King's College Hospital NHS Foundation Trust

AGENDA

Meeting	**Board of Directors**
Time of meeting	**3.30pm-5.30pm**
Date of meeting	**11th March 2021**
Meeting Room	**By Video Conference**
Site	**N/A**

			Encl.	Lead	Time
1.	**STANDING ITEMS** 1.1. Apologies 1.2. Declarations of Interest 1.3. Chair's Action 1.4. Minutes of Previous Meeting – 10th December 2020	**FA**	**Enc**	**Sir H Taylor**	**3.30pm**
2.	**STAFF STORY**			**Prof N Ranger**	**3.35pm**
3.	**QUALITY, PEOPLE FINANCE AND PERFORMANCE**				
	3.1 The Trust Response to Wave 2 of the COVID-19 Pandemic	**FR**	**Enc**	**Prof C Kay**	**3.50pm**
	3.2 COVID-19 Vaccination Programme			**J Lowe**	**4.10pm**
	3.3 Report from the Chief Executive 2.1.1. – Integrated Performance Review (M10) 2.1.2. – Finance Report (M10) 2.1.3. – Safer Staffing Report			**Prof C Kay**	**4.20pm**
	3.4 Ockenden Maternity Review – Trust Response			**Prof N Ranger**	**5.05pm**
4.	**GOVERNANCE AND ASSURANCE**				
	4.1 Report from the Risk and Governance Committee	**FR**	**Oral**	**Prof C Kay**	**5.10**
	4.2 Risk Management Strategy 2021-24	**FA**	**Enc**	**Prof N Ranger**	**5.15pm**
5.	**REPORT FROM THE GOVERNORS**	**FR**	**Oral**	**J Allberry**	**5.20pm**
6.	**FOR INFORMATION** Committee Minutes • Finance and Commercial 26th November 2020 and 17th December 2020 • Quality, People and Performance 3nd December 2020 • Audit Committee 19th November 2020 and 19th January 2021	**FI**	**Enc**		

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

7.	**ANY OTHER BUSINESS**			**Sir H Taylor**	**5.25pm**
8.	**DATE OF NEXT MEETING** 10th June 2021 at 3.30pm				

Members:	
Sir Hugh Taylor	Interim Trust Chair *(Chair*)
Sue Slipman	Non-Executive Director *(Vice Chair)*
Prof Jonathan Cohen	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Steve Weiner	Non-Executive Director
Akther Mateen	Non-Executive Director
Prof Clive Kay	Chief Executive
Lorcan Woods	Chief Finance Officer
Prof Nicola Ranger	Chief Nurse and Executive Director of Midwifery
Dr Leonie Penna	Acting Chief Medical Officer
Louise Clark	Acting Chief People Officer
Julie Lowe	Interim Site CEO – Denmark Hill
Jonathan Lofthouse	Site CEO – PRUH and South Sites
Beverley Bryant	Chief Digital Information Officer
Attendees:	
Claudette Elliott	Interim Director of Equality, Diversity and Inclusion
Siobhan Coldwell	Trust Secretary (Minutes)
Richard Chew	Interim Director of Communications
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 on 10th December 2020, by MS Teams.

Members:

Sir Hugh Taylor	Trust Chair, Meeting Chair
Akther Mateen	Non-Executive Director
Prof. Richard Trembath	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Prof Ghulam Mufti	Non-Executive Director
Steve Weiner	Non-Executive Director
Sue Slipman	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Prof Nicola Ranger	Chief Nurse and Executive Director of Midwifery
Prof Julia Wendon	Executive Medical Director – Clinical Strategy and Research
Dr Leonie Penna	Acting Chief Medical Officer
Julie Lowe	Interim Site Chief Executive - Denmark Hill
Lorcan Woods	Chief Finance Officer
Caroline White	Executive Director of Integrated Governance
Jackie Parrott	Chief Strategy Officer
Jonathan Lofthouse	Site Chief Executive – PRUH
Beverley Bryant	Chief Digital Information Officer
Louise Clark	Acting Chief People Officer

In attendance:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance (minutes)
Rob Beasley	Associate Director of Communications
Claudette Elliott	Interim Director of Equality, Diversity and Inclusion
Members of the Council of Governors	
Members of the Public	

Apologies:

Prof Jonathan Cohen	Non-Executive Director

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

20/56 Apologies

There were apologies for absence from Prof Jon Cohen

020/57 Declarations of Interest

None.

020/58 Chair's Actions

There were no Chair's Actions to report.

020/59 Minutes of the last meeting

The minutes of the meeting held on 10th September 2020 were agreed.

020/60 Report from the Chief Executive

The Board received a report from the Chief Executive Officer that summarised the key issues in relation to operational performance, quality and safety, finance and Workforce. Professor Clive Kay highlighted a number of points. The Chief Nurse and Chief Medical Officer are leading a focused programme of work to improve quality, safety and patient experience, noting the excellent work done by the Trust staff, volunteers and the Chaplaincy in relation to patient experience. The Trust's patient outcomes are consistently good. There is a focus on patient safety and learning from incidents. The Executive remains concerned about incidents that involve violence and confirmed that the Trust takes a zero tolerance approach to violent behaviour towards Trust staff.

In relation to operational performance, the Trust is working with the Acute Provider Collaborative in S E London to ensure that capacity across the system is maximised and activity levels are restored to pre-COVID-19 levels. New ways of working including the need to ensure social distancing and enhanced cleaning regimes have had some impact on productivity. Nevertheless a significant backlog remains and patients are being prioritised according to clinical need. The dental backlog will be particularly challenging, given the aerosol generating nature of the treatment. Performance against the Emergency Care Standard remains a concern, particularly at Denmark Hill.

There has been a slow but steady increase in the number of COVID-19 patients since the Board last met, but the numbers remain relatively low and elective capacity has not been impacted. The Trust has introduced asymptomatic staff testing for all patient facing staff. Testing is done twice a week and is progressing well. The vaccination programme has also commenced.

Prof Kay concluded by noting there had been a number of positive stories about King's and these are highlighted in his report.

The Board welcomed the update and congratulated the Trust in establishing the vaccination programme in a short period of time. The Board also paid tribute to the staff and patients that contributed to the "Surviving COVID" programme.

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

020/61 **Report from the Chair of the Quality, People and Performance Committee (QPPC)**

Nicholas Campbell-Watts provided the Board with a summary of the work of the Trust's Quality, People and Performance Committee highlighting a number of issues, in particular the good patient outcomes that have been reported. The Committee continues to be concerned about the backlog in serious incident investigations but notes that support has been put in place to address this. The Committee was also pleased to see improvements in Duty of Candour compliance particularly at the PRUH. The Committee had a good presentation from the Chief Nurse on the approach being taken to reduce violence and aggression and was very supportive of the programme. The Committee considered a number of workforce issues including vacancies and turnover, where trends are positive but were concerned about statutory and mandatory training compliance levels. The Committee noted the improvements being made to support equality, diversity and inclusion, particularly the new early resolution model being used to resolve staff disciplinary issues.

The Board noted the report.

020/62 **Operational Performance Month 7**

The Board received a report that summarised the Trust's operational performance over the first seven months of the year. The Site Chief Executives noted that the Trust is recovering performance levels as COVID-19 has subsided. The Trust continues to have significant backlog of patients who have waited more than 52 weeks for treatment. Cancer performance is improving and referrals are back to pre-COVID-19 levels. Diagnostic performance is also on a sustained upward trajectory.

Performance against the Emergency Care Standard at the PRUH is positive, but improvement is needed at Denmark Hill. Rapid COVID-19 testing is now in place that will facilitate improved flow and the teams are working with mental health partners to ensure appropriate support is available to patients presenting with mental health needs.

The Board noted the report.

Safer Staffing

The Board received a quarterly update on safer nursing levels across the Trust. The Chief Nurse, Prof Nicola Ranger, noted that there has been an improvement in turnover and although vacancies remain above target, this is due to new investment. The Trust is actively recruiting and is due to welcome a number of new nurses over the coming months.

The Board noted the report.

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Subject **Action**

020/63 **Learning from COVID-19 Wave 1**

The Board received a report that summarised the learning gathered from across the organisation in order to ensure the Trust's experience of Wave 1 of the COVID-19 pandemic, and the lessons learned during this time, are factored into plans for any future waves. Overwhelmingly, the lessons learned process has illustrated the success with which the Trust managed the pandemic, the outstanding care that was provided to patients, the priority given to staff health and wellbeing and the important part KCH played in the wider system response. A number of recommendations were made in the report and the Trust has monitored the implementation of these through the Gold Command.

The Board noted the report.

020/64 **Report of the Chair of the Finance and Commercial Committee (FCC)**

Sue Slipman, the Chair of the Finance and Commercial Committee provided the Board with a summary of its most recent meeting. She highlighted the positive financial position, but that pay expenditure was out of line with last year. The Committee is considering options on how to contain this. The implementation of the new finance system has been a success. The Committee reviewed the Trust's capital programme. It is well funded and capacity is being brought into ensure the programme is properly supported. The Committee has begun to consider how the Trust will approach the sustainability agenda. Meeting the NHS commitments will be challenging.

The Board noted the report.

020/65 **Finance M7 Report**

The Board received a report that summarised the Trust's financial position at M7. The Chief Finance Officer, Lorcan Woods, noted that a block funding arrangement is in place remainder of the year. The Trust continues to record an in-month deficit, but this is consistent month on month. It is increasingly likely that the Trust will break-even by year-end. In relation to pay expenditure, analysis shows that the increases are in part pay inflation, due to cost of living pay awards. Bank and agency expenditure has also increased, due to COVID-19 related issues including staff sickness and cover for staff that are shielding. He noted that there has been limited focus on cost improvement activity during the year, but work will be commencing in the new year to develop a cost improvement plan for 2021/22.

Mr Woods went on to provide a summary of the capital position, noting that the position is significantly better than in previous years. Borrowings have also reduced significantly.

The Board noted the report and welcomed the improved financial position.

020/66 **Patient Story**

The Board was joined by Mr Paul Koloi and his wife to talk about his experience of being a patient at King's. Mr Koloi was brought to King's as an emergency patient having collapsed at home. He received an emergency aortic dissection and was a patient in ICU and on a general ward. He also received outpatient care with weekly cardiac rehabilitation sessions. During his rehabilitation he experience a mini stroke.

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	Subject	Action
020/66 cont	**Patient Story cont…**	
	Mr Koloi reported that he had received excellent care throughout his stay as an in-patient and as an outpatient. His family were also well supported. He was receiving care from a number of specialities within the Trust and coordinating the care and advice from multiple sources creates challenges for patients, particularly if there are inconsistencies in the advice being given. The Board thanked Mr Koloi for sharing his experiences and agreed to follow-up the concerns raised through the Quality, People and Performance Committee.	**NR**
020/67	**Report from the Chair of the Risk and Governance Committee**	
	The Chief Executive provided the Board with a short summary of the recent meetings of the Risk and Governance Committee. The Committee has been focusing on a number of issues including information governance, duty of candour compliance and corporate risk. The Committee had received a number of internal audit reviews and was focused on ensuring recommendations are being implemented.	
020/68	**BAF** The Board noted the contents of the Board Assurance Framework.	
020/69	**Report from the Governors**	
	Jane Allberry, Lead Governor, thanked the Trust's staff for their ongoing hard work and compassion. She noted that although working virtually is difficult, the Governors had recently had a number of very successful meetings. The Chair thanked the Governors for their ongoing support and engagement.	
020/70	**For Information**	
	The minutes of the following meetings were received for information: • Finance and Commercial 24th September 2020 • Quality, People and Performance 1st October 2020 • Major Projects 23rd July 2020 • Strategy Research and Partnerships 10th September 2020 • Audit Committee 17th September 2020	
020/71	**Any Other Business**	
	The Chair concluded the meeting by noting this was the final board meeting for Prof Ghulam Mufti. The Chair paid tribute to the outstanding contribution Prof Mufti has made to King's over the years, as a pioneer in Haematology and more recently as a member of the Board. In that capacity Prof Mufti has engaged in a wide range of issues including quality and safety and research. He has been a consistent champion and advocate for BAME staff having led the BAME network and he has been an extremely strong advocate for patients.	

King's College Hospital NHS
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020/72 **Date of the Next Meeting**

3.30pm 11th March 2021

King's College Hospital NHS Foundation Trust

Report to: Board of Directors

Date of meeting: Thursday 11th March 2021

Subject: Update on the Trust's Response to Wave 2 of COVID-19

Author: Rachel Rutt, Chief of Staff to the Chief Executive Officer

Presented by: Professor Clive Kay, Chief Executive Officer

Sponsor: Professor Clive Kay, Chief Executive Officer

History: n/a

Status: Information

1. Background/Purpose

The attached report provides an overview of the Trust's response to wave 2 of the COVID-19 pandemic.

2. Action required

The Board is asked to note the contents of this report.

3. Key implications

Legal:	There are no legal issues arising out of this report.
Financial:	There are no financial issues arising out of this report.
Assurance:	There are no assurance issues arising out of this report.
Clinical:	The paper addresses a number of clinical issues facing the Trust.
Equality & Diversity:	The paper outlines patient demographics.
Performance:	Responding to COVID-19 Wave 2 resulted in elective activity being halted. The report outlines plans for recovery.
Strategy:	There are no financial issues arising out of this report.
Workforce:	The Board summarises the issues that affected the workforce and the Trust response.
Estates:	The Trust re-opened a Critical Care Unit in response to COVID-19 Wave 2.
Reputation:	An effective Wave 2 response allows the Trust to protect its reputation.

King's College Hospital NHS Trust
Chief Executive's COVID-19 Update – Board report
March 2021

King's College Hospital NHS Trust
Chief Executive's COVID-19 Update – Board report
March 2021

1. Introduction

The first COVID-19 positive swab was processed at King's College Hospital (KCH) on the 25th February 2020. One week later on the 3rd March 2020, the Trust admitted the first COVID-19 inpatient, and the number of COVID-19 inpatients rose rapidly during the month. On 4th March 2020 the Trust declared a Critical Incident, and then declared a Major Incident on the 12th March 2020, and moved into a seven day a week Incident Response. On 11th March 2020 the first patient died from COVID-19 at The Princess Royal University Hospital (PRUH), and 4 days later - on the 15th March 2020 - the first death occurred at Denmark Hill (DH).

I previously presented to the Board of Directors a specific Wave 1 summary Board report, along with a formal Wave 1 review document.

It is important to recognise the speed at which the COVID-19 pandemic has impacted the Trust. King's College Hospital has been one of the largest treatment centres for COVID-19 in the country.

2. Post Wave 1 Period

Between Waves 1 and 2 of the pandemic there was a period of approximately 5 months where, as an organisation, and as a system, the process for recovery commenced.

As with all organisations in the NHS, COVID-19 has triggered incredible transformation. The Trust accelerated innovative ways of working and expanded its horizons to imagine a radically different way of providing patient care.

The Trust developed and implemented a Reset and Recovery programme focusing on using the opportunity of our learning to embed the transformation afforded by the first Wave, to manage the very significant patient backlogs, and to build resilience for a second and any subsequent waves.

A South East London (SEL) Acute Provider Collaborative (APC) with neighboring acute Trusts was established with the goal of working together to provide equity of care across our sector. Worked at a London region level to standardize and formalize our approach in a range of areas including critical care, diagnostics, elective care hubs, and workforce.

The Trust carried out a Wave 1 Review and identified what had worked well, what the Trust needed to do better in future, and what had not been addressed but needed to be in subsequent waves. This Review proved invaluable in dealing with the second wave of the pandemic.

3. Wave 2 of COVID-19

The ongoing pandemic has led to us facing further significant operational, clinical and workforce challenges, and the response of our staff has continued to be inspirational. Not only have our colleagues delivered exceptional care to patients often in some of the most difficult circumstances, but they have also continued to provide each other with great kindness and support.

The second wave of the COVID-19 Pandemic arrived quickly. On the 18th December 2020 there were 90 patients in the Trust with COVID-19, and by the 11th January 2021 this had risen to 776 - a nearly 9-fold increase within a 24 day period. The exponential increase in

COVID-19 patient activity was incredibly challenging for staff, and furthermore at a time of the usual winter pressures, the holiday season, alongside significant staff sickness and exhaustion.
The number of COVID -19 patients receiving critical care in the Trust peaked at 137 on the 19th January 2021 (compared to a peak in Wave 1 of 102). Critical care saw a slower and more sustained increase compared to Wave 1 and this time we saw a more significant increase in General and Acute patients across both main hospital sites.

From the 1st of December 2020 to the 17th February 2021, the Trust admitted 1,566 COVID-19 patients, compared to 979 in the commensurate period of Wave 1. This is an increase of 60%. The trusts average G&A admissions per day have been 24.4 from the peak of the 28th December 2020 onwards, compared to 13.9 in Wave 1. This is an increase of 47.9%.

4. Notable Differences between Waves 1 and Wave 2

In many ways, from an operational perspective, the first two Waves of the pandemic were quite similar. Via a Command and Control Structure, the Trust established a continuous cycle of converting wards to accommodate COVID-19 patients – and in the peak this took place on an almost daily basis. This has represented an immense amount of work for the operational teams, and has been described in detail in section 2 of the Chief Executive's Report published on the 19th June 2020. However, there have been some significant differences between the two Waves of the pandemic that have continued to challenge us as a Trust, and it is the following areas where differences have been most notable:

4.1 Staff Health and Wellbeing
4.2 Patient Demographics
4.3 Patient Mortality
4.4 Changes to Clinical Treatment
4.5 The Vaccination Programme
4.6 Staff Sickness
4.7 Staff Redeployment
4.8 Re-opening of the Critical Care Unit (CCU A&B)
4.9 Recovery of Elective Care
4.10 Staff Recuperation and Decompression
4.11 Communications and Engagement

4.1 Staff Health and Well-being (data as of w/c 8th February 2021)

We have continued our focus on employee wellbeing and have been determined that the care and support shown to our staff in Wave 1 continued. Our focus through Wave 2 has been to listen to our teams to understand what has worked well, and what else we need to focus on.

The two key areas that we are focussing on, amongst a wider programme of work are:

Well-being hubs:
We opened a new well-being hub at the PRUH that enabled the Trust to manage the space and social distancing in a more practical way – i.e. smaller breakout rooms for individuals rather than one large space. Denmark Hill continues to use the Boardroom along with the Neurosciences Rehabilitation gym, and Orpington also has a hub for staff to use.

The hubs are well used and as of the week commencing the 8th February 2021 the footfall within the hubs was 15,316, broken down at the sites as follows:

- PRUH – 3,467
- Orpington – 1,099
- DH Boardroom – 8,394
- DH Neurosciences Rehabilitation Gym – 2,356

Psychosocial Well-being:
Leadership circles and team interventions have taken place in several departments, including the facilitation of 4 check-ins. Resources and signposting support continues within the Trust and the wider NHS, and support is being offered via meetings, posters and central Trust communications.

Overall across groups the psychosocial themes remain as fatigue, trauma, anxiety and an emerging theme about the retention of staff. The workforce team continues to monitor these themes and work with the leadership team to manage issues as they arrive – either generically or to targeted teams and individuals.

4.2 Patient Demographics

Analysis of demographics and mortality in Wave 2 of the COVID-19 pandemic:
As in Wave 1 of COVID-19, the trust was able to obtain good data regarding the patients who were admitted with COVID-19 by interrogation of the Electronic Patient Record (EPR). The trust also continued a process of review of mortality by looking at demographic factors in patients who died and also by carrying out sampling reviews of cases who died.

Analysis of Wave 2 remains provisional as there are a number of patients who remain inpatients and so do not have completed outcomes. The data described are based on an analysis of patients cared for in King's in Wave 2 up to 11th February 2021.

Observations regarding patient demographics:
The number of patients in Wave 2 was greater than in Wave 1 with a total of 2727 included in the analysis compared to the total of 1961 seen in Wave 1. The greater number of male compared to female patients persisted but was significantly reduced (57% male in Wave 1 versus 53% male in Wave 2). The overall cohort of patients admitted with COVID-19 was

significantly younger in Wave 2 compared to Wave 1 (Wave 1 average age 69 and in Wave 2 the average age was 64).

There was a shift of the ethnicity towards the distribution seen in the general population of King's with a significant increase in the number of people admitted with white ethnicity (Wave 1 40% of patients recorded as white and 53% in Wave 2). There was a corresponding reduction in the number of patients recorded as BAME ethnicity in Wave 2 (30% versus 38% in Wave 1).

Based on biochemical parameters, patients admitted in Wave 2 of the pandemic at KCH were less unwell with significantly lower C-Reactive Protein (CRP) and neutrophil counts and less renal impairment. It is possible that this was due to changes in attitude of patients to attending (less fear of attending hospital than during Wave 1), or changes in GP and ambulance threshold for transfer to hospital but these are currently speculative reasons only.

4.3 Patient Mortality

Inpatient death reduced significantly between Wave 1 and Wave 2 with 27% (338) deaths occurring in Wave 1 compared with 17.4% (302) deaths occurring in Wave 2. Mortality in a pandemic is measured using Case Fatality Rate (CFR) which is the total number of deaths observed divided by the sum of deaths and patients discharged alive.

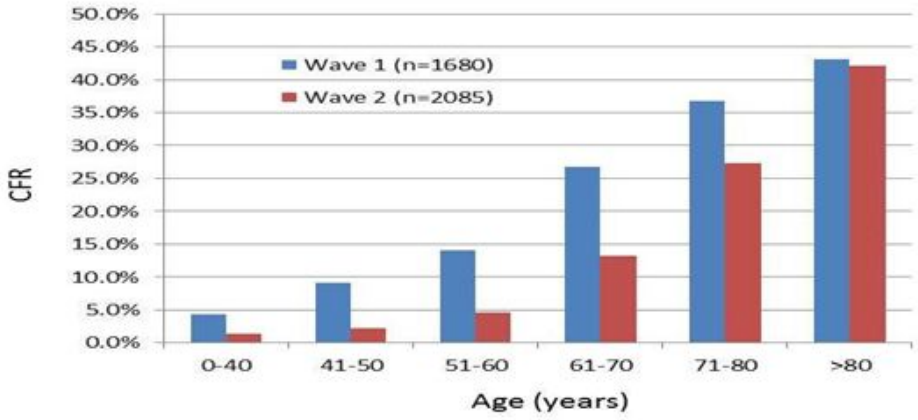
	Wave 1			Wave 2		
	Total admissions	Died	CFR	Total admissions	Died	CFR
PRUH/ South sites	681	202	29.6%	943	192	20.3%
DH	999	259	25.9%	1142	184	16.1%
Total	1680	461	27.4%	2085	376	18.0%

This table shows the reduction on mortality between Wave 1 and Wave 2 of 34%.

	Wave 1			Wave 2		
Site	Admissions	Died	CFR	Admissions	Died	CFR
G & A	1415	361	25.5%	1817	283	15.5%
Critical Care	265	100	37.7%	268	93	34.7%
All	1680	461	27.4%	2085	376	18%

The most marked reduction in CFR was seen in patients managed in the G&A wards with a small reduction only seen in patients admitted to Critical Care.

The reduction in CFR is seen in all groups except those >80 years.



The reduction in CFR was seen in all ethnic groups.

	Wave 1			Wave 2		
Ethnicity	Admissions	Died	CFR	Admissions	Died	CFR
White	809	263	32.5%	1057	250	23.6%
Black	477	107	22.4%	409	51	12.4%
Asian	63	21	33.3%	97	12	12.4%

4.4 Changes to Clinical Treatment

Management of patients with COVID-19 (Wave 2 includes 1251 patients admitted before 25/1/21)

The knowledge from Wave 1 was applied with Remdesivir given much more frequently as part of treatment (33.4% in Wave 2 compared to 0.1% in Wave 1) where this was only given as part of clinical trials. Dexamethasone was given even more frequently with 73.2% of patients receiving this in Wave 2 compared to 0.9% in Wave 1.

It is possible that the administration of these medications contributed to the reduction in critical care admission, length of stay and mortality (see below) but as they formed part of a package of care it is not possible to be certain of their overall contribution.

The average length of stay (LOS) was reduced in Wave 2 compared to Wave 1 for patients not requiring critical care admission (6 days in Wave 1 versus 5 days in Wave 2). This was particularly significant in those aged 61-80 where a reduction from to 6 days was observed. There was no difference in LOS in patients aged above 80 years between Waves 1 and 2.

It is too early to make a comparison of critical care length of stay (LOS) as over 70 patients remain in critical care and therefore the observed LOS will increase and is likely to be comparable with that observed in the first Wave. The percentage of patients requiring admission to critical care (in KCH this indicates a need for mechanical ventilation in most cases as advanced respiratory support was provided in high dependency areas on the wards).

In the 1ST Wave 15.9% (199) of patients required CCU admission and this reduced to 10.2% (224) of patients in the 2nd Wave.

4.5 The Vaccination Programme

The PRUH and DH sites were two of the six first Wave London Vaccination hubs, and two of the first 50 in England. The Trusts commence its Vaccination Programme on 8th December 2020.

Please see subsequent Board of Directors report on the KCH Vaccination Programme.

4.6 Staff Sickness

In Wave 1 we saw a peak of 2,485 staff absences (for all reasons – not just COVID-19) on the 1st April 2020. This has been lower in Wave 2 with a peak on the 13th January 2021 of 1,579. These numbers do not include shielding staff as this has changed throughout depending on government guidance.

The Trust continue to see staff sickness numbers decreasing since January and expect this to continue to be the case.

4.7 Staff Redeployment

The Trust has again redeployed a number of staff through Wave 2 to support the high number of COVID-19 patients that we have had within our hospitals. As of the 8th February the Trust had re-deployed 1,177 staff members, including 445 into Critical Care.

The largest group to be redeployed is 'Nursing and Midwifery Registered', followed by 'Medical and Dental'. 'Additional Clinical Services' follows closely.

During Wave 2 39 Combat Medical Technicians were re-deployed to Denmark Hill who have worked within the Critical Care Unit as support runners for the medical teams.

An outcome of the Trust's Wave 1 Review was that although the redeployment worked well, there were a number of areas which could be improved upon. Initially our redeployment focused more on numbers of staff, but during Wave 2 it has been much more focussed around skill set and help with what the clinical teams need.

4.8 Re-opening of the Critical Care Unit (CCU A & B)

On the 19th January 2021, the Trust took the decision to reopen the new Critical Care Unit at Denmark Hill.

The decision to reopen the Unit has enabled the Trust to deliver a number of benefits for both our patients and our staff:

- It has provided a larger and purpose-designed working environment for critical care staff.
- It has provided a better clinical environment for optimising the care of very sick patients.

- It has resulted in increased flexibility in coordinating the pandemic response.

In addition, it has allowed us to unlock capacity in other clinical areas which we were using temporarily to care for critical care patients as we experienced increasing numbers of patients with COVID-19.

The decision was supported by the critical care leadership team, who were integral to planning the unit's reoccupation. A phased reoccupation of the unit commenced on Thursday 21st January 2021.

The unit played a key role in the first Wave of the pandemic but has had to remain closed since last summer, pending remedial works to improve fire safety.

Since then, the CCU has undergone a major improvement programme. This has included completing works on the internal fire barriers of the building and the extensive testing of the modern fire protection system. The latter includes the fire alarm, water mist, ventilation, and smoke extraction systems.

The Trust has developed a detailed fire risk assessment and mitigation action plan in collaboration with the London Fire Brigade (LFB), who have been very supportive throughout. The LFB has confirmed that in light of our plans, they believe it safe for us to occupy the building.

Among other safeguards in the trust's 14-point action plan is the mobilisation of a 24/7 fire watch team to carry out patrols of the main escape routes and areas of circulation. Typically, the fire watch members are current and former fire brigade staff.

We expect that this arrangement will be an interim one, for a period of 6-12 months – ***or*** until such time as we can establish whether the building's facade can safely be replaced whilst staff and patients remain in occupation. Design work on this full remediation of the facade is progressing at pace, which should mean construction work can start later in the year.

4.9 Recovery of Elective Care

Overall, Wave 2 has seen 68.7% more COVID-19 admissions than seen in Wave 1. The increased magnitude of admissions has placed significant pressure on both General and Acute, and Critical Care bed stock across the Trust, with an associated impact on delivery of elective care.

For Cancer pathways, this has led to a reduction in pathway completion through treatment, and an increase in pathways without a defined treatment plan due to delays in the completion of diagnostic tests. Despite the larger patient volumes, the volume of delayed decisions to treat is a third lower than post-Wave 1. This is in part following learning during Wave 1, and recovery to normal levels is currently expected to be complete within 3 months.

Across non-cancer elective pathways, the combination of reduced capacity, and the need to focus the capacity that is available on patients in clinical priority groups 1 and 2, has generated significant growth in patients exceeding 52 weeks on a referral to treatment (RTT) pathway. As we reach completion of the last formal reporting month (January 2021) the number of patients waiting in excess of 52 weeks had increased to 5,212, and is forecast to grow again in February and March, before a combination of restored elective capacity and lower 'tip in' rates drive reduced long wait volumes.

The majority of the breaches are waiting in Oral Surgery (1,408), Ophthalmology (1,124), and General Surgery (553), and these areas will be the focal points of the Trust's stabilisation and clinical priority phase of the elective recovery programme.

The number of patients exceeding 6 weeks for diagnostic tests has increased by 2,384 to 5,188 patients at the end of January. The highest proportion of breaches have occurred in Echocardiography (1,653), Endoscopy (1,186), MRI (899) and Non-Obstetric Ultrasound (547). As with RTT above, these diagnostic modalities are areas of focal points for the diagnostic recovery strategy currently being developed for presentation to King's Executive. In the example of MRI, COVID-19 pressures have been exacerbated by equipment outages, and the Trust has taken immediate steps to secure mobile alternatives.

Material increases in capacity (as patient numbers continue to decrease), and the turning back on of theatres and associated diagnostic and outpatient referral services is being coordinated by the Site Chief Executives in partnership with the SEL Acute Provider Collaborative. This restart is being supplemented with some independent sector capacity which is being coordinated by the South East London elective clinical senate.

Based on current modelling at the time of writing (February 2021) we anticipate that the vast majority of outpatient, diagnostic and theatre-related services will have been largely restored to normal by early April 2021.

4.10 Staff Recuperation and Decompression

It is widely accepted that there needs to be a programme of staff recovery following the most recent Wave of COVID-19.

This programme will need to meet the needs of staff who have lived through a variety of different experiences e.g. staff redeployed in to critical care, extremely clinically vulnerable staff who remain at home. For some, the period of recovery is likely to take some time and this programme will be developed to provide support for the next 12 months, at least.
The Trust's proactive programme of recovery will seek to do more than just support staff recovery; it will be designed to encourage post traumatic growth and aim to come through COVID-19 a stronger organisation, with more engaged teams and individuals.

It is vital that the recovery programme is based in evidence, and to support this we will be working with our King's College London (KCL) colleagues, who have shared their research in this field and their military medicine expertise.

The draft programme contains five core components:

- Training
- Thank you / recognition
- Reflection
- Return to work interviews
- Absence Monitoring

It is important to note that this programme will run in parallel to a number of other ongoing programmes of work and many have interrelated elements:

- Health and wellbeing programme
- Values refresh
- People and Culture Strategy

- Leadership development programme

The recovery programme will need dedicated resource to lead each of the components, arrange the logistics, communicate it effectively, ensure it remains on track and is agile in order to respond to organisational need and change.

4.11 Communications and Engagement

A key learning from Wave 1 was that we could not communicate enough with staff, and that our people are keen to understand what is going on so they can understand the bigger picture and how this affects them and their patients. However, with teams being incredibly busy, we had to ensure that the communications were easily accessible and available to all. Front and central to this was the launch of Kingsweb Mobile to provide critical information for staff working from home and not based on site.

As a result of feedback after Wave 1, we re-designed my daily bulletins and from the 16th November 2020 we moved to a format of a daily bulletin with the daily sitrep of patient numbers across the Trust, with a breakdown of the numbers in critical care beds and general and acute beds at both the PRUH and Denmark Hill. Included within the bulletin are staff updates, changes to policies and procedures, and reminders regarding pertinent issues that we would like all staff to be aware of. The Friday bulletins include an additional weekly message from me, with a narrative that highlights progress, achievements and thanks.

For this Wave, we have been working with our contractors, other NHS staff based in the Trust (e.g. SLaM) and the King's Hospital Charity, to ensure these bulletins are available to them.

As in Wave 1, we continue to hold regular 'Ask the Chief Executive' broadcast to collect and respond to staff feedback. These have been an invaluable feedback tool for myself and my executive colleagues to understand what the pertinent issues are within teams. These sessions also provided staff with an additional mechanism to communicate directly to the Executive Team.

The Trust also relaunched the "Hearing from you" staff series on Kingsweb, as well as publishing a range of redeployment stories. Over 20 'Hearing from you' and redeployment stories have already been shared - with more to follow.

In December 2020, the Workforce Team launched the 'Big Thank You' campaign which has been hugely successful, and has boosted staff morale. This is now being used as a nursing recruitment campaign across the Trust. The campaign featured photographs of staff members, along with a message of thanks from the specific individual's management team. The messages have been incredibly powerful and has since been nominated for a 'RAD Award' under the Employee Engagement Category.

5.0 Conclusion

As the report shows, this last year has been incredibly challenging for the Trust, and across the NHS and country as a whole. I would like to ask the Board to join me in thanking all King's staff for their hard work and leadership through this very difficult time, and further incredible resilience and dedication.

I would also like to thank our King's College Hospital Charity, along with our volunteers, and our local community for their kind donations and support.

I am incredibly grateful to everyone who has collectively and individually contributed to the Trust. I am confident in the Trust's ability to continue to build as we move towards and continue to focus on the recovery of our services.

King's College Hospital NHS Foundation Trust

Report to:	Board of Directors
Date of meeting:	11th March 2021
Subject:	Update on the COVID 19 Vaccination Programme- Staff Vaccination, Denmark Hill and PRUH Hospital Hubs; Bromley Civic Centre and Demark Hill Campus Mass Vaccination Centres
Author(s):	Julie Lowe, Paul Chandler, Roger Fernandes, Jonathan Lofthouse
Presented by:	Julie Lowe, Site CEO, Denmark Hill
Sponsor:	Julie Lowe, Site CEO, Denmark Hill
History:	N/A
Status:	Information and assurance

Summary of Report

This report provides the Board with an update on the COVID 19 vaccination programme at the Trusts. It summarises the role of the Hospital Hubs at Denmark Hill and the PRUH which opened in December 2020. It explains the development of the Mass Vaccination Centres at Bromley Civic Centre (managed by the PRUH team) which opened on 2 March and Denmark Hill (managed by the DH team) which is due to open later in March. It also details progress on the vaccination programme for our staff (with detailed information provided in appendix 1).

2. Action required

The Board is asked to note the King's contribution to the national COVID-19 vaccination effort.

3. Key implications

Legal:	There are no legal implications arising out of this report.
Financial:	The Trust is able to re-claim the cost of the vaccination programme.
Assurance:	This report aims to provide Board assurance that Hospital Hubs and Mass Vaccination Centres are being well managed and that the staff vaccination programme is effective.
Clinical:	The vaccines are being delivered in accordance with agreed Standard Operating Procedures and there is professional Pharmacist, Nursing and medical involvement.
Equality & Diversity:	EDI impacts on staff are discussed in this report.
Performance:	The report provides an update on progress to achieving vaccine targets.
Strategy:	There are no direct strategy implications.

Workforce:	Staff vaccination is key to protecting our workforce.
Estates:	Estates issues are discussed in the paper.
Reputation:	Early mobilisation of 2 hospital hubs and appointments for over 80s helped enhance King's reputation in the local community. Leading on the Bromley mass vaccination centre is a good example of partnership within the One Bromley system.

1. Hospital Hubs

1.1. In line with the national rollout of the COVID vaccination programme, our Hospital Hubs at PRUH and DH were established in December 2020 administering Pfizer vaccine. Our first vaccines were delivered on 8 December and since then we have delivered at least one box on each site per week giving a total of over 30,600 first vaccines to date. Over 5,400 people in the highest priority groups have also received their second dose vaccinations.

1.2. In line with Joint Committee on Vaccination and Immunisation (JCVI) guidance, we focused initially on patients aged over 80, moving on to Health and Social Care Staff (including those from other local employers). As the priority groups have widened, we have also undertaken vaccinations of Clinically Extremely Vulnerable patients and some younger members of the public. Primary Care Network (PCN) sites and the Mass Vaccination Centres have now been established locally targeting the general public. Our Hospital Hub sites are now focusing on delivering second doses of vaccines and are expected to complete their work by the end of April.

1.3. Staff who have not yet been vaccinated, but who wish to receive their vaccine (and new starters) will be able to book an appointment at a Mass Vaccination Centre or PCN site.

2. Mass Vaccination Centres

2.1. Mass vaccination centres are now being established to supplement the work of the PCN sites and to focus on vaccinating the entire adult population by the end of the summer (with the target for first doses to be complete by the end of July). King's is running a mass vaccination centre at Bromley Civic Centre (which opened on 2 March) and a mass vaccination centre at Denmark Hill, in a KCL building (due to open on 22 March). The mass vaccination centres generally use Astra Zeneca vaccine which is easier to store. People book their own appointments using the electronic national booking system, and so there is very limited administration for the site itself.

2.2. There is a detailed governance process to ensure that the mass vaccination centre works well from a clinical and a non-clinical perspective, including consideration of Infection Prevention and Control and Security. We have registered the Bromley Civic Centre site as a new location with the CQC.

King's College Hospital NHS Foundation Trust

3. Staff Vaccination

3.1. Vaccination of our staff (and other local health and social care staff) began in December, initially focusing on front line staff in critical care, the Emergency Department and COVID positive wards. All staff were offered a vaccine by mid-February. Staff were offered a second dose 10-12 weeks after the first in line with JCVI guidance. Detailed information about staff take-up of the vaccine is given in Appendix 1.

3.2. We have set an internal objective of ensuring that 75% of staff are vaccinated. In the last 2 weeks we have put a programme in place where managers are having an individual conversation with staff who have not yet received the vaccine at the Trust. This conversation gives staff the opportunity to confirm that they have had the vaccine elsewhere (e.g. at a PCN site); that they have made an active decision to decline the vaccine; that they would like advice from Occupational Health; or that they are happy to have the vaccine (in which case the manager can support them to make an appointment).

3.3. The rates of vaccination for some BAME colleagues are considerably lower than for white staff and there are also differences between professional groups. With this in mind there is a programme aimed at overcoming 'vaccine hesitancy' (a term used to describe those who are worried and uncertain about taking the vaccine rather than those who have made an active choice to decline, which is of course their choice). The programme has included webinars, posters, FAQs, small group discussions, video clips and social media. The two most successful areas so far are colleagues providing peer to peer encouragement and sessions where staff can ask trusted senior Clinicians questions.

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Appendix 1: COVID-19 Vaccination of Staff (1st March 2021)

The data below shows current staff who have received at least one dose of the vaccine at a Trust site.

1. Headline Performance against agreed targets

Staff Group	Performance as at 22nd February	Change since 15th February
All Staff vaccination rate	65%	+2%
BAME group vaccination rate	55%	+2%
Contract staff (Medirest, ISS, Sodexo and sub-contractors)	Not yet captured and reported	

2. Staff Vaccinated by Staff Group as at 1 March:

The % increase is compared to Monday 22nd February (i.e. one week on).

Staff Group	Headcount	Unvaccinated	Declined	Vaccinated	% Vaccinated	7-day increase
Nursing and Midwifery Registered	4,610	1,497	84	3,029	66%	3%
Administrative and Clerical	2,601	975	112	1,514	58%	3%
Medical and Dental	2,363	463	11	1,889	80%	2%
Additional Clinical Services	2,150	1,020	65	1,065	50%	4%
Allied Health Professionals	732	132	18	582	80%	3%
Add Prof Scientific and Technic	536	150	15	371	69%	4%
Healthcare Scientists	272	69	1	202	74%	3%
Estates and Ancillary	103	37		66	64%	4%
Grand Total	**13,367**	**4,343**	**306**	**8,718**	**65%**	**3%**

3. Staff Vaccinated by Ethnic Group as at 1 March:

Headline vaccination rates (compared to 22nd February):

- 77% of White staff (+3%),
- 69% of Asian Staff (+2%),
- 60% of staff from mixed ethnic groups (+2%),
- 37% of Black Staff (+2%).

4. Staff Vaccination by Site at 1 March 2021:

- Denmark Hill 64%
- PRUH and South Sites 68%

King's College Hospital NHS Foundation Trust

Report to:	The Board of Directors
Date of meeting:	11th March 2021
Subject:	Report from the Chief Executive
Author(s):	Siobhan Coldwell, Trust Secretary
Presented by:	Professor Clive Kay, Chief Executive Officer
Sponsor:	Professor Clive Kay, Chief Executive Officer
History:	N/A
Status:	Discussion

1. Background/Purpose

This paper outlines the key developments and occurrences since the last Board meeting that the Chief Executive wishes to discuss with the Board of Directors.

