22/04/2019	29/04/2019
General Surgery	£52,522.68	£48,771.06	£71,280.78	£26,261.34	£43,768.90	£46,269.98	£53,773.22
Liver HPB	£127,623.76	£114,189.68	£107,472.64	£60,453.36	£60,453.36	£107,472.64	£120,906.72
Neurosurgery	£317,654.40	£290,426.88	£299,502.72	£226,896.00	£145,213.44	£245,047.68	£317,654.40
Ophthalmology	£43,114.80	£38,803.32	£45,629.83	£37,006.87	£31,258.23	£31,617.52	£40,240.48
Cardiothoracic	£196,465.50	£170,270.10	£261,954.00	£222,660.90	£222,660.90	£183,367.80	£248,856.30
Max Fax	£38,423.00	£34,930.00	£76,846.00	£73,353.00	£59,381.00	£45,409.00	£52,395.00
Overall	**£775,804.14**	**£697,391.04**	**£862,685.97**	**£646,631.47**	**£562,735.83**	**£659,184.62**	**£833,826.12**
Difference to baseline			**£165,294.93**	**-£50,759.57**	**-£134,655.21**	**-£38,206.42**	**£136,435.08**
Running Total			**£165,294.93**	**£114,535.36**	**-£20,119.85**	**-£58,326.27**	**£78,108.81**

THIS MONTH'S IMPROVEMENT

In Session productivity

- ACPS has been above baseline twice in the last 5 weeks, and reached target once partially due to admissions booking issues.
- General Surgery and Liver HPB have shown good ACPS performance.

Total Elective Theatre Activity

- Target cases have been a struggle due to 2 bank holidays and an audit session in month. However, on the weeks with no loss of sessions, we hit or were above target.
- The target level of activity is calculated by multiplying the target ACPS by the number of weekly operating sessions allocated to each specialty within the regular theatre schedule.
- The tables to the left demonstrate how much additional operating the Trust is delivering, partly through increased ACPS and partly through additional weekend sessions.
- Financially we have seen an extra income of £78,109, this has been affected by lost sessions due to bank holidays and audit but we expect to recoup this over the coming months.
- There have been challenges within the admissions booking teams meaning that booking out has reduced to less than 2 weeks. A plan is in place which has now seen this rise back above 2 weeks. This has meant that not all lists have been completely filled because of resource issues.

NEXT STEPS

- On the day cancellation escalation SOP to be signed off at theatre board
- First Consent Audit to be completed in admission areas
- 6-4-2 and Scheduling meetings to be governed more closely with escalation of specialties that close sessions under 2 weeks

Domain 5: Key Delivery Metrics
Transformation – Flow Programme

King's College Hospital NHS Foundation Trust

CURRENT PROGRESS - DENMARK HILL

ED/UCC
- ED Nurse Navigator Pilot taken place in June with positive results.
- ADU now open.
- Consultant interviews have occurred and positions have been filled subject to flexible working discussions.

Surgery
- 9-month trial of Acute Surgical Pathway nurse commenced to facilitate early assessment and streaming from ED, coordination of patient pathways, and start nurse-led clinic to support early discharge.
- Nurse-led discharge commenced on Coptcoat ward for elective colorectal and endocrine surgery patients.
- Options for appropriate cohorting of surgical patients in development through renewed bed modelling.

Medicine
- Draft SOPs for Ambulatory Care Unit have been created for July launch.

Supported Discharge
- Super Stranded Patient Reviews setup.

Network Flow
- Coding work streams are underway with amendments to patient record templates to capture comorbidities.
- Integrated Care Pathway for Endocrine/ Pituitary patients is in development to reduce post operative length stay - up to 3 bed days.
- Paracentesis Ambulatory Pathway drafted and agreed. Trial has commenced in ward setting.

KEY UPCOMING MILESTONES AND RISKS

DH
- Sign off and launch of Ambulatory Care Unit.
- Complete recruitment of ED consultants.
- Meeting with COO to discuss cohorting of surgical patients.
- Identify resource through job planning for Rapid Access lists for laparoscopic cholecystectomies.

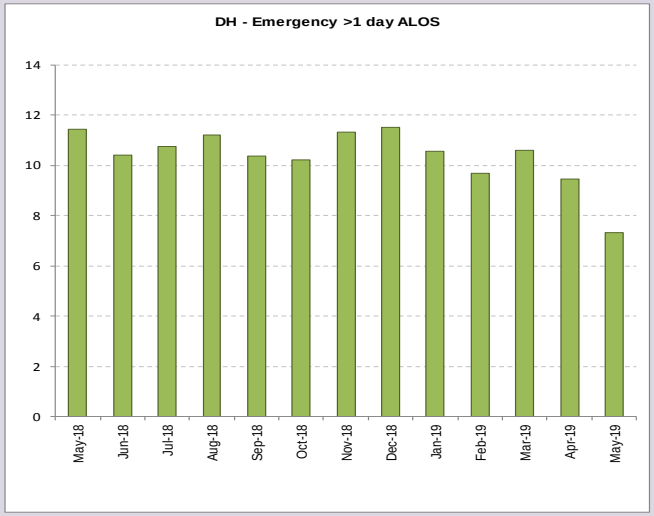
PRUH
- ED: CQC Test and Learn - Frequently Asked and Answered Questions/staff awareness of Trust policies.
- Use of E-board round noting to direct LLoS Reviews.
- Front door frailty MDT for go-live start June 2019.

Networked Care
- Developing day case pathways and compiling a business case for Neuro Ambulatory unit.
- Audit on coding workstreams to take place in early September.
- Pathway for booking routine liver biopsy patients to be trialled in July.

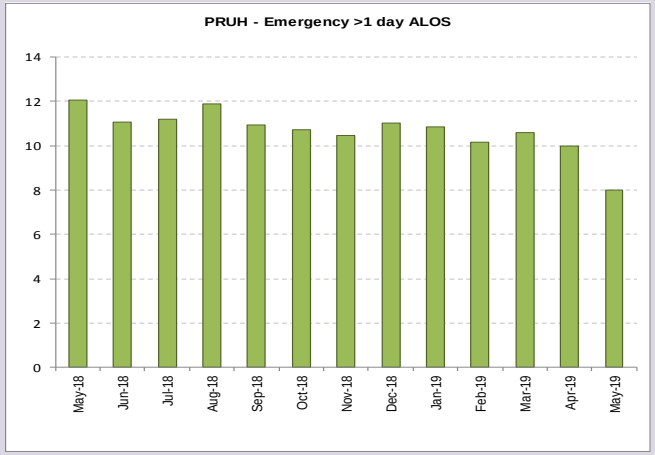
Key Risks
- ED performance and time to treatment still challenged.
- Challenge in implementing Ambulatory due to gaps in current Acute Med Consultant cover.

TRANSFORMATION - FLOW PROGRAMME

- **Average Length of Stay - Emergency Admissions >1 day - DH**



- **Average Length of Stay - Emergency Admissions >1 day - PRUH**



CURRENT PROGRESS - PRUH

ED/UCC
- Internal Professional Standards and Escalation Protocols continue to embed. 20% increase in specialty response within 60 minutes continues to sustain. On-going work to review specialty pathways and align with ambulatory pathway development supported with medical director.
- Patient flow co-ordinator role is back to advert. Assistant Service Manager continues to support role, and working with NIC and EPIC to support early decision making.
- Commenced review of service line agreement with UCC to improve alignment to performance vs 4 hour standard. Monthly meeting with directors and CCG lead now in place.
- Ongoing review of ED non-admitted pathways to achieve >95% performance from 64% baseline. Current non-admitted performance is below 80% in May despite continued utilisation of ambulatory, sub-acute and CDU pathways.
- Approval to appoint to ACP - once appointed plan to trial front door see and treat model. RAT model for ambulance attenders in place.
- FAQs / raising staff awareness of staff policies commenced.

Frailty
- Front door frailty assessment continuing; monitoring frailty scoring.
- Front door frailty MDT pilot commenced in CDU and ED 3.
- Hospital chairs One Bromley Frailty Task and Finish Group: using to drive prioritised planning to deliver Eric Weil recommendations.

Surgery
- Transformation Team Rapid Improvement Support for CEPOD - training complete, engaging with medical director to enhance clinical engagement. Reviewed processes and business case for day surgery CEPOD. 23hr list covered by General Surgery GIRFT. Currently Rapid Access lists remain on-hold pending agreement with consultants on clinical responsibility.
- Agree with surgical team clear pathway or alternative options to ambulatory care: Reverted to using surgical ambulatory for ambulatory TCIs. On-going work with surgical teams to design SAU pathway.

Medicine
- Ambulatory utilisation continues to strengthen with increased pull from nurse to nurse referrals in place.

Supported Discharge
- E-board round noting live on all PRUH adult inpatient wards to plan. Site team working will all wards on accuracy of EDDs. Captured delay codes added to long length of stay reviews to enhance team support to wards.
- Commenced delivery of Red/Green on D1 and D2 with ECIST support to plan.

DOMAIN 6:
Firm Foundations

- Income
- Operating Expenditure

Domain 6: Key Delivery Metrics
Income

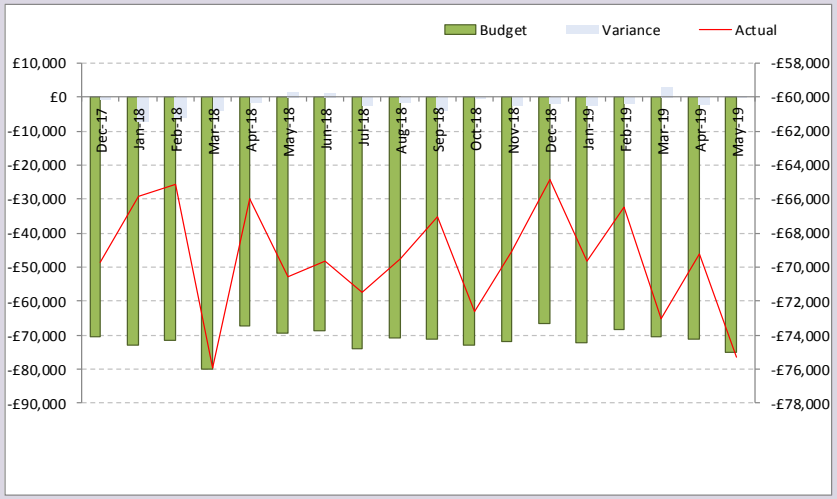
King's College Hospital NHS Foundation Trust

INCOME VARIANCES

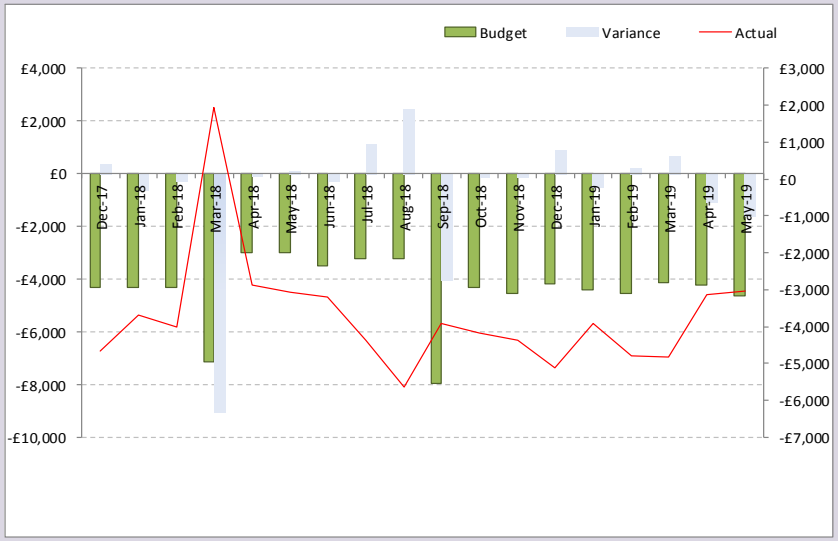
- Clinical Income is £1.8m adverse YTD, - this includes an adjustment at Trust level of £2.8m for over performance on the block contract, a provision for challenges (£1.4m) and RTT 52 week fines (£0.9m).
- Excluding fines and challenges, clinical income would show a £0.5m favourable variance.
- Private Patients income is £0.5m adverse due to the PP Car-T patients being behind plan (Annual plan was for 9 patients. There are potentially 2 patients currently in the work up stage so month 3 position should improve).
- Overseas Visitor income is adverse by £0.8m due to a drop in the number of Overseas patients being identified (47% less than at this time last year).
- Other Operating Income (£2.7m) adverse predominantly due to a £1.9m difference in the phasing of the NHSI plan and the final budget. This will come back into line throughout the year.

2019/20 M2: INCOME AND FINANCIAL POSITION

- Income from Activities (£000s)



- Other Operating Income (£000s)



OVERALL POSITION

- At month 2 the Trust is reporting a year to date deficit of £31.7m, which is £0.2m favourable to plan.
- A £5.2m adverse income variance is offset by favourable variances in pay £3.4m and non pay £1.9m. However, it should be noted that the Trust has benefited from non recurrent £2.1m positive variance relating to receipt of monies from NHS England which had previously been written-off.

CIP DELIVERY

M2 Headlines

- Trust programme has delivered against internal plan of £49m (NHSi plan submitted plan is £45.0m) for M2, apart from £0.1m slippage for PRUH Maternity tariff recharges due to unavailable data. This should recover in subsequent months.
- FIP is on plan against the NHSi submitted plan with the profile increasing from M4 onwards.

Forward View

- Significant values are planned to convert into the programme (circa £20.0m) from June onwards with retrospective achievement.
- NHSi profile to £45.0m is as follows:
  - Q1 – £2.6m
  - Q2 – £10.2m
  - Q3 – £14.0m
  - Q4 – £18.2m
- The in-implementation value is split as 18% non pay, 71% income, and 11% pay with no significant variances in M2.
- In the coming months the dimension of the programme will move closer to our identified split which has 42% non pay, 45% income, and 13% pay when reporting M2.

Domain 6: Key Delivery Metrics
Operating Expenditure

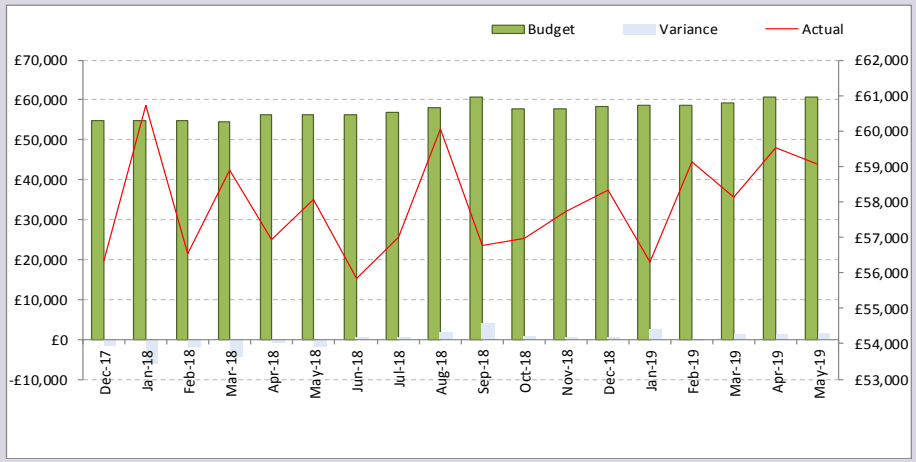
King's College Hospital NHS Foundation Trust

KEY PAY VARIANCES

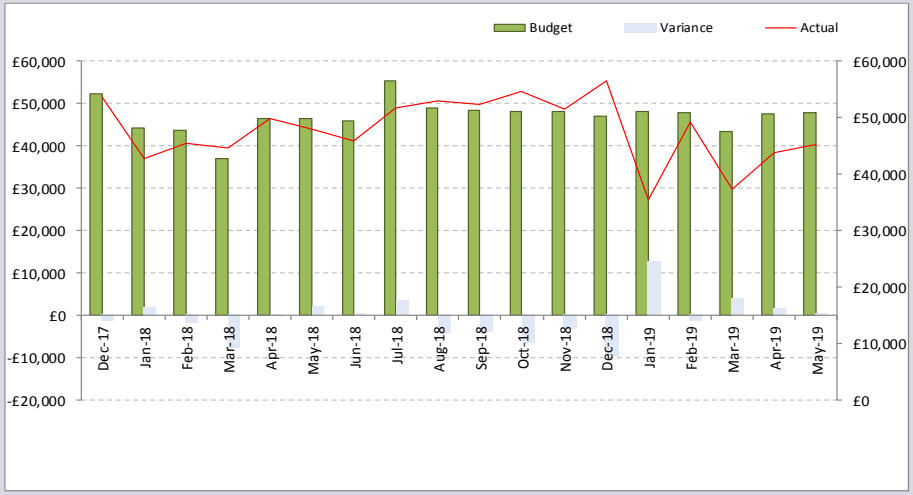
- Pay is £3.4m favourable to plan, with favourable variances across all staff categories.
- Maintaining this positive variance will be essential in coming months, to offset the ramping up of the CIP target phased to deliver in the latter part of the year.
- The underspend in Pay is partially due to vacancies well in excess of the vacancy factor but also indicates £ budgets (e.g. premium budgets) were generous.
- An exercise is being undertaken to understand specific drivers of this variance and the level of underlying opportunity to mitigate the unallocated CIP which is phased Q3 and Q4.

2019/20 M1 OPERATING EXPENDITURE

Pay (£000s): including Admin & Managerial Staff/Agency, Medical Staff/Agency, Nursing Staff/Agency



Non-Pay £000s): including Establishment Expenses, Drugs, Clinical Supplies & Services, General Supplies & Services, Services from Non-NHS Providers, Services from NHS Bodies



KEY NON-PAY VARIANCES

- Non Pay is £1.9m favourable to plan.
- This is driven by the inclusion of a £0.9m positive variance on the KFM position, and the £2.1m positive variance as a result of NHS England paying debt which the Trust had previously written-off.
- £1.3m of cost has been put against clinical supplies in relation to the KFM TSA which should sit in Purchase of Healthcare from non-NHS bodies. Once adjusted, Clinical Supplies would show a £0.1m favourable variance and only a £0.4m positive variance in Purchase of Healthcare from non NHS bodies.

Appendix 1

King's College Hospital NHS Foundation Trust

TRUST INTEGRATED PERFORMANCE SCORECARD

DOMAIN SCORECARDS

Integrated Performance

A selection of core metrics for aggregate KCH performance to Board/FPC and organisational review

Trust (1000)

May 2019

Best Quality of Care - Safety, Effectiveness, Experience

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
476	MRSA Bacteraemias	0	0	0	1	1	0	1	1	1	0	2	0	0	0	0	7	
473	CDT Cases	2	6	13	9	7	5	7	5	5	6	9	9	9	9	18	55	
487	Care hours Per Patient per day	6.3	6.1	5.8	5.7	5.2	5.9	6.4	6.4	6.5	6.6	6.6					6.1	
628	Falls per 1000 bed days	4.09	4.31	4.39	4.43	4.18	3.57	4.17	4.01	4.32	4.35	4.00	3.62	3.75	6.60	3.69	4.09	
509	Never Events	3	0	2	1	2	0	1	0	1	0	1	0	1	0	1	9	
519	Serious Harm/Death Incidents	14	13	12	11	12	8	11	12	13	11	9	19	10		29	141	
516	Moderate Harm Incidents	28	27	20	22	19	24	34	29	26	27	48	30	46		76	352	
520	Total Serious Incidents reported	22	24	20	12	20	18	14	16	18	21	16	13	18		31	210	
436	HSMR	86.9	87.2	87.5	86.7	87.0	86.7	86.0	85.8	85.7	86.5	85.5			100.0			
433	SHMI	94.8	96.0	96.7	96.6	96.8	96.3	95.2	94.6						105.0			
353	Outpatient Cancellations < 6 week notice (Hosp)	6120	5934	6554	5625	6477	7427	7166	5803	6469	6327	7085	6343	6685	6350	13028	77895	
838	Number of complaints per 1000 bed days	1.71	1.86	2.10	1.71	1.51	1.82	2.18	1.22	1.82	1.66	2.03	1.48	1.23	1.78	1.35	1.72	
615	Number of complaints - High & Severe	8	9	14	12	7	8	9	7	7	5	7	7	6	0	13	98	
619	Number of complaints	83	86	100	82	74	94	107	59	93	74	98	70	62	87	132	999	
620	Number of complaints not responded to within 25 Days	46	37	50	52	46	41	55	46	41	33	34	42	49	43	91	526	
839	Surgical Cancellations due to Trust Capacity - OTD	44	40	46	35	52	75	94	50	67	40	59	46	61	56	107	665	

Best Quality of Care - Access

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
364	RTT Incomplete Performance	81.20%	80.85%	80.55%	80.57%	79.41%	79.12%	79.03%	77.95%	77.89%	78.08%	76.95%	77.53%	78.80%	92.00%	78.16%	78.90%	
632	Patients waiting over 52 weeks (RTT)	331	408	448	457	450	404	332	249	262	264	192	171	177	0	348	3814	
412	Cancer 2 weeks wait GP referral	95.29%	85.80%	85.91%	80.51%	76.00%	89.78%	90.00%	93.14%	91.20%	91.16%	92.12%	93.52%	92.90%	93.00%	93.22%	91.93%	
413	Cancer 2 weeks wait referral - Breast	92.42%	90.48%	91.11%	96.67%	100.00%	96.00%	97.60%	100.00%	73.33%	77.78%	92.54%	96.77%	89.36%	93.00%	92.31%	92.43%	
419	Cancer 62 day referral to treatment - GP	83.65%	83.60%	75.38%	76.34%	71.00%	77.40%	79.00%	85.70%	66.51%	80.00%	82.47%	76.79%	76.30%	85.00%	76.55%	77.95%	
420	Cancer 62 day referral to treatment - Screening Service	92.65%	84.91%	83.58%	85.90%	87.80%	84.80%	92.60%	90.80%	87.50%	86.49%	80.33%	94.20%	94.00%	90.00%	94.12%	88.54%	
536	Diagnostic Waiting Times Performance > 6 Wks	3.44%	4.02%	5.52%	5.81%	7.13%	8.61%	11.06%	14.81%	12.70%	9.22%	7.30%	8.17%	8.91%	1.00%	8.55%	8.60%	
459	A&E 4 hour performance (monthly SITREP)	79.83%	82.73%	77.99%	80.54%	76.29%	78.10%	73.84%	71.67%	69.62%	70.39%	73.72%	71.73%	73.50%	95.00%	72.62%	72.81%	
1397	A&E 4 hour performance (Acute Trust Footprint)	86.52%	88.50%	85.25%	86.80%	84.10%	85.05%	82.33%	80.65%	79.11%	79.73%	82.04%	80.64%	81.73%	95.00%	81.19%	82.96%	
399	Weekend Discharges	20.2%	22.0%	19.5%	19.1%	25.1%	18.2%	18.4%	25.3%	19.9%	20.4%	23.8%	19.2%	20.2%	21.1%	19.7%	20.9%	
404	Discharges before 1pm	19.5%	19.1%	18.8%	18.9%	18.1%	18.1%	18.1%	18.6%	19.7%	18.6%	20.5%	18.8%	20.0%	18.9%	19.4%	18.9%	
747	Bed Occupancy	91.0%	87.9%	88.3%	86.0%	90.0%	92.3%	93.0%	89.9%	92.1%	93.1%	92.8%	91.5%	92.5%	90.8%	92.0%	90.8%	
1357	Number of Stranded Patients (LOS 7+ Days)	600	597	552	346	224	204	247	257	254	216	244	226	222	365	448	3589	
1358	Number of Super Stranded Patients (LOS 21+ Days)	851	837	793	593	470	438	484	504	481	434	469	492	468	606	960	6463	
800	Delayed Transfer of Care Days (per calendar day)	8.2	7.0	12.9	13.5	9.0	9.4	10.0	6.6	10.5	10.0	13.8	13.3		0.0	13.3	10.5	
772	12 Hour DTAs	16	21	13	29	20	10	14	19	7	13	14	17		0			

Skilled, Motivated, Can Do Teams

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
715	% appraisals up to date - Combined	50.99%	63.19%	79.19%	87.57%	86.14%	89.41%	88.71%	88.64%	89.46%	89.85%	79.53%	74.07%	64.32%	90.00%			

Business Intelligence Unit
Secure Email: kch-tr.performance-team@nhs.net

Created date: January 2018

721	Statutory & Mandatory Training	83.39%	83.48%	85.17%	81.20%	78.62%	81.77%	81.79%	81.96%	82.35%	81.48%	81.94%	82.07%	83.39%	90.00%			
732	Vacancy Rate %	9.70%	9.86%	9.57%	10.24%	9.88%	9.69%	9.93%	10.88%	10.75%	11.07%	10.76%	11.05%	11.22%	8.00%			
743	Monthly Sickness Rate	2.89%	3.27%	3.36%	3.56%	3.50%	3.65%	3.77%	3.78%	3.91%	3.81%	3.55%	3.35%	3.20%	3.00%			

Top Productivity

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
374	Theatre Utilisation - Main Theatres	82.9%	77.7%	79.5%	81.1%	80.6%	82.4%	81.9%	80.0%	78.3%	78.6%	80.8%	81.2%	81.3%	80.0%	81.2%	80.3%	
373	Theatre Utilisation - Day Surgery Unit	76.9%	75.7%	76.7%	74.7%	75.1%	76.7%	75.8%	75.9%	76.3%	73.8%	75.5%	74.2%	74.3%	80.0%	74.2%	75.4%	
521	Theatre Utilisation - Overall	80.6%	76.9%	78.4%	78.7%	78.6%	80.3%	79.7%	78.7%	77.5%	76.9%	78.8%	78.7%	79.1%	80.0%	78.9%	78.6%	
801	Day Case Rate	78.1%	76.3%	76.0%	76.1%	75.5%	76.8%	75.3%	74.0%	75.5%	74.9%	74.6%	75.5%	75.2%	75.8%	75.4%	75.5%	
345	Outpatient DNA Rate	11.4%	11.1%	11.5%	11.4%	11.5%	11.5%	11.2%	11.6%	11.2%	10.9%	10.3%	10.5%	10.7%	11.3%	10.6%	11.1%	
965	Outpatient DNA Rate - First Attendance	12.1%	12.1%	12.6%	12.4%	12.3%	12.7%	11.9%	12.5%	12.1%	11.6%	11.2%	11.0%	10.9%	10.6%	11.0%	11.9%	
966	Outpatient DNA Rate - Follow Up Attendance	11.1%	10.7%	11.0%	11.0%	11.2%	11.0%	10.8%	11.2%	10.9%	10.7%	10.0%	10.3%	10.6%	12.9%	10.5%	10.8%	
622	First to Follow up ratios - consultant led	2.5	2.5	2.6	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.5	2.6	2.6	2.6	2.6	
426	Average Length of Stay - Elective ALoS	4.2	3.2	3.7	4.2	4.1	4.1	4.0	4.5	3.5	3.4	3.9	4.1	4.0	3.9	4.0	3.9	
428	Average Length of Stay - Non - Elective ALoS	6.5	6.2	6.2	6.3	6.0	6.2	6.2	5.9	6.0	6.3	5.6	6.2	6.4	6.2	6.3	6.1	
429	Zero Length of Stay - Emergency	773	837	865	800	829	796	840	1033	1109	1007	1211	765	862	904	1627	10954	
352	Outpatients waiting more than 12 weeks	12165	13265	12398	12030	12822	14872	14317	10410	14689	12907	13477	12463	12877	12860	25340	156527	
376	Referrals to Consultant led services	36318	33997	34050	32960	31449	36232	34042	27920	33946	31505	34203	31911	31901	33232	63812	394116	
537	Decision To Admit	8882	8540	8275	7670	7972	9082	9017	7063	8571	7668	8053	7721	7817	8239	15538	97449	

Firm Foundations - Finance

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
895	Actual - Overall	15,437	11,242	16,855	17,541	19,804	16,426	20,753	27,140	(1,318)	17,477	(4,778)	18,627	13,063	14,062	31,690	172,833	
896	Budget - Overall	15,182	11,295	15,430	12,547	12,347	9,074	10,315	16,751	10,297	14,747	2,656	17,845	14,062		31,907	147,366	
897	Variance - Overall	(255)	53	(1,425)	(4,994)	(7,458)	(7,352)	(10,439)	(10,389)	11,615	(2,730)	7,434	(782)	999	0	218	(25,467)	
602	Variance - Medical - Agency	(912)	(818)	(848)	(1,070)	(671)	(597)	(1,216)	(798)	(665)	(891)	(71)	(617)	(568)	0	(1,185)	(8,829)	
1095	Variance - Medical Bank	(367)	(340)	(481)	(359)	(345)	(640)	(289)	(304)	(551)	(401)	(667)	(558)	(482)	0	(1,040)	(5,418)	
599	Variance - Medical Substantive	77	801	1,417	923	596	1,043	448	624	742	1,135	1,375	1,574	1,651	0	3,225	12,330	
603	Variance - Nursing Agency	(346)	(176)	(433)	(148)	(258)	(162)	(88)	(124)	(140)	(128)	(123)	(236)	(353)	0	(590)	(2,369)	
1104	Variance - Nursing Bank	(3,063)	(2,491)	(2,059)	(2,070)	(1,932)	(1,909)	(1,913)	(2,302)	(2,083)	(2,409)	(3,306)	(1,728)	(1,481)	0	(3,209)	(25,683)	
606	Variance - Nursing Substantive	2,344	2,317	1,816	638	3,668	2,046	2,165	2,049	2,231	2,267	2,833	2,119	2,306	0	4,424	26,454	

Firm Foundations - Activity

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
401	Elective Inpatient Spells	10513	10112	9999	9465	9158	10667	10340	8484	10000	9408	10157	9539	9756	10209	19295	117085	
403	Non-Elective Inpatient Spells	1717	1670	1720	1698	1729	1819	1596	1690	1682	1517	1646	1563	1733	1664	3296	20063	
424	Elective Excess Beddays	512	412	521	340	317	494	659	363	412	367	571	881	582	0	1463	5919	
425	Non-Elective Excess Beddays	609	183	347	41	440	245	99	196	62	132	110	131	101	0	232	2087	
431	First Outpatient Attendances	25232	24901	25270	22982	22977	27160	26712	20328	24985	22653	24433	25124	26189	25875	51313	293714	
430	Follow Up Outpatient Attendances	80165	74739	78887	74199	72076	81604	79979	63442	80193	70613	74358	73697	76005	78382	149702	899792	
461	A&E Attendances	18559	18056	18531	17070	17596	18221	18217	18109	19071	17518	19621	18370	12362	17846	30732	212742	
464	Procedure coded outpatient attendances	17.9%	19.7%	18.9%	19.5%	20.0%	19.2%	19.4%	20.1%	20.3%	20.1%	20.2%	19.4%	19.7%	19.4%	19.6%	19.7%	

Excellent Teaching & Research

Business Intelligence Unit
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Created date: January 2018

May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
937	Number of Observational Studies	44	63	77	86	92	101	108	111	111	115	116	17	51		68	1048	
938	Number of Interventional Studies	52	73	80	86	89	98	106	113	119	126	130	23	54		77	1097	
939	Number of Large-scale Studies	10	11	12	13	14	15	15	15	15	15	16	0	10		10	151	
888	Number of Commercial Studies	24	33	38	44	49	59	65	74	81	85	94	2	17		19	641	
940	Total number of Studies	130	180	207	229	244	273	294	313	326	341	356	42	132		174	2937	

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Integrated Performance

A selection of core metrics for aggregate KCH performance to Board/FPC and organisational review

Trust (1000)

Item	Definition
345	Number of DNAs as a percentage of the number of DNAs and attendances. Excluding telephone clinics.
352	Number of Outpatients waiting more than 12 weeks from referral to new outpatient appointment
353	The number of outpatient appointments cancelled by the hospital based on a set of cancellation reason codes for which it is deemed that the patient was affected by the appointment change.
364	The percentage of patients on an incomplete pathway waiting 18 weeks or more at the end of the month position. DOH submitted figures.
373	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Day Surgery
374	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Main Theatres
376	Number of consultant referrals received (all referral sources). Only consultant & dental consultant included.
399	The number of patients discharged at the weekend expressed as a percentage of all patients discharged, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
401	Total number of Elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
403	Total number of Non-elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
404	The number of patients discharged before 1pm expressed as a percentage of all patients discharged during the week, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging war
412	The percentage of pathways acheiving a maximum two week wait from an urgent GP referral for suspected cancer to DATE FIRST SEEN by a specialist for all suspected cancers
413	The percentage of pathways achieving a maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to DATE FIRST SEEN.
419	The percentage of pathways acheiving a maximum two month (62-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for all cancers
420	The percentage of pathways acheiving a maximum 62-day wait from referral from a cancer Screening Programme to First Definitive Treatment for all cancers
424	Total excess bed days for elective inpatients, with contract monitoring exclusions applied
425	Total excess bed days for non-elective inpatients, with contract monitoring exclusions applied
426	Total bed days for elective spells / Number of Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
428	Total bed days for non - elective inpatient spells / Number of inpatient Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
429	Number of emergency admission patients with a zero length of stay spell
430	Total number follow up outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
431	Total number new outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
433	The national Summary Hospital Mortality Indicator (SHMI) is a risk adjusted mortality rate expressed as an index based on the actual number of patients discharged who died in hospital or within 30 days compared to the expected numb KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
436	The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group (as per HE This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
459	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: excluding any type 2 and external type 3 activity (Type 3 activity = QMS/Erith UCC and 38% Beckenham Beacon)
461	Total number of A&E attendances in the month based on Contractual SUS data - which uses arrival date. Denominator will therefore differ from A&E performance
464	Percentage of outpatient attendances with a primary procedure code recorded
473	Number of episodes of Clostridium difficile toxin post 48 hours hospital admission (patients > 2 years)
476	Number of episodes of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias post 48 hours hospital admission

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A selection of core metrics for aggregate KCH performance to Board/FPC and organisational review

Trust (1000)

487	Ratio of the number of hours of registered nurses and midwives to the total number of inpatients
509	The number of never events recorded based on the reported date on the Datix system.
516	The number of incidents recorded on Datix that resulted in moderate harm to patients. Based on the reported date recorded on Datix.
519	The number of incidents recorded on Datix that resulted in serious harm or death to patients. Based on the reported date recorded on Datix.
520	Number of Serious Incidents declared to Commissioners. Based on the StEIS (Strategic Executive Information System) reported date on Datix.
521	Sum of used session minutes (excluding overruns and early starts) / planned session minutes
536	% of patients waiting greater than 6 weeks for a diagnostic test
537	Number of Elective DTAs (DOWL) booked & planned
599	Total surplus(+ve) or deficit(-ve) generated by Medical Staff
602	Total surplus(+ve) or deficit(-ve) generated by Medical Staff - Agency Staff
603	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff - Agency Staff
606	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff
615	The number of complaints recorded as High or Severe on the Datix system for the reported month.
619	The number of complaints received in the month.
620	The number of complaints not responded to within 25 working days .
628	Number of Inpatient slips, trips and falls by patients reported based on the reported date recorded on Datix. Per 1000 bed days.
632	Number Patients waiting over 52 weeks (RTT). DOH submitted figures
715	Percentage of staff that have been appraised within the last 12 months (medical & non-medical combined).
721	Percentage of compliant with Statutory & Mandatory training.
732	The percentage of vacant posts compared to planned full establishment recorded on ESR
743	The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.
747	The percentage occupancy of inpatient beds based on the midnight census
800	Calculated by total delayed days during the month / calendar days in month.
801	Number of day cases divided by number of elective spells
839	Number of on-the-day cancellations due to the following reasons: No ward bed available, No critical care/HDU bed available, Overrunning operation list, Emergency took priority, Complications in previous case, Previous list/case overran, More urgent case, Unable to staff
888	Number of commercial clinical trials contracts recruiting patients in the relevant period
937	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 10,000
938	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 5,000
939	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size =/ > 10,000
965	Number of DNAs divided by Number of DNAs and attendances for New OP Appointments
966	Number of DNAs divided by Number of DNAs and attendances for Follow-up OP Appointments
1095	Variance for Medical Bank

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Integrated Performance

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Trust (1000)

1104	Variance for Nursing Bank
1357	Number of stranded patients. Ie: any patient who is in the hospital for 7 days or more.
1358	Number of super stranded patients. Ie: any patient who is in the hospital for 21 days or more.
1397	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: excluding type 2 activity but including external type 3 activity (QMS/Erith UCC and 38% Beckenham Beacon)

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of deaths. This
methodology).

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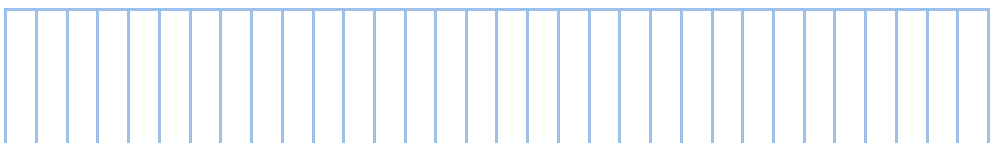

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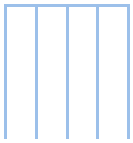

Best Quality of Care – Safety, Effectiveness, Experience

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:21:52

May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Safety - Infection Control																		
	Safety - Infection Control domain score	1.95	2.00	1.98	1.70	1.93	1.93	2.12	1.95	1.98	2.12	1.77	1.72	1.81	2.50	1.92		
	Reportable to DoH																	
476	MRSA Bacteraemias	0	0	0	1	1	0	1	1	1	0	2	0	0	0	0	7	
475	VRE Bacteraemias	5	4	3	4	2	3	1	4	3	4	7	7	10	3	17	52	
473	CDT Cases	2	6	13	9	7	5	7	5	5	6	9	9	9	9	18	55	
470	MSSA Bacteraemias	3	0	0	4	5	5	3	3	4	2	2	2	3	2	5	33	
474	E.Coli Bacteraemias	14	7	13	14	10	10	8	6	7	7	10	11	8	8	19	111	
879	Klebsiella spp. Bacteraemia	5	7	11	10	8	5	14	3	10	6	8	7	10	5	17	99	
880	Pseudomonas aeruginosa Bacteraemia	4	2	4	6	6	7	7	7	9	3	6	9	10	4	19	76	
881	Carbapenemase producing organism (Confirmed CPE/CPO)	15	16	9	17	8	14	10	16	10	11	18	12	13	12	25	154	
	Clusters & Outbreaks																	
477	Clusters of Infection	4	5	3	2	6	1	0	2	1	3	5	2	11	0	13	41	
478	Outbreaks	2	1	0	2	1	2	0	0	5	1	3	1	0	0	1	16	
	All hospital-acquired Alert Orgs																	
490	MRSA	9	7	8	6	5	10	6	5	6	7	13	5	8	7	13	86	
495	Clostridium difficile (including local PCR)	10	16	17	11	14	16	14	11	13	11	10	13	10	13	23	156	
496	VRE	18	25	13	21	21	14	16	26	16	24	28	33	31	18	64	268	
497	Enterobacteriaceae	43	32	31	46	35	64	31	34	36	39	40	41	43	35	84	472	
498	Resistant non-fermenters	7	4	17	20	11	6	11	7	10	8	13	22	19	9	41	148	
882	Norovirus	9	0	3	7	11	3	0	2	19	0	4	5	4	5	9	58	
883	Other Viral Infection	12	15	6	4	10	22	16	41	57	56	61	43	12	24	55	343	
502	Other Alert Organisms	13	5	8	5	6	6	8	5	6	3	4	1	8	6	9	65	
503	Total Hospital-acquired	121	104	103	120	113	141	102	131	163	148	173	163	134	114	297	1595	
	Assurance Audits																	
499	CDT Time to Isolation Compliance	73.3%	90.0%	69.6%	69.2%	68.4%	81.8%	83.3%	76.9%	92.9%	77.8%	94.1%	90.9%	91.7%	100.0%	91.3%	81.7%	
500	MRSA Time to Isolation Compliance	57.1%	47.1%	64.7%	73.3%	33.3%	40.9%	94.4%	53.6%	58.8%	60.0%	36.4%	53.9%	50.0%	100.0%	51.9%	55.9%	
501	MRSA Time to Decolonisation Compliance	60.0%	75.0%	64.3%	83.3%	92.3%	100.0%	88.2%	86.4%	75.0%	91.7%	81.8%	54.6%	85.7%	100.0%	72.0%	82.6%	
492	MRSA Screening - Elective	98.7%	98.6%	95.4%	98.7%	98.0%	97.7%	98.4%	98.6%	97.8%	98.2%	99.3%	76.4%	66.8%	100.0%	73.6%	91.7%	
494	MRSA Screening - Emergency	88.5%	87.1%	86.0%	89.2%	90.9%	90.3%	92.0%	91.6%	91.4%	92.6%	91.9%	92.8%	90.0%	100.0%	92.0%	90.4%	
757	Hand Hygiene Compliance - Inpatients	94.4%	94.0%	94.9%	94.7%	93.7%	92.6%	94.1%	94.7%	94.6%	94.4%	93.5%	95.0%	94.4%	90.0%			
758	Hand Hygiene Compliance - Outpatients	95.5%	98.6%	96.4%	95.9%	95.9%	92.7%	95.1%	93.9%	95.1%	95.8%	96.4%	96.8%	96.8%	90.0%			
	Care of IV Lines																	
522	Dressing Appropriate	94.8%	80.6%	97.2%	84.9%	95.1%	89.0%	95.1%	96.6%	96.4%	93.3%	97.0%	93.8%	97.5%	95.0%	96.4%	94.2%	
523	Date recorded	88.5%	91.6%	84.7%	85.9%	82.5%	88.1%	85.8%	89.3%	85.4%	91.8%	89.3%	87.5%	85.6%	95.0%	86.2%	86.7%	
524	Line Still Needed	92.3%	88.6%	93.9%	89.4%	95.5%	91.0%	92.4%	91.2%	92.3%	96.5%	91.1%	88.7%	91.6%	95.0%	90.7%	92.1%	
525	Documentation is complete	80.4%	57.1%	77.3%	67.3%	79.3%	76.7%	78.2%	79.3%	81.9%	82.8%	78.4%	84.0%	80.9%	95.0%	81.8%	77.7%	
1217	Assessed VIP	97.9%	58.6%	96.7%	75.6%	97.7%	95.4%	98.0%	92.5%	99.2%	98.8%	96.9%	90.2%	95.7%	95.0%	94.1%	93.5%	
1317	Administration Set Dated	96.2%	96.3%	92.2%	98.7%	92.6%	94.5%	97.1%	93.7%	97.6%	97.7%	93.6%	89.5%	94.1%	95.0%	92.7%	94.8%	
	Antibiotic Stewardship																	
569	Antibiotic Stewardship - Clinical indication recorded	97.0%	95.7%	92.1%	96.6%	97.3%	96.6%	98.2%	96.8%	98.1%	98.3%	96.6%	96.6%	93.0%	95.0%	94.7%	96.4%	
571	Antibiotic Stewardship - Stop/Review date recorded	83.0%	83.3%	81.5%	84.3%	80.2%	86.5%	86.0%	77.2%	82.4%	82.3%	80.7%	81.1%	79.2%	95.0%	80.1%	82.0%	
570	Antibiotic Stewardship - IV PO switch not overdue	91.9%	91.6%	82.2%	89.6%	91.6%	93.2%	94.3%	93.5%	93.1%	85.8%	93.0%	91.4%	90.9%	95.0%	91.1%	90.9%	
568	Antibiotic Stewardship - As per Guideline	82.0%	81.5%	86.8%	90.3%	88.7%	90.6%	92.4%	92.2%	91.6%	91.0%	89.9%	89.6%	90.8%	95.0%	90.2%	89.7%	
	Environment																	

Business Intelligence Unit
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Created date: June 2017

Best Quality of Care – Safety, Effectiveness, Experience

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:21:52

760	Medirest/ISS Cleaning	97.9%	97.6%	97.6%	98.2%	97.5%	97.0%	97.6%	98.7%	98.5%	97.8%	98.2%	98.4%	98.4%	97.9%	98.4%	98.0%
761	Nurse Cleaning	96.0%	96.6%	95.4%	96.5%	95.3%	95.1%	96.6%	97.0%	97.3%	96.7%	97.3%	96.6%	95.9%	96.4%	96.3%	96.3%
514	Number of commodes audited	130	176	150	213	300	412	205	177	439	270	237	202	256		458	3037
515	Are Commodes in a Good State of Repair?	96.9%	98.9%	96.7%	99.5%	95.7%	91.8%	86.3%	81.9%	72.7%	98.9%	97.9%	97.0%	98.8%	100.0%	98.0%	91.7%
1805	Are Commodes Clean?				93.9%	93.3%	94.2%	95.6%	96.6%	91.8%	97.8%	94.5%	97.5%	94.5%	100.0%	95.9%	94.7%
1697	Are Commodes Taped?				6.1%	5.7%	26.0%	88.8%	86.4%	92.5%	91.1%	91.6%	88.6%	87.1%	100.0%	87.8%	64.3%
1698	Is there a Commodes Cleaning Poster?				6.5%	3.2%	29.4%	60.3%	61.9%	77.1%	83.3%	85.7%	82.6%	80.4%	100.0%	81.4%	58.2%
	Infection Control Audit Composite																
759	Assurance Audits - Non Compliance %	81.3%	81.3%	81.3%	87.5%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	81.3%	62.5%	10.9%	3.1%	9.9%

Safety - Other

	Safety - Other domain score	2.38	2.19	2.10	2.14	2.24	2.14	2.24	1.95	1.95	2.19	1.95	1.84	2.05	2.50	2.11	
	Safer Care																
469	VTE Risk Assessment	96.7%	96.8%	96.8%	97.0%	97.0%	97.6%	97.8%	97.6%	97.8%	97.7%	97.7%	97.7%	98.3%	95.0%	97.9%	97.5%
1897	Potentially Preventable Hospital Associated VTE	0	4	4	1	6	10	7	2	4	2	5	2	3	0	5	50
487	Care hours Per Patient per day	6.3	6.1	5.8	5.7	5.2	5.9	6.4	6.4	6.5	6.6	6.6					6.1
627	Deteriorating Patient Incidents per 1000 bed days	0.17	0.22	0.19	0.13	0.06	0.17	0.21	0.08	0.21	0.09	0.04	0.06	0.06	0.14	0.06	0.13
846	Deteriorating Patient Incidents resulting in moderate harm, major harm or death per 1000 bed days	0.02	0.02	0.02	0.04	0.00	0.02	0.02	0.02	0.08	0.00	0.00	0.02	0.00	0.00	0.00	0.00
788	Delayed Vital Signs	74	75	77	54	73	64	68	72	71	85	72	55	66		121	832
646	Patients Absconding	28	20	33	32	31	30	22	25	31	21	28	33	36		69	342
647	Violent & Aggressive Behaviour to Staff	185	228	218	198	217	220	217	170	263	206	258	266	303		569	2764
786	Omitted Medication Incidents	42	45	35	32	30	36	25	26	28	43	31	28	27		55	386
787	Delayed Medication Incidents	37	28	47	46	42	54	40	50	51	40	43	63	61		124	565
488	Safer Staffing Average Fill Rate - Day	99.9%	99.2%	98.3%	98.0%	98.3%	98.8%	99.6%	98.3%	97.9%	99.1%	99.1%					98.7%
489	Safer Staffing Average Fill Rate - Night	105.1%	102.1%	101.0%	100.9%	102.3%	102.8%	102.1%	101.9%	102.3%	102.4%	103.0%					102.1%
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	1	2	1	3	2	0	1	0	0	2	1	0	0	0	0
780	Hospital Acquired Pressure Ulcers (Grade 3 or 4) per 1000 bed days	0.00	0.02	0.04	0.02	0.06	0.04	0.00	0.02	0.00	0.00	0.04	0.02	0.00	0.00	0.01	0.02
890	Total Falls	221	206	223	230	213	195	221	216	237	224	215	194	216	217	410	2590
891	Falls Resulting in Moderate Harm	4	2	1	4	1	1	3	2	1	4	4	2	5	0	7	30
893	Falls Resulting in Major Harm	5	2	0	1	2	2	1	1	2	3	3	2	0	0	2	19
892	Falls Resulting in Death	0	0	0	0	1	0	0	1	0	0	0	0	2	0	2	4
628	Falls per 1000 bed days	4.09	4.31	4.39	4.43	4.18	3.57	4.17	4.01	4.32	4.35	4.00	3.62	3.75	6.60	3.69	4.09
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.19	0.09	0.02	0.09	0.09	0.00	0.06	0.06	0.06	0.16	0.14	0.09	0.14	0.19	0.12	0.08
868	Surgery - % WHO checklist Compliance	89.6%	90.2%	94.6%	92.8%	94.5%	95.7%	94.9%	94.3%	94.3%	94.0%	94.8%	95.2%	95.2%	93.2%	95.2%	94.2%
	Incident Reporting																
509	Never Events	3	0	2	1	2	0	1	0	1	0	1	0	1	0	1	9
519	Serious Harm/Death Incidents	14	13	12	11	12	8	11	12	13	11	9	19	10		29	141
516	Moderate Harm Incidents	28	27	20	22	19	24	34	29	26	27	48	30	46		76	352
520	Total Serious Incidents reported	22	24	20	12	20	18	14	16	18	21	16	13	18		31	210
648	Amber RCAs	99	104	102	91	86	85	99	91	92	88	122	90	102		192	1152
	Incident Management																
660	Duty of Candour - Conversations recorded in notes	100.0%	100.0%	93.1%	100.0%	96.6%	93.3%	97.6%	87.8%	91.2%	88.2%	92.5%	82.6%	59.6%	94.6%	71.0%	89.2%
661	Duty of Candour - Letters sent following DoC Incidents	100.0%	100.0%	93.1%	100.0%	96.6%	90.0%	97.6%	87.8%	82.4%	88.2%	88.7%	67.4%	34.0%	93.4%	50.5%	83.7%
1617	Duty of Candour - Investigation Findings Shared	89.7%	87.2%	86.2%	87.1%	89.7%	66.7%	66.7%	46.3%	41.2%	29.4%	28.3%	13.0%	4.3%	64.8%	8.6%	49.7%
842	Number of incidents not reviewed (rolling 12 months)	339	337	338	335	331	311	311	306	349	496	625	875	1557	367		
843	Number of incidents under investigation (rolling 12 months)	1217	1274	1405	1558	1633	1754	1933	2135	2467	2819	3288	3870	4542	1881		
511	Incidents reported in month	2866	2649	3006	2733	2700	2801	2630	2597	2951	2822	2896	2782	3230		6012	33797

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Effectiveness

	Effectiveness domain score	2.27	2.46	2.46	2.46	2.58	2.58	2.35	2.27	2.09	2.35	2.36	2.20	2.28	2.50	2.37	
	CQUIN																
746	Smoking Cessation Screening	57.9%	57.6%	51.1%	52.2%	57.4%	54.9%	51.7%	49.8%	53.3%	53.3%	54.8%	63.2%	78.4%	54.6%	70.3%	56.8%
745	Alcohol Screening	56.8%	56.8%	50.7%	51.8%	57.7%	54.1%	50.8%	49.1%	52.2%	52.6%	55.0%	63.1%	69.9%	53.9%	66.4%	55.5%
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	72.7%	79.5%	82.6%	84.6%	85.4%	78.7%	74.5%	79.0%	90.2%	93.1%	76.1%	81.0%	81.8%	80.2%	81.3%	81.0%
	Improving Outcomes																
862	TOPS - offer of HIV tests	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
863	TOPS - uptake of HIV tests	41.03%	35.90%	31.37%	32.84%	43.66%	32.88%	44.62%	30.77%	38.81%	29.41%	33.33%	23.53%	45.61%	70.00%	33.60%	35.34%
864	TOPS - patients receiving full contraceptive consultation	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
865	TOPS - women leaving on LARC or oral contraceptive pill	64.20%	63.86%	73.08%	68.66%	67.61%	72.97%	77.27%	82.05%	64.18%	72.06%	80.33%	75.00%	78.95%	50.00%	76.80%	72.32%
755	Emergency Readmissions within 30 days	6.2%	6.1%	6.4%	6.2%	6.5%	6.0%	5.6%	6.2%	6.0%	6.4%	6.5%	6.1%	4.1%	5.9%	5.1%	5.9%
436	HSMR	86.9	87.2	87.5	86.7	87.0	86.7	86.0	85.8	85.7	86.5	85.5			100.0		
480	Elective Crude Mortality Rate	0.33%	0.21%	0.16%	0.29%	0.22%	0.20%	0.10%	0.22%	0.30%	0.26%	0.24%	0.28%	0.32%	0.21%	0.30%	0.24%
481	Non Elective Crude Mortality Rate	3.0%	2.6%	2.6%	2.6%	2.8%	2.6%	2.7%	3.2%	3.1%	3.2%	2.3%	2.6%	2.7%	2.8%	2.7%	2.8%
831	Standardised Readmission Ratio	91.3	90.9	90.5	90.1	90.0	90.1	89.5	90.0	90.2	90.1				105.0		
433	SHMI	94.8	96.0	96.7	96.6	96.8	96.3	95.2	94.6						105.0		
540	SHMI - Elective	84.8	84.4	84.1	85.6	83.3	82.2	80.1	78.4						105.0		
	Improving Outcomes - Child Birth																
463	C-Section - Elective	11.3%	11.4%	8.1%	10.6%	8.3%	11.8%	12.2%	12.1%	13.1%	11.8%	10.5%	10.9%	11.3%	10.0%	11.1%	11.0%
465	C-Section - Emergency	16.9%	15.5%	18.3%	16.2%	17.3%	15.5%	18.1%	16.2%	18.7%	16.5%	15.0%	19.1%	16.8%	16.8%	18.0%	16.9%
462	Deliveries complicated by Major Postpartum Haemorrhage (PPH)	34	20	35	28	28	30	32	30	32	34	26	42	26	10		
466	Home Birth	3.4%	3.8%	3.7%	3.8%	3.5%	3.3%	2.3%	2.5%	2.2%	3.1%	3.6%	2.9%	4.2%	3.2%	3.6%	3.2%
467	OASIS/Midwifery led suites birth	98	95	87	97	116	119	114	87	89	94	99	73	82	100	155	1152
750	Admission of Term Babies to Neonatal Care	57	56	56	55	44	53	60	56	48	52	39					519
751	Maternal Deaths	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
678	Unplanned neonatal readmission within 28 days of birth	2	2	9	10	11	29	21	25	9	19	18	14			14	167
679	Unplanned maternal readmission within 42 days of delivery	27	27	22	25	24	37	15	26	8	27	20	19			19	250
	Improving Outcomes for Older Patients																
435	Over 65 emergency admissions discharged to usual residence in 7 days	6.9%	7.3%	7.1%	7.5%	7.0%	6.8%	6.8%	8.1%	7.4%	7.2%	7.6%	7.3%	6.8%	7.2%	7.0%	7.2%
485	Dementia Screening within 72 hours	99.01%	98.12%	95.65%	93.56%	94.44%	96.65%	95.41%	98.19%	94.92%	94.94%	92.21%	95.06%		90.00%	95.07%	95.30%
754	Dementia Screening Leading to Further Referral	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	92.2%	100.0%	100.0%			100.0%	98.9%
815	Night time Ward moves patients > 75	240	195	216	221	200	181	209	244	298	301	306	270	319	235	589	2128
539	SHMI - Over 75	94.7	95.5	96.3	96.4	96.4	96.6	95.3	94.0						105.0		

Patient Experience

	Patient Experience domain score	2.38	2.38	2.10	2.29	2.33	2.10	2.00	2.29	2.19	2.33	2.10	2.32	2.18	2.50	2.23	
	HRWD																
342	How are we doing? (Inpatients)	91%	93%	91%	91%	92%	90%	92%	91%	90%	92%	91%	84%	84%	89%	84%	89%
504	Respect & Dignity	96%	97%	96%	96%	96%	96%	96%	96%	96%	96%	95%	96%	96%	94%	96%	96%
505	Involvement in care	87%	89%	87%	88%	89%	83%	89%	88%	84%	89%	87%	86%	87%	85%	86%	87%
506	Kindness & Understanding	96%	97%	96%	96%	96%	96%	96%	96%	96%	96%	95%	96%	96%	94%	96%	96%
2777	Emotional Support From Staff												90%	92%	100%	91%	91%
2778	Doctors Talking In Front Of You												28%	26%		27%	27%
2779	Help From Staff With Meals												93%	90%		92%	92%
2780	Enough To Drink												94%	94%		94%	94%
507	Control of Pain	94%	95%	93%	94%	94%	93%	94%	95%	94%	94%	94%	93%	94%	93%	94%	94%
508	Involvement in Discharge	80%	84%	81%	81%	83%	83%	83%	81%	82%	84%	83%	83%	83%	75%	83%	83%

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2781	Shared Contact After Discharge												84%	87%		85%	85%	
1337	How are we doing? (Outpatients)	80%	83%	82%	90%	81%	79%	92%	86%	83%	88%	90%	87%	91%	83%	89%	87%	
422	Friends & Family - Inpatients	94.4%	93.9%	93.9%	93.9%	94.0%	94.4%	94.0%	93.5%	95.4%	93.9%	94.9%	93.1%	93.9%	94.2%	93.6%	94.1%	
423	Friends & Family - ED	83.4%	83.8%	84.4%	83.4%	82.0%	78.2%	78.6%	78.5%	74.9%	69.7%	73.4%	76.5%	74.6%	80.6%	75.4%	78.7%	
774	Friends & Family - Outpatients	90.0%	89.0%	86.9%	87.7%	87.0%	87.0%	87.2%	86.3%	88.4%	87.7%	87.8%	88.0%	88.3%	87.7%	88.2%	87.6%	
775	Friends & Family - Maternity	88.2%	87.7%	90.7%	90.3%	90.8%	94.9%	91.4%	91.2%	94.1%	93.7%	90.8%	92.9%	92.3%	91.7%	92.5%	92.2%	
	Operational Engagement																	
353	Outpatient Cancellations < 6 week notice (Hosp)	6120	5934	6554	5625	6477	7427	7166	5803	6469	6327	7085	6343	6685	6350	13028	77895	
440	28 Day Cancelled Operation Rule	17.4%	14.0%	11.4%	27.3%	20.5%	15.0%	12.3%	16.0%	15.1%	17.1%	33.3%	17.6%	26.1%	0.0%	21.7%	17.8%	
460	Inpatient Cancellations (Hosp)	57	81	43	39	62	88	100	56	95	70	67	55	86	0	141	842	
618	PALS Contacts - Concerns	87.8%	91.7%	91.6%	88.9%	91.4%	92.5%	88.6%	77.7%	76.0%	81.1%	79.9%	69.9%	81.3%		73.2%	84.8%	
621	PALS Contacts - Praise	1.8%	1.6%	1.3%	1.9%	1.1%	1.0%	2.2%	3.5%	2.1%	2.6%	4.0%	2.9%	4.5%		3.4%	2.2%	
1537	PALS Contacts - % of Open Cases	1.6%	2.4%	0.3%	1.5%	1.5%	1.5%	1.5%	2.1%	3.3%	8.0%	7.4%	14.2%	42.1%	10.0%	23.2%	4.5%	
839	Surgical Cancellations due to Trust Capacity - OTD	44	40	46	35	52	75	94	50	67	40	59	46	61	56	107	665	
	Other																	
483	Mixed Sex Accommodation	8	11	18	17	20	18	15	19	18	17	3	13	15	0			
	Complaints																	
838	Number of complaints per 1000 bed days	1.71	1.86	2.10	1.71	1.51	1.82	2.18	1.22	1.82	1.66	2.03	1.48	1.23	1.78	1.35	1.72	
615	Number of complaints - High & Severe	8	9	14	12	7	8	9	7	7	5	7	7	6	0	13	98	
619	Number of complaints	83	86	100	82	74	94	107	59	93	74	98	70	62	87	132	999	
620	Number of complaints not responded to within 25 Days	46	37	50	52	46	41	55	46	41	33	34	42	49	43	91	526	

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May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Key Targets																		
	Key Targets domain score	1.97	1.88	1.79	1.97	1.91	1.76	1.76	2.00	1.68	1.68	1.74	1.76	1.86	2.50	1.83		
	Access Management - RTT, CWT and Diagnostics																	
364	RTT Incomplete Performance	81.20%	80.85%	80.55%	80.57%	79.41%	79.12%	79.03%	77.95%	77.89%	78.08%	76.95%	77.53%	78.80%	92.00%	78.16%	78.90%	
365	RTT Incomplete Performance (Admitted)	54.61%	54.53%	54.11%	52.91%	52.57%	53.80%	55.84%	54.87%	54.70%	53.82%	52.02%	53.16%	54.27%	92.00%	53.71%	53.88%	
366	RTT Incomplete Performance (Non-Admitted)	88.57%	87.91%	87.68%	87.84%	86.61%	85.91%	85.43%	84.40%	84.26%	84.66%	83.36%	83.89%	85.03%	92.00%	84.46%	85.59%	
632	Patients waiting over 52 weeks (RTT)	331	408	448	457	450	404	332	249	262	264	192	171	177	0	348	3814	
412	Cancer 2 weeks wait GP referral	95.29%	85.80%	85.91%	80.51%	76.00%	89.78%	90.00%	93.14%	91.20%	91.16%	92.12%	93.52%	92.90%	93.00%	93.22%	91.93%	
413	Cancer 2 weeks wait referral - Breast	92.42%	90.48%	91.11%	96.67%	100.00%	96.00%	97.60%	100.00%	73.33%	77.78%	92.54%	96.77%	89.36%	93.00%	92.31%	92.43%	
414	Cancer 31 Day first definitive treatment	99.63%	98.74%	97.92%	98.36%	95.39%	97.90%	96.60%	98.67%	95.77%	95.89%	96.71%	94.44%	95.76%	96.00%	95.11%	96.59%	
415	Cancer 31 day second or subsequent treatment - Drug	100.00%	100.00%	94.74%	100.00%	100.00%	100.00%	95.50%	100.00%	84.62%	87.50%	75.00%	50.00%	93.33%	98.00%	80.95%	88.82%	
416	Cancer 31 day second or subsequent treatment - Other	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	0.00%		94.00%	0.00%	100.00%	
417	Cancer 31 day second or subsequent treatment - Surgery	91.43%	90.91%	90.24%	94.87%	100.00%	75.00%	100.00%	100.00%	100.00%	81.82%	80.00%	80.00%	91.67%	94.00%	86.36%	88.52%	
418	Cancer 62 day referral to treatment - Consultant Upgrade	97.44%	91.67%	87.88%	93.33%	96.15%	100.00%	81.60%	85.06%	88.54%	82.69%	82.19%	94.57%	81.65%	90.00%	87.56%	87.74%	
419	Cancer 62 day referral to treatment - GP	83.65%	83.60%	75.38%	76.34%	71.00%	77.40%	79.00%	85.70%	66.51%	80.00%	82.47%	76.79%	76.30%	85.00%	76.55%	77.95%	
420	Cancer 62 day referral to treatment - Screening Service	92.65%	84.91%	83.58%	85.90%	87.80%	84.80%	92.60%	90.80%	87.50%	86.49%	80.33%	94.20%	94.00%	90.00%	94.12%	88.54%	
536	Diagnostic Waiting Times Performance > 6 Wks	3.44%	4.02%	5.52%	5.81%	7.13%	8.61%	11.06%	14.81%	12.70%	9.22%	7.30%	8.17%	8.91%	1.00%	8.55%	8.60%	
	RTT Data Quality																	
634	Number of unoutcomed RTT appointments	1381	1447	1493	1513	1646	1270	1715	1497	1511	1300	1205	1428	1312	1438	2740	17337	
482	Planned Waiting List past or without Admit by date	77	50	60	46	67	103	113	105	134	116	136	195	407	97	602	1532	
	Access Management - Emergency Flow																	
409	A&E Patients left before seen rate	5.9%	5.8%	6.8%	5.1%	6.0%	5.9%	5.9%	6.7%	7.3%	7.9%	6.7%	6.1%	6.1%	5.0%	6.1%	6.4%	
408	A&E Re-attendance rate	4.3%	4.1%	4.3%	4.1%	4.3%	4.1%	4.1%	4.0%	3.9%	3.7%	3.7%	3.8%	4.3%	5.0%	4.1%	4.0%	
407	A&E DTAs reaching bed within 60 minutes	35.62%	44.43%	34.58%	38.64%	30.99%	27.90%	21.61%	22.28%	18.41%	17.12%	22.06%	21.52%	22.91%	80.00%	22.21%	25.98%	
458	A&E 4 hour performance (Type 1)	72.89%	76.93%	70.80%	73.99%	68.32%	71.04%	65.48%	61.76%	59.92%	60.09%	65.64%	62.49%	64.49%		63.52%	66.73%	
459	A&E 4 hour performance (monthly SITREP)	79.83%	82.73%	77.99%	80.54%	76.29%	78.10%	73.84%	71.67%	69.62%	70.39%	73.72%	71.73%	73.50%	95.00%	72.62%	72.81%	
1397	A&E 4 hour performance (Acute Trust Footprint)	86.52%	88.50%	85.25%	86.80%	84.10%	85.05%	82.33%	80.65%	79.11%	79.73%	82.04%	80.64%	81.73%	95.00%	81.19%	82.96%	
855	Time to initial assessment (95th percentile)	0	0	0	0	0	0	0	0	0	0	0	0		15			
917	Number of Emergency Admissions	4894	4864	4912	4755	4741	5027	4925	5187	5268	4897	5428	4993	5154	4953	10147	60151	
859	A&E Conversion Rate	26.9%	27.5%	26.6%	28.2%	28.5%	28.4%	27.9%	29.3%	28.1%	28.6%	28.8%	29.5%	28.2%	21.1%	28.8%	28.3%	
770	Urgent Care Centre / ED Activity	50.2%	48.6%	48.0%	47.0%	46.9%	46.3%	47.0%	48.3%	49.3%	50.8%	50.6%	50.5%	50.3%	50.0%	50.4%	48.7%	
	Patient Flow																	
399	Weekend Discharges	20.2%	22.0%	19.5%	19.1%	25.1%	18.2%	18.4%	25.3%	19.9%	20.4%	23.8%	19.2%	20.2%	21.1%	19.7%	20.9%	
404	Discharges before 1pm	19.5%	19.1%	18.8%	18.9%	18.1%	18.1%	18.1%	18.6%	19.7%	18.6%	20.5%	18.8%	20.0%	18.9%	19.4%	18.9%	
747	Bed Occupancy	91.0%	87.9%	88.3%	86.0%	90.0%	92.3%	93.0%	89.9%	92.1%	93.1%	92.8%	91.5%	92.5%	90.8%	92.0%	90.8%	
1357	Number of Stranded Patients (LOS 7+ Days)	600	597	552	346	224	204	247	257	254	216	244	226	222	365	448	3589	
1358	Number of Super Stranded Patients (LOS 21+ Days)	851	837	793	593	470	438	484	504	481	434	469	492	468	606	960	6463	
800	Delayed Transfer of Care Days (per calendar day)	8.2	7.0	12.9	13.5	9.0	9.4	10.0	6.6	10.5	10.0	13.8	13.3		0.0	13.3	10.5	
762	Ambulance Delays > 30 Minutes	204	153	168	127	139	155	251	461	381	294	274	241		0			
763	Ambulance Delays > 60 Minutes	18	4	37	69	65	72	129	197	202	179	40	76		0			
772	12 Hour DTAs	16	21	13	29	20	10	14	19	7	13	14	17		0			
Operational Activity																		
	Operational Activity domain score	2.33	2.25	2.33	2.33	2.08	2.33	2.42	1.92	2.50	2.17	2.33	2.17	2.08	2.50	2.25		
	Contract Monitoring (Operational Activity)																	

Business Intelligence Unit
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Created date: June 2017