2. Action required

The Board is asked to note and discuss the contents of this report.

3. Key implications

Legal:	There are no legal issues arising out of this report.
Financial:	The paper summarises the latest Foundation Trust financial position.
Assurance:	There are no assurance issues arising out of this report.
Clinical:	The paper addresses a number of clinical issues facing the Foundation Trust.
Equality & Diversity:	The Board should note the activity in relation to promoting equality and diversity within the Foundation Trust.
Performance:	The paper summarises the latest operational performance position.
Strategy:	The Board is asked to note the strategic implications of the vision.
Workforce:	The Board is asked to note the workforce changes outlined in this report.
Estates:	There are no estates implications arising out of this report.

King's College Hospital NHS Foundation Trust: Report from the Chief Executive Officer

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King's College Hospital NHS Foundation Trust

1.0 Introduction

1.1. This paper outlines the key developments and occurrences since the last Board meeting that the Chief Executive Officer (CEO) wishes to discuss with the Board of Directors.

1.2. The second wave of the COVID-19 pandemic has been incredibly challenging for the Foundation Trust. The Trust has treated many more patients than it did in Wave 1 and experienced higher levels of demand for urgent and emergency care. Having started to recover our elective position in late 2020, the Trust stopped treating all but the sickest patients on our waiting lists. As the number of COVID-19 patients is now declining, we will revert to focus on elective recovery, balancing the care of the continued smaller cohort of COVID-19 patients with ensuring we bring our elective waiting lists down to an acceptable level, both at King's College Hospital and across South East London (SEL). A detailed report on the Trust's response to COVID-19 can be found elsewhere on this agenda.

1.3. I would like to commend all of our teams for their hard work and dedication. The first two months of this year has been incredibly challenging and our teams have continued to perform outstandingly well under immense pressure, to do the right thing for our patients. I am immensely proud to be the CEO of King's College Hospital NHS Foundation Trust.

2.0 Good news stories

2.1 The Paediatric neurology team has awarded the **'Neuro Team of the Year'** by the Brain Tumour Charity UK. The team were selected from over 300 nominations from across the country. The charity specifically recognised the team's collaborative and innovative approach to caring for children and their families following the diagnosis of a brain and/or spinal tumour.

2.2 **Dr Tom Best**, Clinical Director for Critical Care, has been awarded an MBE for services to critical care, particularly for his work during the COVID-19 pandemic. Dr Best continues to play a key role in ensuring we managed the high volume of patients who needed intensive care in Wave 2 of COVID-19.

2.3 **Jill Demilew**, former Consultant Midwife at King's, has been recognised with an MBE for services to midwifery. During her career, Jill had helped to address health inequalities and improve access to healthcare for the most vulnerable women in south London.

2.4 **Landmark orthoplastic surgery success -** The Denmark Hill team of orthopaedic and plastic surgeons successfully completed their first combined orthoplastic surgical "fix and flap" procedure. This involved combining fixing complex fractures of the femur and tibia, followed by the use of microsurgical techniques to tackle soft tissue injuries using a 'free flap' transfer of skin and muscle from the chest wall. This landmark first for King's is the culmination of over four years of planning and the team aims to establish this as a regular part of the treatment pathway for severely injured patients.

2.5 **Professor John Moxham** has been awarded the British Thoracic Society (BTS) Medal 2020 in recognition of his great contributions to respiratory medicine and his tireless work in tobacco control.

2.6 **King's Facilities Management (KFM)** has been shortlisted for the 'Procurement Project of the Year' by the Health Service Journal (HSJ) Partnership Awards for their work on the Enhanced Supply Chain Service, which has been critical in our response to COVID-19. The KFM project will now go forward to the next round of judging with the results expected to be announced in June 2021.

2.7 We have also been shortlisted for a Health Service Journal (HSJ) Award for the **Workforce Initiative of the Year.** This is for the extraordinary staff wellbeing programme that we developed with the support of colleagues from South London and the Maudsley (SLAM) and King's Health Partners (KHP) in response to the COVID-19 pandemic. The HSJ Awards ceremony for this award will take place virtually on 17 March 2021.

2.8 **Critical Care Unit (CCU) re-opens** We have re-opened the state of the art critical care facility, which played a key role in the first wave of the pandemic. The CCU has undergone an improvement programme since it closed in July, including completing works on the internal fire barriers of the CCU building and the extensive testing of the modern fire protection system. The latter includes the fire alarm, water mist, ventilation and smoke extraction systems. Following a detailed risk assessment and the development of comprehensive mitigation plans with London Fire Brigade (LFB), the unit re-entered service at the end of January 2021.

2.9 **PRUH Hip Fracture Scores** The dramatic and sustained improvement in the treatment of hip fracture patients at the PRUH is now evident in the latest data in the National Hip Fracture Database. This shows that the treatment of hip fracture patients at the PRUH is amongst the best in the country. The improvements follow the complete re-engineering of the service by the team and forms part of the PRUH's focus on frailty – a major factor given the high numbers of older patients in the hospital's local communities. The data shows that the PRUH treats a very high number of hip fracture patients each year and has made great strides against key measures – such as prompt orthogeriatric reviews, patient safety and prompt surgery – which are consistently amongst the best scores in the country.

2.10 **Associated Press and Agence France Presse visit to Denmark Hill** After securing agreement from NHS England, we hosted a team from Associated Press (AP) and the French news agency AFP for a day long visit at Denmark Hill. The filmed and interviewed staff involved in caring for COVID-19 patients, including those who had been redeployed from other areas. AP and AFO have global audiences and the footage and photographs they took have been shared around the world. The AP feature on US ABC News and The Independent showed the breadth of care provided to COVID-19 patients, from intensive care support and proning, to talking to patients relatives via iPads, and staff providing care and support to each other.

2.11 **Virtual ward for COVID patients at Denmark Hill:** A new virtual ward has been established at Denmark Hill to enable patients with suspected or confirmed COVID-19 to return home while remaining under the supervision of clinicians. Patients who have attended the Emergency Department (ED) and not required admission, and inpatients who are preparing for discharge, will have access to nurse-led seven-day telephone follow-up and remote monitoring of breathlessness, oxygen saturations and recovery for up to 14 days.

2.12 **Using hotels to free up beds** To create capacity in the hospital to care for the high number of patients requiring admission, particularly for COVID-19-related conditions, the Trust has partnered with a local hotel to temporarily accommodate mainly homeless patients who are ready to safely leave hospital and will benefit from further support from community partners. It has been used to provide around 120 bed nights so far and this innovative approach was reported on by Sky News, BBC News, The Guardian and Evening Standard. Other Trusts have come to us for advice on how to set up their own schemes and the South East London CCG is now rolling it out in local boroughs.

2.13 **King's College Hospital Charity support** Since the King's College Hospital Charity launched its Hospital Heroes Appeal in March 2020, the charity has been capturing messages of support from the community, all voicing their heartfelt thanks to the incredible staff working across our hospitals. These messages are regularly published on Kingsweb. The charity has also recently sent out an appeal to Support Our Staff as we have faced the surge of COVID-19 patients in the second wave. More details are on the King's College Hospital Charity website.

2.14 The **Chief Medical Officer for the NHS London** region, **Dr Vin Diwaker**, visited the Denmark Hill site on 22nd February 2021 to show his appreciation for our staff. Dr Diwaker, a practicing consultant general paediatrician, met staff in Pharmacy, Paediatric Critical Care and on Lonsdale Ward to thank them for their hard work and learn more about how the Trust have responded to the COVID-19 pandemic at King's.

2.15 The brain tumour centres of London's King's Health Partners of King's College Hospital and Guy's and St Thomas's Hospitals (KHP) and University College London Hospital NHS Foundation Trust (UCLH) have been recognised as a Tessa Jowell Centre of Excellence following rigorous expert-led assessments by the Tessa Jowell Brain Cancer Mission. **The newly introduced 'Tessa Jowell Centre of Excellence status' recognises the delivery of outstanding care and treatment by NHS staff at the London hospitals.**

3.0 Quality, Patient Experience and Safety Report

3.1 The Trust continues to achieve good patient outcomes. Mortality (risk-adjusted) is better than expected or within the expected range for a number of areas including trauma, stroke, intensive care, sepsis, hip fracture, pneumonia, acute kidney injury, liver transplantation and hip and knee replacement. 78 of 79 patient outcome indicators have been rated green, indicating outcomes better than expected, better than peer an or within expected range.

3.2 Highlights included:

- **Diabetes care** – medication and prescription errors are better than the national average and patients are reporting that they are satisfied/mostly satisfied that their care is higher than the national average.
- **Liver transplant outcomes** – 1 year survival for adult elective liver transplants is the second highest out of all the UK transplant centres.
- **Vascular surgery outcomes** – adjusted in-hospital mortality and/or stroke rate is better than expected.
- **Organ donation outcomes** – KCH was rated as exceptional (gold) by the NHS Blood and Transplant's Organ Donation Service for its referral of potential

organ donors after brainstem death, and good (silver) for referrals after circulatory death.

3.3 The Trust has had an **on-going backlog of complaints** which has worsened as key staff have ben redeployed to support the Trust's COVID-19 response. The Chief Nurse has been working with the team to put new processes in place to reduce the backlog and ensure that performance moving forward is in line with Trust policy.

3.4 Feedback from the inpatient survey has indicated that improvement is needed with regard to food and beverages. The Chief Nurse is working with the Nursing Site Directors and the Improvement team to investigate causes and develop an action plan.

3.5 The **main trend of inpatient safety incidents** reported recently involve falls and issues related to assessment, diagnosis, monitoring and review. The Foundation Trust has improvement work well underway to help address these trends to further improve patient safety and staff well- being. In the last two months, the Trust has made significant progress in reducing the backlog of serious incident investigations.

3.6 The Foundation Trust's percentage of no harm related incidents remains above the national average which demonstrates a good reporting culture.

4.0 Operational Performance for the period M1 to M10 inclusive

4.1 Having made a sustained effort to address the backlogs that built as a result of COVID-19 Wave 1, performance has deteriorated as a result of the most recent wave of COVID-19. The Trust made the decision to suspend much of its elective day and inpatient activity in mid-December 2020, Activity has not yet returned to pre-COVID-19 levels. Infection prevention and control measures have reduced productivity and the Trust is outsourcing work to independent sector providers.

4.2 The number of **patients waiting more than 18 weeks following referral in December had decreased** to 15,559 but increased to 17,110 at the end of January and remains a significant proportion of the overall waiting list.

4.3 Having improved its performance against the Emergency Care Standard (the '4-hour' target) in the summer of 2020, there has been a decrease in the proportion of patients treated within 4 hours. Although the number of attendances to the Emergency Departments (EDs) decreased in January 2021, the high proportion of COVD-19 positive patients and the need for Infection Prevention and Control due to COVID-19 put pressure on our performance against the **4-hour emergency care standard**; Trust performance overall has reduced to 67.38% for January.

Referral to Treatment (RTT)

4.4 RTT incomplete performance has reduced from the highest performance of 72.71% achieved in December 2020 to 70.47% for January 2021.

4.4.1 The total number of patients waiting on the Trusts RTT waiting lists has increased from 57,017 at the end of December to 57,942 at the end of January 2021.

4.4.2 Despite a reduction in overall PTL size to December, the 18+ week backlog has been reducing monthly from its highest point in July to 15,559 at the end of December, but increasing to 17,110 at the end of January. This represents 29.53% of the total PTL.

4.4.3 The overall number of patients waiting over 52 weeks has increased from 3,777 at the end of December to 5,212 at the end of January 2021.

Emergency Care Standard

4.5 **Activity levels decreased through COVID-19 wave 2 period** (typically over 18,700 attendances each month across the Emergency Departments at Denmark Hill and the PRUH, and the PRUH's Urgent Care Centre) in November and December. Attendances have reduced to 16,099 in January.

4.6 Since the **12-month peak performance** of 93.63% achieved for July, Trust performance has continued to deteriorate each month to 82.26% in November, 73.69% in December and 67.38% in January 2021. Performance by site has deteriorated similarly:

- from 77.37% in November 2020 to 62.21% in January 2021 at Denmark Hill.
- from 87.54% in November 2020 to 73.22% at the PRUH (95% target).

Diagnostic waiting times

4.7 The additional capacity secured outside the Foundation Trust, extension of Trust capacity, and changes to the infection prevention and control guidance to make it more straightforward to carry out aerosol-generating procedures, have improved waiting times for diagnostic tests. Performance improved month-on-month to November where 19.34% of patients were waiting over 6 weeks for their diagnostic test. With the onset of the second COVID wave, performance has reduced to 21.41% at the end of December to 40.16% at the end of January 2021.

Cancer

4.8 2 Week Wait standard: 89.39% (93% target) latest position for January 2021.

4.9 62 day GP referred First treatments: 58.28% (85% target) latest position for January 2021.

4.10 Further detail can be found in the **Integrated Performance Report** later in this set of papers

King's College Hospital NHS Foundation Trust

5.0 Financial Performance - Summary of Year to Date Financial Position – M07

5.1 As at month 10, the Foundation Trust has recorded an **operating surplus of £12.6m in-month and £5.7m YTD**.

Trust Summary	Last Year	Annual	Last Months	Current Month				Year to Date			
	Outturn	Budget	M9	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income (income)	1,263.3	1,214.9	119.8	103.6	101.5	121.7	20.2	1,005.6	1,011.9	1,196.1	184.2
Employee Operating Expenses (pay)	(753.7)	(756.4)	(67.6)	(61.3)	(62.7)	(66.5)	(3.8)	(599.9)	(631.4)	(656.8)	(25.4)
Operating Expenses (non-pay)	(580.8)	(603.4)	(57.0)	(51.3)	(50.5)	(41.4)	9.1	(496.6)	(511.5)	(521.4)	(9.8)
Non Operating Expenses (financing)	(47.5)	(33.0)	(3.6)	(4.0)	(2.8)	(3.3)	(0.6)	(39.2)	(27.5)	(33.1)	(5.5)
Trust Total	**(118.7)**	**(178.0)**	**(8.4)**	**(13.0)**	**(14.5)**	**10.5**	**25.0**	**(130.2)**	**(158.6)**	**(15.1)**	**143.4**
Less Depr, Impairment	(34.3)	22.9	2.7	1.9	1.9	2.1	(0.2)	(8.8)	19.1	20.8	(1.8)
Trust operating Total	**(153.0)**	**(155.1)**	**(5.7)**	**(15.3)**	**(12.6)**	**12.6**	**24.8**	**(139.0)**	**(139.5)**	**5.7**	**141.7**

*Clinical Income for 2020-21 is now on a block contract due to COVID. ** Last year outturn excludes consolidation of KFM, KCS and Viapath. This is included in YTD figure.

5.2 For the first 6 months of 2020/21 the Trust was provided with retrospective top up funding to help the Trust reach a broadly break even position. For months 7-12, funding arrangements have moved to a system block with the Trust receiving a block income of £107.6m each month until the end of this financial year. This income is sufficient to achieve breakeven for the last 6 months of the year based on the month 5 forecast submitted to the ICS.

5.3 The Trust has been seeing an underlying deficit £4-5m each month over the last 3 months and this continued in-month. However in addition to this, the Trust had a number of non-recurrent benefits as a result of COVID-19 and following a review of prior year provisions. The majority of these provisions now released were included in the month 7 forecast. A summary of movements is provided below.

- **Operating income £1.9m**: Viapath patient testing income of £3.7m YTD has been provided for here. This is an increase of £1.7m from last month (£2.0m), based the number of patient tests carried out. To be reclaimed from NHSE.
- **Employee operating expenses (pay) £1.1m**): Last month we recorded £0.6m for retrospective shift payments and £0.5m relating to the ARC Project. This month the pay position has normalised, hence this favourable movement.
- **Non pay Operating expenses (15.6m):** A number of non-recurrent benefits have been recognised here this month. In summary these include:
    - KFM - £2.6m improvement in the Profit Share recorded as a result of COVID & reduced electives.
    - KHP Royal Brompton Contribution - £2.3m released following GSTT merger with Royal Brompton.
    - NHS Resolution revision to schedules has resulted in a non-recurrent £2.7m benefit this year.
    - HEE Funding for training - £0.7m released as not expected to materialise following lockdown.
    - Viapath legal provisions carried forward from last year - £5.5m released as this will now not materialise.
    - R&D £1m improvement on position following a prudent provision of £0.5m provided last month for expected consultancy costs. It now transpires this is not required.

5.4 Pay is 9.5% (£56.9m) more than the 19/20 YTD figure (c.5% relates to inflation and COVID costs this year). The remainder relates to recruitment to business cases and vacancies.

6.0 Workforce update

6.1 Since the Board last met, the focus of our workforce colleagues has been on redeployment, staff health and well-being and vaccinations, all of which are addressed elsewhere on this Board agenda.

6.2 We have made a number of new Consultant appointments. Full details are include at Appendix 1.

6.3 Since the last Board meeting, **Jackie Parrott** Joint Chief Strategy Officer across King's College Hospital NHS FT, and Guy's and St Thomas' NHS FT and Professor Julia Wendon, Executive Medical Director Clinical Strategy and Research have stepped down from the Board.

6.4 Since March 2020, Professor Wendon has been working with NHSE/I London region on leading the COVID-19 Critical Care response. With the increasing need for more of her time and expertise, she has made the difficult decision to step down from her joint role at King's, and at Guy's and St Thomas' and to join NHSE/I on secondment for six months, to support the London region COVID-19 critical care response full time. Jules has been a part of the team since I arrived and I am very sad that she will no longer be part of our Executive Team. However, I understand this decision and fully support Jules in this move. Please join me in wishing her all the very best in her work with the region.

6.5 Jackie Parrot has returned full time to GSTT. Jackie and Professor Wendon worked in partnership across both organisations to develop our clinical strategies and made great progress. Jackie will continue to work with colleagues across KCH, particularly focussed on our new specialised commissioning taskforce programme, and will also continue in her current role within the Acute Provider Collaborative until the work of the Task and Finish Group is completed. I wish Jackie all the very best for her return to GSTT, and would like to take this opportunity to thank her for her executive leadership of our Strategy Team, and her support to the Executive team, as well as to me on a personal level. I would also like to take this opportunity to welcome Roxanne Smith, Deputy Director of Strategy. Lorcan Woods, Chief Financial Officer, who will be our executive lead for Strategy until a permanent appointment has been made.

6.6 There continues to be on-going work with our **values refresh** and the workshops aimed at reaching a wide range of staff to create our values started at the end of February. Over 3000 members of staff have engaged with the process through surveys and workshops.

6.7 The Foundation Trust launched **a 'thank you' recruitment** campaign late last year and this continues to develop. A large externally-facing recruitment campaign has also been launched and the impact will be seen over the next 3 – 6 months.

6.8 The Foundation Trust re-opened a **refurbished nursery at Mapother House, at SLaM,** in late December 2020. The new nursery has significantly improved the environment both for children in our care and for our colleagues working there. This follows the planned closure at the end of the year of the King's Day Nursery within the Weston Education Centre, which allows King's College London to re-develop the site for medical students.

King's College Hospital NHS Foundation Trust

7.0 Equality, Diversity and Inclusion

7.1 The Foundation Trust continues to place a lot of focus and energy on the Equality, Diversity and Inclusion (EDI) agenda and whilst much of the focus has been on staff health and wellbeing and the vaccination programme (addressed elsewhere on the agenda), good progress has been made.

7.2 The following is an outline of activities and interventions undertaken in recent weeks by the EDI team:

- Focused prioritisation of key deliverables from our overarching EDI Programme Plan that includes:
  - Designing and testing a new Equality Impact Assessment (EIA) Toolkit, guidance and training for managers
  - Design of Trust wide Equality Diversity and Inclusion training
  - Redesign EDI content for Induction
  - EDI communications plan, detailing EDI team offer and support.
- Collaborative input into Values refresh and People and Culture Strategy development from an EDI lens
- Continued staff engagement via our three staff networks. The Trust's three Networks continue to hold meetings to engage and provide pastoral support to staff and will also accelerate efforts to promote the networks to attract those staff that are not already engaged.
- Preparing for the relaunch of the Trust's three staff networks in preparation for reset and recovery
- Responding to ad hoc requests such as virtual meetings with staff groups on request such as Special Care Baby Unit, Theatres Care Group leadership team and Children's Safeguarding team.
- Collaborative approach to developing an inclusive package of training that encases Freedom to Speak up (FTSU) and EDI as one continuum. Training to be made available on the Trust online training platform (LEAP) for all FTSU Ambassadors.
- Religious Identity and working in the NHS - Research has been commissioned by NHS Employers, to which the Trust has been identified as one of five Trusts to contribute to this research. Project focus, scope and timelines to be agreed post current COVID surge.

8.0 Board Committee Meetings

8.1 Since the last public board meeting, the following meetings have taken place:

1. Council of Governors – 10th December 2020.
2. Finance and Commercial/Major Projects Committee 17th December 2020
3. Audit Committee – 19th January and 4th March 2021.
4. Finance and Commercial Committee – 28th January 2021.
5. Council of Governors: Patient Experience and Safety Committee – 11th February 2021.
6. Quality, People and Performance Committee – 4th February 2021.
7. Board Development Session – 18th February 2021.
8. Board Meeting in Committee 18th February 2021

King's College Hospital NHS Foundation Trust

Appendix 1: List of Consultant appointments

Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
Consultant in Orthodontics	Dr Sukhraj Singh Grewal	Replacement	01/01/2021	Permanent
Consultant Orthopaedic Surgeon	Mr Mohit Rajpal Bansal	Replacement	01/01/2021	Permanent
Consultant Haematologist in Stem Cell Transplantation and Ambulatory Care Consultant Haematologist with special interest in Plasma Cell Dyscrasias Myeloma	Dr Daniele Avenoso Dr Carmel Rice	Replacement	01/02/2021 TBC	Permanent Permanent
Consultant Nephrologists	Dr Helen Alston Dr Jonathan Simon Charles Dick Dr Theodoros Kasimatis (Locum)	Replacement	1/2/2021 8/2/2021 TBC	Permanent Permanent Locum
Consultant Orthopaedic Surgeon, Foot & Ankle	Miss Shirley Anne Lyle	Replacement	01/02/2021	Permanent
Consultant in GIM and Endocrinology	Dr James Douglas Crane	New	01/02/2021	Permanent
Consultant Neurosurgeon	Mr Jose Pedro Reis Lavrador	Replacement	01/02/2021	Permanent
Consultant in Emergency Medicine	Dr Eyston Vaughan-Huxley	Replacement	03/02/2021	Permanent
Consultant in Emergency Medicine	Dr Tara Mae Smith	Replacement	05/02/2021	Permanent

Consultant Orthopaedic Surgeon	Mr Dominic Francis Davenport	Replacement	08/02/2021	Permanent
Consultant in Restorative Dentistry	Miss Despoina Chatzistavrianou	Replacement	15/02/2021	Permanent
Consultant Geriatrician and General Physician	Dr Georgina Meredith	New	17/02/2021	Permanent
Consultant Geriatrician and General Physician	Dr Ying Feng Yap	Replacement	TBC	Permanent
Consultant Paediatricians With A Special Interest In Safeguarding Children and Young People And/Or Forensic Medicine	Dr Briony Claire Arrowsmith (Dussard) Dr Alice Mary Monfrinoli	Replacement	TBC	Permanent
Consultant Microbiology and Infection (OPAT) Consultant Microbiology and Infection Control Doctor	Dr Hector George Maxwell-Scott Dr Martin Neville Brown	Replacement	TBC TBC	Permanent
Locum Consultant Anaesthetist	Dr Nishant Ram Rakkha Arora	Replacement	01/02/2021	31/01/2022
Locum Consultant Anaesthetist	Dr Subha Brata Bagchi	Replacement	01/02/2021	31/07/2021
Locum Consultant Anaesthetist	Dr Mitko Iotov	Replacement	03/02/2021	02/02/2022
Locum Consultant in Paediatric Intensive Care/High Dependency Unit	Dr Christina Balnta	Replacement	04/02/2021	31/07/2021
Locum Consultant in Emergency Medicine	Dr Imran Shareef	Replacement	15/02/2021	14/02/2022
Locum Acute Medicine Consultant	Dr Hamedelneel Eltahir Mohammed Neel Hassan	New	15/02/2021	14/02/2022
Locum Consultant Anaesthetist	Dr Kathryn Sarah Laver	Replacement	22/02/2021	21/02/2022
Locum Consultant Respiratory Physician	Dr Pradeep Rajagopalan	Replacement	24/02/2021	23/02/2022

King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 10 (January) 2020/21

Trust Board

11 March 2021

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Trust Board*
Date of meeting:	*11th March 2021*
Subject:	*Integrated Performance Report 2020/21 Month 10 (January)*
Author(s):	*Adam Creeggan, Director of Performance & Planning;* *Steve Coakley, Assistant Director of Performance & Planning;*
Presented by:	*Jonathan Lofthouse, Site Chief Executive – PRUH & South Sites*
Sponsor:	*Jonathan Lofthouse, Site Chief Executive – PRUH & South Sites*
History:	*None*
Status:	*For Discussion*

Summary of Report

- *This report provides the details of the latest performance achieved against key national performance, quality and patient waiting times targets, noting that our required Trust response to COVID-19 continues to impact activity delivery and performance for January 2021 returns.*
- *The report provides a site specific operational performance update on patient access target performance, with a focus on delivery and recovery actions and key risks.*

Action required

- *The Board is asked to approve the latest available 2020/21 M10 performance reported against the governance indicators defined in the Strategic Oversight Framework (SOF).*

3. Key implications

Legal:	*Report relates to performance against statutory requirements of the Trust license in relation to waiting times.*
Financial:	*Trust reported financial performance against published plan.*
Assurance:	*The summary report provides detailed performance against the operational waiting time metrics defined within the NHSi Strategic Oversight Framework .*
Clinical:	*There is no direct impact on clinical issues.*
Equality & Diversity:	*There is no direct impact on equality and diversity issues*
Performance:	*The report summarises performance against local and national KPIs.*
Strategy:	*Highlights performance against the Trust's key objectives in relation to improvement of delivery against national waiting time targets.*
Workforce:	*Links to effectiveness of workforce and forward planning.*
Estates:	*Links to effectiveness of workforce and forward planning.*
Reputation:	*Trust's quarterly and monthly results will be published by NHSi and the DoH.*
Other:(please specify)	

Contents

Executive Summary 2020/21 Month 10

QUALITY

- Summary Hospital Mortality Index (SHMI) improved slightly to 95.7 - better than the expected index of score of 100.
- HCAI:
  - ❑ No MRSA bacteraemia cases reported in January, so 4 cases reported YTD;
  - ❑ 11 new VRE bacteraemia cases reported in January, 72 cases YTD which is above the target of 58 cases;
  - ❑ E-Coli bacteraemia: 10 new cases reported in January, 91 cases YTD which is below the target of 94 cases;
  - ❑ 9 new C-difficile cases reported in January, 75 cases YTD which is below the quota of 83 cases.
- Overall Trust recommendation rate for Inpatients reduced by 1% to 93.2% for January. However the FFT recommendation rate for ED improved from 81.6% in December to 84.9% in January.

PERFORMANCE

- Trust A&E/ECS compliance reduced to 67.38% in January compared to 73.69% in December. By Site: DH 70.28% and PRUH 77.38%
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant and was 68.75% for January (target 85%).
  - ❑ Treatment within 62 days following screening service referral was not compliant at 40.00% for January (target 90%).
  - ❑ The two-week wait from GP referral standard was not compliant at 85.73% (target 93%) for January.
- Diagnostics: performance worsened by 18.75% to 40.16% of patients waiting >6 weeks for diagnostic test in January (National target <1%).
- RTT incomplete performance reduced by 2.24% to 72.71% in January (target 92%).
- RTT patients waiting >52 weeks increased by 1,435 cases to 5,212 cases in January, compared to 3,777 cases in December.

WORKFORCE

- Appraisal rates have improved from 74.74% in December to 75.29% in January for all staff. Compliance is 100% for Deanery doctors.
- The Trust has seen a significant increase in the sickness rate in January which is reported as 7.14%. As expected the COVID-related sickness has significantly increased from 1.24% to 3.37%.
- Statutory and Mandatory Training has increased slightly to 85.93% for January, with Medical & Dental staff as the main contributors to the increase, but remains below the 90% target.
- Vacancy rates reduced from 10.78% in December to 10.28% in January, which is an improved position on the forecast. The Trust establishment increased by 53 posts.
- The Trust is reporting a further reduction in the voluntary turnover rate from 11.52% in December to 11.39% in January, which has remained below the target of 14% since January 2020.

FINANCE

- As at month 10, the Trust has recorded an operating surplus of £12.6m in-month and a surplus of £5.7m YTD.
- For the first 6 months of 2020/21 the Trust was provided with retrospective top-up funding to help the Trust reach a broadly break-even position. For months 7-12, funding arrangements have moved to a system block with the Trust receiving a block income of £107.6m each month until the end of this financial year. This income is sufficient to achieve breakeven for the last 6 months of the year based on the month 5 forecast submitted to the ICS.
  - ❑ **Pay** (£1.9m) - Last month we recorded £0.6m for retrospective shift payments and £0.5m relating to the ARC Project. This month the pay position has normalised, hence this favourable movement.
  - ❑ **Non-Pay** (£15.6m) - A number of non-recurrent benefits have been recognised here this month.

Executive Summary
Quality Heatmap

Quality

	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	YTD	Trend
CQC level of inquiry: Caring															
Complaints															
HRWD															
Operational Engagement															
Other															
Summary															
CQC level of inquiry: Effective															
CQUIN															
Improving Outcomes															
Improving Outcomes - Child Birth															
Improving Outcomes for Older Patients															
Summary															
CQC level of inquiry: Safe															
Reportable to DoH															
All hospital-acquired Alert Orgs															
Antibiotic Stewardship															
Assurance Audits															
Care of IV Lines															
Clusters & Outbreaks															
Environment															
Infection Control Audit Composite															
Incident Management															
Incident Reporting															
Safer Care															
Summary															

Executive Summary
Performance and Workforce Heatmap

Performance

	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	YTD	Trend
CQC level of inquiry: Responsive															
Access Management - Emergency Flow		→	↗	↗	↗	→	↗	→	↘	→	→	↘	↗		
Access Management - RTT, CWT and Diagnostics		↘	↘	↘	↗	↘	↗	↘	↗	↘	↗	↘	↘		
Patient Flow		↗	↘	↗	→	↘	↘	↗	↘	↗	→	↘	↗		
RTT Data Quality		→	→	↑	→	→	→	→	→	→	→	→	↓		
Contract Monitoring (Operational Activity)		↘	↘	↗	↗	↘	↗	→	↗	↗	↘	↘	↗		
Operational Strategic		→	→	→	→	→	→	→	→	→	→	→	→		
Demand & Capacity		→	↘	↗	→	↗	↘	↘	↗	↗	→	↗	↘		
Productivity & Efficiency		↘	↘	↗	↗	↗	→	→	→	↘	↗	↘	→		
Emergency & Acute Care		↗	↘	↗	→	→	↗	↘	↘	↘	↗	→	→		
Kings Way for Wards		→	↘	↑	↓	↗	↘	→	→	→	↗	↘	→		
Outpatient Productivity		→	↘	↗	↗	→	↗	→	→	→	→	↗	↘		
Theatre Productivity		↘	↘	↘	↗	↗	↗	↘	↗	↗	→	↘	↘		
Summary		↘	↘	↗	↗	↗	↗	↘	↗	↗	↗	↘	↘		

Workforce

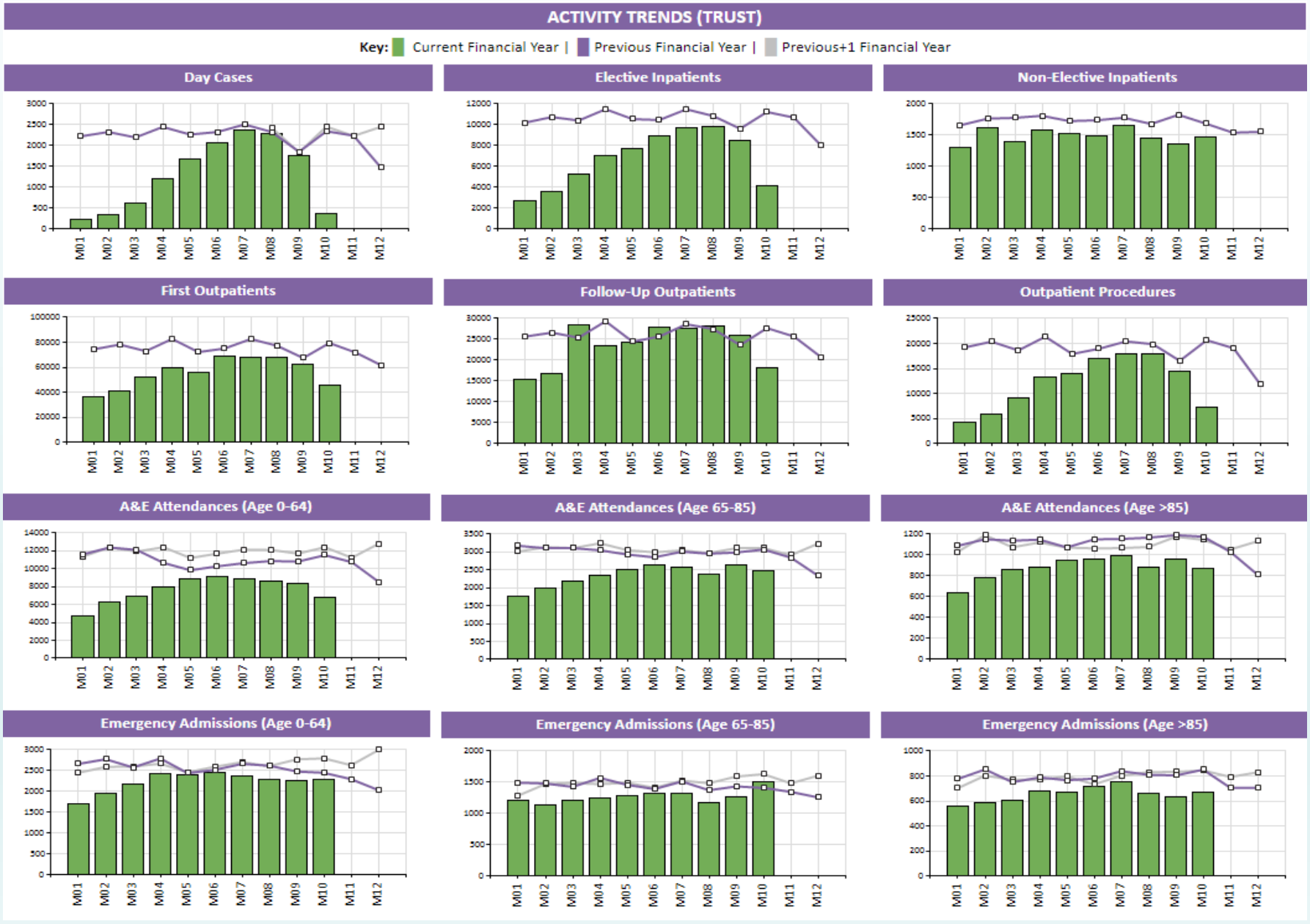
	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	YTD	Trend
CQC level of inquiry: Well Led															
Staff Feedback		→	→	→	→	→	→	→	→	→	→	→	→		
Staff Training & CPD		→			→	→	↘	→	→	↗	→	→	→		
Efficiency		→	↓	→	→	↑	→	↑	↓	→	→	↓	→		
Staffing Capacity		→	→	→	↘	↗	↘	→	→	↗	↗	→	↗		
Summary		→	↘	↘	↘	↗	↘	↗	↘	↗	↗	↘	↗		

Executive Summary
Finance Heatmap

Finance

	Oct 19	Nov 19	Dec 19	Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	YTD	Trend
Use of Resources															
Overall (000s)		→	→	↓	↑	→	→	→	→	→	→	→	→		
Income (000s)		↘	→	↗	↗	↘	↗	→	→	↗	↘	↗	↗		
Nonpay - Financing (000s)		↗	↘	→	→	↘	↗	↘	↗	→	→	↗	↗		
Nonpay - Unallocated CIP (000s)		→	→	↑	↓	→	↑	→	→	↓	→	→	↑		
Non-Pay (000s)		→	↗	↘	→	↗	↘	↗	↗	↘	↗	↘	↑		
Pay - Admin and Clerical (000s)		→	→	→	→	↘	↗	→	→	→	↘	↘	↑		
Pay - Medical Staff (000s)		→	→	→	→	↗	↘	→	→	→	→	↘	↑		
Pay - Nursing Staff (000s)		→	↘	→	→	→	→	↗	↗	↘	→	→	↑		
Pay - Other Staff (000s)		→	→	→	→	↗	↘	→	→	→	→	→	↑		
Pay - Unallocated CIP (000s)		↓	→	→	↑	↓	→	→	→	→	→	→	↑		
SLR Recharges (000s)		→	↘	↗	→	→	→	↘	→	→	↗	↘	↗		
Summary		↘	→	↗	↗	↘	↗	↘	↗	↘	↘	↘	↗		

Executive Summary
Activity Trending



Executive Summary
Operational Productivity Headlines

OPERATIONAL PRODUCTIVITY HEADLINES (TRUST)

OUTPATIENT PATHWAYS	Referrals to Consultant-Led Services	OPA Hospital Cancellations	OPA Hospital Cancellations <6wks	Outpatient DNA Rate	New to Follow-Up Ratio	Clinic Utilisation	Number of Uncashed Appointments
Current Month	39607	29754	21559	9.3%	1.14	24.4%	6211
Last Month	35023	16422	9259	12.0%	1.56	30.3%	
Variance	4584	13332	12300	-2.69%	-0.41	-5.9%	
12 Month Average	27688	19547	11845	10.3%	1.96	30.6%	5885.64
Variance to 12mth Avg.	30.09%	34.30%	45.06%	-11.49%	-71.84%	-25.25%	5.24%

THEATRES	On-Time Starts % Main Theatres	On-Time Starts % Day Surgery	Average Turnaround Main Theatres	Average Turnaround Day Surgery	Theatre Utilisation % Main Theatres	Theatre Utilisation % Day Surgery	On-the-Day Hospital Cancellations
Current Month	6.6%	13.5%	114.57	30.12	52.9%	53.5%	43
Last Month	21.8%	28.0%	67.25	12.64	64.7%	61.3%	192
Variance	-15.2%	-14.4%	47.32	17.48	-11.8%	-7.8%	-149.00
12 Month Average	0	0	72	21.8	61.1%	58.9%	141.0
Variance to 12mth Avg.	-181.84%	-67.11%	37.14%	27.72%	-15.39%	-10.14%	-227.91%

NON-ELECTIVE PATHWAY	Inlier Bed Days	Emergency Admissions	SDEC Activity	Dishcarges Before 11am (excl. Obstetrics)	Average Length of Stay (Non-Elective)	Zero Length of Stay (Non-Elective)	Pre-Operative Length of Stay (Non-Elective)
Current Month	414.8	4476.0	981.00	5.93%	6.64	705.0	2.51
Last Month	543.2	4163.0	1322.00	5.83%	6.25	808.0	1.58
Variance	-128.4	313.0	-341.00	0.10%	0.39	-103.0	0.93
12 Month Average	493	4157	881	6.49%	6.15	856.4	1.9
Variance to 12mth Avg.	-18.86%	7.13%	10.22%	-9.44%	0.07	-21.48%	25.66%

ELECTIVE PATHWAY	Decisions to Admit	On-the-Day Hospital Cancellations	On-the-Day Patient Cancellations	Day Case Rate	Average Length of Stay (Elective)	Zero Length of Stay (Elective)	Pre-Operative Length of Stay (Elective)
Current Month	2831.0	43.0	49.00	84.61%	8.66	102.0	1.56
Last Month	5467.0	192.0	106.00	79.40%	5.41	246.0	1.02
Variance	-2636.0	-149.0	-57.00	5.21%	3.24	-144.0	0.54
12 Month Average	4817	141	80	78.33%	5.19	259.2	1.0
Variance to 12mth Avg.	-70.15%	-227.91%	-62.24%	7.42%	40.02%	-154.08%	38.45%

Domain 1: QUALITY

1. Key Metrics Scorecard
2. Infection
3. Incidents
4. Mortality
5. Friends and Family Test

Domain 1: Quality
Key Metrics Scorecard

		Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																		
Reportable to DoH																		
2717	Number of DoH Reportable Infections	50	47	47	40	57	66	53	62	57	48	71	72	72	52	598	692	
Safer Care																		
629	Falls resulting in moderate harm, major harm or death per 1000	0.16	0.21	0.09	0.14	0.06	0.03	0.10	0.07	0.14	0.09	0.17	0.18	0.17	0.19	0.12	0.12	
1897	Potentially Preventable Hospital Associated VTE	1	2	4	3	1	2	1	2	2	4	6	7	7	0	35	41	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	2	0	0	1	0	0	0	1	0	0	0	0	0			
945	Open Incidents						40			22			34			96	96	
Incident Reporting																		
520	Total Serious Incidents reported	14	22	12	9	10	14	13	6	3	9	10	9	4		87	121	
516	Moderate Harm Incidents	44	33	15	17	16	24	29	27	29	30	26	22	32		252	300	
509	Never Events	0	0	1	0	0	2	0	1	0	1	0	0	0	0	4	5	
CQC level of inquiry: Caring																		
HRWD																		
422	Friends & Family - Inpatients	94.4%	92.6%	95.1%	95.7%	96.0%	94.5%	93.1%	95.0%	94.9%	95.2%	94.0%	94.2%	93.2%	96.0%	94.4%	94.1%	
423	Friends & Family - ED	80.7%	81.5%	83.7%	89.6%	89.0%	84.6%	89.3%	83.4%	82.6%	83.6%	85.0%	81.6%	84.9%	86.0%	85.0%	84.6%	
774	Friends & Family - Outpatients	83.9%	85.2%	86.2%	88.5%	87.1%	85.1%	85.6%	88.2%	88.2%	89.1%	89.7%	88.5%	88.1%	92.0%	88.4%	88.1%	
775	Friends & Family - Maternity	94.2%	95.6%	89.7%	89.1%	96.0%	94.2%	91.8%	94.1%	91.2%	92.4%	95.4%	96.2%	96.9%	94.0%	93.7%	93.5%	
Complaints																		
619	Number of complaints	45	44	43	23	40	70	82	109	92	122	120	94	19	60	771	858	
Operational Engagement																		
620	Number of complaints not responded to within 25 Days	32	17	24	38	16	40	59	53	77	48	92	76	81	39	580	621	
3119	Number of PALS enquiries – unable to contact department	78	74	44	10	12	24	48	52	67	66	41	112	56	29	488	606	
Incident Management																		
660	Duty of Candour - Conversations recorded in notes	98.1%	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	87.5%	93.1%	100.0%	77.8%	100.0%	87.8%	99.6%	94.2%	95.3%	
661	Duty of Candour - Letters sent following DoC Incidents	100.0%	100.0%	95.5%	100.0%	100.0%	92.9%	100.0%	83.3%	93.1%	100.0%	81.5%	100.0%	87.8%	99.6%	93.8%	94.7%	
1617	Duty of Candour - Investigation Findings Shared	63.5%	55.6%	45.5%	43.5%	38.1%	42.9%	39.4%	20.8%	17.2%	13.9%	7.4%	3.3%	0.0%	75.1%	20.9%	26.7%	
CQC level of inquiry: Effective																		
Improving Outcomes																		
831	Standardised Readmission Ratio	88.8	87.7	86.5	86.6	86.4	86.3	86.1	86.8	87.1	86.8				105.0			
436	HSMR	87.6	87.4	88.8	90.9	91.3	90.7	89.9	89.1	90.2	90.5	92.2			100.0			
433	SHMI	93.5	93.8	96.3	97.9	97.4	96.1	96.0	96.0	96.2	95.7				105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	88.1%	81.6%	66.7%	74.3%	88.9%	71.0%	63.0%	71.9%	71.7%	86.8%	67.7%	90.9%	92.3%	79.8%	76.8%	76.8%	
625	Diagnostic Results Acknowledgement	12.8%	12.5%	13.1%	14.7%	13.6%	13.3%	13.8%	13.6%	12.2%	13.1%	12.2%	11.6%	11.1%	12.6%	12.8%	12.8%	

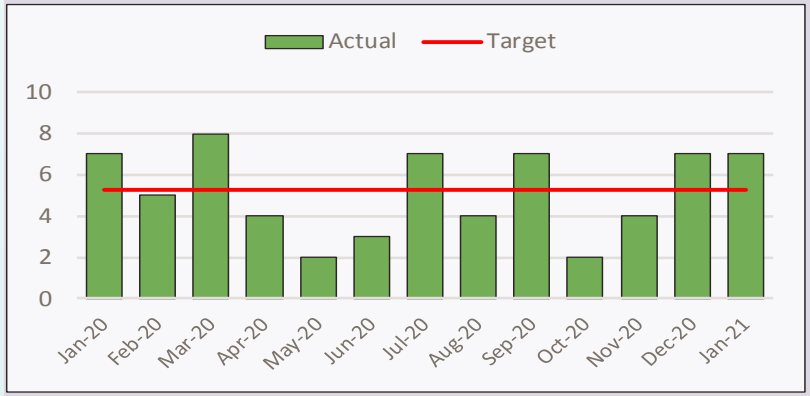
Domain 1: Quality
Infection

M10 - JANUARY 2021 INFECTION PREVENTION AND CONTROL

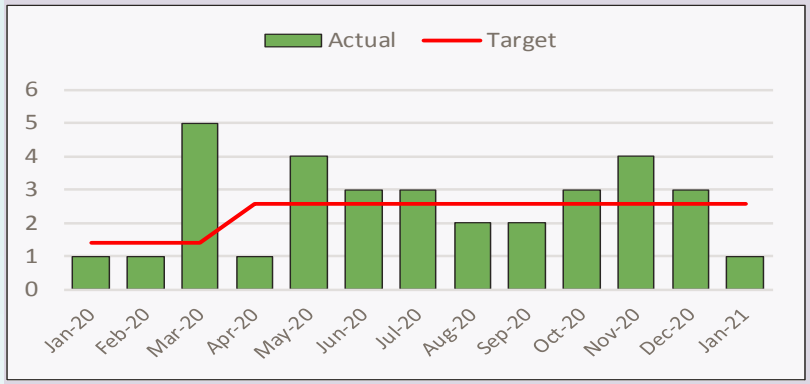
Infection	Current Month	*Denmark Hill*	*PRUH*	Previous Month	Variance	Target	Var. to Target
C.diff	9	7	1	10	-1	8	1
CPE/CPO	7	7	0	19	-12	13	-6
E.coli	10	5	5	19	-9	10	0
Klebsiella spp	23	23	0	10	13	7	16
MRSA	0	0	0	0	0	0	0
MSSA	3	2	1	3	0	3	0
P.aeruginosa	9	9	0	7	2	5	4
VRE	11	9	2	4	7	6	5

C-DIFFICILE DELIVERY

C-difficile: Denmark Hill reported cases



C-difficile: PRUH reported cases



HCAI DELIVERY PLAN

Denmark Hill
MRSA: No MRSA bacteraemia cases reported.

C.difficile (CDI): Seven Trust-apportioned cases reported with 2 cases on Murray Falconer ward and in Child Health, and 1 case in Surgery, Acute Medicine and Critical Care.

Gram-negative blood stream infection (BSI): There has been an increase gram negative BSI cases, specifically *Klebsiella* and *pseudomonas.* A review of the sources of infection will be undertaken.
VRE Cases: Nine cases occurred with 7 cases in critical care, and 1 case in Haematology and Acute Medicine. Work continues on improving cleaning and antimicrobial stewardship.

PRUH
MRSA: No MRSA Bacteraemia cases reported.

C.difficile (CDI): One case reported on surgical ward 3 and RCA is underway.
VRE: Two cases reported in General Medicine care group.

C-DIFFICILE BENCHMARKING

National C. difficile infection: monthly data by prior trust exposure, Apr19 - Jul19

Manchester University	59
Nottingham Teaching Hospital	46
Barts Health	21
Cambridge University	24
Kings College Hospital	23
Newcastle Upon Tyne	25
Imperial College	22
Oxford University	31
Royal Free	0
UCLH	22
St George's	14
Guy's & St Thomas	9

13

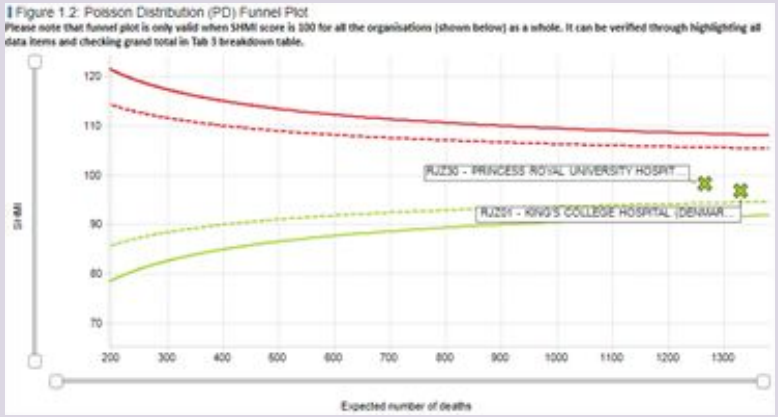
Domain 1: Quality
Mortality & Readmissions

MORTALITY AND READMISSIONS - SHMI, HSMR and RRR

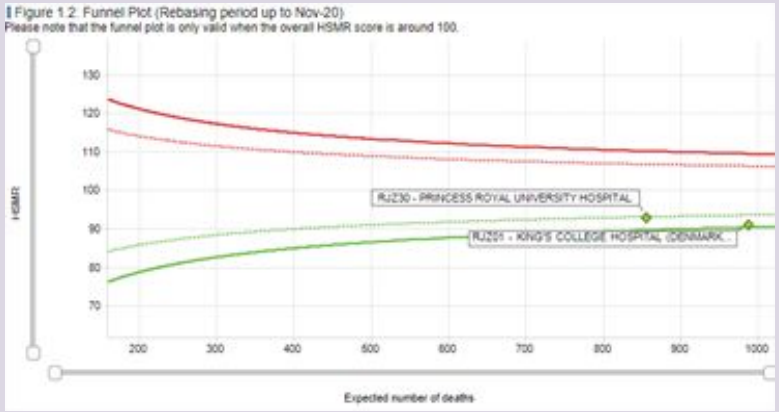
	Contextual indicators (November 2019 to October 2020)							
	Deaths			Admission Method		Palliative Care		Readmissions
	Total number of deaths	Deaths which occurred in hospital (%)	Deaths which occurred outside hospital within 30 days of discharge (%)	Crude in-hospital mortality rate (%) for elective admissions	Crude mortality rate (%) for non-elective admissions	In-hospital deaths with palliative care diagnosis coding (%)	SHMI adjusted for palliative care (95% Confidence Intervals)	Crude 30-day emergency readmissions rate to KCH or elsewhere (%)
Trust Value	2530	72.1%	27.9%	0.63%	3.37%	Not available	86.06 (CI 82.7, 89.5)	12.6%
England Average		65.8%	34.2%	0.69%	3.57%	Not available	100.59 (CI 100.20, 101.0)	14.5%

MORTALITY MEASURES

SHMI: Denmark Hill and PRUH



HSMR: Denmark Hill and PRUH



RISK-ADJUSTED MORTALITY (SHMI / HSMR)

Trust: Risk-adjusted mortality is below expected:

- SHMI for Nov-19 to Oct-20 is 95.74 (95% CI 92.1, 99.50).
- HSMR is below expected for Nov-19 to Oct-20 at 90.54 (95% CI 86.32, 94.92).

Denmark Hill:
SHMI for Nov-19 to Oct-20 is 96.80 (95% CI 91.60, 102.20)

- HSMR is below expected for Nov-19 to Oct-20 at 90.85 (95% CI 85.00,97.00).

PRUH:
SHMI is within expected range for Nov-19 to Oct-20 at 98.25 (95% CI 92.90, 103.90)

- HSMR is below expected for Nov-19 to Oct-20 at 93.11 (95% CI 86.76, 99.81).

RISK-ADJUSTED READMISSION (RRR)

Trust: RRR is below expected for Nov-19 to Oct-20 at 86.80 (95% CI 85.00, 88.60).
Denmark Hill: RRR is below expected Nov-19 to Oct-20 at 82.6 (95% CI 80.30, 85.10).
PRUH: RRR is below expected for Nov-19 to Oct-20 at 92.5 (95% CI 89.60, 95.40)

RISK-ADJUSTED MORTALITY AND READMISSIONS BENCHMARKING

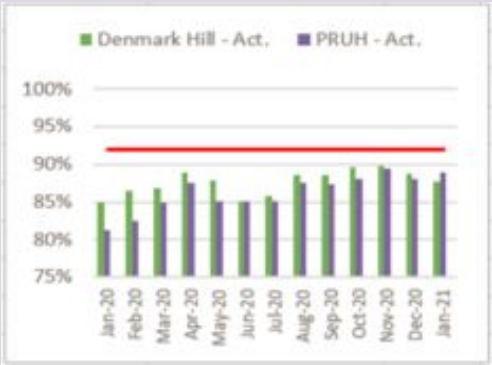
Peer = Shelford Group

Domain 1: Quality
Friends & Family Test

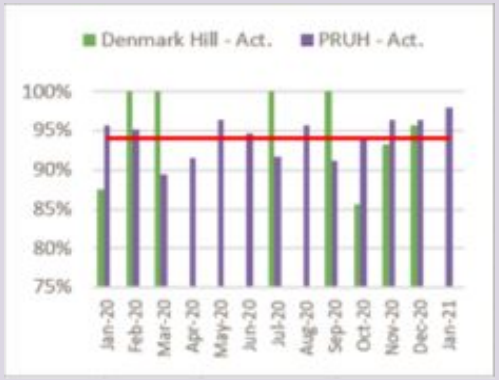
M10 - JANUARY 2021				
Metric	Inpatients	ED	Outpatients	Maternity
Current Month	93.24%	84.94%	88.11%	96.94%
Denmark Hill	*92.98%*	*85.28%*	*87.70%*	*0.00%*
PRUH	*94.44%*	*84.04%*	*88.92%*	*97.94%*
Previous Month	94.24%	81.59%	88.45%	96.23%
Variance	-1.00%	3.35%	-0.34%	0.71%
Target/Plan	96.00%	86.00%	92.00%	94.00%
Variance to target/plan	-2.76%	-1.06%	-3.89%	2.94%

FRIENDS AND FAMILY TEST

FFT Outpatient Scores



FFT Maternity Scores



PERFORMANCE DELIVERY

FFT - A&E
- Trust score recovered from 81% in December to 85% in January.
- The DH score improved by one point to 85% patients recommending, with PRUH recovering significantly from 75% to 84%.
- Field work currently underway for the 2020 CQC Acute and Emergency patient survey.

FFT - Inpatient
- Trust score reduced by one point to 94%.
- The DH score reduced by one point to 93%, with PRUH increasing one point to 98%.

FFT – Outpatients
- Trust FFT score for outpatients improved by one point to 89%, with DH reducing one point to 88%, and PRUH improving by one point to 88%.
- From 1 April 2021 we will include a split in our surveys to gather feedback for both face to face and remote appointments.

FFT – Maternity combined
- Not possible to report at DH as response rate was 0.3%.
- PRUH remains high on 98% of women recommending with a 31.6% response rate.

FFT BENCHMARKING (MONTH IN ARREARS)

FFT Test	Scope	Response Rate (%)	Score (% recom-mending)	Score (% not recom-mending)
Inpatients	**KCH**			
Inpatients	London			
Inpatients	England			
ED	**KCH**			
ED	London			
ED	England			
Outpatients	**KCH**			
Outpatients	London			
Outpatients	England			
Maternity (A-N)	**KCH**			
Maternity (A-N)	London			
Maternity (A-N)	England			

Domain 2: PERFORMANCE

1. Key Metrics Scorecard
2. A&E – 4 Hour Waits
3. Cancer Waiting Times
4. Diagnostic Waiting Times
5. Referral To Treatment (18 Weeks)

Domain 2: Performance
Key Metrics Scorecard

Performance

		Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																		
Access Management - RTT, CWT and Diagnostics																		
364	RTT Incomplete Performance	79.51%	80.44%	76.79%	68.50%	58.70%	46.66%	39.28%	48.20%	57.16%	64.82%	70.36%	72.71%	70.47%	92.00%	59.52%	63.24%	
632	Patients waiting over 52 weeks (RTT)	160	143	196	483	1017	1784	2495	2802	3250	3568	3739	3777	5212	0	28127	28466	
412	Cancer 2 weeks wait GP referral	87.47%	91.47%	92.08%	88.56%	88.23%	84.57%	86.12%	79.80%	85.40%	90.65%	95.41%	95.63%	89.39%	93.00%	88.80%	88.80%	
413	Cancer 2 weeks wait referral - Breast	98.84%	94.25%	95.74%	95.65%	97.50%	98.28%	96.39%	96.23%	93.07%	92.00%	98.11%	86.96%	75.00%	93.00%	94.53%	94.53%	
419	Cancer 62 day referral to treatment - GP	65.28%	69.20%	70.59%	63.38%	66.23%	64.33%	64.55%	73.02%	76.79%	76.61%	80.66%	74.73%	58.28%	85.00%	71.03%	71.03%	
536	Diagnostic Waiting Times Performance > 6 Wks	11.51%	6.66%	19.03%	59.35%	60.25%	51.56%	41.59%	34.71%	26.81%	21.73%	19.34%	21.41%	40.16%	1.00%	36.66%	32.84%	
Access Management - Emergency Flow																		
459	A&E 4 hour performance (monthly SITREP)	69.02%	71.42%	73.99%	82.82%	91.11%	90.72%	93.63%	88.91%	85.26%	81.51%	82.26%	73.69%	67.38%	95.00%	83.82%	83.82%	
Patient Flow																		
399	Weekend Discharges	18.5%	22.6%	19.7%	19.6%	25.5%	20.1%	18.5%	25.5%	18.0%	21.3%	21.4%	17.7%	24.5%	20.7%	21.2%	21.2%	
404	Discharges before 1pm	18.7%	19.0%	16.0%	18.7%	18.1%	17.9%	16.8%	16.9%	16.1%	17.1%	17.0%	15.4%	15.5%	18.4%	16.9%	17.0%	
747	Bed Occupancy	94.4%	93.5%	81.2%	61.4%	63.2%	70.3%	77.6%	80.3%	83.2%	82.9%	81.1%	82.0%	79.4%	91.3%	76.3%	78.0%	
1357	Number of Stranded Patients (LOS 7+ Days)	613	581	382	346	383	420	423	467	467	469	474	528				4940	
1358	Number of Super Stranded Patients (LOS 21+ Days)																	
800	Delayed Transfer of Care Days (per calendar day)														0.0			
762	Ambulance Delays > 30 Minutes	226	744	624	411	258	182	128	223	256	386	314			0	2158	3526	
772	12 Hour DTAs	166	76	43	13	12	28	37	45	34	53	69	249	249	0	789	789	
Theatre Productivity																		
801	Day Case Rate	77.7%	77.3%	76.6%	73.1%	76.0%	76.8%	77.6%	77.7%	79.7%	80.6%	80.6%	79.4%	84.6%	76.1%	79.2%	78.7%	

Domain 2: Performance
A&E / Emergency Care

M10 - JANUARY 2021 EMERGENCY CARE DELIVERY

Metric	4hr Performance	12hr DTA Breaches	Walk-In Att.	Ambulance Att.	Total Attendances	% Treated <60m	Emergency Adm.	NEL ALOS	Stranded	Super-Stranded
Current Month	67.38%	249	10948	5278	16226	66.17%	4476	6.64	0	0
Type 1 Only	54.09%	-	-	-	10179	66.17%	-	0.00	-	-
Type 3 Only	90.20%	-	-	-	6047	0.00%	-	0.00	-	-
Previous Month	73.69%	249	13425	5245	18670	51.48%	4163	6.25	528	0
Variance	-6.31%	0	-2477	33	-2444	14.69%	313	0.39	0	0
Target/Plan	77.06%	0	-	-	-	-	-	-	-	-
Variance to Target/Plan	-9.68%	249	-	-	-	-	-	-	-	-

ACTIONS TO RECOVER

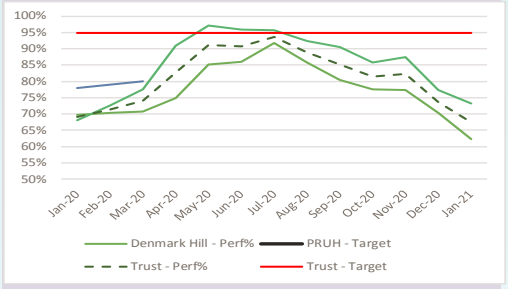
Denmark Hill:

- Paediatric CDU has re-opened and the Ambulatory Decision Unit has also re-opened for non-COVID suspected patients.
- Guthrie ward is starting to be used for refer and move for patients referred to Medicine; and Medical ACU re-opened on 18 February.
- ePlex testing is now live in ED for quicker swab turnaround times, and RAT has also been re-introduced.
- Medical staffing remains strong; nursing gaps still occurring although the position has improved as sickness rates drop.

PRUH:

- **ED - increased side room capacity**: Majors A area of the department has been converted from cubicle spaces to individual side rooms, including 2 resus rooms to support infection control needs within the emergency setting. The work within the adult major's area is now complete, similar work within paediatric ED is due to commence within the next 2 weeks.
- **Front door enhanced assessment**: The team has established a senior clinically-led front door model which includes enhanced triage to ensure we prioritise our patients by process of Senior Intervention following Triage. The model is proving successful with non-admitted performance above 90%.
- **Point of Care Testing**: ED are due to receive 2 COVID point of care testing machines aimed at reducing delays with time from swabbing to receive results. Direct testing in ED will help reduce the timeframe for receiving results by up to 1 hour per patient.

PERFORMANCE



BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon.)	Rank (Eng.)
Attendances (All Types)	18,755	29,952	33	5 of 28	11 of 216
Attendances (Type 1)	11,870	24,782	2,467	4 of 21	16 of 216
Total Emergency Admissions	4,253	11,988	1	5 of 21	39 of 216
Emergency Admissions via A&E	3,741	8,890	1	5 of 21	26 of 216
% Emergencies Admitted via A&E	88.0%	100%	1.3%	7 of 21	22 of 216
4hr performance % (All Types)	73.7%	100%	64.1%	22 of 28	157 of 216
4hr performance % (Type 1)	62.3%	98.6%	40.1%	14 of 21	100 of 216
12hr DTA breaches	249	611	0	19 of 21	214 of 216

Compliance by Activity Volume	No. of Trusts	Com-pliant	% Comp.
<10,000 att.	157	77	49.0%
>10,000 to <20,000	52	1	1.9%
>20,000 att. (inc. KCH)	7	0	0.0%

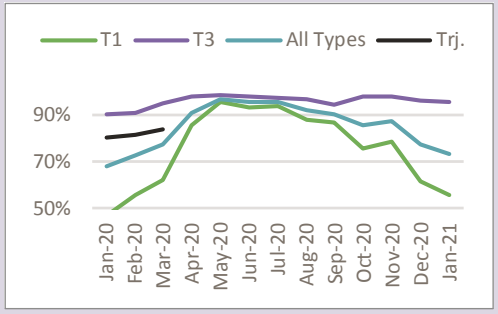
Domain 2: Performance
A&E / Emergency Care (Site Based)

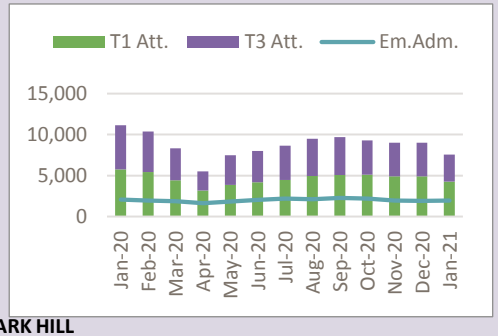
M10 - JANUARY 2021 EMERGENCY CARE DELIVERY

		4hr Perf.%	12hr DTAs	Walk-In Att.	Ambul. Att.	Total Att.	%Treat<60m	Em. Adm.	NEL ALOS	Stranded	Super-S.
DENMARK HILL	Current Month	62.21%	69	5576	2965	8541	83.84%	2502	6.5614	0	0
	Type 1 Only	52.86%	-	-	-	5891	83.84%	-	-	-	-
	Type 3 Only	83.02%	-	-	-	2650	0.00%	-	-	-	-
	Previous Month	70.28%	45	6914	2819	9733	67.50%	2244	6.2575	332	0
	Variance	-8.07%	24	-1338	146	-1192	16.34%	258	0.3039	0	0
	Target/Plan	74.67%	0	-	-	-	-	-	-	-	-
	Variance to Target/Plan	-12.46%	69	-	-	-	-	-	-	-	-
PRUH	Current Month	73.23%	180	5372	2313	7685	41.88%	1974	6.7703	0	0
	Type 1 Only	55.79%	0	0	-	4288	41.88%	-	-	-	-
	Type 3 Only	96.00%	0	0	-	3397	0.00%	-	-	-	-
	Previous Month	77.38%	204	6511	2426	8937	28.01%	1918	6.2422	191	0
	Variance	-4.15%	-24	-1139	-113	-1252	13.87%	56	0.5281	0	0
	Target/Plan	79.78%	0	-	-	-	-	-	-	-	-
	Variance to Target/Plan	-6.55%	180	-	-	-	-	-	-	-	-

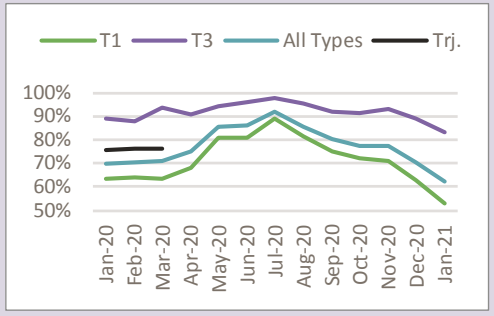
PERFORMANCE

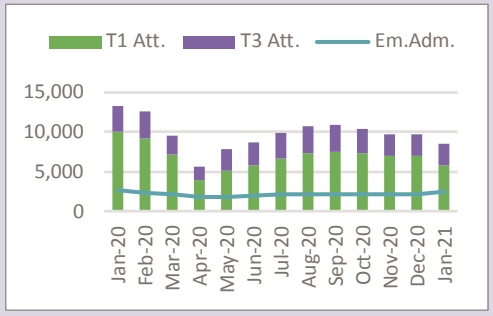
PRUH





DENMARK HILL





PERFORMANCE HIGHLIGHTS: PRUH

- ED type 1 performance has reduced from 61.63% in December to 55.79% in January with attendance levels reducing by 631 patients.
- ED all types performance reduced from 77.38% in December to 73.22% in January.
- There were only 7,554 attendances in January which is a reduction of 1,461 attendances compared to December. This level of activity represents 67.7% of patients seen compared to January last year.
- The number of 12-hour DTA breaches reduced from 204 in December to 180 in January, primarily due to capacity issues.

PERFORMANCE HIGHLIGHTS: DENMARK HILL

- Type 1 ED performance reduced from 62.74% in December to 52.86% in January, and Type 3 performance reduced from 89.16% to 82.98%.
- ED all types performance reduced from 70.28% in December to 62.21% in January.
- There were 8,545 attendances in January which is a reduction of 1,195 attendances compared to December. This represents 64.5% of patients seen compared to January last year.
- The number of 12-hour DTA breaches increased from 45 in December to 65 in January, primarily due to capacity issues.

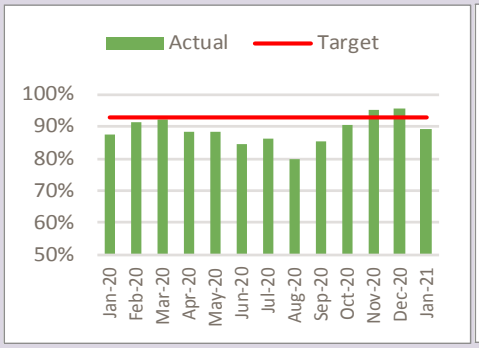
Domain 2: Performance
Cancer

M10 - JANUARY 2021 CANCER DELIVERY

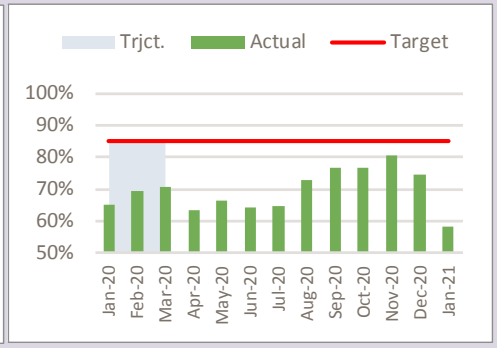
Metric	2WW Referrals Received	2WW Referrals Seen	2WW Referrals Seen <14 Days	% Seen within 14 Days	62-Day Total Treatments	Treatments within 62 Days	% Treatments within 62 Days	% Transfers In < Day 38	% Transfers Out < Day 38	Total Cancer PTL	>62 Days w/o Treatment	>100 Days w/o Treatment
Current Month	2115	1763	1576	89.39%	75.5	44	58.28%	73.17%	55.9%	3320	16	8
Denmark Hill	*1005*	*1020*	*939*	*92.06%*	*34.5*	*18*	*52.17%*	*73.17%*	*55.8%*	*1375*	*9*	*4*
PRUH	*1110*	*743*	*637*	*85.73%*	*40.5*	*26*	*64.20%*	*0.00%*	*55.9%*	*1945*	*7*	*4*
Previous Month	2463	2586	2473	95.63%	138.5	103.5	74.73%	75.56%	61.5%	-	-	-
Variance	-348	-823	-897	-6.24%	-63	-59.5	-16.45%	-2.39%	-5.6%	-	-	-
Target/Plan	-	-	-	93.00%	-	-	85.85%	0.00%	0.0%	-	-	-
Var. to Target/Plan	-	-	-	-3.61%	-	-	-27.57%	0.00%	0.0%	-	-	-

COMPLIANCE TRENDING

2-Week Performance



62-Day Performance



BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon.)	Rank (Eng.)
2 week wait referrals seen	2,710	4,801	3	4 of 21	14 of 142
2 week wait performance %	95.46%	100%	0.00%	11 of 21	95 of 142
2 week wait (breast) performance %	96.52%	100%	0.00%	12 of 18	89 of 119
62 day GP referral performance % (1st treatment)	82.82%	100%	0.00%	6 of 23	54 of 143
62 day screening service performance % (1st treatment)	93.18%	100%	0.00%	10 of 18	75 of 129

PATHWAY REDESIGN & IMPROVEMENT

- Due to the current COVID wave, our cancer waiting time programme has remained suspended. PRUH pathway mapping workshops were held back in November to highlight new themes/areas for improvement. Root cause analysis review process additionally re-commenced in November Trust-wide. As a result there are now 67 open actions on the Trust wide CWT programme plan.
- Late influx of referrals in February has brought demand back to pre COVID position per site, although differences remain at specialty level. Therefore services need to ensure sufficient diagnostic capacity is in place.
- Small numbers of endoscopy procedures and PRUH gynae /urology theatre diagnostics remain delayed by hospital (compared to booking times outside of COVID 19) but are being managed or are on hold due to being P3/P4.

IMPROVING >38 DAY TERTIARY REFERRALS

- Breaking bad news ring-fenced slots required for PRUH prostate patients. Move breaking bad news DH colorectal clinic to within 24 hours of MDM (additional CNS workforce required, but funding now secured).
- DH gynae hysteroscopy capacity now in place for outpatient hysteroscopies, to set up ring-fenced slots for day case hysteroscopies.
- Implement 23-hour stay for DH interventional radiology biopsies to reduce delays due to bed capacity constraints.
- Long term plan to review provision of oncology services in South East London (as no current cover in the event of leave) – KCH to meet with GSTT and LGT to review funding models for full 52 week a year service.
- Trust wide long term plans for increased capacity in radiology and endoscopy is key to long term improvements for CWT performance.

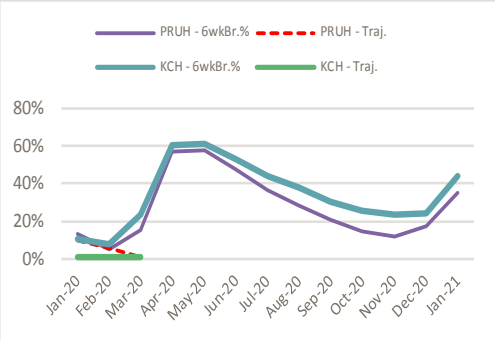
Domain 2: Performance
Diagnostics

M10 - JANUARY 2021 DIAGNOSTICS DELIVERY

	ACTIVITY				WAITING LIST				WAITS BY MODALITY		
Metric	Planned	Unsched.	WL	Total	Total WL	Total 6+ Wks	Total 13+ Wks	% 6+ Wks	Endoscopy	Echocard.	MRI&CT
Current Month	1367	5931	11194	18492	12918	5188	1263	40.16%	1174	1653	1184
Denmark Hill	19	18	1060	1097	7465	3290	862	44.07%	654	790	1070
PRUH	3891	5561	298	9750	5453	1898	401	34.81%	520	863	114
Previous Month	2736	5905	16096	24737	13097	2804	801	21.41%	889	1007	425
Variance	-1369	26	-4902	-6245	-179	2384	462	18.75%	285	646	759

ENDOSCOPY RECOVERY PROGRAMME

- The extended Endoscopy harm review continues with a core team meeting weekly to monitor the review of the cases.
- **Next Steps /Risks** – The Trust has increased the use Endoscopy IS capacity at BMI Chelsfield Park, Shirley Oaks and Lyca Health care. All sites now taking 2WW referrals as well as routine and surveillance. A detailed exercise continues with SEL detailing the future trajectory and identifying any further pressure points.



PERFORMANCE HIGHLIGHTS

- The number of patients waiting over 6 weeks increased from 2,804 at the end of December to 5,188 at the end of January, with 40.16% of patients were waiting over 6 weeks – an increase of 18.75% compared to December.
- There were 18,492 DM01 diagnostic tests performed in January, lower than the 24,737 tests carried out in December across planned, waiting list and un-scheduled activity.
- **Denmark Hill**: 3,754 patients waiting over 6 weeks at the end of January on the diagnostic PTL which represents 36.35% of the PTL compared to 18.34% at the end of December.
- **PRUH**: 1,434 patients waiting over 6 weeks at the end of January on the diagnostic PTL which represents 37.33% of the PTL compared to 37.33% at the end of December.

KEY ACTIONS AND RISKS

- **Cardiac echo** - largest diagnostic backlog is now in cardiac echo (1,976) where the main constraints are staff vacancies and physical space, rather then redeployed staff. Exploring use of an insourcing company to support backlog reduction.
- MRI - Significant volume of long waiters at DH (855) with capacity at circa 60% pre-COVID levels. Recovery being balanced alongside two major equipment replacement programmes for MRI as well as CT. Mitigations in place using IS capacity and mobile scanners.
- **Endoscopy** – significant backlog at both sites with current capacity running to mainly accommodate inpatient, urgent and 2WW demand, but recovery plans are being finalised.

BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon. Acute)	Rank (Eng.)
Planned tests/procedures	2,727	6,891	0	5 of 24	12 of 399
Unscheduled tests/proc.	5,836	12,625	0	2 of 24	7 of 399
Wait. list tests/proc. (ex. planned)	16,008	23,884	1	3 of 24	9 of 399
Total tests/procedures performed	24,571	35,550	1	2 of 24	4 of 399
Total waiting list	13,048	26,954	1	2 of 24	17 of 399
Number waiting 6+ weeks	2,792	13,524	1	6 of 24	44 of 399
% waiting 6+ weeks	21.4%	100.0%	0.0%	15 of 24	254 of 399

Compliance by Volume	No. of Trusts	<1% Comp.	% Comp.
<5,000 tests	297	144	48.48%
>5,000 to <13,000 tests	80	1	1.25%
>13,000 tests (inc. KCH)	18	0	0.00%

Domain 2: Performance
RTT

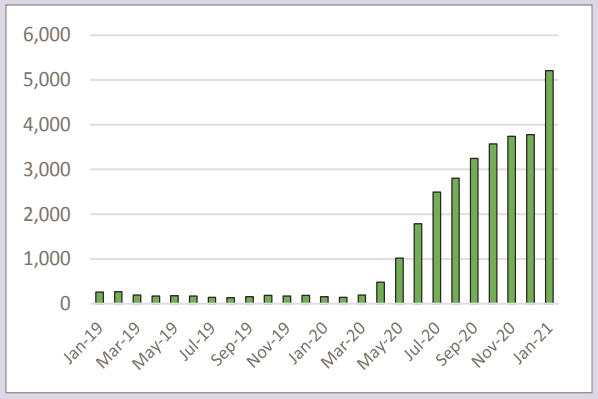
M10 - JANUARY 2021 RTT DELIVERY

Metric	Clock Starts	Clock Stops	Total PTL	< 18 Weeks	> 18 Weeks	RTT Compliance	>30 Weeks	>40 Weeks	>52 Weeks
Current Month	18846	13256	57942	40832	17110	70.47%	10479	9229	5212
Admitted	0	648	11629	5837	5792	50.19%	3976	3437	2306
Non-Admitted	0	12608	46313	34995	11318	75.56%	6503	5792	2906
Previous Month	23832	20654	57017	41458	15559	72.71%	10597	9457	3777
Variance	-4986	-7398	925	-626	1551	-2.24%	-118	-228	1435
Target/Plan	23458	18699	74026	57755	16271	78.02%	-	1899	120
Var. to Target/Plan	-4612	-5443	-16084	-16923	839	-7.55%	-	7330	5092

LONG WAITERS

- Increase of 1,435 breaches from 3,777 in December to 5,212 in January.
- The majority of the breaches are in Oral Surgery (2,517 patients), Ophthalmology (1,894 patients), General/ Bariatric Surgery (1,008 patients), Orthodontics (760 patients), T&O (451 patients) and ENT (419).
- The number of 52 week breaches at Denmark Hill has increased by 975 cases from 2,731 in December to 3,706 in January.
- The number of 52 week breaches at PRUH/South Sites increased by 460 cases from 1,046 in December to 1,506 in January.

52 Week Breaches



ACTIONS TO RECOVER

- Due to the continued reduction of elective and outpatient activity due to the current COVID impact, RTT incomplete performance reduced from 72.71% in December to 70.47% in January.
- **Elective Waiting List Recovery** – a cross-Trust group initially chaired by Mike Farrar continues to meet to plan for the re-starting of all elective and diagnostic activity. The approach will link with the SEL Elective Care Group to ensure a consistent approach is adopted in the Acute Provider collaborative and sector.
- **Clinical Prioritisation** - 97% of DH admitted PTL pathways and 95% of PRUH pathways have been through clinical prioritisation review, which is a significant improvement.
- **OP Delivery Group** – all sites prioritising urgent and 2ww outpatient activity with a new process for re-starting face-to-face activity commencing 1 March. Clinic re-build continues at DH to support Healthcare Comms rollout.
- **Theatres and Bed Planning Group** – 65 half-day sessions allocated in DSU for w/c 1 March. QMS theatres open fully to Ophthalmology.