Best Quality of Care - Access

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

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401	Elective Inpatient Spells	10513	10112	9999	9465	9158	10667	10340	8484	10000	9408	10157	9539	9756	10209	19295	117085	
403	Non-Elective Inpatient Spells	1717	1670	1720	1698	1729	1819	1596	1690	1682	1517	1646	1563	1733	1664	3296	20063	
1183	Emergency Inpatient Spells	4896	4919	4895	4733	4803	5007	4965	5254	5266	4899	5523	5012	5112	4909	10124	60388	
424	Elective Excess Beddays	512	412	521	340	317	494	659	363	412	367	571	881	582	0	1463	5919	
425	Non-Elective Excess Beddays	609	183	347	41	440	245	99	196	62	132	110	131	101	0	232	2087	
1197	Emergency Excess Beddays	1803	2036	1856	962	2015	1502	1251	1361	1140	1559	1357	1501	1312	0	2813	17852	
431	First Outpatient Attendances	25232	24901	25270	22982	22977	27160	26712	20328	24985	22653	24433	25124	26189	25875	51313	293714	
430	Follow Up Outpatient Attendances	80165	74739	78887	74199	72076	81604	79979	63442	80193	70613	74358	73697	76005	78382	149702	899792	
461	A&E Attendances	18559	18056	18531	17070	17596	18221	18217	18109	19071	17518	19621	18370	12362	17846	30732	212742	
464	Procedure coded outpatient attendances	17.9%	19.7%	18.9%	19.5%	20.0%	19.2%	19.4%	20.1%	20.3%	20.1%	20.2%	19.4%	19.7%	19.4%	19.6%	19.7%	
	Operational Strategic																	
622	First to Follow up ratios - consultant led	2.5	2.5	2.6	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.5	2.6	2.6	2.6	2.6	
860	Ethnic Coding	95.45%	95.41%	95.40%	95.48%	95.43%	95.61%	95.46%	95.52%	95.32%	95.53%	95.55%	95.52%	95.55%	90.00%	95.54%	95.48%	

Business Intelligence Unit
Secure Email: kch-tr.performance-team@nhs.net

Created date: June 2017

Excellent Teaching & Research

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:16:05

May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Teaching																		
	Teaching domain score														2.50			
709	PGME - Doctors reporting excessive workload																	
710	PGME - Doctors reporting feeling undermined/harrassed/bullied																	
711	PGME - Doctors reporting Inadequate supervision/working beyond competence																	
713	End of PGME placement composite score																	
Research																		
	Research domain score														2.50			
937	Number of Observational Studies	44	63	77	86	92	101	108	111	111	115	116	17	51		68	1048	
938	Number of Interventional Studies	52	73	80	86	89	98	106	113	119	126	130	23	54		77	1097	
939	Number of Large-scale Studies	10	11	12	13	14	15	15	15	15	15	16	0	10		10	151	
888	Number of Commercial Studies	24	33	38	44	49	59	65	74	81	85	94	2	17		19	641	
940	Total number of Studies	130	180	207	229	244	273	294	313	326	341	356	42	132		174	2937	
978	Raw Recruitment to commercial studies	92	121	147	166	188	220	265	289	419	458	473	15	28		43	2789	
946	Raw Recruitment to NIHR CRN portfolio studies (all)	1823	3603	6044	9461	10632	11034	12257	13562	15789	16479	18184	179	2733		2912	119957	
977	Weighted Recruitment to NIHR CRN portfolio studies (all)	5660	10829	17957	24192	29988	31857	36328	39056	45746	48848	53017	1017	8222		9239	347056	
941	NIHR grants hosted currently active																	
942	CRN funding YTD awarded (£000)																	
943	Total number of research incidents raised		5			11			30								46	
945	Open Incidents		10			15			13								38	
979	Serious breach incidents		0			0			0								0	
887	Numbers recruited to Clinical trials																	
889	Number of citations in peer reviewed papers																	

Business Intelligence Unit
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Skilled, Motivated, Can Do Teams

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:14:32

May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Staff Development & Happiness																		
	Staff Development & Happiness domain score	2.00	2.00	2.33	2.33	2.00	2.33	2.33	2.33	2.33	2.33	2.40	2.33	2.00	2.50	2.22		
	Staff Feedback																	
705	Friends & Family Staff - Care or Treatment (Quarterly)		80%			79%						79%					79%	
706	Friends & Family Staff - Place to Work (Quarterly)		55%			55%						59%					56%	
707	Number of Greatix reported in month	46	45	43	46	42	78	120	82	92	107	138	75	105	1	180	973	
712	Response rate to National Staff Survey														50.00%			
708	GMC Red Flags																	
	Staff Training & CPD																	
715	% appraisals up to date - Combined	50.99%	63.19%	79.19%	87.57%	86.14%	89.41%	88.71%	88.64%	89.46%	89.85%	79.53%	74.07%	64.32%	90.00%			
869	% appraisals up to date - Medical Staff																	
876	% appraisals up to date - Non- Medical Staff																	
721	Statutory & Mandatory Training	83.39%	83.48%	85.17%	81.20%	78.62%	81.77%	81.79%	81.96%	82.35%	81.48%	81.94%	82.07%	83.39%	90.00%			
722	% Medical Staff who have completed local induction																	
Staffing Levels																		
	Staffing Levels domain score	2.60	2.50	2.30	2.70	2.50	2.50	2.50	2.50	2.70	2.40	2.50	2.20	2.20	2.50	2.47		
	Staffing Capacity																	
729	Establishment FTE	12674.01	12674.01	12774.53	12829.06	12882.96	12882.75	12921.95	12975.56	13005.89	13045.04	13036.14	13075.16	13096.16	12864.66			
877	Headcount	12396	12428	12438	12455	12561	12579	12601	12505	12546	12535	12567	12582	12570	12501			
730	In-Post FTE - Total FTE at month end	11444.62	11424.31	11551.48	11515.38	11610.66	11634.48	11638.67	11563.97	11608.05	11600.81	11633.53	11629.91	11626.46	11555.13			
872	Leavers headcount	140	137	468	176	282	241	150	193	183	145	177	143	131	205	274	2426	
873	Starters Headcount	138	164	189	396	378	286	173	88	247	164	186	179	107	222	286	2557	
875	Voluntary Turnover %	13.6%	13.6%	13.7%	13.8%	13.8%	13.9%	14.0%	14.2%	14.4%	14.3%	14.4%	14.2%	14.3%	10.0%			
732	Vacancy Rate %	9.70%	9.86%	9.57%	10.24%	9.88%	9.69%	9.93%	10.88%	10.75%	11.07%	10.76%	11.05%	11.22%	8.00%			
874	Vacancy Rate FTE	1229.39	1249.70	1223.05	1313.68	1272.30	1248.27	1283.28	1411.59	1397.84	1444.23	1402.61	1445.26	1469.71	1309.53			
	Efficiency																	
743	Monthly Sickness Rate	2.89%	3.27%	3.36%	3.56%	3.50%	3.65%	3.77%	3.78%	3.91%	3.81%	3.55%	3.35%	3.20%	3.00%			
740	Number of Red Shifts - Doctors (Awaiting Data Source)																	
741	Number of Red Shifts - Nursing	62	75	71	31	32	51	48	67	82	44	60	48	42	59	90	651	

Business Intelligence Unit
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Created date: June 2017

Top Productivity

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:19:38

May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Transformation																		
	Transformation domain score	2.27	2.31	2.12	2.27	2.12	2.08	2.15	1.96	2.08	2.12	2.27	2.38	2.27	2.50	2.18		
	Outpatient Productivity																	
354	Cancellations less than 6 weeks	11864	11737	12715	10587	11675	13359	13085	10436	11706	11400	12332	11386	11860	11769	23246	142278	
355	Outpatient Discharge Rate	24.0%	24.2%	23.6%	23.4%	23.7%	23.9%	23.2%	23.1%	22.6%	22.4%	22.2%	22.2%	21.9%	23.3%	22.1%	23.0%	
356	Outpatient Hospital Cancellations	11265	11138	12218	11320	11886	13082	12570	10837	13281	11793	12964	11811	12743	11857	24554	145643	
406	New to Follow Up Ratio - all	2.4	2.4	2.5	2.6	2.5	2.4	2.4	2.5	2.6	2.5	2.5	2.4	2.5	2.5	2.4	2.5	
659	Number of uncashed appointments	1610	1730	2063	2379	2070	1627	1737	1507	1439	1870	1419	1780	1951	1708	3731	21572	
795	Clinic Utilisation (Attendances vs Slots)	66.5%	65.7%	63.8%	62.6%	63.5%	60.5%	61.0%	57.2%	59.7%	57.5%	57.6%	58.2%	57.5%	61.4%	57.8%	60.2%	
	Theatre Productivity																	
367	On time Starts % - Main Theatres	33.1%	31.7%	29.8%	29.1%	31.0%	23.2%	29.1%	32.0%	33.8%	31.6%	35.5%	37.3%	35.7%	30.9%	36.5%	31.6%	
368	On Time Starts % - Day Surgery Unit	31.2%	34.4%	29.9%	33.5%	30.8%	24.4%	28.1%	26.8%	31.4%	30.8%	33.3%	33.2%	36.3%	30.4%	34.8%	31.1%	
370	Average Turnaround Time - Day Surgery Unit	10.6	11.6	10.0	6.9	9.0	7.5	13.4	11.3	8.2	12.6	8.8	10.5	9.8	9.8	20.3	119.6	
369	Average Turnaround Time - Main Theatres	28.8	27.1	40.0	28.4	29.0	34.9	28.1	28.9	29.4	26.9	33.5	25.1	29.2	30.7	54.3	360.5	
372	% Early Finishes >45 Minutes - Day Surgery Unit	27.5%	31.2%	29.2%	36.1%	28.6%	28.9%	25.2%	27.4%	30.1%	28.2%	27.7%	27.9%	29.6%	29.3%	28.8%	29.2%	
371	% Early finishes > 45 mins - Main Theatres	32.9%	37.9%	36.1%	32.8%	30.6%	26.1%	30.1%	33.3%	35.0%	35.1%	35.3%	32.5%	30.4%	32.8%	31.4%	32.9%	
373	Theatre Utilisation - Day Surgery Unit	76.9%	75.7%	76.7%	74.7%	75.1%	76.7%	75.8%	75.9%	76.3%	73.8%	75.5%	74.2%	74.3%	80.0%	74.2%	75.4%	
374	Theatre Utilisation - Main Theatres	82.9%	77.7%	79.5%	81.1%	80.6%	82.4%	81.9%	80.0%	78.3%	78.6%	80.8%	81.2%	81.3%	80.0%	81.2%	80.3%	
375	Average Cases per four hour list	2.2	2.1	2.2	2.2	2.1	2.1	2.2	2.0	2.1	2.1	2.1	2.1	2.1	2.1	2.1	2.1	
397	Total Cases - Day Surgery Unit	2108	2103	2134	2052	1930	2256	2168	1600	2135	1921	2122	1911	1991	2035	3902	24323	
396	Total Cases - Main Theatres	1150	1208	1168	1117	1134	1345	1312	1069	1205	1107	1186	1095	1167	1178	2262	14113	
631	Average time in Recovery to leave	151.0	150.4	152.2	154.1	158.0	151.1	150.5	142.9	160.3	145.5	147.0	139.5	144.9	0.0	0.0	0.0	
797	On-The-Day Cancellations - Hospital	172	163	161	147	174	227	218	154	235	179	189	204	225	185	429	2276	
798	On-The-Day Cancellations - Patient	150	134	164	148	134	163	147	112	137	134	141	111	123	142	234	1648	
	Kings Way for Wards																	
438	Discharges Before 11am excluding obstetrics	7.7%	6.9%	7.6%	7.7%	6.6%	7.0%	7.7%	7.3%	7.4%	7.4%	9.2%	6.7%	7.6%	7.5%	7.1%	7.4%	
441	Inlier bed days	695.0	684.6	681.2	671.2	697.2	681.9	696.0	671.0	679.6	683.6	676.4	678.9	697.8	685.7	688.5	683.2	
	Emergency & Acute Care																	
790	Direct AMU Discharges	573	593	629	621	624	651	680	651	596	485	533	585	652	597	1237	7300	
791	% Discharges before 11am - AMU	5.1%	3.4%	4.4%	4.2%	4.7%	4.2%	7.6%	4.0%	5.6%	8.2%	6.0%	5.8%	5.3%	5.3%	5.5%	5.8%	
792	Median LOS on AMU	1.2	1.1	1.2	1.2	1.4	1.3	1.3	1.4	1.4	1.3	1.2	1.3	1.4	1.3	2.7	15.4	
793	Number of AMU Stays >72hrs	268	224	289	255	304	290	284	284	329	269	314	299	316	286	615	3457	
Operational Strategic																		
	Operational Strategic domain score	2.50	2.33	2.50	2.17	2.25	2.42	2.42	2.17	2.33	2.25	2.33	2.33	2.17	2.50	2.32		
	Productivity & Efficiency																	
801	Day Case Rate	78.1%	76.3%	76.0%	76.1%	75.5%	76.8%	75.3%	74.0%	75.5%	74.9%	74.6%	75.5%	75.2%	75.8%	75.4%	75.5%	
345	Outpatient DNA Rate	11.4%	11.1%	11.5%	11.4%	11.5%	11.5%	11.2%	11.6%	11.2%	10.9%	10.3%	10.5%	10.7%	11.3%	10.6%	11.1%	
622	First to Follow up ratios - consultant led	2.5	2.5	2.6	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.5	2.6	2.6	2.6	2.6	
426	Average Length of Stay - Elective ALoS	4.2	3.2	3.7	4.2	4.1	4.1	4.0	4.5	3.5	3.4	3.9	4.1	4.0	3.9	4.0	3.9	

Business Intelligence Unit
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Top Productivity

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

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428	Average Length of Stay - Non - Elective ALoS	6.5	6.2	6.2	6.3	6.0	6.2	6.2	5.9	6.0	6.3	5.6	6.2	6.4	6.2	6.3	6.1	
429	Zero Length of Stay - Emergency	773	837	865	800	829	796	840	1033	1109	1007	1211	765	862	904	1627	10954	
521	Theatre Utilisation - Overall	80.6%	76.9%	78.4%	78.7%	78.6%	80.3%	79.7%	78.7%	77.5%	76.9%	78.8%	78.7%	79.1%	80.0%	78.9%	78.6%	
	Demand & Capacity																	
350	% Unoutcomed Appointments	7.2%	7.0%	7.1%	7.4%	7.1%	6.9%	6.7%	7.4%	6.9%	7.5%	7.6%	7.9%	8.9%	7.2%	8.4%	7.4%	
352	Outpatients waiting more than 12 weeks	12165	13265	12398	12030	12822	14872	14317	10410	14689	12907	13477	12463	12877	12860	25340	156527	
376	Referrals to Consultant led services	36318	33997	34050	32960	31449	36232	34042	27920	33946	31505	34203	31911	31901	33232	63812	394116	
405	First Outpatient Attendances - Consultant Led	23882	23043	22939	20865	20847	24461	24109	17998	22297	19919	21699	22170	22196	21993	44366	262543	
537	Decision To Admit	8882	8540	8275	7670	7972	9082	9017	7063	8571	7668	8053	7721	7817	8239	15538	97449	

Business Intelligence Unit
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Created date: June 2017

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:18:26

May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
	Overall (000s)																	
895	Actual - Overall	15,437	11,242	16,855	17,541	19,804	16,426	20,753	27,140	(1,318)	17,477	(4,778)	18,627	13,063	14,062	31,690	172,833	
896	Budget - Overall	15,182	11,295	15,430	12,547	12,347	9,074	10,315	16,751	10,297	14,747	2,656	17,845	14,062		31,907	147,366	
897	Variance - Overall	(255)	53	(1,425)	(4,994)	(7,458)	(7,352)	(10,439)	(10,389)	11,615	(2,730)	7,434	(782)	999	0	218	(25,467)	
	Income (000s)																	
	Income (000s) domain score	2.09	1.91	1.55	1.91	2.27	1.73	1.36	2.27	1.73	2.09	2.27	1.73	2.09	2.50	1.92		
	Education & Training Income																	
582	Actual - Education & Training Income	(3,397)	(3,910)	(3,667)	(3,751)	(3,736)	(3,728)	(3,506)	(3,739)	(3,774)	(3,908)	(4,460)	(3,373)	(3,127)	(3,215)	(6,501)	(44,679)	
583	Budget - Education & Training Income	(3,670)	(3,670)	(3,731)	(3,731)	(3,731)	(3,731)	(3,731)	(3,731)	(3,731)	(3,743)	(3,737)	(3,215)	(3,215)		(6,431)	(43,694)	
581	Variance - Education & Training Income	(273)	241	(63)	20	5	(2)	(225)	8	43	165	723	158	(88)	0	70	985	
	Fines and Penalties																	
1097	Actual - Fines and Penalties																	
1103	Budget - Fines and Penalties	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1105	Variance - Fines and Penalties														0			
	NHS Clinical Contract Income																	
1107	Actual - NHS Clinical Contract Income	(70,568)	(69,665)	(71,459)	(69,531)	(67,009)	(72,579)	(69,104)	(64,858)	(69,632)	(66,509)	(73,061)	(69,229)	(75,255)	(74,966)	(144,484)	(837,890)	
1108	Budget - NHS Clinical Contract Income	(69,251)	(68,844)	(73,928)	(70,932)	(70,993)	(73,053)	(71,763)	(66,714)	(72,353)	(68,419)	(70,476)	(71,324)	(74,966)		(146,291)	(853,765)	
1109	Variance - NHS Clinical Contract Income	1,317	821	(2,468)	(1,401)	(3,984)	(474)	(2,659)	(1,857)	(2,721)	(1,910)	2,585	(2,095)	289	0	(1,806)	(15,875)	
	Other NHS Clinical Income																	
1110	Actual - Other NHS Clinical Income	(374)	(334)	(407)	(448)	(434)	(391)	(364)	(396)	(420)	(357)	(232)	(374)	(339)	(394)	(712)	(4,493)	
1111	Budget - Other NHS Clinical Income	(395)	(395)	(432)	(395)	(359)	(393)	(393)	(393)	(393)	(393)	(442)	(394)	(394)		(788)	(4,773)	
1112	Variance - Other NHS Clinical Income	(20)	(61)	(25)	53	74	(2)	(29)	3	27	(36)	(211)	(20)	(55)	0	(75)	(280)	
	Other Operating Income																	
585	Actual - Other Operating Income	(3,065)	(3,193)	(4,359)	(5,633)	(3,928)	(4,170)	(4,380)	(5,110)	(3,912)	(4,781)	(4,814)	(3,151)	(3,025)	(4,643)	(6,176)	(50,457)	
586	Budget - Other Operating Income	(2,990)	(3,482)	(3,232)	(3,214)	(7,978)	(4,316)	(4,528)	(4,200)	(4,418)	(4,558)	(4,132)	(4,244)	(4,643)		(8,887)	(52,943)	
584	Variance - Other Operating Income	75	(288)	1,127	2,420	(4,049)	(146)	(147)	910	(506)	223	682	(1,093)	(1,618)	0	(2,711)	(2,486)	
	Overseas Visitor Income																	
1113	Actual - Overseas Visitor Income	(104)	(205)	(418)	(430)	(814)	(579)	(685)	(292)	(494)	(754)	368	(176)	(142)	(547)	(318)	(4,621)	
1114	Budget - Overseas Visitor Income	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)	(547)		(1,095)	(6,567)	
1115	Variance - Overseas Visitor Income	(444)	(342)	(129)	(117)	267	32	138	(255)	(54)	207	(916)	(371)	(406)	0	(777)	(1,946)	
	Pass Through Devices - Income																	
1116	Actual - Pass Through Devices - Income	(931)	(1,972)	(1,282)	(1,455)	(1,947)	(1,613)	(1,508)	(1,880)	(1,245)	(1,915)	(1,491)	(1,522)	(1,601)	(1,522)	(3,123)	(19,433)	
1117	Budget - Pass Through Devices - Income	(1,553)	(1,536)	(1,592)	(1,570)	(1,587)	(1,657)	(1,609)	(1,405)	(1,627)	(1,473)	(1,547)	(1,522)	(1,522)		(3,044)	(18,647)	
1118	Variance - Pass Through Devices - Income	(622)	436	(310)	(115)	360	(43)	(101)	475	(382)	442	(55)	0	79	0	79	785	
	Pass Through Drugs - Income																	
1119	Actual - Pass Through Drugs - Income	(8,033)	(10,222)	(9,511)	(9,950)	(9,981)	(9,055)	(8,132)	(8,616)	(10,335)	(9,516)	(11,959)	(10,547)	(10,696)	(10,099)	(21,243)	(118,520)	
1120	Budget - Pass Through Drugs - Income	(10,842)	(10,733)	(11,473)	(10,880)	(10,989)	(11,557)	(11,244)	(9,916)	(11,361)	(10,359)	(10,840)	(10,099)	(10,099)		(20,198)	(129,549)	
1121	Variance - Pass Through Drugs - Income	(2,809)	(511)	(1,962)	(929)	(1,008)	(2,502)	(3,112)	(1,300)	(1,027)	(844)	1,120	448	597	0	1,045	(11,029)	
	Private Patient Income																	
1122	Actual - Private Patient Income	(2,071)	(1,688)	(1,665)	(1,534)	(1,630)	(2,029)	(1,290)	(1,799)	(1,632)	(1,511)	(1,835)	(1,650)	(1,563)	(1,881)	(3,213)	(19,824)	
1123	Budget - Private Patient Income	(1,651)	(1,653)	(1,665)	(1,651)	(1,653)	(1,651)	(1,651)	(1,653)	(1,651)	(1,651)	(1,653)	(1,881)	(1,881)		(3,761)	(20,292)	
1124	Variance - Private Patient Income	420	35	()	(117)	(23)	378	(361)	146	(18)	(140)	182	(231)	(317)	0	(548)	(467)	

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Created date: June 2017

Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:18:26

	R&I Income																	
1125	Actual - R&I Income	(1,683)	(928)	(954)	(1,418)	(1,458)	(751)	875	(794)	(1,422)	(1,228)	(3,713)	(992)	(1,288)	(1,268)	(2,280)	(14,070)	
1126	Budget - R&I Income	(1,307)	(1,307)	(1,342)	(1,316)	(1,316)	(1,216)	(1,216)	(1,216)	(1,216)	(1,261)	(1,892)	(1,446)	(1,268)		(2,714)	(16,012)	
1127	Variance - R&I Income	376	(379)	(389)	102	143	(465)	(2,091)	(422)	206	(33)	1,821	(454)	20	0	(435)	(1,942)	
	RTA Income																	
1128	Actual - RTA Income	(348)	(251)	(602)	(283)	(346)	(306)	(283)	(323)	(294)	(339)	1,348	(275)	(317)	(305)	(592)	(2,272)	
1129	Budget - RTA Income	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)	(305)		(610)	(3,660)	
1130	Variance - RTA Income	43	(54)	297	(22)	42	1	(22)	18	(11)	34	(1,653)	(30)	12	0	(18)	(1,387)	
	Miscellaneous Income																	
1131	Actual - Miscellaneous Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1132	Budget - Miscellaneous Income	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1133	Variance - Miscellaneous Income	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Nonpay - Financing (000s)																		
	Nonpay - Financing (000s) domain score	2.79	2.14	2.71	3.00	3.00	2.79	3.00	3.00	2.79	3.00	2.14	3.00	2.43	2.50	2.75		
	Interest Payable																	
1134	Actual - Interest payable	3,605	4,136	3,410	3,222	3,494	3,771	3,274	3,268	3,607	3,507	4,323	4,009	4,009	4,009	8,019	44,030	
1135	Budget - Interest payable	3,676	3,676	3,410	3,572	3,596	3,610	3,616	3,519	3,535	3,605	3,595	4,009	4,009		8,019	43,753	
1136	Variance - Interest payable	70	(460)	0	351	102	(160)	342	251	(72)	98	(728)	0	0	0	0	(276)	
	Interest Receivable																	
1137	Actual - Interest receivable	(42)	(42)	(39)	(44)	(85)	(57)	(57)	(57)	(57)	(304)	(81)	(91)	7	(42)	(84)	(908)	
1138	Budget - Interest receivable	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)	(42)		(84)	(501)	
1139	Variance - Interest receivable		0	(3)	2	43	16	16	16	16	262	40	49	(49)	0	0	407	
	Profit/Loss on Disposal of Fixed Assets																	
1140	Actual - Profit/Loss on Disposal of Fixed Assets		62	21	21	21	21	21	21	21	(373)	484	(28)	28	4	0	319	
1141	Budget - Profit/Loss on Disposal of Fixed Assets	21	21	21	21	21	21	21	21	21	21	(179)	4	4		8	17	
1142	Variance - Profit/Loss on Disposal of Fixed Assets	21	(42)	0	0	0	0	0	0	0	394	(663)	32	(24)	0	8	(302)	
	Public Dividend Capital																	
1143	Actual - Public Dividend Capital	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	
1144	Budget - Public Dividend Capital																	
1145	Variance - Public Dividend Capital	0	0	0	0	0	0	0	0	0	0	0		0	0	0	0	
	Depreciation																	
1049	Actual - Depreciation	2,308	2,608	2,308	2,308	2,308	2,308	2,308	2,308	(1,187)	1,935	3,474	2,152	2,152	2,152	4,304	24,981	
1050	Budget - Depreciation	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,308	2,152	2,152		4,304	27,382	
1052	Variance - Depreciation		(300)	0	0	0	0	0	0	3,495	373	(1,166)	0	0	0	0	2,402	
	Impairment																	
1055	Actual - Impairment	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,186	(15,362)	431	(4,938)	2,000	2,000	2,000	4,000	(570)	
1056	Budget - Impairment	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,186	2,000	2,000		4,000	25,856	
1059	Variance - Impairment	()		0	0	0	0	0	0	17,548	1,755	7,124	0	0	0	0	26,426	
	Miscellaneous Nonpay - Financing																	
1063	Actual - Miscellaneous Nonpay - Financing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1065	Budget - Miscellaneous Nonpay - Financing	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1048	Variance - Miscellaneous Nonpay - Financing	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Non-Pay (000s)																		
	Non-Pay (000s) domain score	1.94	2.17	1.94	1.61	1.61	2.11	1.83	1.28	1.72	2.28	2.18	2.35	2.00	2.50	1.92		

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Firm Foundations - Finance

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King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:18:26

	Clinical Supplies																
554	Actual - Clinical Supplies	2,514	3,198	2,952	3,182	2,285	2,862	2,244	2,489	3,274	3,086	5,240	1,342	1,323	791	2,665	33,477
555	Budget - Clinical Supplies	3,648	3,648	2,148	3,336	(2,658)	2,407	2,008	1,949	2,071	2,071	2,029	696	791		1,488	20,496
556	Variance - Clinical Supplies	1,133	450	(804)	153	(4,943)	(455)	(236)	(539)	(1,203)	(1,015)	(3,211)	(645)	(532)	0	(1,177)	(12,981)
	Consultancy																
1068	Actual - Consultancy	1,082	1,127	1,315	1,730	1,838	1,791	1,968	1,878	1,690	105	781	252	428	135	681	14,905
1070	Budget - Consultancy	419	419	2,615	565	477	2,221	494	488	488	484	467	135	135		269	8,986
1072	Variance - Consultancy	(663)	(708)	1,299	(1,165)	(1,361)	429	(1,475)	(1,390)	(1,202)	379	(314)	(118)	(294)	0	(412)	(5,919)
	Drugs																
548	Actual - Drugs	2,056	2,145	2,304	2,284	2,132	2,535	2,208	2,149	2,703	1,938				2,312		20,399
552	Budget - Drugs	2,786	2,797	78	2,063	2,117	2,114	2,086	2,046	2,019	1,985	1,948	2,312	2,312		4,624	23,879
553	Variance - Drugs	730	651	(2,226)	(221)	(14)	(421)	(122)	(103)	(683)	46	(172)	36	277	0	313	(2,952)
	Non-Clinical Supplies																
1074	Actual - Non-Clinical Supplies	4,862	5,452	5,140	4,906	4,826	4,749	7,382	5,525	5,883	1,497	3,507	4,827	5,132	4,872	9,959	58,825
1076	Budget - Non-Clinical Supplies	4,572	4,572	4,592	4,581	4,636	5,194	7,233	4,921	4,921	2,394	4,466	4,868	4,872		9,740	57,251
1079	Variance - Non-Clinical Supplies	(290)	(879)	(548)	(325)	(190)	444	(148)	(604)	(962)	897	959	41	(260)	0	(219)	(1,575)
	Other Non-Pay																
1083	Actual - Other Non-Pay	2,398	530	1,936	2,595	2,405	2,935	860	2,541	3,013	588	9,251	467	2,097	2,186	2,564	29,218
1084	Budget - Other Non-Pay	1,859	1,870	1,859	1,929	1,934	1,797	2,062	1,893	1,889	1,899	2,255	2,114	2,186		4,300	23,687
1087	Variance - Other Non-Pay	(539)	1,341	(77)	(666)	(471)	(1,137)	1,202	(649)	(1,124)	1,311	(6,996)	1,647	89	0	1,736	(5,530)
	Pass Through Drugs - Expenditure																
1146	Actual - Pass Through Drugs - Expenditure	7,846	8,936	9,472	8,593	9,020	9,639	9,378	9,222	9,372	11,239	9,370	9,930	10,537	10,044	20,467	114,710
1147	Budget - Pass Through Drugs - Expenditure	9,207	9,207	15,418	10,821	10,780	10,886	10,876	10,866	10,856	10,846	10,836	10,143	10,044		20,187	131,579
1148	Variance - Pass Through Drugs - Expenditure	1,361	270	5,946	2,227	1,759	1,247	1,498	1,644	1,484	(394)	1,466	213	(493)	0	(280)	16,868
	Purchase of Healthcare from Non NHS Providers																
567	Actual - Purchase of Healthcare from Non NHS Providers	9,278	9,726	14,190	10,727	11,871	11,628	8,723	14,096	11,426	12,688	859	13,713	11,843	13,888	25,556	131,490
573	Budget - Purchase of Healthcare from Non NHS Providers	8,254	8,254	17,029	10,386	17,516	11,761	7,256	12,042	11,673	12,175	12,215	13,588	13,888		27,477	147,783
574	Variance - Purchase of Healthcare from Non NHS Providers	(1,024)	(1,472)	2,839	(341)	5,645	133	(1,467)	(2,054)	247	(513)	11,356	(125)	2,045	0	1,921	16,293
	Services from other NHS Bodies																
576	Actual - Services from other NHS Bodies	5,363	5,120	5,244	5,371	5,367	5,102	4,968	5,916	5,372	5,486	5,029	5,280	5,761	5,479	11,041	64,017
577	Budget - Services from other NHS Bodies	4,696	4,696	6,503	5,355	4,902	5,356	5,469	5,182	5,177	5,183	5,177	5,484	5,479		10,963	63,962
578	Variance - Services from other NHS Bodies	(667)	(424)	1,259	(17)	(465)	254	501	(735)	(195)	(303)	148	203	(281)	0	(78)	(55)
	Miscellaneous Nonpay																
1149	Actual - Miscellaneous Nonpay - Nonpay	8,971	9,645	9,232	10,340	9,146	9,692	10,434	9,560	(10,778)	9,727	0	0	0	7,085	0	66,998
1150	Budget - Miscellaneous Nonpay - Nonpay	11,109	10,417	5,122	8,740	7,992	5,858	9,802	7,266	8,773	10,263	0	0	0		0	74,234
1151	Variance - Miscellaneous Nonpay - Nonpay	2,138	772	(4,110)	(1,599)	(1,154)	(3,833)	(632)	(2,294)	19,551	536	0	0	0	0	0	7,236

Nonpay - Unallocated CIP (000s)

	Nonpay - Unallocated CIP (000s) domain score	3.00	2.00	3.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	3.00	2.00	2.50	2.23	
	Unallocated CIP - Nonpay																
1152	Actual - Unallocated CIP - NonPay	0	0	0	0	0	0	0	0	0	0	0	0	0	(20)	0	0
1153	Budget - Unallocated CIP - NonPay	0	(692)	1,497	(2,458)	(2,868)	(2,968)	(2,754)	(3,280)	(3,150)	(3,055)	(3,798)	54	(20)		35	(23,491)
1154	Variance - Unallocated CIP - NonPay	0	(692)	1,497	(2,458)	(2,868)	(2,968)	(2,754)	(3,280)	(3,150)	(3,055)	(3,798)	54	(20)	0	35	(23,491)
	Miscellaneous Nonpay - Unallocated CIP																
1155	Actual - Miscellaneous Nonpay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1156	Budget - Miscellaneous Nonpay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0

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Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:18:26

1157	Variance - Miscellaneous Nonpay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

Pay - Admin and Clerical (000s)

	Pay - Admin and Clerical (000s) domain score	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.50	2.00	
	Admin & Clerical - Agency																
593	Actual - Admin & Clerical - Agency	227	217	202	104	229	161	153	430	84	315	170	256	374	7	630	2,695
594	Budget - Admin & Clerical - Agency	73	73	41	(102)	32	32	32	32	32	32	32	7	7		15	248
592	Variance - Admin & Clerical - Agency	(154)	(144)	(161)	(206)	(197)	(130)	(121)	(398)	(53)	(283)	(138)	(249)	(366)	0	(615)	(2,447)
	Admin & Clerical Bank																
1158	Actual - Admin & Clerical Bank	408	403	261	340	157	366	206	191	294	226	397	234	306	94	540	3,382
1159	Budget - Admin & Clerical Bank	61	61	61	61	61	61	61	61	61	61	61	94	94		188	799
1160	Variance - Admin & Clerical Bank	(347)	(342)	(200)	(279)	(96)	(305)	(145)	(130)	(233)	(165)	(336)	(140)	(212)	0	(353)	(2,583)
	Admin & Clerical Substantive																
1161	Actual - Admin & Clerical Substantive	7,781	7,331	8,006	8,355	7,581	7,713	7,864	7,990	6,532	9,048	7,490	8,457	8,324	9,193	16,780	94,691
1162	Budget - Admin & Clerical Substantive	8,571	8,599	8,884	9,127	10,020	8,782	8,671	9,123	9,001	9,246	9,039	9,347	9,193		18,540	109,031
1163	Variance - Admin & Clerical Substantive	789	1,268	878	772	2,439	1,068	807	1,132	2,469	197	1,549	890	869	0	1,759	14,340
	Miscellaneous Pay - Admin & Clerical																
1165	Actual - Miscellaneous Pay - Admin & Clerical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1166	Budget - Miscellaneous Pay - Admin & Clerical	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1167	Variance - Miscellaneous Pay Admin & Clerical	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay - Medical Staff (000s)

	Pay - Medical Staff (000s) domain score	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.50	2.00	
	Medical - Agency																
600	Actual - Medical - Agency	1,055	918	947	1,083	771	697	1,316	898	765	820	155	718	669	101	1,386	9,756
601	Budget - Medical - Agency	143	100	100	14	100	100	100	100	100	(71)	84	101	101		202	928
602	Variance - Medical - Agency	(912)	(818)	(848)	(1,070)	(671)	(597)	(1,216)	(798)	(665)	(891)	(71)	(617)	(568)	0	(1,185)	(8,829)
	Medical Bank																
1054	Actual - Medical Bank	372	345	481	363	349	644	293	308	556	406	671	574	498	16	1,072	5,488
1078	Budget - Medical Bank	5	5	()	4	4	4	4	4	4	4	4	16	16		32	70
1095	Variance - Medical Bank	(367)	(340)	(481)	(359)	(345)	(640)	(289)	(304)	(551)	(401)	(667)	(558)	(482)	0	(1,040)	(5,418)
	Medical Substantive																
597	Actual - Medical Substantive	17,666	16,942	16,821	17,086	17,493	17,234	17,866	17,762	17,664	17,602	17,749	17,512	17,472	19,239	34,983	209,204
598	Budget - Medical Substantive	17,743	17,743	18,239	18,009	18,089	18,278	18,315	18,386	18,406	18,737	19,124	19,086	19,122		38,208	221,534
599	Variance - Medical Substantive	77	801	1,417	923	596	1,043	448	624	742	1,135	1,375	1,574	1,651	0	3,225	12,330
	Miscellaneous Pay - Medical Staff																
1058	Actual - Miscellaneous Pay - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1082	Budget - Miscellaneous Pay - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1099	Variance - Miscellaneous Pay - Medical Staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay - Nursing Staff (000s)

	Pay - Nursing Staff (000s) domain score	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.50	2.00	
	Nursing Agency																
607	Actual - Nursing Agency	482	312	455	387	393	297	223	259	276	263	259	311	428	75	740	3,864
608	Budget - Nursing Agency	136	136	22	240	136	136	136	136	136	136	136	75	75		150	1,496
603	Variance - Nursing Agency	(346)	(176)	(433)	(148)	(258)	(162)	(88)	(124)	(140)	(128)	(123)	(236)	(353)	0	(590)	(2,369)

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Firm Foundations - Finance

Directorate: Trust (1000)

King's College Hospital NHS Foundation Trust

Report Executed: 19/06/2019 19:18:26

	Nursing Bank																
1066	Actual - Nursing Bank	3,154	2,582	2,130	2,162	2,073	2,010	2,010	2,399	2,180	2,458	3,397	2,438	2,163	682	4,601	28,002
1088	Budget - Nursing Bank	91	91	71	91	141	100	97	97	97	49	91	710	682		1,392	2,318
1104	Variance - Nursing Bank	(3,063)	(2,491)	(2,059)	(2,070)	(1,932)	(1,909)	(1,913)	(2,302)	(2,083)	(2,409)	(3,306)	(1,728)	(1,481)	0	(3,209)	(25,683)
	Nursing Substantive																
604	Actual - Nursing Substantive	20,055	20,069	20,667	22,667	20,822	20,909	20,861	21,091	21,039	20,905	20,568	21,734	21,604	23,909	43,338	252,936
605	Budget - Nursing Substantive	22,398	22,386	22,483	23,305	24,489	22,955	23,026	23,140	23,269	23,172	23,401	23,853	23,909		47,762	279,390
606	Variance - Nursing Substantive	2,344	2,317	1,816	638	3,668	2,046	2,165	2,049	2,231	2,267	2,833	2,119	2,306	0	4,424	26,454
	Miscellaneous Pay - Nursing Staff																
1061	Actual - Miscellaneous Pay - Nursing staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1085	Budget - Miscellaneous Pay - Nursing staff	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1102	Variance - Miscellaneous Pay - Nursing staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay - Other Staff (000s)

	Pay - Other Staff (000s) domain score	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.50	2.00	
	Other Agency Staff																
1073	Actual - Other Agency Staff	314	286	460	506	420	422	544	532	430	546	516	377	420	77	797	5,459
1092	Budget - Other Agency Staff	36	36	32	35	35	35	35	35	35	35	35	77	77		154	502
1106	Variance - Other Agency Staff	(278)	(250)	(428)	(471)	(385)	(387)	(509)	(496)	(395)	(511)	(481)	(300)	(343)	0	(643)	(4,957)
	Other Bank Staff																
1172	Actual - Other Bank Staff	289	237	179	80	97	156	79	105	175	124	269	156	109	56	265	1,767
1173	Budget - Other Bank Staff	11	11	11	11	11	11	11	11	11	11	11	29	56		85	191
1171	Variance - Other Bank Staff	(279)	(227)	(168)	(70)	(87)	(146)	(69)	(95)	(164)	(113)	(258)	(127)	(53)	0	(180)	(1,575)
	Other Substantive Staff																
1051	Actual - Other Substantive Staff	6,272	6,191	6,398	6,917	6,373	6,350	6,314	6,373	6,312	6,405	6,481	6,777	6,685	7,547	13,462	77,576
1053	Budget - Other Substantive Staff	6,966	6,966	7,076	7,400	7,579	7,237	7,339	7,247	7,465	7,345	7,328	7,550	7,547		15,097	88,078
1057	Variance - Other Substantive Staff	694	775	678	483	1,206	888	1,025	874	1,154	940	846	772	862	0	1,635	10,502
	Miscellaneous Pay - Other Staff																
1062	Actual - Miscellaneous Pay - Other staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1064	Budget - Miscellaneous Pay - Other staff	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1060	Variance - Miscellaneous Pay - Other staff	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

Pay - Unallocated CIP (000s)

	Pay - Unallocated CIP (000s) domain score	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	3.00	2.00	2.00	2.50	2.73	
	Unallocated CIP - Pay																
1067	Actual - Unallocated CIP - Pay												0	0	(161)	0	0
1069	Budget - Unallocated CIP - Pay												(161)	(161)		(322)	(322)
1071	Variance - Unallocated CIP - Pay												(161)	(161)	0	(322)	(322)
	Miscellaneous Pay - Unallocated CIP																
1075	Actual - Miscellaneous Pay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1077	Budget - Miscellaneous Pay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0
1080	Variance - Miscellaneous Pay - Unallocated CIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

SLR Recharges (000s)

	SLR Recharges (000s) domain score	2.50	2.00	2.63	2.50	2.50	2.25	2.25	2.13	2.63	3.00	3.00	3.00	3.00	2.50	2.44	
	SLR Recharges																

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King's College Hospital NHS Foundation Trust

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1164	Actual - SLR Recharges	0	(79,765)	(29,392)	(26,967)	(27,356)	(29,504)	(30,430)	(27,077)	(28,103)							(278,594)	
1086	Budget - SLR Recharges	(26,882)	(26,882)	(27,910)	(27,139)	(27,565)	(28,760)	(29,371)	(27,908)	(27,908)							(223,445)	
1081	Variance - SLR Recharges	(26,882)	52,882	1,482	(172)	(209)	744	1,059	(831)	195					0		55,149	
	SLR Recharges - Fixed																	
1090	Actual - SLR Recharges - Fixed	0	3,549	1,183	1,183	1,183	1,183	1,183	1,183	1,183							11,831	
1091	Budget - SLR Recharges - Fixed	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183	1,183							9,465	
1089	Variance - SLR Recharges - Fixed	1,183	(2,366)				()	()	()						0		(2,366)	
	SLR Recharges - Variable																	
1094	Actual - SLR Recharges - Variable	0	76,216	28,209	25,784	26,173	28,321	29,247	25,894	26,930							266,773	
1096	Budget - SLR Recharges - Variable	25,699	25,699	26,727	25,956	26,382	27,577	28,188	26,725	26,725							213,980	
1093	Variance - SLR Recharges - Variable	25,699	(50,516)	(1,482)	172	209	(744)	(1,059)	831	(205)					0		(52,793)	
	Miscellaneous SLR Recharges																	
1100	Actual - Miscellaneous SLR Recharges	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
1101	Budget - Miscellaneous SLR Recharges	0	0	0	0	0	0	0	0	0	0	0	0	0		0	0	
1098	Variance - Miscellaneous SLR Recharges	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	

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Firm Foundations - Activity

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May 2019

		May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Month Target	F-YTD Actual	Rolling 12mth	Trend
Operational Activity																		
	Operational Activity domain score	2.33	2.25	2.33	2.33	2.08	2.33	2.42	1.92	2.50	2.17	2.33	2.17	2.08	2.50	2.25		
	Contract Monitoring (Operational Activity)																	
401	Elective Inpatient Spells	10513	10112	9999	9465	9158	10667	10340	8484	10000	9408	10157	9539	9756	10209	19295	117085	
403	Non-Elective Inpatient Spells	1717	1670	1720	1698	1729	1819	1596	1690	1682	1517	1646	1563	1733	1664	3296	20063	
1183	Emergency Inpatient Spells	4896	4919	4895	4733	4803	5007	4965	5254	5266	4899	5523	5012	5112	4909	10124	60388	
424	Elective Excess Beddays	512	412	521	340	317	494	659	363	412	367	571	881	582	0	1463	5919	
425	Non-Elective Excess Beddays	609	183	347	41	440	245	99	196	62	132	110	131	101	0	232	2087	
1197	Emergency Excess Beddays	1803	2036	1856	962	2015	1502	1251	1361	1140	1559	1357	1501	1312	0	2813	17852	
431	First Outpatient Attendances	25232	24901	25270	22982	22977	27160	26712	20328	24985	22653	24433	25124	26189	25875	51313	293714	
430	Follow Up Outpatient Attendances	80165	74739	78887	74199	72076	81604	79979	63442	80193	70613	74358	73697	76005	78382	149702	899792	
461	A&E Attendances	18559	18056	18531	17070	17596	18221	18217	18109	19071	17518	19621	18370	12362	17846	30732	212742	
464	Procedure coded outpatient attendances	17.9%	19.7%	18.9%	19.5%	20.0%	19.2%	19.4%	20.1%	20.3%	20.1%	20.2%	19.4%	19.7%	19.4%	19.6%	19.7%	
	Operational Strategic																	
622	First to Follow up ratios - consultant led	2.5	2.5	2.6	2.7	2.6	2.6	2.6	2.7	2.8	2.8	2.7	2.5	2.6	2.6	2.6	2.6	
860	Ethnic Coding	95.45%	95.41%	95.40%	95.48%	95.43%	95.61%	95.46%	95.52%	95.32%	95.53%	95.55%	95.52%	95.55%	90.00%	95.54%	95.48%	

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Best Quality of Care – Safety, Effectiveness,

King's College Hospital NHS Foundation Trust

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4.2

Item	Definition
342	The proportion of positive responses on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response.
353	The number of outpatient appointments cancelled by the hospital based on a set of cancellation reason codes for which it is deemed that the patient was affected by the appointment change.
422	The Friends and Family survey net promoter score for Inpatients and Day Cases submitted to the DH via the Unify system for the reported month.
423	The Friends and Family survey net promoter score for patients attending the A&E department, submitted to the DH via the Unify system for the reported month.
433	The National Summary Hospital Mortality Indicator (SHMI) is a risk adjusted mortality rate expressed as an index based on the actual number of patients discharged who died in hospital or within 30 days compared to the expected number of deaths. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
435	Patients aged over 65 admitted as an emergency and discharged to their usual residence within 7 days as a % of all discharges
436	The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group (as per HED methodology). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
440	Number of hospital initiated cancelled operations, cancelled on the day of surgery for non clinical reasons, who are not admitted within 28 days expressed as a percentage of all hospital initiated cancelled operations.
456	Ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group (as per HED methodology). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
460	Patients who had their operation cancelled by the hospital on the day of admission for non-medical reasons.
462	The percentage of women that have had a PPH of>2L
463	The percentage of Number of women delivered by elective caesarean (procedures) / Number of women delivered
465	The percentage of Number of women delivered by emergency caesarean (procedures) / Number of women delivered
466	The percentage of the Number of women who had a home birth / Number of women who have delivered
467	Number of births on the Midwifery Led Suites/OASIS within Nightingale Birth Centre
469	The number of patients who have been risk assessed as at risk of VTE on admission, expressed as a percentage of all discharges including Renal Dialysis patients
470	Number of episodes of Meticillin Sensitive Staphylococcus aureus (MSSA) bacteraemias post 48 hours hospital admission
473	Number of episodes of Clostridium difficile toxin post 48 hours hospital admission (patients > 2 years)
474	Number of episodes of Escherichia coli bacteraemias post 48 hours hospital admission
475	Number of episodes of Vancomycin-resistant Enterococci bacteraemias post 48 hours hospital admission
476	Number of episodes of Meticillin Resistant Staphylococcus aureus (MRSA) bacteraemias post 48 hours hospital admission
477	Two or more cases with the same alert organism/condition identified within a 7 day period or a PII (period of increased incidence) initiated by the Infection Control Doctor
478	Higher incidence of cases with the same alert organism/condition identified or ward closure is being considered and outbreak meeting held
480	The number of inpatient deaths within the hospital for the month expressed as a percentage of all elective inpatient spells.
481	The number of inpatient deaths within the hospital for the month expressed as a percentage of all non-elective inpatient spells.
483	Number of single sex accommodation breaches and other patients within the ward location affected by the breach excluding clinical exceptions, and who would attract a financial penalty
485	% of all patients aged 75 and above admitted as emergency inpatients, with length of stay > 72 hours, who are asked the dementia case finding question within 72 hours of admission
487	Ratio of the number of hours of registered nurses and midwives to the total number of inpatients
488	Ratio of the number of actual hours to the number of planned hours of registered nurses and midwives - day
489	Ratio of the number of actual hours to the number of planned hours of registered nurses and midwives - night
490	Number of cases of MRSA isolated from any site post 48hours hospital admission
492	The number of elective patients (adjusted for DoH exclusions) who have been screened for MRSA, expressed as a percentage of all admissions.
494	The number of emergency patients (adjusted for DoH exclusions) who have been screened for MRSA, expressed as a percentage of all admissions.
495	Number of episodes of C. difficile including local episodes post 48hours hospital admission (includes DoH reportable toxin positive cases and PCR positive cases)
496	Vancomycin resistant Enterococci isolated post 48 hours hospital admission
497	Multi-resistant Enterobacteriaceae isolated post 48 hours hospital admission
498	Multi-resistant "non-fermenters" isolated post 48 hours hospital admission. Includes Pseudomonas and Acinetobacter.
499	For all identified Clostridium difficile cases (both HAI and CAI) on the ward during this month, the time to isolate is based on whether this is achieved within 4 hours of onset of unexplained diarrhoea
500	For all new MRSA cases (both HAI and CAI) on the ward this month, the time to isolate is based on whether this is achieved by the end of the current shift
501	The MRSA time to decolonise compliance is based on whether the protocol is prescribed within 4 hours of the ward being informed of a positive result
502	Other Alert Organisms not specified above isolated post 48 hours hospital admission
503	Total number of hospital-acquired alert organisms (post 48 hour hospital admission)
504	The proportion of positive responses to the Respect & Dignity question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response
505	The proportion of positive responses to the Involvement in Care question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response.
506	The proportion of positive responses to the Kindness & Understanding question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a +ive response
507	The proportion of positive responses to the Control of Pain question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a positive response.
508	The proportion of positive responses to the Involvement in Discharge question on the "How are we doing?" survey that discharged patients completed during the relevant month. Only the best available answer to the question is counted as a +ive response
509	The number of never events recorded based on the incident date on the Datix system.
511	Number of reported incidents
514	Number of Commodes Audited
515	Are commodes in a good state of repair?
516	The number of incidents recorded on Datix that resulted in moderate harm to patients
518	Are commodes visibly clean and taped?
519	The number of incidents recorded on Datix that resulted in serious harm or death to patients.
520	Number of Serious Incidents declared.
522	A clear, transparent dressing as per Trust policy is in place
523	The dressing has been dated, for PVC with the date of insertion and for CVC with the date of dressing change.
524	There is a clear clinical need for the cannula to remain in situ, i.e. IV medication, IV fluids, etc.
525	The insertion details of the intravascular line and regular observations are documented
526	Peripheral cannulas must not be in situ for longer than 72 hours
538	Number of hospital acquired pressure ulcers - Grade 3 or Grade 4
539	National Summary Hospital Mortality Indicator (SHMI) for patients aged over 75. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
540	National Summary Hospital Mortality Indicator (SHMI) where Admission Method = "Elective". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
541	National Summary Hospital Mortality Indicator (SHMI) where Admission Method = "Non-elective". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
542	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "226 - Fracture of neck of femur (hip)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
543	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "100 - Acute myocardial infarction". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
544	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = "122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)

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Created date: June 2017

545	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = '2 - Septicemia (except in labor)'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
546	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = '109 - Acute Cerebrovascular Disease'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
547	National Summary Hospital Mortality Indicator (SHMI) where Weekend Admission = "Weekend". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
569	Antimicrobial clinical indication (target = 95%). An indication for antimicrobial therapy must be documented on all antimicrobial prescriptions. Data Source is - IC Drs/Ward champions and Infection Surveillance Team
570	IV PO switch (target = 95% for "not overdue"). Patients receiving IV antimicrobial therapy should be reviewed at 24, and then 48 hours and converted to a suitable oral alternative as per King's College Hospital Antibiotic IV to Oral 'Switch' Policy
571	Antimicrobial review/stop dates (target = 95%). A review or a stop date must be documented on all antimicrobial prescriptions. As per King's College Antibiotic 'Stop' Policy. Data Source is - IC Drs/Ward champions and Infection Surveillance Team
615	The number of complaints recorded as High or Severe on the Datix system for the reported month.
618	% of PALS contacts relating to a concern.
619	The number of complaints received in the month.
620	The number of complaints not responded to within 25 working days.
621	% of PALS contacts relating to a praise.
627	Number of deteriorating patient incidents per 1000 bed days
628	Number of Inpatient slips, trips and falls by patients reported based on incident date. Per 1000 bed days.
629	Number of Inpatient slips, trips and falls by patients with moderate or major injury/ death reported based on incident date. Per 1000 bed days.
638	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = '157 = Acute and Unspecified Renal Failure'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
641	National Summary Hospital Mortality Indicator (SHMI) where Diagnostic Group (CCS) = '108 = Congestive Heart Failure'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
646	Incidents in month related to Patients Absconding
647	Incidents in month related to violent & aggressive behaviour to staff
648	Number of Amber RCAs carried out
649	Percentage of patients treated within 36hrs from the time of admission to the time that the patient was seen in theatre for a fractured neck of femur
651	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = '100 - Acute myocardial infarction'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
652	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = '108 = Congestive Heart Failure'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
653	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = '2 - Septicemia (except in labor)'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
654	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = '109 = Acute Cerebrovascular Disease'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
655	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = '226 - Fracture of Neck of Femur (Hip)'. This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
656	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions) where Diagnostic Group (CCS) = '122 - Pneumonia (except that caused by tuberculosis or sexually transmitted disease)". This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extrac
660	Duty of Candour - The percentage of conversations had following reported moderate/severe/death incidents
661	Duty of Candour - Number of letters sent following DoC incidents
678	The number of babies that had a Readmission (admission method codes LIKE '2%' or = '32') within 28 days of the date of birth, excluding readmissions with a length of stay of less than one day and babies with a discharge of death
679	Maternal readmission to hospital within 42 days of delivery – in line with the requirements. Includes only Readmissions (admission method codes LIKE '2%' or = '32') within 42 days of the date of delivery, excluding readmission with a LOS < 1 day
750	Number of Term (37+ weeks) babies admitted to Neonatal Care, treated at DH or PRUH. Admitted from DH, PRUH or Home.
755	Percentage of emergency readmissions within 30 days excluding Renal Dialysis, Well Babies and Regular Day Attenders only
759	This is the percentage of assurance audits that have not reached the target and shown as red in the R/G status column. The audits included in this metric are those in the Assurance Audits, Care of IV Lines, Antibiotic Stewardship, Staming Measures and Environment sections (25 audits in total)
780	Number of hospital aqcuired pressure ulcers (Grade 3 or Grade 4) per 1000 bed days
815	Number of ward transfers between 10pm and 6am for patients aged over 75
816	Number of ward transfers where patient is recorded as having a positive dementia screening
818	Number of cardiac arrest calls per 1000 bed days
831	The relative risk of 30 day emergency readmissions (ie. the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database).
839	Number of on-the-day cancelations due to the following reasons: No ward bed available, No critical care/HDU bed available, Overrunning operation list, Emergency took priority, Complications in previous case, Previous list/case overran, More urgent case, Unable to staff
846	Number of Deteriorating Patient Incidents resulting in moderate harm, major harm or death per 1000 bed days
862	Percentage of TOPS patients offered HIV testing
863	Percentage uptake of HIV testing for TOPS patients
864	Percentage of TOPS patients receiving a full contraceptive consultation
865	Percentage of TOPS patients leaving on LARC or oral contraceptive pill
868	The percentage of theatre cases which had completed surgical safety checklist sign in, time out and sign out
879	Number of episodes of Klebsiella spp bacteraemias post 48 hours hospital admission
880	Number of episodes of Pseudomonas aeruginosa bacteraemias post 48 hours hospital admission
881	Carbapenemase producing organism (Confirmed CPE/CPO) – hospital and community acquired episodes
882	Number of cases of Norovirus post 48 hours hospital admission
883	Other viral infections post 48 hours hospital admission (excluding Norovirus)
891	Falls resulting in moderate harm
892	Falls resulting in death
893	Falls resulting in major harm
918	The percentage of Electronic Discharge Summaries (eDNs) sent by post or electronically
919	The percentage of Electronic Discharge Summaries (eDNs) sent by post or electronically that are sent within 24 hours
957	The number of Alerts not responded to by services within 25 working days
958	The number of alerts received each month based upon the date received from CCG

BIU Business Intelligence Unit

Best Quality of Care - Access

King's College Hospital NHS

Report Executed: 03/01/2018 09:18:57

Directorate: Trust (1000)

Item	Definition
364	The percentage of patients on an incomplete pathway waiting 18 weeks or more at the end of the month position. DOH submitted figures.
365	The percentage of patients on an incomplete pathway, on an admitted waiting list, waiting 18 weeks or more at the end of the month position. DOH submitted figures.
366	The percentage of patients on an incomplete pathway, on an non-admitted waiting list, waiting 18 weeks or more at the end of the month position. DOH submitted figures.
377	Number of Intra Trust Cons to Cons Referrals
399	The number of patients discharged at the weekend expressed as a percentage of all patients discharged, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
401	Total number of Elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
403	Total number of Non-elective spells completed in the month (includes Inpatient and Daycase) –attributed to the specialty of the episode with the dominant HRG.
404	The number of patients discharged before 1pm expressed as a percentage of all patients discharged during the week, excluding renal dialysis patients, patients discharged to other hospitals and zero LOS spells, based on discharging ward.
407	DTAs reaching bed within 60 minutes as a proportion of all ED admissions

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Created date: June 2017

408	The number of re-attendances against the total number of attendances as a percentage
409	The proportion of patient who left before being seen against total attendances as a percentage
412	The percentage of pathways acheiving a maximum two week wait from an urgent GP referral for suspected cancer to DATE FIRST SEEN by a specialist for all suspected cancers
413	The percentage of pathways achieving a maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to DATE FIRST SEEN.
414	The percentage of pathways acheiving a maximum one month (31-day) wait from diagnosis (CANCER TREATMENT PERIOD START DATE) to First Definitive Treatment for all cancers
415	The percentage of pathways acheiving a maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where an Anti-Cancer Drug Regimen is the chosen CANCER TREATMENT MODALITY
416	The percentage of pathways acheiving a maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where Other treatment is the chosen CANCER TREATMENT MODALITY
417	The percentage of pathways acheiving a maximum 31-day wait for all subsequent treatments for new cases of primary and recurrent cancer where Surgery is the chosen CANCER TREATMENT MODALITY
418	The percentage of pathways acheiving a maximum 62-day wait from a CONSULTANTS decision to upgrade the urgency of a PATIENT they suspect to have cancer to First Definitive Treatment for all cancers
419	The percentage of pathways acheiving a maximum two month (62-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for all cancers
420	The percentage of pathways acheiving a maximum 62-day wait from referral from a cancer Screening Programme to First Definitive Treatment for all cancers
424	Total excess bed days for elective inpatients, with contract monitoring exclusions applied
425	Total excess bed days for non-elective inpatients, with contract monitoring exclusions applied
430	Total number follow up outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
431	Total number new outpatient attendances completed in the month – attributed to the specialty of the episode with the dominant HRG.
458	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E Type 1: Major A&E Departments
459	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: all A&E types
461	Total number of A&E attendances in the month
464	Percentage of outpatient attendances with a primary procedure code recorded
482	Number of patients on the waiting list whose admit by date is missing or has passed.
536	% of patients waiting greater than 6 weeks for a diagnostic test
623	The number of occupied bedday delays after 2 days from the repatriation delay being initially recorded on EPR to the date of discharge/transfer to the referring hospital.
632	Number Patients waiting over 52 weeks (RTT). DOH submitted figures
634	Number of unoutcomed RTT appointments
747	The percentage occupancy of inpatient beds based on the midnight census
762	The number of times the LAS Arrival to Patient Handover Time is >15 mins but <=30 mins during any calendar month
763	The number of times the LAS Arrival to Patient Handover Time is >30 mins but <=60 mins during any calendar month
800	Delayed transfer of care days (when a patient is ready to depart from care and is still occupying a bed) within the month for all patients delayed throughout the month. Shown as a percentage of first FCEs.
860	Percentage of FCEs and appointments with a valid ethnicity code (monthly value)
917	The number of inpatient admissions to the Trust with an emergency admission method code

Excellent Teaching & Research

King's College Hospital NHS

Directorate: Trust (1000)

Report Executed: 21/12/2017 10:31:53

Item	Definition
888	Number of commercial clinical trials contracts recruiting patients in the relevant period
937	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 10,000
938	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size < 5,000
939	Studies that are funded by the NIHR, other areas of central Government and NIHR non-commercial Partners. UK total sample size =/ > 10,000
941	Number of NIHR grants currently being supported by R&I for submission to relevant funding streams
942	An allocation based on LCRN recruitment activity and an allocation based on the number of non-commercial studies for which an LCRN was the Lead LCRN. Contingency Funding is available through a competitive bidding process
943	All research related incidents on Datix by incident date
944	All incidents classed as serious breaches reported on Datix
945	All research related incidents which are open on Datix
946	Actual number of participants recruited into NIHR portfolio in the relevant period
977	Recruitment that has been adjusted for study complexity into complexity bands and ratios/weightings which dictates the NIHR CRN funding model
978	Actual number of participants recruited into commercial studies
979	All research related serious breach investigations which are still open on Datix

Skilled, Motivated, Can Do Teams

King's College Hospital NHS

Directorate: Trust (1000)

Report Executed: 03/01/2018 18:11:58

Item	Definition
705	Quarterly data
706	How likely are you to recommend this organisation to friends and family as a place to work Quarterly Data
707	The number of Greatix recorded in the month, sourced from DATIX Greatix is a positive reporting tool for capturing the excellence displayed by colleagues
708	The number of alerts reported to the General Medical Council
715	Percentage of staff that have been appraised within the last 12 months (medical & non-medical combined).
721	Percentage of compliant with Statutory & Mandatory training.
729	FTE Funded established positions as recorded on ESR
730	Staff in post FTE at the end of the month (excludes Bank & Honorary Staff)
732	The percentage of vacant posts compared to planned full establishment recorded on ESR
741	A red shift occurs when fewer Registered Nurses than planned are in place, or when the number of staff planned is correct but the patients are more acutely sick or dependent than usual requiring a higher staffing level (NICE 2015).
743	The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.