BENCHMARKING

	KCH	Highest (Eng.)	Lowest (Eng.)	Rank (Lon.)	Rank (Eng.)
GP Referrals Made (all specs)					
Elective G&A Total Admissions (FFCEs)					
PTL Size	56,775	110,521	21	4 of 23	11 of 174
New Waiting List Starts	23,040	27,947	14	1 of 23	3 of 174
Admitted Completed Pathways	4,236	3,162	5	2 of 23	9 of 174
Non-Admitted Completed Pathways	17,554	21,776	6	2 of 23	4 of 174
RTT Compliance	70.3%	100%	13.9%	9 of 23	91 of 174
>36 Weeks	12,393	29,330	1	22 of 23	163 of 174
>52 Weeks	3731	8021	1	22 of 23	164 of 174
% of PTL >36 Weeks	21.8%	69.6%	0.1%	21 of 23	135 of 174
% of PTL >52 Weeks	6.6%	19.3%	0.1%	21 of 23	146 of 174
Average(median) Waiting Times (in weeks)	9.6707	39.7	113.50%	15 of 23	87 of 174
92nd Percentile Waiting Time (in weeks)	52+	50	4.3	22 of 23	149 of 174

Compliance by PTL Size	No.	>92%	% Comp
PTL <20,000	83	22	26.5%
PTL 20,000 - <50,000	74	0	0.0%
PTL 50,000 - <70,000	12	0	0.0%
PTL >70,000(inc. KCH)	5	0	0.0%

Domain 3: WORKFORCE

1. Key Metrics Scorecard
2. Appraisal Rates
3. Training Rates
4. Sickness Rates
5. Staff Turnover Rates
6. Vacancy Rates

Domain 3: Workforce
Key Metrics Scorecard

Workforce

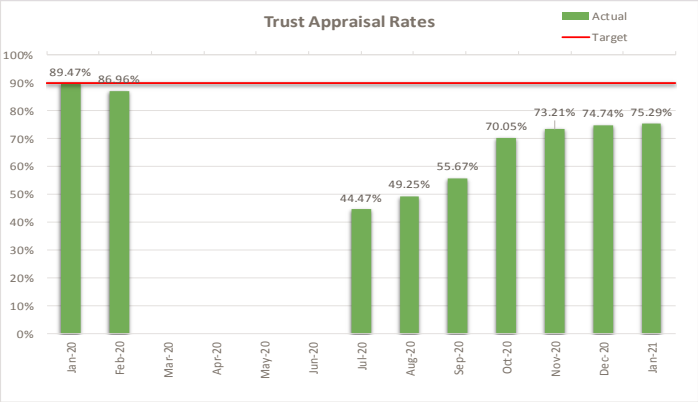
		Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Well Led																		
Staff Training & CPD																		
715	% appraisals up to date - Combined	89.47%	86.95%					44.47%	49.25%	55.66%	70.05%	73.21%	74.74%	75.29%	90.00%			
721	Statutory & Mandatory Training	85.09%	85.36%		84.57%	84.57%	83.47%	83.47%	82.09%	82.72%	84.18%	84.18%	85.55%	85.92%	90.00%			
Staffing Capacity																		
875	Voluntary Turnover %	13.7%	13.8%	13.8%	13.8%	13.5%	13.3%	13.1%	12.6%	11.9%	11.8%	11.7%	11.5%	11.4%	14.0%			
732	Vacancy Rate %	11.38%	11.51%	11.01%	12.83%	12.87%	13.97%	14.29%	15.16%	13.89%	14.19%	11.67%	10.78%	10.28%	10.00%			
Efficiency																		
743	Monthly Sickness Rate	4.05%	3.90%	6.89%	9.98%	5.40%	3.89%	3.66%	3.46%	3.71%	3.83%	3.99%	4.55%	7.14%	3.50%			

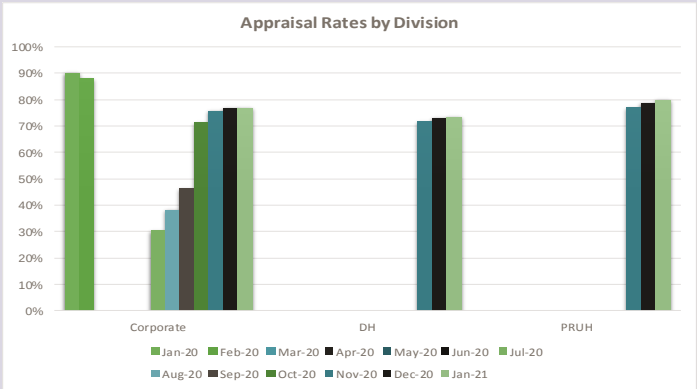
Domain 3: Workforce
Appraisals

M10 - JANUARY 2021 APPRAISALS DELIVERY

	All Appraisals			Appraisal Rate By Staff Group								
	Medical Appraisal %	Non-Medical Appraisal %	Appraisal % (All Staff)	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	76.40%	75.01%	75.29%	77.08%	73.00%	67.06%	84.29%	76.09%	70.80%	76.40%	79.04%	0.00%
DH & Corporate	*77.40%*	*72.64%*	*73.67%*									
PRUH	*72.92%*	*81.18%*	*79.77%*									
Previous Month	71.57%	75.39%	74.74%	77.99%	73.36%	67.34%	86.18%	70.79%	69.78%	71.57%	79.28%	0.00%
Variance (from last month)	4.82%	-0.37%	0.55%	-0.91%	-0.36%	-0.27%	-1.89%	5.30%	1.02%	4.82%	-0.23%	0.00%
Plan KPI	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Variance to target/plan	-13.60%	-14.99%	-14.71%	-12.92%	-17.00%	-22.94%	-5.71%	-13.91%	-19.20%	-13.60%	-10.96%	-90.00%

JANUARY 2021 DELIVERY





PERFORMANCE DELIVERY

Non-Medical:
- There has been a slight decrease this month and the rate falls short of the Trust wide target of 90%.

Medical:
- Compliance has increased, but still lower than in previous years due to the temporary suspension of appraisal activities in response to COVID-19. As per the NHSI letter of 19th March.
- Compliance is 100% for Deanery doctors.

ACTIONS TO SUSTAIN

Non-Medical:
- Window now closed but compliance continues to be monitored.

Medical:
- Those who were still due an appraisal during the temporary suspension are encouraged to complete an appraisal as soon as possible. The appraisal can be a valuable opportunity to reflect on their experience during the pandemic. However, if they do not wish to undertake an appraisal, the appraisal can be considered as 'missed, approved' due to COVID (by completing an appraisal postponement request form).
- Those whose appraisal date falls between October 1st 2020 and March 31st 2021 month should continue to have annual appraisal as normal.
- In addition to the monthly appraisal compliance reports, Site Medical Directors and Clinical Directors are now given appraisal Lead access on SARD which enables them to view appraisal compliance for their individual areas in real time .
- Monthly Appraisal update meetings with RO and Exec Medical Director team.

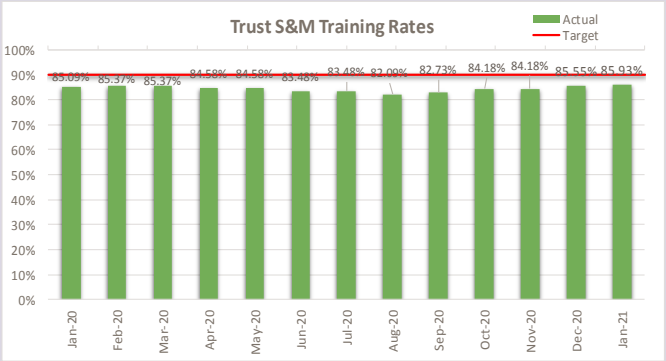
NATIONAL CONTEXT

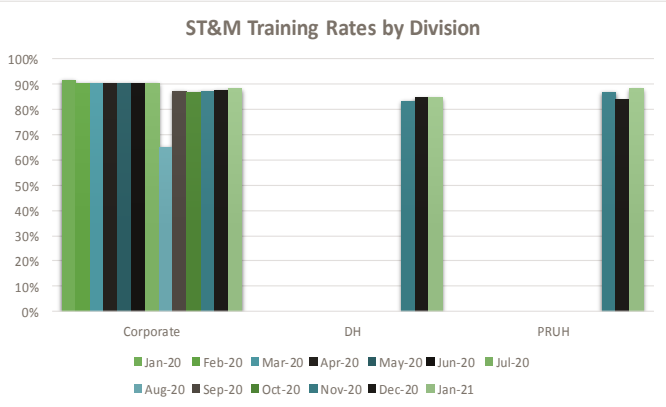
Domain 3: Workforce
Mandatory Training

M10 - JANUARY 2021 TRAINING DELIVERY

	All Staff Statutory & Mandatory	Statutory & Mandatory Training Rate By Staff Group								
	Statutory & Mandatory Training %	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	85.93%	82.18%	83.61%	92.70%	91.50%	91.93%	89.49%	76.90%	87.16%	0.00%
DH & Corporate	*85.17%*									
PRUH	*88.07%*									
Previous Month	85.55%	82.05%	83.22%	92.94%	92.37%	91.61%	89.00%	73.96%	87.63%	0.00%
Variance (from last month)	0.00%	83.29%	82.05%	91.24%	90.12%	92.33%	81.63%	73.67%	86.48%	0.00%
Plan KPI	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Variance to target/plan	-4.07%	-7.82%	-6.39%	2.70%	1.50%	1.93%	-0.51%	-13.10%	-2.84%	-90.00%

JANUARY 2021 DELIVERY





PERFORMANCE DELIVERY

- Compliance is still on an overall upward trend. The M&D staff still the biggest contributors to the rise. The Trust is 4.07% of the compliance target of 90%.
- The implementation of the new Care Group hierarchy is now live on LEAP. The Site data for previous months was manually estimated to fit the new sites.. This accounts for some of the variations.

ACTIONS TO SUSTAIN

Actions going forward:

- LEAP Line Manager check in – 3 monthly check required to maintain hierarchy.
- The F2F delivery of Resus training has moved to an online delivery format only which has had silver approval to help the trust get through the pandemic on a temporary basis. This will be reviewed. This shouldn't have an impact on compliance providing people complete their assigned elearning.
- Audience remapping will commence in the coming month. This will mean cleaning up all audiences in the system some of which are still as they were when copied from KAD (legacy system).
- Care groups to focus on lowest compliance, HRPB's are targeting areas with low compliance, fortnightly meetings with the HRBP's/L&OD.

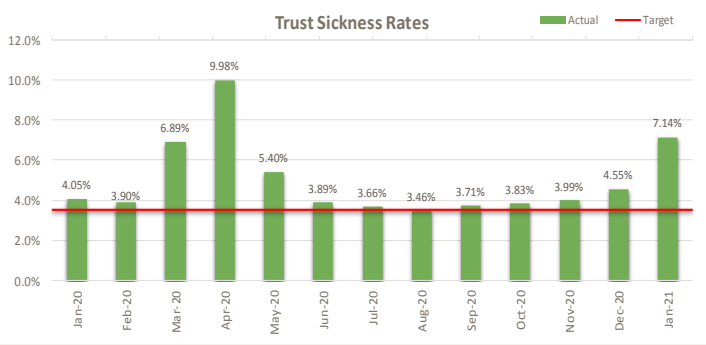
NATIONAL CONTEXT

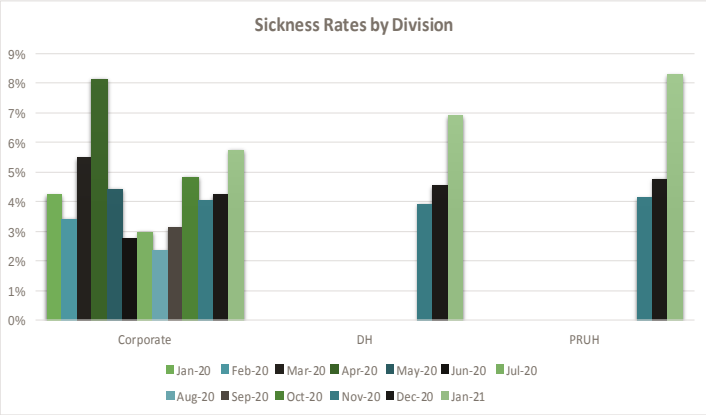
Domain 3: Workforce
Sickness Absence

M10 - JANUARY 2021 SICKNESS DELIVERY

	All Staff Sickness				Sickness Rate By Staff Group								
	Sickness %	Short-Term (%)	Long-Term %	Occurrences	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	7.14%	4.70%	2.44%	3301	6.80%	10.26%	7.26%	5.09%	13.06%	4.22%	2.44%	8.52%	0.00%
DH & Corporate	6.73%	4.34%	2.39%	2319	6.37%	9.24%	7.15%	6.54%	12.07%	4.69%	2.28%	7.90%	0.00%
PRUH	8.29%	5.70%	2.58%	982	12.12%	12.18%	7.75%	4.16%	32.26%	2.82%	2.99%	10.28%	0.00%
Previous Month	4.55%	2.49%	2.07%	2380	4.08%	5.47%	5.19%	3.97%	7.80%	3.12%	1.77%	5.40%	0.00%
Variance (from last month)	2.58%	2.21%	0.38%	921	2.71%	4.79%	2.07%	1.12%	5.26%	1.10%	0.67%	3.12%	0.00%
Plan KPI	3.50%				3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
Variance to target/plan	-3.64%				-3.30%	-6.76%	-3.76%	-1.59%	-9.56%	-0.72%	1.06%	-5.02%	3.50%

JANUARY 2021 DELIVERY





PERFORMANCE DELIVERY

- The Trust has seen a significant increase in the sickness rate in January which is reported as 7.14%. As expected the COVID related sickness has significantly increased from 1.24% to 3.37%. There has also been an increase in non COVID related sickness from 3.32% to 3.76%.
- The rolling sickness rates display a fairly even split between long and short term sickness. The overall sickness rate is higher at the PRUH (5.49%) than DH (4.86%).

ACTIONS TO SUSTAIN

- Comments have been received and work continues on the latest version of the sickness policy. We hope to finalise it early in the new year.
- All staff are being offered a risk assessment to ensure that they remain safe and well at work. At the time of reporting, the Trust had reported 11,775 risk assessments offered and recorded in LEAP (92.21%). (Reported figures on 19/01/21).
- Sickness rates are being monitored and managed. The ER Team Leader (ERTL) has a fortnightly 1-2-1's with the ER Advisors (ERAs) to go through sickness cases.
- Monthly meetings are held with line managers to review and progress sickness cases and ensure that staff have access to the relevant support.

NATIONAL CONTEXT

Sickness Rates (monthly)

Trust	Dec-20
University College London Hospitals NHS Foundation Trust*	3.37%
St George's University Hospitals	3.86%
Guy's & St. Thomas' NHS Foundation Trust	4.03%
Imperial College Healthcare NHS Trust	4.19%
King's College Hospital NHS Foundation Trust	4.55%

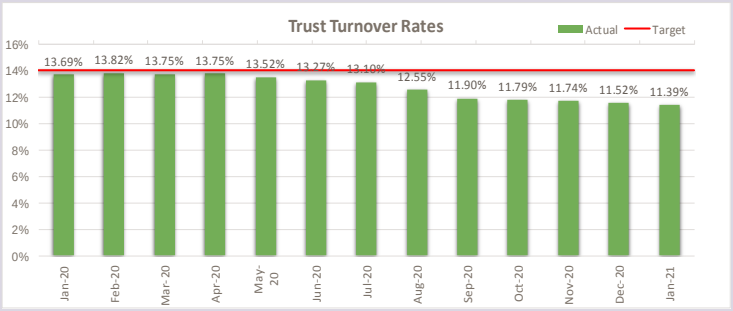
** 12 months Rolling figures*

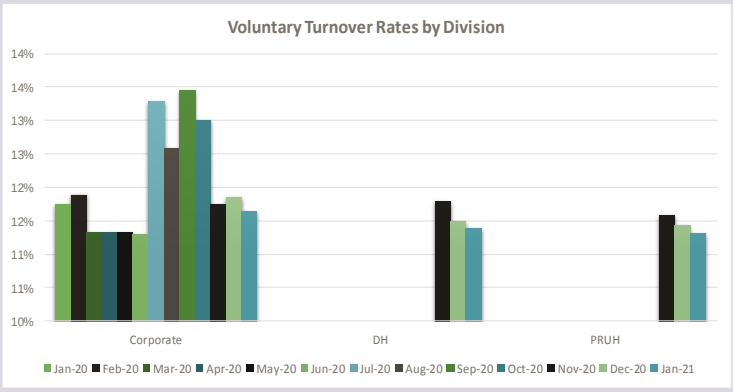
Domain 3: Workforce
Staff Turnover Rates

M10 - JANUARY 2021 DELIVERY

	All Staff Turnover				Voluntary Turnover Rate By Staff Group								
	Turnover %	Voluntary Turnover %	Non-Voluntary Turnover %	Stability Index	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	19.00%	11.39%	7.61%	84.36%	11.03%	12.33%	10.84%	15.08%	6.89%	12.62%	10.51%	11.10%	27.22%
DH & Corporate	*20.24%*	*11.42%*	*8.82%*	*83.94%*	*11.32%*	*12.49%*	*10.96%*	*14.87%*	*7.24%*	*14.01%*	*9.73%*	*11.73%*	*27.44%*
PRUH	*15.53%*	*11.30%*	*4.23%*	*85.54%*	*7.50%*	*12.04%*	*10.30%*	*15.20%*		*8.64%*	*13.26%*	*9.34%*	*0.00%*
Previous Month	19.17%	11.52%	7.65%	84.32%	11.49%	12.00%	10.71%	14.62%	6.93%	12.70%	10.60%	11.66%	27.05%
Variance (from last month)	-0.17%	-0.13%	-0.04%		-0.46%	0.33%	0.13%	0.45%	-0.05%	-0.08%	-0.10%	-0.56%	0.17%
Plan KPI	14.00%	14.00%	14.00%		14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%	14.00%
Variance to target/plan	5.00%	-2.61%	-6.39%		-2.97%	-1.67%	-3.16%	1.08%	-7.11%	-1.38%	-3.49%	-2.90%	13.22%
Stability Index					88.05%	84.15%	89.02%	84.56%	92.63%	90.16%	66.21%	90.05%	20.00%

JANUARY 2021 DELIVERY





PERFORMANCE DELIVERY

- The Trust voluntary turnover rate has again seen a decrease in January to 11.39% which has remained below the target of 14% since January 2020. Both sites remain below the target with DH reporting a slightly higher rate than the PRUH at 11.80% and the PRUH at 11.59%.
- In January there were 130 voluntary leavers, 30 of those left within the first year of service. The top three reasons for leaving were relocation, promotion and work life balance.

ACTIONS TO SUSTAIN

- Exit interview data is being reviewed.
- The retention working group is currently working on various initiatives.
- Initiatives such as the launch of the Feel Good Fund and King's Stars presentation evening, hopefully will drive an improvement in retention.

NATIONAL CONTEXT

Turnover Rates (Voluntary)

Trust	Dec-20
Guy's & St. Thomas' NHS Foundation Trust	9.80%
Lewisham and Greenwich NHS Trust	10.00%
Imperial College Healthcare NHS Trust	10.69%
St George's University Hospitals	11.39%
King's College Hospital NHS Foundation Trust	11.52%
University College London Hospitals NHS Foundation Trust*	17.46%

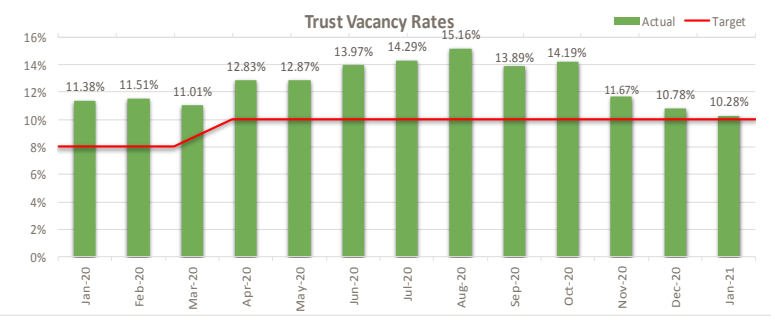
** Gross Turnover*

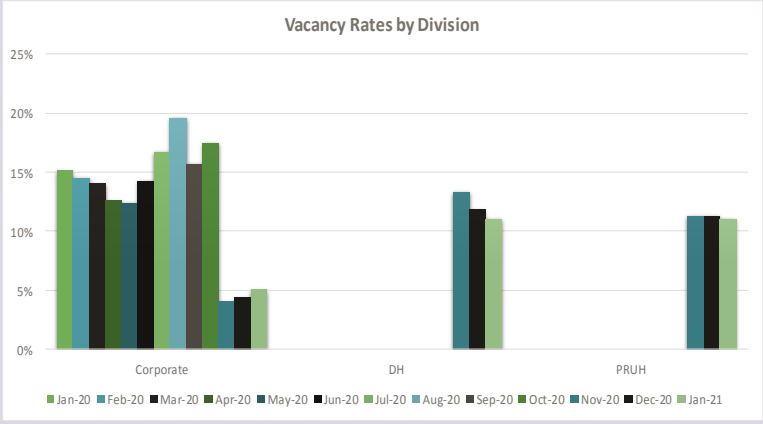
Domain 3: Workforce
Vacancies

M10 - JANUARY 2021 DELIVERY

	All Staff Vacancy				Vacancy Rate By Staff Group								
	Establishment FTE	Vacant FTE	Vacancy % (substantive staff)	Vacancy % (substantive and B&A)	Add. Professional Scientific & Technical	Additional Clinical Services	Admin & Clerical	Allied Health Professionals	Estates & Ancillary	Healthcare Scientists	Medical & Dental	Registered Nurses & Midwifery	Students
Current Month	14300.23	1469.74	10.28%		4.25%	6.98%	11.27%	12.07%	8.01%	9.95%	9.18%	11.95%	82.00%
DH & Corporate	*10595.67*	*1063.61*	*10.04%*		*2.56%*	*6.81%*	*11.85%*	*14.15%*	*8.19%*	*8.67%*	*8.33%*	*11.69%*	*64.00%*
PRUH	*3704.56*	*406.13*	*10.96%*		*22.14%*	*7.31%*	*8.42%*	*10.71%*	*4.00%*	*13.69%*	*11.91%*	*12.71%*	*100.00%*
Previous Month	14247.14	1535.89	10.78%		5.59%	10.34%	10.29%	12.06%	9.90%	7.38%	9.32%	12.41%	82.00%
Variance (from last month)	53	-66	-0.50%	0.00%	-1.34%	-3.36%	0.98%	0.02%	-1.89%	2.56%	-0.14%	-0.46%	0.00%
Plan KPI			10.00%		8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%	8.00%
Variance to target/plan			0.28%		-3.75%	-1.02%	3.27%	4.07%	0.01%	1.95%	1.18%	3.95%	74.00%

JANUARY 2021 DELIVERY





PERFORMANCE DELIVERY

- The month 10 vacancy rate reduced from 10.78% to 10.28%, which is an improved position on the forecast and an improved position on January 2020.
- As the Trust establishment increased by 53 posts this is a positive achievement.
- This continues a positive trend and is now just 0.28% above our end of year target. 5 of the 8 Staff Group areas are now within this years target.

ACTIONS TO SUSTAIN

Strategy and future action:

- On-going recruitment campaigns conducted and planned for AHP should see a more significant reduction by the 31 March 2021.
- A major review of recruitment has commenced with an over-arching recruitment strategy for 2021 and beyond.

Priority areas of recruitment

- Increase in local talent pools staff at B5 and B6 level, promoting specialist roles on social media and are working to convert bank and agency staff on to Trust contracts.
- A targeted medical recruitment campaign has being developed with the Guardian at the PRUH and is helping to reduce vacancies.

NATIONAL CONTEXT

Vacancy Rates (monthly)

Trust	Dec-20
University College London Hospitals NHS Foundation Trust	5.80%
St George's University Hospitals	8.49%
Imperial College Healthcare NHS Trust	10.02%
King's College Hospital NHS Foundation Trust	10.78%
Guy's & St. Thomas' NHS Foundation Trust	11.64%

Domain 4: FINANCE

1. Key Metrics Scorecard
2. Financial Performance

Domain 4: Finance
Key Metrics Scorecard

Finance

		Jan 20	Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																		
895	Actual - Overall				5,580	567	3,535	2,835	4,789	2,546	2,694	7,602	13,671	(5,965)	28,683	37,855	37,855	
896	Budget - Overall				19,224	18,968	18,969	14,466	14,366	14,366	14,695	14,579	24,595	28,683		182,913	182,913	
897	Variance - Overall				13,644	18,401	15,433	11,631	9,577	11,820	12,001	6,977	10,925	34,648	0	145,057	145,057	
Medical - Agency																		
602	Variance - Medical - Agency				(364)	(384)	(230)	(324)	(353)	(581)	(747)	(832)	(658)	(459)	0	(4,932)	(4,932)	
Medical Bank																		
1095	Variance - Medical Bank				(944)	(1,857)	(796)	(1,548)	(1,356)	(1,331)	(2,034)	(1,022)	(1,728)	(1,171)	0	(13,787)	(13,787)	
Medical Substantive																		
599	Variance - Medical Substantive				1,081	303	1,178	1,357	1,877	1,011	1,936	1,252	691	2,095	0	12,781	12,781	
Nursing Agency																		
603	Variance - Nursing Agency				(473)	(417)	(407)	(666)	(583)	(810)	(836)	(676)	(622)	(430)	0	(5,920)	(5,920)	
Nursing Bank																		
1104	Variance - Nursing Bank				(2,442)	(2,116)	(2,003)	(1,645)	(2,194)	(2,659)	(2,496)	(2,942)	(2,861)	(3,274)	0	(24,631)	(24,631)	
Nursing Substantive																		
606	Variance - Nursing Substantive				3,344	2,624	1,684	2,474	3,281	3,656	2,661	3,117	2,615	2,722	0	28,179	28,179	

Domain 4: Finance
M10 (January) – Financial Performance

Surplus / (Deficit)

£12.6m	Actual M10
(£12.9m)	Average 19/20

Pay

(£66.5m)	Actual M10
(£62.2m)	Average Q4 19/20

Non Pay

(£41.4m)	Actual M10
(£42.6m)	Average Q4 19/20

COVID Costs

£49.5m	Actuals YTD – Total
£11.0m	Pay YTD
£38.5m	Non Pay YTD

Payment Compliance

Debtor Days

19.8	Actual M10
19.5	Prior Month

Creditor Days

87.9	Actual M10
88.9	Prior Month

Capital

(£88.0m)	Annual Plan
(£33.5m)	Actual YTD

Appendix 2: COVID-19 Current Wave impact

1. Gold Command COVID metrics summary
2. Daily COVID General & Acute and Critical care bed occupancy
3. Daily COVID Admission and Discharge profiles including deaths
4. Daily COVID and non-COVID Staffing Sickness and Absence

Appendix 2: COVID Current Wave impact

1. Gold Command COVID metrics summary

BIU Business Intelligence Unit

COVID-19 Gold Command Summary

Version 3.34

NHS King's College Hospital NHS Foundation Trust

Covid Metrics

Admissions	Discharges	Deaths
Yesterday: 4	Yesterday: 11	Yesterday: 1
Last 7 Days: 31	Last 7 Days: 93	Last 7 Days: 14
7 Day Growth %: -71.0%	7 Day Growth %: -40.9%	7 Day Growth %: -50.0%
Last 30 Days: 425	Last 30 Days: 827	Last 30 Days: 143
30 Day Growth %: -360.7%	30 Day Growth %: -149.2%	30 Day Growth %: -155.9%
Total: 6,436	Total: 6,229	Total: 1,154

Current Inpatients
General & Acute: 124
ICU & HDU: 42
Pending Result: 346

Workforce
Covid Sickness: 68
Isolation & Shielding: 310
Non-Covid Sickness: 391

Return to BAU Activity

Diagnostics	Outpatients	Electives
Last Week: 2,292	Last Week: 15,737	Last Week: 1,331
Previous Week: 2,600	Previous Week: 17,051	Previous Week: 2,418
BAU Variance: -308	BAU Variance: -1314	BAU Variance: -1087

Definitions

A *Covid-positive patient* is any patient discharged with a U07.1 or U07.2 ICD10 code attached to their spell. Where the patient is as yet uncoded (incuding current inpatients) positivity is indicated via a positive virology result being attached to their EPR visit.

Admission counts are by admission date. If a patient is admitted and subsequently returns a positive result at any later point in the same spell they remain counted by their admission (not test performed nor result) date.

A patient recorded as a *Covid death* is not indicative that Covid was the primary cause of death, but that (as per admission) U07.1/2 or a positive result was attached to the spell.

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Appendix 2: COVID Current Wave impact

2. Daily COVID General & Acute and Critical care bed occupancy

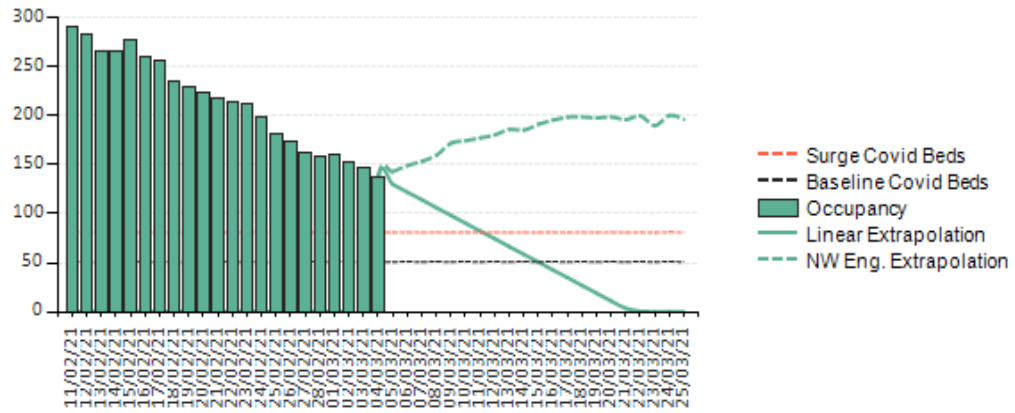
BIU Business Intelligence Unit

COVID-19 Gold Command Summary

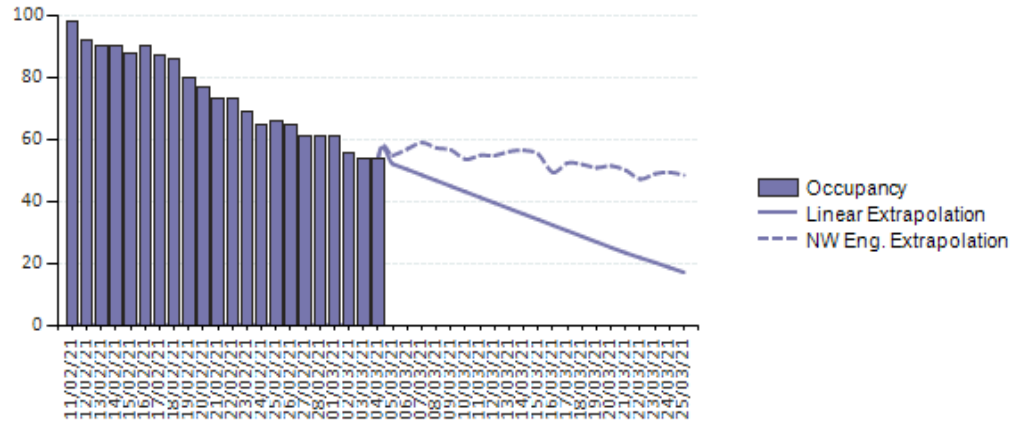
Version 3.34

NHS King's College Hospital NHS Foundation Trust

General & Acute Occupancy & Extrapolation



Critical Care Occupancy & Extrapolation



Definitions

NW England Extrapolation is the daily growth in hospitalisations observed in the NW NHSI Region from the point at which hospitalisations in the North West were at an equivalent level to the current London NHSI Region hospitalisation rate (broadly an 8 week offset). *Linear Extrapolation* is the straight line projection of growth from last 5 day period vs preceding 5 day period.

Covid-19 Admissions (Up) vs Discharges (Down) | G&A/CC

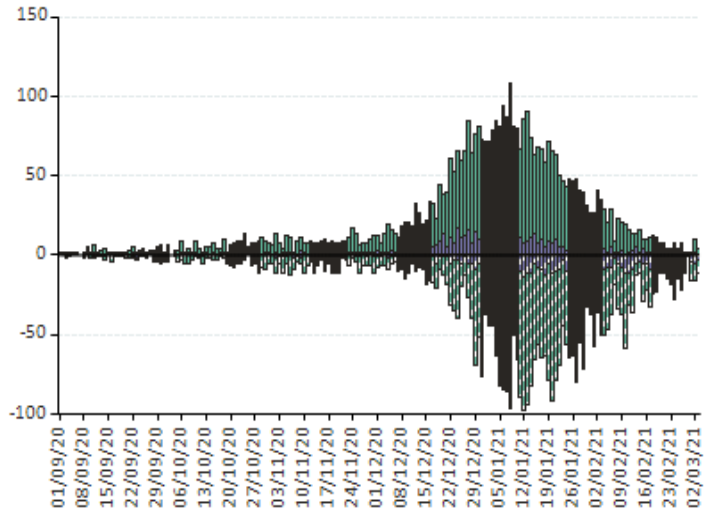


Chart Value	25/02/21	26/02/21	27/02/21	28/02/21	01/03/21	02/03/21	03/03/21
G&A Adm.	4	6	2	2	2	9	4
CC Adm.	0	1	0	0	0	1	0
G&A Disch.	12	15	10	1	12	11	8
CC Disch.	3	7	2	0	4	5	3

Appendix 2: COVID Current Wave impact

3. Daily COVID Admission and Discharge profiles including deaths

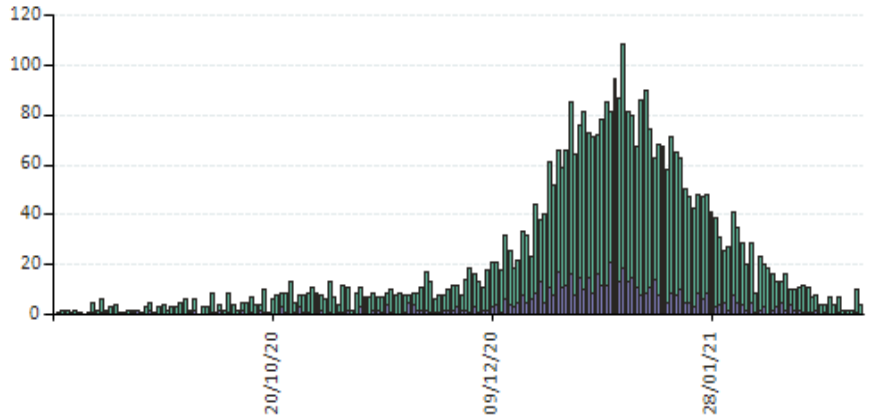
BIU Business Intelligence Unit

COVID-19 Gold Command Summary

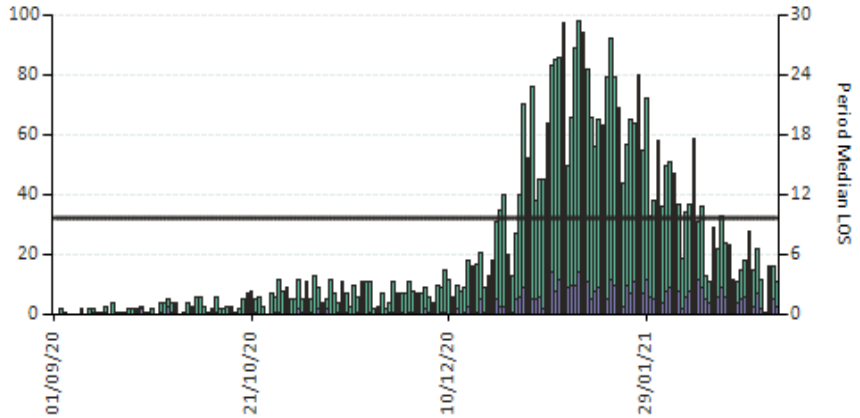
Version 3.34

NHS King's College Hospital NHS Foundation Trust

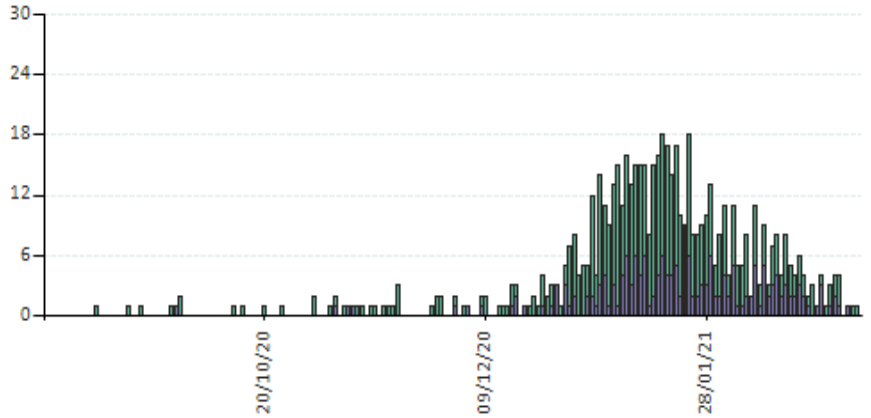
Admissions



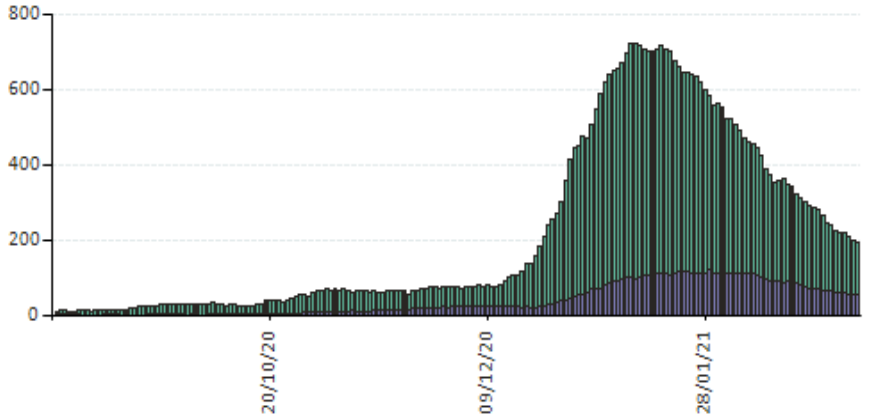
Discharges



Deaths



Midnight Occupancy



Appendix 2: COVID Current Wave impact

4. Daily COVID and non-COVID Staffing Sickness and Absence

BIU Business Intelligence Unit

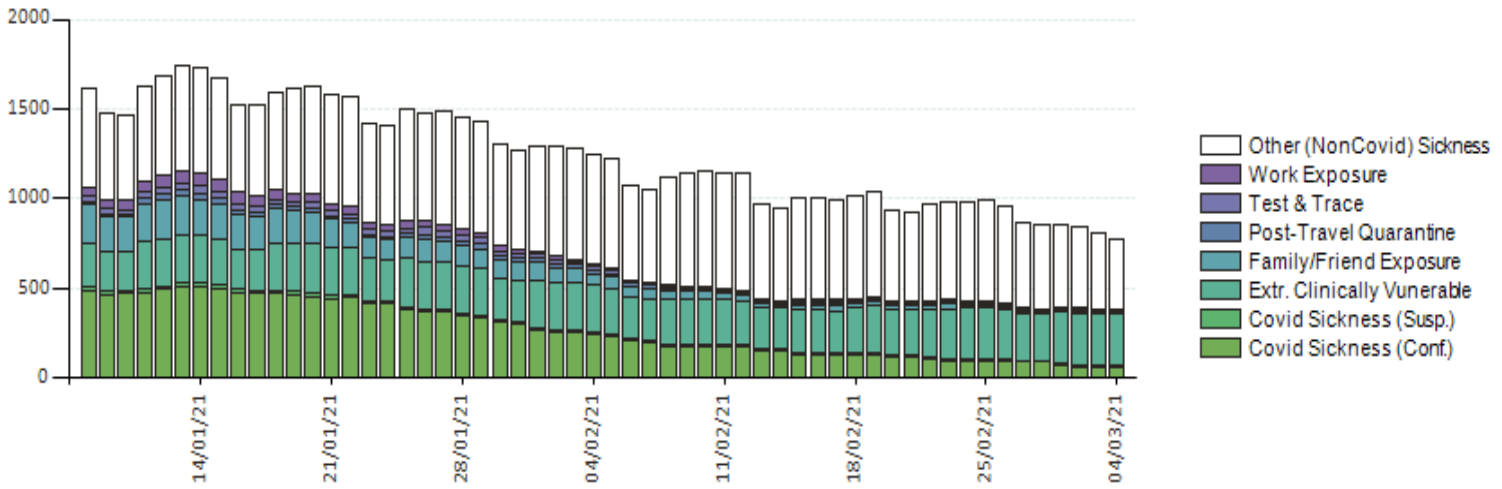
COVID-19 Gold Command Summary

Version 3.34

NHS King's College Hospital NHS Foundation Trust

Staffing Sickness, Isolation & Shielding

Absentees	
Covid	378
Change	-7
All Absence	769



Please note that at the request of Workforce, the data includes those recorded as Working From Home as being absent from work.