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869	**Data not currently available at this granularity**
872	Individuals that have left the Trust during the month. It does not include internal leavers, i.e. those moving to different departments - ESR
873	Individuals that have started working for the Trust during the month. It does not include internal transfers i.e. those moving in from other departments
874	Difference between the establishment recorded on ESR and vacant posts.
875	The total number of voluntary leavers in a 12 month period as a percentage of the average headcount of staff in post in the same 12 month period. Note: Voluntary turnover is determined by the reason of leaving recorded on ESR. Voluntary turnover excludes 'Death in service', 'Dismissal', 'End of fixed-term contract and 'Redundancy' (Compulsory)
876	Percentage of non-medical staff that have been appraised within the last 12 months **Data not currently available at this granularity**
877	Staff employed at the end of the month (excludes Bank & Honorary Staff)

4.2

BIU Business Intelligence Unit

Top Productivity

King's College Hospital NHS

Directorate: Trust (1000)

Report Executed: 21/12/2017 10:37:03

Item	Definition
345	Number of DNAs / Number of DNAs and attendances
350	Percentage of appointments with an outcome of "9 - Unspecified" recorded
352	Number of Outpatients waiting more than 12 weeks from referral to new outpatient appointment
354	The number of outpatient appointments cancelled with less than 6 weeks notice
355	Atteneded appointments where outcome of attendance = "1 - Discharged", as a percentage of all attended appointments
356	Total number of appointments cancelled by the hospital
367	Percentage of Day Surgery Unit sessions that started within 10 minutes of the scheduled start time
368	Percentage of Day Surgery Unit sessions that started within 10 minutes of scheduled start time
369	Average turnaround time (patient out to anaesthetic start) in Main Theatres. (turnaround time/turnaround count).
370	Average turnaround time (patient out to anaesthetic start) in Day Surgery. (turnaround time/turnaround count).
371	Percentage of Main Theatres sessions that finished 45 mins or more before the scheduled end time, where no cancellations occurred. Actual session finish is when the last patient on the list goes into recovery.
372	Percentage of Day Surgery sessions that finished 45 mins or more before the scheduled end time, where no cancellations occurred. Actual session finish is when the last patient on the list goes into recovery.
373	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Day Surgery
374	King's Utilisation: (session actual start time [anaesthetic start] to session actual end time) - (overrun minutes + early start minutes) for Main Theatres
375	Average number of cases held per four-hour "block"
376	Number of consultant referrals received (all referral sources). Only consultant & dental consultant included.
396	Total number of cases done in Day Surgery, excluding cancelled cases.
397	Total number of cases done in Main Theatres, excluding cancelled cases
405	Number of attended new appointments where the referral is to a consultant (based on RTT reporting logic)
406	Ratio of new to follow up attended face-to-face appointments
426	Total bed days for elective spells / Number of Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
428	Total bed days for non - elective inpatient spells / Number of inpatient Spells. Attributed to the dominant episode. Excluding CDU zero stay Spells. Specialties excluded are well babies, rehabilitation and A&E.
429	Number of emergency admission patients with a zero length of stay spell
438	The number of patients discharged between 7am and 11am expressed as a percentage of all patients discharged during the week, excluding obstetrics, renal dialysis patients, patients discharged to other hospitals and zero LOS spells.
441	The number of occupied beddays (based on midnight census) where a Liver, Surgery or TEAM care group specialty has occupied a bed within its division's designated bed pool.
521	Sum of used session minutes (excluding overruns and early starts) / planned session minutes
537	Number of Elective DTAs (DOWL) booked & planned
630	Surgical hours as a percentage of used session hours where surgical hours is the sum of hours from procedure start to end (cut to close) and is the total hours from first patients anaesthetics start to last patient into recovery.
790	Number of patients discharged from hospital where the final ward in their spell was an Acute Medical Unit one (AZ and RDL at Denmark Hill, and EAUP and MW9P at PRUH)
791	The number of patients discharged between 7am and 11am FROM Acute Medical Unit wards (AZ, RDL, EAUP and MW9P) expressed as a percentage of all patients discharged during the week, excluding obstetrics, renal dialysis patients, patients discharged to other hospitals and zero LOS spells.
792	Median length of stay on Acute Medical Unit wards (AZ and RDL at Denmark Hill, and EAUP and MW9P at PRUH). This includes all stays on these wards, regardless of whereabouts in the spell they occurred.
793	Number of stays greater than 72 hours on Acute Medical Unit wards (AZ and RDL at Denmark Hill, and EAUP and MW9P at PRUH). This includes all stays >72hrs, regardless of whereabouts in the spell they occurred.
801	Number of day cases divided by number of elective spells

BIU Business Intelligence Unit

Firm Foundations - Finance

King's College Hospital NHS

Directorate: Trust (1000)

Report Executed: 21/12/2017 10:38:56

Item	Definition
548	Non Pay actual for Drugs
552	Non Pay budget for Drugs
553	Total surplus(+ve) or deficit(-ve) generated by Drugs
554	Non Pay actual for Clinical Supplies & Services
555	Non Pay budget for Clinical Supplies & Services
556	Total non-pay surplus(+ve) or deficit(-ve) generated by Clinical Supplies & Services
576	Non Pay actual for Services from NHS Bodies
577	Non Pay budget for Services from NHS Bodies
578	Total surplus(+ve) or deficit(-ve) generated by Services from NHS Bodies
581	Total surplus(+ve) or deficit(-ve) generated by Education, Training & Research
582	Income for Education, Training & Research
583	Budget for Education, Training & Research
584	Total surplus(+ve) or deficit(-ve) generated by Other Operating Income
585	Income for Other Operating Income

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586	Budget for Other Operating Income
589	Total surplus(+ve) or deficit(-ve) generated by Admin & Managerial Staff
590	Pay actual for Admin & Managerial Staff
591	Pay budget for Admin & Managerial Staff
592	Total surplus(+ve) or deficit(-ve) generated by Admin & Managerial Staff - Agency Staff
593	Pay actual for Admin & Managerial Staff - Agency Staff
594	Pay budget for Admin & Managerial Staff - Agency Staff
597	Pay actual for Medical Staff - Agency Staff
598	Pay budget for Medical Staff
599	Total surplus(+ve) or deficit(-ve) generated by Medical Staff
600	Pay actual for Medical Staff - Agency Staff
601	Pay budget for Medical Staff - Agency Staff
602	Total surplus(+ve) or deficit(-ve) generated by Medical Staff - Agency Staff
603	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff - Agency Staff
604	Pay actual for Nursing Staff
605	Pay budget for Nursing Staff
606	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff
607	Pay actual for Nursing Staff - Agency Staff
608	Pay budget for Nursing Staff - Agency Staff
1048	Total non-pay surplus(+ve) or deficit(-ve) generated by miscellaneous nonpay financing.
1049	Actual for depreciation.
1050	Budget for depreciation.
1051	Actual for Other Substantive Staff
1052	Total surplus(+ve) or deficit(-ve) generated by depreciation.
1053	Budget for Other Substantive Staff
1054	Actual for Medical Bank
1055	Actual for impairment.
1056	Budget for impairment.
1057	Total surplus(+ve) or deficit(-ve) generated by Other Substantive Staff
1058	Actual Miscellaneous Pay for Medical Staff
1059	Total surplus(+ve) or deficit(-ve) generated by impairment.
1060	Total surplus(+ve) or deficit(-ve) generated by Miscellaneous Pay - Other staff
1061	Actual Miscellaneous Pay for Nursing Staff
1062	Actual for Miscellaneous Pay - Other staff
1063	Actual for miscellaneous nonpay financing.
1064	Budget for Miscellaneous Pay - Other staff
1065	Budget for miscellaneous nonpay financing.
1066	Actual for Nursing Bank
1067	Actual for Unallocated CIP - Pay
1068	Actual for consultancy.
1069	Budget for Unallocated CIP - Pay
1070	Budget for consultancy.
1071	Total surplus(+ve) or deficit(-ve) generated by Unallocated CIP - Pay
1072	Total surplus(+ve) or deficit(-ve) generated by consultancy.
1073	Actual for Other Agency Staff
1074	Actual for non-clinical supplies.
1075	Actual for Miscellaneous Pay - Unallocated CIP
1076	Budget for non-clinical supplies.
1077	Budget for Budget - Miscellaneous Pay - Unallocated CIP
1078	Budget for Medical Bank
1079	Total surplus(+ve) or deficit(-ve) generated by non-clinical supplies.
1080	Total surplus(+ve) or deficit(-ve) generated by Miscellaneous Pay - Unallocated CIP
1081	Actual for SLR Recharges
1082	Budget for Miscellaneous Pay for Medical Staff
1083	Actual for other non-pay.
1084	Budget for other non-pay.
1085	Budget for Miscellaneous Pay for Nursing Staff
1086	Budget for SLR Recharges
1087	Total surplus(+ve) or deficit(-ve) generated by other non-pay.
1088	Budget for Nursing Bank
1089	Total surplus(+ve) or deficit(-ve) generated by SLR Recharges - Fixed
1090	Actual for SLR Recharges - Fixed
1091	Budget for SLR Recharges - Fixed
1092	Budget for Other Agency Staff
1093	Total surplus(+ve) or deficit(-ve) generated by SLR Recharges - Variable
1094	Actual for SLR Recharges - Variable
1095	Variance for Medical Bank
1096	Budget for SLR Recharges - Variable
1097	Actual for Fines and Penalties
1098	Total surplus(+ve) or deficit(-ve) generated by Variance - Miscellaneous SLR Recharges
1099	Variance for Miscellaneous Pay for Medical Staff
1100	Actual for Miscellaneous SLR Recharges
1101	Budget for Miscellaneous SLR Recharges
1102	Variance for Miscellaneous Pay for Nursing Staff
1103	Budget for Fines and Penalties
1104	Variance for Nursing Bank
1105	Total surplus(+ve) or deficit(-ve) generated by Fines and Penalties
1106	Variance for Other Agency Staff

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1107	Actual for NHS Clinical Contract Income
1108	Budget for NHS Clinical Contract Income
1109	Total surplus(+ve) or deficit(-ve) generated by NHS Clinical Contract Income
1110	Actual for Other NHS Clinical Income
1111	Budget for Other NHS Clinical Income
1112	Total surplus(+ve) or deficit(-ve) generated by Other NHS Clinical Income
1113	Actual for Overseas Visitor Income
1114	Budget for Overseas Visitor Income
1115	Total surplus(+ve) or deficit(-ve) generated by Overseas Visitor Income
1116	Actual for Pass Through Devices - Income
1117	Budget for Pass Through Devices - Income
1118	Total surplus(+ve) or deficit(-ve) generated by Pass Through Devices
1119	Actual for Pass Through Drugs - Income
1120	Budget for Pass Through Drugs - Income
1121	Total surplus(+ve) or deficit(-ve) generated by Pass Through Drugs
1122	Actual for Private Patient Income
1123	Budget for Private Patient Income
1124	Total surplus(+ve) or deficit(-ve) generated by Private Patient Income
1125	Actual for R&I Income
1127	Total surplus(+ve) or deficit(-ve) generated by R&I Income
1128	Actual - RTA Income
1129	Budget for RTA Income
1130	Total surplus(+ve) or deficit(-ve) generated by RTA
1131	Actual for Miscellaneous Income
1132	Budget for Miscellaneous Income
1133	Total surplus(+ve) or deficit(-ve) generated by Miscellaneous Income
1134	Actual for Interest payable
1135	Budget for Interest payable
1136	Total surplus(+ve) or deficit(-ve) generated by Interest payable
1137	Actual for Interest receivable
1138	Budget for Interest receivable
1139	Total surplus(+ve) or deficit(-ve) generated by Interest receivable
1140	Actual for Profit/Loss on Disposal of Fixed Assets
1141	Budget for Profit/Loss on Disposal of Fixed Assets
1142	Total surplus(+ve) or deficit(-ve) generated byFixed Assets
1143	Actual for Public Dividend Capital
1144	
1145	Total surplus(+ve) or deficit(-ve) generated by Public Dividend Capital
1164	Actual for SLR Recharges
1165	Actual for Miscellaneous Pay - Admin & Clerical
1166	Budget for Miscellaneous Pay - Admin & Clerical
1167	Total non-pay surplus(+ve) or deficit(-ve) generated by Miscellaneous Pay - Admin & Clerical
1171	Total surplus(+ve) or deficit(-ve) generated by Other Bank Staff
1172	Actual for Other Bank Staff
1173	Budget for Other Bank Staff

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King's

Month 02 Finance Report

Public Board Meeting

Wednesday 3rd July 2019

King's

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

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Contents

Summary of Year to Date Financial Position

Total Trust	Annual Budget	Year to Date at Month 2		
		Budget	Actual	Variance
	£'000	£'000	£'000	£'000
Income*	1,215,345	197,627	192,451	(5,176)
Pay	(736,615)	(121,999)	(118,596)	3,403
Non Pay	(586,369)	(99,593)	(97,610)	1,983
Financing	(47,661)	(7,943)	(7,935)	8
Operating Deficit (excl PSF)	(167,823)	(31,907)	(31,690)	218

* Clinical income is based on M1 flex data, a better picture will be available next week once we get our first month of freeze data.

Overall Position

- At month 2 the Trust is reporting a year to date deficit of £31.7m, £0.2m favourable to plan. A £5.2m adverse income variance is offset by favourable variances in pay £3.4m and non pay £1.9m. However, it should be noted that the Trust has benefited from non recurrent £2.1m positive variance relating to receipt of monies from NHS England which had previously been written off.

Income

- Clinical Income is £1.8m adverse YTD, this includes an adjustment at Trust level of £2.8m for over performance on the block contract, a provision for challenges (£1.4m) and RTT 52 week fines (£0.9m). Excluding fines and challenges clinical income would show a £0.5m favourable variance. Private Patients income is £0.5m adverse due to the PP Car-T patients being behind plan (Annual plan was for 9 patients. There are potentially 2 currently in the work up stage so month 3 position should improve).
- Overseas Visitor income is adverse by £0.8m due to a drop in the number of Overseas patients being identified (47% less than at this time last year).
- Other Operating Income (£2.7m) adverse predominantly due to a £1.9m difference in the phasing the NHSI plan and the final budget. This will come back into line throughout the year.

Pay

- Pay is £3.4m favourable to plan, with favourable variances across all staff categories. Maintaining this positive variance will be essential in coming months to offset the ramping up of the CIP target phased to deliver in the latter part of the year.

Non Pay

- Non Pay is £1.9m favourable to plan. This is driven by the inclusion of a £0.9m positive variance on the KFM position and the £2.1m positive variance as a result of NHS England paying debt which the Trust had previously written off.

Detailed Year to Date Financial Position (1/2)

Type / Division	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
NHS Clinical Contract Income	898,475	74,966	75,255	289	146,291	144,484	(1,806)
Pass Through Devices -	18,266	1,522	1,601	79	3,044	3,123	79
Pass Through Drugs - Income	121,186	10,099	10,696	597	20,198	21,243	1,045
NHS Clinical Contract Income	**1,037,927**	**86,587**	**87,552**	**964**	**169,533**	**168,850**	**(683)**
Other NHS Clinical Income	4,726	394	339	(55)	788	712	(75)
Other NHS Clinical Income	**4,726**	**394**	**339**	**(55)**	**788**	**712**	**(75)**
RTA Income	3,660	305	317	12	610	592	(18)
Other Non-NHS Clinical Income	**3,660**	**305**	**317**	**12**	**610**	**592**	**(18)**
Overseas Visitor Income	6,567	547	142	(406)	1,095	318	(777)
Private Patient Income	22,567	1,881	1,563	(317)	3,761	3,213	(548)
Private Patient & Overseas Income	**29,134**	**2,428**	**1,705**	**(723)**	**4,856**	**3,530**	**(1,325)**
Education & Training Income	43,419	3,215	3,127	(88)	6,431	6,501	70
Financial Recovery Fund (FRF)	14,807	740	740	0	1,480	1,480	0
Marginal Rate Emergency	1,728	144	144	0	288	288	0
Other Operating Income	43,969	4,643	3,025	(1,618)	8,887	6,176	(2,711)
R&I Income	15,555	1,268	1,288	20	2,714	2,280	(435)
Sustainability and	20,421	1,021	1,021	0	2,042	2,042	0
Other Operating income	**139,899**	**11,031**	**9,345**	**(1,686)**	**21,842**	**18,766**	**(3,075)**
Income	**1,215,345**	**100,745**	**99,257**	**(1,488)**	**197,627**	**192,451**	**(5,176)**
Medical Agency	(1,210)	(101)	(669)	(568)	(202)	(1,386)	(1,185)
Medical Bank	(191)	(16)	(498)	(482)	(32)	(1,072)	(1,040)
Medical Substantive	(228,588)	(19,122)	(17,472)	1,651	(38,208)	(34,983)	3,225
Medical Staff	**(229,990)**	**(19,239)**	**(18,638)**	**601**	**(38,442)**	**(37,442)**	**1,000**
Nursing Agency	(900)	(75)	(428)	(353)	(150)	(740)	(590)
Nursing Bank	(8,350)	(682)	(2,163)	(1,481)	(1,392)	(4,601)	(3,209)
Nursing Substantive	(287,152)	(23,909)	(21,604)	2,306	(47,762)	(43,338)	4,424
Nursing staff	**(296,401)**	**(24,666)**	**(24,196)**	**471**	**(49,304)**	**(48,679)**	**625**
A&C agency	(89)	(7)	(374)	(366)	(15)	(630)	(615)
A&C Bank	(1,128)	(94)	(306)	(212)	(188)	(540)	(353)
A&C Substantive	(109,926)	(9,193)	(8,324)	869	(18,540)	(16,780)	1,759
Admin and Clerical	**(111,143)**	**(9,294)**	**(9,004)**	**291**	**(18,743)**	**(17,951)**	**792**
Other Agency Staff	(921)	(77)	(420)	(343)	(154)	(797)	(643)
Other Bank Staff	(511)	(56)	(109)	(53)	(85)	(265)	(180)
Other Substantive Staff	(90,695)	(7,547)	(6,685)	862	(15,097)	(13,462)	1,635
Other Staff	**(92,127)**	**(7,680)**	**(7,214)**	**466**	**(15,336)**	**(14,524)**	**811**
Pay Reserves	(14,397)	(497)	(0)	497	(497)	(0)	497
Pay Reserves	**(14,397)**	**(497)**	**(0)**	**497**	**(497)**	**(0)**	**497**
Unallocated CIP - Pay	7,443	161	(0)	(161)	322	(0)	(322)
Unallocated CIP - Pay	**7,443**	**161**	**(0)**	**(161)**	**322**	**(0)**	**(322)**
Pay	**(736,615)**	**(61,216)**	**(59,052)**	**2,165**	**(121,999)**	**(118,596)**	**3,403**

Includes an adjustment at Trust level of £2.8m for over performance on the block contract, a provision for challenges (£1.4m) and RTT 52 week fines (£0.9m).

Overseas Visitor income is adverse by £0.8m due to a drop in the number of Overseas patients being identified (47% less than at this time last year).

Private Patients income is £0.5m adverse due to the PP Car-T patients being behind plan (Annual plan was for 9 patients. Currently there are potentially 2 currently in the work up stage).

Other Operating Income (£2.7m) adverse predominantly due to a £1.9m difference in the phasing the NHSI plan and the final budget. This will come back into line throughout the year.

Pay is significantly underspent. This is partially due to vacancies well in excess of the vacancy factor but also indicates £ budgets (e.g. premium budgets) were generous. An exercise is being undertaken to understand specific drivers of this variance and the level of underlying opportunity to mitigate the unallocated CIP which is phased Q3 and Q4.

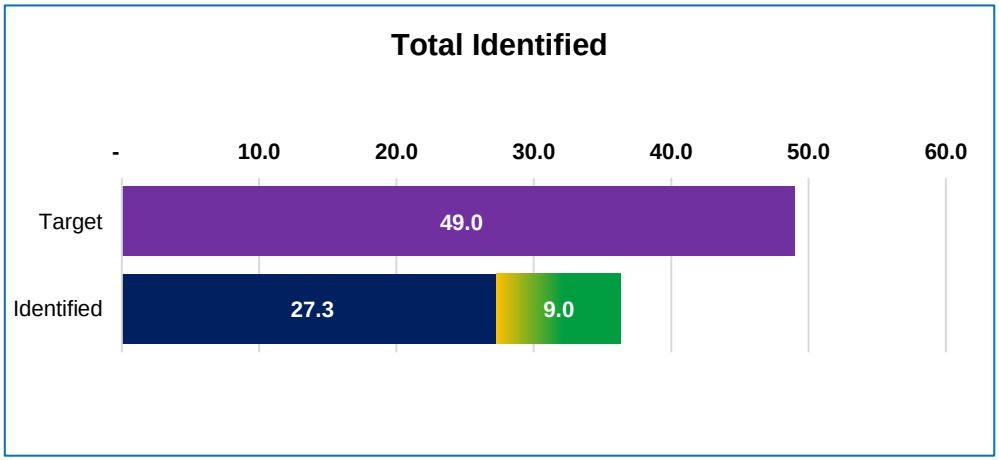
Detailed Year to Date Financial Position (2/2)

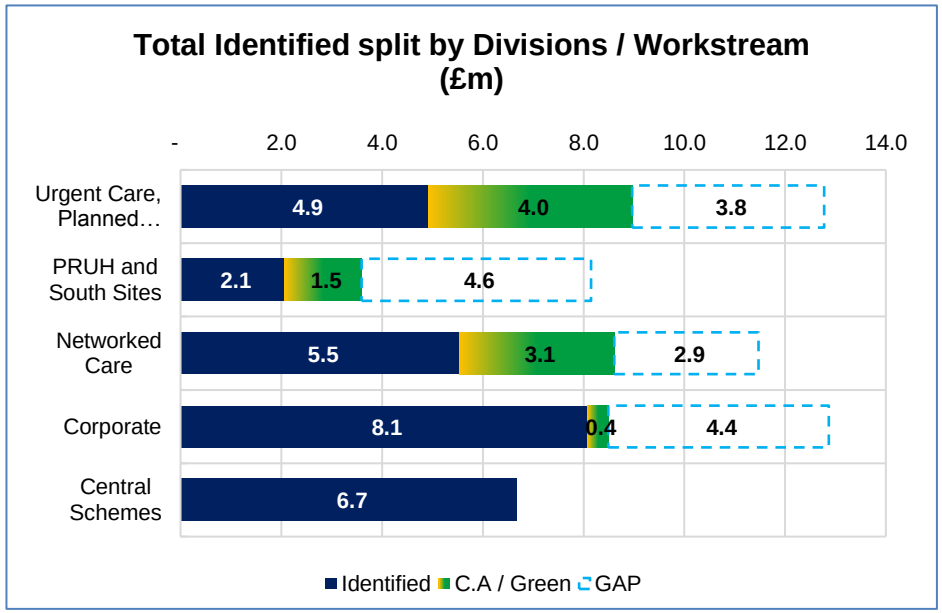
Type / Division	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
Clinical Supplies	(9,210)	(791)	(1,323)	(532)	(1,488)	(2,665)	(1,177)
Drugs	(27,746)	(2,312)	(2,035)	277	(4,624)	(4,311)	313
Pass Through Drugs -	(121,145)	(10,044)	(10,537)	(493)	(20,187)	(20,467)	(280)
Consultancy	(1,612)	(135)	(428)	(294)	(269)	(681)	(412)
External Services	(68,376)	(5,719)	(5,915)	(196)	(11,839)	(12,062)	(224)
Purchase of Healthcare from	(164,410)	(13,888)	(11,843)	2,045	(27,477)	(25,556)	1,921
Services from other NHS	(57,932)	(5,479)	(5,761)	(281)	(10,963)	(11,041)	(78)
Non-Clinical Supplies	(58,473)	(4,872)	(5,132)	(260)	(9,740)	(9,959)	(219)
Other Non-Pay	(26,549)	(2,186)	(2,097)	89	(4,300)	(2,564)	1,736
Reserves	(16,921)	(60)	(0)	60	(367)	(0)	367
Unallocated CIP - NonPay	15,827	20	(0)	(20)	(35)	(0)	35
Depreciation	(25,824)	(2,152)	(2,152)	0	(4,304)	(4,304)	0
Impairment	(24,000)	(2,000)	(2,000)	0	(4,000)	(4,000)	0
Nonpay	**(586,369)**	**(49,619)**	**(49,224)**	**396**	**(99,593)**	**(97,610)**	**1,983**
Interest payable	(48,112)	(4,009)	(4,009)	0	(8,019)	(8,019)	0
Interest receivable	501	42	(7)	(49)	84	84	(0)
Profit/Loss on Disposal of	(50)	(4)	(28)	(24)	(8)	(0)	8
Public Dividend Capital			(0)	0		(0)	0
Financing	**(47,661)**	**(3,972)**	**(4,044)**	**(73)**	**(7,943)**	**(7,935)**	**8**
TRUST TOTAL (deficit per ledger)	**(155,301)**	**(14,062)**	**(13,063)**	**999**	**(31,907)**	**(31,690)**	**218**
Less Donated Depreciation	(756)	(63)	(63)	0	(126)	(126)	0
Less Donated Income	2,050	(0)	(171)	(171)	(0)	0	0
Less FRF	14,807	740	740	0	1,480	1,480	0
Less Impairement	(24,000)	(2,000)	(2,000)	0	(4,000)	(4,000)	0
Less PSF funding	20,421	1,021	1,021	0	2,042	2,042	0
OPERATING DEFICIT (excluding STF)	**(167,823)**	**(13,760)**	**(12,590)**	**1,170**	**(31,303)**	**(31,086)**	**218**

£1.3m of cost has been put against clinical supplies in relation to the KFM TSA which should sit in Purchase of Healthcare from non NHS bodies. Once adjusted Clinical Supplies would show a £0.1m favourable variance and only a £0.4m positive variance in Purchase of Healthcare from non NHS bodies

Other non pay includes £2.1m one off benefit as a result of bad debt received from NHS England which had previously been written off

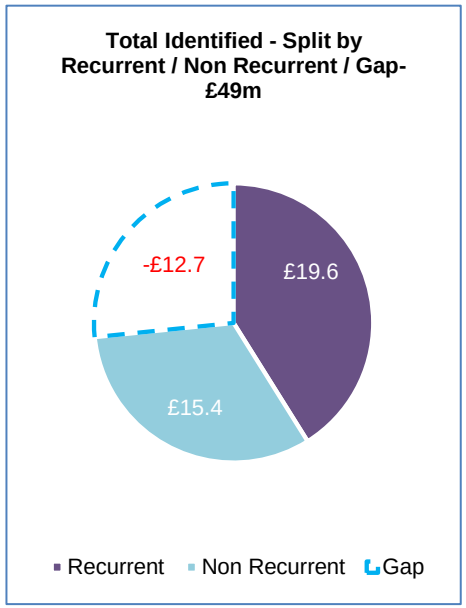
19/20 CIP Scheme Development Dashboard

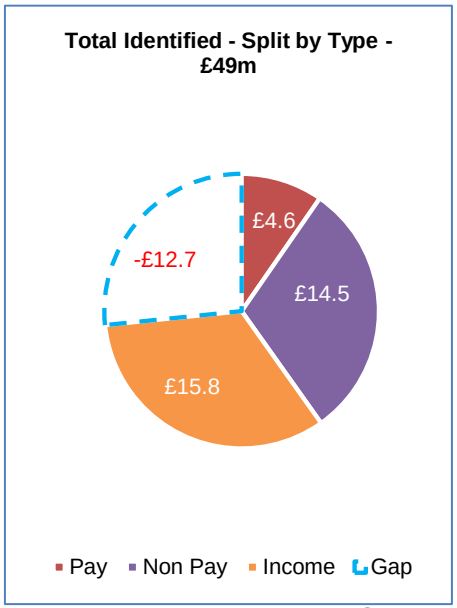




Theme	Identified £m	Red £m	Amber £m	CA/Green £m
18-19 Flow Through	1.4	0.0	0.0	*1.4*
Clinical Divisions	19.7	5.6	7.0	7.2
Corporate	8.5	0.0	8.1	0.4
Central Schemes	6.7	3.7	3.0	0.0
Gap Remaining	**(12.7)**	-	-	-
Grand Total	**36.3**	**9.3**	**18.0**	**9.0**

Conversion Phase	£m committed to 'green'	£m converted to C.A / Green	% Conversion rate to green
Phase 1 – End of March '19	9.3	1.2	13%
Phase 2 – End of April '19	5.9	7.7	130%
Phase 3 – End of May and further	15.3	0.2	0%
Phase 4 – Contacts/ Commissioner dependant	8.9	0.0	0%
Grand Total	**39.3**	**9.0**	





CIP Delivery – Overview

£49m - Split by Division	19-20 COST IMPROVEMENT PROGRAMME										FORECAST				
	Full Year	Full Year	In Month (M1)				YTD (M1)				Year End Forecast (M1-12)				
	Annual FY Plan	Green & CA Plan	Plan	Actual	Variance	%	Plan	Actual	Variance	%	Annual FY Plan	Green & CA Plan	Forecast	Variance	%
18-19 Flow Through	**0.0**	**1.4**	**0.2**	**0.2**	**(0.0)**	**96%**	**0.5**	**0.5**	**(0.0)**	**96%**	**1.4**	**1.4**	**1.4**	**0.0**	**100%**
Networked Care Div A	5.0	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Networked Care Div B	6.5	3.0	0.2	0.2	0.0	100%	0.6	0.5	(0.1)	81%	3.0	3.0	3.0	0.0	101%
PRUH and South Sites	8.1	1.0	0.0	0.0	(0.0)	0%	0.0	0.0	(0.0)	0%	1.0	1.0	1.0	0.0	97%
Urgent Care, Planned Care and ACS - Planned	6.4	3.2	0.2	0.2	0.0	100%	0.4	0.4	0.0	100%	3.2	3.2	3.2	0.0	100%
Urgent Care, Planned Care and ACS - Urgent	6.4	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Corporate	16.6	0.4	0.2	0.2	0.0	100%	0.2	0.2	0.0	100%	0.4	0.4	0.4	0.0	100%
Division Total	**49.0**	**9.0**	**0.9**	**0.8**	**(0.0)**	**97%**	**1.7**	**1.5**	**(0.2)**	**90%**	**9.0**	**9.0**	**9.0**	**0.0**	**100%**
£49m - Split by Workstream / Theme															
Corporate	2.5	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
CAR-T income	3.1	2.9	0.2	0.2	0.0	103%	0.5	0.5	(0.1)	0%	2.9	2.9	2.9	0.0	101%
Central Workforce	7.5	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Digitisation	0.4	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Divisional Scheme	20.4	2.9	0.3	0.2	(0.0)	92%	0.3	0.3	(0.0)	92%	2.9	2.9	2.9	0.0	100%
GIRFT - NWC	0.0	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
GIRFT - Ophthalmology	2.2	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
GIRFT - T&O	3.3	1.8	0.1	0.1	0.0	100%	0.3	0.3	0.0	100%	1.8	1.8	1.8	0.0	100%
King's Commercial/PP	0.3	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Outpatients	0.0	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Pharmacy	5.0	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Procurement	1.0	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Theatre Productivity	3.3	0.0	0.0	0.0	0.0	0%	0.0	0.0	0.0	0%	0.0	0.0	0.0	0.0	0%
Workstream Total	**49.0**	**7.6**	**0.6**	**0.6**	**(0.0)**	**98%**	**1.2**	**1.1**	**(0.1)**	**91%**	**7.6**	**7.6**	**7.6**	**0.0**	**100%**
Unallocated Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**40.0**	**0.0**	**0.0**	**0.0**	**0.0**
Total Cost Improvement Programme	**49.0**	**9.0**	**0.9**	**0.8**	**(0.0)**	**98%**	**1.7**	**1.5**	**(0.1)**	**91%**	**9.0**	**9.0**	**9.0**	**0.0**	**100%**

M2 Key Metrics

- Full Year Plan – 49.0m
- In Implementation – 9.0m
- In Month Delivery – 0.8m
- In Month Variance – 0.0m Break even
- YTD Delivery – 1.5m
- YTD Variance To Plan – 0.2m Adverse

M2 Headlines

In Month

- Trust programme has delivered against internal plan of £49m (NHSi plan submitted plan is £45.0m) for M2 apart from 0.1 slippage for PRUH Maternity tariff recharges due to unavailable data. This should recover in subsequent months.
- FIP is on plan against the NHSi submitted plan with the profile increasing from M4 onwards.

Forward View

- Significant values are planned to convert into the programme (circa 20.0m) from June onwards with retrospective achievement.
- NHSi profile to £45.0m is as follows:
  - Q1 – 2.6m
  - Q2 – 10.2m
  - Q3 – 14.0m
  - Q4 – 18.2m

Programme Performance By Type

The in implementation value is split as 18% non pay, 71% income, and 11% pay with no significant variances in M2.

In the coming months the dimension of the programme will move closer to our identified split which has 42% non pay, 45% income, and 13% pay when reporting M2.

Cash Flow & Revenue Support - Debtors and Creditors

Cash Position	Cash Balance Forecast at 06 May (31 May 19)	Actual (31 May 19)	Variance (Act - Fcast)
	£11.8m	£24.7m	£12.9m

Trust's Borrowings	31 Mar 2019	30 Apr 19	30 May 19
Revenue Working Capital	(514)	(514)	(517)
Capital borrowings (incl. £47m re Windsor Walk)	(£141)	(£141)	(£141)
PFI, Finance Leases & other borrowings	(£149)	(£146)	(£146)
TOTAL	**(£782)**	**(£782)**	**(£782)**

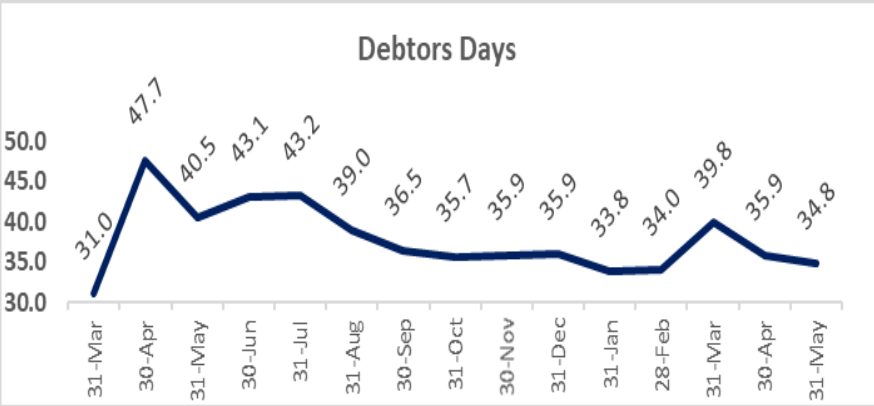
Outstanding Debtors	31 Mar 2019	30 Apr 19	31 May 19
	£121m	£108m	£110.4m
Debtor Days	39.8 Days	35.9 Days	34.8 Days

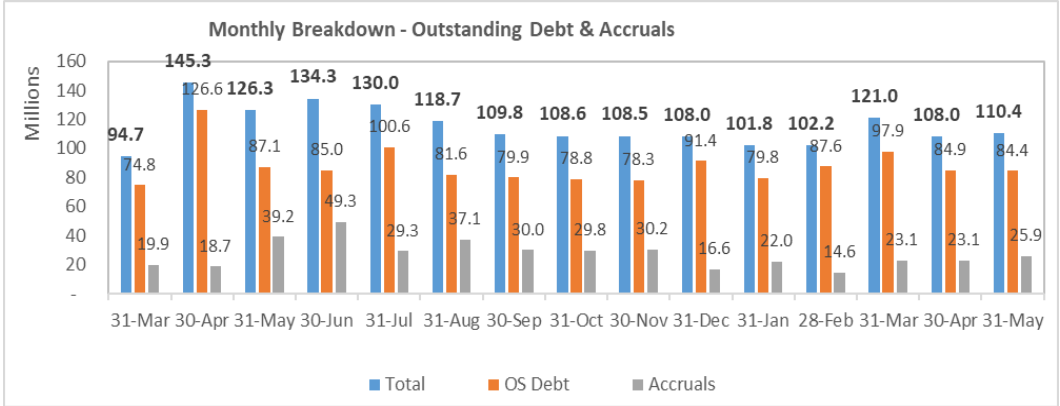
Outstanding Creditors	31 Mar 19	30 Apr 19	31 May 19
	(£159.8m)	(£156.3m)	(£172.5m)
Creditor Days	112.4 Days	98.5 Days	112.5 Days

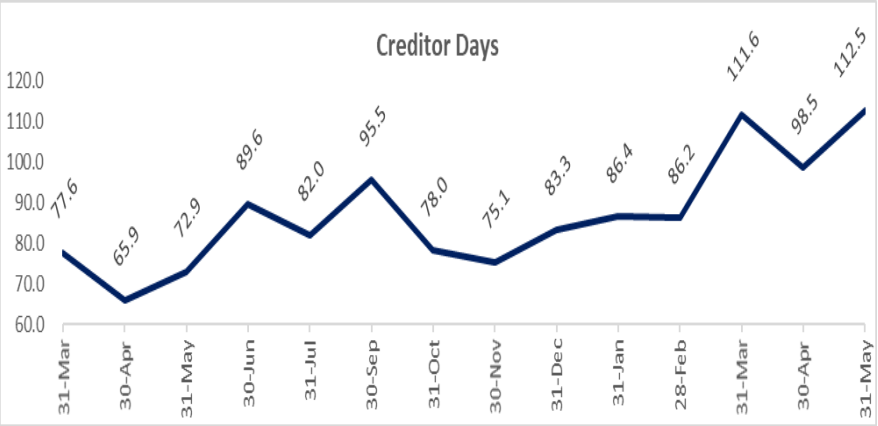
Highlights for the period

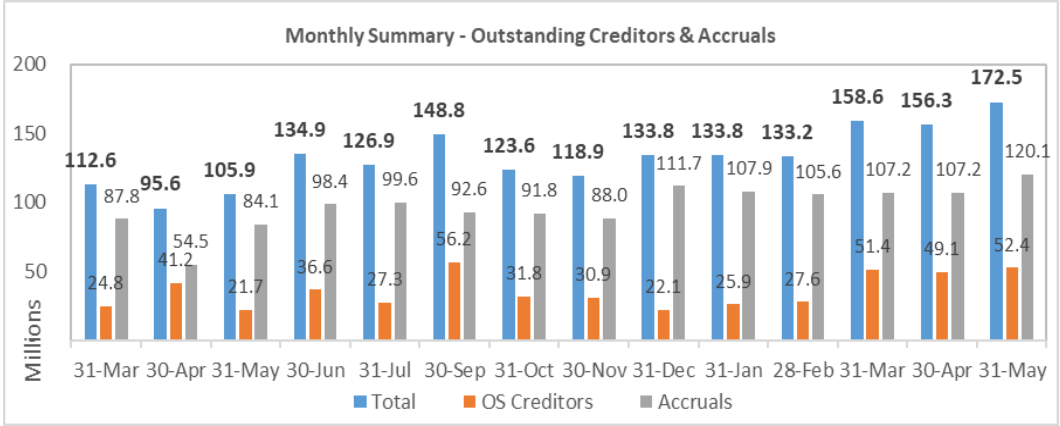
- Cash balance at 31 May is £24.7m, £12.9m favourable compared to forecast. The favourable variance is due to higher than expected operating receipts (£1.5m), lower than anticipated operating payments (£11.8m) offset by higher than expected capital and financing flows (£0.4m) which are all largely expected to be timing related.
- Total Revenue funding of £5.5m has been drawn down to the end of May 2019 to support the 19/20 YTD Trust revenue deficit position.
- The Trust has requested additional revenue funding of £22.9m for June 19.
- Planned cash balances reflect the expectation that a minimum cash balance of £3m will be held, but due to timing of receipts and payments actual balances will fluctuate throughout the month.
- A revenue term loan of £98.9m was due to be repaid on 18 Nov 2018, Trust is currently in discussion with NHSI/DH on how this loan will be extended or renegotiated.
- The Trust continues to run its weekly cash forecast process, to ensure accuracy of draw down requests, and control. Planned cash balances reflect the expectation that a minimum cash balance of £3m will be held, but due to timing of receipts and payments actual balances will fluctuate throughout the month.

Debtors and Creditors Summary – FY 18-19 and FY 19-20









Highlights for the period:

- May 19 Debtor days are 34.8 (35.9 Days – Apr 19), broadly in line with previous month.
- Outstanding Debtors at 31 May are £110.4m which include £25.9m of accruals.
- May 19 Creditors days are 112.5 (98.5 Days – May 19), higher compared to previous month and largely due to increased level of accruals.
- Outstanding Creditors at 31 May are £172.5m which include £120.1m of accruals.

Planned activity for next period:

- Ongoing focus on the old debt and reconciliation of both sides of the ledger.
- Meeting with our key customers & partners to resolve the outstanding issues and arrange reciprocal payments on both sides of the ledger.

Appendices

Network Care- Summary of Year to Date Financial Position

Type	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
NHS Clinical Contract Income	**451,905**	**37,480**	**39,214**	**1,733**	**73,774**	**75,009**	**1,236**
Other NHS Clinical Income	**4,117**	**343**	**290**	**(53)**	**686**	**617**	**(69)**
Private Patient & Overseas Income	**5,466**	**455**	**(0)**	**(455)**	**911**	**(0)**	**(911)**
Other Operating income	**26,716**	**2,261**	**2,098**	**(162)**	**4,516**	**4,170**	**(346)**
Income	**488,204**	**40,539**	**41,602**	**1,063**	**79,887**	**79,796**	**(91)**
Medical Agency	(281)	(23)	(156)	(133)	(47)	(156)	(110)
Medical Bank			(237)	(237)		(556)	(556)
Medical Substantive	(81,299)	(6,786)	(6,369)	417	(13,550)	(12,635)	914
Medical Staff	**(81,580)**	**(6,809)**	**(6,762)**	**47**	**(13,597)**	**(13,348)**	**249**
Nursing Agency	(210)	(18)	(78)	(60)	(35)	(132)	(97)
Nursing Bank	(1,697)	(128)	(627)	(499)	(283)	(1,157)	(874)
Nursing Substantive	(102,962)	(8,523)	(7,650)	873	(17,053)	(15,355)	1,698
Nursing staff	**(104,869)**	**(8,668)**	**(8,355)**	**313**	**(17,371)**	**(16,645)**	**726**
A&C agency			(23)	(23)		(40)	(40)
A&C Bank			(56)	(56)		(91)	(91)
A&C Substantive	(17,346)	(1,457)	(1,333)	124	(2,895)	(2,655)	240
Admin and Clerical	**(17,346)**	**(1,457)**	**(1,412)**	**45**	**(2,895)**	**(2,786)**	**109**
Other Agency Staff	(453)	(38)	(304)	(266)	(75)	(591)	(516)
Other Bank Staff	(166)	(28)	(61)	(33)	(28)	(156)	(129)
Other Substantive Staff	(26,270)	(2,191)	(1,953)	238	(4,382)	(3,935)	447
Other Staff	**(26,889)**	**(2,257)**	**(2,318)**	**(62)**	**(4,485)**	**(4,682)**	**(198)**
Unallocated CIP - Pay	1,090	(0)	(0)	0	(0)	(0)	0
Unallocated CIP - Pay	**1,090**	**(0)**	**(0)**	**0**	**(0)**	**(0)**	**0**
Pay	**(229,594)**	**(19,191)**	**(18,847)**	**344**	**(38,348)**	**(37,461)**	**886**
substantive	(226,787)	(18,957)	(17,305)	1,652	(37,880)	(34,581)	3,299
Bank	(1,863)	(155)	(981)	(826)	(311)	(1,961)	(1,650)
Agency	(944)	(79)	(562)	(483)	(157)	(920)	(763)
Clinical Supplies	(10,883)	(924)	(916)	7	(1,814)	(1,686)	128
Drugs	(11,363)	(947)	(792)	155	(1,894)	(1,841)	53
Pass Through Drugs - Expenditure	(73,462)	(6,060)	(6,583)	(523)	(12,244)	(12,388)	(144)
Consultancy	(13)	(1)	20	21	(2)	(0)	2
External Services	(2,129)	(177)	(165)	12	(355)	(262)	93
Purchase of Healthcare from Non-NHS Provider	(53,376)	(4,510)	(4,328)	183	(8,896)	(8,699)	197
Services from other NHS Bodies	(2,979)	(248)	(232)	16	(497)	(471)	26
Non-Clinical Supplies	(2,278)	(184)	(339)	(155)	(380)	(474)	(94)
Other Non-Pay	(971)	(79)	92	172	(162)	261	423
Unallocated CIP - NonPay	1,832	(25)	(0)	25	(51)	(0)	51
Nonpay	**(155,621)**	**(13,156)**	**(13,243)**	**(87)**	**(26,293)**	**(25,559)**	**734**
TRUST TOTAL (deficit per ledger)	**102,989**	**8,192**	**9,512**	**1,320**	**15,246**	**16,776**	**1,530**

PRUH - Summary of Year to Date Financial Position

Type	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
NHS Clinical Contract Income	**249,444**	**20,861**	**23,571**	**2,711**	**40,698**	**43,021**	**2,323**
Other Non-NHS Clinical Income	**479**	**40**	**33**	**(7)**	**80**	**51**	**(29)**
Private Patient & Overseas Income	**55**	**5**	**(0)**	**(5)**	**9**	**0**	**(9)**
Other Operating income	**9,222**	**783**	**703**	**(79)**	**1,575**	**1,433**	**(142)**
Income	**259,200**	**21,688**	**24,308**	**2,620**	**42,361**	**44,505**	**2,143**
Medical Agency	(575)	(48)	(336)	(288)	(96)	(711)	(615)
Medical Bank	(142)	(12)	(129)	(117)	(24)	(266)	(242)
Medical Substantive	(49,922)	(4,169)	(3,702)	468	(8,339)	(7,518)	821
Medical Staff	**(50,639)**	**(4,229)**	**(4,166)**	**63**	**(8,459)**	**(8,495)**	**(37)**
Nursing Agency	(123)	(10)	(76)	(66)	(20)	(122)	(102)
Nursing Bank	(1,790)	(149)	(710)	(561)	(298)	(1,420)	(1,121)
Nursing Substantive	(80,541)	(6,716)	(6,172)	544	(13,424)	(12,361)	1,063
Nursing staff	**(82,454)**	**(6,876)**	**(6,958)**	**(83)**	**(13,743)**	**(13,903)**	**(161)**
A&C agency			0	0		0	0
A&C Bank	(0)	(0)	(18)	(18)	(0)	(34)	(34)
A&C Substantive	(12,418)	(1,039)	(978)	60	(2,070)	(1,981)	88
Admin and Clerical	**(12,418)**	**(1,039)**	**(997)**	**42**	**(2,070)**	**(2,015)**	**54**
Other Agency Staff	(150)	(13)	(40)	(27)	(25)	(80)	(55)
Other Bank Staff	(217)	(18)	(13)	5	(36)	(44)	(8)
Other Substantive Staff	(6,397)	(533)	(465)	68	(1,065)	(926)	139
Other Staff	**(6,764)**	**(564)**	**(518)**	**46**	**(1,127)**	**(1,050)**	**77**
Unallocated CIP - Pay	639	(0)	(0)	0	(0)	(0)	0
Unallocated CIP - Pay	**639**	**(0)**	**(0)**	**0**	**(0)**	**(0)**	**0**
Pay	**(151,636)**	**(12,707)**	**(12,639)**	**68**	**(25,397)**	**(25,464)**	**(66)**
substantive	(148,638)	(12,457)	(11,317)	1,141	(24,898)	(22,787)	2,111
Bank	(2,149)	(179)	(870)	(691)	(358)	(1,764)	(1,406)
Agency	(848)	(71)	(452)	(381)	(141)	(913)	(772)
Clinical Supplies	(3,022)	(282)	(389)	(107)	(504)	(497)	7
Drugs	(7,085)	(590)	(554)	36	(1,181)	(1,122)	59
Pass Through Drugs - Expenditure	(15,654)	(1,316)	(1,411)	(95)	(2,606)	(2,718)	(112)
External Services	(2,805)	(234)	(164)	69	(468)	(379)	89
Purchase of Healthcare from Non-NHS Provider	(18,129)	(1,593)	(1,594)	(1)	(3,097)	(3,098)	(1)
Services from other NHS Bodies	(4,807)	(400)	(639)	(239)	(805)	(871)	(66)
Non-Clinical Supplies	(733)	(68)	(112)	(45)	(122)	(243)	(121)
Other Non-Pay	(319)	(64)	(42)	22	(53)	(227)	(174)
Unallocated CIP - NonPay	3,095	37	(0)	(37)	(0)	(0)	0
Nonpay	**(49,460)**	**(4,511)**	**(4,906)**	**(395)**	**(8,834)**	**(9,155)**	**(321)**
TRUST TOTAL (deficit per ledger)	**58,104**	**4,470**	**6,763**	**2,293**	**8,130**	**[illegible]**	**1,756**

UPAC - Summary of Year to Date Financial Position

Type	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
NHS Clinical Contract Income	**349,621**	**29,636**	**29,648**	**12**	**57,390**	**56,839**	**(552)**
Other NHS Clinical Income	**608**	**51**	**48**	**(3)**	**101**	**96**	**(6)**
Other Non-NHS Clinical Income	**3,180**	**265**	**284**	**19**	**530**	**542**	**12**
Private Patient & Overseas Income	**183**	**15**	**5**	**(10)**	**30**	**16**	**(15)**
Other Operating income	**24,574**	**2,116**	**1,974**	**(142)**	**4,174**	**3,935**	**(240)**
Income	**378,166**	**32,083**	**31,959**	**(124)**	**62,227**	**61,427**	**(800)**
Medical Agency	(354)	(29)	(177)	(148)	(59)	(519)	(460)
Medical Bank			(113)	(113)		(217)	(217)
Medical Substantive	(91,061)	(7,592)	(6,918)	674	(15,169)	(13,809)	1,360
Medical Staff	**(91,415)**	**(7,622)**	**(7,209)**	**413**	**(15,228)**	**(14,545)**	**683**
Nursing Agency	(552)	(46)	(273)	(227)	(92)	(484)	(392)
Nursing Bank	(3,766)	(314)	(687)	(373)	(628)	(1,521)	(894)
Nursing Substantive	(89,190)	(7,460)	(6,686)	774	(14,866)	(13,371)	1,495
Nursing staff	**(93,508)**	**(7,820)**	**(7,647)**	**173**	**(15,585)**	**(15,376)**	**209**
A&C agency			(80)	(80)		(108)	(108)
A&C Bank			(105)	(105)		(173)	(173)
A&C Substantive	(24,177)	(2,016)	(1,887)	129	(4,023)	(3,746)	278
Admin and Clerical	**(24,177)**	**(2,016)**	**(2,072)**	**(56)**	**(4,023)**	**(4,027)**	**(4)**
Other Agency Staff	(308)	(26)	(76)	(50)	(51)	(125)	(74)
Other Bank Staff			(26)	(26)		(50)	(50)
Other Substantive Staff	(53,045)	(4,405)	(3,927)	478	(8,815)	(7,900)	915
Other Staff	**(53,353)**	**(4,431)**	**(4,029)**	**403**	**(8,866)**	**(8,076)**	**791**
Unallocated CIP - Pay	1,090	117	(0)	(117)	234	(0)	(234)
Unallocated CIP - Pay	**1,090**	**117**	**(0)**	**(117)**	**234**	**(0)**	**(234)**
Pay	**(261,362)**	**(21,771)**	**(20,956)**	**816**	**(43,469)**	**(42,024)**	**1,445**
substantive	(256,383)	(21,356)	(19,427)	1,930	(42,639)	(38,836)	3,803
Bank	(3,766)	(314)	(923)	(609)	(628)	(1,952)	(1,324)
Agency	(1,214)	(101)	(606)	(505)	(202)	(1,236)	(1,034)
Clinical Supplies	(2,488)	(207)	121	329	(415)	(36)	378
Drugs	(8,938)	(745)	(640)	105	(1,490)	(1,279)	211
Pass Through Drugs - Expenditure	(31,296)	(2,608)	(2,484)	124	(5,216)	(5,246)	(30)
Consultancy	(43)	(4)	5	8	(7)	(1)	6
External Services	(1,813)	(151)	(192)	(41)	(302)	(369)	(66)
Purchase of Healthcare from Non-NHS Provider	(34,659)	(2,888)	(2,818)	70	(5,776)	(6,173)	(397)
Services from other NHS Bodies	(1,848)	(154)	(173)	(19)	(308)	(199)	109
Non-Clinical Supplies	(3,221)	(268)	(203)	65	(537)	(487)	50
Other Non-Pay	(1,028)	(86)	(209)	(123)	(171)	(509)	(338)
Unallocated CIP - NonPay	644	8	(0)	(8)	16	(0)	(16)
Nonpay	**(84,688)**	**(7,103)**	**(6,592)**	**511**	**(14,206)**	**(14,299)**	**(93)**
TRUST TOTAL (deficit per ledger)	**32,115**	**3,209**	**4,411**	**1,203**	**4,552**	**5,[illegible]**	**[illegible]**

CORPORATE - Summary of Year to Date Financial Position

Type	Annual Budget £'000	Current Month Budget £'000	Current Month Actual £'000	Current Month Variance £'000	Year to Date Budget £'000	Year to Date Actual £'000	Year to Date Variance £'000
NHS Clinical Contract Income	**(13,044)**	**(1,390)**	**(4,881)**	**(3,492)**	**(2,329)**	**(6,019)**	**(3,690)**
Private Patient & Overseas Income	**23,430**	**1,953**	**1,699**	**(253)**	**3,905**	**3,514**	**(391)**
Other Operating income	**79,387**	**5,872**	**4,569**	**(1,302)**	**11,577**	**9,229**	**(2,348)**
Income	**89,774**	**6,435**	**1,388**	**(5,047)**	**13,153**	**6,724**	**(6,429)**
Medical Agency			0	0		(0)	0
Medical Bank	(49)	(4)	(19)	(15)	(8)	(33)	(25)
Medical Substantive	(6,306)	(575)	(482)	93	(1,151)	(1,021)	130
Medical Staff	**(6,356)**	**(579)**	**(502)**	**78**	**(1,159)**	**(1,054)**	**105**
Nursing Agency	(16)	(1)	(1)	0	(3)	(1)	1
Nursing Bank	(1,097)	(91)	(139)	(48)	(183)	(503)	(320)
Nursing Substantive	(14,459)	(1,210)	(1,096)	114	(2,420)	(2,250)	169
Nursing staff	**(15,571)**	**(1,303)**	**(1,236)**	**67**	**(2,605)**	**(2,754)**	**(149)**
A&C agency	(89)	(7)	(271)	(263)	(15)	(482)	(468)
A&C Bank	(1,128)	(94)	(127)	(33)	(188)	(242)	(54)
A&C Substantive	(55,985)	(4,681)	(4,125)	556	(9,552)	(8,398)	1,153
Admin and Clerical	**(57,202)**	**(4,783)**	**(4,523)**	**260**	**(9,755)**	**(9,123)**	**632**
Other Agency Staff	(10)	(1)	(0)	1	(2)	(0)	1
Other Bank Staff	(128)	(11)	(9)	2	(21)	(14)	7
Other Substantive Staff	(4,984)	(417)	(340)	77	(835)	(702)	133
Other Staff	**(5,122)**	**(429)**	**(349)**	**80**	**(858)**	**(716)**	**142**
Pay Reserves	(14,397)	(497)	(0)	497	(497)	(0)	497
Pay Reserves	**(14,397)**	**(497)**	**(0)**	**497**	**(497)**	**(0)**	**497**
Unallocated CIP - Pay	4,624	44	(0)	(44)	88	(0)	(88)
Unallocated CIP - Pay	**4,624**	**44**	**(0)**	**(44)**	**88**	**(0)**	**(88)**
Pay	**(94,023)**	**(7,547)**	**(6,610)**	**937**	**(14,785)**	**(13,647)**	**1,138**
substantive	(91,507)	(7,337)	(6,044)	1,294	(14,366)	(12,371)	1,994
Bank	(2,402)	(200)	(294)	(94)	(400)	(792)	(391)
Agency	(115)	(10)	(272)	(262)	(19)	(484)	(465)
Clinical Supplies	7,183	622	(139)	(761)	1,245	(445)	(1,690)
Drugs	(360)	(30)	(49)	(19)	(60)	(70)	(10)
Pass Through Drugs - Expenditure	(733)	(61)	(59)	2	(122)	(115)	7
Consultancy	(1,556)	(130)	(453)	(323)	(260)	(679)	(420)
External Services	(61,629)	(5,156)	(5,393)	(237)	(10,714)	(11,053)	(339)
Purchase of Healthcare from Non-NHS Provider	(58,246)	(4,897)	(3,104)	1,793	(9,708)	(7,586)	2,122
Services from other NHS Bodies	(48,298)	(4,677)	(4,717)	(40)	(9,354)	(9,500)	(146)
Non-Clinical Supplies	(52,242)	(4,351)	(4,478)	(127)	(8,701)	(8,755)	(54)
Other Non-Pay	(24,230)	(1,956)	(1,938)	18	(3,913)	(2,089)	1,824
Reserves	(16,921)	(60)	(0)	60	(367)	(0)	367
Unallocated CIP - NonPay	10,256	(0)	(0)	0	(0)	(0)	0
Depreciation	(25,824)	(2,152)	(2,152)	0	(4,304)	(4,304)	0
Impairment	(24,000)	(2,000)	(2,000)	0	(4,000)	(4,000)	0
Nonpay	**(296,600)**	**(24,849)**	**(24,482)**	**366**	**(50,259)**	**(48,597)**	**1,662**
Interest payable	(48,112)	(4,009)	(4,009)	0	(8,019)	(8,019)	0
Interest receivable	501	42	(7)	(49)	84	84	(0)
Profit/Loss on Disposal of Fixed Assets	(50)	(4)	(28)	(24)	(8)	(0)	8
Public Dividend Capital			(0)	0		(0)	0
Financing	**(47,661)**	**(3,972)**	**(4,044)**	**(73)**	**(7,943)**	**(7,935)**	**8**
TRUST TOTAL (deficit per ledger)	**(348,510)**	**(29,933)**	**(33,749)**	**(3,816)**	**(59,835)**	**(63,454)**	**(3,619)**
Less Donated Depreciation	(756)	(63)	(63)	0	(126)	(126)	0
Less Donated Income	2,050	(0)	(171)	(171)	(0)	0	0
Less FRF	14,807	740	740	0	1,480	1,480	0
Less Impairement	(24,000)	(2,000)	(2,000)	0	(4,000)	(4,000)	0
Less PSF funding	20,421	1,021	1,021	0	2,042	2,042	0
OPERATING DEFICIT (excluding STF)	**(361,032)**	**(29,631)**	**(33,276)**	**(3,646)**	**(59,231)**	**(62,850)**	**(3,619)**
Operating surplus / (deficit)	**(300,849)**	**(25,961)**	**(29,705)**	**(3,744)**	**(51,891)**	**(55,519)**	**(3,628)**
Add back all I&E impairments/(reversals)	**(24,000)**	**(2,000)**	**(2,000)**	**0**	**(4,000)**	**(4,000)**	**0**
Add back depreciation and amortisation	**(25,824)**	**(2,152)**	**(2,152)**	**0**	**(4,304)**	**(4,304)**	**0**
Less cash donations / grants for the purchase of capital assets	**2,050**	**(0)**	**(171)**	**(171)**	**(0)**	**0**	**0**
EBITDA	**(253,075)**	**(21,809)**	**(25,382)**	**(3,573)**	**(43,587)**	**(47,2**	**(3)**

Cash Flow Summary 01 Apr 19 to 27 Sep 19

FY 2019 - 20 Cash Flow Summary - 01 Apr 19 to 27 Sep 19

£'m	FY 2019 - 20 Actual 30-Apr	Actual 31-May	Act-Fcast 28-Jun	Forecast 31-Jul	Forecast 31-Aug	Forecast 27-Sep	FY 19-20 YTD 01 Apr 19 27 Sep 19	FY 2019 - 20 Actual 01 Apr 19 27 Sep 19	Act-Fcast 01 Apr 19 27 Sep 19
Opening Balance	**31.8**	**48.2**	**24.7**	**13.2**	**3.0**	**3.0**	**31.8**	**31.8**	**24.7**
Receipts - Patient Care	86.4	97.0	77.7	83.8	84.4	83.6	512.9	183.4	329.4
Receipts - Non-Patient Care	29.4	5.1	9.0	19.6	9.3	8.9	81.3	34.4	46.9
Operating Receipts	**115.8**	**102.1**	**86.7**	**103.4**	**93.7**	**92.6**	**594.2**	**217.9**	**376.3**
Payments - Pay	(51.1)	(68.8)	(59.9)	(60.4)	(61.5)	(60.2)	(361.8)	(119.9)	(241.9)
Payments - Non-Pay	(51.1)	(50.8)	(55.5)	(59.1)	(62.1)	(60.7)	(339.4)	(101.9)	(237.5)
Operating Payments	**(102.3)**	**(119.6)**	**(115.4)**	**(119.5)**	**(123.6)**	**(120.9)**	**(701.2)**	**(221.8)**	**(479.4)**
Net Operating Cashflow	**13.5**	**(17.5)**	**(28.7)**	**(16.1)**	**(29.9)**	**(28.3)**	**(107.0)**	**(4.0)**	**(103.1)**
Capital Receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital payments	(2.2)	(3.5)	(3.6)	(4.1)	(2.4)	(3.3)	(19.0)	(5.7)	(13.4)
Facility Drawdown	5.5	0.0	22.9	10.9	33.0	35.0	107.3	5.5	101.8
Facility Repayments	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Interest receipts	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.0
Interest payments	(0.5)	(2.6)	(2.1)	(0.9)	(0.7)	(3.4)	(10.1)	(3.1)	(7.0)
Capital/Financing Cashflow	**2.9**	**(6.0)**	**17.2**	**5.9**	**29.9**	**28.3**	**78.2**	**(3.1)**	**81.3**
Net Cashflow	**16.4**	**(23.5)**	**(11.5)**	**(10.2)**	**0.0**	**0.0**	**(28.8)**	**(7.1)**	**(21.7)**
Closing Balance	**48.2**	**24.7**	**13.2**	**3.0**	**3.0**	**3.0**	**3.0**	**24.7**	**3.0**

Key commentary:

- The Trust did not request revenue funding in May 19.
- £22.9m revenue funding has been received in Jun 19.
- Forecast operating receipts and payments for the forecast period (01 June 19 to 27-Sep-19) are £376.3m and (£479.4m).

King's College Hospital NHS Foundation Trust

Inspection report

Denmark Hill
London
SE5 9RS
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Date of inspection visit: 30 Jan to 21 Feb 2019
Date of publication: 12/06/2019

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

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

This report is a summary of our inspection findings. You can find more detailed information about the service and what we found during our inspection in the related Evidence appendix.

Ratings

Overall rating for this trust	Requires improvement
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

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

Summary of findings

Background to the trust

King's College Hospital NHS Foundation Trust provides in-patient and out-patient services from King's College Hospital, Princess Royal University Hospital, Orpington Hospital, Queen Mary's Hospital, Sidcup, and Beckenham Beacon. The trust has satellite Dialysis units in Dulwich, Dartford, Bromley, Woolwich and Sydenham. The trust refers to the Princess Royal University Hospital (PRUH) and its nearby locations as the PRUH and south sites.

As a foundation trust it is still part of the NHS and treats patients according to NHS principles of free healthcare according to need, not the ability to pay. Being a foundation trust means the provision and management of its services are based on the needs and priorities of the local community, free from central government control.

The trust works with King's College London, Guy's and St Thomas' and South London and Maudsley Foundation Trusts, and are members of King's Health Partners, which is an Academic Health Science Centre.

The trust was last inspected in September/October 2017 (report published January 2018). The trust rating stayed the same as the previous inspection ratings, of requires improvement.

Overall summary

Our rating of this trust stayed the same since our last inspection. We rated it as Requires improvement

➔➔

What this trust does

King's College Hospitals NHS Foundation Trust provides local general services and specialist care and is well known for being an educational trust for medical, nursing and dental students with its academic partners, King's College London and other local universities.

The trust is one of four major trauma centres, covering south east London and Kent. King's College Hospital is also a heart attack centre and the regional hyper acute stroke centre. The Hospital offers a range of services, including: a 24-hour emergency department, medicine, surgery, paediatrics, maternity and outpatient clinics. Specialist services are available to patients, which provide nationally and internationally recognised work in liver disease and transplantation, neurosciences, haemato-oncology and fetal medicine.

The Princess Royal University Hospital offers a range of local services including a 24-hour emergency department, medicine, surgery, paediatrics, maternity, critical care, and outpatient clinics. Services provided at Queen Mary's Hospital Sidcup, and Orpington Hospital include care of the elderly, orthopaedics, diabetes, ophthalmology and dermatology. Outpatient services are provided at Beckenham Beacon.

The trust employs 12,455 staff (headcount as of August 2018) and has 82 wards, with 1,638 inpatient beds, two-day case beds and 100 children's beds. This large trust according to CQC acute Insight falls within the top 20% for activity levels. The trust had 176,545 inpatient admissions, 1,869,207 outpatient appointments and 229,730 Emergency Department attendances between July 2017 and June 2018.

The health of people in Bromley is generally better than the England average. Life expectancy for both men and women is higher than the England average. Whereas the health of people in Southwark and Lambeth are varied compared with the England average. Southwark and Lambeth are within the 20% most deprived districts/unitary authorities in England.

Summary of findings

Rates of sexually transmitted infections and TB are worse for Lambeth and Southwark. Rates of violent crime and early deaths from cardiovascular diseases are worse than average for Lambeth. The rates of statutory homelessness, violent crime and early deaths from cancer are worse than average for Southwark.

Key questions and ratings

We inspect and regulate healthcare service providers in England.

To get to the heart of patients' experiences of care and treatment, we ask the same five questions of all services: are they safe, effective, caring, responsive to people's needs, and well-led?

Where we have a legal duty to do so, we rate the quality of services against each key question as outstanding, good, requires improvement or inadequate.

Where necessary, we take action against service providers that break the regulations and help them to improve the quality of their services.

What we inspected and why

We plan our inspections based on everything we know about services, including whether they appear to be getting better or worse. Our planning decisions took account of information provided by the trust, and information we had collected and reviewed during the past year. This included feedback from patients, the public, staff, a local MP and other stakeholders.

We carried out the unannounced core service inspection on 30 and 31 January, and 1 February 2019. We undertook a further inspection visit to one core service at the Princess Royal University Hospital (PRUH) on 16 February to check if concerns we reported to the trust had been addressed.

We inspected the locations of King's College Hospital (KCH) and Princess Royal University Hospital and south sites.

At KCH we inspected the core services of the Emergency Department, Surgery, Maternity, End of Life, and Outpatients. The latter included satellite Dialysis services.

At the PRUH and south sites we inspected the Emergency Department, Surgery, End of Life, and outpatients, which also included satellite Dialysis.

We also inspected the well-led key question for the trust overall. We summarise what we found in the section headed Is this organisation well-led? The announced well-led part of the inspection took place on 19 to the 21 February 2019.

We held discussion with staff prior to inspection and attended several of the governance committee meetings and attended trust board meetings.

During inspection we spoke to staff from a range of clinical areas and disciplines and at different grades. This included: healthcare assistants; portering and housekeeping, nurses, doctors, consultants, and allied health professionals. We spoke with members of the leadership team, which included executives, non-executive directors, the interim chair and company secretary.

We reviewed patient related information, including many care records and risk assessment tools. We looked at policies and procedures, safety checks and medicines records. In addition, we reviewed minutes of meetings, formal performance reports, risk registers and other governance information.

What we found

Princess Royal University Hospital:

Summary of findings

- At Princess Royal University Hospital and its south sites, we found a deterioration in expected standards in the Emergency Department. Our findings indicated some inadequacies in safety standards, the responsiveness of the service and its overall leadership. Because of this we saw the effectiveness of its services and elements of the ability of staff to provide care to patients had gone down.
- The Outpatient Department was previously rated in conjunction with diagnostics, so cannot be compared. At this inspection we found some improvements were needed for it to be a safe, responsive and a well-led service. Caring was found to be good. We do not currently rate the effectiveness of this service area.
- Surgery had retained its former ratings across all domains, with safety and responsiveness needing some improvements, and all other domains as good.
- Although there were improvements in End of Life care with respect to having a responsive service and leadership, other domains had not changed, with safety and effectiveness still requiring additional work, and caring staying as good.

King's College Hospital:

- At King's College Hospital we found two of the Emergency Department domains had decreased, with safety and well-led dropping from good to requires improvement. Responsiveness stayed the same as requires improvement and effectiveness and caring stayed as good.
- Surgery had dropped its ratings from good to requires improvement in safety and leadership, but stayed the same for effectiveness and responsive, as requiring improvements. Caring remained good.
- Maternity services had stayed the same as good for effective and caring and increased its ratings by one level for responsive and well-led up to good. Safety stayed the same as requires improvement.
- Outpatient services were previously rated in conjunction with diagnostics, so cannot be compared. During this inspection we found safety and responsiveness required improvements, effectiveness is not currently rated, and caring and well-led were rated as good.
- End of Life care had improved in safe, effectiveness, responsiveness and well-led, moving from a requires improvement to good.

Overall trust

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

- We rated safe and responsive as requires improvement. Effective, caring and well-led as good at King's college Hospital. Safety was rated as requires improvement in six core services, and two as good. One core service was rated requires improvement, and six as good for effectiveness. One was not rated. All eight core services were rated as good for caring. Three core services were rated as requires improvement for responsive, and five as good. The ratings for well-led were; two core services as requires improvement, and six as good.
- We rated safe, effective, responsive and well-led as requires improvement at Princess Royal University Hospital and caring as good. Four core services were rated as requires improvement for safety, one as inadequate and three as good. Two core services were rated as requires improvement for effectiveness, one was not rated and five were rated as good. Seven core services had a good rating, with one a requires improvement for caring. There were three requires improvement, one inadequate, three goods and one outstanding for responsive. Well-led had five good ratings, one inadequate, and two requires improvement.
- We rated five of the trust's services at King's College Hospital as good and three as requires improvement.

Summary of findings

- We rated one service as inadequate, three as requires improvement and four as good at Princess Royal University Hospital.
- We rated well-led for the trust overall as requires improvement.

In rating the trust, we considered the current ratings of the four services not inspected this time.

We rated the trust as requires improvement because:

- The provider had not ensured the required mandatory training was completed by its staff to the expected target. This was the same as our previous findings.
- Staffing levels in some key areas did not always meet the needs of the services being delivered.
- Environmental and equipment risks related to patient safety were not always fully considered and acted upon.
- The trusts expected infection prevention and control standards and practices were not consistently applied across some areas.
- Medicines optimisation was not always managed in the safest possible way.
- The learning arising from investigations was not always communicated effectively, and opportunities to improve were not always taken in a timely manner.
- Patient outcome information and performance targets were not always meeting the expected standards.
- Information used by staff to inform their practices was not always up to date.
- The responsiveness of services did not always meet patient's needs with regards to some of the expected targets, including timely access, appointments and surgery.
- Work was still required to ensure staff across all services understood the trust vision and its strategy, and for all specialties to develop their own strategies.
- Further work was needed to ensure risk registers were fully understood, were reviewed and updated.
- From what we heard in some of the core services there was a disconnect between what the executive did and how this was perceived by staff.

However:

- Patients in most areas inspected were treated by compassionate staff who showed kindness, empathy and respect.
- Patients individual needs were assessed, including where patients lacked capacity, and care was generally delivered in accordance with these needs and their preferences. Patients families and loved ones were involved where appropriate.
- Staff continued to have a good understanding of their responsibilities for safeguarding vulnerable people and could demonstrate their knowledge and awareness in this area.
- Technical equipment and other resources were readily available to support the delivery of treatment and care. Maintenance and routine electrical safety checks were carried out at regular intervals.
- Opportunities for staff development and progression had been improved, and the trust worked hard to retain staff.
- The incident reporting process was well-established and was widely used by staff. There was a positive culture around reporting and the value of learning from the investigative process. Formal systems were regularly used to review serious incidents and unexpected deaths, with findings reported through the well-developed governance arrangements.

Summary of findings

- Information of importance was shared with patients, and other providers of services including, GP, and community services.
- There was a good level of awareness of the complaints process. Where the duty of candour principles applied to unexpected incidents or complaints, this generally happened.
- The local governance arrangements had been strengthened since our previous inspection

Our full Inspection report summarising what we found and the supporting Evidence appendix containing detailed evidence and data about the trust is available on our website – www.cqc.org.uk/provider/RJZ/reports.

Are services safe?

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

- Although mandatory safety training subjects were provided for staff, the required training was not always completed to the trust's targets. This had not improved since our previous inspection.
- Patient risk assessments were not always completed and updated as expected in surgery. This had not improved since our previous inspection findings.
- Although there were safe practices for staff to follow for keeping the environment and equipment suitably clean, and minimising infection control risks, staff did not always follow these. Risks related to infection control were not fully considered and managed with consistency across all areas.
- Patients attending the Outpatients and Emergency Departments (ED) at the Princess Royal University Hospital (PRUH) and King's College Hospital (KCH) received care in areas which were not always sufficiently safe and where risks had not been fully considered.
- The layout of the ED at the PRUH was not suitable for the number of admissions the service received. There was significant overcrowding, and, at times, patients were being cared for on trolleys along corridors. At times, two patients were nursed in cubicles designed for only one person.
- The endoscopy unit at PRUH had not been improved since our previous inspection. There were insufficient procedure rooms to meet the demands for the service. Endoscopy decontamination was carried out in a room used for both clean and dirty equipment. Since the inspection the trust informed us there was a considerable backlog of patients waiting for urgent and routine endoscopies. We have reviewed the Trust's action plan and will continue to monitor its progress in reducing this backlog.
- In the trauma and orthopaedics (fracture) clinic at KCH, there was no separate waiting area for adults and children.
- There were inconsistencies in checking equipment was suitable for use and was within its expiry date in the Emergency Departments at both King's College and Princess Royal University Hospitals, and in Outpatients at KCH.
- Within the ED and King's College Hospital and Princess Royal University Hospital staff did not always follow best practice when storing, supplying, preparing or administering medicines. Medicine audit results in surgery at PRUH showed the service performed below trust standards for several indicators.
- Although there was a strong culture around incident reporting, and staff recognised the value of learning from such events. Staff working in some areas reported not receiving information following the investigation process, including actions to take and learning arising from the investigation.
- The Emergency Department at the PRUH did not manage patient safety incidents well. Whilst staff recognised the types of incidents they should report, including near misses, lessons learned were not always effectively introduced across the department resulting in similar incidents occurring.

Summary of findings

- Patients arriving into the PRUH Emergency Department were not always protected from avoidable harm. There were significant handover delays for patients arriving by ambulance. The management of patients requiring resuscitation was poor due to flow challenges across the emergency care pathway.
- Staffing levels and skill mix within the PRUH ED was not sufficient to meet the needs of patients as a result; patients did not have their care and treatment carried out in a timely manner.
- Vacancy, turnover and sickness rates for nursing staff in KCH Outpatient Department were higher (worse) than the trust target, although it should be noted that this varied by clinical speciality as outpatients was managed by several divisions.
- Although gaps in doctor's rotas were usually filled by locum and agency staff, vacancy rates for medical staff were worse than the trust's target, and junior doctors informed us they were overworked.
- Patient treatment folders were not always stored securely due to a lack of storage space at Dartford Dialysis Unit.

However:

- Other core service areas inspected were generally staffed to a level which maintained the safety of patients, and enabled safe treatment and care to be delivered
- Patient records, including care plans, safety checks and medicines charts were mostly completed to the required standards.
- Staff understood their responsibilities for safeguarding vulnerable people and could demonstrate their knowledge and awareness in this area.
- The ward pharmacists conducted medicines reconciliation, discharge prescriptions and handled any medicines related concerns. (Medicines reconciliation is the process of identifying an accurate list of a person's current medicines and comparing it with the current list in use.) The trust had implemented a system which provided assurance that blood glucose testing kits were calibrated before use.
- The management of prescription charts used within the Outpatient Department at PRUH had improved since our last inspection.
- There were enough equipment resources to support the delivery of treatment and care, and items were subject to maintenance and routine electrical safety checks. Improvements had been made in the assessment of equipment and its availability for end of life care since the last inspection.
- Training was provided on the duty of candour to staff. In most areas there was a good level of awareness of what the duty of candour related to and how it was applied in practice. The principles of duty of candour had mostly been applied in the serious incident review process and complaints, where applicable.
- There were well defined guidance documents to inform staff of the action to take where safeguarding concerns were identified. Staff understood their responsibilities and could demonstrate their knowledge in this area.
- Incidents of a serious nature were fully considered and reviewed through various committee meetings. Learning was communicated back through several channels, although there was a degree of reliance on staff having the time and commitment to read information.
- The trust was working hard to ensure vacancies were recruited to, and to promote internal development opportunities as a means of improving retention.

Are services effective?

Our rating of effective stayed the same. We rated it as requires improvement because:

Summary of findings

- Care and treatment was generally delivered in clinical areas in line with evidence based national and professional guidance, and trust protocols. We noted however, some policies were out of date.
- Professional information was mostly used to inform decisions around patient diagnosis, treatment and care, and staff in most services worked well together to deliver effective care and treatment. However, staff who worked in the ED at the PRUH did not always work together as a team, and there was a lack of consistency in working practices, dependent on who was leading the team. There were challenges when referring patients to individual specialties, with patients often waiting a significant length of time to be seen.
- The surgical outcome targets did not meet the national benchmark and the trust were not performing well in key areas.
- Trauma and orthopaedics patients had a lower expected risk of readmission for elective surgery when compared to the England average.
- There were a range of maternity outcome indicators that were not meeting the trust's standards and actions in response to these were not always timely.
- It was not clear from the recorded information that patient's needs related to pain management in KCH Emergency Department were being met.
- Although the trust had made significant improvements in the appraisal rates for staff since our previous inspection, the target was not yet being achieved in this area.

However:

- Patient outcomes continued to be monitored and actions were taken to address areas which required improvement.
- Staff had opportunities to update their existing skills and develop new ones through a range of training methods, which was what we previously found.
- Patients nutrition and hydration needs were identified by staff and met.
- Most staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- There was good documentation of do not resuscitate decisions, an improvement on our previous findings.

Are services caring?

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

- Patients told us they were treated well and with kindness and care, and staff provided information and support in a timely way.
- We observed staff to be compassionate and caring towards patients and their relatives in most areas inspected.
- Patients individual care needs were assessed and acted upon. There was access to staff with expertise where additional support was needed. Volunteers provided support and help in most service areas.
- There was access to multi-faith chaplaincy and the bereavement team.

However:

- Patients attending the ED at PRUH were not always being involved in discussions and their treatment was not always delivered with compassion and kindness. Patients were not always treated with dignity and respect.

Summary of findings

Are services responsive?

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust did not always plan and provide services in a way that met the needs of local people. Waiting times in some specialties were lengthy, and the waiting times for referral to treatment were less than expected for some services. The trust failed to meet several key national targets across referral to treatment and cancer waits.
- Outpatient appointment contact information was not always responsive for services at King's College Hospital.
- People could not always access surgical service when needed. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice.
- There were significant numbers of non-surgical patients on surgical wards and patients were sometimes recovered in theatres due to a lack of surgical beds.
- Patients could not access care and treatment in a timely way at PRUH Emergency Department. Waiting times for treatment and arrangements to admit, treat and discharge patients were worse than the England average and national standard.
- The Outpatient facilities at KCH were not always appropriate and patient centred, due to restrictions on space. The ophthalmology waiting area often became overcrowded, and about half of the self-check in screens were broken.
- Patients we spoke with in KCH Outpatient services told us they did not always have a choice of appointment times, and they were not kept informed of waiting times when they arrived at clinics.
- Privacy and dignity of patients was not always maintained in the Outpatient services at the Princess Royal University Hospital because of the environment.
- There was a well understood process for handling complaints, and staff were involved with this where applicable. Improvements had been made in response times for closure of minor complaints, but there remained some delays with final response letters for some more complex matters.

However:

- The trust had several services which had been designed and adapted to suit demand in the local population. This included an expansion in the dialysis programme and the introduction of a virtual fracture clinic.
- End of life care pathways were designed and managed with full consideration of the wishes of patients and their families.
- Services were planned, delivered and co-ordinated to take account of the needs of different people, including those with protected characteristics, and in vulnerable circumstances.
- The Maternity service at KCH recognised the rights and choices of women receiving care and met these as far as they were able.
- Peoples discharge summaries detailed the verbal and written information provided to patients about the medicines they were given. Pharmacy teams and ward staff provided appropriate medicines counselling.
- Where learning was identified from the complaints review process, staff were made aware of this using a range of methods.

Are services well-led?

Our rating of well-led stayed the same. We rated it as requires improvement because:

Summary of findings

- There was a lack of effective leadership in the ED at Princess Royal University Hospital. This impacted on the departments capacity and capability to deliver high-quality, sustainable care, as well as staff morale. This had got worse since our last inspection.
- Morale amongst administrative staff across most Outpatient services at King's College Hospital was low. Staff in some clinical areas did not feel valued or respected.
- Most staff in other core service areas across the trust's sites reported having good level of leadership and support at a local level. There remained however, a concern about the visibility and connectivity of trust executives with some core service teams on both sites, particularly at the PRUH, which and had not improved since our previous inspection.
- Some staff reported a disconnect between the executive team and clinical leaders within surgery services.
- Service level vision and strategies were not always clearly stated, this included Maternity services at King's College Hospital and Outpatient services. As a result, staff in these areas were not clear on priorities, plans or timescales.
- The governance structure for Outpatient services at the PRUH and the south sites was not always clear and consistent. Lines of accountability and management were not clear, and there was a lack of a systematic or consistent approach to improving the quality of services.
- Local risk registers were not consistently reviewed, as a result it was not clear if all risks were being identified and addressed.

However:

- The committee structures generally supported a strong and well-defined approach to enable effective reporting on performance, review such information and to bring about positive changes.
- There were more opportunities to hold local team meetings in areas where staffing levels had improved.
- Most managers at all levels in the surgical division had the right skills and abilities to run a service providing high-quality sustainable care. Many staff felt motivated and were proud to work for the trust.
- The ED at King's College Hospital engaged with a variety of stakeholders to plan and manage appropriate services.

Ratings tables

The ratings tables show the ratings overall and for each key question, for each service, hospital and service type, and for the whole trust. They also show the current ratings for services or parts of them not inspected this time. We took all ratings into account in deciding overall ratings. Our decisions on overall ratings also took account of factors including the relative size of services and we used our professional judgement to reach fair and balanced ratings.

Outstanding practice

We found examples of outstanding practice in the leadership of the trust and within maternity. For more information, see the Outstanding practice section of this report.

Areas for improvement

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

We told the trust that it must take action to bring services into line with eleven legal requirements. This action related to the Emergency Department and Outpatients, Surgical and Maternity services.

Summary of findings

Trust-wide:

- The trust must ensure the required mandatory training is completed to the trusts target.

King's College Hospital:

Emergency Department:

- The trust must ensure sure medical and nursing staff working in the emergency department have enough time to complete mandatory and safeguarding training.
- The trust must ensure they follow best practice when prescribing, giving, recording and storing medicines.
- The trust must ensure patient records are completed in line with trust policy.
- The trust must make sure there is a suitable environment for assessing children and young people presenting with mental health needs.
- The trust must ensure that resuscitation trolleys in ED are fully stocked with in-date medication and equipment and checked in line with trust policy.
- The trust must ensure there is a safe, confidential environment for patients to speak to staff without being over heard by members of the public and other patients.
- The trust must ensure that patients are admitted, transferred or discharged within four hours of arriving in the emergency department.
- The trust should ensure there are sufficient nursing and medical staff working in the ED to meet patient needs.
- The trust should ensure people's pain is properly assessed and clearly recorded in patient records.
- The trust should make sure they have clear systems for identifying risks and a clear plan of how to reduce or eliminate risk.
- The trust should engage with local communities to help improve services.

Surgery:

- The trust should ensure cross infection practices within theatres and the recovery area are improved upon.
- The trust should ensure it improves waiting times from referral to treatment and arrangements to admit, treat and discharge patients.
- The trust should consider how it improves the storage space and facilities within main theatres.
- The trust should consider how it can improve the nutritional risk assessment records.
- The trust should consider how it improves communication and decision making between the senior executive team and clinical leaders within the surgery division.

Maternity:

- The trust should ensure all patient complaints are investigated and closed within the trust's published policy timescales.
- The trust should ensure data is recorded regularly in the obstetrics scorecard without omission.
- The trust should ensure actions are recorded at review on the maternity risk register, including dates and progress of actions.

Summary of findings

- The trust should ensure all policies and procedures are reviewed, updated and contain a next review date.
- The trust should consider having tailgating notices on all maternity wards and departments to avoid unauthorised access.
- The trust should improve patients and visitors access to drinking water.
- The trust should consider how it can improve maternity staff appraisal rates to meet trust targets.
- The trust should consider how it can improve maternity staff training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards to meet trust targets.
- The trust should consider developing a specific, measurable strategy for maternity.
- The trust should consider how it may engage with local communities to help improve services.
- The trust should consider how leadership teams within Maternity develop their respective vision and strategies with the involvement of staff.

Outpatients:

- The trust must ensure suitable equipment is provided and subject to regular checking procedures.
- The trust should continue work to improve referral to treatment times and other targets.
- The trust should continue its work related to improving vacancies, turnover and sickness rates to bring them into line with the trust target.
- The trust should make consideration of measures to improve the storage of patient records at Dartford Dialysis Unit.
- The trust should continue to address the issues caused by unsuitable Outpatient clinic environments, which impact upon patient safety and privacy.
- The trust should increase support for administrative staff across Outpatients, particularly those taking calls from patients.

End of Life:

- The trust should ensure there is dedicated consultant cover for weekends.
- The trust should ensure there is a dedicated face to face registrar cover during out of hours and at the weekends.

Princess Royals University Hospital:

Emergency Department:

- The trust must ensure patients have their clinical needs assessed and care delivered in accordance with national best practice standards, and within nationally defined timescales.
- The trust must ensure the environment and equipment is suitable and fit for purpose.
- The trust must ensure staff comply with trust infection control protocols.
- The trust must ensure medicines are managed, stored, supplied and administered in accordance with trust and national policy.
- The trust must ensure learning from incidents is identified, and actions instigated, without delay to reduce the likelihood of similar incidents occurring again.
- The trust must ensure the service consistently complies with the regulatory requirements of the duty of candour

Summary of findings

- The trust must ensure guidelines are up-to-date and reflect national best practice.
- The trust must ensure patients and visitors are treated with kindness and compassion.
- The trust must ensure the governance arrangements are reviewed so that reporting is consistent with defined trust governance structures. Information must be considered in the round and used to improve the quality and safety of care delivered across the emergency pathway.
- The trust should ensure staff are appraised in accordance with trust policies.
- The trust should ensure speciality doctors review their patients within defined timescales to reduce the occurrence of breaches associated with delayed speciality reviews.
- The trust should consider how it can introduce a robust action plan which addresses the multi-factorial flow challenges within the emergency care pathway.
- The trust should ensure there are enough nursing and medical staff working in the ED to meet patient needs.

Surgery:

- The trust should ensure there are suitable endoscopy facilities to meet the demands for the service.
- The trust should consider how it may improve referral to treatment times to ensure they are in line with national standards.
- The trust should ensure patients are cared for in areas that are appropriate and meet all their needs.
- The trust should work to improve access and flow within surgical services.
- The trust should work to improve medicines audit ratings for surgical services.

Outpatient services:

- The trust must ensure that all rooms where patients are seen and treated have call bell facilities, specifically the plaster room at Princess Royal University Hospital.
- The trust should consider how it may increase the visibility of the executive team to outpatient staff.
- The trust should consider how it can improve the consistency of feedback from incidents and complaints, so staff can learn, and services can improve.
- The trust should consider how it can improve the consistency and clarity of management and governance structures across services and sites to ensure that oversight and lines of accountability are clear.
- The trust should consider how it may promote the value of regular team meetings being held so staff are informed, learning is shared, and staff can raise issues.
- The trust should consider how it may further improve routes by which patients are able to give feedback and engage with local services.
- The trust should continue work to address the issues caused by unsuitable clinic environments, which impact upon patient privacy and dignity.

End of Life:

- The provider should ensure that all aspects of NICE guidance NG31 ‘Care of dying adults in the last days of life’ are followed.

Summary of findings

- The trust should ensure there is a plan to integrate an end of life care plan into the electronic patient record as soon as possible to adapt to the needs of the service.
- The trust should ensure there are individualised care plans to enable staff to identify appropriate end of life care specific to each patient.
- The trust should ensure staff complete and update risk assessments for each patient such as a malnutrition universal screening tool (MUST) risk assessment score.
- The trust should ensure that there is improved documentation of 'do not attempt cardio pulmonary resuscitation' status on patient treatment escalation plans (TEP).
- The trust should ensure there is improvement in recording of preferred place of care and preferred place of death within the palliative care database.
- The trust should ensure patients are offered the opportunity to meet with a member of the chaplaincy in accordance with the 'priorities of care of the dying patient'.

Action we have taken

We issued three requirement notices to the trust and took three enforcement actions. This meant the trust had to send us a report saying what action it would take to meet these requirements. Our action related to breaches of one legal requirement at a trust-wide level and seven in a number of core services or locations. For more information on action we have taken, see the sections on Areas for improvement and Regulatory action.

What happens next

We will make sure that the trust takes the necessary action to improve its services. We will continue to monitor the safety and quality of services through our continuing relationship with the trust and our regular inspections.

Outstanding practice

Trust wide:

- The trust had worked closely with stakeholders to improve services for patients experiencing mental health and challenging behaviour related matters. King's had led work in south east London to reduce the length of stay for patients with mental health conditions in crisis attending the ED.
- The trust had developed a training scheme where staff had the opportunity to develop their leadership and quality improvement project skills.
- The trust had trained 2000 staff in LEAN quality improvement methodologies.
- The trust is acknowledged for its innovative work and project developments, including frailty pathways and its collaboration on aseptic services in the wider south-east London area.
- The trust is recognised for the outstanding contribution of volunteers who help and support staff, patients and those who visit the hospitals.

Maternity:

- Staff in the fetal medicine unit (FMU) were involved in research into acute kidney injury (AKI) in pregnancy.
- Maternity services advertised and participated in an umbilical cord blood donation scheme. Women were encouraged to donate their umbilical cord blood for use in the treatment of people with blood cancer.

Summary of findings

- Staff were nominated in three categories for the London Maternity and Midwifery Festival awards.
- Staff had been shortlisted in two categories for the Royal College of Midwives annual awards.

Areas for improvement

We issued the trust with a section 31 letter of intent and requested an action plan to be provided within an agreed timeframe. The trust provided the action plan and we returned to the trust to review some of the actions and were assured the action plan would be implemented.

We issued three warning notices and four requirement notices to the trust which are detailed in the regulatory action section of the report.

Is this organisation well-led?

Our comprehensive inspections of NHS trusts have shown a strong link between the quality of overall management of a trust and the quality of its services. For that reason, we look at the quality of leadership at every level. We also look at how well a trust manages the governance of its services – in other words, how well leaders continually improve the quality of services and safeguard high standards of care by creating an environment for excellence in clinical care to flourish.

Our rating of well-led at the trust stayed the same. We rated well-led as requires improvement because:

- The Board Assurance Framework required work to make its core purposes clear, and to identify its principle risks, and a structured approach and assurance of their management.
- Risks were not always identified on risk registers, and risks which were successfully managed through the mitigations or actions were often not removed. Some risk registers at divisional level still required work to demonstrate how they successfully mitigate and manage each risk.
- Risks related to the altered use of clinical areas were not always fully considered or monitored. Where staff were required to follow mitigative actions, these were not always checked.
- The trust and board members recognised they had work to do to improve diversity and equality across the trust and at board level. There was recognition of the work to be done to improve negative behaviours in a small number of clinical areas to change the culture.
- The non-executive team did not always provide enough level of challenge. There were many governance meetings but the timing of these did not always enable enough discussion and debate.
- The leadership team were viewed negatively in respect to the expectation around completion of mandatory training. Staff reported having to do this training in their own time, and as a result expected targets were not being met in some areas.
- Leaders in some areas did not always ensure their staff had opportunities to review their performance and appraise their work.
- There was disparity between what the executive team were doing to engage with staff to that perceived by staff working in several core service areas.

Summary of findings

- Low morale and perceived bullying and harassment continued to be reported from some groups of staff, including at managerial level. Staff did not always recognise the leadership team as dealing with their concerns around these matters. There were still some staff who did not feel able to express their concerns or speak up for fear of reprisal.
- There was still work to be done to ensure all committees had clarity around the purpose and focus of meetings.
- The governance arrangements around safeguarding needed to be strengthened to ensure matters reported were followed up sooner, that delays in update of information were escalated to the trust board, so they had the opportunity to fully analyse and consider information.

However:

- Although the trust had experienced several changes in membership of the executive leadership team, they had the skills, abilities, and commitment to provide high-quality services. They recognised the training needs of managers at all levels, including themselves, and worked to provide development opportunities for the future of the organisation.
- The board and senior leadership team had set a clear vision and values that were at the heart of all the work within the organisation. They worked hard to make sure staff at all levels understood them in relation to their daily roles.
- The recently refreshed trust strategy was directly linked to the current vision and values of the trust. Work was progressing well on the development of a new strategy, which involved the engagement of clinicians, staff, patients and groups from the local community as well as other stakeholders. The trust's focus was clearly set out with aims focused on high-quality care with financial stability.
- The trust was aware of areas of concern around its financial situation, performance, most risks, and matters which impacted on its staff. There was focus on improving and managing these well.
- Although visibility was sometimes difficult to achieve, senior leaders and non-executive directors were approachable and visited some areas of the trust. They fed back to the board to discuss challenges staff and the services faced.
- The trust worked hard to promote a culture which enabled staff to speak up about concerns or matters which affected their working. The freedom to speak up arrangements had been enhanced since our previous inspection.
- Equality, diversity and the health and well-being of staff continued to be a focus of the leadership team. Measures had been established to address these important aspects of working within the trust.
- The trust had a clear structure for overseeing performance, quality and risks, with board members represented across the divisions and some specialty areas. This gave them greater oversight of issues facing the service and they responded when services needed more support.
- The leadership team worked well with clinical leads and encouraged divisions to share learning across the trust.
- The trust made sure the views of patients, staff, the public, and local organisations were fully considered. Divisions were encouraged and supported to develop their own communication and engagement strategies, and staff were actively involved with projects affecting the future of the trust.
- The board reviewed performance reports and data about the services, which they and the divisional leads could challenge.
- The trust recognised and managed the risks related to the use of its information technology systems. The board was regularly sighted on activities related to the digital and technological programme, cyber security and compliance with data protection.
- The trust was committed to improving services by learning from when things went well and when they did not. There was awareness of the need to improve complaints response times in some areas.

Summary of findings

- The trust actively promoted training and development opportunities, research activities and innovation across service areas.

Use of resources

Please see the separate use of resources report for details of the assessment and the combined rating.

Ratings tables

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

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

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

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement ➔➔ May 2019	Requires improvement ↓ May 2019	Good ➔➔ May 2019	Requires improvement ➔➔ May 2019	Requires improvement ➔➔ May 2019	Requires improvement ➔➔ May 2019

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

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
King's College Hospital	Requires improvement ➔➔ May 2019	Good ↑ May 2019	Good ➔➔ May 2019	Requires improvement ➔➔ May 2019	Good ➔➔ May 2019	Requires improvement ➔➔ May 2019
Princess Royal University Hospital	Requires improvement ➔➔ May 2019	Requires improvement ↓ May 2019	Good ➔➔ May 2019	Requires improvement ➔➔ May 2019	Requires improvement ➔➔ May 2019	Requires improvement ➔➔ May 2019
Overall trust	Requires improvement ➔➔ May 2019	Requires improvement ↓ May 2019	Good ➔➔ May 2019	Requires improvement ➔➔ May 2019	Requires improvement ➔➔ May 2019	Requires improvement ➔➔ May 2019

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

Ratings for King's College Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↓ May 2019	Good → ← May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement ↓ May 2019	Requires improvement ↓ May 2019
Medical care (including older people's care)	Good ↑ Sept 2017	Good → ← Sept 2017	Good → ← Sept 2017	Good → ← Sept 2017	Good → ← Sept 2017	Good → ← Sept 2017
Surgery	Requires improvement ↓ May 2019	Requires improvement → ← May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Requires improvement ↓ May 2019	Requires improvement → ← May 2019
Critical care	Requires improvement → ← Sept 2017	Good → ← Sept 2017	Good → ← Sept 2017	Good ↑ Sept 2017	Good ↑ 2017	Good ↑ Sept 2017
Maternity	Requires improvement → ← May 2019	Good → ← May 2019	Good → ← May 2019	Good ↑ May 2019	Good ↑ May 2019	Good ↑ May 2019
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Good ↑ May 2019	Good ↑ May 2019	Good → ← May 2019	Good ↑ May 2019	Good ↑ May 2019	Good ↑ May 2019
Outpatients	Requires improvement May 2019	N/A	Good May 2019	Requires improvement May 2019	Good May 2019	Requires improvement May 2019
Overall*	Requires improvement → ← May 2019	Good ↑ May 2019	Good → ← May 2019	Requires improvement → ← May 2019	Good ↑ May 2019	Requires improvement → ← May 2019

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

Ratings for Princess Royal University Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ May 2019	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Inadequate ↓↓ May 2019	Inadequate ↓ May 2019	Inadequate ↓ May 2019
Medical care (including older people's care)	Good ↑ Sept 2017	Good ↑ Sept 2017	Good →← Sept 2017	Good ↑ Sept 2017	Requires improvement ↓ Sept 2017	Good ↑ Sept 2017
Surgery	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019	Requires improvement →← May 2019	Good →← May 2019	Good →← May 2019
Critical care	Good ↑ Sept 2017	Good →← Sept 2017	Good →← Sept 2017	Requires improvement →← Sept 2017	Good ↑ Sept 2017	Good ↑ Sept 2017
Maternity	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015	Good Sept 2015
Services for children and young people	Requires improvement Sept 2015	Good Sept 2015	Good Sept 2015	Outstanding Sept 2015	Good Sept 2015	Good Sept 2015
End of life care	Requires improvement →← May 2019	Requires improvement →← May 2019	Good →← May 2019	Good ↑ May 2019	Good ↑ May 2019	Requires improvement →← May 2019
Outpatients	Requires improvement Apr 2019	N/A	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
HIV and sexual health services						
Overall*	Requires improvement →← May 2019	Requires improvement ↓ May 2019	Good →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019	Requires improvement →← May 2019

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

King's College Hospital

Denmark Hill
London
SE5 9RS
Tel: 020 3299 9000
www.kch.nhs.uk

Key facts and figures

King’s College Hospital is located on Denmark Hill, Camberwell in the London Borough of Lambeth, and is referred to locally and by staff simply as "King's" or abbreviated internally to "KCH". It is managed by King's College Hospital NHS Foundation Trust.

The hospital provides a full range of general and specialist services for both inpatient and outpatients. This includes a 24-hour emergency department, critical care, acute and investigative medicine, elective and emergency surgery, paediatrics, maternity and outpatient clinics. Specialist services in liver disease and transplantation, neurosciences, haemato-oncology and fetal medicine are also provided.

There are 47 inpatient wards, with approximately 1,126 beds. A full range of outpatient services are provided for both adults and children and there is access to on-site diagnostics. This includes plain x-ray, computerised tomography (CT) scans and magnetic resonance imaging (MRI) scans. Other services, such as pathology and pharmacy are provided along with dietetics, physio and occupational therapists.

Across the whole trust there were 176,545 inpatient admissions and 1,867207 outpatient appointments between July 2017 and June 2018.

During the inspection we spoke with more than 137 staff from different roles and reviewed the records of 58 patients. We spoke with 58 patients and relatives. We reviewed formal documentation requested prior to and during the inspection.

Summary of services at King's College Hospital

Requires improvement  

Our rating of services stayed the same. We rated it them as requires improvement because:

- Not all staff had completed the required safety related mandatory training, which was as we found on our previous inspection.
- The environment in which patients received treatment and care was not always suitable or risk assessed. Privacy was not always achieved in some areas, and equipment had not been checked in a consistent manner.
- Medicines optimisation was not always achieved, and standards related to infection prevention and control were inconsistent.
- Patient risk assessments were not always completed and updated.

Summary of findings

- Expected patient outcomes were not always met in some specialties.
- Access to some services were not meeting some of the expected targets in outpatients and once referred for admission. Waiting times from referral to treatment, arrangements to admit, treat and discharge patients was not always in line with good practice.
- Communication and engagement with staff by leaders was not always as strong as it could be, and some staff reported low morale.

However:

- There were enough staff with the right skills and experiences and staff had access to professional development, were competent for their roles, and had opportunities for a review of their performance.
- Care and treatment was delivered by a multidisciplinary team, in line with evidence based national guidance such as National Institute for Health and Care Excellence (NICE) and professional colleges.
- The staff recognised the importance of reporting and learning from incidents. Investigations led to the sharing of information learned and improvements.
- Patients were treated with respect and dignity, were involved in decisions about their care and were provided with information and choices.
- The co-ordination and delivery of services took account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.
- Most clinical areas were led by staff who had the right experience, skills and knowledge. They understood the trusts values and strategic aims and fostered a culture where staff could do their best.

Our rating of services stayed the same. We rated it them as requires improvement because:

- Not all staff had completed the required safety related mandatory training, which was as we found on our previous inspection.
- The environment in which patients received treatment and care was not always suitable or risk assessed. Privacy was not always achieved in some areas, and equipment had not been checked in a consistent manner.
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- Care and treatment was delivered by a multidisciplinary team, in line with evidence based national guidance such as National Institute for Health and Care Excellence (NICE) and professional colleges.

Summary of findings

- The staff recognised the importance of reporting and learning from incidents. Investigations led to the sharing of information learned and improvements.
- Patients were treated with respect and dignity, were involved in decisions about their care and were provided with information and choices.
- The co-ordination and delivery of services took account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.
- Most clinical areas were led by staff who had the right experience, skills and knowledge. They understood the trusts values and strategic aims and fostered a culture where staff could do their best.

Urgent and emergency services

Requires improvement 

Key facts and figures

The Emergency Department (ED) at King's College Hospital is a Major emergency centre for the south east. It is a major trauma centre, hyper acute stroke unit, cardiac arrhythmia and cardiac arrest centre. It also fulfils its obligations as a type 1 emergency department for the local population. The department has different areas where patients are treated depending on their needs, including a resuscitation area, one major's areas, and a 'sub-acute' area for patients with less serious needs, and a clinical decision unit (CDU). A separate paediatric ED with its own waiting area, cubicles and CDU is within the department.

There are over 350 staff, including 80 doctors and 180 nurses. From August 2017 to July 2018 there were 230,385 attendances at the trust's urgent and emergency care services.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by a nurse from a co-located urgent care centre (UCC) and, if determined suitable to be treated in the ED await triage (Triage is the process of determining the priority of patients' treatments based on the severity of their condition). The UCC is managed by a different provider and was not part of the inspection.

We visited adult majors, resuscitation, paediatric and minor injury/illness areas. We inspected ED from 30 January 2019 to 1 February 2019. We spoke with eight patients and six relatives. We looked at 20 sets of patient records. We spoke with 28 members of staff, including nurses, doctors, allied health professionals, managers, support staff and ambulance crews. We reviewed and used information provided by the organisation in making our decisions about the service.

Summary of this service

Our rating of this service went down. We rated it as requires improvement because:

- The service did not ensure staff had completed mandatory training, and expected targets were not always being achieved. Staff we spoke with felt mandatory training was ineffective and did not help them in their role.
- The service did not have suitable premises and equipment was not looked after well. The design and layout of the emergency department (ED) did not always protect patient's privacy and dignity. There was no dedicated paediatric mental health assessment room available and there was a lack of consideration given to ligature points. Safety checks on equipment were not carried out consistently across all areas and we found several items within resuscitation trolleys which were out of date.
- The service did not always follow best practice when prescribing, giving, recording and storing medicines. We could not be assured patients received the right medicines at the right dose at the right time. Patient records were inconsistent in their recording of administered medicines and dosage amounts.
- Patients could not access care and treatment in a timely way.Waiting times for treatment and arrangements to admit, treat and discharge patients were worse than the England average and national standard.
- The trust did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

Urgent and emergency services

- Staff we spoke with felt leadership within the ED was not always effective and staff did not always feel their ideas were listened too.

Is the service safe?

Requires improvement 

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

- **Although the service provided mandatory training in key skills, they did not ensure everybody had completed it.** Mandatory training rates were not always being achieved to the expected target.
- **The premises were not designed to meet the needs of all its patients. People's privacy and dignity could not always be maintained, and there was no dedicated paediatric mental health assessment room available.** Equipment was not always checked in accordance with the trust's policies.
- **The Emergency Department did not always have enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.**
- **Staff did not always keep detailed records of patients' care and treatment.** Records we viewed were inconsistent in their recording of information.
- **Medicines fridges were unlocked, and controlled medicines were not always signed out according to best practice.**

However:

- **Staff understood how to protect patients from avoidable harm and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse, and they knew how to apply it.**
- **The service-controlled infection risks well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.**

Is the service effective?

Good 

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

The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed best practice guidance.

- **The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.**
- **Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.**
- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.**

Urgent and emergency services

- **Staff from different disciplines worked well together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.**

However:

- **It was unclear if patient's pain had been properly assessed and treated due to the inconsistencies in recording pain information in a patient's medical record.**

Is the service caring?

Good 

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

- **Staff cared for patients with compassion and professionalism. Feedback from patients confirmed that staff treated them well and with kindness.**
- **Staff provided emotional support to patients to minimise their distress. They involved patients and those close to them in decisions about their care and treatment.**

Is the service responsive?

Requires improvement 

Our rating of responsive stayed the same. We rated it as requires improvement because:

- **People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit treat and discharge patients were not in line with good practice.**
- **The individual needs of patients were not always assessed or delivered. Poor patient flow across both the department and wider hospital meant patients often had a long wait in the ED before being admitted.**

However:

- The ED planned and provided services in a way that met the needs of local people.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement 

Our rating of well-led went down. We rated it as requires improvement because:

- **The ED had a vision for what it wanted to achieve, however staff were unaware of this vision and any workable plans to turn it into action.**
- **Managers across the department did not always promote a positive culture within the ED that supported and valued staff, creating a sense of common purpose based on shared values.** Staff told us that some managers did not value their opinion and showed little willingness to support new ideas.

Urgent and emergency services

- **The ED did not have effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.**
- **Staff we spoke with felt senior leaders including executives did not have a clear understanding of the challenges within the ED.**
- **Senior staff told us that business cases and action plans were not always signed off by executives despite prior discussion. Staff felt they had wasted time giving possible solutions to flow issues with no interest from senior executives.**

However:

- **The ED collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.**
- **The ED was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.**

Areas for improvement

Action the provider MUST take to improve:

- The trust must ensure sure medical and nursing staff working in the emergency department have enough time to complete mandatory and safeguarding training.
- The trust must ensure they follow best practice when prescribing, giving, recording and storing medicines.
- The trust must ensure patient records are completed in line with trust policy.
- The trust must make sure there is a suitable environment for assessing children and young people presenting with mental health needs.
- The trust must ensure that resuscitation trolleys in ED are fully stocked with in-date medication and equipment and checked in line with trust policy.
- The trust must ensure there is a safe, confidential environment for patients to speak to staff without being over heard by members of the public and other patients.
- The trust must ensure that patients are admitted, transferred or discharged within four hours of arriving in the emergency department.

Action the provider SHOULD take to improve:

- The trust should ensure there are enough nursing and medical staff working in the ED to meet patient needs.
- The trust should ensure people's pain is properly assessed and clearly recorded in patient records.
- The trust should make sure they have clear systems for identifying risks and a clear plan of how to reduce or eliminate risk.
- The trust should engage with local communities to help improve services.

Surgery

Requires improvement 

Key facts and figures

Surgical services at Kings College Hospital NHS Foundation Trust comprised of general, tertiary, neurosurgery, paediatric, liver and cardiothoracic surgery. The hospital carries out major trauma surgical treatment for the south east of England, and the trust as a whole had 63,084 surgical admissions from June 2018 to May 2018. Emergency admissions accounted for 11,554 (18.3 %), 41,763 (66.2%) were day case, and the remaining 9,767 (15.5%) were elective.

During our inspection we visited the main theatres and several surgical wards within different specialties. We visited the day surgery unit, pre-assessment and the surgical assessment unit. We spoke with approximately 30 members of staff including nurses, healthcare assistants, doctors of all grades, managers and allied health professionals. We spoke to nine patients and their relatives. We observed care throughout surgical services and looked at 12 sets of patient records, and other requested documentation prior to, during and following our visit.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service provided mandatory training in key skills to all staff but did not make sure everybody had completed it. Compliance rates for medical staff were poor and we issued the trust with a requirement notice for them to address this matter.
- The service did not always control infection risks well. Staff did not always keep premises and equipment clean. They did not always use control measures to prevent the spread of infection.
- Staff did not always complete an updated risk assessment for each patient. The completion of malnutrition universal screening tool (MUST) scores did still not reach the trust target of 100% and this had not improved since our last inspection.
- Patient outcome targets did not meet the national benchmark and the trust were not performing well in key areas.
- People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice.
- Most managers at all levels in the surgical division had the right skills and abilities to run a service providing high-quality sustainable care. However, there was a distinct lack of communication and strategic level engagement with clinical staff from the senior executive team.

However:

- The trust had enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Surgery

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff cared for patients with compassion and took account of their individual needs. Feedback from patients confirmed that staff treated them well and with kindness.
- There were systems and processes for effective learning, continuous improvement and innovation.

Is the service safe?

Requires improvement ↓

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

- The service provided mandatory training in key skills to all staff but did not make sure everybody had completed it. Medical staff compliance rates were poor, and these included key modules, such as infection control, safeguarding, mental capacity and consent and resuscitation.
- The service did not always control infection risks well. Staff did not always keep premises and equipment clean. They did not always use control measures to prevent the spread of infection. We found dust in theatres and the recovery area and storage space within theatres was limited.
- Staff did not always complete an updated risk assessment for each patient. However, the completion of malnutrition universal screening tool (MUST) scores did still not reach the trust target of 100% and this had not improved since our last inspection.

However:

- Overall, the service had enough nursing and medical staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. We found a good level of nursing clinical and medical staff cover across all surgical wards and within theatres
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Is the service effective?

Requires improvement →←

Our rating of effective stayed the same. We rated it as requires improvement because:

- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them. However, some patient outcomes indicators did not meet the national benchmark and the trust were not performing well in key areas.
- Staff did not always access the correct up to date policy on the trusts computer system. This meant some staff may not have been following current guidelines.

However:

- The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.

Surgery

- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses, and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Is the service caring?

Good ➔➔

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

- Staff cared for patients with compassion, dignity and respect. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice. Referral-to-treatment time (RTT) performance remained below the England average.
- The trust did not always plan and provide services in a way that met the needs of local people. There were frequent on the day cancellations.

However:

- The service took account of patients' individual needs and made arrangements to meet these in a responsive manner.

Is the service well-led?

Requires improvement ➔

Our rating of well-led went down. We rated it as requires improvement because:

- Most managers at all levels in the surgical division had the right skills and abilities to run a service providing high-quality sustainable care. However, there was a disconnect and lack of effective communication between the senior executive team and the surgical clinical team.
- The trust had a vision for what it wanted to achieve, however there was a lack of engagement with staff to turn it into action. There was a lack of executive level strategic engagement with clinical staff to help improve the service.

However:

Surgery

- The trust used a systematic approach to continually improve the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care would flourish.
- There were strong systems and processes in use to learn, continuously improve and be innovative.
- The trust ensured that patients, and their relatives and carers, the public, and external partners were actively engaged and involved in identifying and driving improvements in services.

Areas for improvement

We found areas for improvement in this service. See the Areas for Improvement section above.

The service MUST:

- The trust must ensure all medical staff are compliant with mandatory training.

The service SHOULD:

- The trust should ensure cross infection practices within theatres and the recovery area are improved upon.
- The trust should ensure it improves waiting times from referral to treatment and arrangements to admit, treat and discharge patients.
- The trust should consider how it improves the storage space and facilities within main theatres.
- The trust should consider how it can improve the nutritional risk assessment records.
- The trust should consider how it improves communication and decision making between the senior executive team and clinical leaders within the surgery division.

Maternity

Good ↑

Key facts and figures

King's maternity service is divided on two sites the Kings College Hospital (KCH) site; and the Princess Royal University Hospital (PRUH) site); both sites provide full range of maternity services. In addition, KCH site is a tertiary unit taking referrals for fetal medicine, women with abnormally invasive placenta, hypertension, liver disease, renal disease and other co-morbidities.

Women have a wide range of choices for each part of their maternity pathway- antenatal, post-natal and intrapartum care. Women can choose their place of birth from a homebirth, alongside birth centre at the Oasis birth centre, PRUH site and along- side birthing rooms at KCH.

The midwifery team provide midwifery services in a wide range of community settings and has specialist staff supporting women with issues with such as perinatal mental health, migrant women, safeguarding and substance misuse. Other initiatives include a successful continuity of carer case-load model for women with 17% of our women receiving this model of care.

The trust is a teaching centre for both medical and midwifery students.

Between July 2017 to June 2018 there were 9,134 deliveries at the trust, with 98.3% being single births, this was close to the England average of 98.6%.

During our inspection we spoke to 12 women who used the service and their relatives. We observed care in outpatient clinics and looked at 10 sets of women's records. We spoke with 20 members of staff.

We last inspected Kings College Hospital NHS Foundation Trust maternity services in April 2015 as part of a joint maternity and gynaecology inspection. We found combined maternity and gynaecology services maternity services required improvement overall. The purpose of this inspection was to see if maternity services performance had been maintained or if any improvements had been made by the service in the interim. We did not inspect gynaecology during this inspection.

Summary of this service

Our rating of this service improved. We rated it as good because:

- There had been an improvement in the visibility of senior management since the director of midwifery and women's health had taken up their post six months earlier. Maternity had a clearly defined accountability structure.
- Medicines optimisation was managed well. The pharmacist visited daily and checked drugs and administration charts.
- Staff kept detailed records of women and babies care and treatment. There had been action to improve assessment of risks to women and their babies since our previous inspection. Staff completed and updated women and babies risk assessments and care records.
- All staff we spoke to were aware of their responsibilities relating to duty of candour under the Health and Social Care Act (Regulated Activities Regulations) 2014.

Maternity

- Care was being provided in accordance with the National Institute for Health and Care Excellence (NICE) quality standards. All guidance and policies within maternity services had been reviewed and were based upon current guidance.
- The antenatal unit was midwife led. We found staff were committed to providing and promoting normal birth.
- The trust was working towardsUnited Nations (UN) Children's Fund Baby Friendly accreditation. The Baby Friendly Initiative is based on a global accreditation programme ofUnited Nations Children's Fund and the World Health Organisation.
- There were good training and education opportunities available to staff. The trust employed a dedicated maternity education team. New midwives joining the trust completed a preceptorship programme.
- Most women we spoke with told us they felt involved in planning and making decisions about their care.
- The maternity service had completed actions to meet the requirements of the 'saving babies lives' care bundle, with the aim of reducing stillbirths, neonatal deaths, and intrapartum brain injuries.

However:

- There were a range of outcome indicators that were not meeting the trust's standards and actions in response were not always timely. The trust's key performance indicator (KPI) for all caesarean sections (CS) was above the trust's KPI standard.
- Rates of Hypoxic Ischemic Encephalopathy (HIE), this is a type of brain damage that occurs when an infant's brain doesn't receive enough oxygen and blood, from January to December 2018 were worse that the trust's target of zero.
- The service provided mandatory training in key skills to all staff. However, mandatory training targets were not being met.
- Some staff had not had not updated training in safeguarding vulnerable adults and children in accordance with the trust's training schedule.
- The maternity department had been closed on eight occasions between January and December 2018 due to labour ward capacity.
- Although some staff understood how and when to assess whether women had the capacity to make decisions about their care. Training rates for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were low.
- Staff recognised incidents, reported them appropriately, and managers investigated them. However, lessons learnt were not always shared with the whole team and the wider service.
- The service took concerns and complaints seriously, investigated them and learnt lessons from the results. However, the time taken to respond to complaints was not always achieved in accordance with the trust's complaints policy.
- The service did not have a defined vision and strategy for what it wanted to achieve and workable plans to turn it into action.

Is the service safe?

Requires improvement → ←

Our rating for safe stayed the same. We rated it as requires improvement because:

Maternity

- The service provided mandatory training in key skills to all staff. However, mandatory training targets were not being met. Staff had not met the trust's compliance target of 80% for any of the 19 required mandatory courses.
- All staff did not have up to date training in safeguarding. As a result there was risk that staff would not know how to recognise and report abuse. In February 2019 the trust's target for level three safeguarding children training was not being met.
- From January to December 2018 there had been 27 cases of Hypoxic Ischemic Encephalopathy (HIE), this is a type of brain damage that occurs when an infant's brain doesn't receive enough oxygen and blood, this was worse that the trust's target of zero.
- Staff recognised incidents and reported them appropriately. Managers investigated incidents. However, lessons learnt were not always shared with the whole team and the wider service. Some staff told us the incident reviews were not always timely.

However:

- The service-controlled infection risks well. Staff followed infection prevention and control procedures to minimise and prevent the spread of infection.
- The environment in which services were provided was suitable. There had been improvements since our previous inspection with two dedicated lifts for staff use. Staff had access to a range of equipment and kept these items serviced and checked before use.
- There had been action to improve assessment of risks to women and their babies since our previous inspection. Staff completed and updated most risk assessments. Where additional help was required they requested this from suitably skilled and experienced colleagues.
- Staff kept detailed records of women and babies care and treatment. Records were clear, up-to-date and easily available to all staff providing care.
- Maternity followed best practice when prescribing, giving, recording and storing medicines. Women received the right medication and dose at the right time.
- Maternity had enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and to provide the right care and treatment. All women had a named consultant (for high-risk pregnancies) or a named midwife (for low risk pregnancies).

Is the service effective?

Good ➔➔

Our rating for effective stayed the same. We rated it as good because:

- The service made sure staff were competent for their roles. Appraisal rates had improved since our previous inspection in April 2015. Managers held supervision meetings with staff to provide support and monitor the effectiveness of the service. The trust employed a dedicated practice development team for midwifery. New midwives joining the trust completed a comprehensive preceptorship programme.
- Staff from different roles worked together as a team to benefit women and babies. Doctors, midwives and other healthcare professionals supported each other to deliver the right treatment and care. There were joint monthly maternity risk multidisciplinary meetings between Kings College Hospital (KCH) and Princess Royal University Hospital (PRUH).

Maternity

- There was a range of training and educational development opportunities available to staff. The trust employed two dedicated maternity education lead midwives. New midwives joining the trust completed a preceptorship programme. However, the trust only had one professional midwifery advisor (PMA) to roll out the new model of midwifery supervision.

However:

- Although managers monitored the effectiveness of care and treatment, there were a range of outcome indicators that were not meeting the trust's standards. Actions in response to these indicators were not always timely.
- Although staff we asked understood how and when to assess whether women had the capacity to make decisions about their care, training rates for the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were low.

Is the service caring?

Good ➔➔

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

- Staff cared for women and babies with compassion, dignity and respect. Feedback from women and those close to them confirmed that staff treated them with kindness and respect.
- Staff provided emotional support to women and those close to them to minimise their distress. Maternity had two named bereavement midwives who supported women and their families following stillbirth or neonatal death.
- Staff involved women and those close to them in decisions about their care and treatment. Women we spoke with told us nurses and midwifery staff involved them in their care planning and decision making.

Is the service responsive?

Good ➔

Our rating for responsive improved. We rated it as good because:

- The trust planned and provided services in a way that met the needs of local people, and they could access the service when they needed it. There had been improvements in managing the capacity of maternity services with the introduction of a maternity triage and a system of flexing available space on the wards.
- The service took account of women's individual needs. Women were given choices to give birth at home or in a midwifery unit. Maternity had pathways of care for women with learning disabilities. Maternity had a strategy for women with mental health needs.
- There were arrangements to admit, treat and discharge women and babies to manage the access and flow through maternity

However:

- The maternity department had been closed on eight occasions between January and December 2018 due to reduced labour ward capacity.
- Although the service treated concerns and complaints seriously, investigated them and learnt lessons from the results. The time taken to respond to complaints was not in accordance with the trust's complaints policy.

Maternity

Is the service well-led?

Good ↑

Our rating for well-led improved. We rated it as good because:

- Managers in the maternity services had the right skills and abilities to run a service providing high-quality sustainable care. There were appointed clinical leads in all maternity and obstetric departments, the role of the clinical leads was spoken about positively by most staff. Staff told us there had been an improvement in the visibility of senior management since the director of midwifery and women's health had taken up their post six months earlier.
- The maternity services collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.
- Maternity staff engaged well with women using the service and those close to them. Staff, the public and local organisations were involved in planning and managing maternity services.
- Staff Maternity staff were engaged in a range of research projects.

However:

- The service did not have a defined vision and strategy for what it wanted to achieve and workable plans to turn it into action. Maternity had an action plan in response to national maternity strategies, but, there were no timescales for implementing the planned actions.
- Although managers promoted a positive culture which supported and valued staff, some staff reported the culture in maternity as hierarchical.
- The systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected were not always updated in a timely way.

Outstanding practice

- Staff in the fetal medicine unit (FMU) were involved in research into acute kidney injury (AKI) in pregnancy.
- Maternity services advertised and participated in an umbilical cord blood donation scheme. Women were encouraged to donate their umbilical cord blood for use in the treatment of people with blood cancer.
- Staff were nominated in three categories for the London Maternity and Midwifery Festival awards.
- Staff had been shortlisted in two categories for the Royal College of Midwives annual awards.

Areas for improvement

Actions the provider must take

The trust must should ensure staff mandatory training rates meet trust targets.

Actions the provider SHOULD take to improve

- The trust should take action to follow up the Hypoxic Ischemic Encephalopathy (HIE) in audit and audit recommendations with a further audit to assess the impact of the recommendations from the HIE audit.
- The trust should ensure all complaints are investigated and closed within the trust's published policy timescales.

Maternity

- The trust should ensure data is recorded regularly in the obstetrics scorecard without omission.
- The trust should ensure actions are recorded at review on the maternity risk register, including dates and progress of actions.
- The trust should ensure all policies and procedures are reviewed and updated, and contain a next review date.
- The trust should ensure tailgating notices are displayed on all maternity wards and departments to avoid unauthorised access.
- The trust should ensure women and visitors have access to drinking water at all times.
- The trust should ensure appraisal rates meet trust targets.
- The trust should ensure maternity staff training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards meets trust targets.
- The trust should develop a measurable strategy for maternity.

End of life care

Good ↑

Key facts and figures

Kings College Hospital provides end of life care to patients across all clinical areas and treats patients with a variety of conditions, including cancer, liver disease, stroke, cardiac and respiratory disease.

The hospital does not have a dedicated ward for end of life care. The specialist palliative care team (SPCT), which consists of specialist consultants and nurses, provide advice, assessment and treatment to patients across all clinical areas within the hospital. The SPCT also supports ward staff to deliver care to patients at the end of life.

The trust had 2,370 deaths from August 2017 to July 2018.

The SPCT was available five days a week, from 9am to 5pm, Monday to Friday. There is an on-call telephone service by the registrar outside of these hours. A consultant provided on-call cover twenty-four hours a day.

A bereavement team provided support to relatives from Monday to Friday 9am to 5pm and a chaplaincy service was available to patients, relatives and staff, 24 hours a day, seven days a week. There is a clinical director with responsibility in their portfolio for end of life care.

The service was previously inspected in May 2015 and was rated overall as requires improvement.

We carried out the announced inspection of the end of life care service on the 30 and 31 January 2019 to enable us to observe routine activity. We visited medical and surgical wards, including the intensive care unit, accident and emergency department. We also visited the mortuary and the chapel. We spoke with five patients. We spoke with 25 members of staff including medical and nursing staff, allied health professionals, the SPCT, porters, mortuary and chaplaincy staff. We reviewed 10 patient care records and Do Not Attempt Cardiopulmonary Resuscitation orders on the medical records.

Summary of this service

Our rating of this service improved. We rated it as good because:

- The trust provided mandatory training in key end of life skills to all new staff at induction and at regular updates.
- There were enough staff with the right skills and experiences to ensure the delivery of care. Staff had access to professional development, were competent for their roles, and had opportunities for a review of their performance.
- Risk assessment of equipment and its availability had improved since the last inspection. There was greater oversight of competence for the use of specialised equipment.
- There was good multidisciplinary working. The specialist palliative care team worked closely with the local hospice and there was access to clinical expertise within the hospital.
- Care and treatment was delivered in line with evidence based national guidance such as National Institute for Health and Care Excellence (NICE) guidance.
- Patient outcomes were monitored and improved through participation in the national care of the dying audit and subsequent internal audits relating to the end of life care for the dying patient.

End of life care

- There were a range of training initiatives available for a variety of staff groups involved in end of life care so that staff had the skills, knowledge and experience to deliver effective end of life care.
- Patients at the end of life and those close to them were treated with kindness, respect and compassion. They were involved in making decisions about their care.
- There was a clear vision and strategy in place with identified priorities and monitoring of action taken by the end of life care team.
- Governance structures around end of life care were in place to ensure continuous improvement.
- There was a strong culture of quality end of life care across the trust, with active engagement, involvement, commitment and representation from a range of staff groups.

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good because:

- The trust provided mandatory training in key end of life skills to all new staff at induction. The specialist palliative care team were trained in the safety systems, processes and practices needed to deliver safe care.
- The service managed patient safety incidents well. Staff understood how to report incidents and shared lessons learned with the whole team and the wider hospital.
- The hospital-controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.
- The clinical areas we visited were visibly clean and well maintained by the staff.
- Records were generally clear, up-to-date, and available to all staff providing care.
- Staff within the service had all completed appropriate safeguarding training and all were up to date with their required mandatory training.
- The service prescribed, gave, recorded and stored medicines well. Patients received the right medicines at the right dose and at the right time. There was timely and appropriate prescribing of anticipatory medicines.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good because:

- Patient's needs were assessed, and care and treatment provided in line with evidence based guidance to achieve effective outcomes. End of life care was based on relevant National Institute for Health and Care Excellence (NICE) guidance and there was evidence of the review of national guidance as part of governance processes within the hospital.
- Patient's nutrition and hydration needs were identified and met in relation to national guidance for caring for people in the last days and hours of life.

End of life care

- Patient's care and treatment outcomes were monitored through trust participation in the national end of life care audit.
- The hospital ensured that staff had the skills, knowledge and experience to deliver effective end of life care.
- There was evidence of good multidisciplinary working. Clinical staff worked together across the hospital to deliver effective end of life care. This included engagement with a wide range of specialist services that provided end of life care services.
- The service monitored the effectiveness of care and treatment and used the findings to improve them. They collected and compared local results with those of other services to learn from them.
- Staff understood their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005. They knew how to support patients experiencing mental ill health and those who lacked the capacity to make decisions about their care.
- There was good documentation of do not resuscitate decisions which was available electronically in the EPR system. We were given examples of best interest decisions that had been held with patients.

However:

- The trust did not provide twenty-four-hour face to face service to support the care of patients at the end of life. They provided a seven-day visiting service for dying and palliative care patients and twenty-four-hour telephone advice service.

Is the service caring?

Good ➔➔

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

- Staff provided a caring, kind and compassionate care to end of life care patients. We saw examples of staff being supportive and kind to patients and their relatives.
- Feedback from patients and their relatives were positive.
- Observations of care showed staff-maintained patients' privacy and dignity, and patients and their families were involved in their care.
- The chaplaincy team offered emotional support to patients of all faith. Families could also access the bereavement team for support and follow up.
- Staff recognised and respected the totality of patient's needs. They always considered patient's personal, cultural, social and religious needs, and found innovative ways to meet them.
- Staff saw patient's emotional, psychological and social needs as being as important as their physical needs.
- Staff consideration of patient's privacy and dignity was consistently embedded in everything they did, including awareness of any specific needs as these were recorded and communicated.

Is the service responsive?

Good ↑

End of life care

Our rating of responsive improved. We rated it as good because:

- Staff were proactive in their approach to understanding individual patients' needs and wishes. They were positive in their approach to meeting the needs of vulnerable people.
- The end of life care team reacted promptly to referrals, usually within one working day. This meant that end of life care was begun appropriately and engaged those close to the patient.
- Rapid discharge was provided for patients when the appropriate packages of care or placements were available in the community.
- The bereavement and mortuary services provided a flexible and compassionate approach to meeting the individual needs of patients and their families.
- Patients were provided with good written information and appointments were arranged flexibly to meet individual needs.
- All clinical staff and volunteers who worked within the chaplaincy service, bereavement office and the mortuary were aware of and acted accordingly on cultural and religious differences in end of life care.
- Where possible patients approaching the end of their life were cared for in side rooms.
- Staff had access to translators when needed giving patients the opportunity to make decisions about their care, and day-to-day tasks.
- Visitors to the trust had access to a variety of information leaflets pertaining to end of life care.

Is the service well-led?

Good ↑

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

- The leadership of the service and staff at all levels had the right skills and experience to run a service providing high-quality sustainable end of life care.
- There was strong medical and nursing leadership in the service which was supported by the other partners in the delivery of end of life care to patients.
- The service had a vision for what it wanted to achieve. End of life priorities had been identified and there was an action plan in place for the service based on these priorities.
- Managers of the service promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values. Staff told us that there was a positive culture within the service and that they enjoyed working at the hospital.
- Staff told us they enjoyed caring for end of life patients and were aware of the end of life care strategy.
- Staff were aware of improvements which had taken place since our previous inspection. They saw these as positive recognitions of the importance of the service.
- End of life care had a clear governance framework, which ensured responsibilities were identified from the trust board, directors and managers through to ward staff. Performance measurements were monitored and addressed through the divisional and organisations' dashboard.

End of life care

- Clinical staff had access to accurate and comprehensive information on patients' care and treatment and could always access electronic records .
- The end of life care team and the bereavement office staff provided practical information and advice for relatives of the bereaved.

Outpatients

Requires improvement

Key facts and figures

Kings College Hospitals NHS Foundation Trust had 1.3 million outpatient attendances a year across four main sites and other community centres. This report relates to outpatient services at the King's College Hospital site. The service provided outpatient care and treatment for people of all ages.

The trust also provided several satellite dialysis units, for patients receiving dialysis treatment in the community. Staff at the units were employed by the trust, and medical staff from the King's College Hospital site visited the units at specified times to see patients.

Our inspection was announced (staff knew we were coming) on a short-notice basis, to ensure that everyone we needed to talk to was available.

The trust ran a wide range of outpatient clinics. During our inspection we visited clinics in the following specialities: clinical gerontology, dermatology, ophthalmology, stoma care, diabetic foot care, gastroenterology, general surgery, breast, cardiology, haematology, neurology, endocrinology and the pain clinic. We visited two satellite dialysis units – Dartford and Sydenham. We spoke to 54 members of staff including nurses, healthcare assistants, doctors of all grades, administrators, technicians, therapists and managers. We spoke to 16 patients and their relatives. We observed care in outpatient clinics and looked at six sets of patient records.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated outpatients as requires improvement because:

- The service did not take steps to ensure all staff completed the required mandatory training. Compliance rates for required safety related training amongst medical staff was poor.
- The service did not always have suitable premises or equipment and did not always look after them well.
- Patient's privacy and dignity was not always maintained due to the environments staff were working in, although staff tried their best to maintain standards where possible.
- Outpatient services showed generally poor performance in referral to treatment (RTT) and cancer waiting times. The trust was performing worse than the England average and national standard for both the RTT incomplete pathway, where patients should be seen within 18 weeks, and for urgent cancer referrals, where patients should be seen within two weeks. This meant the service was not always responsive and could not always meet patient urgent clinical needs in a timely manner.
- Services did not always provide the right information to service users prior to their appointments. Incorrect telephone numbers were often printed on appointment letters.
- Morale amongst administrative staff across most services was low.
- Not all risks on the risk register for OPD had not been reviewed recently, and it was not clear if all risks were being addressed.

Outpatients

- There were some additional plans for the long-term future of the OPD, but these were not an immediate priority due to the current challenges faced by the department. Plans did not always have clear timescales, and staff could not give examples of being involved in such plans.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Services were delivered and co-ordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.
- The trust used a mostly systematic approach to continually improving the quality of its service, with clear escalation and reporting structures.

Is the service safe?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated safe as requires improvement because:

- The service did not take robust steps to ensure all staff completed mandatory training. Compliance rates for required safety related training amongst medical staff were poor. This meant that not all medical staff had received training essential to providing safe patient care.
- The service did not always have suitable premises or equipment and did not always look after them well. For example, daily checking of resuscitation trolleys was inconsistent, and some items were out of date.
- Vacancy, turnover and sickness rates for nursing staff were higher (worse) than the trust target. This meant there were not always enough permanent nursing staff to care for patients in outpatients. It should be noted this varied by clinical speciality as outpatients was managed by several divisions.
- In Dartford Dialysis Unit, records were not always stored securely due to a lack of storage space. Staff remained vigilant to try to mitigate the risk of unauthorised persons accessing records, but this was not a reliable or long-term solution.

However:

- There were clear pathways and processes for the assessment of people within outpatient clinics who became unwell and needed hospital admission.
- The service-controlled infection risks well. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.

Outpatients

Is the service effective?

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We do not rate effective. However, we found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service mostly made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Is the service caring?

Good

We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff at all levels understood the impact that a patient's care, treatment or condition would have on their wellbeing and those close to them.
- Staff involved patients and those close to them in decisions about their care and treatment.

However:

- Patient's privacy and dignity was not always maintained due to the environments staff were working in, although staff tried their best to maintain standards where possible.

Is the service responsive?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated responsive as requires improvement because:

- The facilities in clinic areas we visited were not always appropriate and patient centred, due to restrictions on space. For example, the ophthalmology waiting area often became crowded, and about half of the self-check in screens we saw were broken.

Outpatients

- Patients we spoke to told us they did not always have a choice of appointment times, and they were not kept informed of waiting times when they arrived at clinics.
- Outpatient services showed generally poor performance in referral to treatment (RTT) and cancer waiting times. The trust was performing worse than the England average and national standard for both the RTT incomplete pathway, where patients should be seen within 18 weeks, and for urgent cancer referrals, where patients should be seen within two weeks. This meant the service was not always responsive and could not always meet patient urgent clinical needs in a timely manner.
- Services did not always provide the right information to service users prior to their appointments. For example, administrative staff told us that incorrect telephone numbers were often printed on appointment letters, meaning patients would often call through to the wrong department. Staff told us this was frustrating for patients and was the source of complaints.

However:

- The trust provided some specialist clinics for the local population.
- Services were delivered and co-ordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated well led as requires improvement because:

- Whilst there was work in progress to improve the outpatients service, there were several issues that remained outstanding. Many managers were new in post and motivated but had not had time to make any impact or improvement at the time of the inspection.
- Morale amongst administrative staff across most services was low. Administrative staff told us they were carrying a lot of stress and felt “drained”.
- Not all risks on the risk register had been reviewed recently, with the oldest review date being February 2018. This meant risk status may not have been addressed or updated for long periods of time, which was not good practice.
- There were some additional plans for the long-term future of the OPD, but these were not an immediate priority due to the current challenges faced by the department. Not all plans had clear timescales, and staff could not give examples of being involved in such plans.
- IT systems could be slow and caused problems with printers when trying to print appointment letters. This meant administrative staff had to make a note of the appointment made and reminders to send the letter out at a later date.
- Staff both on the main outpatient site and the dialysis units we visited told us they often had issues accessing mandatory training, due to slow running information technology systems.

However:

Outpatients

- The trust had a vision for what it wanted to achieve in the short term and workable plans to turn it into action, developed with some involvement from staff.
- The trust used a mostly systematic approach to continually improving the quality of its service, with clear escalation and reporting structures.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found six things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. For more information, see the Areas for improvement section of this report.

The service MUST:

- Improve medical staff compliance rates with mandatory training.
- Ensure that daily and weekly checks of resuscitation trolleys are consistently completed.

The service SHOULD:

- The trust should ensure it continues work to address the issues caused by unsuitable clinic environments, which impact upon patient safety and privacy.
- The trust should ensure it continues work to improve upon referral to treatment times.
- The trust should consider ways to improve vacancy, turnover and sickness rates to bring them into line with the trust target.
- The trust should ensure patient records cannot be accessed by unauthorised persons in Dartford Dialysis Unit.
- The trust should consider ways to develop a longer-term vision and strategy for the service and involve staff in this.
- The trust should consider ways to increase support for administrative staff across outpatients, particularly those taking calls from patients.

Princess Royal University Hospital

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Key facts and figures

Princess Royal University Hospital is located in Farnborough Common, Kent. It is managed by King's College Hospital NHS Foundation Trust. The hospital has 33 inpatient areas with 512 in patient beds. The hospital has an Accident and Emergency department, intensive care and other clinical areas, such as a planned investigation unit and special care baby unit. Outpatient services are provided at the hospital along with its south site; Beckenham Beacon and Queen Mary's Hospital in Sidcup and at Orpington Hospital. There is provision for diagnostic services, including x-ray, computerised tomography (CT) scans, magnetic resonance imaging (MRI) scans, ultrasound scans, mammography and interventional radiology. Nuclear medicine including diagnostic tests for a range of conditions are also available.

Allied health professions including physio and occupational therapists and dietitians are provided.

Services are available in most clinical areas 24 hours, seven days a week.

During the inspection we spoke with 156 staff from a range of roles and spoke with 57 patients and/or relatives. We reviewed 59 patient related records and considered other formal documentation.

Across the whole trust there were 176,545 inpatient admissions and 1,867207 outpatient appointments between July 2017 and June 2018.

Summary of services at Princess Royal University Hospital

Requires improvement ● →←

Our rating of services stayed the same. We rated it them as requires improvement because:

- Although the mandatory training completion rates had improved since our previous inspection, some subjects including the safeguarding of vulnerable people had not been completed by all the required staff.
- The environment in which people received treatment and care was not always suitably safe and risks had not been fully considered in some areas. The privacy of patients in some areas was less than expected.
- Equipment was not always checked, and some consumable items were out of date.
- Staffing in some areas was not always ideal, which impacted on the ability of staff to deliver timely holistic care. In some areas staff did not work effectively together and there were some variations in leadership style and department culture.

Summary of findings

- Medicine optimisation was not always achieved to a consistent level.
- Infection prevention and control practices were less than expected in some areas.
- Patient risk assessments and instructions were not completed with consistency, and treatment and care was not always provided in accordance with best practice guidance. The monitoring of effectiveness of treatment and care was not always reviewed.
- Patients could not access care and treatment in a timely way. Waiting times for treatment and arrangements to admit, treat and discharge patients were worse than the England average and national standard.

However:

- Staff were knowledgeable about the incident process and learning from incidents were discussed in departmental and governance meetings and action was taken to follow up on the results of investigations.
- Staff understood their responsibilities to protect people from avoidable harm and were knowledgeable about safeguarding procedures. They were also aware of their responsibilities under the mental capacity act.
- Staff had opportunities for professional development and were competent to perform the required treatment and care in their respective areas.
- There had been improvements in palliative care provision with the introduction of a clinical nurse specialist seven-day service since April 2018.
- Services were generally arranged and delivered considering the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.

Urgent and emergency services

Inadequate 

Key facts and figures

Details of emergency departments and other urgent and emergency care services

The emergency department (ED) at the Princess Royal University Hospital (PRUH) is open 24 hours a day, seven days a week. It sees approximately 5500 patients per month with serious and life-threatening emergencies and is also a Hyper Acute Stroke Unit (HASU).

The department includes a paediatric emergency department dealing with all emergency attendances under the age of 18 years with approximately 900 attendances per month.

Patients present to the department either by walking into the reception area or arrive by ambulance via a dedicated ambulance-only entrance. Patients transporting themselves to the department are seen initially by a nurse from a co-located urgent care centre (UCC) and, if determined suitable to be treated in the ED await triage (Triage is the process of determining the priority of patients' treatments based on the severity of their condition). The UCC is managed by a different provider and was not part of the inspection.

The department has different areas where patients are treated depending on their needs, including a resuscitation area, two major's areas, and a 'sub-acute' area for patients with less serious needs, and a clinical decision unit (CDU). A separate paediatric ED with its own waiting area, cubicles and CDU is within the department.

We visited the ED over three days during our unannounced inspection and returned unannounced during a weekend. We looked at all areas of the department and we observed care and treatment. We looked at 30 sets of patient records. We spoke with 35 members of staff, including nurses, doctors, allied health professionals, managers, support staff and ambulance crews. We also spoke with 19 patients and eight relatives who were using the service at the time of our inspection. We reviewed and used information provided by the organisation in making our decisions about the service.

Summary of this service

Our rating of this service went down. We rated it as inadequate because:

- Patients were not always protected from avoidable harm. There were significant handover delays for patients arriving by ambulance. The management of patients requiring resuscitation was poor due to flow challenges across the emergency care pathway.
- Staffing levels and skill mix were not sufficient to meet the needs of patients as a result; patients did not have their care and treatment carried out in a timely manner.
- The emergency department did not manage patient safety incidents well. Whilst staff recognised the types of incidents they should report, including near misses, lessons learned were not always effectively introduced across the department resulting in similar incidents occurring.
- The layout of the emergency department was not suitable for the number of admissions the service received. There was significant overcrowding, and, at times, patients were being cared for on trolleys along corridors. At times, two patients were nursed in cubicles designed for only one person. There continued to exist inherent ligature risks. Equipment was not consistently checked, and a range of consumable equipment was found which had expired.