Chart Value	15/02/21	16/02/21	17/02/21	18/02/21	19/02/21	20/02/21	21/02/21	22/02/21	23/02/21	24/02/21	25/02/21	26/02/21	27/02/21	28/02/21	01/03/21	02/03/21	03/03/21	04/03/21
Covid Sickness (Confirmed)	141	135	136	133	129	125	121	108	101	103	97	96	89	88	78	71	68	66
Covid Sickness (Suspected)	3	3	3	3	7	4	5	4	6	5	5	4	0	0	1	1	1	2
Extm. Clinically Vunerable	236	239	236	253	263	251	251	266	280	282	287	287	271	270	288	290	291	287
Family/Friend Exposure	29	30	30	25	26	20	24	30	31	27	24	20	18	18	19	17	14	12
Post-Travel Quarantine	11	11	11	10	11	11	10	5	4	4	2	2	2	2	2	2	2	2
Test & Trace	11	11	11	11	7	4	4	5	5	4	2	2	2	2	2	2	3	3
Work Exposure	8	8	8	8	8	9	7	7	7	8	7	5	7	6	7	7	6	6
Other (NonCovid) Sickness	566	565	562	567	583	515	506	540	547	551	569	540	478	470	462	448	427	391

Key Metrics - IPR Summary

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

Trust (100)

January 2021

Performance

		Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																	
Access Management - RTT, CWT and Diagnostics																	
364	RTT Incomplete Performance	80.44%	76.79%	68.50%	58.70%	46.66%	39.28%	48.20%	57.16%	64.82%	70.36%	72.71%	70.47%	92.00%	59.52%	63.24%	
632	Patients waiting over 52 weeks (RTT)	143	196	483	1017	1784	2495	2802	3250	3568	3739	3777	5212	0	28127	28466	
412	Cancer 2 weeks wait GP referral	91.47%	92.08%	88.56%	88.23%	84.57%	86.12%	79.80%	85.40%	90.65%	95.41%	95.63%	89.39%	93.00%	88.80%	88.80%	
413	Cancer 2 weeks wait referral - Breast	94.25%	95.74%	95.65%	97.50%	98.28%	96.39%	96.23%	93.07%	92.00%	98.11%	86.96%	75.00%	93.00%	94.53%	94.53%	
419	Cancer 62 day referral to treatment - GP	69.20%	70.59%	63.38%	66.23%	64.33%	64.55%	73.02%	76.79%	76.61%	80.66%	74.73%	58.28%	85.00%	71.03%	71.03%	
536	Diagnostic Waiting Times Performance > 6 Wks	6.66%	19.03%	59.35%	60.25%	51.56%	41.59%	34.71%	26.81%	21.73%	19.34%	21.41%	40.16%	1.00%	36.66%	32.84%	
Access Management - Emergency Flow																	
459	A&E 4 hour performance (monthly SITREP)	71.42%	73.99%	82.82%	91.11%	90.72%	93.63%	88.91%	85.26%	81.51%	82.26%	73.69%	67.38%	95.00%	83.82%	83.82%	
Patient Flow																	
399	Weekend Discharges	22.6%	19.7%	19.6%	25.5%	20.1%	18.5%	25.5%	18.0%	21.3%	21.4%	17.7%	24.6%	20.7%	21.2%	21.2%	
404	Discharges before 1pm	19.0%	16.0%	18.7%	18.1%	17.9%	16.8%	16.9%	16.1%	17.1%	17.0%	15.4%	15.4%	18.4%	16.9%	17.0%	
747	Bed Occupancy	93.5%	81.2%	61.4%	63.2%	70.3%	77.6%	80.3%	83.2%	82.9%	81.1%	82.0%	79.4%	91.3%	76.3%	78.0%	
1357	Number of Stranded Patients (LOS 7+ Days)	586	575	361	327	393	419	415	500	458	467	470	510		4320	5481	
1358	Number of Super Stranded Patients (LOS 21+ Days)	250	272	171	119	139	167	162	191	181	174	173	193		1670	2192	
800	Delayed Transfer of Care Days (per calendar day)													0.0			
762	Ambulance Delays > 30 Minutes	744	624	411	258	182	128	223	256	386	314			0	2158	3526	
772	12 Hour DTAs	76	43	13	12	28	37	45	34	53	69	249	245	0	785	785	
Theatre Productivity																	
801	Day Case Rate	77.3%	76.6%	73.1%	76.0%	76.8%	77.6%	77.7%	79.7%	80.6%	80.6%	79.4%	84.8%	76.1%	79.2%	78.7%	

Quality

		Feb 20	Mar 20	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																	
Reportable to DoH																	
2717	Number of DoH Reportable Infections	47	47	40	57	66	53	62	57	48	71	72	72	52	598	692	
Safer Care																	

Business Intelligence Unit
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Created date: October 2019

Key Metrics - IPR Summary

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

Trust (100)

629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.21	0.09	0.14	0.06	0.03	0.10	0.07	0.14	0.09	0.17	0.18	0.19	0.19	0.12	0.13	
1897	Potentially Preventable Hospital Associated VTE	2	4	3	1	2	1	2	2	4	6	7	7	0	35	41	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	2	0	0	1	0	0	0	1	0	0	0	0	0			
945	Open Incidents					40			22			34			96	96	
Incident Reporting																	
520	Total Serious Incidents reported	22	12	9	10	14	13	6	3	9	10	9	4		87	121	
516	Moderate Harm Incidents	33	15	17	15	24	29	26	28	30	25	22	29		245	293	
509	Never Events	0	1	0	0	2	0	1	0	1	0	0	0	0	4	5	
CQC level of inquiry: Caring																	
HRWD																	
422	Friends & Family - Inpatients	92.6%	95.1%	95.7%	96.0%	94.5%	93.1%	95.0%	94.9%	95.2%	94.0%	94.2%	93.2%	96.0%	94.4%	94.1%	
423	Friends & Family - ED	81.5%	83.7%	89.6%	89.0%	84.6%	89.3%	83.4%	82.6%	83.6%	85.0%	81.6%	84.9%	86.0%	85.0%	84.6%	
774	Friends & Family - Outpatients	85.2%	86.2%	88.5%	87.1%	85.1%	85.6%	88.2%	88.2%	89.1%	89.7%	88.5%	88.1%	92.0%	88.4%	88.1%	
775	Friends & Family - Maternity	95.6%	89.7%	89.1%	96.0%	94.2%	91.8%	94.1%	91.2%	92.4%	95.4%	96.2%	96.9%	94.0%	93.7%	93.5%	
Complaints																	
619	Number of complaints	44	43	23	40	70	82	109	92	121	120	93	18	60	768	855	
Operational Engagement																	
620	Number of complaints not responded to within 25 Days	17	24	38	16	40	59	53	77	48	91	76	81	39	579	620	
3119	Number of PALS enquiries – unable to contact department	74	44	10	12	24	48	52	67	66	41	112	56	29	488	606	
Incident Management																	
660	Duty of Candour - Conversations recorded in notes	100.0%	100.0%	100.0%	100.0%	96.4%	100.0%	91.3%	92.9%	100.0%	74.1%	100.0%	95.0%	99.6%	95.1%	96.1%	
661	Duty of Candour - Letters sent following DoC Incidents	100.0%	95.5%	100.0%	100.0%	92.9%	100.0%	87.0%	92.9%	100.0%	77.8%	100.0%	95.0%	99.6%	94.8%	95.5%	
1617	Duty of Candour - Investigation Findings Shared	55.6%	45.5%	47.8%	45.0%	46.4%	42.4%	21.7%	17.9%	16.7%	7.4%	3.3%	0.0%	75.6%	22.9%	28.5%	
CQC level of inquiry: Effective																	
Improving Outcomes																	
831	Standardised Readmission Ratio	87.7	86.5	86.6	86.4	86.3	86.1	86.8	87.1	86.8				105.0			
436	HSMR	87.4	88.8	90.9	91.3	90.7	89.9	89.1	90.2	90.5	92.2			100.0			
433	SHMI	93.8	96.3	97.9	97.4	96.1	96.0	96.0	96.2	95.7				105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	81.6%	66.7%	74.3%	88.9%	71.0%	63.0%	71.9%	71.7%	86.8%	67.7%	91.4%	88.9%	79.8%	77.0%	77.0%	
625	Diagnostic Results Acknowledgement	12.5%	13.1%	14.7%	13.6%	13.3%	13.9%	13.7%	12.3%	13.1%	12.3%	12.0%	12.4%	12.5%	13.0%	13.0%	

Workforce

Business Intelligence Unit
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Key Metrics - IPR Summary

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

Trust (100)

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CQC level of inquiry: Well Led																	
Staff Training & CPD																	
715	% appraisals up to date - Combined						44.47%	49.25%	55.66%	70.05%	73.21%	74.74%	75.29%	90.00%			
721	Statutory & Mandatory Training			84.57%	84.57%	83.47%	83.47%	82.09%	82.72%	84.18%	84.18%	85.55%	85.92%	90.00%			
Staffing Capacity																	
875	Voluntary Turnover %	13.8%	13.8%	13.8%	13.5%	13.3%	13.1%	12.6%	11.9%	11.8%	11.7%	11.5%	11.4%	14.0%			
732	Vacancy Rate %	11.51%	11.01%	12.83%	12.87%	13.97%	14.29%	15.16%	13.89%	14.19%	11.67%	10.78%	10.28%	10.00%			
Efficiency																	
743	Monthly Sickness Rate	3.90%	6.89%	9.98%	5.40%	3.89%	3.66%	3.46%	3.71%	3.83%	3.99%	4.55%	7.14%	3.50%			

Finance

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Overall (000s)																	
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Medical Bank																	
1095	Variance - Medical Bank			(944)	(1,857)	(796)	(1,548)	(1,356)	(1,331)	(2,034)	(1,022)	(1,728)	(1,171)	0	(13,787)	(13,787)	
Medical Substantive																	
599	Variance - Medical Substantive			1,081	303	1,178	1,357	1,877	1,011	1,936	1,252	691	2,095	0	12,781	12,781	
Nursing Agency																	
603	Variance - Nursing Agency			(473)	(417)	(407)	(666)	(583)	(810)	(836)	(676)	(622)	(430)	0	(5,920)	(5,920)	
Nursing Bank																	
1104	Variance - Nursing Bank			(2,442)	(2,116)	(2,003)	(1,645)	(2,194)	(2,659)	(2,496)	(2,942)	(2,861)	(3,274)	0	(24,631)	(24,631)	
Nursing Substantive																	
606	Variance - Nursing Substantive			3,344	2,624	1,684	2,474	3,281	3,656	2,661	3,117	2,615	2,722	0	28,179	28,179	

Business Intelligence Unit
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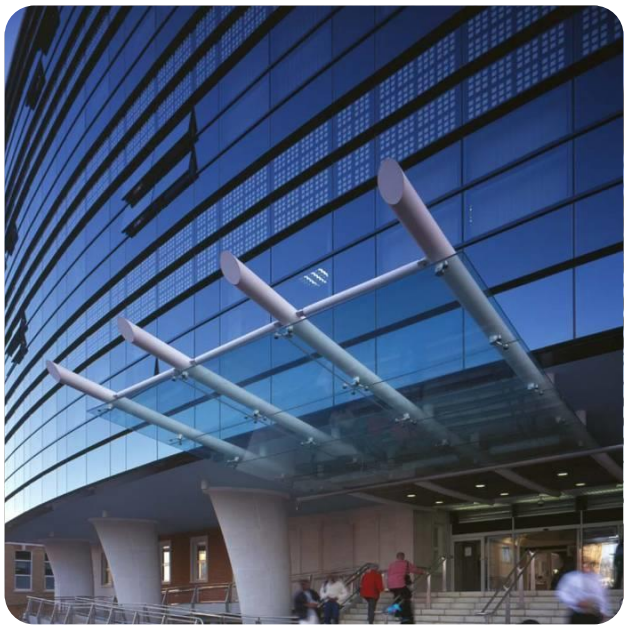
Created date: October 2019

Month 10 Finance Report

Trust Board

11 March 2021



KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Summary of Year to Date Financial Position – M10

As at month 10, the Trust has recorded an operating surplus of £12.6m in-month and a surplus of £5.7m YTD.

Trust Summary	Last Year	Annual	Last Months	Current Month				Year to Date			
	Outturn	Budget	M9	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income (income)	1,263.3	1,214.9	119.8	103.6	101.5	121.7	20.2	1,005.6	1,011.9	1,196.1	184.2
Employee Operating Expenses (pay)	(753.7)	(756.4)	(67.6)	(61.3)	(62.7)	(66.5)	(3.8)	(599.9)	(631.4)	(656.8)	(25.4)
Operating Expenses (non-pay)	(580.8)	(603.4)	(57.0)	(51.3)	(50.5)	(41.4)	9.1	(496.6)	(511.5)	(521.4)	(9.8)
Non Operating Expenses (financing)	(47.5)	(33.0)	(3.6)	(4.0)	(2.8)	(3.3)	(0.6)	(39.2)	(27.5)	(33.1)	(5.5)
Trust Total	**(118.7)**	**(178.0)**	**(8.4)**	**(13.0)**	**(14.5)**	**10.5**	**25.0**	**(130.2)**	**(158.6)**	**(15.1)**	**143.4**
Less Depr, Impairment	(34.3)	22.9	2.7	1.9	1.9	2.1	(0.2)	(8.8)	19.1	20.8	(1.8)
Trust operating Total	**(153.0)**	**(155.1)**	**(5.7)**	**(15.3)**	**(12.6)**	**12.6**	**24.8**	**(139.0)**	**(139.5)**	**5.7**	**141.7**

*Clinical Income for 2020-21 is now on a block contract due to COVID. ** Last year outturn excludes consolidation of KFM, KCS and Viapath. This is included in YTD figure. *A glossary is available. Please refer to appendix 2.

- For the first 6 months of 2020/21 the Trust was provided with retrospective top up funding to help the Trust reach a broadly break even position. For months 7-12, funding arrangements have moved to a system block with the Trust receiving a block income of £107.6m each month until the end of this financial year. This income is sufficient to achieve breakeven for the last 6 months of the year based on the month 5 forecast submitted to the ICS.

- The Trust has been seeing an underlying deficit £4-5m each month over the last 3 months and this continued in-month. However in addition to this, the Trust had a number of non-recurrent benefits as a result of COVID and following a review of prior year provisions. The majority of these provisions now released were included in the month 7 forecast. A summary of movements is provided below.

Category	£m	Key Drivers
Operating income (Income)	1.9	Viapath patient testing income of £3.7m YTD has been provided for here. This is an increase of £1.7m from last month (£2.0m), based the number of patient tests carried out. To be reclaimed from NHSE.
Employee operating expenses (Pay)	1.1	Last month we recorded £0.6m for retrospective shift payments and £0.5m relating to the ARC Project. This month the pay position has normalised, hence this favourable movement.
Operating expenses (non-pay)	15.6	A number of non-recurrent benefits have been recognised here this month. In summary these include: ❑ KFM - £2.6m improvement in the Profit Share recorded as a result of COVID & reduced electives. ❑ KHP Royal Brompton Contribution - £2.3m released following GSTT merger with Royal Brompton. ❑ NHS Resolution revision to schedules has resulted in a non-recurrent £2.7m benefit this year. ❑ HEE Funding for training - £0.7m released as not expected to materialise following lockdown. ❑ Viapath legal provisions carried forward from last year - £5.5m released as this will now not materialise. ❑ R&D £1m improvement on position following a prudent provision of £0.5m provided last month for expected consultancy costs. It now transpires this is not required.
Non operating expenses (financing)	0.3	A small loss on asset disposal of £0.2m non-recurrent was recognised last month. The position has now normalised this month.

- Pay is 9.5% (£56.9m) more than the 19/20 YTD figure (c.5% relates to inflation and COVID costs this year). The remainder relates to recruitment to business cases and vacancies. Please refer to appendix 1.2 for details.

Year to Date - Pay run rate

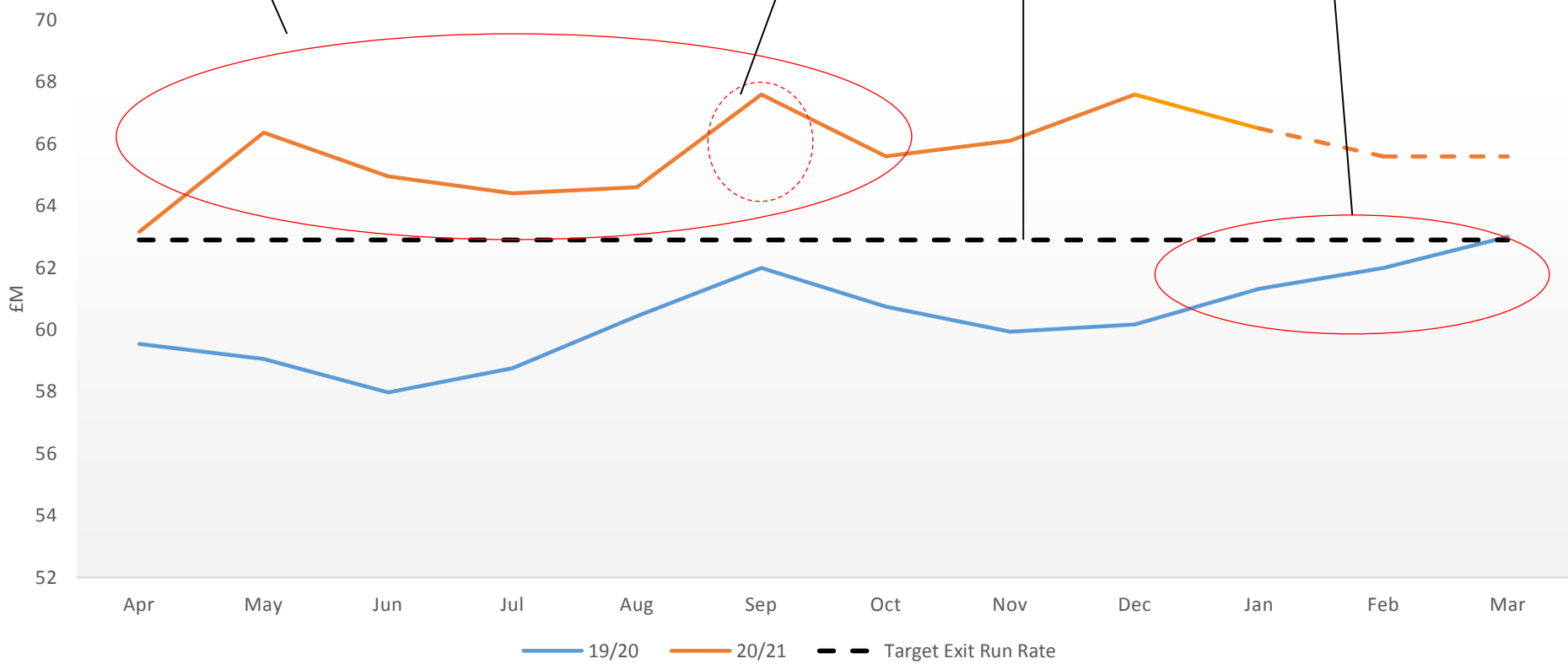
The Trust is expecting to exit 2020/21 with an exit run rate of £155m as per our pre-COVID control total. Within this financial envelope, the Trust has a planned pay budget of £754m.

Pay has increased by 9.5% compared to months 8-10. Partially due to COVID but also due to recruitment to 19/20 business cases. For the first 10 months, pay is showing an increase of £59.9m (excluding COVID and Inflation) compared to last year*.

Budgeted pay level with investments offset by cost savings.

£1.7m Medical Pay Awards paid in M06 covering April to September 2020.

Steady increase in pay from Dec 2019 to March 2020 relates to impact of ACU & AMU (£0.9m), additional ED shifts (£1.1m) and escalation areas at DH (£1.1m) and PRUH (£0.4m). Only Quebec ward was expected to continue post March in pre COVID plan.



*Please refer to appendix 1.2 for further details on current month actuals.

Month 10 – Detail (1/3) - Income

	Last Year	Annual	Last Months	Current Month				Year to Date			
	Outturn	Budget	M9	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
NHS England	481.8	495.7	40.9	38.4	41.3	41.1	(0.2)	392.2	413.1	494.5	81.4
Clinical Commissioning Groups	569.7	566.8	69.9	43.5	47.2	72.8	25.6	467.3	472.3	570.6	98.3
NHS Foundation Trusts	0.2	0.1	0.0	0.0	0.0	0.0	(0.0)	0.1	0.1	(0.0)	(0.1)
NHS Trusts	1.2	0.9	0.2	0.4	0.1	0.0	(0.1)	1.3	0.7	0.7	0.0
Local Authorities	4.1	4.0	0.3	0.5	0.3	0.2	(0.1)	3.4	3.3	2.9	(0.4)
NHS Other (Including Public Health England)	30.1	1.8	0.3	0.6	0.1	0.5	0.4	2.1	1.5	2.7	1.2
Non NHS: Private Patients	18.9	20.0	0.4	2.1	1.7	0.7	(1.0)	17.4	16.7	5.2	(11.5)
Non-NHS: Overseas Patients	4.8	4.6	0.2	1.1	0.4	0.2	(0.1)	4.5	3.8	4.2	0.4
Injury Cost Recovery Scheme	4.0	3.7	0.3	0.3	0.3	0.2	(0.1)	3.1	3.0	2.9	(0.1)
Operating Income From Patient Care Activities (1)	1,114.7	1,097.6	112.4	86.9	91.5	115.9	24.4	891.5	914.7	1,083.9	169.2
Research and Development	16.4	15.3	1.4	1.3	1.3	1.2	(0.1)	13.9	12.8	15.5	2.7
Education and Training	43.4	41.4	3.8	3.0	3.5	3.6	0.2	34.3	34.4	36.3	1.8
Cash Donations/Grants Purchase Capital Assets	1.4	2.0	(0.6)	0.1	0.2	0.0	(0.2)	1.0	1.7	0.0	(1.7)
Charitable and Other Contributions To Expenditure	0.1	0.1	0.0	(0.0)	0.0	0.0	(0.0)	0.1	0.1	0.1	0.0
Non-Patient Care Services To Other Non Wga	3.0	2.5	0.3	0.3	0.2	0.3	0.1	2.4	2.1	2.7	0.6
PSF, FRF, MRET funding and Top-Up	37.0	0.0	35.1	4.3	0.0	0.0	0.0	28.4	0.0	35.1	35.1
Income In Respect Of Employee Benefits Accounted On A Gross Basis	8.5	8.1	0.5	0.6	0.7	0.8	0.1	7.0	6.7	7.1	0.4
Rental Revenue From Operating Leases	1.2	1.1	0.1	0.1	0.1	0.1	(0.0)	0.8	0.9	0.8	(0.1)
Other (Operating Income)	37.6	46.8	(33.1)	6.9	4.1	(0.1)	(4.3)	26.1	38.6	14.7	(23.9)
Other Operating Income (2)	148.5	117.3	7.4	16.6	10.1	5.9	(4.2)	114.1	97.2	112.2	15.0
Operating Income	1,263.3	1,214.9	119.8	103.6	101.5	121.7	20.2	1,005.6	1,011.9	1,196.1	184.2

(1) **Operating Income from Patient Care Activities – £3.5m improvement from last month**

For months 7-12, the Trusts funding arrangements have moved to a system block income of £107.6m each month until the end of this financial year. This includes a system top of £15m and a £5m COVID top up each month.

NHS England (NHSE) and Clinical Commissioning Groups (CCG) income amounts to £109m. This is largely made up of system block (£107m) and £1m each month for NHSE drugs.

CCG income includes a £3.7m provision for Viapath patient testing to be reclaimed from NHSE. This is an increase of £1.7m compared to last month (£2m).

An increase of £1.3m has been recorded for pass-through drugs following a £2.3m catch up in Homecare drugs recorded as part of expenditure this month.

A further £0.3m has been recorded for overseas following successful recouping of monies from an international patient from last year.

(2) **Other Operating Income – £1.9m deterioration from last month**

Last month, a remapping of the NHSE top-up had been applied following updated guidance from NHSE/I. This had impacted Other (Operating Income) and Top-Up funding.

However, the main driver for the adverse movement this month is due to an increase in bad debt provisions c£1.1m.

Other (Operating Income); included here are income streams relating to NHS provider to provider activity such as breast screening, imagining, dental and ophthalmology.

Month 10 – Detail (2/3) - Pay

Pay is 9.5% (£56.9m) more than the 19/20 YTD figure (c.5% relates to inflation and COVID costs this year). The remainder relates to recruitment to business cases and vacancies.

	Last Year	Annual	Last Months	Current Month				Year to Date			
	Outturn	Budget	M9	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff	(215.5)	(242.2)	(19.7)	(17.8)	(20.6)	(18.5)	2.1	(178.4)	(201.8)	(189.0)	12.8
Bank Staff	(9.8)	(0.3)	(1.8)	(1.0)	(0.0)	(1.2)	(1.2)	(6.8)	(0.3)	(14.0)	(13.8)
Agency / Contract	(6.0)	(1.6)	(0.8)	(0.6)	(0.1)	(0.6)	(0.5)	(5.9)	(1.3)	(6.3)	(4.9)
Medical Staff 1	(231.2)	(244.1)	(22.2)	(19.5)	(20.7)	(20.3)	0.5	(191.1)	(203.4)	(209.3)	(5.9)
Substantive Staff	(256.8)	(306.7)	(22.9)	(21.6)	(25.9)	(23.1)	2.7	(214.3)	(255.5)	(227.3)	28.2
Bank Staff	(32.7)	(7.5)	(3.5)	(3.0)	(0.6)	(3.9)	(3.3)	(25.8)	(6.2)	(30.9)	(24.6)
Agency / Contract	(6.1)	(1.1)	(0.7)	(0.6)	(0.1)	(0.5)	(0.4)	(4.6)	(0.9)	(6.9)	(5.9)
Nursing Staff 2	(295.7)	(315.3)	(27.2)	(25.3)	(26.6)	(27.6)	(1.0)	(244.7)	(262.6)	(265.0)	(2.4)
Substantive Staff	(133.4)	(95.5)	(9.5)	(8.7)	(6.9)	(9.8)	(2.9)	(86.5)	(80.8)	(96.7)	(15.8)
Bank Staff	(3.5)	(0.4)	(0.5)	(0.3)	(0.0)	(0.2)	(0.1)	(2.8)	(0.3)	(2.9)	(2.6)
Agency / Contract	(2.7)	0.0	(0.2)	(0.1)	0.0	(0.4)	(0.4)	(2.6)	0.0	(1.8)	(1.8)
Admin & Clerical	(139.6)	(95.8)	(10.1)	(9.1)	(6.9)	(10.3)	(3.4)	(91.9)	(81.2)	(101.4)	(20.2)
Substantive Staff	(82.2)	(100.1)	(7.7)	(7.0)	(8.4)	(7.9)	0.4	(67.9)	(83.4)	(76.0)	7.4
Bank Staff	(2.1)	(0.0)	(0.2)	(0.2)	(0.0)	(0.1)	(0.1)	(1.6)	(0.0)	(1.7)	(1.7)
Agency / Contract	(2.9)	(1.0)	(0.2)	(0.3)	(0.1)	(0.3)	(0.2)	(2.8)	(0.8)	(3.4)	(2.5)
Other Staff	(87.2)	(101.2)	(8.2)	(7.5)	(8.5)	(8.4)	0.1	(72.3)	(84.2)	(81.1)	3.2
Employee Operating Expenses	(753.7)	(756.4)	(67.6)	(61.3)	(62.7)	(66.5)	(3.8)	(599.9)	(631.4)	(656.8)	(25.4)

1 **Medical Staff – £1.9m improvement from last month**

Last month's movement was caused by retrospective payments of shifts worked from prior months (£0.6m). This fluctuates monthly due to when shifts are approved. There was also an increase of £0.5m relating to R&D ARC project, put in prudently whilst being investigated.

It transpired that this £0.5m for R&D was not required and has been reversed out this month resulting in £1m favourable movement. The remainder of this favourable movement is due to normalisation of shift payments.

2 **Nursing Staff – £0.4m deterioration from last month**

Recruitment of nurses, particularly in CCU, resulted in an increase this month as some double running is expected. Some additional COVID related costs are also filtering through in addition to payments for bank holiday cover.

Month 10 – Detail (3/3) – Non Pay

	Last Year	Annual	Last Months	Current Month				Year to Date			
	Outturn	Budget	M9	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	(12.3)	(16.5)	(2.9)	(0.9)	(1.4)	1.8	3.1	(13.1)	(13.8)	(9.4)	4.4
Purchase Of Healthcare From Non-NHS Bodies (1)	(178.1)	(173.8)	(15.2)	(15.7)	(14.4)	(15.2)	(0.7)	(136.8)	(144.3)	(145.2)	(0.9)
Supplies and Services - Clinical (Excluding Drugs Costs)	(14.9)	(22.8)	(1.5)	(2.1)	(1.9)	(0.9)	1.0	(15.2)	(19.0)	(14.3)	4.7
Supplies and Services - General	(0.9)	(1.6)	(0.1)	(0.2)	(0.1)	(0.1)	0.1	(1.3)	(1.3)	(1.1)	0.2
Drugs Costs (2)	(149.5)	(154.0)	(12.5)	(11.4)	(12.8)	(14.7)	(1.9)	(126.0)	(128.4)	(125.9)	2.5
Consultancy (3)	(8.9)	(2.8)	(0.7)	(0.3)	(0.3)	5.9	6.2	(3.7)	(2.4)	2.9	5.2
Establishment	(6.9)	(8.4)	(0.6)	(0.9)	(0.7)	(0.2)	0.5	(6.2)	(7.1)	(7.1)	(0.1)
Premises - Business Rates Payable To Local Authorities	(4.2)	(4.7)	(0.5)	(0.4)	(0.5)	(0.5)	(0.0)	(4.5)	(4.7)	(4.6)	0.1
Premises - Other	(100.9)	(103.5)	(9.7)	(8.5)	(8.6)	(6.4)	2.2	(83.4)	(86.2)	(85.8)	0.4
Transport	(10.0)	(9.8)	(1.2)	(0.8)	(0.8)	(0.8)	(0.0)	(8.1)	(8.2)	(9.4)	(1.3)
Depreciation	(25.8)	(27.0)	(2.3)	(2.2)	(2.3)	(2.3)	(0.1)	(21.5)	(22.5)	(23.3)	(0.8)
Increase/(Decrease) In Impairment Of Receivables	(3.1)	(28.2)	(2.4)	(2.3)	(2.3)	(2.3)	0.1	(18.4)	(23.5)	(25.0)	(1.5)
Audit Fees and Other Auditor Remuneration	(0.3)	(0.3)	(0.0)	(0.1)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	(0.3)	(0.0)
Clinical Negligence	(37.7)	(45.7)	(4.6)	(4.0)	(4.6)	(2.7)	1.9	(37.7)	(45.7)	(43.8)	1.9
Research and Development - Non-Staff		(2.5)	(0.1)		(0.2)	(0.0)	0.2		(2.1)	(0.5)	1.7
Education and Training - Non-Staff (4)	(2.4)	(5.6)	(0.4)	(0.3)	(0.5)	(0.5)	0.0	(2.2)	(4.7)	(4.1)	0.6
Other	(24.7)	4.0	(2.3)	(1.5)	1.0	(2.5)	(3.4)	(18.1)	2.5	(24.4)	(26.9)
Operating Expenses Excluding Employee Expenses	(580.8)	(603.4)	(57.0)	(51.3)	(50.5)	(41.4)	9.1	(496.6)	(511.5)	(521.4)	(9.8)
Operating Expenses Excluding Employee Expenses	(580.8)	(603.4)	(57.0)	(51.3)	(50.5)	(41.4)	9.1	(496.6)	(511.5)	(521.4)	(9.8)

(1)

Purchase of Healthcare – £4.7m improvement from last month

Here we have costs associated with the Trusts outsourcing of services from Commercial and Independent sector and other Foundation Trusts.

Following the merger of GSTT and Royal Brompton Trusts, a £2.3m KHP contribution carried forward from last year has now been released following confirmation of this being no longer required. A non-recurrent benefit this month.

The rest of this favourable movement is caused by last month adding back a £1m QMS Pharmacy provision (having previously been released), and £0.7m for Hurley Group was added, due to receipt of delayed invoices.

(2)

Drug costs – £2.2m deterioration from last month

Here we have the costs for pass through (high cost) and on tariff drugs. The adverse movement this month is caused by a catch up in Homecare invoicing, £2.3m. Further income has been provided against this.

(3)

Consultancy – £6.6m improvement from last month

The £5.5m improvement relates to releasing prior year provisions for Viapath legal challenges that will now not materialise. This is a one-off benefit in-month.

The rest of the favourable movement from last month is a result of releasing a £0.5m provision relating to R&D ARC project that is no longer required.

(4)

Premises Other – £3.3m improvement from last month

Here we have costs relating to KFM profit share, PFI, building maintenance, rent and utilities.

A £2.6m increase in the KFM profit share has been recorded this month following reduced elective activity.

In addition, a release of £1m radiology outsourcing provision has been recognised here following reconciliation with current supplier statements. This has been noted as an in-month one–off benefit.

Appendices

Appendix 1.1 – Run Rate Detail - Income

Run Rate - current month actuals	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
NHS England	55.1	55.8	55.4	55.4	55.4	55.4	39.4	40.6	40.9	41.1	494.5
Clinical Commissioning Groups	47.9	48.7	48.3	47.9	50.0	47.9	68.9	68.4	69.9	72.8	570.6
NHS Foundation Trusts	0.0	(0.1)	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	(0.0)
NHS Trusts	0.1	0.1	0.0	0.1	0.0	0.1	0.1	0.1	0.2	0.0	0.7
Local Authorities	0.2	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.2	2.9
NHS Other (Including Public Health England)	0.1	0.1	0.1	0.1	0.6	0.4	0.4	0.1	0.3	0.5	2.7
Non NHS: Private Patients	0.6	0.4	0.4	0.7	0.9	0.4	0.3	0.4	0.4	0.7	5.2
Non-NHS: Overseas Patients	0.3	0.4	0.7	0.4	0.6	0.6	0.4	0.6	0.2	0.2	4.2
Injury Cost Recovery Scheme	0.3	0.3	0.4	0.3	0.3	0.2	0.3	0.3	0.3	0.2	2.9
Operating Income From Patient Care Activities	**104.5**	**106.0**	**105.6**	**105.1**	**108.1**	**105.3**	**110.2**	**110.8**	**112.4**	**115.9**	**1,083.9**
Research and Development	2.3	1.2	2.9	1.3	1.6	1.5	0.8	1.3	1.4	1.2	15.5
Education and Training	3.4	3.9	4.2	4.2	2.8	1.4	3.2	5.8	3.8	3.6	36.3
Cash Donations / Grants For The Purchase Of Capital Assets	0.6	(0.6)	0.0	0.0	(0.0)	0.0	0.0	0.6	(0.6)	0.0	0.0
Charitable and Other Contributions To Expenditure	(0.0)	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Non-Patient Care Services To Other Non Wga Bodies	0.2	0.3	0.3	0.3	0.2	0.2	0.2	0.4	0.3	0.3	2.7
PSF, FRF, MRET funding and Top-Up									35.1	0.0	35.1
Income In Respect Of Employee Benefits	0.4	1.0	0.5	0.6	1.1	0.7	1.0	0.6	0.5	0.8	7.1
Rental Revenue From Operating Leases	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.8
Other (Operating Income)	1.4	10.7	4.3	7.1	3.1	17.9	3.6	(0.1)	(33.1)	(0.1)	14.7
Other Operating Income	**8.4**	**16.5**	**12.3**	**13.5**	**8.9**	**21.7**	**8.9**	**8.8**	**7.4**	**5.9**	**112.2**
Operating Income	**112.8**	**122.5**	**117.9**	**118.6**	**117.0**	**127.0**	**119.1**	**119.5**	**119.8**	**121.7**	**1,196.1**

Appendix 1.2 – Run Rate Detail - Pay

Run Rate - current month actuals	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff	(18.5)	(19.3)	(18.4)	(18.3)	(18.4)	(20.5)	(18.3)	(19.2)	(19.7)	(18.5)	(189.0)
Bank Staff	(1.0)	(1.9)	(0.8)	(1.5)	(1.4)	(1.4)	(2.1)	(1.0)	(1.8)	(1.2)	(14.0)
Agency / Contract	(0.5)	(0.5)	(0.4)	(0.5)	(0.5)	(0.7)	(0.9)	(1.0)	(0.8)	(0.6)	(6.3)
Medical Staff	**(20.0)**	**(21.7)**	**(19.6)**	**(20.3)**	**(20.2)**	**(22.5)**	**(21.3)**	**(21.2)**	**(22.2)**	**(20.3)**	**(209.3)**
Substantive Staff	(22.1)	(22.8)	(23.8)	(23.1)	(22.4)	(22.0)	(22.7)	(22.5)	(22.9)	(23.1)	(227.3)
Bank Staff	(3.0)	(2.8)	(2.6)	(2.3)	(2.8)	(3.3)	(3.1)	(3.6)	(3.5)	(3.9)	(30.9)
Agency / Contract	(0.6)	(0.5)	(0.5)	(0.8)	(0.7)	(0.9)	(0.9)	(0.8)	(0.7)	(0.5)	(6.9)
Nursing Staff	**(25.6)**	**(26.1)**	**(26.9)**	**(26.1)**	**(25.8)**	**(26.2)**	**(26.7)**	**(26.8)**	**(27.2)**	**(27.6)**	**(265.0)**
Substantive Staff	(9.5)	(9.2)	(9.6)	(9.5)	(10.2)	(10.1)	(9.7)	(9.6)	(9.5)	(9.8)	(96.7)
Bank Staff	(0.3)	(0.4)	(0.4)	(0.3)	(0.3)	(0.5)	(0.1)	0.0	(0.5)	(0.2)	(2.9)
Agency / Contract	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.2)	(0.0)	(0.3)	(0.2)	(0.4)	(1.8)
Admin & Clerical	**(9.9)**	**(9.8)**	**(10.1)**	**(9.9)**	**(10.7)**	**(10.8)**	**(9.8)**	**(9.8)**	**(10.1)**	**(10.3)**	**(101.4)**
Substantive Staff	(7.1)	(7.9)	(7.8)	(7.4)	(7.4)	(7.5)	(7.5)	(7.7)	(7.7)	(7.9)	(76.0)
Bank Staff	(0.1)	(0.2)	(0.2)	(0.2)	(0.2)	(0.3)	(0.1)	(0.1)	(0.2)	(0.1)	(1.7)
Agency / Contract	(0.5)	(0.6)	(0.3)	(0.4)	(0.2)	(0.3)	(0.2)	(0.3)	(0.2)	(0.3)	(3.4)
Other Staff	**(7.6)**	**(8.7)**	**(8.3)**	**(8.1)**	**(7.8)**	**(8.1)**	**(7.8)**	**(8.1)**	**(8.2)**	**(8.4)**	**(81.1)**
Employee Operating Expenses	**(63.2)**	**(66.4)**	**(65.0)**	**(64.4)**	**(64.6)**	**(67.6)**	**(65.6)**	**(66.0)**	**(67.6)**	**(66.5)**	**(656.8)**

Appendix 1.3 – Run Rate Detail – Non Pay

Run Rate - current month actuals	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Purchase Of Healthcare From NHS Bodies	(1.2)	(1.2)	(1.3)	(1.3)	(1.2)	(1.2)	(1.1)	0.4	(2.9)	1.8	(9.4)
Purchase Of Healthcare From Non-NHS Bodies	(14.0)	(14.8)	(14.2)	(13.8)	(14.2)	(14.3)	(15.1)	(14.5)	(15.2)	(15.2)	(145.2)
Supplies and Services - Clinical (Excluding Drugs Costs)	(3.0)	(0.3)	(1.3)	(1.6)	(1.8)	(1.7)	(0.5)	(1.8)	(1.5)	(0.9)	(14.3)
Supplies and Services - General	(0.2)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.1)	(0.2)	(0.1)	(0.1)	(1.1)
Drugs Costs	(12.6)	(10.3)	(11.5)	(13.3)	(12.0)	(13.1)	(12.7)	(13.2)	(12.5)	(14.7)	(125.9)
Consultancy	(0.3)	(0.6)	0.0	(0.2)	(0.0)	(0.5)	(0.5)	(0.2)	(0.7)	5.9	2.9
Establishment	(1.0)	(0.7)	(0.9)	(0.8)	(0.7)	(0.8)	(0.6)	(0.9)	(0.6)	(0.2)	(7.1)
Premises - Business Rates Payable To Local Authorities	(0.4)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(0.5)	(4.6)
Premises - Other	(5.3)	(4.7)	(5.8)	(9.8)	(15.6)	(10.2)	(11.8)	(6.4)	(9.7)	(6.4)	(85.8)
Transport	(0.8)	(1.0)	(1.0)	(0.8)	(0.6)	(1.5)	(0.8)	(1.0)	(1.2)	(0.8)	(9.4)
Depreciation	(2.2)	(2.5)	(2.4)	(2.4)	(2.4)	(2.4)	(2.4)	(2.1)	(2.3)	(2.3)	(23.3)
Increase/(Decrease) In Impairment Of Receivables	(0.3)	(4.6)	(2.4)	(2.5)	(2.4)	(2.4)	(2.6)	(3.1)	(2.4)	(2.3)	(25.0)
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)
Clinical Negligence	(4.5)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.6)	(4.5)	(4.6)	(2.7)	(43.8)
Research and Development - Non-Staff	(0.0)	(0.1)	(0.1)	0.0	0.0	(0.1)	0.0	(0.0)	(0.1)	(0.0)	(0.5)
Education and Training - Non-Staff	(0.4)	(0.5)	(0.5)	(0.4)	(0.4)	(0.4)	(0.2)	(0.5)	(0.4)	(0.5)	(4.1)
Other	(4.5)	(4.9)	(4.5)	0.0	4.9	(6.8)	0.2	(4.0)	(2.3)	(2.5)	(24.4)
Operating Expenses Excluding Employee Expenses	**(50.7)**	**(51.4)**	**(51.0)**	**(52.0)**	**(51.6)**	**(60.5)**	**(53.1)**	**(52.6)**	**(57.0)**	**(41.4)**	**(521.4)**
Operating Expenses Excluding Employee Expenses	**(50.7)**	**(51.4)**	**(51.0)**	**(52.0)**	**(51.6)**	**(60.5)**	**(53.1)**	**(52.6)**	**(57.0)**	**(41.4)**	**(521.4)**
Finance Expense	(4.0)	(4.1)	(4.1)	(4.4)	(4.1)	0.3	(2.2)	(3.9)	(3.4)	(3.3)	(33.1)
Gains/(Losses) On Disposal Of Assets	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	0.0	0.0
Non Operating Expenses	**(3.7)**	**(4.1)**	**(4.1)**	**(4.4)**	**(4.1)**	**0.3**	**(2.2)**	**(3.9)**	**(3.6)**	**(3.3)**	**(33.1)**
Non Operating Expenses	**(3.7)**	**(4.1)**	**(4.1)**	**(4.4)**	**(4.1)**	**0.3**	**(2.2)**	**(3.9)**	**(3.6)**	**(3.3)**	**(33.1)**
TRUST TOTAL (deficit per ledger)	**(4.8)**	**0.6**	**(2.1)**	**(2.1)**	**(3.4)**	**(0.8)**	**(1.8)**	**(2.9)**	**(8.4)**	**10.5**	**(15.1)**
Less Depr On Donated Assets	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.9
Less Donated Assets Income	(0.6)	0.6	0.0	(0.0)	0.0	0.0	(0.0)	(0.6)	0.6	(0.0)	(0.0)
Less Fixed Asset Impairments	0.0	4.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	20.0
STF Total:	**(0.5)**	**4.7**	**2.1**	**2.1**	**2.1**	**2.1**	**2.1**	**1.5**	**2.7**	**2.1**	**20.8**
OPERATING DEFICIT (excluding STF)	**(5.3)**	**5.3**	**0.0**	**(0.0)**	**(1.3)**	**1.3**	**0.3**	**(1.5)**	**(5.7)**	**12.6**	**5.7**

Appendix 2.0 – Glossary

Glossary of Terms

OLD (Aptos)		NEW (NEP Oracle)	
FOM Type	**FOM Summary**	**NHSI Type**	**NHSI Category**
Income	NHS Clinical Contract Income	Operating Income	Operating Income from Patient Care Activities
	Private Patient & Overseas Income		
	Other Non-NHS Clinical Income		
	Other Operating Income		Other Operating Income
Pay	Medical Staff	Employee Operating Expenses	Medical Staff
	Nursing Staff		Nursing Staff
	Admin & Clerical		Admin & Clerical
	Other Staff		Other Staff
Non Pay	Drugs	Operating Expenses Excluding Employee Expenses	Operating Expenses Excluding Employee Expenses
	Clinical Supplies		
	External Services		
	Other Non-Pay		
	Capital		
Financing	Finance Expense	Non Operating Expenses	
	Gains/(Losses) on Disposal of Assets		
	FOM Lookup		**NHSI Sub Type**
a few examples:	RTA Income		Injury Cost Recovery Scheme
	Salary Recharge		Income In Respect Of Employee Benefits Accounted On A Gross Basis
	Pass Through Drugs Expenditure		Drugs Costs (Drug Inventory Consumed and Purchase Of Non-Inventory Drugs)
	Drugs		
	Other Non-Pay (Bad Debt)		Increase/(Decrease) in Impairment of Receivables

Other: Abbreviations

PSF	Provider Sustainability Fund
FRF	Financial Recovery Fund
MRET	Marginal Rate Emergency Funding

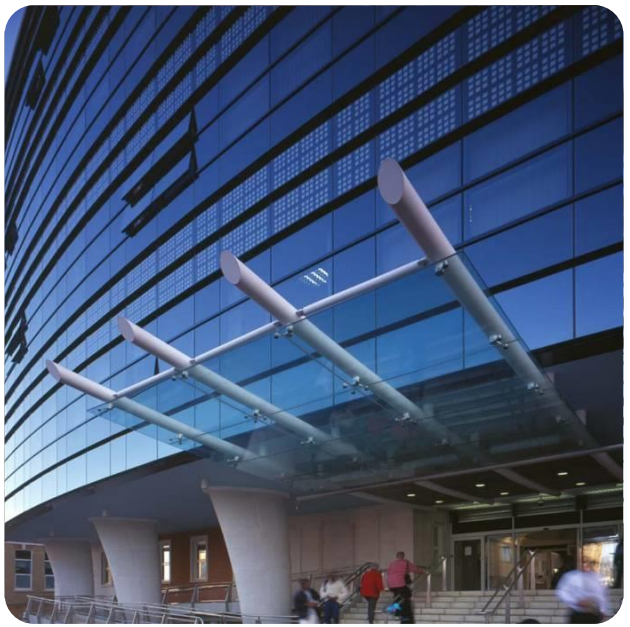
King's College Hospital NHS
NHS Foundation Trust

3 Monthly Safer Staffing Report for Nursing and Midwifery

November 2020 – January 2021

Trust Board February 2021

Nicola Ranger
Chief Nurse



KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

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3 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.