Urgent and emergency services

- Staff did not always work together as a team to deliver effective care and treatment. There was not always consistency in working practices, practices would change daily, depending on who was leading the team that day. Medical staff faced challenges when referring patients to individual specialties, with patients often waiting a significant length of time to be seen.
- Patients were not always involved and treated with compassion, kindness, dignity and respect.
- Patients could not access care and treatment in a timely way. Waiting times for treatment and arrangements to admit, treat and discharge patients were worse than the England average and national standard.
- There was not the leadership capacity and capability to deliver high-quality, sustainable care. Leadership within the department was not effective, there did not appear to be one individual taking overall responsibility for the day to day running of the department. Front line staff did not feel supported, respected or valued by their immediate line manager(s). Staff were not engaged and morale in the department was low; frustrations around leadership, low staffing, capacity and flow and the environment had led to a culture of acceptance with staff lacking the drive to challenge systems and processes within the department.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate because:

- **The service provided mandatory training in key skills and topics to all staff but did not ensure everyone had completed it.**
- **The service failed to control infection risks fully. Whilst the environment was kept clean, control measures to prevent the spread of infections were poorly complied with.**
- **Resuscitation equipment was not always safe and ready for use in an emergency. Gaps in records suggested equipment had not been checked in line with trust policy. A range of consumable, single use equipment had expired but remained accessible for use.**
- **Patients were observed being treated in parts of the emergency department which were not fit for purpose.**
- **There was a lack of consideration given to ligature points and other environmental factors that could allow patients with suicidal tendencies to come to harm.**
- **There was no effective system in place to assess and monitor the ongoing care and treatment to patients whilst in the emergency department. Patients at risk of falls were not always identified and therefore risks were not always mitigated in a timely way. This was despite this being an area of long-standing concerns.**
- **Staff did not always best practice when storing, supplying, preparing or administering medicines.**
- **The service did not manage patient safety incidents well. Whilst staff recognised the types of incidents they should report, including near misses, there was limited evidence of lessons being learnt following serious incidents. There was variability against compliance with the duty of candour regulations.**
- **The service did not employ or deploy enough staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and abuse and to provide the right care and treatment.**

However:

Urgent and emergency services

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

Is the service effective?

Requires improvement  

Our rating of effective went down. We rated it as requires improvement because:

- **The service provided care and treatment based on national guidance and evidence of its effectiveness. However, a range of policies and clinical guidelines had expired.**
- **Staff gave patients on the clinical decision's unit enough food and drink to meet their needs and improve their health. However, the fluid and nutritional needs of patients in the major's area were not always assessed or met in a timely way.**
- **There were arrangements to ensure staff were appraised by managers. However, only 74% of staff had been appraised compared to a trust target of 90%.**

However:

- **Patients had their pain assessed and managed in line with the Core Standards for Pain Management Services in the UK (2015).**
- **Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.**
- **The number of patients who reattended the department within seven days was general lower (better) than the England average.**
- **Staff with different roles worked together as a team to benefit patients. Nurses and other healthcare professionals supported each other to provide care within the frailty pathway.**
- **Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.**

Is the service caring?

Requires improvement  

Our rating of caring went down. We rated it as requires improvement because:

- **The trust's urgent and emergency care Friends and Family Test performance (% recommended) was worse than the England average from October 2017 to September 2018.**
- **Some staff displayed an apathy towards patients and visitors. Whilst patients were complimentary about the attitudes of staff, our observations suggested staff did not always put the needs of patients first.**
- **During times of surge and peak activity, two patients were nursed in cubicles designed for only one person. This had become accepted practice amongst staff.**
- **Staff did not always provide emotional support to relatives.**

Urgent and emergency services

Is the service responsive?

Inadequate 

Our rating of responsive went down. We rated it as inadequate because:

- **The trust continued to fail to meet constitutional performance targets. Data suggested further deterioration in key performance indicators. Previous improvements had not been sustained.**
- **The total time in A&E the ED (average per patient) for the hospital was consistently significantly higher than the national average.**
- **Although staff could demonstrate an understanding of the needs of the local population, services were not planned or delivered in a way which met those needs. Previously introduced initiatives including a consultant-led frailty pathway was no longer delivering the same level of service due to the very limited availability of consultant geriatricians.**
- **The individual needs of patients were not always assessed or delivered. Vulnerable patients experienced delays in their care due to poor patient flow across both the department and wider hospital.**

However

- **The percentage of patients who left the department without being seen was lower (better) than the England average.**
- **Complaints were responded to in line with trust timescales.**

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate because:

- **The department continued to be led by a level of interim cover. This led to "Change fatigue". Managers did not always have the right skills and abilities to run a service, which impacted on the ability of the trust to provide high-quality sustainable care.**
- **There was no clear vision or strategy for the emergency department. Whilst there was several business cases and action plans, there was no strong supporting mechanisms to describe how these would be delivered.**
- **Morale across the department was low.**
- **There was a consensus amongst front line staff that organisational leadership was poor and inconsistent; and had a view the executive did not understand the challenges of the department. In comparison, organisational leaders considered the challenges of poor performance to be associated with the behaviours and attitudes of staff in the department and across the wider hospital. It was apparent through our interviews with staff that a "Done too" culture existed amongst staff in the emergency department. Learned helplessness and a lack of accountability both contributed to a lack of change across the emergency department.**

Urgent and emergency services

- **There was no clear local ownership of the non-admitted pathway breaches which occurred on a frequent basis. Data presented in the "Access and Flow" section of this report reflects the lack of impact any improvement initiatives have had in the department. Most noticeably, performance against the non-admitted pathway remains stagnant whilst performance against the number of patients in the "Majors" admitted pathway" were seeing increasingly longer waits.**
- **There was a sense of reactive firefighting across the emergency care pathway as compared to there being a joined-up approach. Escalation protocols were weak and had little impact on assisting the emergency department to decompress. Delays in specialities reviewing their patients were observed; there was a lack of escalation to more senior clinical decision makers.**
- **Minutes of the ED governance meeting were high level and often lacked any significant detail. Whilst risks were discussed, there appeared little insight in to why developments or progress had not been made. Performance and quality trajectory graphs showed consistent "yo-yo" performance, with improvements made one month and then deteriorating performance the following.**
- **Whilst staff reported actions and work plans to resolve areas of challenge and risk, sustained non-compliance and poor performance was suggestive of a lack of insight in to the real challenges of the department and wider hospital operational workings. Repeated poor performance had appeared to go unchallenged, with a level of acceptance apparent due to a lack of grip and robust action to resolve what were, long standing issues.**

Areas for improvement

The trust must ensure that:

- The trust must ensure staff receive mandatory training in accordance with trust policies
- The trust must ensure patients have their clinical needs assessed and care delivered in accordance with national best practice standards, and within nationally defined timescales.
- The trust must ensure the environment and equipment is suitable and fit for purpose.
- The trust must ensure staff comply with trust infection control protocols.
- The trust must ensure medicines are managed, stored, supplied and administered in accordance with trust and national policy.
- The trust must ensure learning from incidents is identified, and actions instigated, without delay to reduce the likelyhood of similar incidents occurring again.
- The trust must ensure the service consistently complies with the regulatory requirements of the duty of candour
- The trust must ensure guidelines are up-to-date and reflect national best practice.
- The trust must ensure patients and visitors are treated with kindness and compassion.
- The trust must ensure the governance arrangements are reviewed so that reporting is consistent with defined trust governance structures. Information must be considered in the round and used to improve the quality and safety of care delivered across the emergency pathway.
- The trust should ensure staff are appraised in accordance with trust policies.
- The trust should ensure speciality doctors review their patients within defined timescales to reduce the occurrence of breaches associated with delayed speciality reviews.

Urgent and emergency services

- The trust should consider how it can introduce a robust action plan which addresses the multi-factorial flow challenges within the emergency care pathway.
- The trust should ensure there are sufficient nursing and medical staff working in the ED to meet patient needs.

Surgery

Requires improvement 

Key facts and figures

Princess Royal University Hospital (PRUH) provided care and treatment for patients undergoing general and specialist surgery. This includes urology, trauma and orthopaedics, geriatrics, gynaecology, colorectal, bariatrics, ophthalmology and endoscopy services.

Surgical services consist of 110 beds across five surgical wards, six main operating theatres and a recovery unit, the day surgery unit and the endoscopy unit.

The endoscopy unit consist of a nine-bedded admission and recovery area, and two procedure rooms.

The Alan Cumming Day Surgery Unit is a standalone unit consisting of a large reception area, 30 trolley beds, six theatres, a six-bedded recovery area, an ophthalmology waiting area, a discharge room and two pre-assessment rooms.

The service had 30033 surgical admissions between January and December 2018. Of these, 4782 were elective admissions, 14259 were day cases and 10992 were emergency admissions.

In addition, 7461 patients were admitted for endoscopy procedures between January and December 2018.We visited five surgical wards and theatres, the endoscopy unit and the day surgery unit during our inspection from 30 January 2019 to 1 February 2019. We spoke with 28 members of staff including consultants, junior doctors, nurses, allied health professionals and ancillary staff. We spoke with 12 patients and three relatives. We also spoke with four parents who accompanied their children to the day surgery unit at the time of our inspection. We reviewed 11 patient records and prescription charts.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- There had been no improvements in mandatory training completion rates for medical staff since our last inspection. The 80% target was not met for any of the 22 mandatory training modules for which medical staff were eligible.
- Safeguarding training completion rates for medical staff were below the trust target with completion rates as low as 12% for level 3 safeguarding children training.
- The endoscopy unit was not suitable and there were insufficient procedure rooms to meet the demands for the service. Endoscopy decontamination took place in theatres due to space constraints. Decontamination of endoscopes was carried out in a room used for both clean and dirty equipment.
- Plans to improve endoscopy services had not been implemented since our last inspection.
- Medicine audit results showed the service performed below trust standards for a number of indicators.
- Vacancy rates for medical staff were worse than the trust's target.
- Staff felt there was a disparity in the way resources were allocated across trust sites.
- The trust did not always provide services in a way that met the needs of local people. There was a significant number of medical outliers in surgical wards. Mixed specialities were admitted on surgical wards due to bed pressures.
- Waiting times from referral to treatment were not always in line with good practice.

Surgery

However:

- Nurse staffing had improved since our last inspection. The service had enough nursing staff with the right mix of qualifications and skills, to keep patients safe and provide the right care and treatment.
- Staff kept records of patients' care and treatment. Staff completed risk assessments and followed escalation protocols for deteriorating patients.
- There were effective systems to protect people from avoidable harm. Learning from incidents were discussed in departmental and governance meetings and action was taken to follow up on the results of investigations.
- Staff provided evidence-based care and treatment in line with national guidelines and local policies. There was a program of local audits to improve patient care.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Staff were aware of their responsibilities under the mental capacity act.
- There was effective multidisciplinary working, including liaison with community teams, to facilitate timely discharge planning.
- Feedback for the services inspected were positive. Staff respected confidentiality, dignity and privacy of patients.
- There was good local leadership on surgical units. Staff felt valued and they were supported in their role. There was a good governance structure, both within surgical care and within the directorate.

Is the service safe?

Requires improvement 

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

- Mandatory training completion rates for medical staff were below the trust target. The target was not met for any of the mandatory training modules. These included key modules, such as safeguarding, infection control, resuscitation, and mental capacity and consent.
- The endoscopy unit environment was insufficient to meet the demands for the service. Patients were waiting longer than they should be for endoscopies. Endoscopy decontamination took place in theatres due to space constraints.
- Although there were systems to ensure the safe supply and administration of medicines, some medicine audit results were below trust standards.
- There were high vacancy rates for medical staff.

However:

- Nurse staffing had improved since our last inspection and the service had enough nursing staff to support safe care.
- Staff understood how to protect patients from avoidable harm, and the service managed patient safety incidents well.
- Patients' care and treatment records were clear, up-to-date and easily available to all staff providing care.

Surgery

Is the service effective?

Good ➔➔

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

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed best practices.
- Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.
- Staff assessed and monitored patients regularly to see if they were in pain.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them.
- The service made sure staff were competent for their roles. Managers appraised staff's work performance.
- Staff worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care.

Is the service caring?

Good ➔➔

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

- Staff cared for patients with compassion. Feedback from patients confirmed staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress.
- Staff involved patients and those close to them in decisions about their care and treatment.

Is the service responsive?

Requires improvement ➔➔

Our rating of responsive stayed the same. We rated it as requires improvement because:

- The trust did not always provide services in a way that met the needs of local people. There were frequent on the day cancellations. There were a significant number of non-surgical patients on surgical wards and patients were sometimes recovered in theatres.
- People could not always access the service when they needed it. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with good practice.

However:

- The service took account of patients' individual needs. Staff treated concerns and complaints seriously, investigated them. Lessons from the results were shared with all staff.

Surgery

Is the service well-led?

Good ➔➔

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

- Managers had the right skills and abilities to run a service providing sustainable care.
- Managers promoted a positive culture, which supported and valued staff. There was a sense of common purpose based on shared values and quality of care.
- The trust used a systematic approach to continually improve the quality of its services.
- The surgical team used a systematic approach to improve the quality of its services and care. Staff in surgery were committed to improving services by learning and undertaking training.
- The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected.

However:

- Staff felt there was a disparity in the way resources were allocated across trust sites.
- Issues regarding the provision of endoscopy services remained a risk on the risk register since our last inspection. The trust had not implemented plans regarding this service.

Areas for improvement

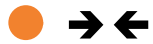
Action the provider MUST take to improve:

- The trust must make sure surgical staff complete mandatory training.

Action the provider SHOULD take to improve:

- The trust should ensure there are suitable endoscopy facilities to meet the demands for the service.
- The trust should consider how it may improve referral to treatment times to ensure they are in line with national standards.
- The trust should ensure patients are cared for in areas that are appropriate and meet all their needs.
- The trust should work to improve access and flow within surgical services.
- The trust should work to improve medicines audit ratings for surgical services.

End of life care

Requires improvement 

Key facts and figures

The Princess Royal University Hospital is part of Kings College Hospital NHS Trust and provides end of life care to patients across all clinical areas and treats patients with a variety of conditions, including cancer, liver disease, stroke, cardiac and respiratory disease.

The hospital does not have a dedicated ward for end of life care. The specialist palliative care team (SPCT), which consists of specialist consultants, clinical nurse specialists and a social worker provide advice, assessment and treatment to patients across all clinical areas within the hospital. The SPCT also supports ward staff to deliver care to patients at the end of their life.

There were 1,175 deaths at the Princess Royal University Hospital from January 2018 to December 2018. The trust submitted data which showed there were 1,329 inpatient referrals to and seen by the specialist palliative care team (SPCT) between August 2017 to July 2018. This included 996 new referrals. Of these, 36% were for patients with a main diagnosis of cancer, and 60% were for patients with non-cancer diagnoses.

The clinical director is responsible for end of life care at the Princess Royal University Hospital and King's College Hospital. The clinical nurse specialists provide a service between 9am and 5pm Monday to Sunday, including bank holidays. Consultants provide a service between 9am and 5pm Monday to Friday and telephone on-call outside of these hours.

The chaplaincy service is available to patients, relatives and staff, 24 hours a day, seven days a week.

The service was previously inspected in May 2015 and was rated overall as requires improvement.

Our inspection was announced (staff knew we were coming) on a short-notice basis, to ensure that everyone we needed to talk to was available. We carried out the inspection of the end of life care service on the 30 and 31 January 2019 to enable us to observe routine activity. We visited medical and surgical wards, including the intensive care unit, stroke unit, discharge lounge and accident and emergency department. We also visited the mortuary and the chapel.

We spoke with two patients and four relatives. We spoke with 39 members of staff including medical and nursing staff, allied health professionals, healthcare assistants, the SPCT members, porters, mortuary and chaplaincy staff. We reviewed twelve patient care records and five Do Not Attempt Cardiopulmonary Resuscitation orders on the medical records.

Summary of this service

Our rating of this service stayed the same. We rated it as requires improvement because:

- The service did not always provide care and treatment based on national guidance or evidence its effectiveness.
- Staff did not always complete and update risk assessments for each patient or have an action plan to address any identified risk. We found little evidence of individualised planning or regular review of the dying patient in place.
- The end of life care plan was not integrated into the electronic patient record and we were not assured there was an identified date by which this would be available.
- There was incomplete documentation of discussions with relatives when recoding 'do not attempt cardio pulmonary resuscitation' status on patient treatment escalation plans (TEP).

End of life care

- There was no on-site consultant presence at weekends.
- It was not always clear whether all patients were offered the opportunity to meet with a member of the chaplaincy.

However:

- There was an improved palliative care clinical nurse specialist seven-day service introduced in April 2018. Referrals to the SPCT were responded to in a timely manner with 91% of referrals seen within one day of referral and 98% within three days.
- The specialist palliative care team (SPCT) now included a palliative care social worker who provided emotional support for patients and their families.
- There was improved weekday on-site provision of palliative care medical staff with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment.
- Patients and their family members told us staff treated them with dignity, respect and compassion. They said staff explained what was happening and were caring. There were no visiting time restrictions for family and friends in the last days or hours of a person's life.
- End of life care had a clear governance framework. This ensured responsibilities for end of life care went right up to trust board level. End of life priorities had been identified and there was an action plan for the service based on these priorities.

Is the service safe?

Requires improvement

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

- We found little evidence of individualised care plans or regular monitoring for comfort and the end of life care plan was not integrated into the electronic patient record.
- Staff did not always complete and update risk assessments for each patient.
- There was incomplete documentation of 'do not attempt cardio pulmonary resuscitation' status on patient treatment escalation plans (TEP).

However:

- The service had enough nursing staff, with the right mix of qualification and skills, to keep patients safe and provide the right care and treatment. The service had been enhanced by having more on-site provision of medical staff with the right skills.
- The service provided mandatory training in key skills to all staff and made sure everyone completed it. Staff had training on how to recognise and report abuse, and they knew what to do in such situations.

Is the service effective?

Requires improvement

Our rating of effective stayed the same. We rated it as requires improvement because:

- The service did not always provide care and treatment based on national guidance or evidence its effectiveness.

End of life care

- Similar to our findings at the last CQC inspection in May 2015, there were no care plans and review system for care of the dying patient readily accessible to nursing or clinical staff on the wards. As a result, not all aspects of NICE guidance NG31 'Care of dying adults in the last days of life' were followed.
- Staff did not always complete and update risk assessments for each patient. Action plans to address the identified risk were not always updated.
- Electronically recorded 'do not attempt cardio pulmonary resuscitation' status on patient treatment escalation plans did not always record discussions with family; this was similar to findings at the last CQC inspection in 2015.
- There was no seven-day week on-site consultant cover. They provided a telephone on-call service between 5pm and 9am Monday to Friday, and 24-hour telephone on-call at weekends.

However:

- Staff were regularly appraised and so the service made sure they were competent for their roles.

Is the service caring?

Good ➔➔

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

- Patients and their family members told us staff treated them with dignity, respect and compassion. We observed several examples of staff interacting with patients and those close to them with kindness and dignity.
- Staff provided emotional support to patients and their families to minimise their distress.
- Additional emotional support for patients and their families was available from the recently established palliative care social work service.

Is the service responsive?

Good ➔

Our rating of responsive improved. We rated it as good because:

- The hospital planned and provided services in a way that met the needs of local people. Referrals to the specialist palliative care team (SPCT) could be made any time during a patient's treatment. The SPCT responded quickly when asked to review a patient and were most likely to be called when a patient presented with challenging pain and symptom management needs.
- Ninety-one per cent (1,160) of referrals were seen by the specialist palliative care team within one day of referral and 98% within three days. The staff took account of patients' individual needs in planning their care.
- There was an improved seven-day service provided by the palliative care clinical nurse specialists introduced in April 2018.
- The specialist palliative care team now obtained parking permits for relatives who stayed for prolonged periods of time with their dying relative. There were no visiting time restrictions in the last days or hours of life, which allowed family and friends unlimited time with the patient.

End of life care

- The addition of a palliative care social worker (in January 2018) to the SPCT made a positive difference to patients at the end of life and their relatives. The social worker offered group and individual sessions which allowed them to explore the practical and emotional aspects of death and dying.
- Arrangements were in place to ensure documentation needed to help with the registration of death was handled swiftly.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

However:

- The 2016 audit of preferred place of care and preferred place of death concluded there was under recording within the palliative care database of patient preferences. A re-audit was recommended which had not yet happened. The trust submitted data which showed that of the total number of referrals to the SPCT, 23% of patients were discharged home, 5% were discharged to a hospice and 7% were discharged to a care home. It was not always clear whether all patients were offered the opportunity to meet with a member of the chaplaincy team in accordance with the 'priorities of care of the dying patient'.
- Family members who wished to stay overnight did not always have access to a folding bed since there was just one allocated per floor.

Is the service well-led?

Good ↑

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

- Managers at all levels in the service had the right skills and abilities to run a service providing sustainable care. They promoted a positive culture that supported and valued staff, creating a sense of common purpose based on shared values.
- End of life care had a clear governance framework, and the service used a systematic approach to continually improve the quality of its services. Information about end of life care, including risks and performance went up to trust board level. There was an up to date cross site palliative care risk register which reflected the risks staff told us about throughout our inspection.
- The service had a vision for what it wanted to achieve. End of life priorities had been identified and there was an action plan for the service based on these priorities.
- Staff we spoke with within the SPCT understood their role in delivering the end of life care strategy and reviewed progress against key milestones set out in the strategy document.

However:

- At the time of the inspection no assurance was given to inspectors about a timescale for when an end of life care plan would be embedded in the electronic patient record.

Areas for improvement

We found areas for improvement in this service.

Action the hospital SHOULD take to improve:

End of life care

- The provider should ensure that all aspects of NICE guidance NG31 'Care of dying adults in the last days of life' are followed.
- The provider should ensure there is a plan to integrate an end of life care plan into the electronic patient record as soon as possible.
- The provider should ensure there are individualised care plans to enable staff to identify appropriate end of life care specific to each patient.
- The provider should ensure staff complete and update risk assessments for each patient such as a malnutrition universal screening tool (MUST) risk assessment score.
- The provider should ensure that there is improved documentation of 'do not attempt cardio pulmonary resuscitation' status on patient treatment escalation plans (TEP).
- The provider should ensure there is improvement in recording of preferred place of care and preferred place of death within the palliative care database.
- The provider should ensure patients are offered the opportunity to meet with a member of the chaplaincy in accordance with the 'priorities of care of the dying patient'.

Outpatients

Requires improvement

Key facts and figures

Kings College Hospital NHS Foundation Trust have 1.3 million outpatient attendances a year across four main sites and other community centres. Each of the trust three divisions are responsible for their own outpatient service delivery and quality. The Princess Royal and south sites had a single central booking team, while King's College Hospital had separate booking function/teams for a variety of services across the Divisions.

Between January and November 2018, the trust reported over 72,000 first and over 228,000 follow-up attendances in outpatient services across The Princess Royal and south sites

During our inspection we visited outpatient services at the Princess Royal University Hospital (PRUH), Queen Mary's Hospital at Sidcup (QMS) and Beckenham Beacon. We visited clinics in the following specialities: colorectal surgery, renal medicine, general surgery, trauma and orthopaedics, ophthalmology, dermatology, urology, haematology and the phlebotomy service. We spoke to 35 members of staff including nurses, healthcare assistants, doctors of all grades, administrators, technicians and managers.

We spoke to 10 patients and their relatives. We observed care in outpatient clinics and looked at nine sets of patient records.

Summary of this service

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated outpatients as requires improvement because:

- The service did not take steps to ensure all staff completed the required mandatory training. Compliance rates for required safety related training amongst medical staff was poor.
- The service did not always have suitable premises or equipment and did not always look after them well.
- Patient's privacy and dignity was not always maintained due to the environments staff were working in, although staff tried their best to maintain standards where possible.
- Outpatient services showed generally poor performance in referral to treatment (RTT) and cancer waiting times. The trust was performing worse than the England average and national standard for both the RTT incomplete pathway, where patients should be seen within 18 weeks, and for urgent cancer referrals, where patients should be seen within two weeks. This meant the service was not always responsive and could not always meet patient urgent clinical needs in a timely manner.
- Services did not always provide the right information to service users prior to their appointments. Incorrect telephone numbers were often printed on appointment letters.
- Morale amongst administrative staff across most services was low.
- Not all risks on the risk register for OPD had not been reviewed recently, and it was not clear if all risks were being addressed.

Outpatients

- There were some additional plans for the long-term future of the OPD, but these were not an immediate priority due to the current challenges faced by the department. Plans did not always have clear timescales, and staff could not give examples of being involved in such plans.

However:

- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Services were delivered and co-ordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.
- The trust used a mostly systematic approach to continually improving the quality of its service, with clear escalation and reporting structures.

Is the service safe?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated safe as requires improvement because:

- The service did not take robust steps to ensure all staff completed mandatory training. Compliance rates for required safety related training amongst medical staff were poor. This meant that not all medical staff had received training essential to providing safe patient care.
- The service did not always have suitable premises or equipment and did not always look after them well. For example, daily checking of resuscitation trolleys was inconsistent, and some items were out of date.
- Vacancy, turnover and sickness rates for nursing staff were higher (worse) than the trust target. This meant there were not always sufficient levels of permanent nursing staff to care for patients in outpatients.
- In Dartford Dialysis Unit, records were not always stored securely due to a lack of storage space. Staff remained vigilant to try to mitigate the risk of unauthorised persons accessing records, but this was not a reliable or long-term solution.

However:

- There were clear pathways and processes for the assessment of people within outpatient clinics who became unwell and needed hospital admission.
- The service-controlled infection risk well. Staff kept themselves, equipment and the premises visibly clean. They used control measures to prevent the spread of infection.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service

Outpatients

Is the service effective?

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We do not rate effective. However, we found the following areas of good practice:

- The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
- Managers monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
- The service mostly made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and monitor the effectiveness of the service.
- Staff of different kinds worked together as a team to benefit patients. Doctors, nurses and other healthcare professionals supported each other to provide good care.
- Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They followed the trust policy and procedures when a patient could not give consent.

Is the service caring?

Good

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated caring as good because:

- Staff cared for patients with compassion. Feedback from patients confirmed that staff treated them well and with kindness.
- Staff provided emotional support to patients to minimise their distress. Staff at all levels understood the impact that a patient's care, treatment or condition would have on their wellbeing and those close to them.
- Staff involved patients and those close to them in decisions about their care and treatment.

However:

- Patient's privacy and dignity was not always maintained due to the environments staff were working in, although staff tried their best to maintain standards where possible.

Is the service responsive?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated responsive as requires improvement because:

- The facilities in clinic areas we visited were not always appropriate and patient centred, due to restrictions on space. For example, the ophthalmology waiting area often became crowded, and about half of the self-check in screens we saw were broken.

Outpatients

- Patients we spoke to told us they did not always have a choice of appointment times, and they were not kept informed of waiting times when they arrived at clinics.
- Outpatient services showed generally poor performance in referral to treatment (RTT) and cancer waiting times. The trust was performing worse than the England average and national standard for both the RTT incomplete pathway, where patients should be seen within 18 weeks, and for urgent cancer referrals, where patients should be seen within two weeks. This meant the service was not always responsive and could not always meet patient urgent clinical needs in a timely manner.
- Services did not always provide the right information to service users prior to their appointments. For example, administrative staff told us that incorrect telephone numbers were often printed on appointment letters, meaning patients would often call through to the wrong department. Staff told us this was frustrating for patients and was the source of complaints.

However:

- The trust provided some specialist clinics for the local population.
- Services were delivered and co-ordinated to take account of the needs of different people, including those with protected characteristics under the Equality Act and those in vulnerable circumstances.
- The service treated concerns and complaints seriously, investigated them and learned lessons from the results, and shared these with all staff.

Is the service well-led?

Requires improvement

We previously inspected outpatients jointly with diagnostic imaging so we cannot compare our new ratings directly with previous ratings. We rated well led as requires improvement because:

- Whilst there was work in progress to improve the outpatients service, there were several issues that remained outstanding. Many managers were new in post and motivated but had not had time to make any impact or improvement at the time of the inspection.
- Morale amongst administrative staff across most services was low. Administrative staff told us they were carrying a lot of stress and felt “drained”.
- Not all risks on the risk register had been reviewed recently, with the oldest review date being February 2018. This meant risk status may not have been addressed or updated for long periods of time, which was not good practice.
- There were some additional plans for the long-term future of the OPD, but these were not an immediate priority due to the current challenges faced by the department. Not all plans had clear timescales, and staff could not give examples of being involved in such plans.
- IT systems could be slow and caused problems with printers when trying to print appointment letters. This meant administrative staff had to make a note of the appointment made and reminders to send the letter out at a later date.
- Staff both on the main outpatient site and the dialysis units we visited told us they often had issues accessing mandatory training.

However:

Outpatients

- The trust had a vision for what it wanted to achieve in the short term and workable plans to turn it into action, developed with some involvement from staff.
- The trust used a mostly systematic approach to continually improving the quality of its service, with clear escalation and reporting structures.
- The trust collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Areas for improvement

We found areas for improvement including two breaches of legal requirements that the trust must put right. We found six things that the trust should improve to comply with a minor breach that did not justify regulatory action, to prevent breaching a legal requirement, or to improve service quality. For more information, see the Areas for improvement section of this report.

The service MUST:

- Improve medical staff compliance rates with mandatory training.
- Ensure that daily and weekly checks of resuscitation trolleys are consistently completed.

The service SHOULD:

- The trust should ensure it continues work to address the issues caused by unsuitable clinic environments, which impact upon patient safety and privacy.
- The trust should ensure it continues work to improve upon referral to treatment times.
- The trust should consider ways to improve vacancy, turnover and sickness rates to bring them into line with the trust target.
- The trust should ensure patient records cannot be accessed by unauthorised persons in Dartford Dialysis Unit.
- The trust should consider ways to develop a longer-term vision and strategy for the service and involve staff in this.
- The trust should consider ways to increase support for administrative staff across outpatients, particularly those taking calls from patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that the service provider was not meeting. The provider must send CQC a report that says what action it is going to take to meet these requirements.

For more information on things the provider must improve, see the Areas for improvement section above.

Please note: Regulatory action relating to primary medical services and adult social care services we inspected appears in the separate reports on individual services (available on our website www.cqc.org.uk)

This guidance (see goo.gl/Y1dLhz) describes how providers and managers can meet the regulations. These include the fundamental standards – the standards below which care must never fall.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes

Regulated activity	Regulation
Diagnostic and screening procedures Nursing care Surgical procedures Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Enforcement actions

We took enforcement action because the quality of healthcare required significant improvement.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Section 29A HSCA Warning notice: quality of health care

Regulated activity	Regulation
Treatment of disease, disorder or injury	S29A Warning Notice: quality of healthcare

Regulated activity	Regulation
Treatment of disease, disorder or injury	S29A Warning Notice: quality of healthcare

Our inspection team

Stella Franklin, Inspection Managerled the inspection. An executive reviewer, Christine Outram, supported our inspection of well-led for the trust overall.

The team included two Inspection managers, 12 inspectors,one assistant inspector, one pharmacy inspector, 18 specialist advisers and three observers.

Executive reviewers are senior healthcare managers who support our inspections of the leadership of trusts. Specialist advisers are experts in their field who we do not directly employ.

King's College Hospitals NHS Foundation Trust

Use of Resources assessment report

King's College Hospital
Denmark Hill
London
SE5 9RS

Tel: 020 3299 9000
www.kch.nhs.uk

Date of publication: 12 June 2019

This report describes our judgement of the Use of Resources and our combined rating for quality and resources for the trust.

Ratings

Overall quality rating for this trust	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive?	**Requires improvement**
Are services well-led?	**Requires improvement**

Our overall quality rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led. These ratings are based on what we found when we inspected, and other information available to us. You can find information about these ratings in our inspection report for this trust and in the related evidence appendix. (See www.cqc.org.uk/provider/RF4/reports)

Are resources used productively?	**Inadequate**

Combined rating for quality and use of resources	**Requires improvement**

We award the Use of Resources rating based on an assessment carried out by NHS Improvement.

Our combined rating for Quality and Use of Resources summarises the performance of the trust taking into account the quality of services as well as the trust's productivity and sustainability. This rating combines our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating.

Use of Resources assessment and rating

NHS Improvement are currently planning to assess all non-specialist acute NHS trusts and foundation trusts for their Use of Resources assessments.

The aim of the assessment is to improve understanding of how productively trusts are using their resources to provide high quality and sustainable care for patients. The assessment includes an analysis of trust performance against a selection of initial metrics, using local intelligence, and other evidence. This analysis is followed by a qualitative assessment by a team from NHS Improvement during a one-day site visit to the trust.

Combined rating for Quality and Use of Resources

Our combined rating for Quality and Use of Resources is awarded by combining our five trust-level quality ratings of safe, effective, caring, responsive and well-led with the Use of Resources rating, using the ratings principles included in our guidance for NHS trusts.

This is the first time that we have awarded a combined rating for Quality and Use of Resources at this trust. The combined rating for Quality and Use of Resources for this trust was requires improvement, because:

- We rated safe, effective, responsive and well-led as requires improvement, and caring as good at King's college Hospital.
- We rated safe, effective, responsive and well-led as requires improvement at Princess Royal University Hospital and caring as good.
- We took into account the current ratings of the four core services across the two locations not inspected at this time. Hence, six services across the trust are rated overall as requires improvement, and the remaining two services are rated good;
- the overall ratings for each of the trusts acute locations remained the same; and
- the trust was rated inadequate for Use of Resources.

King's College Hospitals NHS Foundation Trust

Use of Resources assessment report

King's College Hospital
Denmark Hill
London
SE5 9RS

Tel: 020 3299 9000

www.kch.nhs.uk

Date of site visit:
21 January 2019

Date of publication:
12 June 2019

This report describes NHS Improvement's assessment of how effectively this trust uses its resources. It is based on a combination of data on the trust's performance over the previous twelve months, our local intelligence and qualitative evidence collected during a site visit comprised of a series of structured conversations with the trust's leadership team.

The Use of Resources rating for this trust is published by CQC alongside its other trust-level ratings. All six trust-level ratings for the trust's key questions (safe, effective, caring, responsive, well-led, use of resources) are aggregated to yield the trust's combined rating.

How effectively is the trust using its resources?	**Inadequate**

How we carried out this assessment

The aim of Use of Resources assessments is to understand how effectively providers are using their resources to provide high quality, efficient and sustainable care for patients. The assessment team has, according to the published framework, examined the trust's performance against a set of initial metrics alongside local intelligence from NHS Improvement's day-to-day interactions with the trust, and the trust's own commentary of its performance. The team conducted a dedicated site visit to engage with key staff using agreed key lines of enquiry (KLOEs) and prompts in the areas of clinical services; people; clinical support services; corporate services, procurement, estates and facilities; and finance. All KLOEs, initial metrics and prompts can be found in the Use of Resources assessment framework.

We visited the trust on 21 January 2019 and met the trust's executive team (including the chief executive), a non-executive director (in this case, the chair) and relevant senior management responsible for the areas under this assessment's KLOEs.

Findings

Is the trust using its resources productively to maximise patient benefit?

Inadequate

We rated use of resources as inadequate because the trust is not managing its resources in a way that supports the delivery of high-quality care or demonstrates adequate use of resources being achieved. There are significant and wide-ranging unmet efficiency opportunities.

The trust has several areas with poor outcomes, including significant failure against all the major NHS constitutional (operational) standards, the largest financial deficit in the NHS and lack of control of both pay and non-pay costs. The trust is beginning to unpick the causes for the underlying issues and has more recently begun to improve financial grip.

- The trust has not delivered against key operational standards for much of financial year 2017/18 and 2018/19; performance against the Accident & Emergency (A&E) and Referral to Treatment (RTT) standards are among the worst in the country and Cancer performance has deteriorated over the previous 12 months.
- The trust's forecast financial position is a deficit of £193m for the current financial year (2018/19), which is a deterioration from the previous financial year, and is among the worst five deficits in the NHS nationally. The trust has now begun to unpick the causes of the deficit, and is in the early stages of developing plans, alongside system partners, to deal with these.
- Until recently, the trust has been unable to demonstrate robust cost control and has reported significant overspends against both pay and non-pay budgets. Notably, nursing costs have been higher than planned, with cost overruns not related to patient safety issues. We noted that while the trust has recruited to previously vacant nursing posts, it has not reduced agency and bank costs.
- More widely, the trust's use of workforce planning through rostering and job planning has been weak (the number of signed off job plans for the current year is 19%).
- On non-pay costs, the trust has several complex and high value contracts for the outsourcing of key services, including facilities management (FM), and pathology. In addition, procurement is undertaken by a wholly owned subsidiary of the trust. The trust is only beginning to unpick the commercial terms of these and is not yet able to evidence that these are being efficiently managed.
- The trust reports a lean finance and Human Resources (HR) function and noted high turnover in operational management and admin and clerical staff. This has resulted in historically weak operational and financial grip. However, the trust has recently refreshed their financial strategy and has plans to improve controls in this area and has set out the framework under which efficiencies can be developed and implemented.
- We note that the trust recognises that controls and operational management are areas for improvement, and that it has begun to take steps to introduce greater control to the organisation. The trust notes that there is greater stability at senior levels to provide the

capacity and capability to deal with the challenges. However, continued and significant focus from the trust will be required to develop plans for greater efficiencies, implement these and see improved outcomes for patients.

How well is the trust using its resources to provide clinical services that operate as productively as possible and thereby maximise patient benefit?

- The trust has experienced significant issues in terms of delivery of operational standards. A&E performance at the trust is among the worst nationally; since December 2017, the trust's performance against the 4-hour A&E wait standard has been below 80% in all but two months and no improvement has been demonstrated. The national standard is 95%. RTT performance (the proportion of patients awaiting treatment who are waiting less than 18 weeks) has been below 81% throughout the financial year 2017/18 and up to November 2018. This is significantly below the standard of 92%. The Trust also has a significant number of patients waiting over a year for treatment and has only recently begun to address this. Equally, performance against the Cancer target of beginning treatment for all patients with a suspected cancer diagnosis within 62 days of referral has been deteriorating from 86.9% in April 2018 and was 77.4% at October 2018, below the standard of 85%. These key performance metrics indicate that a material number of patients have not received care in a timely manner.
- The Did Not Attend (DNA) rate for the trust was 10.09% as at September 2018. This is worse than the national median of 7.32%.
- The data suggests that more patients are waiting less time in hospital prior to emergency treatment compared to most other hospitals in England as of September 2018. On pre-procedure non-elective bed days, at 0.52 days, the trust is performing better than the national median of 0.65 days. The trust's average length of stay for emergency admissions (rolling for 6 months) to September 2018 is 10.4, which is in the third (worst) quartile and compares to a national median of 9.3, and a London median of 9.5.
- However, at 7.60%, emergency readmission rates are better than the national median of 9.06% as at September 2018. This means patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally.
- In terms of elective activity, the average rolling length of stay over the 6 months to September 2018 is 3.9, which is similarly worse than the national median of 3.0, and the London median of 3.8. Additionally, patients are waiting more time in hospital before their procedures compared to other trusts; pre-procedure elective bed days to September 2018 is 0.40 compared to the national median of 0.12. Part of this variance can be explained by some of the specialist work undertaken at the trust sites.
- We note that high turnover among administrative and operational management staff at the trust has increased over the previous year, and that this is likely to have impacted on operational grip across clinical services.
- The trust has begun several initiatives to improve clinical efficiency including; a refreshed Urgent and Emergency Care recovery plan, Multidisciplinary board rounds and specific meetings on Mondays and Wednesdays to review complex cases and improve discharges. The trust also notes that commissioners and other system partners are involved in these discussions. However, these are yet to have impact on reducing waiting times for patients.
- The trust's engagement with the Getting It Right First Time (GIRFT) process has been variable. The trust can demonstrate good progress in Trauma and Orthopaedics (T&O) where significant external support was provided. The trust has set up a T&O elective hub

at the Orpington site and have re-routed emergency cases to Guys' and St. Thomas' NHS Foundation Trust. The impact of these is that pre-operative waits in T&O has reduced and overall length of stay (LoS) is under two days at Orpington, which compares favourably to the overall LoS at the trust.

- Despite the plans in the process of being implemented, we note that the impact of these has not yet translated into an improvement in the overall performance. Given A&E, RTT and Cancer performance is weak against national standards, the high LoS suggests that there is significantly more work the trust needs to undertake to improve patient benefit in this area.

How effectively is the trust using its workforce to maximise patient benefit and provide high quality care?

- Over the previous 12-18 months several wards have exceeded their approved nursing establishment numbers. Notably, while the trust had improved substantive nursing staffing to wards, this was not offset by a reduction in agency and bank staffing. Accordingly, the trust was incurring significant additional costs of "over-established" wards. However, there are signs of some improvement and grip, and a reduction in agency costs that better reflect patient needs is expected in the last quarter of the financial year 2018/19. More widely, the trust's approach to job planning is basic, and further work is required to obtain the benefits of a systematic and consistent approach to deployment of all clinical staff.
- In financial year 2017/18 the trust had an overall pay cost per Weighted Activity Unit (WAU) of £2,152, compared with a national median of £2,180, placing it in the second lowest (best) cost quartile nationally. While this means that it spends less on staff per unit of activity than most trusts, it is partly explained due to staff employed through a number of outsourced contractual arrangements including facilities management, pathology and procurement not being reflected in the pay costs (rather these are part of non-pay costs).
- Within this headline metric, the trust's pay cost per WAU is better than the national median for nursing professional staff group (£700, national median £710) but is worse than the median for the medical professional staff group (£585, national median £533).
- The trust spent £38.2m on agency in the previous financial year, which was £6.3m greater than the planned agency ceiling of £31.9m. Within this, £16.6m was on medical locums (against a target of £11.3m). For the current financial year, the trust is forecasting to spend £22.9m on agency, which is an improvement on the prior year, and betters the planned ceiling of £29.4m. The trust notes that the Medical Oversight Committee reviews locum spend on a monthly basis to ensure cost controls are enforced.
- Staff retention at the trust has improved over the six months to September 2018 to 81.8%. This compares to a national median is 85.9%. At 3.57% in August 2018, staff sickness rates are among the best nationally (national average of 3.90%).
- The trust uses Allocate to provide their electronic rostering solution. Over the previous year the trust has been working with external consultants and NHS Improvement to develop the processes for the close monitoring and oversight of the rosters to maximise productivity and remove any unwarranted variation. Improvements have been made in the last half of financial year 2018/19, however these efforts need to continue to ensure that these changes are embedded as business as usual across all divisions.
- The trust notes that 19% of consultants have signed off job plans. This is an improvement as the trust have previously not had a comprehensive process of job planning. However, there is still no evidence that the trust links job plans to activity based on demand and capacity on a systematic basis. The trust notes that for paediatrics, cardiac and tertiary specialist areas,

job planning is better linked to demand, but for the majority of activity this is still considered a work in progress.

- Accordingly, the trust has several areas where, while grip and cost control is improving, driving out efficiencies through systematic processes such as rostering and job planning is not yet embedded.

How effectively is the trust using its clinical support services to deliver high quality, sustainable services for patients?

- The trust's medicines cost per WAU (£514) is in the highest quartile nationally (national median £309). The trust's medicines spend is also higher than trust type peer median of £396 which is based on clinical output (which takes into account the higher proportion of specialist work undertaken by the trust). This is driven by eculizumab prescribing in paroxysmal nocturnal haemoglobinuria and by increased medicines costs associated with acting as the specialist commissioning hub for Hepatitis C and Multiple Sclerosis.
- In addition, the trust can evidence several improvements made across the pharmacy service. It has achieved a 111% against its savings targets on biosimilars to March 2018. It is above the upper benchmark and London Region median values for the top 10 medicines target. The trust is working collaboratively with Sustainability and Transformation Partnership (STP) partners to deliver the introduction of adalimumab and, while adalimumab is excluded from tariff, the trust has a block contract in place with Clinical Commissioning Groups (CCGs) for financial year 2018/19, consequently all savings count towards the CCG QIPP target for this period are retained by the trust for this period.
- Clinical Pharmacy services are well developed; 80% pharmacists time is spent on clinical activity and 33.9% of pharmacists are actively prescribing. Moreover, Sunday clinical pharmacy services to Medical Assessment Unit (MAU) and A&E have been enhanced.
- The trust's radiology cost per report is £36.90 against a national median of £50.06. While this benchmarks as lower cost have been issues with staffing and operational performance relating to diagnostics. The trust's Did Not Attend (DNA) rates across Computed Tomography (CT), Magnetic Resonance Imaging (MRI), non-obstetric Ultrasound and Dual-Energy X-ray Absorptiometry (DEXA) were all in the worst performing quartiles. Vacancy rates for radiologists are high, particularly for Gastrointestinal radiologists. In addition, the trust's performance against the diagnostic performance of completing and reporting tests within 6 weeks of referral is 88.9% as at November 2018 against a standard of 99% (and a national median of 99.23%). This is one of the worst 10 trusts in the country.
- The trust's overall pathology cost per test is £3.79 against a national median of £1.86. The trust's own calculation is that cost per test is £3.05, which is still higher than national median. Some of the higher cost is explained due to the trust's position as a tertiary referral centre with specialist testing. The trust outsources most of their pathology to a joint venture partner. The commercials of this arrangement and identifying whether best value is being received through the Joint Venture (JV) partner is an area where the trust have not historically had the capacity to unpick and challenge. However, the trust notes that the testing at the Princess Royal University Hospital (PRUH) was included in the contract on a marginal cost basis. The trust notes that a retendering process is underway, and this is therefore an area for the trust to consider their cost base and deliver greater efficiencies.

How effectively is the trust managing its corporate services, procurement, estates and facilities to maximise productivity to the benefit of patients?

- For financial year 2017/18 the trust had an overall non-pay cost per WAU of £1,701 compared with a national median of £1,307. This places it in sixth worst place nationally. The trust notes that it the overall non-pay costs are higher than peers due the inclusion of a number of outsourced functions, including pathology (considered above), and facilities management (FM) as part of the Private Finance Initiative (PFI) estate.
- The cost of the finance function is £721,330 per £100m of turnover, against a national median of £676,480. Similarly, the Human Resources (HR) function costs 661,770 per £100m turnover compares below the national median of £898,020. While these corporate functions are shown to be lean, the outcomes are not evidenced across the trust. As noted in the workforce section above, the trust had had issues with cost control and staffing. As part of being in Financial Special Measures (FSM), the trust benefits from significant external resource (both from NHS Improvement and external consultants), and accordingly some of the grip and control is due to temporary resource. The trust will need to ensure that there is sufficient capacity to continue with the operational grip that is now in place, and deliver additional efficiencies going forward.
- It is noted however, that the Procurement function cost per £100m trust turnover is £345,100, which is significantly higher than both national median (£206,200) and peer median (£218,300). Procurement is carried out for the trust by a wholly owned subsidiary. Given the number of complex contracts at the trust, having suitable scrutiny and oversight to manage the contracts and obtain best value out of these is a key requirement at the trust. The trust has only recently appointed a new substantive Director of Procurement (the first in the previous 18 months), and accordingly are at the early stages of unpicking these arrangements. The high cost of the function to date is a result of agency and interim staffing in this area.
- However, the Procurement Price Performance Score for the trust is 67.9, which compares favourably to the national median of 63.1 (although lower than the peer median of 80.0). The trust has also delivered its planned efficiencies in this area of £5.3m in this area in the prior financial year. Similarly, the Procurement League table shows the trust at 71 against a national median of 57.
- Estate costs per m2 is £516, which is in the fourth (worst) quartile nationally, against a national median of £342. Hard facilities management (FM) costs are 14% below (better than) peer median, although soft FM are 39% worse than peer medians across the total estate with the key components of particularly high cost being the same as with the PFI.
- The total Hard FM opportunities are £3.21m (of which £1.60m relates to the PFI estate). Total soft FM opportunities are £10.23m (£6.51m PFI). As noted above, management of complex contracts has historically been a weakness at the trust, and the PFI contract and the soft FM component in particular are areas that the trust requires further work to unpick. The trust notes that management of their PFI operator is challenging, particularly with the capacity that the trust operates with.

How effectively is the trust managing its financial resources to deliver high quality, sustainable services for patients?

- The trust reported the largest deficit in the NHS in England in financial year 2017/18 and is on track to do the same in financial year 2018/19. Excluding discretionary funding from the Sustainability and Transformation Fund (STF) or Provider Sustainability Fund (PSF), the trust reported a deficit of £141.4m in financial year 2017/18 and is forecasting a deficit of £193m in financial year 2018/19. This is against a plan of £146m in year. Accordingly, the trust's position has worsened over the previous year.

- However, we note that while the underlying position has worsened over the year, the trust has made discrete improvements as illustrated through the control of agency pay costs more recently. Additionally, the trust has begun to understand the causes of the underlying deficit and has set out high level plans to deal with these. As noted in the section above, having sufficient capacity and capability at senior levels to unpick the complex contractual arrangements at the trust and drive value through these is essential. The trust has only recently put some of this capacity in place and is yet to drive the efficiency outcomes from these.
- A key issue noted by the trust as a cause for the underlying position was the under-recovery of income from commissioners under their block contract arrangements. The trust is in discussion with system partners on this issue. Negotiating and agreeing a settlement must therefore be a key focus for the trust board. Equally, the trust should ensure that income recovery is sustainable, through better data capture, analysis and robust demand forecasting, underpinned through sufficient financial capacity and expertise in this area.
- The trust delivered Cost Improvement Programmes (CIPs) of 39.6m in financial year 2017/18, which was lower than the plan of £45m. For the current financial year, the Trusts plan is to deliver £44m of CIPs and £21m of pay disinvestment (together 5.1% of operating expenditure). While the Trust has set out that it is on track to deliver c90% of these savings and that pay will achieve budget, the bottom line is significantly worse. The trust has overspent, both to income under performance and the lack of grip noted in the early part of the financial year.
- The trust is reliant on significant cash support from the Department of Health and Social Care (DHSC). The trust obtained £131.8m of revenue support in the previous financial year, and, as at November 2018, obtained a further £109, of revenue funding. It is forecast to receive a further £47.5m by March 2019.

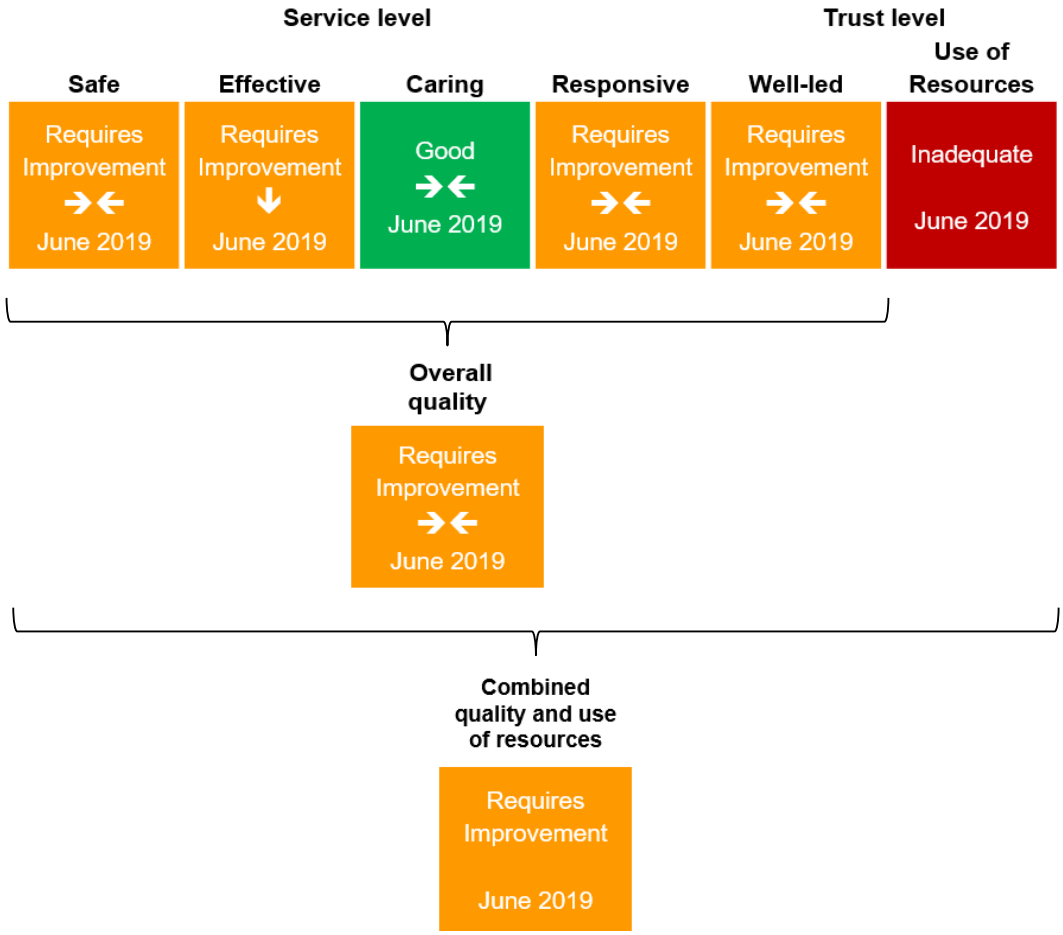
Areas of outstanding practice

- Staff retention at the trust has improved over the six months to September 2018 to 81.8%. This compares to a national median is 85.9%. At 3.57% in August 2018, staff sickness rates are among the best nationally (national average of 3.90%).
- In addition, the trust can evidence several improvements made across the pharmacy service. It has achieved a 111% against its savings targets on biosimilars to March 2018. It is above the upper benchmark and London Region median values for the top 10 medicines target. The trust is working collaboratively with Sustainability and Transformation Partnership (STP) partners to deliver the introduction of adalimumab and, while adalimumab is excluded from tariff, the trust has a block contract in place with Clinical Commissioning Groups (CCGs) for financial year 2018/19, consequently all savings count towards the CCG QIPP target for this period.
- Clinical Pharmacy services are well developed; 80% pharmacists time is spent on clinical activity and 33.9% of pharmacists are actively prescribing. Moreover, Sunday clinical pharmacy services to Medical Assessment Unit (MAU) and A&E have been enhanced.
- Currently at 7.60%, emergency readmission rates are better than the national median of 9.06% as at September 2018. This means patients are less likely to require additional medical treatment for the same condition at this trust compared to other trusts nationally.

Areas for improvement

- The trust has not delivered against key operational standards for much of 2017/18 and 2018/19; performance against the A&E and Referral to Treatment (RTT) standards are among the worst in the country and Cancer performance has deteriorated over the previous 12 months. High turnover in among administrative and operational management staff at the trust has been high over the previous year, and that this is likely to have impacted on operational grip across clinical services. Identifying the underlying causes and putting in place the right infrastructure to improve operational performance must remain the key focus for the trust.
- Over the previous 12-18 months several wards have exceeded their approved nursing establishment numbers. Notably, while the trust had improved substantive nursing staffing to wards, this was not offset by a reduction in agency and bank staffing. The trust was incurring significant additional costs of “over-established” wards. Accordingly, dealing with this issue and having a more sustainable staffing structure is vital.
- The trust’s approach to job planning is basic, and further work is required to obtain the benefits of a systematic and consistent approach to deployment of all clinical staff
- Putting in place sufficient capacity and capability at senior levels to unpick the complex contractual arrangements at the trust and drive value through these is essential. The trust has only recently put some of this capacity in place and is yet to drive the efficiency outcomes from these.
- The trust reported the largest deficit in the NHS in England in 2017/18 and is on track to do the same in 2018/19. Excluding discretionary funding from the Sustainability and Transformation Fund (STF) or Provider Sustainability Fund (PSF), the trust reported a deficit of £141.4m in 2017/18 and is forecasting a deficit of £193m in 2018/19. This is against a plan of £146m in year. As part of being in Financial Special Measures (FSM), the trust benefits from significant external resource (both from NHS Improvement and external consultants), and accordingly some of the grip and control is due to temporary resource. The trust will need to ensure that there is sufficient capacity to continue with the operational grip that is now in place, and deliver additional efficiencies going forward.
- The total Hard FM opportunities are £3.21m (of which £1.60m relates to the PFI estate). Total soft FM opportunities are £10.23m (£6.51m PFI). Management of complex contracts has historically been a weakness at the trust, and the PFI contract and the soft FM component in particular are areas that the trust requires further work to unpick. The trust notes that management of their PFI operator is challenging, particularly with the capacity that the trust operates with.

Ratings tables



Use of Resources report glossary

Term	Definition
18-week referral to treatment target	According to this national target, over 92% of patients should wait no longer than 18 weeks from GP referral to treatment.
4-hour A&E target	According to this national target, over 95% of patients should spend four hours or less in A&E from arrival to transfer, admission or discharge.
Agency spend	Over reliance on agency staff can significantly increase costs without increasing productivity. Organisations should aim to reduce the proportion of their pay bill spent on agency staff.
Allied health professional (AHP)	The term ‘allied health professional’ encompasses practitioners from 12 diverse groups, including podiatrists, dietitians, osteopaths, physiotherapists, diagnostic radiographers, and speech and language therapists.
AHP cost per WAU	This is an AHP specific version of the pay cost per WAU metric. This allows trusts to query why their AHP pay is higher or lower than national peers.

	Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Biosimilar medicine	A biosimilar medicine is a biological medicine which has been shown not to have any clinically meaningful differences from the originator medicine in terms of quality, safety and efficacy.
Cancer 62-day wait target	According to this national target, 85% of patients should begin their first definitive treatment for cancer within 62 days following an urgent GP referral for suspected cancer. The target is 90% for NHS cancer screening service referrals.
Capital service capacity	This metric assesses the degree to which the organisation's generated income covers its financing obligations.
Care hours per patient day (CHPPD)	CHPPD measures the combined number of hours of care provided to a patient over a 24-hour period by both nurses and healthcare support workers. It can be used to identify unwarranted variation in productivity between wards that have similar speciality, length of stay, layout and patient acuity and dependency.
Cost improvement programme (CIP)	CIPs are identified schemes to increase efficiency or reduce expenditure. These can include recurrent (year on year) and non-recurrent (one-off) savings. CIPs are integral to all trusts' financial planning and require good, sustained performance to be achieved.
Control total	Control totals represent the minimum level of financial performance required for the year, against which trust boards, governing bodies and chief executives of trusts are held accountable.
Diagnostic 6-week wait target	According to this national target, at least 99% of patients should wait no longer than 6 weeks for a diagnostic procedure.
Did not attend (DNA) rate	A high level of DNAs indicates a system that might be making unnecessary outpatient appointments or failing to communicate clearly with patients. It also might mean the hospital has made appointments at inappropriate times, eg school closing hour. Patients might not be clear how to rearrange an appointment. Lowering this rate would help the trust save costs on unconfirmed appointments and increase system efficiency.
Distance from financial plan	This metric measures the variance between the trust's annual financial plan and its actual performance. Trusts are expected to be on, or ahead, of financial plan, to ensure the sector achieves, or exceeds, its annual forecast. Being behind plan may be the result of poor financial management, poor financial planning or both.
Doctors cost per WAU	This is a doctor specific version of the pay cost per WAU metric. This allows trusts to query why their doctor pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Delayed transfers of care (DTOC)	A DTOC from acute or non-acute care occurs when a patient is ready to depart from such care is still occupying a bed. This happens for a number of reasons, such as awaiting completion of assessment, public funding, further

	non-acute NHS care, residential home placement or availability, or care package in own home, or due to patient or family choice.
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation divided by total revenue. This is a measurement of an organisation's operating profitability as a percentage of its total revenue.
Emergency readmissions	This metric looks at the number of emergency readmissions within 30 days of the original procedure/stay, and the associated financial opportunity of reducing this number. The percentage of patients readmitted to hospital within 30 days of discharge can be an indicator of the quality of care received during the first admission and how appropriate the original decision made to discharge was.
Electronic staff record (ESR)	ESR is an electronic human resources and payroll database system used by the NHS to manage its staff.
Estates cost per square metre	This metric examines the overall cost-effectiveness of the trust's estates, looking at the cost per square metre. The aim is to reduce property costs relative to those paid by peers over time.
Finance cost per £100 million turnover	This metric shows the annual cost of the finance department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Getting It Right First Time (GIRFT) programme	GIRFT is a national programme designed to improve medical care within the NHS by reducing unwarranted variations.
Human Resources (HR) cost per £100 million turnover	This metric shows the annual cost of the trust's HR department for each £100 million of trust turnover. A low value is preferable to a high value but the quality and efficiency of the department's services should also be considered.
Income and expenditure (I&E) margin	This metric measures the degree to which an organisation is operating at a surplus or deficit. Operating at a sustained deficit indicates that a provider may not be financially viable or sustainable.
Key line of enquiry (KLOE)	KLOEs are high-level questions around which the Use of Resources assessment framework is based and the lens through which trust performance on Use of Resources should be seen.
Liquidity (days)	This metric measures the days of operating costs held in cash or cash equivalent forms. This reflects the provider's ability to pay staff and suppliers in the immediate term. Providers should maintain a positive number of days of liquidity.
Model Hospital	The Model Hospital is a digital tool designed to help NHS providers improve their productivity and efficiency. It gives trusts information on key performance metrics, from board to ward, advises them on the most efficient allocation of resources and allows them to measure performance against one another using data, benchmarks and good practice to identify what good looks like.

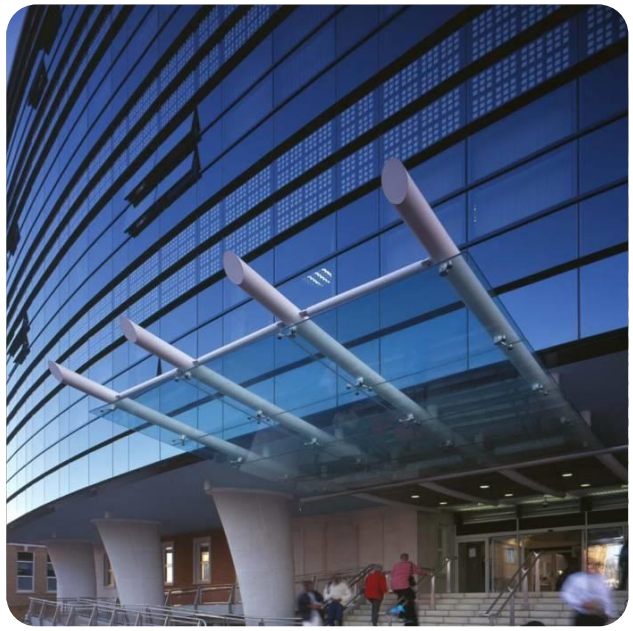
Non-pay cost per WAU	This metric shows the non-staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less per standardised unit of activity than other trusts. This allows trusts to investigate why their non-pay spend is higher or lower than national peers.
Nurses cost per WAU	This is a nurse specific version of the pay cost per WAU metric. This allows trusts to query why their nurse pay is higher or lower than national peers. Consideration should be given to clinical staff mix and clinical staff skill mix when using this metric.
Overall cost per test	The cost per test is the average cost of undertaking one pathology test across all disciplines, taking into account all pay and non-pay cost items. Low value is preferable to a high value but the mix of tests across disciplines and the specialist nature of work undertaken should be considered. This should be done by selecting the appropriate peer group ('Pathology') on the Model Hospital. Other metrics to consider are discipline level cost per test.
Pay cost per WAU	This metric shows the staff element of trust cost to produce one WAU across all areas of clinical activity. A lower than average figure is preferable as it suggests the trust spends less on staff per standardised unit of activity than other trusts. This allows trusts to investigate why their pay is higher or lower than national peers.
Peer group	Peer group is defined by the trust's size according to spend for benchmarking purposes.
Private Finance Initiative (PFI)	PFI is a procurement method which uses private sector investment in order to deliver infrastructure and/or services for the public sector.
Patient-level costs	Patient-level costs are calculated by tracing resources actually used by a patient and associated costs
Pre-procedure elective bed days	This metric looks at the length of stay between admission and an elective procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Pre-procedure non-elective bed days	This metric looks at the length of stay between admission and an emergency procedure being carried out – the aim being to minimise it – and the associated financial productivity opportunity of reducing this. Better performers will have a lower number of bed days.
Procurement Process Efficiency and Price Performance Score	This metric provides an indication of the operational efficiency and price performance of the trust's procurement process. It provides a combined score of 5 individual metrics which assess both engagement with price benchmarking (the process element) and the prices secured for the goods purchased compared to other trusts (the performance element). A high score indicates that the procurement function of the trust is efficient and is performing well in securing the best prices.
Sickness absence	High levels of staff sickness absence can have a negative impact on organisational performance and productivity. Organisations should aim to reduce the number of days lost through sickness absence over time.

Single Oversight Framework (SOF)	The Single Oversight Framework (SOF) sets out how NHS Improvement oversees NHS trusts and NHS foundation trusts, using a consistent approach. It helps NHS Improvement to determine the type and level of support that trusts need to meet the requirements in the Framework.
Service line reporting (SLR)	SLR brings together the income generated by services and the costs associated with providing that service to patients for each operational unit. Management of service lines enables trusts to better understand the combined view of resources, costs and income, and hence profit and loss, by service line or speciality rather than at trust or directorate level.
Supporting Professional Activities (SPA)	Activities that underpin direct clinical care, such as training, medical education, continuing professional development, formal teaching, audit, job planning, appraisal, research, clinical management and local clinical governance activities.
Sustainability and Transformation Fund (STF)	The Sustainability and Transformation Fund provides funding to support and incentivise the sustainable provision of efficient, effective and economic NHS services based on financial and operational performance.
Staff retention rate	This metric considers the stability of the workforce. Some turnover in an organisation is acceptable and healthy, but a high level can have a negative impact on organisational performance (eg through loss of capacity, skills and knowledge). In most circumstances organisations should seek to reduce the percentage of leavers over time.
Top Ten Medicines	Top Ten Medicines, linked with the Medicines Value Programme, sets trusts specific monthly savings targets related to their choice of medicines. This includes the uptake of biosimilar medicines, the use of new generic medicines and choice of product for clinical reasons. These metrics report trusts' % achievement against these targets. Trusts can assess their success in pursuing these savings (relative to national peers).
Weighted activity unit (WAU)	The weighted activity unit is a measure of activity where one WAU is a unit of hospital activity equivalent to an average elective inpatient stay.

Monthly Safer Staffing Report for Nursing and Midwifery May 2019

Trust Board June 2019

Dr Shelley Dolan
Chief Nurse /Chief Operating Officer



KING'S HEALTH PARTNERS

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Monthly Nursing Report

King's College Hospital NHS Foundation Trust

Background

From June 2014 it is a national requirement for all hospitals to publish information about staffing levels on wards, including the percentage of shifts meeting their agreed staffing levels. This initiative is part of the NHS response to the Francis Report which called for greater openness and transparency in the health service.

During 2013 NHS England produced guidance to support NHS Trusts in ensuring safe staffing requirements: How to ensure the right people, with the right skills are in the right place at the right time - A guide to nursing, midwifery and care staffing capacity and capability. This has been supported further by the recent guidance Developing workforce safeguards: Supporting providers to deliver high quality care through safe and effective staffing (NHSi, October 2018). This guidance contains new recommendations to support Trusts in making informed, safe and sustainable workforce decisions, and identifies examples of best practice within the NHS.

Introduction

The international evidence demonstrates that the six critical issues for safe staffing, quality patient care and experience are the following:

1. Expert clinical leadership at Sister /Charge Nurse and Matron level
2. Appropriate skill mix for the acuity and dependency of the patient group
3. Appropriate establishment for the size / complexity of the unit
4. Ability to recruit the numbers required to fill the establishment
5. Good retention rates , ensuring staff are experienced in the clinical speciality and context / environment
6. Ability to flex at short notice to fill with temporary staff when there are unplanned vacancies / or to use staff from other areas.

This report provides evidence to the Board on the Nursing, Midwifery and care staff levels across the Trust for **May 2019**. This report includes high level data and information relating to nurse/midwifery staffing levels, CHPPD, bank and agency spend, starters versus leavers and vacancies. In addition, information is provided regarding retention, BIU development and reducing vacancies with Band 2.

Staffing Position

King's College Hospital NHS Foundation Trust

The number of staff required per shift is calculated using an evidence based tool, dependent on the acuity level of the patients. This is further informed by professional judgement, taking into consideration issues such as ward size and layout, patient dependency, staff experience, incidence of harm and patient satisfaction and is in line with NICE guidance. This provides the optimum planned number of staff per shift.

For each of the 79 clinical inpatient areas, the actual number of staff as a percentage of the planned number is recorded on a monthly basis.

The table below represents the high level summary of the planned and actual ward staffing levels reported for **May 2019.**

	% Fill Rates - Day & Night				Care Hours Per Patient Day (CHPPD)		
	Avg Fill Rate RN/Midwives (Day) %	Avg Fill Rate RN/Midwives (Night) %	Avg Fill Rate Care Staff (Day) %	Avg Fill Rate Care Staff (Night) %	RN & Midwives	Care Staff	Total CHPPD
DH	98%	99%	116%	129%	7.6	2.8	10.5
PRUH & South Sites	98%	97%	99%	108%	4.8	3.2	8.0

Some clinical areas were unable to achieve the planned staffing levels due to vacancies and sickness, staffing levels are however maintained through the relocation of staff, use of bank staff and where necessary agency staff.

Please note: CHPPD is a metric which reflects the number of hours of total nursing staff versus the number of in-patient admissions in a 24 hour period. This metric is widely used as a benchmarking tool across the NHS.

Critical care units provide 1:1 nursing to their patients, this in turn increases the overall CHPPD for Denmark Hill due to the amount of critical care beds that are provided on this site.

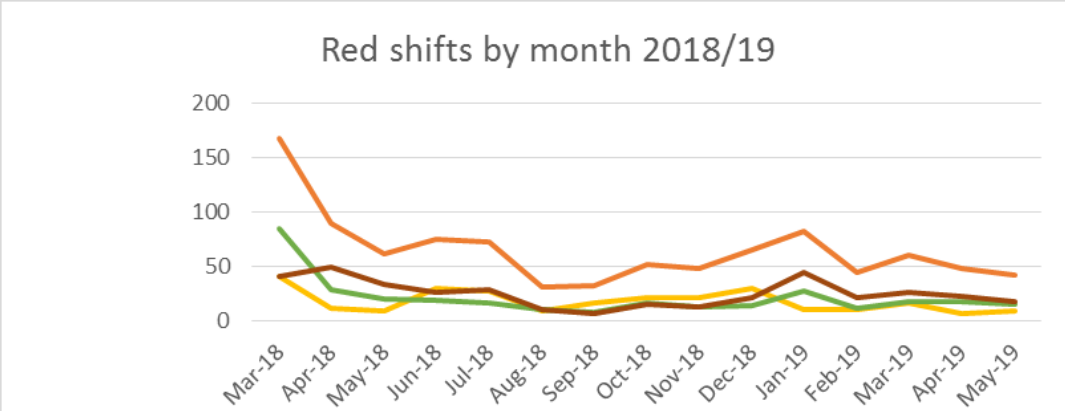
Red Shifts & Hotspots

King's College Hospital NHS Foundation Trust

Red Shifts

A red shift occurs when there is a shortfall in the expected numbers of staff to manage the acuity and dependency of the patients of a ward / department. Twice a day there is a trust wide red shift alert issued to senior nursing staff; this highlights the location of wards and departments with red shifts which in turn enables senior nursing staff to support these wards.

During May 2019 the total number of red shifts was 42 across the trust. 24 were recorded at the Denmark Hill Site and 18 at the Princess Royal University Hospital; 64% of these red shifts occurred on day shifts. The number of recorded red shifts have decreased slightly since March 2019. Work is on-going with BIU to improve reporting, which will be presented within next months safe staffing board paper.

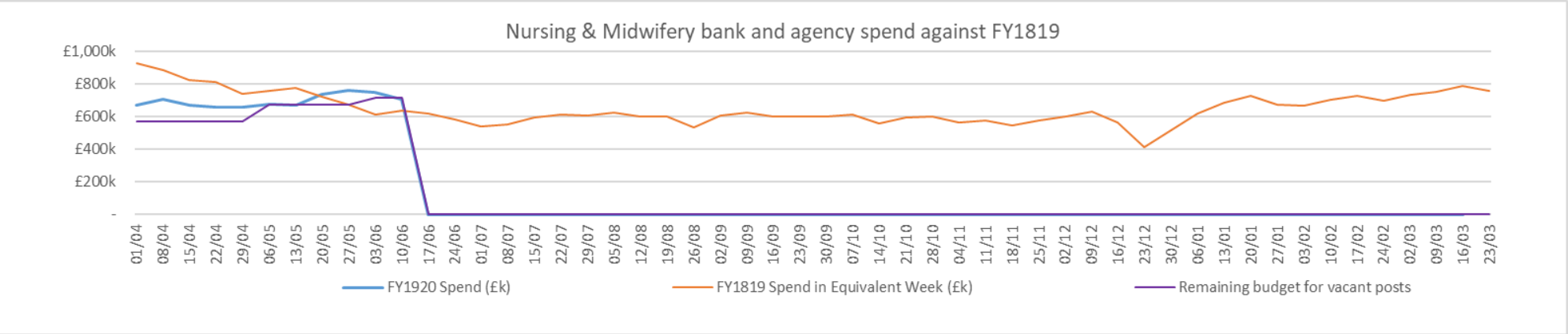


	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
total red shifts	167	90	62	75	72	31	32	52	48	65	82	44	60	48	42
NetWorked	41	12	9	30	27	9	17	21	22	30	10	11	16	7	9
UPAC	85	29	20	19	16	11	8	16	13	14	28	12	18	18	15
PRUH	41	49	33	26	29	11	7	15	13	21	44	21	26	23	18

Bank and Agency Spend

King's College Hospital NHS Foundation Trust

The following graph shows the bank and agency expenditure for FY18/19 spend against FY16/17.



All divisional Directors of Nursing/Midwifery hold weekly bank and agency meetings, reviewing the temporary staffing usage, both retrospectively and prospectively. This process has had a positive impact to reduce the use of temporary staffing.

The Trust has seen a rise above FY16/17 spend levels for the organisation since May 2019. The increase in expenditure for May 2019 and June 2019 has been required for enhanced care, initiative and escalation. During May 2019 and June 2019 accounting for enhanced care, initiative and escalation, the Trust has consistently used under its vacancy level, which the Table below demonstrates.

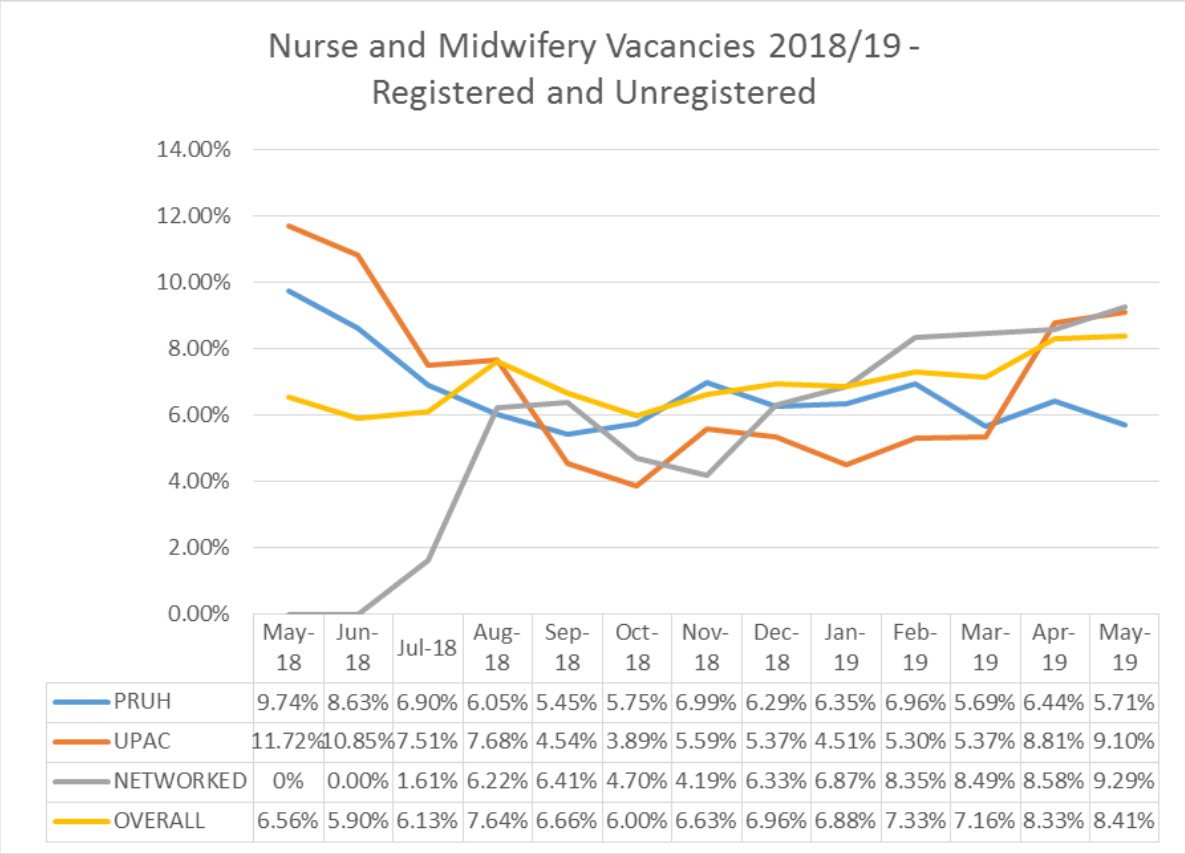
		WTE Under Vacancy Level May and June 2019					
Date	07-May	14-May	21-May	28-May	04-Jun	11-Jun	18-Jun
WTE	28	42	67	40	67	69	14

Nursing and Midwifery Vacancies

King's College Hospital NHS Foundation Trust

The graph below outlines the Trust vacancies for Nursing and Midwifery for the divisions for registered and unregistered staff, of all bands.

The current vacancy overall for May 2019 is 8.41%, this is a 2.41% increase since October 2018. The vacancies are being monitored closely within the Divisional Recruitment and Retention Meetings, by the Director's of Nursing along with the Heads of Nursing for the Care Group and HR. This ensures a timely placement of staff into the vacant posts, although the start date is held up on occasions due to completing courses or the new staff working their notice period.



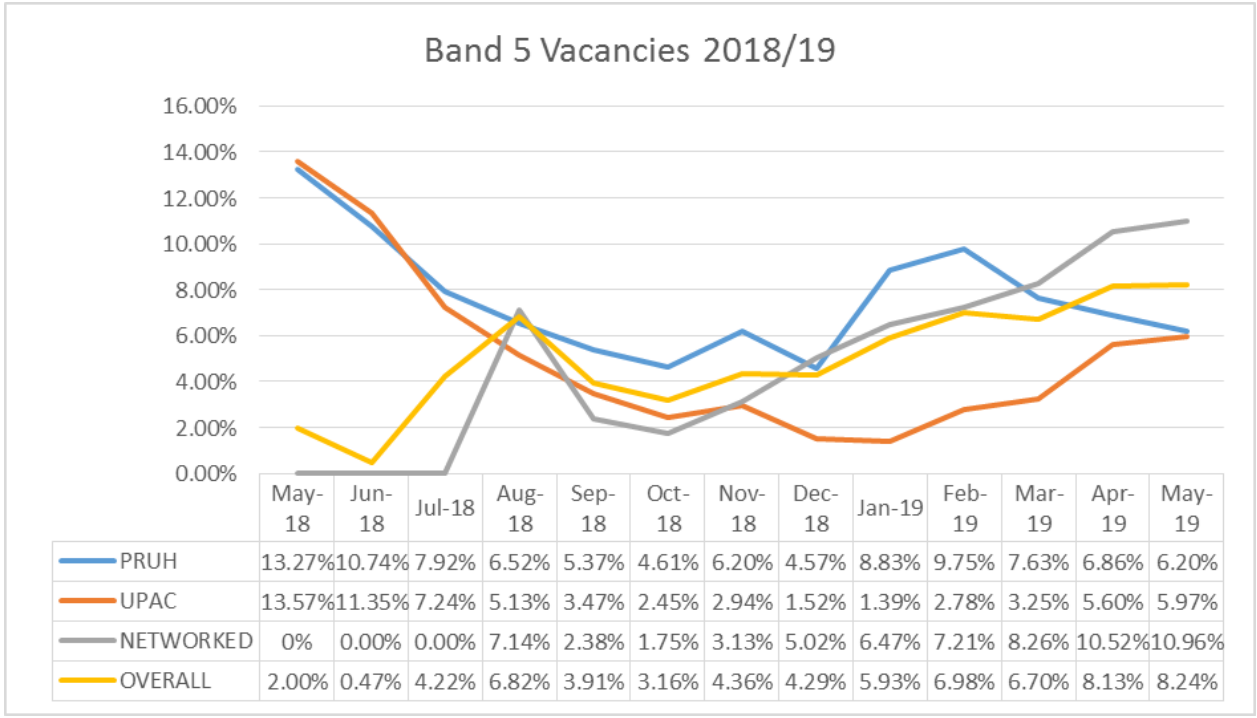
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
PRUH	9.74%	8.63%	6.90%	6.05%	5.45%	5.75%	6.99%	6.29%	6.35%	6.96%	5.69%	6.44%	5.71%
UPAC	11.72%	10.85%	7.51%	7.68%	4.54%	3.89%	5.59%	5.37%	4.51%	5.30%	5.37%	8.81%	9.10%
NETWORKED	0%	0.00%	1.61%	6.22%	6.41%	4.70%	4.19%	6.33%	6.87%	8.35%	8.49%	8.58%	9.29%
OVERALL	6.56%	5.90%	6.13%	7.64%	6.66%	6.00%	6.63%	6.96%	6.88%	7.33%	7.16%	8.33%	8.41%

Nursing and Midwifery Band 5 Vacancies

King's College Hospital NHS Foundation Trust

The graph below outlines the Trust vacancies for Band 5 Nursing and Midwifery for the divisions and overall in percentages.

The current vacancy overall for May 2019 is 8.24%, this is a 5.08% increase since October 2018. This is being monitored closely within the Divisional Recruitment and Retention Meetings, by the Director's of Nursing along with the Heads of Nursing for the Care Group and HR.
The Chief Nurse has also asked for increased executive level scrutiny with 2 weekly oversight meetings.
During August 2019 there is a planned deployment of Internationally Educated Nurses, and during October 2019 there will be deployment of Newly Qualified Nurses. Therefore it is expected that October 2019 vacancy level will be in line with October 2018.



	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19
PRUH	13.27%	10.74%	7.92%	6.52%	5.37%	4.61%	6.20%	4.57%	8.83%	9.75%	7.63%	6.86%	6.20%
UPAC	13.57%	11.35%	7.24%	5.13%	3.47%	2.45%	2.94%	1.52%	1.39%	2.78%	3.25%	5.60%	5.97%
NETWORKED	0%	0.00%	0.00%	7.14%	2.38%	1.75%	3.13%	5.02%	6.47%	7.21%	8.26%	10.52%	10.96%
OVERALL	2.00%	0.47%	4.22%	6.82%	3.91%	3.16%	4.36%	4.29%	5.93%	6.98%	6.70%	8.13%	8.24%

'Hotspot' areas for nursing/midwifery staffing

The aggregate nursing and midwifery staff vacancy for May 2019 has increased slightly this month to 8.41%. This has steadily increased since October 2018 when the overall vacancy was 6.0%.

The registered nursing recruitment hotspots are outlined below. Various successful recruitment campaigns have decreased the vacancies, but some areas still remain with an above 10% vacancy rate.

DH: Acute and Emergency Care (13.26%), Theatres and Anaesthetics (15.17%), Children's (18.23%), Cardiovascular (12.77%), Cancer (13.98%)

PRUH: Acute and Emergency Care (18.20%),

Please note: Paediatric Services at the PRUH have a vacancy of 9.08% during May 2019. This is a decrease of 3.29%, since December 2018, the Children's Care Group across both sites have been working closely with HR to address this and have a pipeline due to start during October 2019, from the Newly Qualified Nurse deployment.

Nursing and Midwifery Retention Plan 2019/20

Four work streams have been identified to support and improve the Retention within the Nursing and Midwifery staff group across the Trust

1. **Support for existing staff –** 3 R's campaign (rest, rehydrate and refuel), self rostering, experienced nurse project, culture of care with a pilot of the Capital Nurse Film Ella and Abi, transfer window and rotation for NQN
2. **Learning, Development and Careers –** preceptorship development, KCH early careers (2 year offer), career development fairs, ACP workforce development, HCA career pathway development, career clinics
3. **Leadership and Line Management –** ward managers development programme (Band 7 is a key role for retention of staff), master classes around budgets, finance, HR processes etc. that supports the role

4. The Chief Nurse has requested that the Exec led oversight meeting on recruitment and retention is increased to two weekly.

Recommendations & Next Steps

King's College Hospital NHS Foundation Trust

- The retention work plan for Nursing and Midwifery Retention for 2019/20 now in place, with further engagement planned, with a roll out of the initiatives to improve retention for Nursing and Midwifery staff across the Trust.
- Further work is currently happening on the recording of the Red Shifts and how this is managed for all in-patient areas. This will be presented in the new format for June 2019 data, and will improve the reporting to Trust Board once embedded.
- The 6 monthly establishment reviews started during May 2019. BIU have produced a dashboard to support this work, bringing together the recommendations for staffing drawn from the Safer Nursing Care Tool (SCNT), the current nursing establishment, budgeted nursing establishments and quality metrics for all ward areas. This will be presented to Trust Board once completed.

The Board of Directors are asked to note the information contained in this briefing: the use of the red shift system to highlight concerns raised and the continued focus on recruitment, retention and innovation to support effective workforce utilisation.

King's College Hospital 19/20 Workforce Plan

KING'S HEALTH PARTNERS

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Contents page

Workforce plan
Context and workforce trends

King's currently employs over 11,500 people and invests in 13,045 (M11) funded posts across five main sites as well as a number of community services. 46% of our workforce comes from BME backgrounds, 76% are female, and we are a major employer for the London boroughs of Lambeth, Southwark and Bromley.

WTE movements: Establishment increased by 505 WTE in 18/19 (Outturn to M11). The main drivers being: funding previously unfunded positions, positions for Critical Care Unit, externally funded positions and service developments. Our Corporate Services funded posts reduced by 8 WTE in year.

Vacancy rates: Our overall vacancy started 18/19 at 9.77% (M1] and finished the year at 11.07% [M11], against our target of 8%:

- Two divisions, Networked Care and UPACS, achieved the 8% vacancy aspirational target with levels as low as 5.88% and 7.03% respectively during 18/19; These areas moved to 12.09% and 8.82% at M11 because of the increase of WTE in year.
- The PRUH has achieved its lowest vacancy rate of 10.41%, although targeted support will be required during 19/20 to deliver further improvement.
- Our Corporate Services has a 15.22% vacancy rate at M11, this is a strong contributor to the 11.18% vacancy rate for the Admin & Clerical staff group.

Staff turnover: Our turnover figure has moved from 13.38% to 14.31% (M1 to M11), which equates to 2288 leavers. This is an additional 133 staff who have left the organisation in 18/19 as in same period of the prior year.

Pay spend: The pay budget for 19/20 is £746m, of which £61m is expected to be temporary staffing costs (including agency premium), covering budgeted vacancies in the Trust.

Temporary staffing: We have delivered a series of policies and controls for temporary staffing expenditure during 18/19 which has reduced agency spend by £11m in year and bank spend by £12m, our planned spend for 19/20 has been set at:

- Agency: £22m (below cap) of 29M; and
- Bank: £39m

- **Sector wide workforce challenges**: The economic and service demand challenges facing the NHS continue to be significant and the following external factors will have an impact on our ability to attract, retain and deploy the future workforce capacity and capability the Trust requires.
- **Overseas workforce**: Kings employs over 3900 WTE from overseas and they all continues to be a valued part of our team and to make King's the diverse organisation is it today. The combined impact of Brexit and the increased costs and complexity of obtaining visas means we will have to plan for these changes in our longer term resourcing approach.;
- **Demand growth:** The UK wide and London workforce supply is already insufficient to meet rising service demands, particularly across nursing, medical and AHPs. New role design and service re-configuration will be a key feature of our 19/20 activity, as will closer working across the STP; and
- **Local housing market:** The London cost of living and housing constraints will continue to make the employment market a challenge for all London employers.

Outturn as at 31 March:	2016/17	2017/18	2018/19 (M11)	19/20 plan
WTE posts	12,315	12,539	13,045	13,183
Actual WTE in post	10,872	11,383	11,601	12,127
Vacancy rate	11.73%	9.22%	11.07%	11-8%
Staff turnover	15.80%	13.23%	14.31.%	14.-15%
Sickness absence (NHS average 4.2%)	3.47%	3.19%	3.81%	3.5%
Total pay spend £000s	636,659	674,495	633,108	746,000
Agency spend £000s	36,256	35,490	23,679	21,998
Bank Spend £000s	41,402	51,744	35,656	38,869
% spend on agency staffing	5.73%	5.26%	4.31%	2.95%

Trust Wide People Priorities

	Priority area
1	Engagement, morale and behaviours
2	Diversity and Inclusion
3	Leadership and Talent
4	Performance Management
5	Valued and Recognised
6	Health and Wellbeing

Our Corporate People Priorities will be delivered and assured in the following ways;

- A central people plan will be developed and tracked monthly;
- assurance conducted through EWDC, KE, and the Trust Planning and Delivery Board;
- Outcomes will be measured through our KPI dashboard;
- Page 32 outlines our people KPI's, governance & assurance forums for the workforce plan.

Engagement, morale and behaviours
Improving the working lives of all people across Kings is our key priority for 19/20, this will be done through a new Leader and Manager engagement focus so that we can all feel part of building the future vision and ways of working that we aspire to across the organisation.

Diversity and Inclusion
Our diversity and Inclusion priorities will be identified through a combination of staff forums, people data and Board commitment. Emerging priorities from our staff networks are: career development and promotion, disciplinary processes and leadership visibility to drive the change. Gender pay gap work and disability priorities such as reasonable adjustments will form part of the 19/20 work programme.

Leadership and Talent
The delivery of our advanced leadership programme commences in April 2019 which is aimed at all our senior leader community. This is supported by a range of manager learning much of which has a accredited qualification from the ILM. Nursing talent will continue to be embedded during 19/20 and a new profession (operational delivery) will launch during 19/20 with a particular emphasis on operational retention.

Performance Management
Continuing to embed the new appraisal system and focusing on the quality of appraisals will be our focus for 19/20, with targeted support for those areas that have the furthest to go.

Valued and Recognised
Increasing the reach of Kings stars will be our Corporate focus for 19/20 together with building an environment where everyone knows how their contribution helps and supports our patients.

Health and Wellbeing
Two main strands to our focus in 19/20:
- An enhanced approach to protecting and supporting our staff if they experience violence or aggression from those who use our services, and
- A programme of well-being initiatives together with a enhanced focus on identifying and dealing with bullying and harassment.

Workforce plan
Delivery against 18/19 plan

Looking back at 18/19 pay bill

The Trust set a pay bill budget of £702m in 18/19 against a 17/18 outturn of £676m (this included £20m to cover inflation, incremental uplifts and clinical excellence awards). End of year forecast shows we have a planned end of year pay spend of £694m. Pay underspends occurred in admin and clerical £7m, AHP's 6m and a overspend in nursing and medical of £8m and £7m respectively. The admin and clerical underspend is due to the 12m budget increase in 18/19 and the £3m AHP budget increase in 18/19 together with high turnover rates.

Pay dis-investment 18/19

Pay bill setting in 18/19 included 21m of pay dis-investment made up of £12m of bank and agency overspend reduction and permanent nursing staffing reductions identified as part of the nursing establishment review process. The temporary staffing pay dis-investment total was removed before pay bill was set and allocated in 18/19.

Establishment 18/19

- Our budget allocation principles for 18/19 included the statement that 'every member of staff in the organisation will be funded at the actual cost of the person in post', during this process 226 unfunded posts were identified that increased our funded establishment over planned levels for 18/19. **Continued Improvement area for 19/20**

- Budgets and FTE are now reconciled across the Trust; in order to keep the budget, posts and people aligned the system hierarchy of the ledger and ESR has been flipped and all customers have been given access to their own staffing raw data. From 19/20 ESR will become the primary system for WTE information, a new front end people information system will be required during 19/20 to ensure we can provide accessible re-time people information down to speciality level. **Continued Improvement area for 19/20**

Nursing establishment and headroom

- A Trust wide nursing establishment review was conducted in 18/19 which has resulted in a set of agreed budgets and FTE; a new governance process has been introduced to assure all future changes to nursing establishment from now on; **Continued Improvement area for 19/20**
- Nursing headroom was again set at 19.5%
- Nursing establishment numbers are inclusive of the 19.5% headroom and 2% has been reflected in budgets for maternity cover. A review was conducted in 18/19 to determine whether all headroom posts should go into the funded establishment for recruitment or kept as a bank temp staffing pot, this will be reviewed again in 19/20.

Temporary staffing

- Bank may only be used to cover a vacant post that has funding attached and to the equivalent level of budget available;
- Agency non clinical cover may be used only by exception and cover should be reduced in hours to fit within the budget, allowing for higher rates and premium;
- Agency medical cover should be clinical only (e.g. 6 or 8 PAs instead of 10 PAs) to stay within budget; where this presents an unacceptable level of clinical risk, the Medical Oversight Committee will assure the decision;
- Agency premium has not been converted in to WTE but will be used as contingency cover where clinical need requires us to go over the 6-8PAs.

Maternity funding policy

- Nursing: 2% has been historically been incorporated into budgets but not WTE across nursing, giving a notional headroom of 21.5%.
- All other staff groups except corporate: Each division has a fund equivalent to a WTE assumption (although not in ESR) that needs to be drawn down through divisional and central VAP and WAP approval processes;
- Corporate areas: A central fund will be held and allocated via the central VAP and WAP process.
- The maternity funding policy above was not consistently implemented during 18/19 which has resulted in a large amount of FTE movement and freezing to fund essential maternity cover posts, this needs to be improved for 19/20. **Continued Improvement area for 19/20**

Workforce plan
Delivery against 18/19 plan

Changes to pay control processes

- *Controlling establishment*
  - The Trust wide investment committee has been redesigned to strengthen focus on ROI and ensure any approvals given have money to support them;
  - As the reconciliation of people and funding is now done at the post level, it is no longer possible to have an unfunded post.
- *Controlling permanent recruitment*
  - VAP/WAP review panels have been put in place at the division/ corporate level to ensure that the post is (a) required and (b) funded;
  - A central Vacancy Control Panel provides further scrutiny and assures the divisional process. **Improvements made in 18/19 to be monitored**
- *Controlling temporary staffing spend*
  - Approval of temporary staffing has been raised to a more senior level of the organisation (Director of Nursing and Divisional Medical Director); this will continue until spend has been brought back in line with 16/17 levels;
  - A new set of Trust wide controls and forecasts will improve visibility and will ensure agency spend remains within cap: for medical this is the Medical Oversight Committee and a new central nursing forum assesses performance against forecast, **Medical 19/20 continued improvement area**
  - The nursing establishment reviews across the Trust will conclude in April 19 and alignment of e-Rostering to the outcomes of these reviews will prevent overspends against budget; **Continued Improvement area in 19/20**
  - New sets of real time data will give early warning of any areas of overspend and facilitate plans to bring the area back within budget. **Medical 19/20 Continued Improvement area.**

Workforce Tracker

- A new trust wide workforce tracker was introduced in 18/19 which details the movement in funded establishment against plan for the year;
- A Workforce and Finance establishment forum was established in 18/19 to improve the visibility and decision making process for increasing funded establishment;
- A new Executive Team and Board FTE summary tracker are now issued each month;
- A summary of the 18/19 movements are detailed below ;

17-18 Outturn Position	12,540	In's	Outs
Adjustments:			
17/18 Unfunded Posts	226	226	
18/19 Cost Pressures	22	22	
Nursing Establishment	(13)		(13)
Investment/Disinvestment Adjustments:			
Critical Care Unit	113	113	
Carter/GIRFT initiatives	19	19	
Service Developments	130	130	
NHSi Nursing Establishment	(79)		(79)
PRUH E&C Ward	(40)		(40)
Paeds Rota	(6)		(6)
CIP	(15)		(15)
Medical Assessment Centre	5	5	
Corrections	1	1	
Transfer of Budget	(12)		(12)
Skill Mix Adjustments	45	45	
External Funded	109	109	
Sub total of FTE change	**505**	**671**	**(166)**
Workforce Budget After Adjustments (WTE M11)	**13,045**		

Workforce plan
Plans for 19/20

Pay bill setting for 19/20

Pay bill has been set at £746m and changes/improvements to the pay bill setting principles are listed below:

Maternity

- A consistent allocation and draw down process will be used for 19/20 which will improve the transparency and simplify the maternity cover processes across the Trust;
- Nursing will receive £2.4m of maternity cover money (not converted into WTE) which will be drawn down in the Divisional VAP/WAP meetings;
- This in effect increases our overall headroom for nursing from 19.5% to 21.5%.
- For other staff groups £2.887m has been set aside for maternity cover, for operational divisions this will be drawn down in the same way as nursing above, for Corporate divisions the central VAP/WAP process will be used.
- This will reduce the movement of WTE across the trust and create more stability in the ESR/ledger.

Agency Premium

- The same principles will be used for 19/20 but with a strengthening of the principle that agency premium should not be used to create new temporary posts that are then reported as cost pressures (via the substantiated bank and agency heading) for the next year as this undermines the pay control processes across the Trust . The premium should only be used to cover the increased unit cost of filling business critical vacancies with agency staff. £3.1m has been set aside this year to cover this.

Enhanced Care

- A formal Bank pot has been set aside to cover enhanced care across the Trust of £2.84m. We need to agree the process for draw down of money and the resourcing approach. At current average salary rates this pot of money equates to an equivalent additional temporary WTE of 50 WTE across Nursing.

Vacancy Factor

- £7.5m has been deducted from the overall pay bill for a Trust wide vacancy factor (the natural cost reduction opportunity created by staff turnover and limited available bank cover). This is broken down into 5 % for Admin and Clerical and 2.5% of AHPs, this will be reviewed quarterly.

Winter pressures/escalation

- £496k has been set aside to pay for winter and ward escalation requests, this won't be translated into WTE but held in the reserves pot until needed. We need to review the governance and tracking of this pot.

Improvements to ESR/ledger reporting during 19/20

The following areas have been highlighted for continued improvement during 19/20:

- With the new ESR/ledger process now in operation consideration needs to be given to implementing a monthly ledger update process and restricting the ledger update role across the Finance function;
- The way that R and D money and WTE are tracked and reported;
- The junior doctor rotation process;
- The re-charge in and out process and reporting;
- Externally funded principles & process;
- The people data transparency and reporting;
- The admin and clerical v corporate service reporting;
- Ensuring the changes to the establishment control process are embedded.

Control total

- Each division will be given a WTE control total for the start of 19/20, and agency/bank spend targets. The only way the WTE control can be increased is through Trust wide approval processes; the Investment Board or through a defined external funding source.

Workforce plan
Pay bill initiatives for 19/20

We have reviewed our workforce pay and productivity approach and developed a number of improvement themes and activities for 19/20. These can be grouped under 5 main headings:

Workforce Productivity

- Work with the strategy team and business on reviewing the workforce opportunities highlighted in the model hospital data;
- Conduct the Trust wide nursing establishment review process for 19/20;
- Continue to work on the E- roster Carter metrics KPI improvements ;
- Review the reporting structure for the new bank and agency targets for 19/20;
- Implement medical e-roster during 19/20.

Reducing Pay Costs

- Agency and bank management:
  - London wide agency cap compliance for all professions;
  - Review agency shift length/grading of shift and breaks;
  - Align bank rates with the STP
  - Move ADH payments to the bank
  - Introduce a new WLI rate for consultants.
- Ensure our re-charge processes are working correctly;
- Introduce new principles for paying overtime across the Trust.

Controlling Establishment Increases

- At the end of quarter 1 review the requirement for the Vacancy Control Panel;
- Improve the business case process to ensure the impact on all services is captured accurately;
- Continue to run the establishment control meetings with Workforce and Finance.

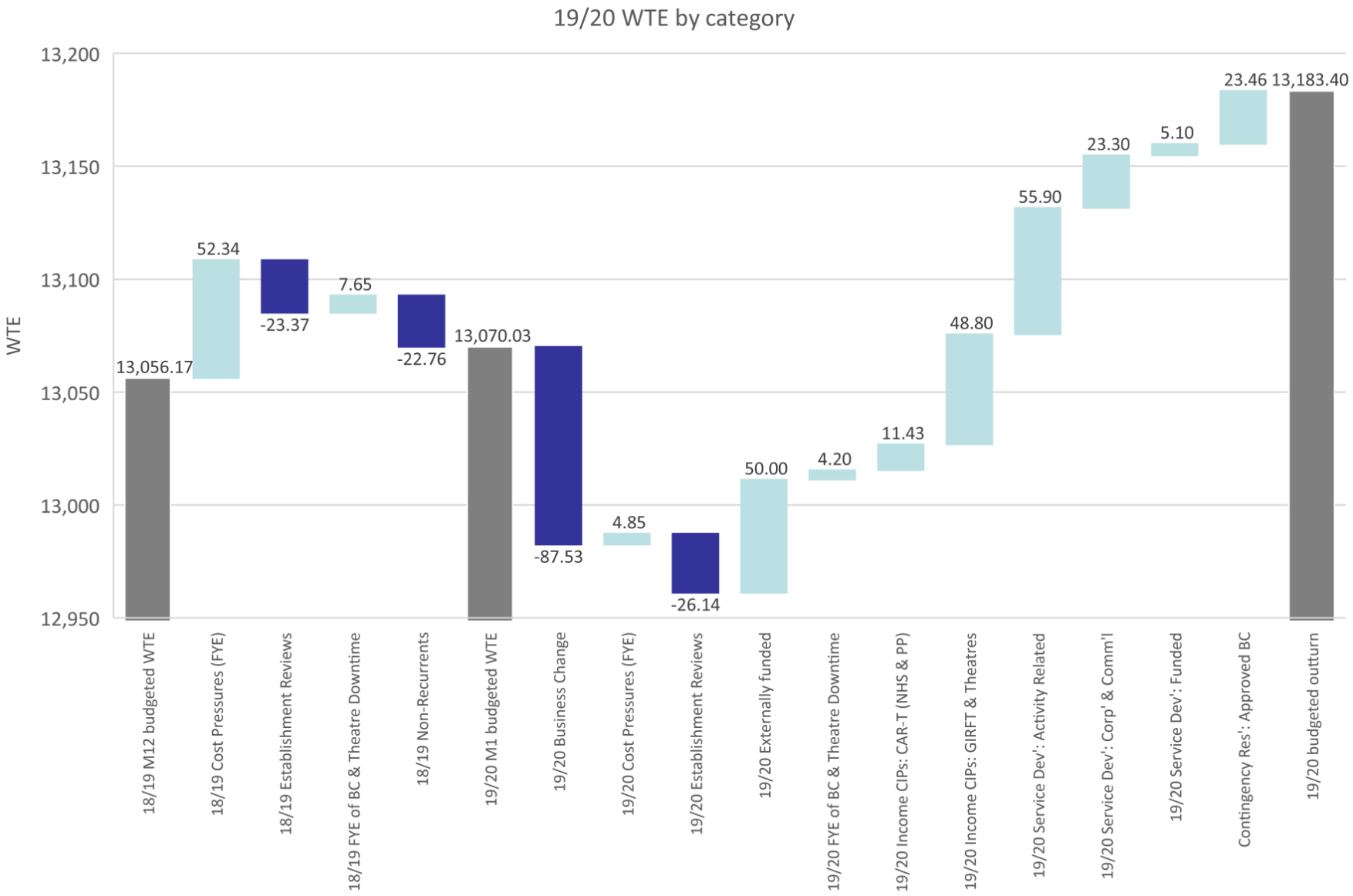
Improving Workforce & Finance Data

- Single data set:
  - Work with BIU to introduce a Trust wide set of finance/ people/ performance data to below care group level;
  - Continue to run the divisional VAP/WAP and reconciliation meetings to ensure the alignment of finance and people data;
- Review the performance of our new bank partner 12 months into the new contract.

Workforce Transformation

- Support the centralisation of our outpatients function to improve it's effectiveness and efficiency;
- Conduct a review of AHP staffing and delivery model across the Trust;
- Provide bespoke people support for theatres and ED;
- Conduct a corporate services zero based resourcing review to help inform the structure and priorities of our corporate services
- Explore the introduction of new roles for hard to fill areas.

Workforce plan
WTE bridge



Workforce plan
WTE table

	Admin and Clerical WTE	Medical Staff WTE	Nursing staff WTE	Other Staff WTE	Total WTE
18/19 M12 budgeted WTE	**2,611.29**	**2,313.84**	**4,788.40**	**3,342.64**	**13,056.17**
18/19 Cost Pressures (FYE)	2.41	9.80	29.54	10.59	52.34
18/19 Establishment Reviews			-23.37		-23.37
18/19 FYE of Business Cases & Theatre Downtime	2.45	1.00	3.00	1.20	7.65
18/19 Non-Recurrent	-7.50	-7.00	-10.11	1.85	-22.76
18/19 M12 net forecasted movement	*-2.64*	*3.80*	*-0.95*	*13.64*	*13.86*
19/20 M1 budgeted WTE	**2,608.65**	**2,317.64**	**4,787.46**	**3,356.28**	**13,070.03**
19/20 Business Change	-40.53			-47.00	-87.53
19/20 Cost Pressures (FYE) (relating to 18/19)	1.00	2.00	1.00	0.85	4.85
19/20 Establishment Reviews	-5.00	-5.00	-1.14	-15.00	-26.14
19/20 Externally funded	25.00	5.00	15.00	5.00	50.00
19/20 FYE of Business cases and Theatre Downtime (relating to 18/19)		3.20		1.00	4.20
19/20 Income CIPs: CAR-T (NHS & PP)		3.20	7.63	0.60	11.43
19/20 Income CIPs: GIRFT & Theatres		34.10	14.70		48.80
19/20 Service Developments: Activity Related	7.14	6.90	24.08	17.78	55.90
19/20 Service Dev': Corporate & Commercial	18.80	-1.50		6.00	23.30
19/20 Service Developments: Funded	0.40		2.60	2.10	5.10
Contingency Reserve: Approved Business Cases	5.50	6.52	11.44		23.46
19/20 net forecasted movement	*12.31*	*54.42*	*75.31*	*-28.67*	*113.37*
Net overall movement	*9.67*	*58.22*	*74.37*	*-15.03*	*127.23*
19/20 budgeted outturn	**2,620.96**	**2,372.06**	**4,862.77**	**3,327.61**	**13,183.40**

Workforce plan
WTE summary

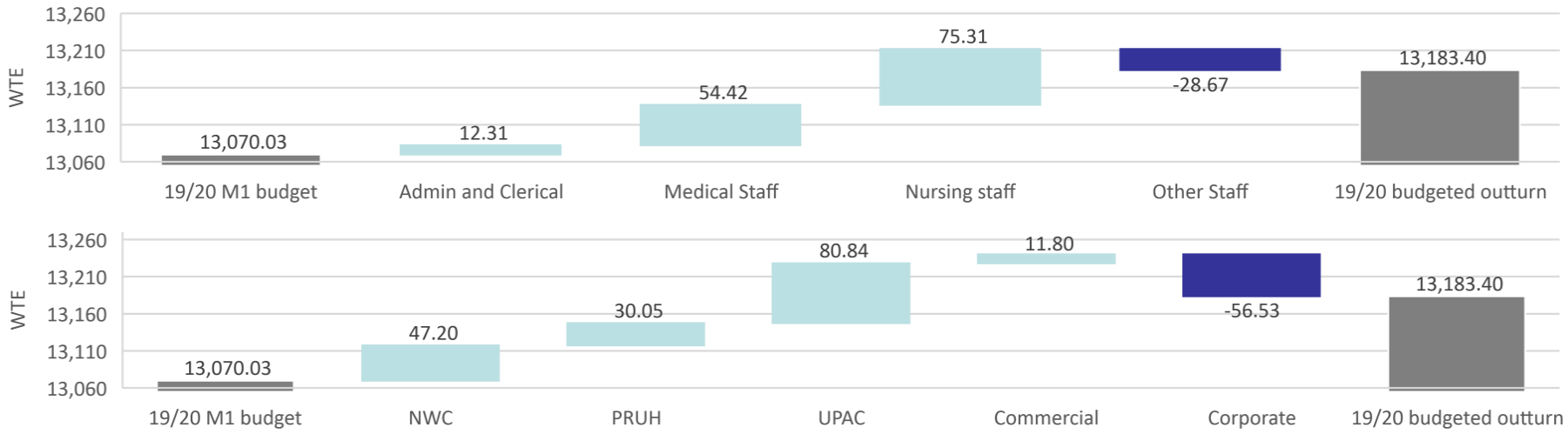
Heading	Total WTE	Narrative
18/19 M12 budgeted WTE	13,056.17	• The workforce is forecasted to be composed of the following: ○ 36.7% Nursing staff, 17.7% of Medical staff and 20% Admin and Clerical staff ○ There is further 25.6% of Other Staff, this includes Dieticians, Pharmacists, Physiotherapists, Radiographers and others
18/19 Cost Pressures (FYE)	52.34	• This is been split in line with phasing, this line relates to those that start 18/19 but 19/20 is set out on next page • The majority (67%) of cost pressures belong in UPAC, 38.40 WTE - 11.81 WTE of this relates to endoscopy weekend working and 4.1 WTE relating to Critical Care Phase 1 posts that were approved but not funded. • The division with next largest element (24%) is PRUH with 13.99 WTE - 5.25 WTE of this relates to the ACP programme and a further 4.01 WTE relates to 7 day endoscopy working. • 14.01 WTE of the total relates to the resolution of historical budget setting errors that have been unearthed in 18/19
18/19 Establishment Reviews	-23.37	• 20 WTEs relate to a hold on the vacancies attributable to the Critical Care Unit due to the delay in its opening. • A further 3.37 WTE is also forecasted to be removed based on a review of the midwifery establishment.
18/19 FYE of Business Cases & Theatre Downtime	7.65	• This relates to embedding the full year effect of approved 18/19 business cases where there is phased increased in WTE. This line represents the phasing for the end of 18/19 with remainder (19/20) set out on the next page. • The majority of this (90%) is in UPAC with 10.65 WTE, of this 4 WTE relates to a business case for Bowel Screening (BC1604), 3.2 WTE relates to a business case for Dermatology (BC1649), and 2 WTE relates to a business case for Sleep Studies (BC1627).
18/19 Non-Recurrent	-22.76	• There is a planned reduction of 25.13 WTE at the PRUH which accounts for the largest movement in this section • The PRUH reduction consists of 18.93 WTE relating to the removal of a business case for Ambulatory Winter Funding. It also includes a further 7 WTE reductions relates to the removal of 6 month's of ACN funding. • The reversal of non-recurrent initiatives in UPAC accounts 3.37 WTE which is the only division with an increase in this area.
18/19 M12 net forecast	*13.86*	
19/20 M1 budgeted WTE	13,070.03	• There is a forecasted increase of 22.91 WTE from the M12 budgeted WTE above, the largest increase expected is in UPAC with 49.05 WTE. WTE reductions are forecasted for NWC and PRUH of 18.8 WTE and 10.14 WTE respectively. • The increase by staff group is primarily in Other Staff (15.49 WTE) and Medical (9 WTE) with the former being primarily Sub Allied Health Professionals of 5.32 (Physiotherapy 2.1 WTE and Radiographers of 2 WTE) and other scientific, therapeutic and technical staff of 9.97 (Pharmacy 3.85 WTE and HEE/STP (3.27WTE).

Workforce plan
WTE summary

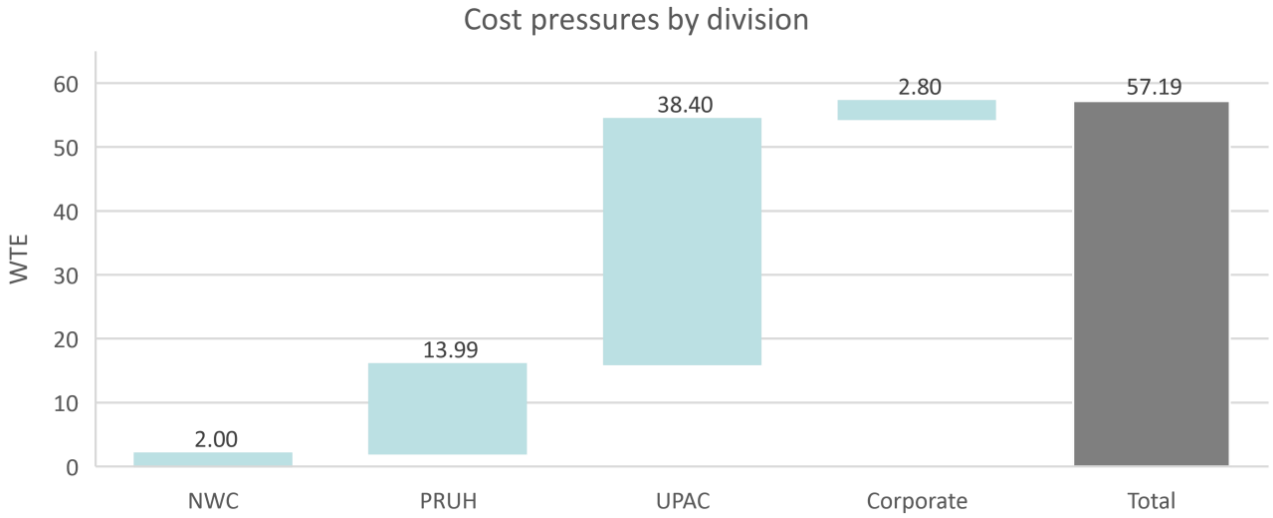
Heading	Total WTE	Narrative
19/20 M1 budgeted WTE	13,070.03	• This includes cost pressures, establishment reviews, the full year effect of business cases and non-recurrent items.
19/20 Business Change	-87.53	• A planned group level ADM movement with 87.53 WTE being removed from Corporate and being moved into KFM.
19/20 Cost Pressures (18/19)	4.85	• Relates to 18/19 cost pressures phased for 19/20 - see corresponding line on previous page for details
19/20 Establishment Reviews	-26.14	• The identification of further efficiencies by reviewing the establishment across the trust. This includes a targeted removal of 20 WTE as part of a planned cleanse of historic vacancies which are not used across all areas and 16 WTE targeted in relation to supply chain efficiencies following the service moving to KFM. • At a divisional level, the majority of the reductions planned have been identified in UPAC with 21.33 WTE - of this, there is an additional reduction of 9.26 WTE based on a further stage of the Midwifery establishment review. • NWC have a forecasted 9.85 WTE increase in this area due to the unfreezing of the 20 WTE vacancies held due to the delate in the opening of the critical care unit.
19/20 Externally funded	50.00	• In 18/19, there was an increase in externally funded establishment of 80 WTE. In accordance with this, an increase of a similar value has been forecasted for 19/20 as there are no expected changes to the respective landscape. • Divisionally, the majority of this is expected to be in Corporate and Networked Care with 20 and 18 WTE respectively based on the historical trend. UPAC and PRUH are expected to have a much smaller increase with 6 WTE each.
19/20 FYE of BC & Theatre Downtime (relating to 18/19)	4.20	• Relates to 18/19 business cases phased for 19/20 - see corresponding line on previous page for details
19/20 Income CIPs - CAR-T (NHS & PP)	11.43	• Relates to business case for the CAR T-Cell Therapy Unit (BC1609) of which a 10.83 WTE increase is planned in NWC (7.63 WTE in Nursing with the rest in Medical) and a 0.6 WTE increase in UPAC.
19/20 Income CIPs - GIRFT & Theatres	48.80	• This consists of two business cases in UPAC: 30.6 WTE in Ophthalmology GIRFT (BC1650), all Medical; and 18.2 WTE in BC1618 T&O GIRFT (BC1618), 81% Nursing and 19% Medical.
19/20 Service Developments - Activity Related	55.90	• Business cases which are entirely dependent on the commissioner's approval for the respective income. Should the commissioner reject the relevant additional income, the respective WTE will not be added. • The largest of these business cases is 21.28 WTE relating to the Ambulatory business case at the PRUH which consists of predominantly Nursing staff (10.57 WTE). • The remaining related to UPAC and the largest is an increase if 9.41 WTE for a NICU business case.
19/20 Service Developments - Corporate & Commercial	23.30	• Initiatives in the Corporate and Commercial area with the largest initiative relating to an increase of 13.3 WTE (all Admin & Clerical) in relation to the increased budget for KHP Haematology Institute. • Restructuring in PMO and Finance are forecasted to also increase the establishment by 6 WTE and 4 WTE respectively.

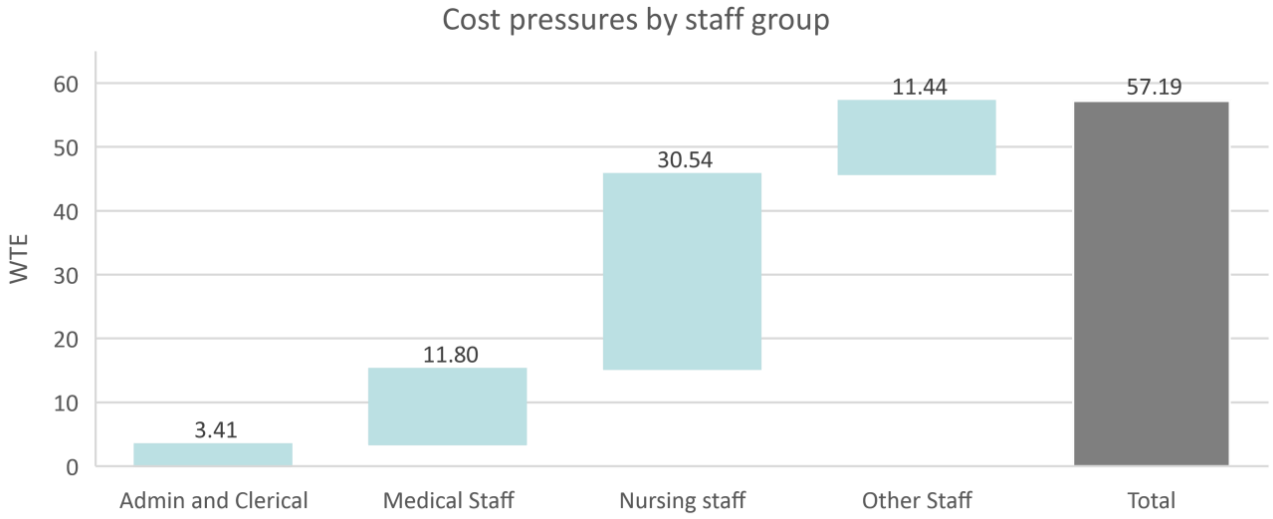
Workforce plan
WTE summary

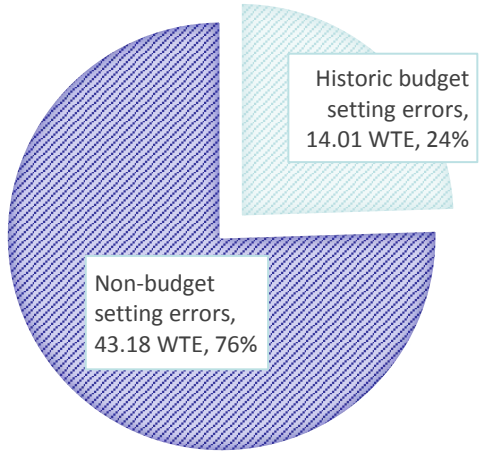
Heading	Total WTE	Narrative
19/20 Service Developments - Funded	5.10	• UPAC have two funded developments expected: Diabulimia Pathway Pilot (T1DE Type 1 Diabetes Disordered Eating Service) (3.1 WTE primarily Sub Allied Health Professionals) and capacity increase of Havens CYP Psychology to meet NICE requirements (2 Nursing WTE).
Contingency Reserve - Approved Business Cases	23.46	• 13.44 WTE relates to PRUH, 10.44 WTE of which is CNST requirement for uplift (BC1416) • 6.52 WTE relates NWC, 4 WTE of which is for Microbiologists (BC1663) and remainder is AOS (BC1666)
19/20 net forecast	*113.37*	• Forecasted increase of 104.32 WTE from the M1 budgeted WTE above, the largest increase (71% of net change) is expected in UPAC (73.79 WTE) with increases in NWC and PRUH expected to be 45.2 WTE (43%) and 30.05 WTE (29%) respectively.
19/20 budgeted outturn	13,183.40	• The Corporate area is expected to see a decrease of 56.53 WTE (-54%) which is largely driven by the ADM movement • Nursing is forecasted to see the largest increase with 74.31 WTE (71%) which is primarily driven by the establishment reviews 16.85 WTE (NWC), GIRFT 14.7 WTE and Activity related initiatives 13.51 WTE (both UPAC). • Medical is forecasting an increase of 49.22 WTE with the GIRFT initiative (UPAC) accounting for 34.1 WTE. • A&C WTE is expected to remain relatively stagnant (increase of 11.31 WTE) with Other staff expecting to decrease by 30.52 WTE - both are significantly influenced by the ADM movement from Corporate to KFM.



Workforce plan
Cost pressures







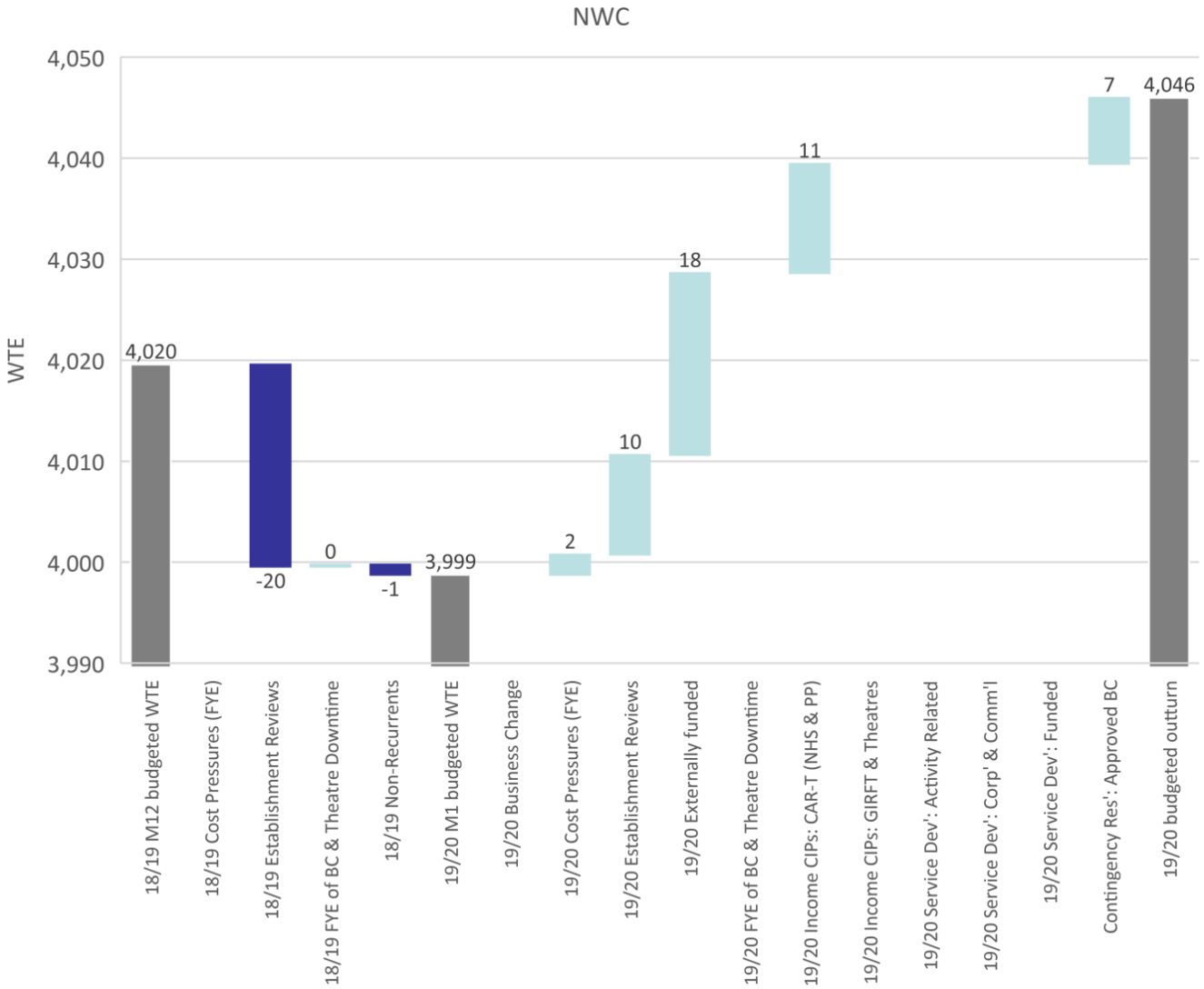
The cost pressures consist of known cost pressures that impact the start of 19/20 (52.34 WTE) plus those known to impact in year (4.85 WTE). This together equals the 57.19 WTE.

The largest cost pressures are:

- 11.81 WTE for Endoscopy weekend working in UPAC across 3 room
- 5.25 WTE for the ACP programme
- 4.1 WTE for Critical Care Phase 1 posts that were approved but not funded, a budget setting error. These errors make up 24% of the cost pressure total.
- 4.03 WTE for Endoscopy 7 day working at the PRUH
- 3.27 WTE for HEE funded posts (PYE April to September 2019) funded in 17/18.

Workforce plan

WTE bridges by division



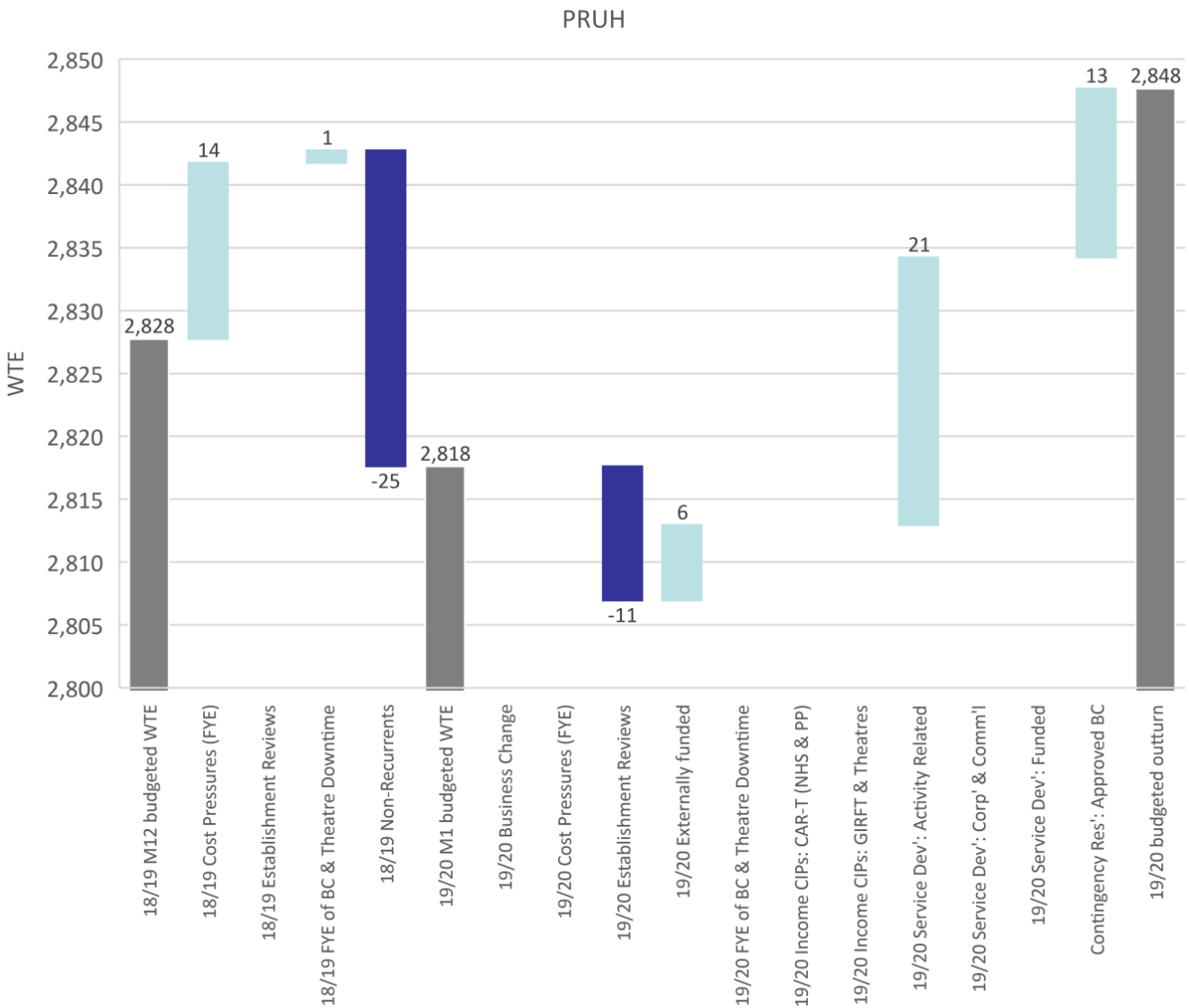
Net change for NWC between M12 budget of 18/19 to 19/20 budgeted outturn is 26.4 WTE.

Details of the three largest forecasted movements in NWC are set out below:

- *18/19 establishment reviews (20 WTE)* – vacancies will be held as a result of the delay to the opening of the Critical Care Unit ("CCU").
- *19/20 externally funded posts (18 WTE)* - it is anticipated, based on the trajectory of 18/19, that these will be added to the establishment which will be externally funded.
- *Car-T (Income Generating) (10.83 WTE)* - forecasted to be added in relation to Car-T cell. This will be offset by the additional income generated by this service.

Workforce plan

WTE bridges by division



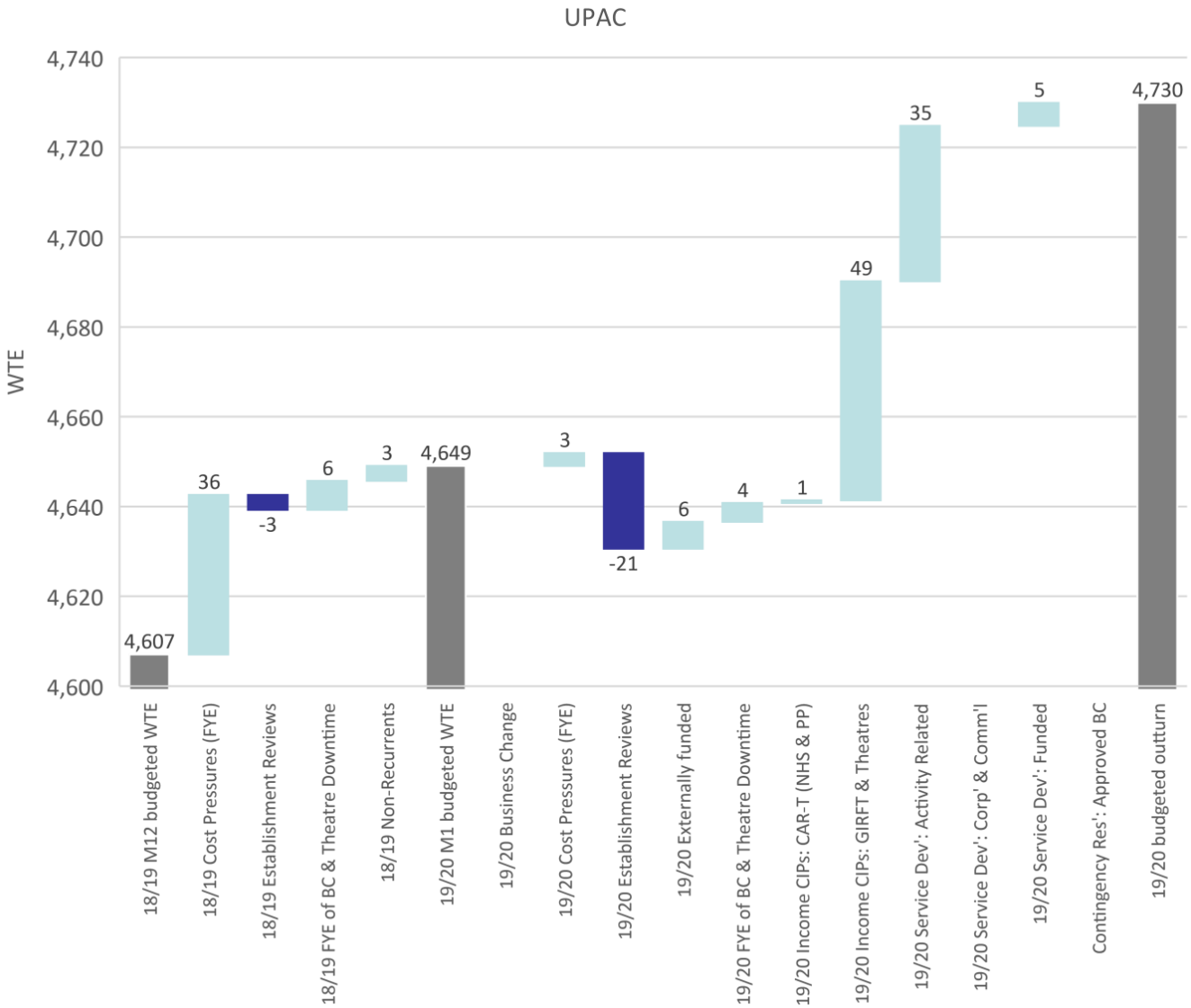
Net change for PRUH between M12 budget of 18/19 to 19/20 budgeted outturn is 19.9 WTE.

Details of the three largest forecasted movements in PRUH are set out below:

- *18/19 non-recurrents (-25 WTE)* – the majority of this relates to the removal of the Ambulatory Winter Funded Business Case (18.93 WTE) with further reduction (7 WTE) applying to the removal of ACN funding
- *Service developments – activity related* (21 WTE) – this relates entirely to the ambulatory business case, this increase is subject to the approval from commissioners. Should this not be obtained, the changes set out in the business case will not be applied
- *18/19 Cost pressures (14 WTE)* – the three largest cost pressures are.
  - 5.25 WTE for the ACP programme
  - 4.03 WTE for Endoscopy 7 day working at the PRUH
  - 3.2 WTE for 18/19 Unfunded recharge from St. Georges

Workforce plan

WTE bridges by division



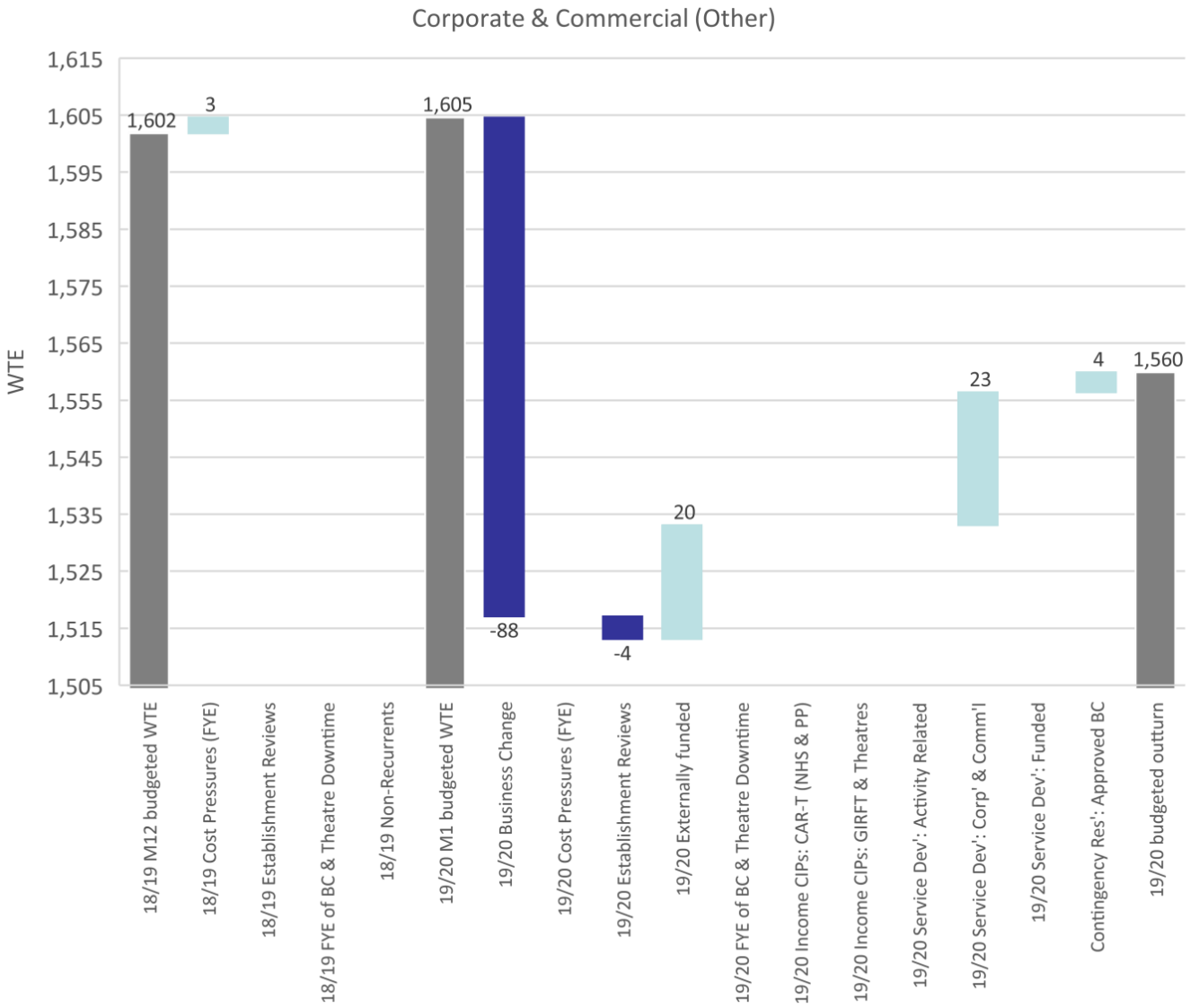
Net change for UPAC between M12 budget of 18/19 to 19/20 budgeted outturn is 122.84 WTE.