- NHS Improvement's Developing Workforce Safeguards report provides recommendations to support Trusts in making informed, safe and sustainable workforce decisions, and identifies examples of best practice in the NHS, this builds on the National Quality Board's (NQB) guidance. NQB's guidance states that the Trust must deploy sufficient suitably qualified, competent, skilled and experienced staff to meet care and treatment needs safely and effectively (through the use of e-rostering, clinical site management and operational meetings and decisions.)

- The Trust's compliance will be assessed with the 'triangulated approach' to deciding staffing requirements described in NQB's guidance. This combines evidence-based tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time. It is based on patients' needs, acuity, dependency and risks, and as a Trust this should be monitored from ward to board.

- This 3 monthly safer staffing report, for the nursing and midwifery workforce, will provide assurance to the board by outlining trends over the previous 3 month period. This is in line with the recommendations from NHSi's Workforce Safeguards ensuring we are reporting from ward to board.

- Monthly assurance will be monitored through the Trust wide Nursing Midwifery Workforce Governance Group (relaunching post COVID in April 2021.)

Staffing Position

King's College Hospital NHS Foundation Trust

The number of staff required per shift is calculated using an evidence based tool (the Safer Nursing Care Tool, which provides specific multipliers depending on the acuity and dependency levels of 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 which is in line with NICE, NQB and NHSi 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 actual ward staffing levels reported for January 2021 (national CHPPD reporting was ceased for Mar and Apr 20 and again in Nov and Dec 20 due to COVID-19.)

	% 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
Urgent Care, Planned Care and Allied Clinical Services	87%	84%	93%	108%	3.1	2.1	5.3
PRUH and South Sites	88%	88%	86%	98%	3.2	2.4	5.6
Networked Care	87%	88%	94%	120%	6.6	2.2	8.8

- Care staff usage on night shifts was increased in January due to a higher demand for enhanced care/specialling of patients.
- Lower RN/Midwives fill rates are noted due to some clinical areas not achieving planned staffing levels due to vacancies/sickness particularly as a result of COVID-19. Staffing levels are maintained through relocation and redeployment of staff, use of bank staff and where necessary agency staff to ensure safety.

Please note: CHPPD is a metric which reflects the number of hours of total nursing support staff and registered staff versus the number of inpatients at 23:59 (aggregated for the month.) 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 Networked Care due to the amount of critical care beds that are provided in this division.

Red Flags

King's College Hospital NHS
NHS Foundation Trust

In order to be compliant with NHSi's Workforce Safeguards see below our updated Red Flag procedure for nursing within the Trust. The below process has been adhered to from July 20 onwards in line with the next planned focused acuity & dependency collection.

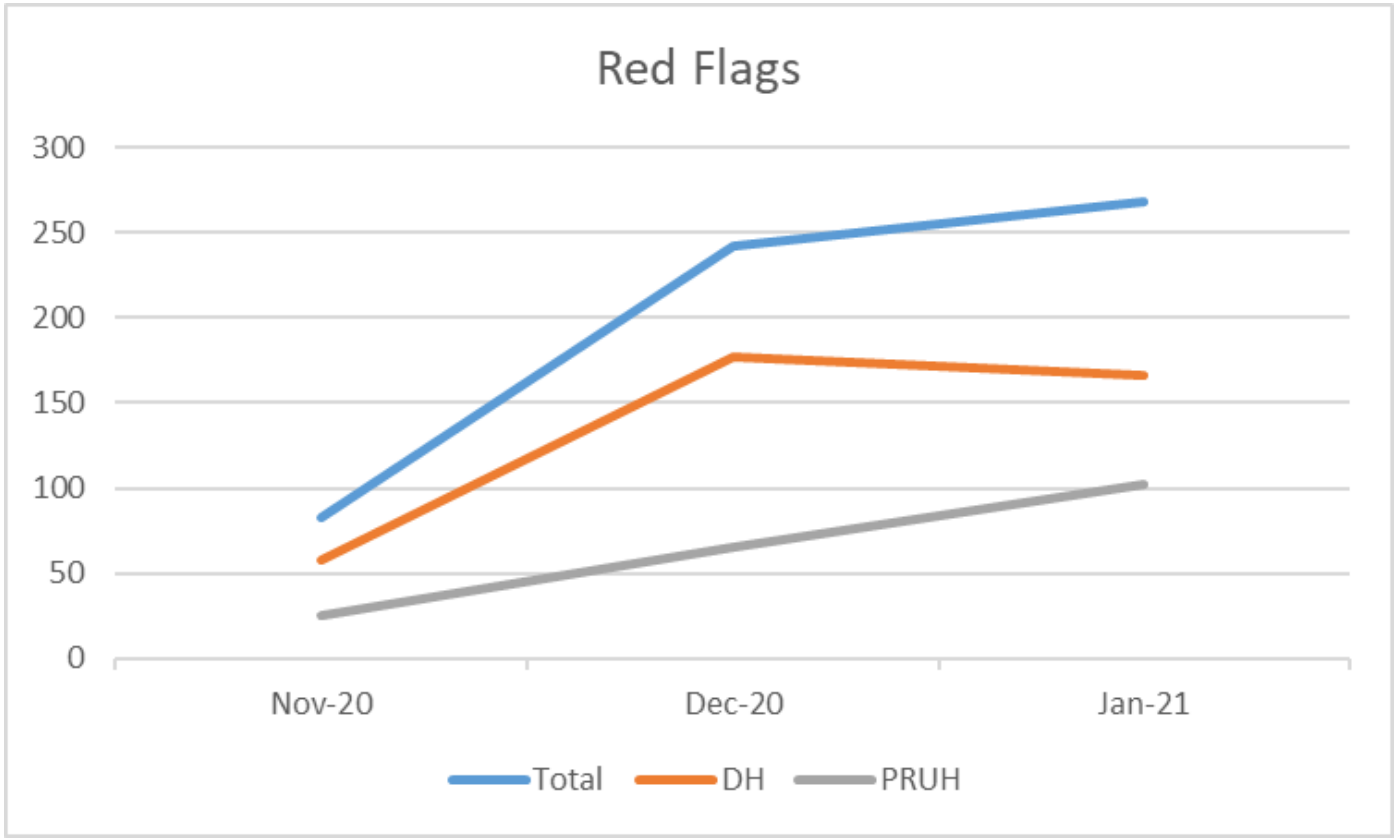
'Staffing' Red Flags	• A shortfall of more than eight hours or 25% (whichever is reached first) of registered nurse time available compared with the actual requirement of the shift • Fewer than two registered nurses present on a ward during any shift
'Patient Safety/ Quality' Red Flags	• Unplanned omission in providing patient medications • Delay of more than 30 minutes in providing pain relief • Patient vital signs not assessed or recorded as outlined in the care plan • Delay or omission of regular checks on patients to ensure that their fundamental care needs are met as outline in the care plan (intentional rounding)

- The purpose of a Red Flag being raised is to identify those times where either essential nursing care has not been delivered, or where there is a risk that the quality of patient care may be impacted. If clinical areas do not have enough nurses on duty with the right skills to safely meet the needs of your ward/unit, they will raise a Red Flag.
- <u>Updated process for raising Red Flags:</u>
  - Ward nurse to inform Matron (in hours) and Clinical Site Manager (out of hours)
  - All Red Flags reported will be reviewed at the time by the senior nurse receiving this information and any mitigating actions taken
  - All Red Flags must be recorded on Datix once the above operational process has been followed and any mitigating actions taken

Red Flags

King's College Hospital NHS
NHS Foundation Trust

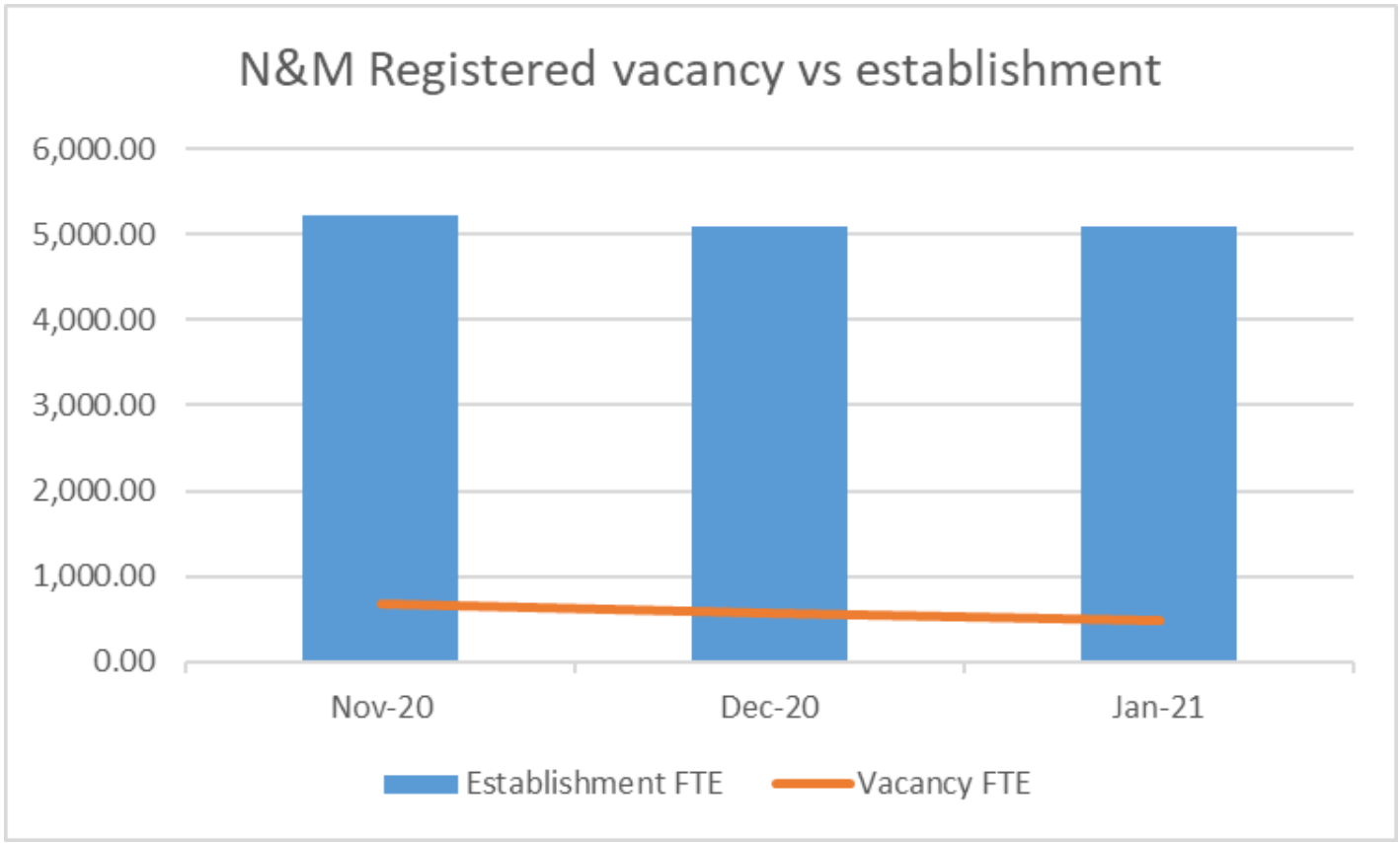
- Twice a day there is a Trust wide red alert issued to senior nursing staff highlighting the location of departments with red flags which in turn enables senior nursing staff to ensure the right staff are in the right place at the right time.
- There is an upward trend in red flags across all sites Nov-20 to Jan-21 this is due to previous underreporting (refresher training has been undertaken with all HoNs, Matrons and Ward Leaders in Sep/Oct-20.) There are also particular staffing challenges at present due to the impact of COVID-19 and staff shielding/isolating.
- Staffing issues mitigated on a daily basis with the site management team, operational matrons and senior nurses to maintain safe nurse to patient staffing levels.
- The graph below outlines the trend for the last 3 months:



Registered N&M Vacancies

King's College Hospital NHS Foundation Trust

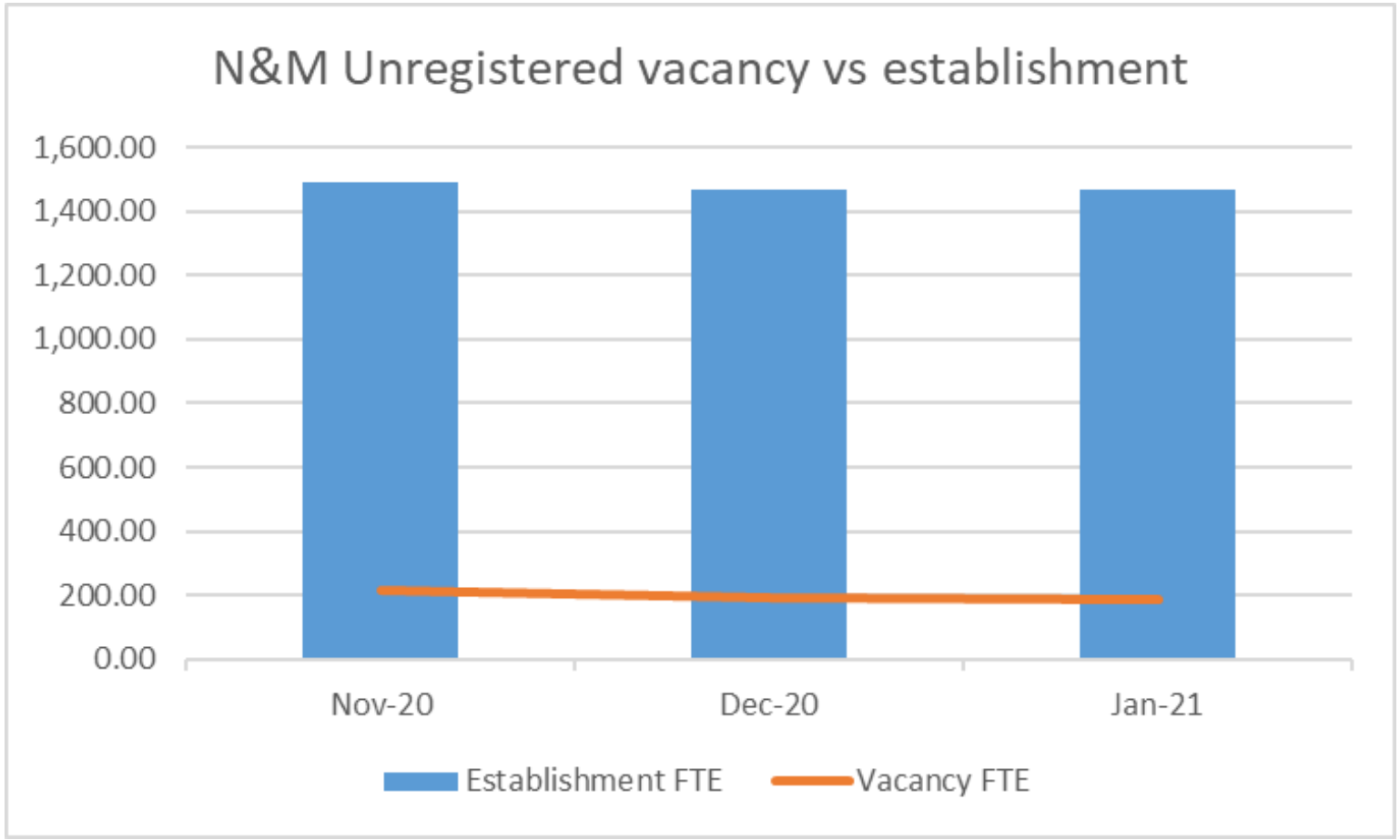
- The current vacancy for January 2021 is 9.39% for registered Nursing and Midwifery staff. The Trust's national N&M recruitment campaign (with TMP) fully launched in Nov 20-Jan 21.
- **Registered vacancies have decreased from Nov-20 to Jan-21:**
  - Due to Covid-19, the Trust's usual international recruitment activity had been temporarily suspended which affected the vacancy rate and will continue to do so until restrictions are fully lifted. However, multiple IEN deployments have been facilitated Nov-20 to Jan-21 with further deployments planned for the coming months.
  - The graph below outlines this position:



HCA & CSW Vacancies

King's College Hospital NHS Foundation Trust

- The current vacancy for January 2021 is 12.77% for all unregistered Nursing and Midwifery staff.
- **There has been a downward trend to unregistered N&M vacancies from Nov-20 to Jan-21:**
  - HCA advertising and recruitment centres have been increased in line with the national drive to reduce Health Care Support Worker vacancies to 0%.
  - The Trust is also actively engaged with pan London widening participation events for new starters into the NHS. The graph below outlines the current position:

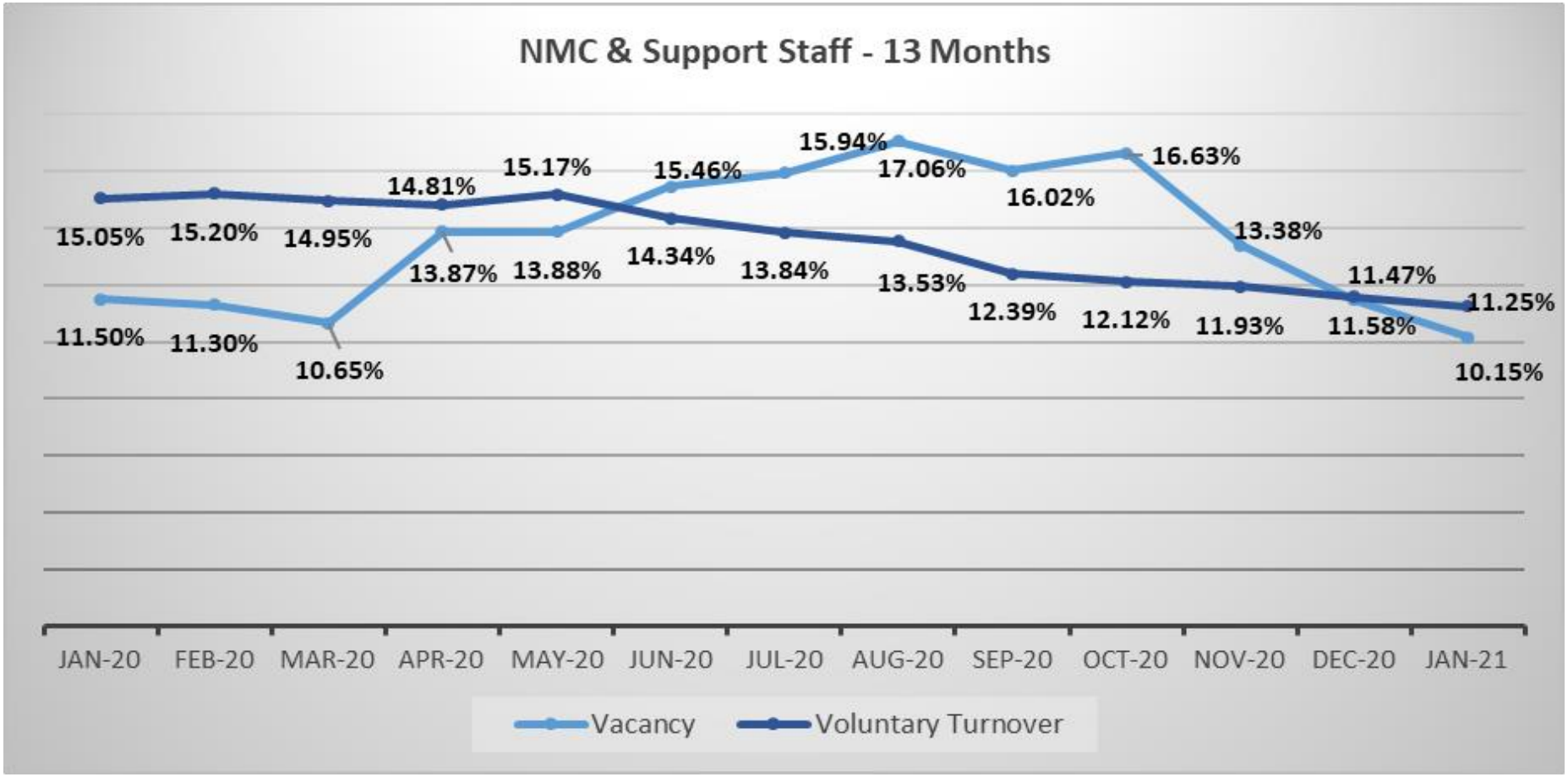


Nursing and Midwifery Turnover

King's College Hospital NHS
NHS Foundation Trust

As of January 2021, the voluntary turnover for registered nursing and midwifery staff is 11.04% and is currently 12.77% for the unregistered workforce. The monthly Trust wide N&M recruitment meeting monitors vacancies alongside care group-specific recruitment and retention work plans with the aim to reduce registered vacancies and total voluntary turnover to 10% by the end of 2021.

The graph below outlines the current position highlighting a reduction in turnover to the lowest value it has been for over a year.



Recruitment Hotspots & Next Steps

King's College Hospital NHS Foundation Trust

The aggregate nursing and midwifery staff vacancy for January 2021 has decreased this month to 10.15%. This is a significant reduction over the last 4 months. The current N&M hotspots are outlined below, plans for these areas are actioned departmentally with support from the divisional recruitment partner and will be flagged at monthly recruitment meetings.

As of January 2021 there are no inpatient areas with an above 30% vacancy rate. Due to some recruitment challenges during the national and international response to COVID-19 there are 4 departments with a total vacancy rate above 20%.

Inpatient area with a vacancy rate above 20% listed below:

- **PRUH**: SCBU (22.51% - this represents 5.80 WTE)
- **DH:** Adult ED (22.27%), Katherine Monk (21.96%), Frank Cooksey Rehab Unit (20.23%)

The Trust wide N&M monthly recruitment meeting considers the pathways to successful recruitment and the key principles of retention. The group supports the Directors of Nursing and Midwifery to lead on identifying, securing and developing a stable workforce for their designated areas:

- Work plans are being reviewed to improve the recruitment and retention of the Nursing and Midwifery staff across the Trust. It is recognised that the Trust has relied heavily on international recruitment and work is underway to review this plus a national recruitment campaign for N&M with TMP Worldwide launched at the end of 2020.
- There are robust divisional-specific recruitment plans to support hot spot areas, local talent pools of HCAs creating a pipeline for each care group plus a number of Bands 2-7 staff currently on-boarding waiting to fill the above vacancies.
- These monthly meetings will have oversight of the Trust's 3-5 year plan for nursing and midwifery (N&M) to enable the senior N&M team, alongside HR/ Workforce colleagues, to forecast for the future workforce by monitoring the pipeline of new starters at both a strategic and ward level.

The Board of Directors are asked to note the information contained in this briefing: the use of the red flag system to highlight concerns raised and the continued focus on recruitment, retention and innovation to support effective workforce utilisation.

Recruitment & Retention Next Steps

King's College Hospital NHS
NHS Foundation Trust

The below points further highlight the key work streams/priorities being focussed on to further improve vacancy and turnover % in N&M. Updates in relation to the below are shared at Nursing and Midwifery Board monthly and at relevant Workforce & Education Trust wide updates.

Target - 10% vacancy RN and 0 WTE HCA vacancies by the end of 2021

Recruitment:

- Increased HCA interview dates continue to support filling vacancies and collaborative working with local job centres to grow our own from the local community
- Workforce transformation: Trainee Nursing Associates (TNA) recruitment in Feb/March for next cohorts
- International nurse recruitment: recent IEN deployments November – 52, December – 35, January – 79, February – 58 planned, March – 26 planned and additional 40 IENs to be deployed by April 2021
- IEN OSCE pass rate: Jan – 86% passed 1st attempt, Feb – 92% passed 1st attempt
- New streamlined recruitment pack (colourful pdf) with welcome letter from Nicola Ranger and the relevant DoN or DoM now used on jobs sites

Target - 10% vacancy RN and HCA turnover by the end of 2021

Retention:

- Flexible working policy review ongoing with HR colleagues
- Departmental Retention meetings: set up with each ward area led by Nicola to listen to the teams and review retention initiatives, ensuring a joined up approach to retention strategy and to discuss flexible working, rostering/self rostering
- Trust wide Retention working group commencing in Feb 2021
- Review of CPD/in-house modules and post grad offer ongoing
- Educational programmes to restart in April 21 (to include Preceptorship and student forums)
- Improved pastoral support for IENs: new high quality accommodation provided for 6 (previously 4) weeks and support packages provided incl food deliveries, laptops and virtual support calls during quarantine period

King's College Hospital NHS Foundation Trust

Report to:	Trust Board
Date of meeting	11th March 2021
Subject:	King's Maternity – Assurance Assessment Tool of the 1st Ockenden Review of Maternity services
Author(s):	Jenny Cleary, Director of Midwifery
Presented by:	Nicola Ranger, Chief Nurse & Executive Director of Maternity
Sponsor:	Nicola Ranger, Chief Nurse & Executive Director of Maternity
History:	QPPC 4th February
Status:	Approval and Information

1. Background/Purpose

Brief summary:
Following the publication of Donna Ockenden's first report: *Emerging Findings and Recommendations from the Independent Review of Maternity Services at the Shrewsbury and Telford Hospitals NHS Trust* on 11th December 2020, this report sets out the current position in the Maternity Service at King's against the 7 Immediate and Essential actions (IEA's) with 12 urgent clinical priorities from the IEA set out in the Ockenden Report to make lasting improvements to maternity services:

1/Enhanced Safety
2/ Listening to Women & their Families
3/ Staff training and working together
4/ Managing complex pregnancy
5/ Risk assessment throughout pregnancy
6/ Monitoring fetal wellbeing
7/ Informed consent

Along with compliance to NICE guidance relating to Maternity and workforce plans for the service

These are linked to the 2 further National documents, which are the 10 Maternity Safety Actions in the Maternity CNST Incentive Scheme (Submission July 2021) as well as the 5 Elements in the Saving Babies Lives v.2 Care Bundle for reducing perinatal mortality.

The aim of this report is to provide assurance is to for the Maternity unit to identify the work that is required to meet the requirements set out in the Report and assure the Trust Board that poor care and avoidable deaths with no visibility or learning does not happen in the maternity service.

Of the 7 IEA additional work is required as the standards are new and the infrastructure across the Local Maternity System (working with Guy's & St Thomas and Lewisham & Greenwich Maternity Services) has yet to be established

IEA	
1	LMS development required
2	Awaiting national guidance and change to job plans
3	Covid issues with training and new audit requirements
4	New audit to complete, Covid issues with testing women for smoking and staff training
5	New audit to complete, Covid issues with testing women for smoking and staff training
6	Covid issues with testing women for smoking and staff training
7	Changes to Trust website and some LMS project work to be completed

Maternity have commissioned Birthrate plus to do a midwifery workforce assessment- the results of which will be complete by March/ April 2021

Progress on eth action plan will be bought to the Trust Board on a regular basis to demonstrate service improvements and complains with actions

2. Action required

The Board is asked to note that the attached Assurance tool and support the Chief Executive, was signed by Prof Clive Kay following discussion at QPPC, so that it could be reported with the South East London Maternity System and then shared with the Regional Team in order to complete a gap analysis and thematic analysis for the National Maternity Transformation Board

3. Key implications

Legal:	
Financial:	
Assurance:	**yes**
Clinical:	**yes**
Equality & Diversity:	**yes**
Performance:	
Strategy:	
Workforce:	
Estates:	
Reputation:	**yes**
Other:(please specify)	

Maternity services assessment and assurance tool

We have devised this tool to support providers to assess their current position against the 7 Immediate and Essential Actions (IEAs) in the Ockenden Report and provide assurance of *effective* implementation to their boards, Local Maternity System and NHS England and NHS Improvement regional teams. Rather than a tick box exercise, the tool provides a structured process to enable providers to critically evaluate their current position and identify further actions and any support requirements. We have cross referenced the 7 IEAs in the report with the urgent clinical priorities and the ten Maternity incentive scheme safety actions where appropriate, although it is important that providers consider the full underpinning requirements of each action as set out in the technical guidance.

We want providers to use the publication of the report as an opportunity to objectively review their evidence and outcome measures and consider whether they have *assurance* that the 10 safety actions and 7 IEAs are being met. As part of the assessment process, actions arising out of CQC inspections and any other reviews that have been undertaken of maternity services should also be revisited. This holistic approach should support providers to identify where existing actions and measures that have already been put in place will contribute to meeting the 7 IEAs outlined in the report. We would also like providers to undertake a maternity workforce gap analysis and set out plans to meet Birthrate Plus (BR+) standards and take a refreshed view of the actions set out in the Morecambe Bay report. We strongly recommend that maternity safety champions and Non-Executive and Executive leads for Maternity are involved in the self-assessment process and that input is sought from the Maternity Voices Partnership Chair to reflect the requirements of IEA 2.

Fundamentally, boards are encouraged to ask themselves whether they really know that mothers and babies are safe in their maternity units and how confident they are that the same tragic outcomes could not happen in their organisation. We expect boards to robustly assess and challenge the assurances provided and would ask providers to consider utilising their internal audit function to provide independent assurance that the process of assessment and evidence provided is sufficiently rigorous. If providers choose not to utilise internal audit to support this assessment, then they may wish to consider including maternity audit activity in their plans for 2020/21.

Regional Teams will assess the outputs of the self-assessment and will work with providers to understand where the gaps are and provide additional support where this is needed. This will ensure that the 7 IEAs will be implemented with the pace and rigour commensurate with the findings and ensure that mothers and their babies are safe.

Section 1

Immediate and Essential Action 1: Enhanced Safety partially Compliant

Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMS) oversight.

- Clinical change where required must be embedded across trusts with regional clinical oversight in a timely way. Trusts must be able to provide evidence of this through structured reporting mechanisms e.g. through maternity dashboards. This must be a formal item on LMS agendas at least every 3 months.

- External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death, maternal death, neonatal brain injury and neonatal death.

- All maternity SI reports (and a summary of the key issues) must be sent to the Trust Board and at the same time to the local LMS for scrutiny, oversight and transparency. This must be done at least every 3 months

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
Yes- well established meetings

Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
yes- achieved score of 11 in last scorecard

Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?- Yes

Link to urgent clinical priorities:

(a) A plan to implement the Perinatal Clinical Quality Surveillance Model
(b) All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB

What do we have in place currently to meet all requirements of IEA 1?	Describe how we are using this measurement and reporting to drive improvement?	How do we know that our improvement actions are effective and that	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will mitigate risk in the short term?

		we are learning at system and trust level?				
<u>Trust status</u> Each Serious Incident is reviewed within 72 hours and discussed with the executive team All SIs are presented at the at the Cross-site Clinical Governance Board, then presented to the Trust Serious Incidence Committee (SIC), chaired by the Deputy Medical Director for Safety. These reports are reviewed & signed off by an Executive (Chief Nurse or Chief Medical Officer). Once approved the reports are then shared with the CCG. Who monitor the compliance of the action plans Monthly Maternity safety Briefings presented by Executive Maternity Safety Champion to Quality, People & Performance meeting	Regular review of all incidents to agree grading of incidents and level of investigation required-well attended review meetings by all staff groups Minutes of meetings: • Quality , People & Performance meeting • Maternity Board • Clinical Governance • Maternity Risk • Labour ward forum • Audit meetings Actions and recommendations from SI's are cascaded by a variety of means- Safety Huddles, Safety Briefings, emails, posters, changes to training sessions, Unit up-dates,	Monitoring of clinical incidents to see that repetition of incident themes is reducing by audit Success such as Improvement in the pathways have been made for babies in the community with weight loss jaundice – improved experience for women and their families	Continue to review methods used to communicate learning to all staff groups Expand attendants at the various meetings using Teams Link the audit program to lessons learnt from incidents to demonstrate service improvements Further review of the information presented at the Board and frequency of presentation in line with the new Trust organisational restructure and new meeting structures Sharing SI , themes, lessons learnt across	September 2021 Senior Maternity Teams -CD's DOM/ HOM's Involve MVP representatives	National guidance on structured reporting mechanism across the LMS and the PCQSM Consider protected time for staff to be released to attend meetings or be involved with quality improvements plans Enhanced Governance and Compliance role in the Maternity Team Have identified time in consultant job plans to attend various meetings- Trust and LMS More IT solutions to enable more staff to access	Continue with actions to share learn and involve all staff groups

(Sub-Committee of the Board) Maternity & Neonatal safety Champions are actively involved with the LMS workstreams **HSIB** The Maternity service works collaboratively with the Healthcare safety Investigation Branch(HSIB) in each investigation which fulfils their criteria, such as maternal or neonatal death, neonatal brain injury or intrapartum stillbirth) There is close working relationship with the Maternity Service throughout the investigation. Where there have been cases of serious concern this has been raised immediately by HSIB and the Director of Midwifery and Clinical Director as well as the Chief Nurse. Regular meetings are held to monitor progress on HSIB	Saving Babies Lives Report is shared with staff Maternity Staff attend the regular LMS training and update sessions to share learning across the LMS On receipt of the final HSIB report, the safety recommendation are reviewed and action plan written. This plan is monitored at the Risk and Governance meetings to ensure completion of points raised and lessons learnt. Any immediate concerns letter is discussed immediately with Senior Managers and necessary actions taken	Recent HSIB reports have limited safety recommendations Regular Quarterly feedback meetings with HSIB identifies Trust learning and service improvements have been made	the LMS on a regular basis Implement the Perinatal Clinical Quality Surveillance Model(PCQSM) once the final model has been agreed by the National Team	Senior Maternity Team-CD/DOM/HOM	the meeting remotely	

cases and the completion of the actions plans All relevant cases are referred and investigated by HSIB, reports are presented at Trust Serious Incident Committee with a completed action plan 100% of qualifying cases to HSIB have been reported to NHS Resolution's Early Notification scheme – *CNST Safety action 10*						

PMRT (Perinatal Mortality Review Tool) The Trust has well established PMRT meetings to review or eligible cases with good multidisciplinary attendants. External clinical specialists are asked to attend the meetings, via Teams, and where cases involve more than one Trust joint reviews are done. Recommendations are followed up on a regularly reviewed action plan. The service has met the required standard of the *CNST Safety Action 1* of reviewing 75% of the perinatal deaths that occurred in the first seven months of 2020 by the 31/12/2020	Quarterly reports are presented at the Maternity Board meeting in line with *CNST Safety Action 1*	PMRT identified improvements in the use of aspirin for women in early pregnancy – guidelines and information for women have been written	Establish an LMS list of staff who can attend other Trusts meetings Identify consultant lead for PMRT at the PRUH site	Bereavement Team	More IT solutions to enable more staff to access the meeting remotely	
The Maternity Scorecard This is discussed locally at the Labour Ward Forum, Risk and Governance meetings, along with any Serious incidents. In turn this is		Improvement of clinical data as a result of staff discussion and action to improve outcomes			Time from the Trust IT team to help better understanding of the MSDS data requirements to improve data	

disused at the Care Group Performance meetings and the Maternity board. Further scrutiny and assurance is provided by the Quality, People & {Performance meeting (Sub-Committee of the Board)						
MSDS Maternity data is submitted to the Maternity Services Data Set (MSDS) to the required standard *CNST Safety Action 2*		The maternity service has been improving the documentation of ethnicity at the point of referral to the maternity services – the December MSDS scorecard King's scored a maximum of 11				
LMS (Local Maternity System) Status The LMS in partnership with the provider trusts will ensure that all trust SI's are reported, reviewed and any learning disseminated at a quarterly meeting.			Increase collaboration working across the LMS to ensure learning from Serious Incidents and HSIB cases The development of a LMS dashboard is ongoing		Time for Trust staff to attend LMS events	
Immediate and essential action 2: Listening to Women and Families Maternity services must ensure that women and their families are listened to with their voices heard. **partially Compliant**						

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards. – awaiting further national guidance

- The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are discussed, particularly where there has been an adverse outcome. – awaiting further national guidance

- Each Trust Board must identify a non-executive director who has oversight of maternity services, with specific responsibility for ensuring that women and family voices across the Trust are represented at Board level. They must work collaboratively with their maternity Safety Champions. Non- executive newly appointed