Details of the three largest forecasted movements in UPAC are set out below:

- *Income CIP GIRFT & Theatre (49 WTE)* – this relates to approved business cases for GIRFTs for Ophthalmology and T&O
- *18/19 Cost pressures (36 WTE)* – the three largest cost pressures are:
  - 11.81 WTE for Endoscopy weekend working across 3 room
  - 4.1 WTE for Critical Care Phase 1 posts that were approved but not funded, a budget setting error. 3.27 WTE for HEE funded posts (PYE April to September 2019) funded in 17/18
- Service developments – activity related (35 WTE) – there are 23 different initiatives of which the largest is the NICU business case with Network services. All are subject to the approval from commissioners

Workforce plan

WTE bridges by division



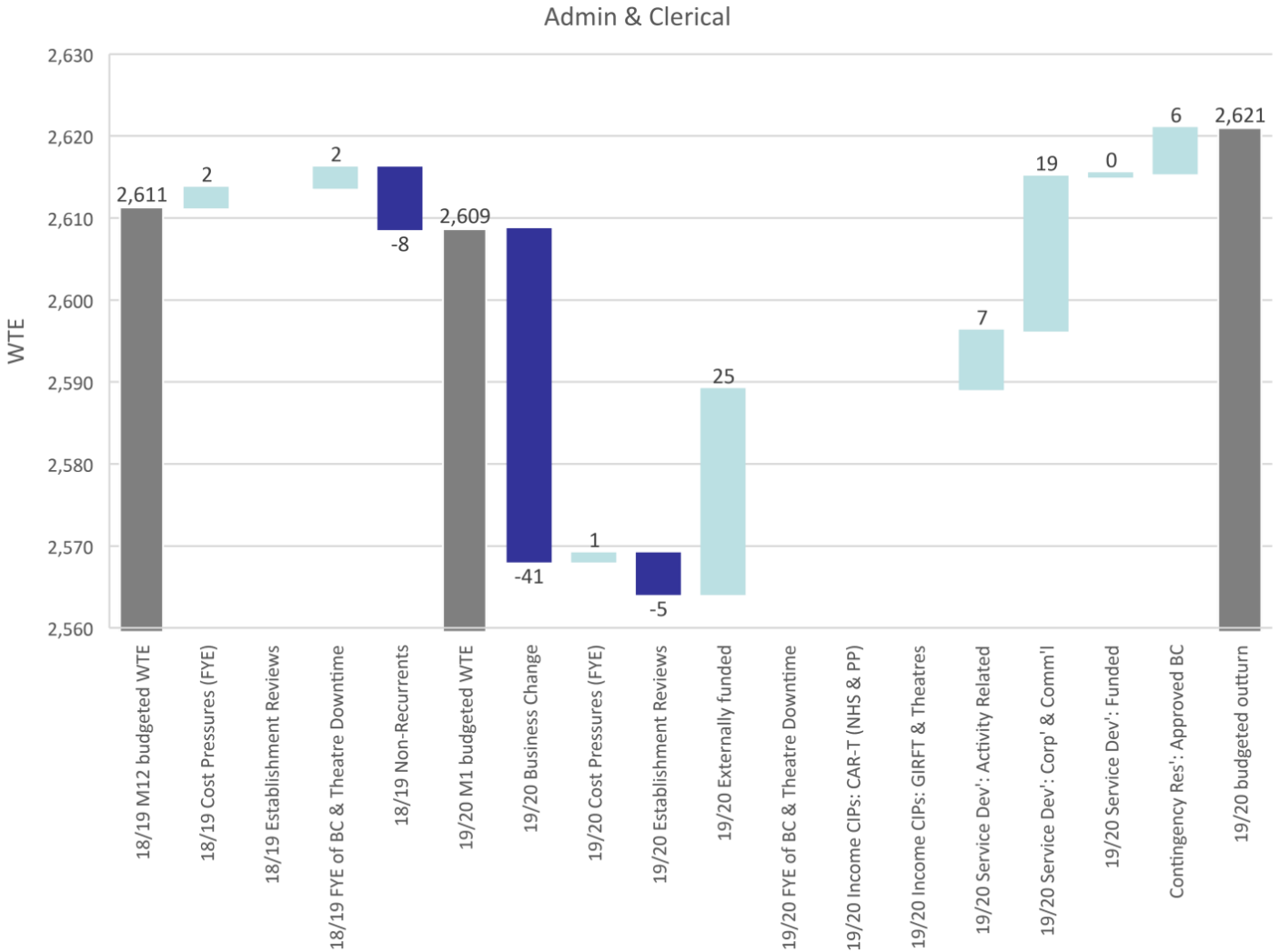
Net change for this area between M12 budget of 18/19 to 19/20 budgeted outturn is -41.93 WTE.

Details of the three largest forecasted movements are set out below:

- *Business change (-88 WTE)* – a group level move of posts to KFM
- *Service developments (23 WTE)* – predominantly relates to KHP Haematology Institute Budget for 19/20 (13.3 WTE) and PMO restructure (6 WTE)
- *19/20 externally funded posts (20 WTE)* - it is anticipated, based on the trajectory of 18/19, that these will be added to the establishment which will be externally funded

Workforce plan

WTE bridges by staff group

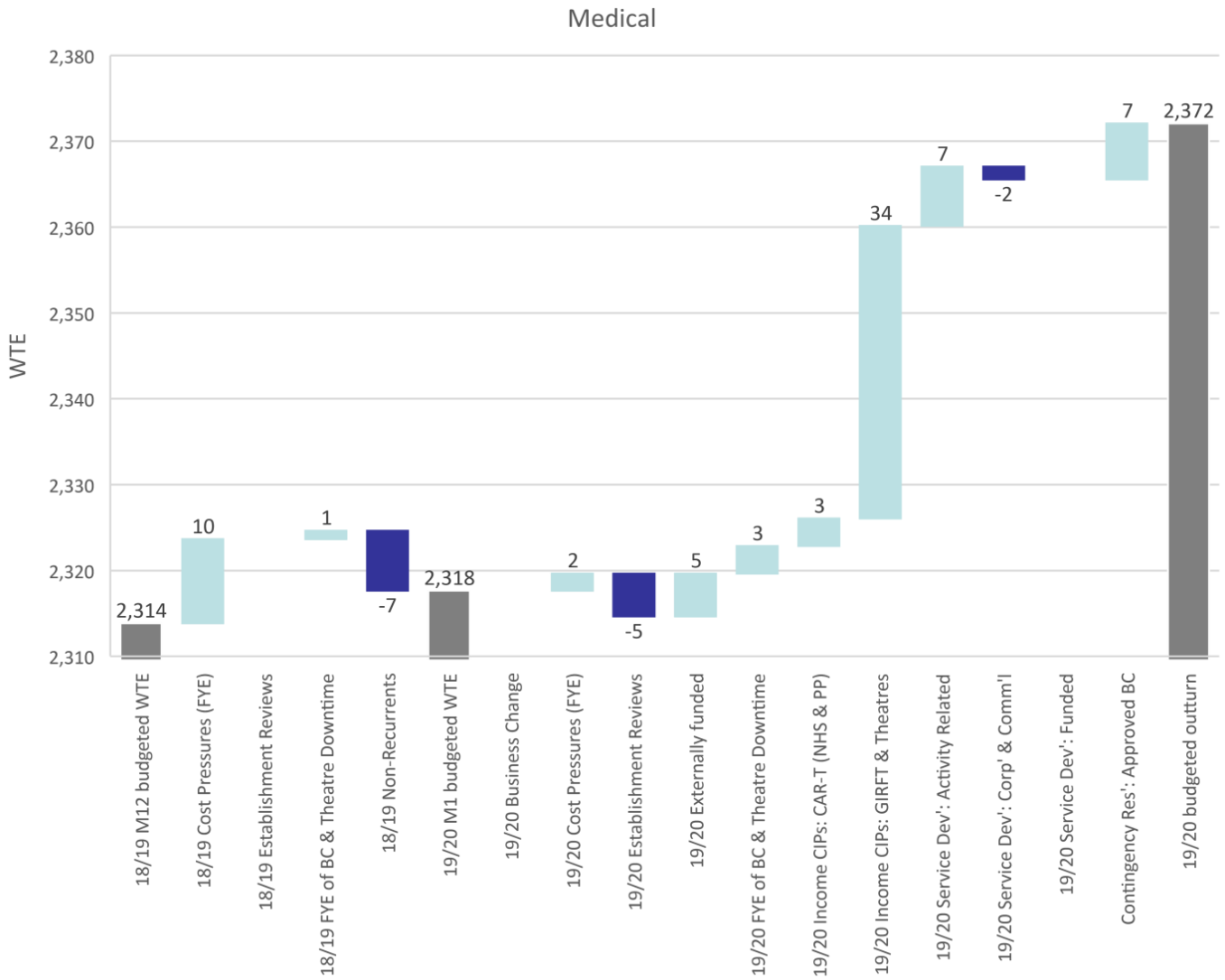


Grade	WTE
B3	3.34
B4	2.70
B5	14.21
B6	-0.05
B7	4.50
B8A	1.50
B8B	5.00
VSM	-1.00
Not known	*-20.53*
Total	**9.67**

The Not Known category consists of the WTE relating to a fixed value apportioned across the Divisions and Staff Groups but not Staff Grades. This will be identified in due course. In A&C, this is driven largely by ADM restructure from KCH to KFM.

Workforce plan

WTE bridges by staff group

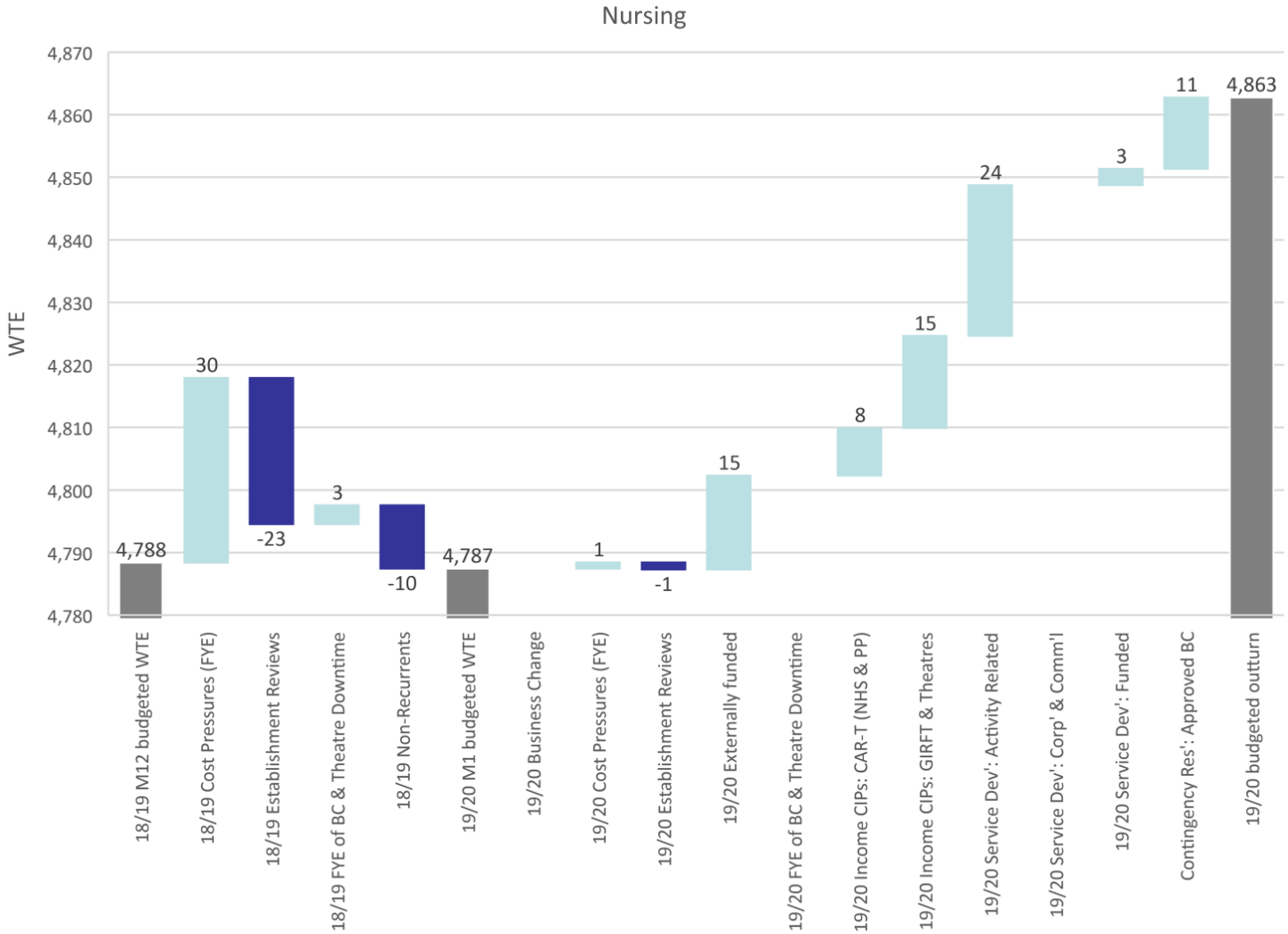


Grade	WTE
Clinical Fellow	-2.50
Community Senior Dental Officer	-1.00
Consultant	49.52
Foundation 1 Trainees	3.00
GP Trainee	3.20
Junior Clinical Fellow	-3.20
Junior Doctors ST1-ST3	3.20
Specialist registrar	6.00
Total	**58.22**

The 49.52 WTE of Consultants relates primarily to 30.6 WTE planned for the Ophthalmology GIRFT business case which will be offset by income. There are also 5 WTE planned for the ED Olympic Entrance and a further 4 WTE Frailty 7-Day Opening.

Workforce plan

WTE bridges by staff group



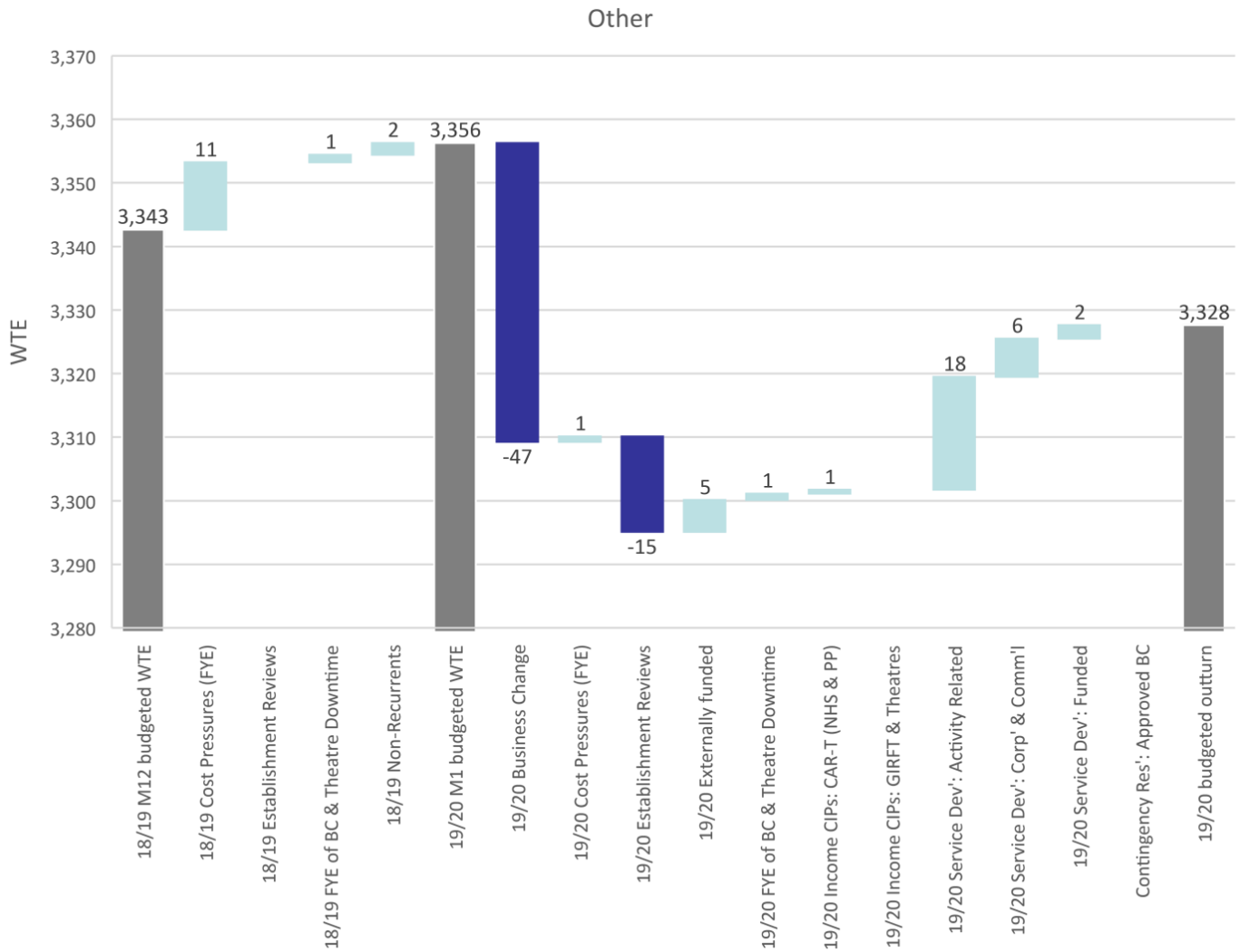
Grade	WTE
B2	3.23
B3	8.85
B4	0.63
B5	19.75
B6	9.49
B7	10.22
B8A	18.20
Not known	*4.00*
Total	**74.37**

The largest single increase to B5 nurses, accounting for 7 WTE, arises from the Frailty 7-day working initiative which is subject to commissioners approval.

In relation to B8A, 14.7 WTE relates to the GIRFT T&O business case.

Workforce plan

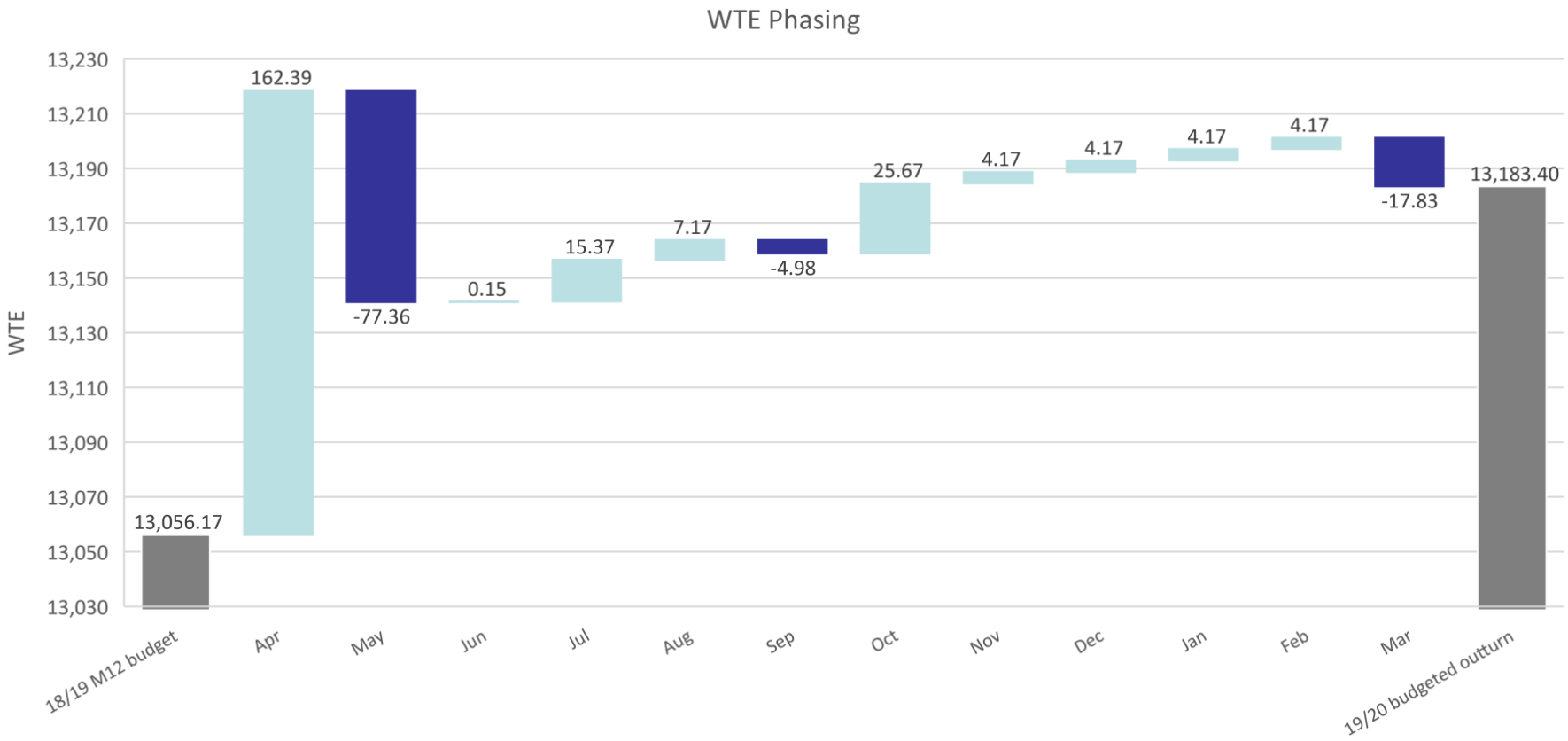
WTE bridges by staff group



Grade	WTE
Ancillary	-47.00
Dietician B7	4.98
Dietician B8B	0.80
Med' Tech' Officer B2	3.00
Med' Tech' Officer B4	1.22
Med' Tech' Officer B5	2.00
Med' Tech' Officer B6	1.00
Med' Tech' Officer B7	1.00
Occup'l Therapist B7	3.95
Occup'l Therapist B8B	0.10
Pharmacist B7	3.00
Pharmacist B8A	4.35
Pharmacist B8B	0.77
Physiotherapist B6	2.10
Physiotherapist B7	2.50
Physiotherapist B8A	0.60
Podiatrists B8A	-0.28
Psychologist B8A	1.00
Psychologist B8C	0.20
Radiographer B7	2.00
Scientist B7	-1.00
Scientist B8A	1.00
Speech Therapist B7	1.68
Not known	*-4.00*
Total	**-15.03**

The 47 WTE reduction forecasted in Ancillary relates to the ADM move from KCH to KFM.

Workforce plan
Phasing of initiatives

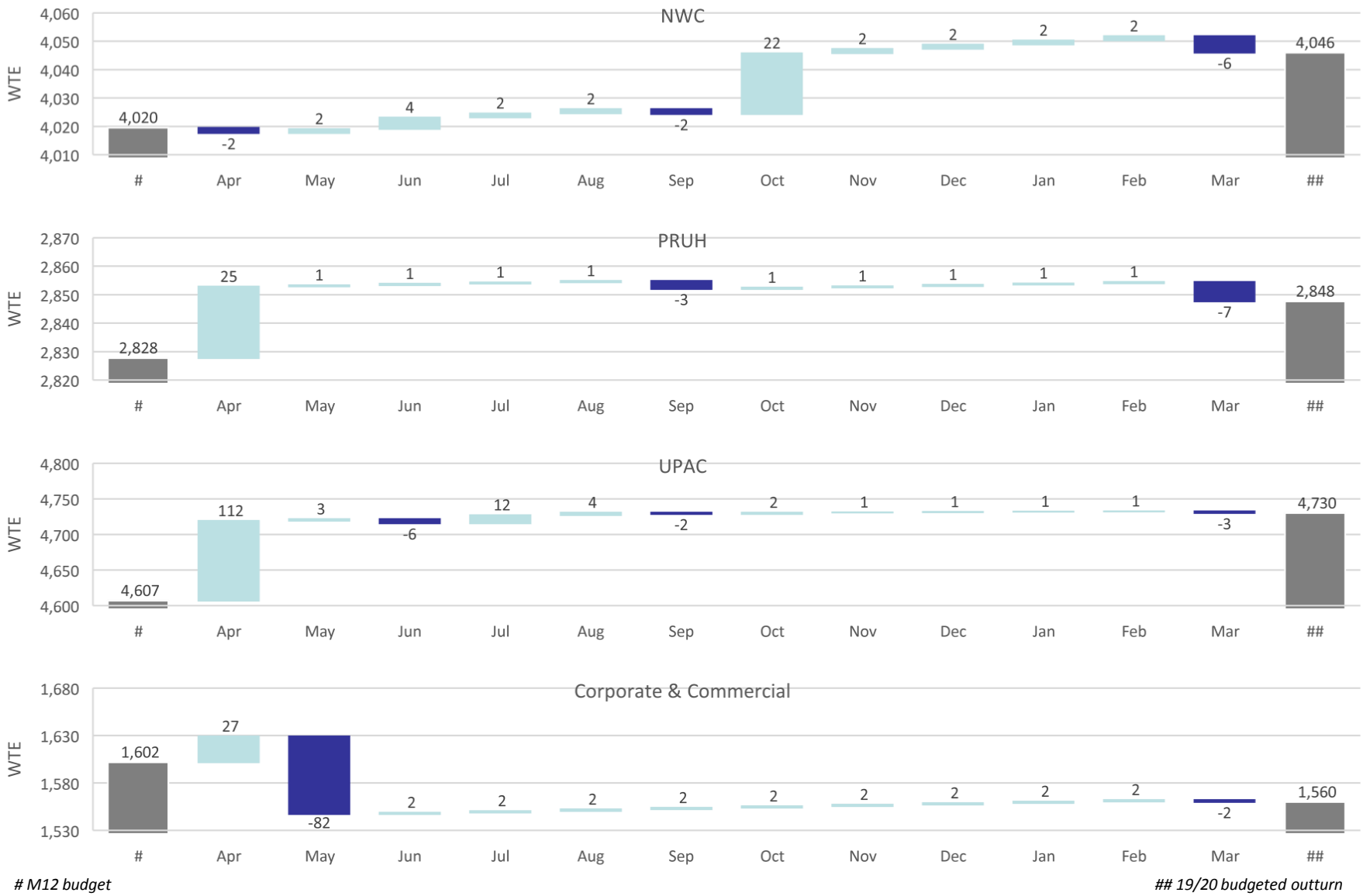


The overall change between 18/19 M12 budget and 19/20 budgeted outturn is the addition of 127.23 WTE. Of this, the large majority (162.39 WTE) is forecasted to impact by April 2019 and within this there is only 13.86 WTE which relates to 18/19 categories. However, 60.23 WTE relates to Income Generating CIPs with a further 36.29 WTE is driven by activity related Service Developments which are subject to commissioner approval.

After M1, there is a forecasted net reduction of 35.17 WTE for the rest of the 19/20 financial year. The phasing is set out by division on the next page.

Workforce plan

Phasing of initiatives by division



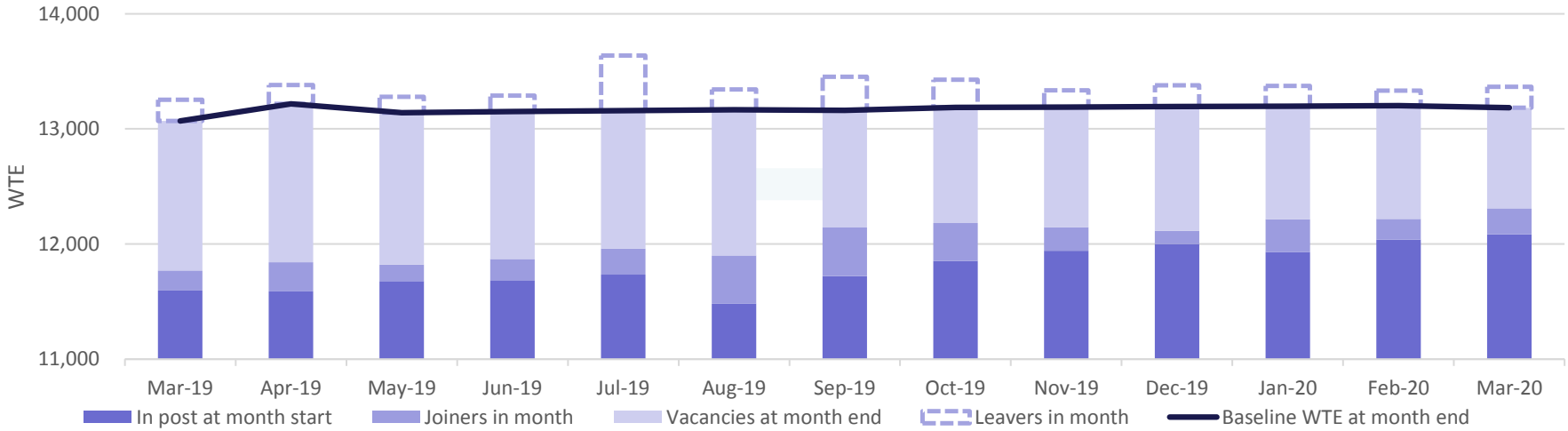
 # M12 budget

19/20 budgeted outturn

Workforce plan
Phasing of initiatives overlaid with joiners, leavers and vacancies

Assumptions

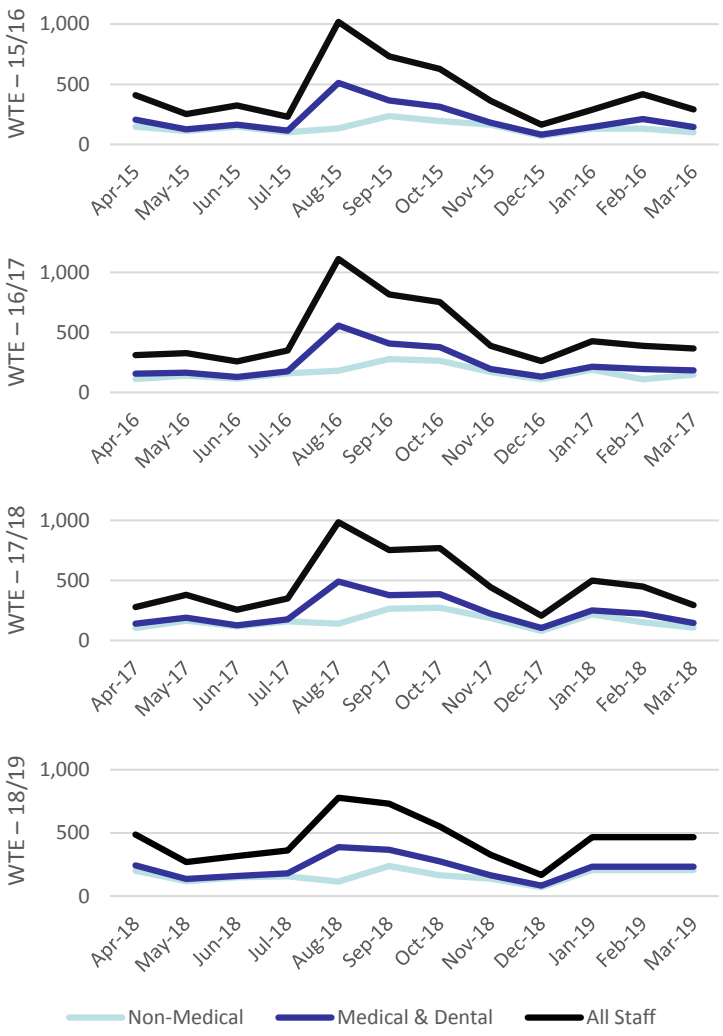
- **Joiners**: Estimated on the basis of our recruitment plan, which targets an 8% vacancy rate by 31 March, phased in line with previous years (see next page). This has been reflected across all staff groups.
- **Leavers**: Estimated on the basis of our target 13% turnover, phased in line with previous years, taken across a range of staff groups.
- **Junior doctors rotation**: Excluded from WTE movements (WTE neutral).
- **Vacancies**: The difference between our WTE baseline plan for the month and the number of staff expected to be in post at month start.
- **Workforce initiatives**: The net monthly WTE impact of the investments and disinvestments set out in this document.



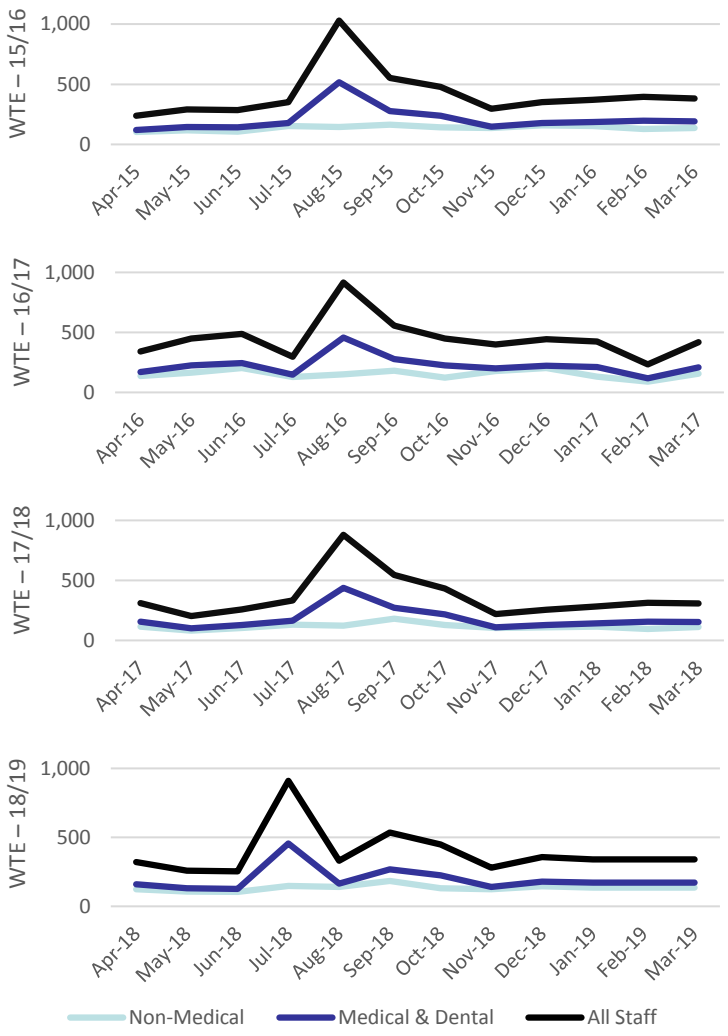
	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
In post at month start	11,596	11,588	11,677	11,685	11,733	11,481	11,722	11,851	11,942	12,000	11,931	12,037	12,085
Joiners in month	174	253	144	185	227	418	421	332	204	116	283	179	224
Leavers in month	-182	-164	-136	-137	-479	-177	-292	-241	-146	-185	-177	-132	-182
In post at month end	11,588	11,677	11,685	11,733	11,481	11,722	11,851	11,942	12,000	11,931	12,037	12,085	12,127
Baseline WTE at month start	13,056	13,070	13,218	13,142	13,152	13,158	13,165	13,160	13,185	13,189	13,193	13,197	13,201
Workforce initiatives in month (WTE)	13.86	148.37	-76.53	10.24	5.94	7.00	-5.15	25.50	4.00	4.00	4.00	4.00	-18.00
Baseline WTE at month end	13,070	13,218	13,142	13,152	13,158	13,165	13,160	13,185	13,189	13,193	13,197	13,201	13,183
Vacancies at month start	1,460	1,482	1,541	1,457	1,419	1,677	1,443	1,309	1,243	1,189	1,262	1,160	1,117
Vacancies at month end	1,482	1,541	1,457	1,419	1,677	1,443	1,309	1,243	1,189	1,262	1,160	1,117	1,057
Vacancies % of baseline at month end	11.34%	11.66%	11.09%	10.79%	12.75%	10.96%	9.95%	9.43%	9.02%	9.57%	8.79%	8.46%	8.02%

Workforce plan
Historical starters and leavers performance

Starters



Leavers



The forecasted outturn of 18/19 shows it is expected to have the lowest leavers level compared to the prior three years. This shows a greater stability in the turnaround of the workforce.

The forecasted outturn of 18/19 is also expected to show steadier starter levels compared to the prior 3 years.

The highest number of leavers in a single calendar month (within a financial year) is August for each of the three years to the end of 17/18. However, in 18/19, it was July. This resulted from Jr doctor rotation.

Please note M11 and M12 of 18/19 are forecasted to be consisted with M10 levels, this is in line with the outturn of 17/18.

Workforce plan
Workforce KPIs

Workforce supply and recruitment plans

Our Trust wide recruitment plans aim to bring in 3074 new starters into the Trust in 2019/20. In addition the Trust will on-board c.650 Junior Doctors on rotation programmes, doctors to fill rota gaps and nursing students during 19/20. We will continue to welcome 250 overseas nursing staff into the Trust during 19/20 as they are a valued part of our workforce supply. The breakdown into the main occupational groups is listed below. Our new recruitment application and tracking system, TRAC, was launched in 2018. This will give us much greater management information and allow us to further reduce our time to hire.

Staff group	18/19 M12 budgeted establish-ment (WTE)	Disinvest-ments (WTE)	Invest-ments (WTE)	19/20 budgeted outturn (WTE)	In post (18/19 FOT) (WTE)	Turnover expected in 19/20	Vacancy rate	Staff to recruit in 19/20 (WTE)
Medical	2,313.84	-15.30	73.52	2,372.06	1,982.09	7%	8%	342.12
Nursing	4,788.40	-58.21	132.58	4,862.77	4,345.84	14%	8%	747.63
AHP	690.58	-0.28	17.03	707.33	597.93	18%	8%	157.57
All others	5,263.35	-119.18	97.07	5,241.24	4,670.42	13%	8%	758.68
Trust-Wide	13,056.17	-192.97	320.20	13,183.40	11,596.28	14%	8%	2,005.99

Our Trust wide recruitment target together with improved retention and a stable establishment should reduce the Trust vacancy rate to 8% for 19/20. Our current Trust wide vacancy rate stands at 11.07%, which is a change from 1.3% at April 18. Our nursing & midwifery vacancy rate at March 18 stands at 9.17% and our medical & dental rate at 9.99%.

Our areas for intensive focus during 19/20 are currently Consultants in Gerontology, Ophthalmology and Radiology. Consultants across acute medicine are a recruitment hotspots, along side nurses in ED services.

Retention plans

Our overall turnover rate currently stands at 14.4% this is a decline on the March 18 position of 13.23%. Nursing & Midwifery have produced a retention plan (as part of the NHSI retention support work) which sets a target of reducing our N&M turnover (including support staff) to below 14% by March 20, and outlines the actions that are being put in place to deliver this.

Given that the Trust is in financial special measures, which might have an impact on turnover, the Trust turnover target will be set to 14% to be achieved by March 2019.

Improving bank fill

A key aim of our temporary staffing priorities is a greater number of medical shifts being covered by Bank rather than Agency and for the Bank/ Agency split to be increased from 84%/ 16% (December data) to 86%/ 14% by the end of March 2020. The contract for management of our staff banks across the Trust has been awarded to Bank Partners and the one year contract review will take place in July 19.and the new contractor will start on the 1st July 2018.

Agency usage plan (£)	17/18 Actual	18/19 Actual*	19/20 Plan
Administrative and Clerical Staff	1,747,634	2,588,725	2,404,926
Medical Staff	16,631,452	11,265,349	10,465,509
Nursing Staff	11,575,773	4,356,877	4,047,539
Professional and Technical	4,720,520	5,180,699	4,803,579
Professions Allied to Medicine	779,824	304,368	282,758
Scientific and Professional Staff	35,099	-6,943	-6,450
Total	**35,490,302**	**23,679,075**	**21,997,861**

Bank usage plan (£)	17/18 Actual	18/19 Actual*	19/20 Plan
Administrative and Clerical Staff	4,604,563	3,352,209	3,352,209
Ancillary Staff	275,714	130,093	130,093
Medical Staff	5,322,003	4,918,813	4,918,813
Nursing Staff	39,140,485	28,783,487	28,783,487
Professional & Technical	2,341,681	1,479,143	1,479,143
Professions Allied to Medicine	45,600	192,946	192,946
Scientific & Professional Staff	14,440	12,541	12,541
Total	**51,744,486**	**38,869,232**	**38,869,232**

** M12 forecasted*

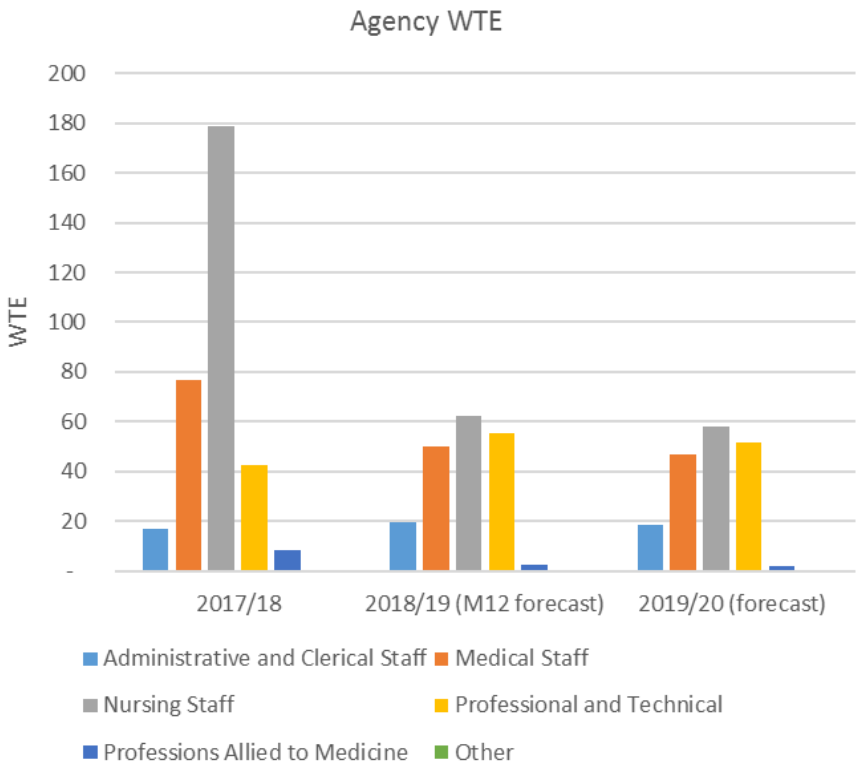
Workforce plan
Bank & Agency forecast

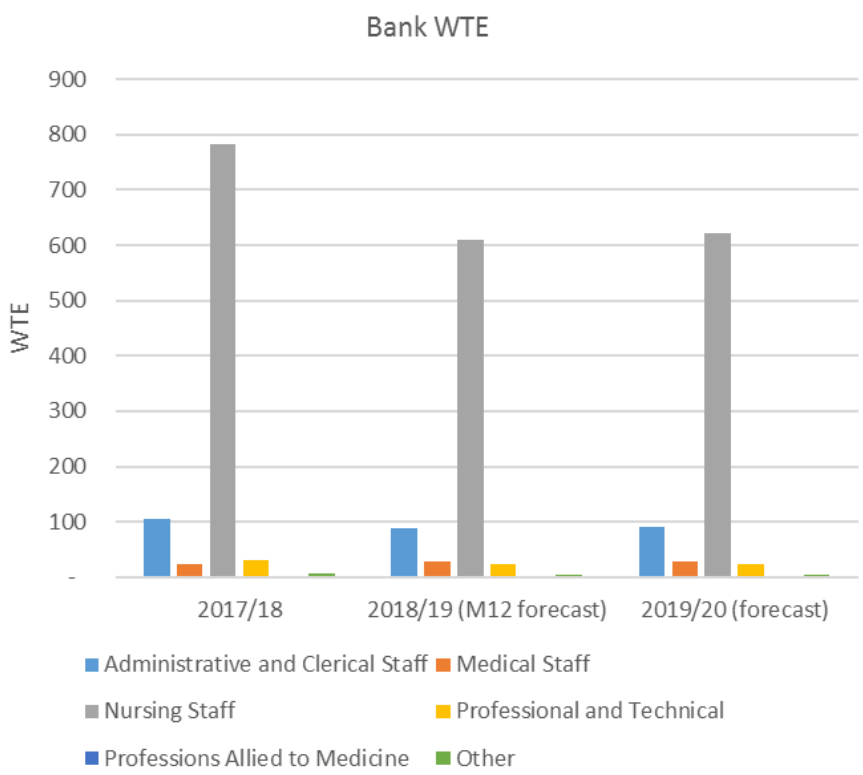
Shifting Agency spend to Bank, and planned Bank savings

Reliance on temporary staffing resource (WTE) has reduced between 17/18 and the forecasted outturn position for 18/19 as the below charts set out. As previously mentioned, there is a planned reduction on agency spend of £1.7m. This has been estimated as 13.55 WTE and will instead shift to Bank

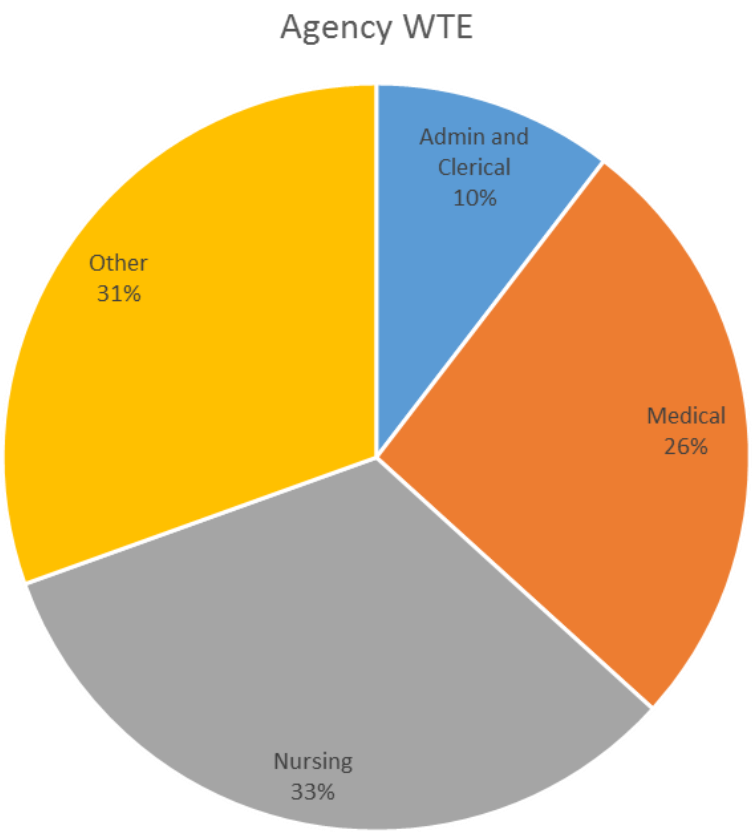
The shift in spend will generate a saving of 30% premium on the agency spend (£500k) but will subsequently increase the spend on bank by £1.2m. In order to mitigate this increase, there is a planned initiative to negotiate cheaper nursing bank rates. This has been targeted to generate a saving to the same value. The outcome of this is therefore that the an increase in Bank resource is forecasted compared to 18/19 but the spend will remain constant to 18/19 levels.

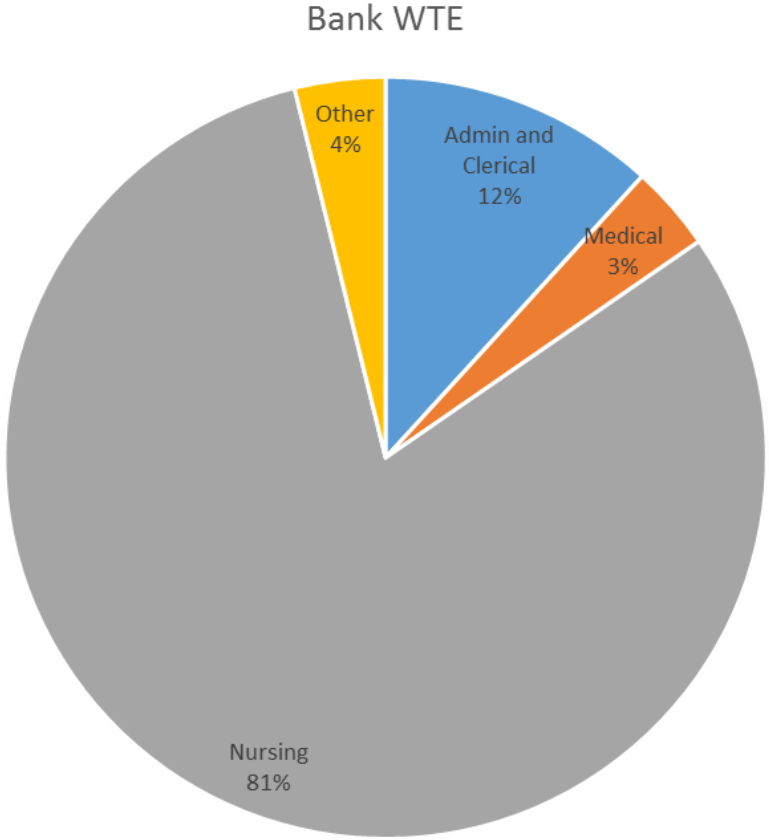
The graphs on the next page sets out the 19/20 forecast in greater detail.





Workforce plan
Bank & Agency forecast 19/20





Planned Bank savings

As the charts above indicate, Nursing accounts for 81% of the resource used across the staff groups. A bank rate negotiation has therefore been targeted as this area will yield the greatest benefit to the trust. It is anticipated a reduction in rates will generate a saving of £1.2m.

Largest Bank users

The largest users of Nursing Bank staff in 18/19 is the Post-Acute Medicine care group at PRUH (98 WTE), Post-Acute and Planned – Urgent in UPAC (57 WTE) and Neurosciences in Networked Care (53 WTE). A deep dive into Agency usage is set out on the Annex.

Workforce plan
Priorities for controlling bank & agency spend and pay bill

Controlling Demand

- E-roster (all staff)
- Improved Governance and Decision making
- Weekly data
- Divisional recruitment planning

Managing Supply

- Move nursing rates in line with STP
- Move ADH payments to Bank
- Agency usage linked to vacancy

Reducing Cost

- Divisional targets
- Introduce new overtime principles

Workstream	Initiative	Q1			Q2			Q3			Q4		
		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
DEMAND	Job Planning	Start			Report			Report					
	Governance and Decision Making	Scope			Review	Report		Implement					
	Divisional recruitment plans	Start	Implement Refine										
SUPPLY	Bank rates and breaks	Implement											
	ADH payments to Bank	KE Decision			Implement			Report					
	Agency linked to vacancy	Scope			Develop			Implement					
REDUCING COSTS	Divisional Targets	Scope	Refine		Implement								
	New overtime principles	Scope			Refine			Implement					

Workforce plan
CIP plans for 19/20

Divisions and corporate areas are developing plans and have put in the relevant controls required to reduce temporary spend and implement workforce CIPs for 19/20. The below information is from the central PMO tracker as at 04 April 2019.
Important note: these schemes are at varying stages of development and are subject to removal / amendment through the work up of PODs.

Overall reporting - 27 WS & Div	Project Reference number	Project name	Indicative 19/20 value (£m)
Central Workforce	AD400	All Divisions - Medical Recharges	£ -
Central Workforce	WF400	Nursing Bank Rates	£ 1.2
Central Workforce	WF401	Standardising of Breaks (B&A)	£ 0.8
Central Workforce	WF403	ADH Rate Change	£ 0.5
Central Workforce	WF404	ADH Payments	£ 0.3
Central Workforce	WF405	Overtime	£ -
Central Workforce	WF406	Recruitment Hotspots/ agency conversion to bank	£ 0.5
Networked Care Div A	NWC487	Reduction in Agency for Neo Natal	£ 0.1
Networked Care Div B	NWC416	Inpatients to Outpatients- increase in day case income	£ 0.1
Networked Care Div B	NWC485	Precision Medicine NR Pay savings	£ 0.1
Networked Care Div B	NWC489	ISLET transplants	£ 0.3
Networked Care Div B	NWC490	Reviewing Junior Doctor rotas to consider ways to reduce bank spend	£ -
Networked Care Div B	NWC491	Stopping Transplant coordinators overtime	£ -
Networked Care Div B	NWC492	Reviewing rotas on Kinnier Wilson	£ -
PRUH and South Sites	PRU405	ED Workforce review	£ -
PRUH and South Sites	PRU406	Acute Workforce review	£ -
PRUH and South Sites	PRU433	CNS Activity review	£ -
PRUH and South Sites	PRU450	Radiology Staffing and Model review	£ -
PRUH and South Sites	PRU471	Specialing to Substantive	£ 0.0
Urgent Care, Planned Care and ACS - Planned	UPAC445	DSU Admin Team Establishment Review	£ 0.0
Urgent Care, Planned Care and ACS - Planned	UPAC453a	UPAC Workforce redesign (skill mix) - planned care	£ 0.3
Urgent Care, Planned Care and ACS - Planned	UPAC453b	UPAC Workforce redesign (skill mix) - planned care	£ 0.0
Urgent Care, Planned Care and ACS - Urgent	UPAC454	UPAC Workforce redesign (skill mix) - urgent care	£ 0.0
			£ 4.1

Workforce plan

KPIs

Workforce KPI	Measure	Frequency	Data reported through	Main Governance	Assurance
				Forum	Governance Forum
Trust wide establishment	WTE and £	Monthly	Trust wide scorecard	Main Board	EWDC
Growth/ reduction in posts	WTE in month changes	Monthly	WTE one pager	KE monthly	EWDC quarterly
Vacancy rate	8%	Monthly	Trust wide scorecard, divisional/care group scorecard	Divisional IPR	Main Board(as part of data set)
Staff costs including bank and agency usage targets	Against forecast	Monthly	Trust wide scorecard, divisional /care group scorecard. Weekly ward data	Divisional FOM/IPR	KE (monthly)
Turnover	14%	Monthly	Trust wide scorecard, divisional/care group scorecard	Divisional IPR	EWDC
Sickness levels	3.50%	Monthly	Trust wide scorecard, divisional/care group scorecard	Divisional IPR	EWDC
Appraisals	90% by 1st August 2019	Monthly	Weekly until August - Trust wide scorecard, divisional/care group scorecard. By name stats until the end of July 2019.	Divisional IPR	Trust Planning and Delivery Board
Mandatory Training	90% by March 2020	Monthly	Trust wide scorecard, divisional/care group scorecard.	Divisional IPR	Trust Planning and Delivery Board
Friends and Family test	Improvement %	Quarterly	Data down to care group every quarter.	KE (quarterly)	EWDC
WRES Indicators	Improvements %	Yearly	Board, KE	Main Board	KE / EWDC

Workforce plan
Challenges, risks and mitigations

Our current workforce challenges, risks and mitigations are set out below together with their impact and our strategic response.

Description of workforce challenge or risk`	Impact (high, medium, low)	Response strategy	Timescales and progress to date
Morale and engagement decreases	Medium	• Continuing our investment in King's recognition scheme • Diversity strategy	• Scheme launched in 2018 and held first awards ceremony
Trust response to hard to recruit areas and safe staffing levels	Medium	• Each area has a very clearly defined recruitment and retention plan • Establishment review and e-roster re-templating has been conducted across the Trust	• Significant reduction in bank and agency to date • Vacancy rates have also reduced (i.e. nursing vacancy rates amongst lowest in country) • Ratio of bank to agency has improved (i.e. less agency usage) • Carter metrics have improved
Brexit – unknown outcome therefore risk is that larger percentage of the 1,180 EU staff leave	Medium	• Monitor attrition rates attributable to this group • Overseas Recruitment strategy for nursing and medical posts in place	• Trust has written to all affected staff, communications campaign planned; • Continue to ensure a strong UK pipeline • International recruitment campaigns planned for 19/20
Staff turnover increases	Medium	• Use more temporary staffing to cover gaps • Manager learning in place to improve working environment • Retention project in nursing	• Bank contract re-awarded in July 18 • Manager learning in place • Learning High Potential programme in place for nursing
Senior Leadership stability	Medium	• Talent and succession for Senior Roles • Appointment to Senior vacancies • Senior Leader Development investment	• Executive level recruitment almost complete • Talent strategy launched and succession planning in place for top 2 tiers of the organisation
Pay control culture breaks down	Low	• MI produced weekly for early warning • Financial oversight meetings monthly • Weekly pay control meetings	• Establishment control and recruitment forum in place • E-roster challenge forum in place • Senior leader sign off process in place

Workforce plan
Long-term vacancies

King's vacancy rate has improved significantly with a reduction to 11.07% (M11) compared to 13.68% in April 2017. The overall nursing and midwifery vacancy rate has reduced to a rate of 7.87% (M11) from 15.53% in April 2017, the recruitment of overseas nurses has helped maintain a low rate. There are 250 of these planned for 2019/20.

The PRUH, where vacancy rates were historically high, saw a significantly reduction, achieving 10.41% (M11) compared to 14.78% in April 2017. The AHP and A&C vacancies remain areas of focus as they were the highest at 16.33% and 13.85% respectively at M11. Band 5 nurses have seen a significant reduction to 6.68% (M11) from 9.98% at Mar 2018 supporting patient care. Detailed recruitment plans are in place with each of the divisions, these have been prioritised so that vacancies against high spend agency staff is mitigated.

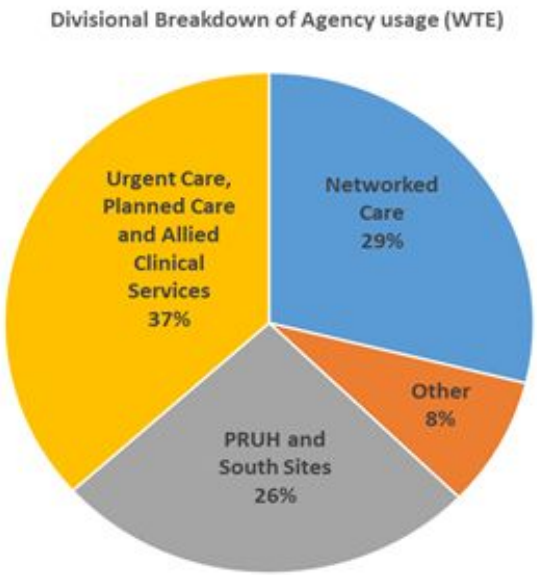
The Trust's top five areas of hard-to-fill posts (over 6 months) are set out below:

Description of long-term vacancy	Whole-time equivalent (FTE) impact	Impact on service delivery	Initiatives in place, along with timescales
Consultants in Gerontology PRUH. Recruiting from Feb 2018.	5 FTE vacancies across Elderly Medicine	Impact on rostering and patient safety. Also, financial impact as the service is covered by very expensive Bank and Agency staff.	Recurring adverts on NHS Jobs as standard (5 in last year, 0 appointments). Additional advertising on Guardian Jobs. Several agencies being utilised to actively recruit for suitable candidates, locally and internationally. Currently shortlisting. Supporting with junior clinical fellows.
Consultants in Ophthalmology	2.68 FTE (December 18) this included DH, PRUH and QMS)	Impact on rostering and patient safety. Also, financial impact as the service is covered by very expensive Bank and Agency staff.	Adverts placed for post. A 3 tier process in place to progress difficult to recruit to vacancies – 2 adverts, Approach agency, Review of service and structure. Exploring new external specialist publications.
Band 7 Adult TL Ed Nurses	7.19 FTE vacancies	Reduced support of staff and additional pressure for current band 7s.	Previous initiatives that have been used but not successful – headhunting agencies, magazine advert and relocation package Rolling adverts & utilising social media yield low applications/results. Development of current staff and roles that sit above band 7 are being reviewed.
Consultants in Radiology & Consultant Microbiology	3 FTE vacancies	Impact on rostering and patient safety. Also, financial impact as the service is covered by very expensive Bank and Agency staff.	Adverts placed for post. A 3 tier process in place to progress difficult to recruit to vacancies – 2 adverts, Approach agency, Review of service and structure. Exploring new external specialist publications.
Radiographers (all levels) NC and PRUH	PRUH: 10.28 FTE all bands DH: 7 FTE Band 5 - 7	Impact on rostering and patient safety	PRUH: Recurring adverts on NHS Jobs as standard. Additional advertising on Guardian Jobs. Reviewing advertising on external websites. Looking at potential relocation packages. Reviewing banding, Band 5/6 mix, B7/8a mix-posts, career progression plans, open/study days. DH: SNAP campaign & open days. Web page advertising. Started New initiative with our Host Trust students.

Annex

King's

Workforce plan
Bank & Agency forecast



Agency deep-dive for 18/19 (M1 to M11)

The division to rely most on agency staff is UPAC with 37% of the overall resource (WTE) as set out in the chart to the left.

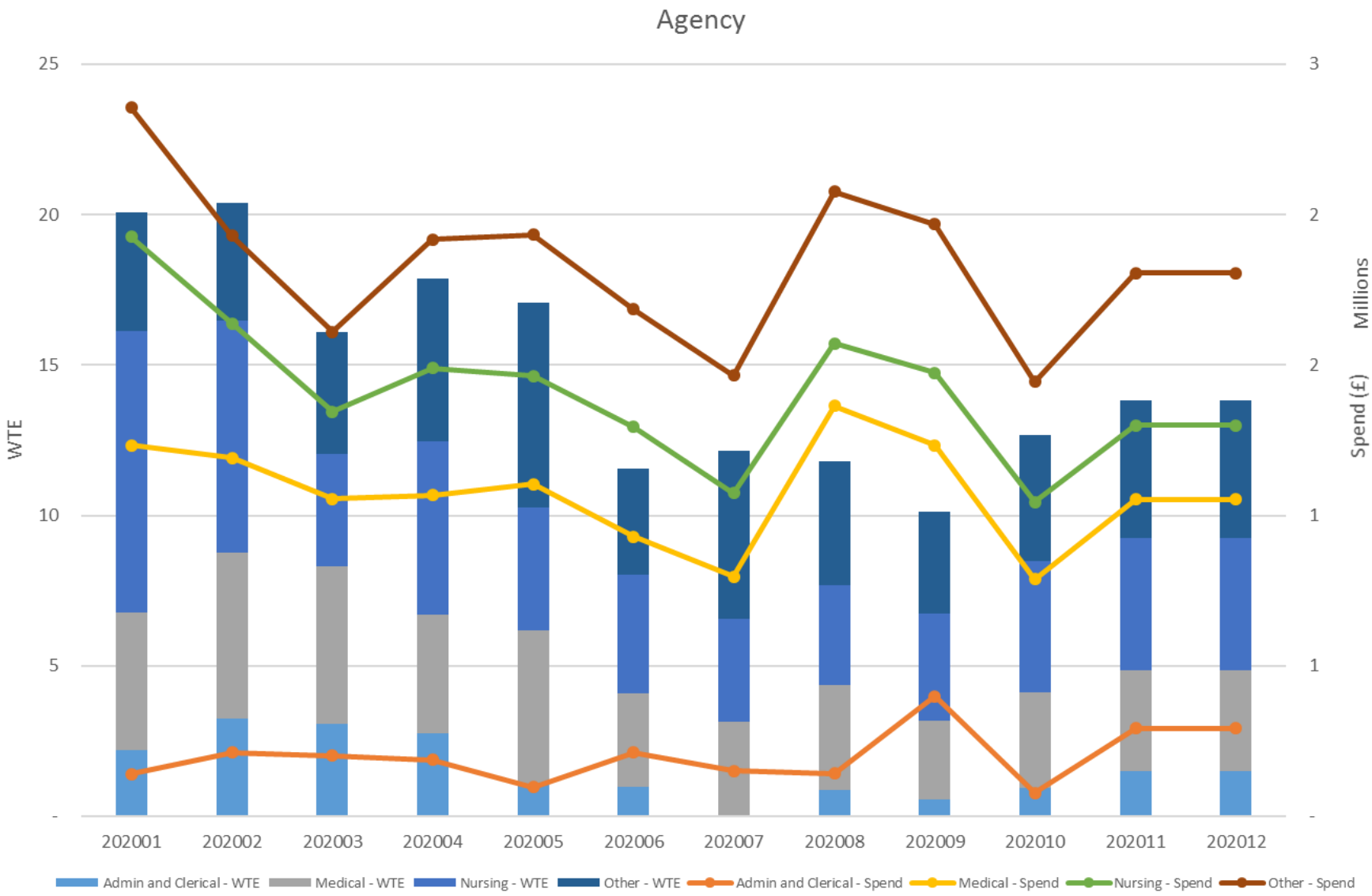
The Care Group with the largest usage is Critical Care, Radiology and MEP in NWC with 17.36% of the overall usage (WTE). This is primarily driven by Radiology.

Post-Acute Medicine is the second largest user of Agency at the PRUH (highest at the PRUH cumulative of 17/18 and 18/19).

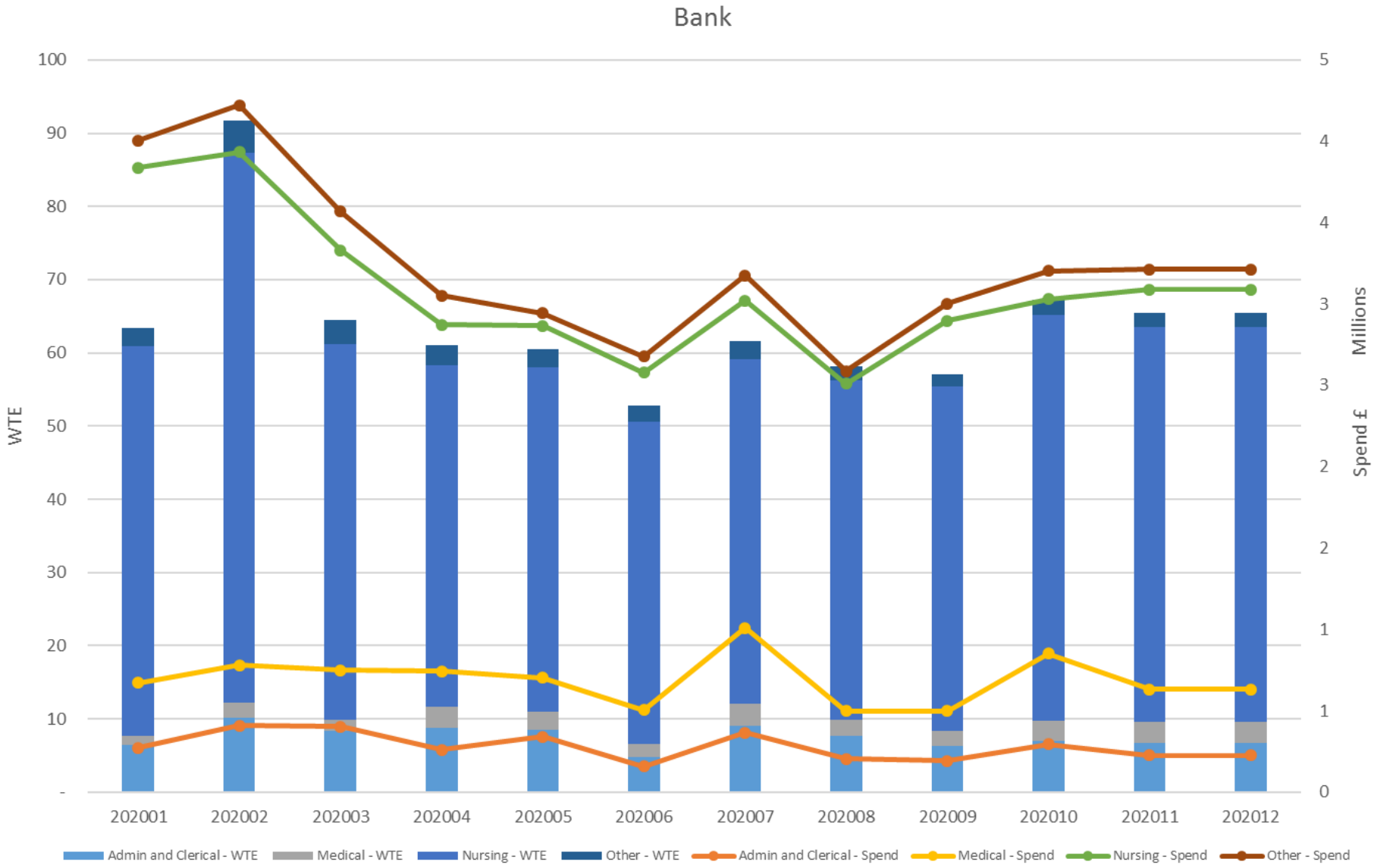
It is anticipated that these temporary staffing trends will largely continue in the same manner across divisions and care groups in 19/20. However, the £1.7m (13.55 WTE) shift in Agency to Bank spend will mean the total Agency cost is reduced.

Ranking	Care Group	Division	WTE Usage	% of overall usage
1	Critical Care, Radiology and MEP	NWC	30.54	17.36%
2	Post-Acute Medicine	PRUH	16.97	9.64%
3	Acute and Emergency	UPAC	16.47	9.36%
4	Planned surgery and Ophthalmology	UPAC	13.82	7.86%
5	Surgery, theatres, Anaesthetics and Endoscopy	PRUH	12.71	7.22%
6	Post-Acute and Planned - Urgent Care	UPAC	11.73	6.67%
7	Acute and Emergency Care	PRUH	8.44	4.80%
8	Women's and Children's and core services	PRUH	8.34	4.74%
9	Variety Children's Hospital	NWC	7.92	4.50%
10	Therapies	UPAC	6.93	3.94%

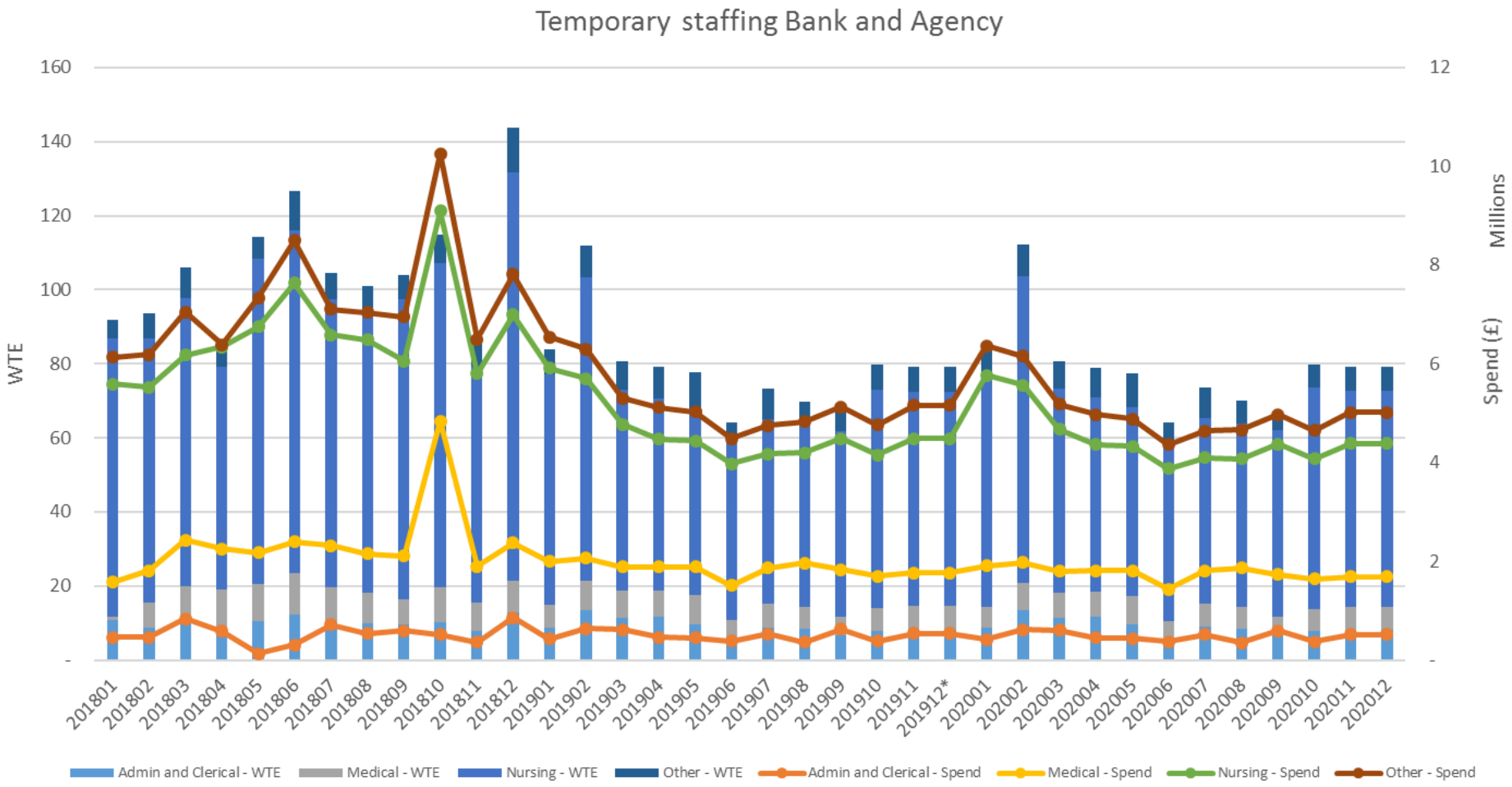
Workforce plan
Agency forecast



Workforce plan
Bank forecast



Workforce plan
Bank & Agency trend analysis

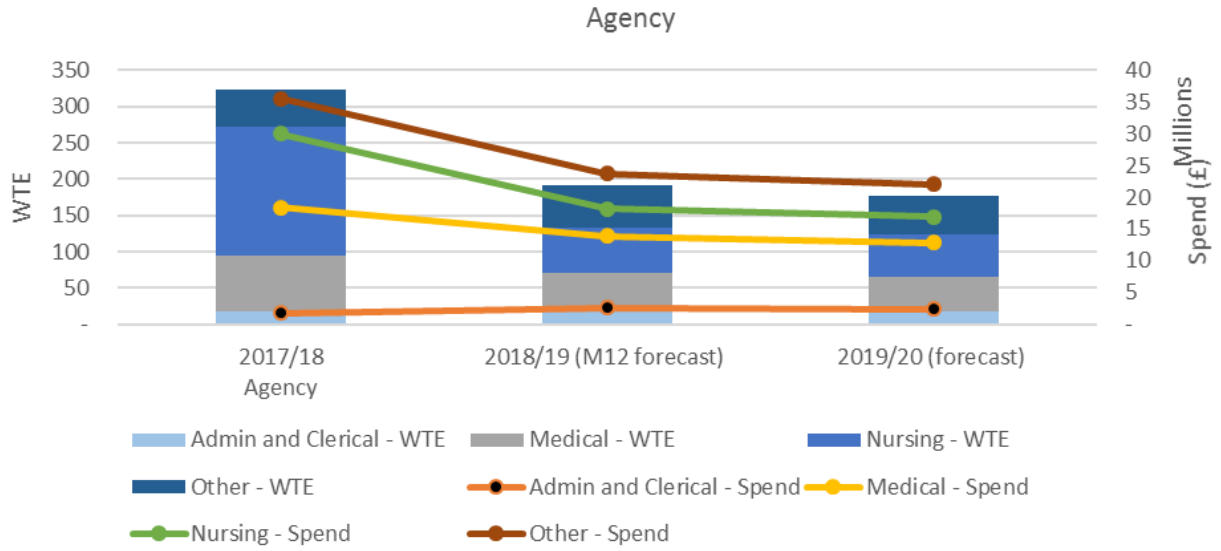


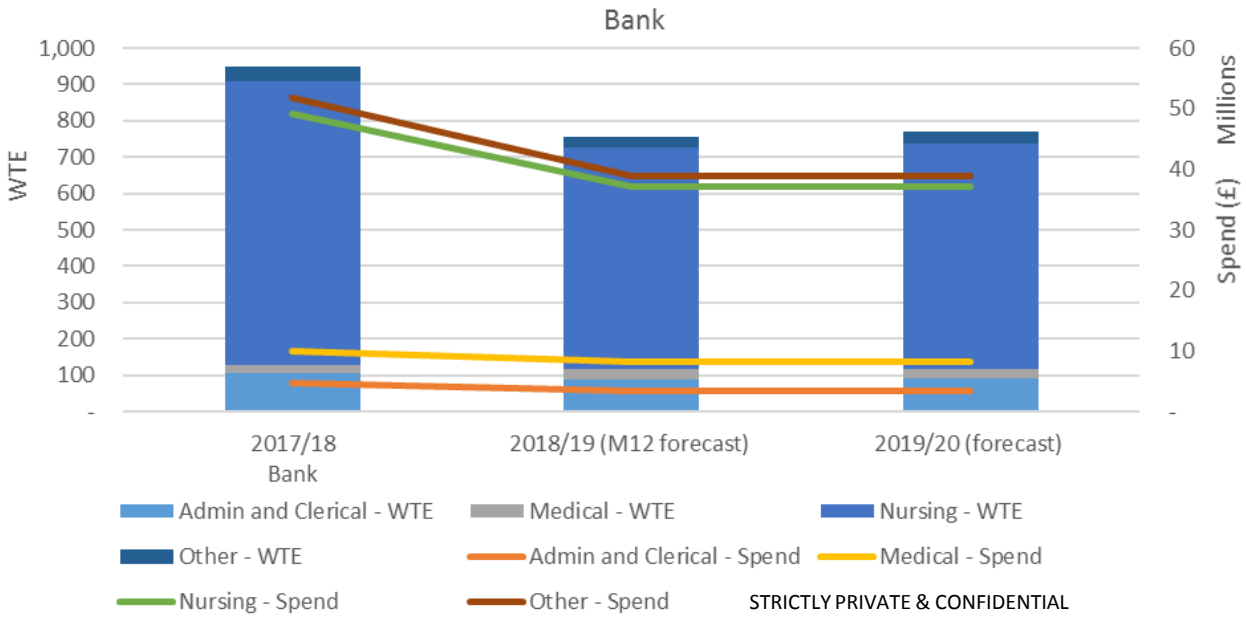
Reduction in reliance on temporary staffing

The above graph sets out the monthly use (in WTE and spend) for the trust from 17/18 to forecasted 19/20. It is clearly visible that on both levels, there is a significant reduction on bank and agency. Whilst the WTE isn't forecasted to reduce in 19/20, as explained on previous pages, there is a plan for a further saving of £1.7m through agency premium and reduced bank rates.

The trajectory of annual totals between 17/18 and 19/20 forecast is set out on the next page.

Workforce plan
Bank & Agency trend analysis





Agency	WTE	Spend £
2017/18	324	35.5m
2018/19 (FOT)	191	23.7m
2019/20 (forecast)	177	22.0m

In 2018/19, the forecasted outturn on agency spend is estimated to be 33% less than the previous year (a reduction of £11.8m). A further reduction of £1.7m is forecasted on this for 19/20.

Bank	WTE	Spend £
2017/18	947	51.7m
2018/19 (FOT)	755	38.9m
2019/20 (forecast)	769	38.9m

In addition to the significant drop in agency spend described above, the forecasted outturn of bank spend in 18/19 is 25% less than 17/18 (£12.9m).

As part of the initiative to shift £1.7m spend (equivalent to 13.55 WTE) from Agency to Bank, it is expected the resource will increase but the overall spend will remain constant due to securing cheaper bank rates for nurses.

03 June 2019

on the day BRIEFING

NHS Providers

4.7

Interim NHS People Plan – national workforce strategy

NHS Improvement, NHS England and HEE have published the interim NHS People Plan (the plan) which sets the national strategic framework for the workforce over the next five years. The plan has been drawn up under the direction of Baroness Dido Harding, NHS Improvement Chair and senior responsible officer Julian Hartley, Chief Executive of Leeds Teaching Hospital NHS Trust. During the first quarter of 2019, a national steering group was set up to support engagement with key stakeholders and ensure wide input into the interim plan from across the sector. NHS Providers contributed significantly to the work of the steering group and its sub-groups. A final people plan will be published in the months following the 2019 spending review.

This briefing provides an overview of the key proposals within the document and a summary of each section within the plan.

Overview of key proposals

- A "new offer" to NHS staff will be developed through consultation this summer to ensure the NHS rapidly becomes a better place to work.
- A consultation on changes to pensions policy has been announced, which includes the proposed introduction of some added flexibility for senior clinicians through a "50:50" option enabling them to halve their pension growth beyond a certain point in exchange for halving their contribution.
- The NHS will engage on a "new leadership compact", establishing the cultural values and behaviours expected from leaders at all levels across the service.
- The compact will include a review of regulatory oversight frameworks and implementation of 360 degree feedback from providers, commissioners and Sustainability and Transformation Partnerships (STPs)/Integrated Care Systems (ICSs) on support received from regional and national leaders.
- A "new operating model" for increase workforce devolution to regions, ICSs and local organisations will be developed, utilising an ICS maturity matrix to benchmark workforce planning capabilities.
- A series of initiatives will aim to recruit an additional 40,000 nurses to the NHS in the next five years, including a rapid expansion and review of clinical placement capacity; increasing the acceptance rate; and consolidating national recruitment campaigns with a particular focus on learning disability and mental health nurses.
- Funding for CPD should be restored to its previous levels over the next five years, depending on the spending review.
- An independent review of HR/OD best practice in the NHS will be carried out later in 2019.
- NHSE will develop a new procurement framework for approved international recruitment agencies, while STPs and ICSs will implement 'lead recruiter' arrangements for staff coming from overseas.
- The NHSI national retention programme will be expanded to all trusts and into primary care.
- The NHS will review its levels of undergraduate medical school places and launch a national conversation on what patients and the public require from 21st century medical graduates.

NHS – the best place to work

A new offer to staff

A key pillar of the plan is its aim to ensure the NHS rapidly becomes "a much better place to work". This is to be achieved through the development of a "new offer" to staff, the details of which will emerge in full following a period of consultation this summer.

The idea of a new offer comes following an acknowledgement from NHS leaders that the service needs to make significant progress to ensure healthcare careers remain an attractive option. The plan argues that jobs in the sector have become "increasingly demanding", noting that staff are overstretched and struggling from the impact of poor recruitment and retention. The document also states that the NHS is operating "in a highly competitive employment market with changing generational expectations about careers".

This reflects widespread concern around the lack of flexibility that NHS organisations – including trusts – are able to provide particularly to younger members of staff in the current environment. HEE's draft workforce strategy in 2018 first acknowledged the need to consider a different approach for "millennial" staff seeking career breaks and non-linear careers, and this requirement is reflected in the people plan's goal for the NHS to be a "modern" and "flexible" employer.

The offer will ultimately be made up from a series of new or revised commitments in the NHS Constitution and form the basis of a "balanced scorecard" under the NHS Oversight Framework which will inform future CQC well-lead assessments. It will make explicit commitments around the broad themes of:

- Creating a healthy, inclusive and compassionate culture, with a focus on equality and inclusion, bullying and harassment.
- Enabling development and fulfilling careers, with a focus on CPD, credentialing of expertise and line management.
- Ensuring voice, control and influence for NHS staff, by improving health and wellbeing, work-life balance and conditions for whistleblowers.

The document also calls for an independent review of HR/OD best practice in the NHS, to be carried out later in 2019. The plan's authors are seeking a greater focus on people issues at board level which it feels is lacking following "a quick survey of board papers" during the development of the plan.

Leadership compact and culture

The plan has placed a heavy emphasis on improving leadership and organisational culture throughout all levels of the NHS. This work comes on the back of the Developing People Improving Care Framework in 2016 which, according to document, has "not led to the widespread culture change it set out to deliver". The plan has also noted the impact of greater systems collaboration, which it says introduces new and different leadership challenges.

The plan frequently refers to the need for inclusivity, diversity, compassion and positivity in leadership and culture, stressing that these ideals apply to the NHS arms length bodies as they do to frontline leaders across the country. Its central ambition in this area is to undertake system-wide engagement on a "new NHS leadership compact" establishing the cultural values and behaviours expected from leaders. The compact will be a "gives and gets" agreement, also setting out the type of development and support local leaders can expect from the centre.

Within the leadership compact, the people plan also calls for:

- The development of competency, values and behaviour frameworks for all senior leadership roles (an extension of the Kark Review's recommendation for board members to meet specified measures of competence).
- A review of regulatory and oversight frameworks to ensure "a greater focus on leadership, culture, improvement and people management".
- Implementation of 360 degree feedback from providers, commissioners and STPs/ICSs on support received from regional and national teams.
- The roll-out of talent boards to every region and an expansion of the NHS Graduate Management Training Scheme.
- Development of a central database for directors and engagement over the remaining recommendations from the Kark report.

Pensions

The NHS workforce has been hit hard by the impact of the annual and lifetime pension allowances, causing large and unpredictable tax bills for senior doctors and managers in particular over the past year. Increasingly, NHS trusts have been struggling to stem the tide of senior medical staff leaving the NHS pensions scheme, reducing their working hours and – sometimes – leaving the NHS altogether to avoid effective 100% marginal tax rates brought about by a poorly designed taxation system.

Following extensive discussions between all key parties, including DHSC, it's arms-length bodies, the Treasury and the British Medical Association (BMA), the government has announced a policy change increasing pensions contributions flexibility for scheme members. The people plan says briefly describes a proposal to allow senior clinicians the option of halving their pension growth beyond a certain point in exchange for halving their contribution. This has been described as the "50:50" option in the sector and is similar to the offer given in local government pensions.

Alongside the release of the interim people plan, the Department of Health and Social Care (DHSC) said it was consulting on new plans enabling senior clinicians to "freely take on additional shifts to reduce waiting lists, fill rota gaps or take on further supervisory responsibilities". However, it is not clear whether this goes beyond the "50:50" option, which the doctors' union opposes. Additional funding will come from DHSC, instead of the Treasury.

Tackling nursing shortages

NHSI, NHSE and HEE have identified the nursing workforce as the key group in need of support, with a fear that the current level of vacancies – 40,000 across NHS trusts – is set to rise exponentially without concerted action to address the gap. The plan says shortages in nursing are "the single biggest and most urgent we need to address", predicting that the policy initiatives outlined in the document can grow the size of the workforce by 40,000 over the next five years "to keep pace with rising demand". It states that further action will be needed within the final people plan to hit a 5% vacancy rate target by 2028 (currently 11%).

Increasing supply through undergraduate training

Given the time it takes to train a nurse through an undergraduate degree, the plan highlights the need to immediately increase the supply of newly trained nurses through this route. It sets out the ambition to provide capacity for all suitable applicants to secure a place. The NHS will work with higher education institutions (HEIs) to expand their intakes and identify the correct number of corresponding clinical placements by improving coordination between HEIs and trusts.

Alongside this, a more comprehensive review of current clinical placement activity will take place to identify outliers and support the removal of barriers to expanding capacity, including the potential to expand placements in primary and social care.

Further initiatives to increase undergraduate supply include:

- A rapid expansion programme to increase clinical placement capacity by 5,000 for September 2019, with NHSE working alongside trust directors of nursing to assess organisational readiness and provide targeted infrastructure support.
- Increasing the acceptance rate from its 2018 level of 55% to 70%, with a programme of work to understand what is behind the decline, ensuring that intake levels are increased without compromising rigorous standards for entry or patient safety.
- A consolidation of current recruitment campaigns run by different national bodies, including the recent 'we are the NHS' campaign, to develop a single campaign that reflects the realities of a career in modern nursing.
- ALBs working with the Office for Students to agree a standard definition for attrition for all healthcare programmes.
- Further work with DHSC to improve awareness and effectiveness of financial support programmes for trainee nurses through the Learning Support Fund (LSF).

The full people plan will identify concentrated action in areas of nursing with the greatest shortages, including mental health, learning disability, and primary and community nursing. NHSE will work with HEIs to identify and address these shortages by promoting nursing roles in these areas and highlighting the rewarding nature of these career options.

International recruitment

The plan acknowledges the need to increase international recruitment significantly in the short and medium term to rapidly increase supply. This will involve ensuring the system for overseas recruitment is effective and achieves economy of scale. Specifically, the plan promises that:

- HEE will continue to build global partnerships and exchanges and NHSE/I regional teams will become responsible for the coordination of local health systems' recruitment efforts.
- STPs and ICSs will implement 'lead recruiter' arrangements as part of delivering their five year workforce plans.
- NHSE will develop a new procurement framework of approved international recruitment agencies for these lead recruiters to draw on to ensure consistent operational and ethical standards.
- A best-practice toolkit will be developed with NHS Employers to highlight good practice and improve the experience and retention of international nurses through improved pastoral support. NHSE will work with DHSC and professional regulators to streamline regulatory processes.

Retention and return to practice

NHSI's retention programme launched in 2017 has contributed to minor progress in nursing turnover, with rates reducing from 12.5% to 11.9% in participating trusts. The plan outlines further actions to improve retention, including:

- An expansion of the national programme to all trusts and into primary care, focusing on early years retention and providing hands-on support where the need is greatest.
- Boosting the numbers of nurses with lapsed registration to return to practice, working with Mumsnet to launch a new marketing campaign to inspire nurses to enrol in return to practice courses and make them aware of opportunities and support available.
- Further work in the full people plan to convert participation in return to practice courses into employment for mature staff and filled vacancies in shortage areas.

Continuing professional development and flexible entry

The plan admits that funding pressures on the CPD budget has led the NHS to invest less in developing current staff in order to invest in training new staff. The budget for CPD and workforce development has dropped by almost half since 2013/14. The plan's authors argue that CPD should remain a mixed model with investment from local employers supplementing the national investment from HEE.

In terms of CPD funding, action will be taken to inform the full people plan, reviewing how to increase national and local investment with the aim of achieving phased restoration over the next five years of previous funding levels for CPD. Alongside increased development opportunities for current staff, the plan has identified new entry routes as a priority, proposing:

- That the final people plan explores the potential for a blended learning nursing degree programme with an online theoretical component.
- The development of a clear model that sets out the different routes into nursing and their benefits, and an expanded pilot programme for nursing associates wishing to continue their studies to registered nurse level.
- Consideration of job guarantee approaches at system level to maximise opportunities for nurses using the blended model to qualify.

Workforce devolution

A significant policy shift is offered in the plan through its call for increased workforce devolution from the centre. The document proposes a "new operating model", arguing that a complex architecture at ALB level and a lack of alignment between workforce, service and financial planning at national and local levels has hampered efforts to put forward clear and coherent plans to tackle rising vacancies.

The plan emphasises the need for "honest conversations …about who needs to do what at which level to increase our chances of success" in workforce planning. Contrary to some reports, it does not simply demand a shift to full control for ICSs, but instead proposes differentiated responsibilities under the following principles:

National workforce activity where:

- it is necessary to meet statutory responsibilities;
- to benefit from economies of scale;

- Planning is needed over a longer timeframe, eg over 15 years;
- There are clear benefits from a national role in standardisation or coordination/implementation; and/or
- National teams have specific and scarce skills/knowledge that it is not possible or desirable to duplicate sub-nationally.

Regional workforce activity where:

- There is a need for an assurance role in delivering national priorities such as international recruitment.
- Planning is needed over a medium-term time frame, e.g. over five years.
- There is demand for improvement support on a large scale.
- There is a need to help foster capacity and capability in local health systems.
- Decisions need to be made across a regional labour market.

ICS workforce activity where:

- Regional footprints are too large to affect change.
- Strong local partnerships are required.
- Planning is needed over a short- to medium-term time-frame, eg in-year or over three years.
- Decisions need to be made across a local labour market.

Local workforce activity to:

- Develop and sustain a clear vision for the organisations aligned to the overall ambition of the ICS.
- Develop and embedding local values, derived from the NHS Constitution.
- Build an inclusive, compassionate and improvement-focused culture.
- Ensure all people are able to do their best work.
- Recruiting and retain people for a local organisation.
- Account for the wellbeing of employees and advance equality of opportunity.
- Develop and implement organisational people plans and contribute to ICS people plans.

Shifting responsibility for planning and other workforce activity will not happen immediately, particularly in respect to ICSs, with the document announcing plans for a co-produced ICS maturity framework to benchmark workforce activities at system level. This will both inform the support that systems can expect from HEE and NHSI and their regional teams, and influence decisions on the pace and scale at which systems can take on additional responsibility.

The plan underlines consistent and timely data as a key to enhanced workforce planning while – at a national level – a new People Board, chaired by the new NHS Chief People Officer Prerana Issar, and its advisory group , will oversee the development of the full people plan later in 2019/20.

Transformation and skills mix

While the headline announcements for healthcare professionals relate mostly to the nursing workforce, the document sets out its expectations for the development of other professions towards the goal of "delivering 21st century care".

The people plan calls for a "transformed workforce with a more varied and rich skills mix" to support the move towards new care models and better multidisciplinary working. This ambition reflects a drive to 'do things differently' in workforce planning: not simply relying on linear and inflexible staffing models of the past.

A vision for the future of various medical and clinical professionals outside of nursing is provided, with an acknowledgment of the need to "refine our estimates of the number and mix of new posts needed over the next five years". Further work will need to take place in this space to ensure these estimates reflect priorities set out in the Long Term Plan, and within local and national implementation plans due to be published this financial year. An "open debate" will take place on the level of growth needed in different staff groups, closely coinciding with discussions on education and training funding through the spending review.

Specific proposals around workforce transformation include:

- Recruitment of an additional 7,500 nurse associate trainees by December 2019.
- The establishment of a national programme board to address geographic and specialty shortages in doctors.
- A review of undergraduate medical school places, with potential to expand beyond the recent addition of 1,500 places.
- Work with the GMC and medical colleges to roll out credentialing.
- Expansion of the NHSI national retention programme to include allied health professional (AHP) support.
- Support for every STP/ICS to put in place a collaborative approach to apprenticeships and maximise levy use.
- Developing infrastructure for a new pharmacy foundation training programme.
- More flexible career entry routes for healthcare scientists;
- Training to ensure a core level of digital ability for all non-technical NHS staff.
- A new internal medicine training model for junior doctors, with the aim of increasing generalist expertise.
- The launch of a national consultation on what the NHS, patient and the public require from 21st century medical graduates.

NHS Providers View

Trust leaders tell us that the range of workforce challenges they face, centred on recruiting and retaining the right number of staff, and building a positive culture, are their number one concern. The interim people plan is the first, clear, public recognition from our national system leaders of the severity of this issue.

As such, it is a welcome statement, containing an important acknowledgement that solving our workforce challenge isn't just about future workforce planning and more money, important though these are. We welcome the focus on making the NHS a great place to work, changing its leadership culture and training a workforce equipped for the future. Trust leaders have a key role to play on each of these issues.

The plan also seeks to pull all of the NHS together behind this single, clear, approach: a unity of purpose that's been sadly lacking for far too long. Government, arms length bodies and front line leaders all have a vital part to play here, with more responsibility and resource rightly being devolved towards local systems. We particularly welcome the much more inclusive way this plan has been developed and the speed of the work, which have genuinely felt different.

However the publication of the interim plan also makes clear how far the NHS has to go to stabilise the workforce challenges we face. We are conscious that the development of some of the solutions helpfully flagged in the interim plan will take time and that we remain dependent, to some extent, on the publication of the final document later this year, after the 2019 spending review, and on a sustainable approach to recruitment and retention of the social are workforce.

The interim plan promises several consultations and significant further work to inform the final strategy. Itis important the positive and inclusive approach of the national steering group continues under new structures in the coming months to ensure new proposals and solutions deliver maximum benefit as they are implemented at the frontline. Consultations on leadership behaviours, HR/OD practice, and systems maturity are particularly important areas for which NHSI and NHSE must receive wide input and where there will be learning for leaders across the system, nationally, regionally at system and individual organisational levels.

Colleagues in the national bodies must also continue to work closely with national stakeholders to come to a sector-wide consensus on future workforce design and the levels of funding necessary for education and training. We cannot ignore the significance of the upcoming spending review. Priorities include a clear increase in funding for CPD; clarity over financial support and targets for international recruitment; and a revision to the currently unworkable apprenticeship levy.

NHS Providers will continue to engage closely with the work of the new National People Board, ensuring that the provider voice is heard and the momentum we have helped to create is maintained in addressing both the short, and longer term, challenges facing workforce planning for health and care

King's College Hospital NHS
NHS Foundation Trust

Report to: **Private Board**

Date of meeting: **3rd July**

By: **Professor Julia Wendon**

Executive Sponsor **Professor Julia Wendon**

Subject: **Transfer of RO**

This report is for (tick as appropriate):			
Decision	**Discussion**	**Assurance**	**Information**
X	**X**		

Executive Summary

Summary of Report

- The Responsible Officer (RO) role has previously always been undertaken with the Executive Medical Director at KCHFT, albeit a distinct role. Many of the Shelford Group and larger hospitals align the RO role with that of their Medical Director for Professional Standards and Workforce.
- This paper provides background of the role and asks for Board agreement of the nomination of Dr Chris Palin, Medical Director for Professional Standards and Workforce to undertake this role.

- **Action Required**

- Board agreement of the nomination.

Key implications

Legal:	Legal requirement for an RO
Financial:	Nil
Assurance:	RO role is a requirement by the GMC
Clinical:	Assures appropriate appraisal processes and revalidation.
	Nil specific

Equality & Diversity:	
Performance:	Nil
Strategy:	Nil
Workforce:	Aligned closely with workforce colleagues but nil effect re wte
Estates:	Nil
Reputation:	Nil
Other:(please specify)	Nil

Main report

See attached

Responsible Officer Role : Transfer to the Corporate MD for Professional Standards and Workforce.

Background

The Medical Profession (Responsible Officer) Regulations came into force on 1 January 2011 and were amended on 1 April 2013 (The Medical Profession (Responsible Officers) (Amendment) Regulations 2013). The regulations require all designated bodies to nominate or appoint a responsible officer (RO).

Historically at KCHFT the RO role has always been undertaken by the Executive Medical Director. Increasingly in large hospitals and much of the Shelford group the role of RO is undertaken by the Corporate Medical Director with responsibility for professional standards and workforce, working closely with the Medical Director in respect of disciplinary processes, restrictions and GMC referrals.

KCHFT has a large number of connected doctors, at present slightly more than 1400. This is made up of the majority of our consultant staff (KCH and KCL employees), Trust grade doctors and clinical fellows. Deanery trainees, whilst in active training programs/ roles have an RO within the Deanery. General Practioners have an RO within NHSe. The RO is connected to NHSe for the purposes of appraisal and revalidation.

Proposed change of RO

The rationale of the transfer of the RO role was to provide some extra time for the Executive MD to address to external and strategic roles. Close working relationships would remain in regard of disciplinary processes, GMC referrals. This is achieved at present, and will continue to, through the ongoing process of

2 weekly meetings : GMC and Disciplinary concerns
1 x month meeting re appraisal audits and concerns
1 x month meeting re job planning

These meetings are attended by workforce colleagues, appraisal lead, workforce and professional standards MD, Exec MD and divisional MDs.

The process by which a transfer of responsibility of the RO role can be undertaken are as below :-

1. By competition / expressions of interest for those who would be considered to have suitable experience and background knowledge.
2. Nomination

It was proposed, after discussion with Workforce colleagues and the then CEO (Mr Peter Herring) that the role of RO might be transferred to the Corporate Medical Director for Professional Standards and Workforce, Dr Chris Palin by nomination. Appraisal lead still being undertaken by Dr Ed Glucksman and thus Dr Glucksman reporting appraisal issues to Dr Palin.

Any change in RO also has to be endorsed by NHSe. Letters from CEOs (Mr Herring and Dr Kay) have been sent to NHSe in support of this transfer of role and this has been agreed by NHSe.

The Board should approve any change in RO.

The RO role can be transferred to other appropriate indivdiuals in the future if felt appropriate. The transfer as described above brings us in line with many other Shelford and large London hospitals eg GSTT and St Georges.

Responsible Officer Responsibilities

The RO must ensure the following are in place and have arrangements to ensure that systems are in place to satisfy all of the qualifying conditions described in the Regulations. There should be appropriate administrative support to undertake the role of the RO

The RO should have no conflict of interest or bias.

The RO should ensure

Appraisal

That as part of appraisal the following are considered by appraisers relating to the general performance and quality information and are undertaken annually except in scenario when that is not appropriate.

i) routine performance data, quality indicators and outcome data and identify any areas of concern
ii) complaints
iii) significant events or significant untoward incidents (SUIs)
iv) audit and clinical indicators relating to outcomes for patients.
v) Probity and Health
vi) Patient feedback and Colleague feedback
vii) Quality Improvement and Audit
viii) CPD

Ensuring relevant information relating to all the doctor's roles is available for monitoring fitness to practise and appraisal and thence revalidation (SARD and MAG).

Maintaining records of all fitness to practise evaluations, including appraisals, investigations and assessments. Ensuring information governance and information sharing principles and protocols are adhered to

Ensure that any conduct or performance issues are feedback for actions

Maintain accurate prescribed connections with the GMC for those doctors connected with KCHFT

Maintain effective connections with the GMC Liason officer (3 monthly meetings)

Maintain effective relationship and advice from NCAS and appropriate Royal Colleges.

Initiate Peer reviews along with exec MD and HR colleagues when indicated.

All roles

Ensuring that appraisals take account of relevant information relating to all the roles the doctor performs for the designated body, and for any other bodies.

Information should be obtained from all roles eg external charitable duties, private work.

Ensure MPIT forms are completed and actioned : transfer of information between RO's

Respond to concerns by:

1. Responding appropriately when variation in individual practice is identified;
2. Taking any steps necessary to protect patients;
3. Establishing procedures to investigate concerns about the conduct, performance or fitness to practise of a doctor
4. Initiating investigations with appropriately qualified investigators and ensuring that all relevant information is considered;
5. Recommending where appropriate that the doctor should be suspended or have conditions or restrictions placed on their practice
6. Ensuring that appropriate measures are taken to address concerns, which include but are not limited to:
    1. requiring the doctor to undergo training or retraining
    2. Providing OH support to the doctor and offering PHP
    3. Offering rehabilitation services
    4. Providing opportunities to increase the doctor's work experience; and addressing any systemic issues within the designated body which may contribute to the concerns identified.
    5. Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out; i)
    6. Maintaining accurate records of all steps taken in responding to concerns.

Work with workforce colleagues to

Ensure that appropriate contracts of employment or contracts for the provision of services are in place by:

Ensuring that doctors have qualifications and experience appropriate for the work to be performed;

Ensuring that appropriate references are obtained and checked;

Taking any steps necessary to verify the identity of doctors; and

Maintaining accurate records of all steps taken in undertaking such pre- employment / pre-contract checks.

Communicate appropriately with the GMC

Maintain Policies related to said ie *Maintaining High Professional Standards in the Modern NHS* / NCAS guidance

Co-operating with the GMC to enable it to carry out its responsibilities;

1. Making recommendations to the GMC about doctors' fitness to practise taking all relevant information into account;
2. Where appropriate, referring concerns about the doctor to the GMC; and
3. Monitoring a doctor's compliance with conditions imposed by or undertakings agreed with the GMC.

Provide other, general responsibilities as reasonably required, which include but are not limited to:

1. Governance responsibilities
2. Reporting responsibilities

Organisational readiness self-assessment (ORSA) reports and associated action plans, reports for external governance or quality assurance reviews, reports for internal audit or quality assurance activities.

Participation in activities which include but are not limited to Identifying and addressing training and development needs (commissioning training where necessary) for clinical, managerial and other relevant staff (including board members) to improve understanding of revalidation and the supporting systems within the designated body.

Undertaking appropriate quality assurance and ensuring the designated body has sufficient trained appraisers.

Ensuring the designated body has access to appropriately qualified investigators.

Engagement and support:

Responsible officer network activities – regular engagement in regional responsible officer support networks, training and other activities.

Training and other personal development activities – to maintain fitness to practise in the role of responsible officer.

Enc [No.]

King's College Hospital NHS
NHS Foundation Trust

5.2

Report to:	Trust Board
Date of meeting:	3rd July 2019
Subject:	Information Governance Policy
Author(s):	Nick Murphy O'Kane
Presented by:	Lisa Hollins/Nick Murphy O'Kane
Sponsor:	Lisa Hollins
History:	Information Governance Steering Group 28th October 2018 Kings Executive – 12th November 2018
Status:	Decision

1. Background/Purpose

Brief summary
The Information Governance Policy is one of the six policies that the Board is required to agree. The policy has been amended in the light of the changes to data protection described within the General Data Protection Regulations (GDPR) passed in May 2018 and the further guidance on implementing the GDPR regulations published in throughout 2018 and 2019.

2. Action required

The Board is asked to agree the policy and note the responsibilities of board members as well as key roles within the organisation.

3. Key implications

Legal:	Non-compliance with the NHS Data Security and Protection (DSP) Assurance Framework (previously IG Toolkit) can breach contractual obligations as set out in the General Conditions.
Financial:	Increased risk of monetary penalties with breaches of the Data Protection Act 2019 if the Assurance Framework is breached.
Assurance:	Lack of compliance will present a risk within internal and external audits.
Clinical:	Lack of awareness of approach to Information Governance can lead to issues with the use of
Equality & Diversity	None
Performance:	None
Strategy:	None
Workforce:	There will be a time commitment for all staff to be trained

Enc [No.]

Estates:	None
Reputation:	Impact on reputation to be a trusted organisation with personal data from patients, regulators and other external stakeholders.
Other:(please specify)	None

4. Appendices

a. Information Governance Policy

Enc [No.]

Information Governance Policy

Executive summary

The purpose of this policy is to outline roles and responsibilities for information governance at every level within the organisation including the Trust Board. The Information Governance Policy is the overall policy that steers our governance approach and cites 14 underpinning policies, recently refreshed that underpin our governance and data protection at the Trust.

Recommendations

The Board is asked to agree the policy and note the responsibilities of the organisation in implementing a programme of activities to ensure high levels of data protection across the Trust.

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1. Background/purpose

The General Data Protection Regulation 2016 (GDPR) tabled by the European Commission in 2012 and finally agreed by the European Parliament and Council in May 2016, is set to replace the Data Protection Directive 95/46/EC. The GDPR which has been hailed as the most significant change to data protection legislation in 20 years, contains a few new protections for data subjects (individuals the Trust holds information about) and threatens significant fines and penalties for non-compliant data controllers and processors.

- These new requirements will come into force in the United Kingdom (UK) on 25 May 2017; Brexit has no bearing on the application of GDPR in the UK.

- These protections and rights will be enacted under new data protection legislation (Data Protection Act 2018). Parliament has published the Data Protection Bill, which includes provisions on how GDPR applies in the UK. When passed in May 2018, the Bill became the Data Protection Act, 2018 and replaced the current Act (see Information Commissioner's Office website).

- The Bill must be considered in the context of GDPR, as it has a direct impact on the processing of personal data. This means the Bill must be read alongside GDPR to understand the full legislative framework. There will be new obligations on our Trust for data subject consent, data anonymisation, use of IT, IT security, data breach notification, overseas data transfers, and the appointment of data protection officers. GDPR will require all organisations handling data to adequately prepare for the changes and undertake major operational reform.

2. Key implications

In December 2017, the Trust sought additional specialist resources and contracted the services of a GDPR lead expert manager to support the then Information Governance Manager to provide specialist training and awareness to the Kings Executive Board members and specialist groups such as the Patient Services in preparation for May 2018.

Since this time, and with the departure of the permanent IG Manager, the Trust has commissioned an independent contractor to cover the IG role and manage the overall project for preparation and compliance for GDPR. This role is supported by an IG Advisor and IG Officer.

The Information Governance (IG) Manager has led the delivery of an engagement programme across the Trust including personalised awareness sessions, subject matter expert work streams and a communications campaign.

These ongoing activities focus on raising awareness and reviewing processes (documented policies/procedures and working practice) to prepare for changes in regulations and application of best practice across the Trust.

Other key leads including the Senior Information Responsible Officer (SIRO) and Caldecott Guardian have attended external training sessions to ensure that the latest information is being identified and feed back into the overall project planning. The Data Protection Officer (DPO) is a mandatory requirement under the Data Protection Bill and the Trust appointed a Data Protection Office in January 2018.

The notable changes to the policy are indicated below:

- Revised roles and responsibilities including the appointment of a Trust Data Protection Officer
- Strengthening of the Information Governance Steering Group that oversees the data protection within the organisation
- Refresh of 28 policies that underpin Information Governance at the Trust – 14 of which are referenced in this document
- Application of a refreshed training approach that offers enhanced and bespoke training to information asset owners and other roles that undertake a larger role in data protection
- Additional guidance is expected over the next 12 months and the requirements of the data protection toolkit will change in 2020
- Note the substantial increase in fines for breaches of data protection and breaches of the processes supporting data protection.

The policy describes the structures and approach of the organisation to respond to regulatory changes.

3. Conclusion

The policy outlines the framework to strengthen our governance and protection of data throughout the organisation. This includes expanding the IG team, refreshing relevant policies, increasing the breadth of training and communicating key risks and responsibilities.

4. Recommendations

- Agree the appended policy
- Note the responsibilities required of the Board

King's College Hospital NHS
NHS Foundation Trust

Information Governance Policy

Main Document Information	
Version:	V6.0
Publication Date:	12th November 2018
Approval Body:	Information Governance Steering Group
Approval Date:	28th October 2018
Ratification Body:	Board of Directors
Ratification Date:	3rd July 2019
Document Author:	Head of Information Governance
Responsible Executive Director:	Director of Improvement, Informatics and ICT & SIRO
Periodic Review Date:	**01/06/2021**
Policy Category:	Trust-wide
Document Change from Previous:	Major Change
Consideration of **counter fraud, corruption or bribery measures** was given.	Consideration was given
Readership (Target Audience)	All Staff
Relevant External Requirements (CQC / NHSLA / HSE / IGT etc.)**:**	• The Data Protection Act 2018 • General Data Protection Regulation. • The common law duty of confidence. • The Confidentiality NHS Code of Practice. • The NHS Care Record Guarantee for England. • The Social Care Record Guarantee for England. • The international information security standard: ISO/IEC 27002: 2005. • The Information Security NHS Code of Practice. • The IGA Records Management NHS Code of Practice 2016. • The Freedom of Information Act 2000. • CQC Outcome 21 • Data Security & Protection Toolkit • The Public Records Act 1958 • Health and Social Care Act 2012 and 2013

Document Location and History	
Current Document Title:	Information Governance Policy
Current Document Location:	Information Governance policy update v4.1.docx
Current Document Replaces:	
Previous Document Name:	Information Governance Policy
Previous Version Number:	4.1
Previous Publication Date:	22/02/2017
Location of Archived Document:	http://kingsdocs/docs/kchdocs/Information Governance Policy 2012.doc

Document Authors	
Document Owner:	Information Governance Manager / DPO
Other Contributing Authors:	Information Governance Steering Group

Consultation Distribution		
Sent To		**Date**
Group:	Information Governance Steering Group	28th October 2019

Version Control History				
Version	**Date**	**Type of Change**	**Summary of Changes**	**Author**
2	23/05/2010	Major	Bring up to date and change to Trust standard format.	Information Governance Steering Group
3	06/04/2012	Minor as agreed by audit	Incorporation of Management Framework	Colin Sweeney
Draft 3.3	29/11/2013	Major	To align with IG Toolkit requirements and revised policy format	Sally Grover
5	25/10/2018	Major	To align with changes in legislation and regulatory requirements	Nick Murphy-O'Kane

Dissemination Schedule (Following Ratification)				
Target Audience	**Method of Distribution**	**Person Responsible**	**Confirmation Receipt Required?**	**Method of Replacement for Previous Version**
All Staff	Kingsdocs	Head of Information Governance	Yes	Remove old version, replace with current
All Staff	Kwiki	Head of Information Governance	No	Link to policy on related Kwiki pages

Document Keywords	
Keywords:	Information Governance, policy, confidentiality, data security

Supporting Documentation (complete and added as appendices)	
Policy Checklist:	Yes
Equality Impact Assessment:	Yes
Ratification Sheet:	Yes

Table of Contents

1. Introduction

Information is a vital asset and resource, both in terms of the clinical management of individual patients and the efficient management of services. It plays a key part in clinical governance, service planning and performance management. All information used in the NHS is subject to handling by individuals and it is necessary for these individuals to be clear about their responsibilities and for the Trust to ensure and support appropriate education and training.

The Trust recognises the need for an appropriate balance between openness and confidentiality in the management and use of information. The Trust fully supports the principles of corporate governance and recognises its public accountability, but equally places importance on the confidentiality of, and the security arrangements to safeguard, both personal information about patients and staff and commercially sensitive information necessary for the operation of the Trust. In balancing openness and confidentiality there is also a need to ensure that access to clinical care is not unduly compromised by information governance arrangements.

The Trust also recognises the need to share patient information with other health organisations and other agencies in a controlled manner consistent with the interests of the patient and, in some circumstances, the public interest.

The Trust believes that accurate, timely and relevant information is essential to deliver the highest quality health care. As such it is the responsibility of all clinicians, professionals and managers to ensure and promote the quality of information and to actively use information in decision making processes.

The Trust recognises that appropriate accountability, standards, policies and procedures provide a robust governance framework for information management.

The Trust will offer support through appropriate learning to enable all staff to:

- Hold information securely and confidentially
- Obtain information fairly and efficiently
- Record information accurately and reliably
- Use information effectively and ethically
- Share information appropriately and lawfully

The Trust has established a committee, the Information Governance Steering Group, chaired by the Senior Information Risk Owner to recommend, establish and monitor Information Governance processes.

2. Definitions

Term	Definition
Information	All facts, knowledge or data concerning a person, situation or event, whether held on paper, computer, visually or audio recorded, or held in the memory of an individual.
Confidentiality	The limitation to those with specified Trust authority to access the information.
Integrity	The requirement that all system assets are operating correctly according to specification and in the way current users believe they should be operating, to ensure that data is preserved in its original form. The data must not be altered overtly or covertly, either accidentally or for malicious reasons. It must not be unintentionally destroyed. Integrity is a measure of the information's accuracy and reliability.
Availability	The requirement to ensure that information is delivered to the right person when it is needed.
Accountability	The Requirement to ensure that every individual is held accountable for their obligations in relation to the use of information.

3. Purpose and Scope

The purpose of this policy is to set a clear direction for Information Governance within King's College Hospital NHS Foundation Trust (the Trust) and to demonstrate management support and commitment to information security and confidentiality and its responsibilities for the management of information assets and resources. It sets out the Trust's approach to ensuring the confidentiality; integrity; availability and accountability of Trust information and describes the framework for implementation of the Information Governance Strategy and Annual Action Plans developed through the Information Governance Steering Group (IGSG).

This policy applies to the use of all information and information systems within the Trust including but not limited to:

- Copying, storage and processing of information;
- Structured record systems - paper and electronic;
- Transmission of information by post, fax, electronic mail and other electronic means;
- Transmission of information by means of the spoken word, including telephone, mobile phone, voicemail and answering machines
- Information held on mobile data storage including laptops, data sticks and mobile phones.
- All information systems purchased, developed and managed by or on behalf of the Trust.

4 Duties

4.1 The Senior Information Risk Owner (SIRO), also chair of the Information Governance Steering Group, is an executive who is familiar with and takes ownership of the Trust's Information Risk Policy and acts as an advocate for information risk on the Trust Board.

4.2 The Caldecott Guardian is responsible for agreeing and reviewing protocols governing the disclosure of patient information across organisations boundaries, e.g. with social services and other partner organisations contributing to the local provision of care. These protocols should underpin and facilitate the development of cross boundary working, health improvement programmes and other changes heralded in the NHS Plan.

4.3 The Deputy Senior Information Risk Owner (Deputy SIRO), is a senior manager who has responsibility for monitoring the operational delivery of the information governance strategy and agenda within the Trust and reporting progress and issues to the SIRO.

4.4 The Information Governance Manager & Data Protection Officer is responsible for managing the Trust's Information Governance agenda across the entire Trust, bringing together Information Quality Assurance, Data Protection, Caldicott, Records Management, Registration Authority, Information Security, Freedom of Information and Data Quality into a comprehensive work programme.

4.5 The ICT Security Manager has primary responsibilities for ICT Security and will provide expert technical advice in this field. Their role involves the development, implementation and audit of all policies and procedures related to Information Security within the Trust with a specialist focus on ensuring the Trust complies, and remains compliant, with relevant legislation.

4.6 Information Asset Owners are senior individuals who have the responsibility for the protection of information assets, in accordance with this policy document, within the department(s) for which they are responsible. Their role is to understand and address risks to the information assets they "own" and to provide assurance to the SIRO on the security and use of those assets.

4.7 System Managers must maintain documented procedures relating to their information systems that ensure implementation and conformance with these policies and procedures. The level of protection needs to be agreed and assessed with the Information Governance Manager with assistance from the Caldecott Guardian.

4.8 Individual Users - all staff within the Trust have an obligation to safeguard the confidentiality and availability of personal and other Trust information. The Law governs this, as does contracts of employment, and in many cases professional ethics and codes of conduct. The requirements set out in this policy therefore apply to all staff working within the Trust including non-Executive Directors, locums, agency staff, contractors, students and suppliers of goods and services.

4.9 The Registration Authority Manager (RAM) is responsible for ensuring that all users of National CRS applications and smartcard systems are correctly identified and given appropriate timely levels of system access necessary for the protection of patient confidentiality, in accordance with local and national guidelines. The RAM is accountable to the Executive Director of Workforce Development.

5. Policy Specific Information

5.1 Freedom of Information - The Freedom of Information Act 2000 gives everyone the right of access to information held by government bodies, such as NHS hospital trusts, subject to certain exemptions. To exercise this right under the Act, the requestor does not have to reside in the UK or even provide a reason for the request. This does not undermine the data subject's right to confidentiality, as provided under the Data Protection Act. Non-confidential information about the Trust and its services will be available to the public through a variety of media and the Trust has established and will maintain policies and procedures to ensure it complies with the Freedom of Information Act and has clear arrangements for handling queries from patients and the public.

5.2 Data Protection – Data Protection legislation provides data subjects, including patients, staff and visitors to the Trust, with the right to access information held about them/ For patients this includes information relating to their own health care, their options for treatment and their rights as patients. All requests for personalised information shall be dealt with in accordance with the Data Protection Act 2018.

5.3 Information Quality Assurance - Information Quality is an important part of the Information Governance agenda in terms of data quality and integrity. Quality is generally defined as "fit for purpose". It is the responsibility of **all staff** to ensure that data is relevant and accurate. Good quality data means that data is recorded in full, as accurately as possible and in a timely manner. Where it is not possible to enter data in real time this data should be recorded as soon after the event as possible. Data should not be duplicated unless absolutely necessary and this fact should be recorded with the original data. If duplicated the data owner must ensure that all copies of the data are kept up to date and synchronised.

To promote Information Quality the Trust will**:**

- Establish and maintain policies and procedures for information quality assurance and the effective management of records.
- Undertake or commission annual assessments and audits of its information quality and records management arrangements.
- Expect managers to take ownership of, and seek to improve, the quality of information within their services.
- Provide appropriate training to ensure individuals who record information are aware of their responsibility to ensure the quality and accuracy of that information

5.4 Information Security (including cyber security) - It is the responsibility of managers and staff to ensure they follow information security guidelines and best practice. The Trust aims to achieve compliance with the Cyber Essentials Plus standard and the ISO/IEC 27001:2005 the required standard for Information Security. To ensure Information Security the Trust will:

- Establish and maintain standards and policies for the identification of information risks and the secure management of its information assets and resources.
- Promote effective confidentiality and security practice to its staff through policies, procedures and training
- Establish and maintain incident reporting procedures and monitor and investigate all reported instances of actual or potential breaches of confidentiality and security
- Commission or undertake annual assessments and audits of its information security procedures and practices.

5.5 Legal and Regulatory Compliance – The Trust is required to comply with legislation and NHS regulations and guidance as listed in Annex A.

As part of this compliance the Trust will:

- Regard all identifiable personal information relating to patients and staff as confidential
- Establish and maintain policies to ensure compliance with the common law of confidentiality, the Data Protection Act, Human Rights Act and NHS Code of Practice on Confidentiality.
- Establish and maintain policies for the controlled and appropriate sharing of patient information with other agencies and will continue to monitor and establish new agreements when necessary.

5.6 Records Management – The Trust is required by the Records Management: NHS Code of Practice 2006 to have a systematic and planned approach to the management of records.

To support this requirement the Trust will:

- Establish and maintain policies and procedures for the effective management of records
- Expect managers to ensure effective records management within their service areas.
- Promote records management through formal and informal training.

5.7 Management of Information Governance

INFORMATION GOVERNANCE MANAGEMENT FRAMEWORK		
Heading	**Requirement**	**Notes**
Senior Roles	IG Lead and Senior Information Risk Owner (SIRO) Caldicott Guardian	The Trust IG Lead and SIRO is Lisa Hollins Director of Improvement, Informatics & ICT The Caldicott Guardian is Dr Alastair Baker.
Key Policies	Over-arching IG Policy Patient Health Records Policy Personal Information Management and Confidentiality Policy Records Management Policy Information Risk Policy Freedom of Information	This Document http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Patient Health Records Policy.doc http://kingsdocs/docs/policies/Human Resources/Personnel Information Policy.doc http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Records_Management_Policy.doc http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Information Risk Policy.doc http://kingsdocs/docs/policies/DOCUMENTS

	Policy	POLICIES/Freedom of Information Policy.doc
	Internet Usage and Security Policy	http://kingsdocs/docs/policies/IT Policies/KCH Internet Usage Security Policy.DOC
	Clinical Audit Policy	http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Clinical Audit Policy.doc
	Risk Management Strategy	http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Risk Management Strategy.DOC

Heading	Requirement	Notes
Key Governance Bodies	Quality Executive Board Information Governance Steering Group	See Terms of reference incorporated in Risk Management Strategy IGSG Terms of Reference
Resources	Membership of the IG Steering Group	• Associate Director of Governance • Caldicott Guardian • Head of Operational Performance / Deputy SIRO / Freedom of Information Lead • Head of Patient Records Service • Assistant Director of Performance and Contracts • IG & Corporate Records Manager • Data Protection Officer • Senior HR Advisor (Transactional HR Contract Manager) • ICT Security Manager • Representative of Divisions
Governance Framework	How responsibility and accountability for IG is cascaded through the organisation.	Information Governance Structure (Annex B) and this table.
Training & Guidance	Training for all staff	Staff may access required training via LEAP http://kingsdocs/docs/policies/Human Resources/Statutory and Mandatory Training Policy.doc Information on various aspects of IG is available to all staff via “Kwiki” an on-line staff resource
	Training for specialist IG roles	Staff in specific roles are required to make use of the NHS Digital on-line training modules and attend IG forums and training sessions.
	Organisation Security Policy	http://kingsdocs/docs/policies/IT Policies/KCH Information Systems Security Policy ISSP2.doc
	Staff Code of Conduct	http://kingsdocs/docs/policies/Human Resources/Personnel Information Policy.doc http://kingsdocs/docs/policies/IT Policies/KCH ConfidentialityCoC.doc
Incident Management	Documented procedures and staff awareness	http://kingsdocs/docs/policies/DOCUMENTS POLICIES/Information Risk Policy.doc

6. Implementation

The Trust will use the Data Security and Protection Toolkit (DSPT) to help ensure that it is meeting the obligations of each of the key elements identified above.

7. Monitoring Compliance

Measurable Policy Objectives	Monitoring / Audit Method	Frequency	Responsibility of Monitoring	Responsible Committee
DSPT Toolkit Compliance	IG Management Report	bi-monthly	IG and Records Manager	Information Governance Steering Group
Annual IG Report	Annual Report	Annual	IG and Records Manager	Board of Directors

8. Associated documents

The following are linked to the delivery of this policy

- KCH Confidentiality Policy
- KCH Data Protection Policy
- KCH Information Security Policy

9. References

The following are referenced in this policy:

- NHS Digital (https://digital.nhs.uk/)
- UK Legislation (http://www.legislation.gov.uk/)

Annex 1: Legal and Regulatory Framework

The Trust is bound by the provisions of a number of items of legislation and statutory instruments affecting the stewardship and control of information. Including but not limited to:

- Abortion Regulations 1991
- Access to Health Records Act 1990 (where not superseded by the Data Protection Act 1998)
- Audit & Internal Control Act 1987
- Children's Act 2004
- Computer Misuse Act 1990
- Copyright, Designs and Patents Act 1988 (as amended by the Copyright (Computer Programs)
- Crime & Disorder Act 1998
- Criminal Justice Act 2008
- Data Protection Act 2018 (and subsequent Special Information Notices)
- Electronic Communications Act 2000
- Environmental Information Regulations 2004
- Freedom of Information Act 2000
- General Data Protection Regulation
- Human Fertilisation & Embryology Act 1990
- Human Rights Act 1998
- Health and Social Care Act 2012
- National Health Service Act 1977
- NHS Sexually transmitted disease regulations 2000
- Public Interest Disclosure Act 1998
- Regulation of Investigatory Powers Act 2000 (& Lawful Business Practice Regulations 2000)
- Prevention of Terrorism (Temporary Provisions) Act 1989 & Terrorism Act 2000
- Regulations under Health & Safety at Work Act 1974
- Road Traffic Act 1988

Regulatory framework:

In relation to the above requirements the NHS has set out and mandated a number of elements of regulation that constitute 'Information Governance' through a national programme. This area is developing and the focus within this section will need significant periodical review.

- Data Security and Protection Toolkit.
- Caldicott Reviews
- Information: To share or not to share? The Information Governance Review – March 2013
- Confidentiality: NHS Code of Practice (2003)
- NHS guidance on Consent to Treatment
- IGA Records Management Code of Practice 2016
- Care Quality Commission Standards – Outcome 21: Records
- Information Security Management: NHS Code of Practice (2007)
- Connecting for Health Information Governance Statement of Compliance.

Wider NHS and national regulation elements:

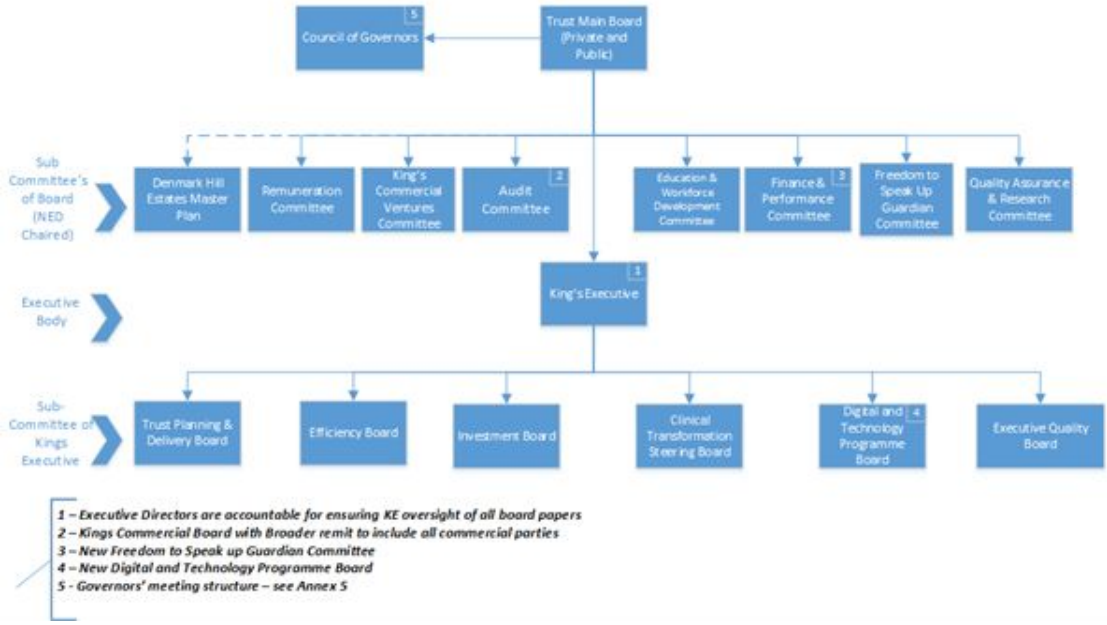
Controls Assurance Standards (IM&T & Records Management)
Commission for Health Improvement (CHI) [Commission for Health Audit and Improvement (CHAI) from 01/04/04] Clinical Governance reviews
Clinical Negligence Scheme for Trusts (CNST) - via NHS Litigation Authority
Data Handling Procedures in Government (November 2008)
Also related but not NHS specific - 'Clinical Professionals Regulatory Framework'

King's College Hospital NHS
NHS Foundation Trust

Annex 2: Information Governance Structure

King's College Hospital NHS
NHS Foundation Trust

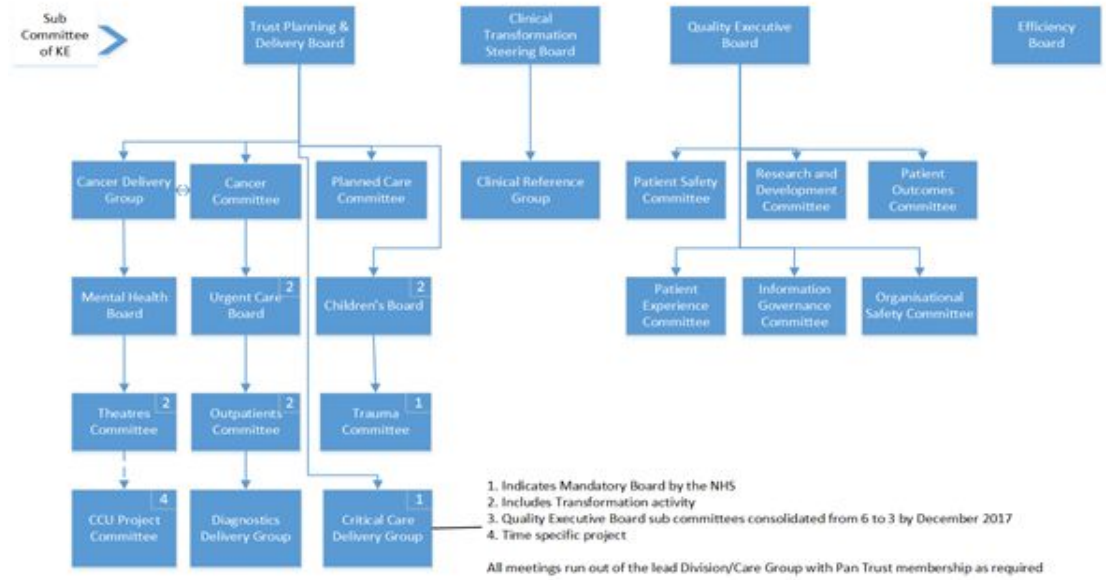
Trust Governance Structure – Level 1



1 – Executive Directors are accountable for ensuring KE oversight of all board papers
2 – Kings Commercial Board with Broader remit to include all commercial parties
3 – New Freedom to Speak up Guardian Committee
4 – New Digital and Technology Programme Board
5 - Governors' meeting structure – see Annex 5

King's College Hospital NHS
NHS Foundation Trust

Trust Governance Structure – Level 2



1. Indicates Mandatory Board by the NHS
2. Includes Transformation activity
3. Quality Executive Board sub committees consolidated from 6 to 3 by December 2017
4. Time specific project

All meetings run out of the lead Division/Care Group with Pan Trust membership as required

Annex 3: Checklist for the Review and Approval of Information Governance Policy

Check		If No, why?
Is the font Arial size 12 throughout, excluding headings which are Tahoma size 12?	Yes	
Have the 'Style & Format' requirements of the 'Policy on Policies' been followed in the development and review of this document?	Yes	
Are the following headings with supporting information included?		
• Introduction	Yes	
• Definitions	Yes	
• Purpose and Scope	Yes	
• Duties	Yes	
• Implementation	Yes	
• Monitoring of Compliance	Yes	
• Associated Documents	Yes	
• References	No	See Section 5.7 which replaces a reference section
• Appendix: Checklist for the Review and Approval of Trust-Wide Policies	Yes	
• Appendix: Equality Impact Assessment	Yes	
Does the document clearly detail who has been involved as part of the consultation?	Yes	
Has the document received final approval from the appropriate committee / group as described in the 'Policy on Policies' prior to submission for ratification?	Yes / No	
Does the 'Document Location and History' section clearly state where the current document can be located, the document that it replaces and where the archived document can be found?	Yes / No	
Does the 'Version Control History' clearly outline the type of changes that have taken place and when?	Yes	
Have all relevant external legislative and regulatory requirements been considered and / or added with internal advice sought where necessary?	Yes	

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Annex 4: Equality Impact Assessment

Service/Function/Policy	Directorate / Department	Assessor(s)	New or Existing Service or Policy?	Date of Assessment
Information Governance Policy	Operations		Existing	

1.1 Who is responsible for this service / function / policy? Information Governance Steering Group

1.2 Describe the purpose of the service / function / policy? Benefit to staff, patients and the organisation by clarifying Information Governance requirements

1.3 Are there any associated objectives? Compliance with the Information Governance Toolkit

1.4 What factors contribute or detract from achieving intended outcomes? Staff engagement

1.5 Does the service / policy / function / have an impact in terms of race, disability, gender, sexual orientation, age and religion? Details: No

1.6 If yes, please describe current or planned activities to address the impact.

1.7 Is there any scope for new measures which would promote equality? No

1.8 Equality Impact Rating [low, ~~medium, high*]~~.

Race ☐ **Age** ☐ **Disability** ☐ **Gender** ☐ **Religion** ☐ **Sexual Orientation** ☐

If you have rated the policy, service or function as having a high impact for any of these equality dimensions, it is necessary to carry out a detailed assessment and then complete section 2 of this form

1.9 Date for next review 01/12/2016

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Annex 5: Ratification Form

Policy Title:	Information Governance Policy
Version:	Version 5
Author:	Nick Murphy-O'Kane
Approval Committee:	Information Governance Steering Group
Approval Date:	28th October 2018
Responsible Executive Director:	Director of Improvement, Informatics and ICT
Date of KE Meeting:	28th October 2018
Policy Ratified (delete as appropriate):	**Yes**
Ratified Subject to Amendments (delete as appropriate):	No
If Yes, Summary of the Changes Required:	