Link to Maternity Safety actions:

Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard? Yes, well attended multidisciplinary meetings

Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services? Yes Regular meetings, minutes available; good discussions about changes during pandemic

Action 9: Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues? Yes- Maternity Board meeting- chaired by Chief Nurse, alternate months being set up for a Operational meeting with Trust safety champions attending

Link to urgent clinical priorities:

(a) Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services. regular meetings help with MVP

(b) In addition to the identification of an Executive Director with specific responsibility for maternity services, confirmation of a named non-executive director who will support the Board maternity safety champion bringing a degree of independent challenge to the oversight of maternity and neonatal services and ensuring that the voices of service users and staff are heard. Non- executive newly appointed

What do we have in place currently to meet all requirements of IEA 2?	How will we evidence that we are meeting the requirements?	How do we know that these roles are effective?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Trust status King's has all local requirements in place *CNST Safety Action 1* PMRT meetings – see IEA 1 to demonstrate compliance *CNST Safety Action 7* – Maternity Voice Partnership – regular meetings with MVP groups across the Trust Women are involved with and HSIB or PMRT case for their opinions or questions about the case 'Listening' Clinics for women to discuss their birth experience with the PMA- feedback given to staff involved Complaints are reviewed regularly to ensure prompt response and lessons learnt *CNST safety action*	Improved attendants by staff at meetings Minutes of meetings For : • PMRT • MVP • Labour Ward Forum • Maternity Board • Trust Board Minutes • Maternity Voice Partnership • PMA feedback from meetings with women • Complaints meetings • FFT responses • Social media comments	Improved understanding by the Trust Board of issues effecting Maternity Staff know who the key roles are Feedback from MVP chairs Comments on social media, PALS, complaints Feedback from women involved in investigations	Further work with local MVP to build on coproduction of local services, especially in regards to BAME women and their families Complete actions from National Maternity survey results and Friends & Family feedback Improve feedback to staff on issues raised by women in complaints and SI meetings Work with Non-Executive to establish the Safety Champion role and strengthen relationship with the Trust Board Clear consultant roles identified in job plans on both maternity sites to	Senior Midwifery Team- ongoing Chief Nurse Non- Executive MVP Chairs Senior Midwifery Team- ongoing Chief Nurse /DOM CD's	Time with Executive members Review to see how women who do 'not have a voice ' can express their thoughts and opinions about the service to help make service improvements Staff Time to manage the social media requirements and maintain web-site	Continue with actions Continue engagement with MVP Chairs PMA continue with Listening clinics

9 – Maternity Board supports regular meetings with trust Safety Champions Non -Executive Director identified to have oversight of Maternity **<u>LMS status</u>** The LMS will await further guidance from the National Team around the independent senior advocate role. SEL LMS will support sustainable improvements through engagement and co-production with the existing MVP's.	Post to be nationally funded, engage with National Team in regards to recruitment	Work with the National Team and the LMS to ensure that these processes are in place to monitor effectiveness	identify consultant leads for PMRT and Patient Experience and time to attend Maternity Board meetings Monthly walk about by Board safety Champion to meet staff Improved Trust website to help inform women about the Maternity Services Once the details of the Independent Senior Advocate Role is known the Trust will be fully supportive of appointing into this post September 2021	Chief Nurse Non- Executive Trust Communication Director	Await information from the National Team	

Immediate and essential action 3: Staff Training and Working Together partially Compliant
Staff who work together must train together

- Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally validated through the LMS, 3 times a year. Agreement of how to provide evidence for this to be agreed with the LMS-Yes , plans in place but currently restricted due to Covid reasons, auditing process through LMS to be approved
- Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and present multidisciplinary ward rounds on the labour ward. Achieved

- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only agree access to CNST funds to assist with staff training

Link to Maternity Safety actions:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard? Yes
Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Yes, but currently compliance affected due to Covid reasons

Link to urgent clinical priorities:

(a) Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.
(b) The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be implemented. In the meantime we are seeking assurance that a MDT training schedule is in place

What do we have in place currently to meet all requirements of IEA 3?	What are our monitoring mechanisms?	Where will compliance with these requirements be reported?	What further action do we need to take?	Who and by when?	What resource or support do we need?	How will we mitigate risk in the short term?
Trust status *CNST Safety Action 8* Staff training is on-going but currently in a revised virtual format due to the current Covid Pandemic. Multidisciplinary training is embedded	Staffing training numbers discussed at Clinical Governance meetings • minutes of meetings • Attendants logs	Discussed compliance to Mandatory training at the following meetings: • Labour ward • Clinical Governance • Risk • Maternity Board	Review of training opportunities during covid Then plan for post covid to increase training opportunities for all staff groups Clear consultant roles identified in job	Practice Development Midwives CD/ DOM/ HOM College Tutors Obstetric Anaesthetist	Protected study leave for all staff groups when Covid pandemic situation improves	Virtual training opportunities when possible due to Covid pandemic Continue with Mandatory training

throughout maternity PrOMPT- emergency training, situation training on the labour ward going through emergency scenarios including theatre staff. New starters prioritised to attend PrOMPT Achieved 90% in 2019 of the staff (in each professional group including anaesthetic, obstetric and midwifery) at the annual PROMPT training. Fetal monitoring MDT training weekly good attendance via Teams Increased staffing uplift in maternity to 24% for backfill *CNST Safety Action 4* King's has commissioned Birth rate Plus to do a full maternity staffing review- This report is due in April 2021	• Feedback from attendants • Annual Training needs analysis	• Part of CNST assessment	plans on both maternity sites All external funding which is provided for specific maternity training is ring fenced for the purposes intended in the relevant funding agreement. The monies are held centrally in corporate nursing to ensure that they are spent on intended training initiatives and can be tracked by the Director of Nursing and Midwifery. Where funding bridges multiple years the Trust looks to get agreement from the funding body to defer the income and allocates budget during business planning	CD's Care Group *July 2021* April 2021	More IT solutions to enable more staff to access the meeting remotely National guidance as to how CNST refunds can be accessed by Maternity services to help with training	Continue with Consultant ward rounds

Twice daily consultant led labour ward round every day – all women reviewed and care plan agreed and documented **LMS status** SEL LMS will continue to support multi-disciplinary training and learning across the three provider trusts.			Audit of ward round compliance		MDT training program across the LMS to be developed	

Immediate and essential action 4: Managing Complex Pregnancy **partially Compliant**
There must be robust pathways in place for managing women with complex pregnancies

Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those cases to be discussed and /or referred to a maternal medicine specialist centre. Yes

- Women with complex pregnancies must have a named consultant lead. Yes
- Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and the team. Yes

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? working progress to complete 3 of the 5 elements – which includes amendments to guidelines, have recently recommenced testing carbon monoxide levels and issues with staff training due to Covid reasons

Link to urgent clinical priorities:

a) All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.
b) Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres.

What do we have in place currently to meet all requirements of IEA 4?	What are our monitoring mechanisms?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Trust status Every woman booked to deliver at KINGS is allocated a named consultant. The pregnant woman is only referred to her link consultant if any risk factors are identified either at booking or developed during pregnancy. There is a clear list of risk factors embedded within the maternity electronic system to aid the midwife in referral. If the woman's pregnancy is uncomplicated she will not be seen by her link consultant however, should she develop a complication at	Mandatory field in MIS – Badgernet. Named consultant allocated based on clinical need No formal assurance mechanism in place currently – Audit sessions – Clinical Outcomes	No reporting at present as no assurance Assurance process to be agreed Clinical outcomes reported to London Maternal Medicine Network	Audit to monitor compliance with this data Roll out restart of Carbon monoxide testing national guidance in regards to Covid precautions Regular training / refresher for staff on documentation on Badgernet (Maternity IT system) to ensure data is captured accurately Alterations to guideline to reflect Saving Babies Lives Care Bundle v.2	Audit team Badgernet IT Supplier working on a digital solution Community Matrons Guideline Committee	IT support Training for maternity staff on Badgernet IT system	Continue with actions

delivery the link/allocated consultant will lead the follow up consultation (e.g. unexpected admission to NICU, stillbirth, massive obstetric haemorrhage). Specialist Maternal Medicine team in place at Denmark Hill site The Trust is working with the LMS to align clinical path ways , share knowledge and education e.g. diabetes, placenta accrete, hypertension, fetal medicine Kings is on track to fulfil all 5 elements of *CNST Safety Action 4 Saving Babies Lives* **LMS status** The LMS are waiting for further guidance around the implementation of maternal medicine centres.			Formalised pathways for women with complex conditions which have clearly defined guidance on where care/delivery should take place Hub and spoke pathways to be agreed across the LMS.			
Immediate and essential action 5: Risk Assessment Throughout Pregnancy partially Compliant Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.						

a) All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional – complete -recorded on Maternity IT system Badgernet

b) Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture. complete - recorded on Maternity IT system Badgernet

c)

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? working progress to complete 3 of the 5 elements – which includes amendments to guidelines, have recently recommenced carbon monoxide levels and issues with staff training due to Covid reasons

Link to urgent clinical priorities:

a) A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place of birth. This is a key element of the Personalised Care and Support Plan (PSCP). Regular audit mechanisms are in place to assess PCSP compliance. complete -recorded on Maternity IT system Badgernet

What do we have in place currently to meet all requirements of IEA 5?	What are our monitoring mechanisms and where are they reported?	Where is this reported?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Trust status A risk assessment is formally completed at booking. Risk assessment is undertaken at every scheduled antenatal contact with a	Monitoring Mechanism and where it is reported to be formally agreed	Currently there is no formal monitoring of initial ri Improved Trust website to help inform women about the Maternity Services risk assessment and the conversation at 36	Audit of risk assessments On- going Training/ refresher for maternity staff on Badgernet IT system	Audit team Community Matrons Consultant Midwives	More community IT equipment with good connectivity to Trust IT systems to capture essential data in real time	Continue with actions All midwives reminded of importance of ongoing risk assessments

discussion about maternal and fetal wellbeing. A formal review of the birth plan takes place at 36 weeks gestation, this includes discussion and review of the place of birth, specific risk factors during pregnancy and the potential implications for birth, the details are documented in the maternity electronic system All women intending to have a home birth or birth on the midwifery led unit have a risk assessment at 36 weeks to ensure that their pregnancy remains low risk , this is documented on Badgernet On admission (either in labour or through the maternity assessment unit). There is a daily consultant antenatal ward round of all women and a consultant review of postnatal women for complex cases or	Progress on improving data for Saving Babies Lives report monitored at Risk meetings – included smoking, growth of baby, reduced fetal movements- audits for CNST On Badgernet	weeks review of place of birth Once in place will be presented at Clinical Governance meetings Audit meetings	to ensure accurate documentation Alterations to guideline to reflect Saving Babies Lives Care Bundle v.2 Improvement in the data collection for the saving Babies Lives Audit Improved Trust website to help inform women about the Maternity Services			Review of datix and risks Senior Midwives out of hours on call support Consultant midwives continue to support women choosing birth options outside of guidance

within 24 hours of re-admission. This is documented on the electronic Badgernet maternal notes IT system Birth option clinic for women with complex care needs requesting' out of guidance ' birth plans – recorded on maternity IT system id done with the Consultant midwives and shared with midwifery team if needed New hand held maternity notes has information about reduced fetal movements King's is on track to fulfil all 5 elements of *CNST Safety Action 4 Saving Babies Lives* <u>LMS status</u> SEL LMS will ensure that monitoring of this standard will be incorporated within dashboard development.	On Badgernet					

Immediate and essential action 6: Monitoring Fetal Wellbeing **partially Compliant**

All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.

The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: -

- Improving the practice of monitoring fetal wellbeing –
- Consolidating existing knowledge of monitoring fetal wellbeing –
- Keeping abreast of developments in the field –
- Raising the profile of fetal wellbeing monitoring –
- Ensuring that colleagues engaged in fetal wellbeing monitoring are adequately supported –
- Interfacing with external units and agencies to learn about and keep abreast of developments in the field, and to track and introduce best practice.
- The Leads must plan and run regular departmental fetal heart rate (FHR) monitoring meetings and cascade training.
- They should also lead on the review of cases of adverse outcome involving poor FHR interpretation and practice. •
- The Leads must ensure that their maternity service is compliant with the recommendations of Saving Babies Lives Care Bundle 2 and subsequent national guidelines.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2? **working progress to complete 3 of the 5 elements – which includes amendments to guidelines, also not testing carbon monoxide levels and issues with staff training due to Covid reasons**

Action 8: Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019? Yes – levels currently effected due to Covid pandemic

Link to urgent clinical priorities:

a) Implement the saving babies lives bundle. Element 4 already states there needs to be one lead. We are now asking that a second lead is identified so that every unit has a lead midwife and a lead obstetrician in place to lead best practice, learning and support. This will include regular training sessions, review of cases and ensuring compliance with saving babies lives care bundle 2 and national guidelines. complete

What do we have in place currently to meet all requirements of IEA 6?	How will we evidence that our leads are undertaking the role in full?	What outcomes will we use to demonstrate that our processes are effective?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Trust status Denmark Hill – 1 fetal monitoring lead midwife in post who have designed a specific training package for staff and review this annually. PRUH – the labour ward matrons are responsible for monitoring the CTG skills of midwives There is a cross site obstetric consultant and midwifery consultants working on fetal monitoring training which across the whole services on both sites, along with site specific consultants responsible for staff training in fetal monitoring, reviewing guidelines, and providing onsite support and supervision.	Training records for mandatory training and CTG meetings Achieved 90% in 2019 of the staff had attended the necessary fetal monitoring training CNST *Safety Action 6* Attendance sheets to CTG meetings Job plans for consultants Job Description of Fetal Wellbeing midwife Monitoring of Serious incidents involving fetal monitoring ATTAIN data- (Unexpected admission to the neonatal unit of term babies) Progress on improving data for Saving Babies Lives report monitored	Consistent high levels of staff being trained Reduction in clinical incidents with concerns about fetal monitoring Reduction in Term admission to the neonatal unit involving fetal monitoring Reduction in Hypoxia Brain injury rates Improvement of numbers of staff attending fetal monitoring training passing competence assessment	LMS agreement for LMS wide • training • Job plan/ JD for Consultant role in fetal monitoring training Fetal monitoring meeting across the LMS to share learning etc. Further training on Saving Babies Lives for all staff to increase awareness of the important national program Fetal monitoring midwife on PRUH to mirror the Denmark Hill site Alterations to guideline to reflect Saving Babies Lives Care Bundle v.2	Fetal Monitoring Team (Consultant Matrons, Fetal Monitoring Midwife Education Team College Tutor	Time in consultant job plan to fulfil the fetal monitoring role Protected Time for staff to attend training More IT solutions to enable more staff to access the meeting remotely	Continue with actions Staff to attend fetal monitoring training and pass asesssment

Both sites have weekly CTG meetings , which are well attended (currently via TEAMs)- presentation shared widely New labour ward CTG stickers in place The use of Dawes Redman criteria is well established on one site , currently in progress at PRUH site Good ante natal guidelines that supports staff to interpret CTG's Roll out of central fetal monitoring on both sites King's is on track to fulfil all 5 elements of *CNST Safety Action 4 Saving Babies Lives* <u>LMS status</u> SEL LMS will support the implementation of a fetal wellbeing consultant position at each trust and will agree a standardised job description.	at Risk meetings – included smoking, growth of baby, reduced fetal movements- audits for CNST	Improvement in the data collection for the saving Babies Lives Audit				

Immediate and essential action 7: Informed Consent partially Compliant All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery. Complete Badgernet portal has some information but there are challenges in keeping this and our website up to date. All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guidance. This must include all aspects of maternity care throughout the antenatal, intrapartum and postnatal periods of care complete Badgernet portal Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care complete Badgernet portal Consultant midwifery clinics individualised personalised care plans Women's choices following a shared and informed decision-making process must be respected – complete. Consultant midwifery clinics individualised personalised care plans. FFT responses						
Link to Maternity Safety actions: **Action 7: Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?**						
Link to urgent clinical priorities: a) Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the trust website. An example of good practice is available on the Chelsea and Westminster website. No. Website under development Complete - Yes						
What do we have in place currently to meet all	**Where and how often do we report this?**	**How do we know that our processes are effective?**	**What further action do we need to take?**	**Who and by when?**	**What resources or support do we need?**	**How will we mitigate risk in the short term?**

requirements of IEA 7?						
Trust status. The Badgernet Maternal Portal provides women access to various documents to help women think about their birth options – available for all women to use The Trust website is currently under review to review the information available for women Information regarding place of birth is also available via online classes Birth options with Consultant Midwife Dedicated homebirth team Place of birth discussed with all women at booking, 36 weeks **LMS status** As part of LMS wide initiative the mum and baby app, originally developed by Chelsea	Discussed at Clinical governance and maternity Board Maternity Dashboard shows trends and maps where women live in regards to homebirths place of birth , maternal request for c/sections	Improved FFT results Improved national CQC Maternity Survey results Complaints and complements MVP feedback Social media platforms	Improved Trust website to help inform women about the Maternity Services Ensure al staff know about the information amiable for women such as the Mum and Baby app, information on Badgernet and promote the use of Further work to further improve co-production. Better working relationship with the commissioners to ensure there is a better working relationship with the MVPs across both sites Funding of translation services for information for women Action plan for National Maternity Survey and Friends & Family results	Maternity Team MVP chairs	Funding to develop the Trust website and the maternity pages Staff Time to manage the social media requirements and maintain web-site and support the data being distributed via the Maternal Portal from Badgernet so women get up to date relevant information The LMS has funding for 3 years for the Mum and baby App	Continue with actions On- going training for staff to support discussions with women about their choices

and Westminster has been purchased for the Maternity service. We are currently going through the testing phase prior to implementation of this app for use at and there is a provisional go live date for January 2021			New Maternity website which makes access to information easy for women and their partners			

Section 2

MATERNITY WORKFORCE PLANNING

Link to Maternity safety standards:

Action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard
Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

We are asking providers to undertake a maternity work-force gap analysis, to have a plan in place to meet the Birthrate Plus (BR+) (or equivalent) standard by the 31st January 2020 and to confirm timescales for implementation.

What process have we undertaken?	How have we assured that our plans are robust and realistic?	How will ensure oversight of progress against our plans going forwards?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Trust status Kings have commissioned Birthrate plus to do a full midwifery staffing review. Results will be available April 2021 – There is no national tool for Obstetric staff so benchmarking is done against local services – Compliance against London Quality Standards (2012)	Maternity services were rated good in 2019 by the CQC Staffing discussed at monthly Risk meetings The maternity scorecard is discussed at key meetings- labour ward forum, risk and governance meetings Feedback from Junior doctor survey	Staffing review results are discussed at the Maternity Board	Time for staff to complete Birthrate plus Once Birthrate Plus review has been published a workforce action plan will be completed to implement any recommendations with appropriate governance and monitoring arrangements to measure progress and impact	Maternity Team	Time for staff to complete work for Birthrate plus	Monitor staff staffing levels daily- staffing levels are discussed at site Risk meetings and escalation taken accordingly

– Best practice guidance – Professional Judgement	Birthrate plus acuity tool monitors staffing on labour ward					

MIDWIFERY LEADERSHIP

Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director and describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwifery leadership: a manifesto for better maternity care

Compliant with Strengthening midwifery leadership: a manifesto for better maternity care

The Director of Midwifery is accountable to the Chief Nurse (executive director)

The Trust meets the following leadership requirements set out by the Royal College of Midwives: -

Director of Midwifery in every Trust

The Director of Midwifery is directly accountable to the Chief Nurse/ Executive Board maternity Safety Champion. This post is responsible for the strategic leadership within the service as well as ensuring a safe and high quality service and is the lead for Governance in maternity

Each of the 2 Maternity sites has Heads of Midwifery who are accountable to the Director of Midwifery and are responsible for the operational needs of the service

Consultant Midwives
The Trust currently three Consultant Midwives specialising in Public Health, Complex Pregnancy and Normality

Specialist Midwives
The Trust has invested in a number of specialist midwifery roles at Band 7 level, including

- diabetes,
- hypertension,
- vulnerable women,
- mental health
- bereavement

- Research
- Infant feeding
- Fetal monitoring
- PMA
- Ante natal and Newborn screening
- Practice Development Midwives
- Midwifery Practice Facilitator
- Digital Midwife
- Fetal Medicine
- ECG champions- externally funded
- Pre-term Champions- externally funded

Sustaining leadership in education and research
The Trust works closely with 2 Universities City and Kings College to provide excellent midwifery education and there is also a strong research ethos at the Trust with many midwives working part time or full time on a variety of research projects. –
Commitment to fund on-going midwifery leadership development The Trust has committed to support the Matrons on-going development and has recently commissioned external development teams to facilitate this. There is also internal leadership development available to the Band 7 midwives via the Kings Fund Leadership module and other internal opportunities as well as secondment opportunities and Masters support

At Kings' Maternity Services sits within the Women's Care Group at Denmark Hill and Women's & Surgery at eth PRUH site. Maternity 's Governance structure is cross site The Clinical Director of the Care Groups are responsible and accountable to the Chief Operating Officer. The Director of Midwifery is professionally accountable to Site Chief Executive and the Chief Nurse (Exec Director).

NICE GUIDANCE RELATED TO MATERNITY
We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and implemented where appropriate. Where non-evidenced based guidelines are utilised, the trust must undertake a robust assessment process before implementation and ensure that the decision is clinically justified.

What process do we have in place currently?	Where and how often do we report this?	What assurance do we have that all of our guidelines are clinically appropriate?	What further action do we need to take?	Who and by when?	What resources or support do we need?	How will we mitigate risk in the short term?
Monthly guideline meetings. Guidelines for approval are circulated to the senior team for wider review Governance midwife completes a NICE guideline gap analysis with the audit midwives Monthly MDT guideline meetings	Monthly Guidelines meeting which reports to Clinical Governance Maternity Board	Tracker Minutes of meetings Gap analysis completed when external reviews are published	Continue to monitor guideline data Guidelines to be part of a consultant job plan Continue to have monthly guideline reviews to ensure e guidelines are regularly updated and new ones published when need requires	Senior Maternity Team CD		

King's College Hospital NHS Foundation Trust

Committee:	Trust Board
Meeting date:	Thursday 11th March 2021
Subject:	Risk Management Strategy and Policy
Author:	Ashley Parrott, Director of Quality Governance
Presented by:	Ashley Parrott, Director of Quality Governance
Sponsor:	Professor Nicola Ranger, Chief Nurse
History:	Audit Committee
Status:	For ratification

Summary of Report
This report provides the Risk Management Strategy, The Risk Management Policy and the improvement plan to embed the documents and risk process within the trust.
The Risk Management Strategy has undergone a complete re-write since the March 2020 version reviewed by this committee. This is to clearly outline the risk escalation and management process within the trust. The risk appetite statements have not been changed since approved by the Board last February 2020.

The Risk Management Policy replaces the guidelines that were previously presented. This document has changed to provide clarity to the actual risk process for staff to follow.

The Risk Management Strategy and Policy were reviewed by the Audit Committee at its meeting on 4th March 2021 and Committee agreed to recommend the strategy and policy to the Board for approval.

Action Required

The Board is asked to approve the Trust Risk Managmenet Strategy and Policy.

Key implications.

Legal:	
Financial:	
Assurance:	Effective risk management will assist with objective setting
Clinical:	Driving quality care through implementation of risk actions
Equality & Diversity:	
Performance:	
Strategy:	
Workforce:	
Estates:	
Reputation:	Effective risk management – improved reputation
Other:(please specify)	

Risk Management Strategy and Improvement Plan

1. Introduction

Risk Management moved to the Executive Nursing and Quality Directorate in November 2020. Following this move a review of the current status in terms of process and structure has been completed with improvement actions already underway. This report provides a broad overview of the current position and the immediate steps that have been taken since November 2020. It also includes the proposed risk improvement plan to embed the Risk Management Strategy (subject to approval by this committee).
Additional documents for review and approval to this report are:

- Risk Management Strategy 2021-2023
- Risk Management Policy

2. Immediate action taken following transfer to Executive Nursing

2.1 The new Care Group structure is now in place with additional management time provided to these leaders which will enable improved governance (includes risk). The Site Executive Teams have now established integrated quality reviews (quality and finance) to support and challenge the Care Groups on these domains. This provides a robust foundation to identify, evaluate, manage and follow up on risks and escalate where required.
We have contacted a number of Care Groups to attend governance meetings and provide risk management support and we have initiated a review of risks with Care Groups to ensure clear and robust. This is on-going – see risk improvement plan.

2.2 The Corporate Risk Register had not been regularly reviewed and updated with a number of risks over 1 year since the last review. A number of risks are no longer relevant and there are other risks in the system that should be included on this register. This is not acceptable practice for a risk register that should hold the high level risks for the organisation.
A review, update and clear format of all the current risks on this register with all the owners was completed and the full register submitted for review by the Risk and Governance Committee for 23rd December and subsequent review and submission to February 2021 Risk and Governance Committee.

2.3 There is currently a lack of clarity on how risks are escalated and reviewed to ensure there is a clear risk assurance process. There needs to be a process to manage risks at the appropriate level and to escalate when they are unable to be controlled by the previous level of ownership. Not all groups and committees embed risk management into their business, seeing this as a separate function.
The Risk Strategy has now been revised and submitted for approval providing detail on the framework to manage the control and escalation of risks through operational and committee pathways. The current risks in the system are under review with a top down and bottom up approach. We have already reviewed the high level corporate risks and will continue to work through these whilst also reviewing with owners the low risks with longest time since last review. It will enable us to have clarity on the actual risk through improved descriptions and to check all risks are relevant, whilst we start to embed the new framework.

2.4 Risk training had been taking place for a number of months (August to November) however there has not been a clear strategy as to priority and roll out. Many staff trained do not own any risk on the register and are not part of the Care Group Triumvirate or Specialty leads. There needs to be a focus on current risk owners and department and Care Group leaders. We have paused training due to COVID pressures and to revise content to suit different levels and requirements which is described in the revised Risk Strategy. As soon as possible we will restart and focus sessions initially on department, specialty and care group leaders and current risk owners within the revised roll out plan. See section 2 below for further detail.

2.5 New Datix software was purchased in March 2020 as concerns were raised the current system could not support the risk or incident process. There is a delay in the new software implementation as there are some critical issues with the system identified by the Risk Team. These are now being worked on with the Datix Management Team.
A review of new compared to existing system in progress to provide clarity on the advantages and disadvantages to implementation and ensure all possible issues identified. Once completed we will provide a status report and a clear implementation plan. The current system is being revised to suit the new trust structure and to support the risk process and framework. The new system is not critical to the delivery of the risk framework but it does have improved functionality for the risk module that will enhance the management of risks.

3. The proposed risk improvement and implementation plan

To embed the framework described in the Risk Management Strategy and deliver effective risk management there must be a clear plan with timescales for delivery. Assessing success for implementation is difficult as an effective risk culture is part of good governance and this improves over time. Our aim is to have a system in place to achieve the following objectives;

- Clear ownership and accountability – appropriate escalation of risks with a clear flow from floor to Board;
- Embedded within trust business – Governance and committee meetings use risk as part of the meeting and not a separate agenda. Consideration within discussions on current risks or potential new risks;
- Awareness of risk – Staff at meetings are aware of top three risks to their business/objectives and the current mitigations and required actions to reduce;
- Planning for the future – risks are used by groups and committees for business planning and objective setting;
- Prevention and not reactive – Risks are considered with plans to mitigate prior to the issue arising;
- Effective management and review of risks – Risks are reviewed and updated as an ongoing process.

The essential criteria to achieve these are;

- a robust system – Risk Strategy (Principles, framework and process);
- a clear structure – new trust structure for Care Groups and corporate services;
- A clear committee reporting structure (see agenda item on Care Group Governance Handbook);
- Training and support for advice and guidance.

The following implementation plan provides detail on the three simultaneous approaches we will undertake to embed the risk framework within the trust and to achieve the stated objectives.

Plan	Process	Area and timescale 2021-22			
		Q1	Review and confirm Q2 roll out	Q2	Q3
Approach 1 Risk review implementation	Review all open risks in complete register with the owners to address description, controls, rating and actions. At the same time a simple bite size teaching session will be completed, followed up with the review of the risks.	All Risks 25-15 All risks 1-4		All risks 10-12 All risks 5-8	All risks 8 -10
Approach 2 Operational ownership implementation	Support Care Groups and their departments/specialties to ensure clear ownership and escalation (based on	5 Care Groups 1 Corporate Service		5 Care Groups 1 Corporate Service	TBC Potential increase numbers

	framework) in place through attendance and support at the relevant meetings and training for the leaders of these areas.				
Approach 3 Trust wide committee implementation	Support trust wide committees at operational and executive level to ensure risks assigned and reviewed and escalated as required in the framework. Where required appropriate escalation of these will then filter into the Risk and Governance Committee and relevant Non-Executive led Committee if confirmed (escalated) as a Corporate Risk.	Health and Safety Committee Patient safety Committee – Sub groups and senior executive Committee supporting these		Workforce Committee and sub groups ICT structure and senior executive Committee supporting these	TBC – Potential increase in areas

This is a phased approach due to the size of the trust and number of Care Groups, Corporate Services and committees. As we progress, the process and culture should spread with increased awareness and understanding of the framework. A review at the end of quarter one will enable us to check and amend if required.

It may be possible to increase the support and therefore expedite progress if we are successful in the bid to have external support for Care Group governance. The plan above is based on the support from the Director of Quality Governance, Head of Risk and an interim for risk support. Additional external support will significantly decrease the implementation timescale and would be welcomed. This is based on starting full support from April (quarter1) but is reliant on the following critical success factors;

Critical Success Factors to delivery of plan	Timeframe
Risk Management Strategy Approval	March 2021
Risk Management Policy Approval	March 2021
COVID Wave 2 resolved	End of March 2021
Approval of all committee structures	March 2021

2 Summary

The immediate actions taken in late November and December along with the framework and implementation plan should provide assurance there is a clear and robust plan to deliver an effective risk management process within the trust. The implementation plan will work through Care Groups, Corporate Services and Committees on a planned roll out to ensure we support and review progress, and success at each stage. This staged approach should facilitate embedding risk in the culture and will require support from the Executive Team to ensure a consistent approach in language, ownership and review of risk. Review of progress and effectiveness can be supported by our internal audit programme.

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King's College Hospital NHS Foundation Trust

Risk Management Strategy

2021 - 2023

Version	2.0
Status	Draft
Date Ratified	TBC
Job Title of Owner	Director of Quality Governance
Name of Sponsor Group	Risk and Governance Committee
Name of Ratifying Group	Board of Directors
Type of Procedural document	Strategy
Document Reference	
Date issued	January 2021
Review date	March 2023
Target audience	All staff
EIA Status	Complete
The latest approved version of this document supersedes all other versions. Upon receipt of the latest approved versions all other version should be destroyed, unless specifically stated that the previous version(s) are to remain extant. If in any doubt please contact the document owner or Policy Coordinator.	

King's College Hospital NHS Foundation Trust

CONTENTS

Appendices

Change history			
Version	**Date**	**Author/Lead**	**Details of change**
7.3	Revised Sept 2017	Lorraine Schwanberg, Judith Seddon, Shelley Dolan, Jules Wendon	To include the Freedom to Speak up Guardian and elaborate on the roles of Corporate Directors in relation to non-clinical risks. New Governance Structure embedded.
1.0	March 2020	Executive Director of Integrated Governance	Full replacement – new Risk Management Strategy for 2020 – 2022 – Approved but required further review to address new structure once implemented
2.0	January 2021	Director of Quality Governance	Full revision to ensure clarity on risk control and escalation and training requirements and new trust structure – major edit. Incorporates the existing Board approved risk appetite statement

King's College Hospital NHS Foundation Trust

1. Statement of Intent

The Trust recognises that a key factor in driving its priorities is to ensure that effective risk management arrangements are in place and embedded in the organisation's practices and processes.

Effective risk management is imperative not only to provide a safe environment and high quality of care for service users and staff, it is also critical in the business planning process where a more competitive edge and greater public accountability in delivering healthcare services is required. It is an active component in improving our governance and, ultimately, our performance.

In pursuit of the objective of implementing effective risk management arrangements the Trust is committed to adhering as far as possible to the international best practice Standard ISO 31000:2018 *Risk management – Guidelines*. The Standard sets overarching principles, framework and process for managing risk.

The Trust accepts that it carries a number of risks which have the potential to cause harm to patients, staff and visitors and loss to its assets and reputation if not properly managed and controlled. It is acknowledged and accepted that, given the nature of the services provided by the Trust, some risks cannot be totally eliminated. However, it is essential that the Trust has in place good risk management systems and practices which eliminate risk wherever possible and reduce the impact of those risks that cannot be eliminated to an "acceptable level".

This Risk Management Strategy is owned by Trust senior management, who support its implementation by ensuring a progressive, honest, open and just environment where all types of risks can be identified and managed in a timely, positive and constructive way.

2. Scope

Trust-wide: Risk management activities applies equally to all staff and individuals employed by the Trust including; contractors, volunteers, students, locum, agency and staff employed with honorary contracts.

3. Purpose

Risk management is a statutory requirement and a crucial element to effective management within an organisation. This Risk Management Strategy will outline the principles, framework and process for effective risk management of key functions to comply with health and safety legislation, its Provider Licence, CQC registration and the Trust strategic objectives.

4. Introduction

The Trust's overall strategic aim is to make the effective management of risk an integral part of everyday management practice. This is achieved by having a comprehensive and cohesive risk management system (principles, framework and process) in place which is underpinned by clear responsibility and accountability arrangements throughout the organisational structure of the Trust.

The Trust has set the following risk management objectives;

- Minimise the potential for harm to patients, all staff and visitors to a level as low as reasonably practicable.
- Protect everything of value (such as high standards of patient care, staff safety and welfare, reputation and assets or income streams).
- Anticipate and respond to changing circumstances (social, environmental, legal, financial etc.).
- Maximise opportunity by adapting and remaining resilient to changing risk factors.
- Ensure that risk management is clearly and consistently integrated at all levels and departments in the Trust.
- Inform policy, operational and strategic decisions by identifying risks and their likely impact.

This Strategy will ensure these objectives will be achieved by;

- Clearly defining the roles, accountability and reporting lines within the Trust for risk management.
- Embedding risk management into governance meetings, strategic decisions and prioritisation of funding.
- Demonstrating the application of risk management principles in all activities of the Trust.
- Reinforcing the importance of effective risk management as part of the everyday work of all staff employed or engaged by the Trust.
- Maintaining comprehensive risk registers at all levels of the organisation that are regularly reviewed and managed documenting progress.
- Ensuring controls are in place and effective to mitigate the risk wherever possible.
- Ensuring gaps in controls are rectified through the tracking and delivery of actions and assurances are reviewed and acted on in a timely manner.
- Ensuring department clinical and non-clinical risk assessments are undertaken to manage individual patient safety or environment and staff safety.
- Preparing contingency plans to secure business continuity where there is a potential for an event to have a major impact upon the Trust's ability to function.
- Monitoring all arrangements and seeking continuous improvement.

5. Definitions

Risk Management: *Coordinated activities to direct and control the organisation with regard to risk* (ISO 31000:2018 Risk Management – Guidelines). This is the systematic process of the identification, analysis, evaluation and control of actual and potential risks to patients, visitors, staff, contractors, property and to the achievement of the Trust's strategic priorities.

Risk: *Is the combination of the probability of an event and its consequence. The consequence can range from positive to negative. (Institute of Risk Management –IRM)* This is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets.

Hazard: Is something that has the potential to cause harm, such as substances, equipment, methods of work, and other aspects of work organisation.

Event: *The occurrence or change of a particular set of circumstances, this could be expected or unexpected* (ISO 31000:2018 Risk Management – Guidelines).

Likelihood: *Is the chance of something happening* (ISO 31000:2018 Risk Management – Guidelines).This is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.

Consequence (impact): *Is the outcome of an event affecting objectives* (ISO 31000:2018 Risk Management – Guidelines). This can be measured as the level of harm that has, or may be suffered (Trust scale of 1 to 5.

Risk Level (rating): The likelihood of a risk occurring (on a scale of 1-5) multiplied by its impact (also on a scale of 1-5) to give a score out of 25. The higher the score the more serious the risk to the organisation, see the Risk Scoring Matrix and Action Guide **(Appendix A)**.

Controls: Are arrangements and systems that are intended to maintain and or modify the risk such as minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

Controls Assurance: Is the means by which the organisation, Board of Directors, trust senior leadership, manager, or clinical lead knows that the controls designed to manage/ mitigate risks are effective and being properly implemented.

Gap in Assurance/control: Is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective. A negative assurance (a poor internal audit report for example) highlights gaps in control.

The Risk Register: Is a management tool that allows the Trust to understand its comprehensive risk profile through accessing the various risks. The Trust has different risk register levels which are Department/Specialty, Care Group, Site, Corporate or Board Assurance Framework.

Board Assurance Framework (BAF): The BAF provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives and deliverables outlined in the Trust strategy.

Inherent or Initial Risk: Is the risk linked to the activity itself without the application of controls i.e. when first identified.

Current or Residual Risk Rating: Is the risk remaining after the controls put in place to mitigate the inherent or initial risk are fully effective. The current risk status can be changed at any time if and when the controls change.

Target Risk Rating: The level of risk the department, Care Group or Trust is willing to accept once all the controls are in place. This is set depending on the risk appetite for the risk type. When a risk has been managed to its target level, the remaining risk reflects that all reasonable and additional controls have been applied and are known to be effective.

Managed (Tolerable) Risk: Is the remaining risk when all reasonable and additional controls have been applied and the risk is at its target rating.

Health and Safety Risk Assessment: Is proactive examination of the risks arising from work. This includes risks from activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments inform the risk register where a risk has been identified which is unable to be controlled to as low as reasonably practicable (i.e. the control measures identified in the risk assessment are unable to be implemented locally) and could have a wider impact or a high impact in the relevant department. The risk must be entered onto the risk register in this instance. The Health and Safety risk assessments are stored on the Datix system.

Patient Risk Assessments: These are clinical assessments conducted by clinicians to ensure the safe care of patients, recorded and stored within the health record.

Risk Owners: Are throughout the organisation in accordance to the accountabilities and responsibilities. They are responsible for updating risks. There will be individuals and Group/Committee ownership.

Risk Appetite: Is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept / retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.

Internal Control: Is the process designed to provide reasonable assurance that the Trust's objectives will be met with regards to: (1) Effectiveness and efficiency of operations; (2) Reliability of financial reporting and (3) Compliance with applicable laws and regulations.

6. Risk Principles

The Trust is aligned to the ISO 31000:2018 *Risk management – Guidelines* where it states *"the purpose of risk management is the creation and protection of value. It improves performance, encourages innovation and supports the achievement of objectives".* The following principles are aligned to these standards.

6.1 Integrated – Clinical risks and staffing risks are assessed and managed on a daily basis through patient risk assessments and specific Health and Safety assessments for staff. All core meetings will ensure members are aware of the top risks and the plans to mitigate and have regular review of all risks related to the subjects covered.

6.2 Structured, comprehensive and customised – the risk management system for the Trust will be used to record, review and update risks, using standard templates for specific meetings, increasing detail where appropriate.

6.3 Inclusive – Stakeholders to risks will be involved in the identification, assessment and continuous review of risks through clear ownership at individual and committee level.

6.4 Dynamic – Each risk will have continuous review to ensure updated in terms of the risk description, the controls in place and the actions required to mitigate the risk aligned to the organisation, specialty, care group or department objectives and external changes.

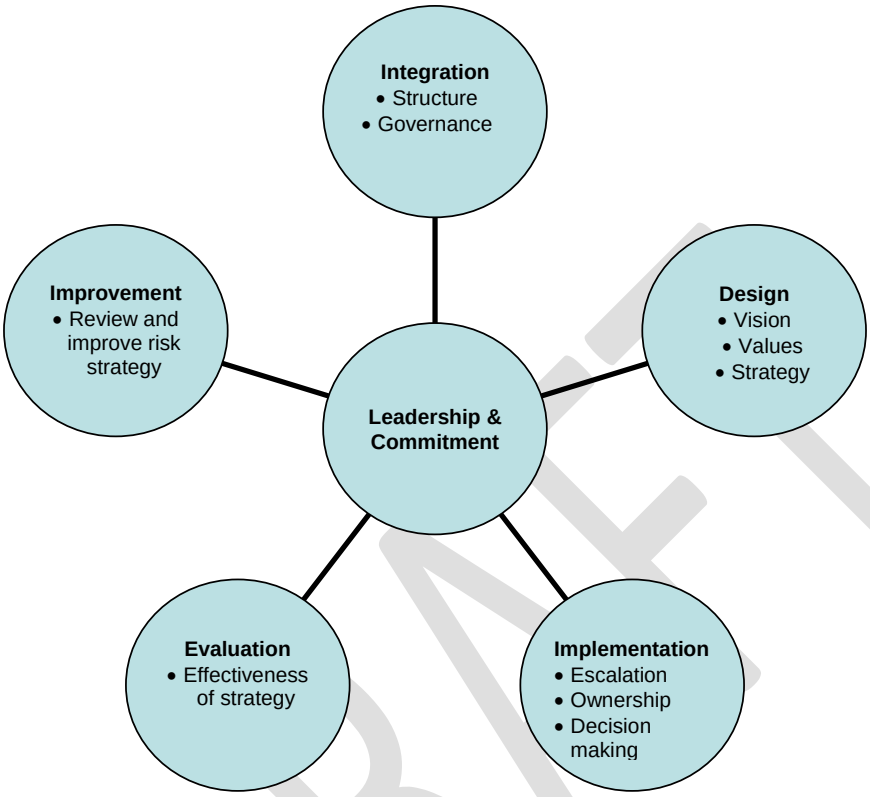
6.5 Best available information and human and cultural factors – All risks will be updated based on the information available and will consider behaviour and cultures impacting on them.

6.6 Continuous Improvement – The risk principles, framework and process will improve over the duration of this strategy and an annual review will determine progress to effective risk management. In addition risks will be reviewed as part of the quality priority setting process to further embed risk management into the organisational culture.

7. Risk Framework

The following framework (figure 1) is aligned to the ISO 31000:2018 *Risk management – Guidelines*. This framework will ensure the organisation integrates risk within its functions and activities. This includes the ownership of this strategy and the commitment to embed risk management within the organisation.

Figure 1



7.1 Leadership and Commitment – The Executive Risk and Governance Committee will ensure the organisation continues to improve risk management and fully implement this strategy. The senior leaders of the organisation will ensure the groups and committees they are responsible for review and manage risks as part of normal business as this will integrate the identification, review and ownership of risks. As part of this all members of committees and quality governance meetings should be aware of the top 3 risks to their particular service. All staff are responsible to know their risks and support the actions required to mitigate them or reduce to target rating.

7.2 The following flowcharts (figure 2 and figure 3) provides the implementation framework for managing, control and escalation of risks within the Trust (risk accountability and escalation framework):

King's College Hospital NHS Foundation Trust

Figure 2 **Risk Control and Escalation – Operational Risks**

Identification of New Risk - Recorded on Datix
Potential impact on Quality, Operational, Financial, Strategy, Reputational, Regulatory and Staff Safety Risks

Board Assurance Framework (BAF)
These are the Board identified key risks to achieving the trust strategic objectives and their deliverables.
Owner: Director of Corporate Affairs and Executive Leads
Responsible Group: Trust Board, Audit Committee and Quality, People and Performance Committee
Minimum Review timescale: Quarterly

The BAF should reference the specific corporate risk impacting on each strategic objective and inform how mitigating at highest level.

↕ The corporate risks should inform and align to the BAF strategic risk areas and act as a source of assurance.

Corporate Risk Register
Risks impacting on the whole trust or high level individual risks that cannot be resolved immediately at Care Group or Site Level. These could be from a high level risk in a Care Group, a cluster of risks impacting on a number of Care Groups or Corporate Services.
Owner: Director of Quality Governance and Executive Leads
Responsible Group: Risk and Governance Committee
Minimum Review timescale: Every 2 months

The risk level below is a guide. Any risk unable to be controlled at current level of authority should be escalated for discussion and decision to accept.

Current High Level Risks 15-25

↑ Risk accepted for escalation to the Corporate Register as unable to be controlled and all possible actions and controls in place*

Site Risk Register
These are risks that cannot be mitigated by Care Group or Corporate Services or could impact across a number of areas, the whole site or Trust.
Owner: Member of Site Executive Team
Responsible Group: Site Quality Reviews and or Site Executive/Governance Meeting
Minimum Review timescale: Every 2 months

Current Moderate Level Risks 8-12

↑ Risk accepted for escalation and onto Site Risk Register as unable to be controlled and all possible actions and controls in place*

Care Group or Corporate Service Risk Register
These are the specific risks owned by each Care Group or Corporate Service. They are identified through the operational and clinical teams and could be a risk from the specialty or department.
Owner: General Manager, Head of Nursing or Clinical Director from Care Group (one of these), or Corporate Director for Corporate Services
Responsible Group: Care Group or Corporate Service Governance Meeting
Minimum Review timescale: Every 2 months

Current Moderate Level Risks 8-12

Current Low Level Risks 1-6

↑ Risk accepted for escalation and onto Care Group Risk Register as unable to be controlled and all possible actions and controls in place*

Department / Specialty Risk Register
These are risks owned by the department or specialty and should be managed and reviewed locally. These could be a ward or department within a specialty or Corporate Service.
Owner: Department Manager/Clinical Lead,
Responsible Group: Department or Specialty Meeting
Minimum Review timescale: Every 2 months

Current Moderate Level Risks 8-12

Current Low Level Risks 1-6

*The escalation and subsequent transfer of a risk to the next level will only be accepted if it cannot be controlled and if the risk is deemed to have a greater and or wider impact. A high risk for a department may not be significant for the Site or Trust. It may be the risk remains at the initial level with a specific escalated action for the risk. Cross-site care groups report escalate to the relevant site CEO.

Key principles to Risk Control and Escalation of the Operational Risks

Each department and specialty will ensure they identify and assess their risks and complete the following;

- Ensure risk register reviewed as part of governance meeting;
- Awareness of top 3 risks to department/specialty (this should normally be against achieving objectives – e.g. deliver high quality care to patients)
- Consider if these and any other risk controlled?
- What else can be done to reduce these risks to target rating?
- Are we able to control these risks immediately?
- If unable to control or require support for actions, escalate to Care Group or Corporate Services Senior Meeting and or a trust wide committee.

The Care Group or Corporate Services Meeting will consider the following at each meeting;

- Ensure Care Group Risk Register reviewed as part of governance meeting;
- What risks have been escalated and have we accepted the risk?
- What are our top 3 risks?
- Are these or any other risks controlled?
- Is there anything else we can do to immediately control the risk?
- Do we need to escalate this/these risks to the site executive and or a trust wide committee as unable to control?

The Site Executive Team will consider the following during quality reviews, team or governance meetings;

- Ensure Site Risk Register reviewed as part of meeting
- What are the top 3 risks?
- Are these or any other risks controlled?
- Is there anything else we can do to immediately control the risk?
- Do we need to escalate this/these risks to the Corporate Risk Register (submit to Risk and Governance Committee) and or a trust wide committee as unable to control?

The Risk and Governance Committee will review the risks and accept onto the corporate register where appropriate. The Risk Escalation Form (**Appendix C)** must be completed for this committee to accept or remove risks from the Corporate Risk Register. These risks will be reviewed at each meeting and shared with the Board Assurance Committees. Should the Risk and Governance or Board Assurance Committee decide it has an impact on the Trust Strategic Objectives it will be considered as part of a Board Assurance Entry to ensure Board aware and assured on the management of the risk.

If at any stage there is serious risk identified by any team, group, committee it must also be escalated immediately to the Executive Director and then the King's Executive Committee without delay. The process outlined above does not have to be time limited. For example a serious information governance breach with inadequate process would require immediate escalation. The governance trail and risk register process can follow. A risk at any level can be escalated directly to the Corporate Risk Register if approved by the Executive Owner and accepted by the Risk and Governance Committee.

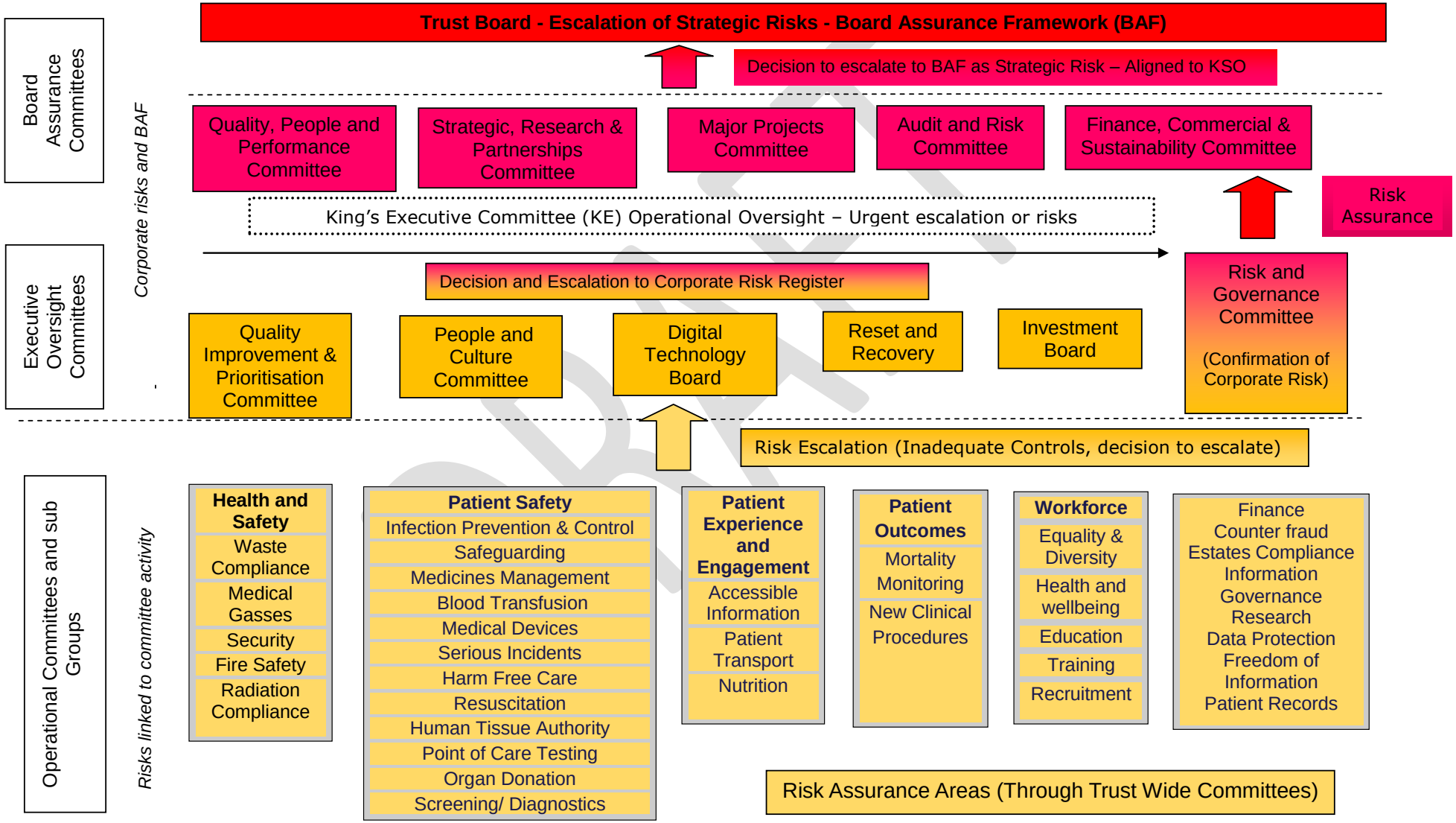
Although all risks will be aligned to the relevant trust wide committee on the Risk Management System (Datix) so they are visible and shared, any of the above operational groups (e.g. Care Group or Corporate Service) can escalate a risk to a trust wide committee should they have a concern or deem the committee appropriate to support and or manage the risk. There is alignment between the operational and committee structures.

Trust Wide Risk Assurance - Risk Control and Escalation

The operational risks will generally be specific to one department or Care Group however there will be risks that will impact across the whole trust. The risk assurance areas managed by operational committees as shown in figure 3 below will ensure these risks are identified and managed or escalated.

King's College Hospital NHS Foundation Trust

Figure 3 **Trust Wide Risk Assurance**



Key principles to Trust Wide Risk Assurance - Risk Control and Escalation

The risks will be identified through review of data across the trust (such as incident data across all Care Groups or a trust compliance report) by operational committees who will need to determine if the risk is controlled to an acceptable level (based on the trust risk tolerance) or whether it should be escalated if unable to control.

The operational committees will ensure there is a rolling programme to review risks aligned to the committee function and at each meeting the following must be considered;

- What are our top 3 risks for this committee?
- Are these and all other risks controlled?
- Do we need to escalate to the Executive Level Committee
- Is anything discussed in the meeting impacting on current risk or a new risk?

The Executive Oversight Committees will ensure they are sighted on risks escalated to them and will review their moderate and high level risks assigned to their activity on a rolling basis. These committees will confirm the need for addition to the Corporate Risk Register and will as a result recommend this to the Risk and Governance Committee.

The Risk and Governance Committee is the only committee that will finally approve and confirm additions to the Corporate Risk Register and will ensure these risks are regularly updated by owners.

The Board level committees provide oversight and assurance of the corporate level risks assigned to their activity (terms of reference) to ensure the risks are being managed. These committees will also determine the impact against the strategic objectives and will ensure aligned with the appropriate Board assurance entry. For example a high level (corporate risk) may impact on a strategic objective on delivering quality care, therefore the assurance of controls to this risk should be reflected within the BAF strategic risk to ensure the Board are sighted and assured the trust is working to mitigate the risk.

Escalation of risks from trust wide committees or operational groups/committees will be reviewed by the more senior level and either accepted or returned to the existing area depending on the most appropriate management for the risk. The risk owner may need to be changed to reflect the higher level of ownership.

All risks are aligned to committees and the operational levels within the trust Risk Management System to ensure delivery of this framework and to enable effective reporting.

7.3 In addition to the framework above there are other risk assessment consideration types that need ownership by departments and managers, and if a theme arising from the assessments incorporation to the main risk registers. These are:

- **Department Safety Risks (Health and Safety)**

There are a number of department risk assessments required to ensure safety to staff, patients and visitors. These are owned by the department and the manager with advice provided by the Trust Health and Safety Team. Examples of these are:
Fire Risk assessment, Control of Substances Hazardous to Health (COSHH), Lone Working, Display Screen Equipment (DSE) and workplace assessments. These assessments are recorded under separate categories on the Datix system. Where a risk has been identified that cannot be controlled to as low as reasonably practicable and could have a wider or high impact in the department it must be entered onto the main trust risk register on the Datix system and managed as per the accountability and escalation process for the department.

- **Patient Specific Risk Assessments**

Each clinical area will conduct individual patient risk assessments to maintain patient safety such as a falls risk assessment or moving and handling assessment. Any concerns identified from these should be managed immediately to ensure patient safety. These are recorded in patient health record. The ownership of these assessments is the responsible clinician treating and caring for the patient.

- **Corporate Services - Supporting Functions Responsibilities**

Non Clinical areas/departments supporting clinical functions are defined as Corporate Services. These services should ensure risk management is embedded within their business and ensure staff are aware of the core risks to a project, management system, staffing, objectives etc. The management and escalation of these risks is the same as for clinical areas therefore included within the Risk Accountability and Escalation Process detailed in section 7.2 above.

- **Specific Risk Registers**

Alongside the risk registers incorporating the risks aligned to Care Groups, Departments, Specialties, Site or Corporate Levels as described in figure 2, or committee registers in figure 3 above there will also be a requirement to group risks to specific registers to enable review and scrutiny. This could be required for project, transformation or emergency planning risks. Where this is required the most suitable committee or group will review and monitor the risk register (the risks) in addition to the risk owner.

7.4 Roles and Accountability

The Trust Board is responsible for ensuring the organisation has effective systems in place for the identification and management of risk (principles, framework and process). The following are the key roles and responsibilities for risk:

- **Trust Board**

Ownership of the Board Assurance Framework (BAF). This is a top down approach to identify, describe, analyse and monitor the risks to achieving the trust strategic objectives. The Board will conduct an annual workshop to identify any new risk and review the trust risk appetite. The Board will monitor the BAF on a quarterly basis and ensure part of trust business.

- **Chief Executive**

Has overall responsibility for ensuring Risk Management is robust within the Trust to cover all of its activities. The Chief Executive is required to sign the Annual Governance Statement on behalf of the Board of Directors to provide stakeholders with an assurance that the Trust has met its governance responsibilities.

- **Chief Nurse**

The Chief Nurse is the executive accounting officer responsible for risk management on behalf of the Trust Board responsible for this strategy and ensuring it is deliverable, implemented and monitored for effectiveness. The Chief Nurse is supported by the Director of Quality Governance and the Head of Risk to produce and deliver this strategy and support staff within the implementation.

- **Executive Directors**

All Executive Directors are responsible for the management of risks within their area of responsibility. This includes ensuring their teams identify, update and act to reduce the risks.

- **Non-Executive Directors**

Non-executive Directors have responsibility for reviewing the establishment and maintenance of an effective risk management system across the whole of the Trust's activities (clinical and non-clinical) that support achievement of the organisation's strategy (strategic objectives). This will be through the senior committees outlined in the assurance section within this strategy.

- **Director of Quality Governance**

The Director of Quality Governance has delegated responsibility to deliver this strategy ensuring there is a robust and workable risk management system in place for the Trust. This includes the ownership of the Corporate Risk Register to review and oversee the identification and management of the risks escalated to corporate level. This will include regular review of the total risk register for assurance the appropriate risks are identified.

- **Head of Risk**

To provide support, training and expert advice to leaders, teams and owners of risks to enable delivery of the strategy. This role will also ensure the Risk Management Software is suitable for the delivery of this strategy.

- **Trust Secretary**

The Trust Secretary is responsible for producing, populating, updating and maintaining the Board Assurance Framework and ensuring it is scrutinised and used by the Trust Board as part of normal business, embedding into practice.

- **Risk and Governance Committee**

This committee will ensure the trust corporate risks (corporate risk register) are reviewed and updated and escalated to the Board Assurance Framework where impact on key strategic objectives. The committee will review and accept or remove risks from the corporate risk register.

- **Audit Committee**

This committee will ensure the risk management system is effective within the trust through internal audit and review of the management control, internal control measures and risk functions in place.

- **Site Executive Teams, Care Group Leaders, Specialty Leads, Corporate Services Leaders and Managers**

These senior managers are responsible for implementing risk management within their areas and for their relevant risk registers. This includes identification of risks, escalating and accepting escalated risks onto their registers when the previous group have done all possible to reduce the risk but actions are outside their level of authority. They will not accept a risk onto the register if the actions can be resolved or if it is linked to an existing risk on the register.
This senior team or manager must ensure there is a culture of risk identification and management at appropriate levels and there is an opportunity to escalate risks and discuss concerns at department, specialty, corporate services, care group or site team and or quality governance meetings.

- **All staff (including agency staff and contractors)**

All staff within the organisation have a responsibility to identify and escalate risks to their managers and to follow the required controls to mitigate risks. They can achieve this through completing their required level of training and adopting an open culture of raising concerns to managers and other staff where necessary. Where staff feel that raising issues may compromise them or may not be effective they should be aware of and encouraged to follow the Trust's Raising Concerns (whistle blowing) guidance or access the Freedom to Speak up Guardian.

7.5. Leadership and Assurance Committees (see also section 7.2)

It is important that risk review and management is embedded within the culture and meeting structure for the trust but there must be a process within this for assurance and oversight of the risk registers. The system for this internal assurance will be through the sub-board committees chaired by the Non-Executive Director's. Each committee will be responsible for oversight of the risks linked to them, based on risk type (finance, workforce, quality, estates and facilities, IT). This will not require in depth analysis of the risks as this will be done through risk accountability and escalation but it will enable the committees to see the risks aligned to their business and consider what is missing or requires increased focus to reduce. This will further embed awareness of risks with senior leaders. The following table in figure 4 provides the assurance committees, the risk profile and frequency they will review:

Figure 4

Risk Assurance				
Trust Board Ownership of the Board Assurance Framework (BAF) – Quarterly. Annual Board risk workshop to identify strategic risks to achieving the trust objectives and review risk appetite.				
Risk and Governance Committee Ownership of the Corporate Risk Register - Monthly Review of all high level risks (15 and above) - Quarterly Review of all moderate level risks (8-12) every 6 months				
Finance, Commercial and Sustainability Committee	**Strategy, Research and Partnerships Committee**	**Major Projects**	**Quality People and Performance Committee**	**Audit Committee**
Investment risks Estates risks Finance risks BAF risks	Strategic risks Research risks BAF risks	Project risks ICT risks BAF risks	BAF risks Quality risks Workforce risks Performance risks	BAF risks Corporate Risk Register Risk Management System
Assurance review timescales for the relevant risks to each committee (please note this is for awareness of the risks aligned to the committee business rather than ownership and management so does not require in depth scrutiny). High (15 and above) – every meeting Moderate (8-12) – every 6 months Low (1-6) – Annual submission – optional to each committee				

8. Risk Process

The risk process is critical for effective risk management within the organisation. The core functions within this section are based on the ISO 31000:2018 *Risk management – Guidelines*.

8.1 Identification of risk

Risks will be identified and triangulated through a number of groups and committees but also through ongoing governance activities such as:

Management and investigation of adverse incidents including moderate harm (Amber) and Serious Incidents
There is a process for managing incidents detailed in the Policy for the Management, Reporting and Investigation of Adverse Incidents. The Departments and Specialties, Care Groups, and the Patient Safety Committee will through review and discussion identify any further risk or tends to harm and ensure recorded on the relevant risk register if it cannot be resolved immediately.

Safety Alerts
The Trust has a system for managing, implementing and monitoring safety alerts received through the Central Alerting System (CAS). This is described in detail in the Policy for the Management of Safety Alerts. Any risk to mitigating an alert will be placed on the risk register.

Claims and Inquests management
The Legal Department ensure the timely and effective response to any legal claim or inquest. The Patient Outcomes Committee and Patient Safety Committee will review trends and themes to inquests and claims and include on risk register where required. Any prevention of future death actions (regulation 28) from the coroner that cannot be immediately resolved will be placed on the risk register. The process for claims management is set out in the Legal Claims Management Policy and Procedure, and the inquest management process is detailed in the Policy on Coroner's Inquests.

Patient Experience (complaints, Patient Advice and Liaison Service, national and local surveys)
Regular experience data, complaints and national experience survey results are shared and monitored and any trend or theme or poor compliance risk will be recorded and monitored by the Care Groups and the Patient Experience Committee.

Patient Outcomes and Clinical Audit and Best Practice
All national and mandatory clinical audits, latest guidance and recommendations from the National Institute for Health and Clinical Excellence (NICE) and the relevant National Confidential Enquiries and patient outcomes are coordinated through the Patient Outcomes Team and reviewed at the relevant Care Group level. Quarterly reports are provided to the Quality People and Performance Committee. The Patient Outcomes Committee will ensure any risk to patient safety or non-compliance will be considered for the appropriate risk register aligned to the specialty or if required trust wide.

Learning from Deaths and Mortality Monitoring
The Trust has a Mortality Monitoring Policy which describes in detail its approach to reviewing deaths, making an assessment of 'avoidability' and acting upon findings. Learning from deaths data is provided within the Patient Outcomes report on a quarterly basis to the Quality People and Performance Committee. The Medical Director oversees the learning from death process and will ensure any risks are raised and discussed at the appropriate committee. The Patient Outcomes Committee will have oversight of the learning from deaths process and findings.

External regulation, compliance and reviews (e.g. Care Quality Commission)
Any external review identifying concerns will be scrutinised and a clear action plan developed. A recognised theme from the actions that cannot be resolved may require a risk register entry depending on the impact of not resolving the

action to safety, reputation or compliance. The decision for this will be at Care Group or Site level when managing their action plan or at Corporate level when managing the high level action plan.

Business Continuity and Emergency Planning
The Trust has systems in place for the management of business continuity and emergency planning. Identified risks will be included on the risk register by the Emergency Planning Officer.

Quality Impact Assessment
Any proposed change in service, clinical layout, staffing model, work-flow or cost improvement plan must have a completed quality impact assessment to identify any potential impact to safety. The sign off and approval of these is by the Medical Director and Chief Nurse and they will be tracked and monitored through the Planning and Delivery Board. The process is outlined in the Quality Impact Assessment Policy.

8.2 Awareness of Risk

All staff and their managers have a responsibility to identify and raise a risk with impact on patients, staff or the organisation and to discuss these openly and honestly. The greater the openness about the risks the greater the opportunity to resolve and manage them. Many risks should be considered against achieving objectives for a service, department or the organisation and this should be considered when writing the risk description. Although there are four main types of risk (compliance risks, hazard risks, control risks, opportunity risks), the following are the main categories used in the trust for specific risks;

- **Quality and operational (including safety risk to patients and staff)**
  The Trust recognises that there is inherent risk as a result of being ill or injured, and that the responsibility of the Trust is to inform patients and relatives and work to reduce that risk where possible. Risks to quality and operational performance will include safety, patient experience and effectiveness. These could be identified from incidents, workforce, delivery of core business, complaints, claims, inquests, learning from deaths, national audits, performance data and meetings, external/internal reviews and through quality and governance meetings.

- **Reputational risk**
  These are any risks that could impact on the Trust reputation and could be as a result of service changes, staff changes and organisational decisions. The Board of Directors recognises that the challenge is balancing its own internal actions with unfolding, often rapidly changing events in the external environment, and must identify these risks.

- **Financial risk**
  These could be from operational delivery, organisational changes and strategic decisions all with an impact on the delivery of the budget setting and performance. This could be trust wide or within departments.

- **Regulatory and Compliance risk**
  Regulation and compliance is essential for the delivery of services and care to patients. Risks could be related to governance and compliance from frameworks, accreditation and regulation such as Care Quality Commission or organisations such as the Human Tissue Authority (HTA).

- **Strategic risk**
  The Trust will continue to maximise opportunities for developing and growing its services by encouraging innovation and creative thinking aligned to the wider health system. Any risks to acting on these ideas or delivering the Trust strategic plans must be identified and managed. These risks could be opportunities or threats to the delivery of trust strategies.

8.3 Consultation for risk

As described in the risk framework risk management will be embedded within daily functions through the committees and the operational structure when managing the control and escalation of risk. This will enable key stakeholders to input into the specific risk to ensure the appropriate hazards, controls and actions are addressed.

It is advisable for each level of risk ownership (Departments, Specialties, Care Groups, Corporate Services, Site, Executive Team, Trust Board and trust committees) to regularly consider any other risk to achieving objectives. This can be part of the normal meeting business or as an annual workshop. This will enable members of the relevant groups to consider what could be missing.

8.4 Risk Appetite and Risk Appetite Statement

The resources available for managing risk are often limited therefore the aim is to achieve an optimum response to risk, prioritised in accordance with an initial evaluation. Risk is unavoidable, and every organisation needs to take action to manage risk in a way that it can justify to a level which is tolerable. The amount of risk that is judged to be tolerable and justifiable is the "risk appetite".

Risk appetite is therefore 'the amount and type of risk that an organisation is willing to take in order to meet their strategic objectives," as defined by the Institute of Risk Management. It is not a set decision for all risks and should be considered for different risk types. It can be influenced by personal experience, political factors and external events. Risks need to be considered in terms of both opportunities and threats and are not usually confined to money - they will invariably also impact on the capability of the organisation, its performance and its reputation.

It is important for the Trust to know about its risk appetite because if unclear this may lead to erratic or inopportune risk taking, thereby exposing the organisation to a risk it cannot tolerate. However, an overly cautious approach can be taken which may stifle growth and development. If the leaders of the organisation do not know the levels of risk that are legitimate for them to take, or do not take important

opportunities when they arise, then service improvements may be compromised and patient outcomes affected.

The Board of Directors recognises that risk appetite cannot simply be addressed by developing a risk appetite statement as it is far more than a policy statement and should be derived from a robust ongoing process that helps the Board understand and manage its exposures and make appropriate risk-based strategic decisions.

The Board is committed to maturing risk appetite discussions and processes and it is conscious to avoid decisions being made with an incomplete understanding of risks and the capacity to manage those risks.

Risk appetite discussions will help management create a consistent message for various stakeholders and in turn will help the Board to better understand management's attitudes toward risks.

When properly defined and communicated a risk appetite will drive behaviour by setting the boundaries for running the Trust and capitalising on opportunities.

A discussion of risk appetite should address the following questions:

- Corporate values - What risks will we not accept?
- Strategy - What are the risks we need to take?
- Stakeholders - What risks are they willing to bear, and to what level?
- Capacity - What resources are required to manage those risks?

For 2021- 2023, whilst we strengthen risk management systems, processes and understanding across the organisation, the Board has set its risk appetite to be pragmatic enough to facilitate ownership and usage across the Trust and is developed at a high-level and requires more specific definition for strategic objectives and activities across the Sites, Care Groups and departments.

The Trust recognises that its strategic objectives and risk profile may change with new strategies, and with changes in the business environment, economic conditions, competition, and other factors. The Board will take these dynamics into account and make sure they stay current on their understanding of risk appetite.

The Board will set the risk appetite annually for the risks identified on the BAF.

The Trust Board Risk Appetite Statement is detailed in **Appendix B**.

8.5 Risk Assessment (Identification, Evaluation/Analysis, Actions and closing risks)

Please refer to the Risk Management Policy for full details on this process. **Appendix A** of this strategy provides the assessment matrix and the immediate actions to take when a risk has been identified.

8.6 Recording the risk

Once the risk is identified the owner must record on the Datix risk management system. The full process is detailed in the Risk Management Policy. The description must be a succinct statement stating "there is a risk that… which is caused by…. And could impact on….". Each risk must have the following recorded as a minimum:

- Risk ID
- Opened date
- Risk title
- Risk description
- Inherent risk score
- Controls in place
- Adequacy of controls (strong, moderate, weak)
- Current rating (with the controls in place)
- Actions (required to reduce the risk)
- Target risk rating
- Target risk completion/closure date
- Risk owner
- Risk type
- Risk plan (4 T's of hazard response) – tolerate, treat, transfer, terminate
- Monitoring committee
- Location/department
- Risk register level

A full explanation of all these is within the Risk Management Policy section 7.5.

8.7 Responding to Risk

When managing risks there are four key considerations for every risk that may change depending on the risk rating, level of authority for the risk, risk appetite and individual risk decisions as detailed below;

Treat - This is the most common response and allows the Trust to continue with the activity giving rise to the risk whilst working on developing controls to reduce the risk to its target (and tolerable) rating which will be the acceptable level;

Tolerate – The decision for tolerating a risk may be done at first identification or once the risk has been reduced to its target rating. Risks may be acceptable on identification because their realisation may be tolerable without any further action being taken, or; the ability to do anything about the risk may be limited, or; the cost of taking action is disproportionate to the potential benefit gained. The Trust's ability to tolerate risks will depend on its risk appetite however as a general rule hazard and compliance risks scoring high or moderate are not tolerated unless all possible strategies to mitigate the risk have first been considered and (where appropriate) implemented. When a risk has been managed to its target rating it is a tolerable risk and therefore a managed risk that can be closed, or if deemed necessary kept open for minimum of an annual review.

Transfer - An effective response to risks is to transfer them if financially and operationally viable. This is usually achieved through conventional insurance, or by paying a third party to take the risk in another way. This option is particularly good for mitigating financial risks or risks to assets. An existing risk may also be transferred from one risk register to another if requires a higher level of authority to deliver the mitigating actions.

Terminate - This is usually the final option available and will not always have a favourable outcome without impacting on reputation. If a risk is so high and cannot be mitigated swiftly there may need to be a decision to terminate the activity causing the risk. This will be a limited option within the Trust as a healthcare provider.

9 Risk Training

Training for staff is essential for robust risk management. The following levels of training will be provided by the Trust, the format (face to face or e-learning) will be arranged with the Learning and Development Team;

All training levels below are once only unless identified through appraisals that refresher training may be required.

Level 1 – Identification and assessment - For all trust staff (this can be included within patient safety or health and safety)

- To understand what a risk is;
- To identify and escalate risk;
- To understand the risk assessment (risk matrix, risk controls and actions);
- To identify any immediate risks to patient safety and correct them;

Level 2 - Risk management and escalation – For all managers with responsibility for their Department, Specialty, Care Group, Site and Corporate Services (Band 6, 7, 8 and senior management teams)

- To undertake formal risk assessments, clearly describing the risk and assessing the ratings, identifying controls and actions;
- Use of Datix WEB risk module to enter a risk, update and extract report;
- To be able to action and document mitigations against risks (controls) and assess adequacy of controls;
- To be able to escalate risks when unable to control risks within own / risk register level resources (including completion of risk escalation process);
- To understand the process of risk escalation and de-escalation;
- Awareness of the escalation process and the committee scrutiny and ownership of risks – risk control and escalation and risk registers;
- To understand risk tolerance against risk appetite for the organisation.

Level 3 – Strategic risk management and control – For the Executive Team

- To understand the Board Assurance Framework and its use within the Board environment;
- Overview of risk principles, framework and process within the organisation detailed within this strategy.

10. Monitoring and Assurance of this strategy and the Risk Management Policy

The internal audit plan will include specific reviews of the trust risk management system and assurance framework. The frequency and content of these will be determined by the Audit Committee.

The monitoring of this strategy will be on-going through the effectiveness of risk registers at each level and the quality of the risk entries. An annual review of the risk system across the trust will be completed by the Head of Risk. The following indicators will be monitored and reported to the Risk and Governance Committee and Audit Committee on an annual basis;

Strategy Compliance	Monitoring methods	Assurance
Risks containing the minimum dataset and clear description	Audit of 20 Random risks on the system	Audit results annually to Risk & Governance & Audit Committee
Risk review/discussion included in Care Group Governance and Corporate Service Meetings	Audit of sample of governance meetings and minutes with evidence of review of risk	
Risk review/discussion included in trust wide committee meetings	Audit of sample of committee meetings and minutes with evidence of review of risk	
Risks on the corporate risk register have evidence of escalation from appropriate levels	Sample of risks and review of minutes of meetings and Datix audit trail	
Annual review of Risk Strategy to ensure relevant with guidance and legislation.	Risk and Governance Committee minutes documenting review.	
Percentage of Care Groups, specialties and departments with risk registers held on Datix	Key performance indicator extracted from Datix	Quarterly review – Risk Team and annual report to Risk & Governance & Audit Committee
Number of risks within appropriate review date	Random sample of 20 risks - Key performance indicator extracted from Datix	
Number of closed risks with clear audit of approval to close	All closed risks for the previous quarter - Key performance indicator extracted from Datix	
Percentage of actions completed by target date (once new software in place)	All completed actions in quarter - Key performance indicator extracted from Datix	
Percentage of risks closed by target date	All closed risks for the previous quarter - Key performance indicator extracted from Datix	
Percentage of staff with owning a risk trained in risk management	Key performance indicator extracted from Datix	

11. Associated documents

Some of the related policies are outlined below.

- Risk Management Policy

- Trust organisational structure charts and committee structure
- Health and Safety Policy

12. Approval and review

This Strategy will be owned by the Director of Quality Governance on behalf of the Board and will be reviewed on an ongoing basis to ensure it remains relevant, especially in relation to organisational structure and risk appetite. Minor amendments will be delegated to the Risk and Governance Committee to approve as required.

13. References

- Care Quality Commission (2009). Guidance about compliance: summary of regulations, outcomes and judgement framework.
- ISO 31000:2018. Risk management – Guidelines.
- HM Government – The Orange Book, Management of Risk – Principles ad Concepts (2020)
- A Risk Matrix for Risk Managers, National Patient Safety Agency (2008)
- Defining Risk Appetite and Managing Risk by Clinical Commissioning Groups and NHS Trusts, Good Governance Institute (2012)

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Appendix A - Risk Scoring Matrix and Action guide

CONSEQUENCE TABLE: GUIDANCE ONLY – USE ONLY THE MOST APPROPRIATE ATTRIBUTES

	ATTRIBUTE	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
PEOPLE	**Patient safety**	No obvious injury/harm	Minor non-permanent injury/harm. Increase in length of hospital stay by 1-3 days.	Semi–permanent injury/harm (up to 1 year,) e.g.: • Medication error due to wrong drug, wrong patient, wrong dose, wrong route, wrong time/omission, wrong frequency, wrong diluent or wrong infusion volume/rate • Adverse drug/blood reaction e.g. any untoward reaction to the blood transfused or correct drug administered such as allergic/anaphylactic reactions, skin rash, nausea and vomiting, etc. • Equipment failure e.g. cylinder runs out of oxygen while transporting patient; laser or diathermy burns; etc. • Patient falls e.g. from bed, stretcher, chair, toilet, etc. • Adverse outcome of procedure, e.g. perforation of bowel following peritoneal dialysis catheter insertion	Incidents involving major permanent injury/harm or any of the following: • Infant Abduction • Infant Discharged to Wrong Family • Mismatch (Haemolytic) Blood Transfusion • Rape or serious assault • Surgery on Wrong Patient or Wrong Body Part • Wrong radiological or laboratory results causing wrong treatment or procedure being carried out when it is not necessary or may even cause morbidity to the patient	Death e.g.: • Death resulting from 'medical error' • Death following adverse outcome of procedure • Any fatal cardiac or respiratory arrest that occurs intra-operative or in recovery room Any event that impacts on a large number of patients.
	Clinical effectiveness	No significant impact on clinical outcome	Minor impact on clinical outcome, readily resolvable	Unsatisfactory clinical outcome related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory clinical outcome related to poor treatment/care resulting in long term effects, less than 10 patients affected.	Unsatisfactory clinical outcome related to poor treatment/care resulting in long term effects, more than 10 patients affected.
	Patient experience	No significant impact on patient experience	Unsatisfactory patient experience related to treatment/care given, e.g. inadequate information or not being treated with honesty, dignity and respect - readily resolvable.	Unsatisfactory patient experience related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, less than 10 patients affected.	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, more than 10 patients affected.

	Staff safety	No harm. Injury/ill health resulting in less than 7 days absence from work.	Short term / non-permanent injury/ill health. > 7 days to 1 month absence from work. (RIDDOR reportable)	Medical treatment required, i.e. fracture, penetrating eye injury. > 1 month absence from work. (RIDDOR reportable)	Permanent or extensive injury/ ill health / permanent disability or loss of limb. (RIDDOR reportable)	Death
	Staff morale	No significant impact on staff morale	Minor short-term staff discontent – readily resolvable	Moderate staff discontent causing short term staff turnover	Major staff discontent causing some short-medium term staff turnover	Extreme, prolonged staff discontent resulting in high staff turnover
	Public safety	No significant impact on public (e.g. visitor) safety	Minor non-permanent injury or ill health	Semi-permanent injury or ill health (up to 1 year)	Major permanent injury or ill health	Death

	ATTRIBUTE	Negligible	Minor	Moderate	Major	Extreme
ORGANISATION	**Objectives**	No significant impact	Minor impact on objectives.	Moderate impact on objectives	Gross failure to meet some of key objectives.	Gross failure to meet most or all of key objectives.
	Compliance e.g. standards, policies/protocols, targets, contracts, etc.)	No significant non-compliance	Single failure to meet internal standards or follow protocol. Minor recommendations that can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Important recommendations that can be addressed with an appropriate management action plan.	Gross failure to meet external standards. Repeated failure to meet national norms and standards/regulations.
	Service impact	Insignificant interruption of service(s) which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service(s) with minor impact on patient care	Some disruption to service(s) provision with unacceptable short-term impact on patient care. Temporary loss of ability to provide service(s).	Sustained loss of service which has serious impact on patient care resulting in major contingency plans being involved.	Permanent loss of core service or facility.
	Information governance	No significant breach of data confidentiality	*Potentially* serious breach of data confidentiality	Serious breach of data confidentiality with up to 100 people affected.	Serious breach of data confidentiality involving either particular sensitivity (e.g. sexual health) or up to 1000 people affected.	Serious breach of data confidentiality with potential for ID theft or over 1000 people affected.

	Adverse publicity/ reputation	No significant adverse publicity or impact on reputation	Local media coverage – short term Some public concern. Minor effect on staff morale/public attitudes	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Review/investigation necessary.	National media/adverse publicity. Public confidence in King's seriously undermined. Use of resources questioned. Need to report to SHA/Monitor etc.	Total loss of public confidence. Political intervention.
	Finance	Small loss, e.g. less than 1 % budget or less than £1k	Minor loss, less than 5% budget up to £100k	Moderate loss,20% of budget up to <£1m	Major loss, 30-40% budget or up to £1M-£10M	Extreme loss greater than 40% total budget or > £10M
ENVIRONMENT	**Environmental impact**	No significant damage to environment	Short-term minor pollutant release to air or water. Non-damaging. Includes noise and fire pollution.	Short-term minor pollutant release to air or water on-site causing some non-lasting damage	Major spill of toxic/hazardous substance(s) with potential to seriously affect people, animals and/or plants life	Major spill of toxic/hazardous substance(s) causing harm/damage to people, animals and/or plant life

LIKELIHOOD TABLE

	Actual frequency	**Will occur:**	**Probability**
Almost certain (5)	Will occur given existing controls	Daily	> 90%
Likely (4)	Will probably occur given existing controls	Weekly	50% - 90%
Possible (3)	Could occur given existing controls	Monthly	10% - 50%
Unlikely (2)	Not expected to occur, except for in exceptional circumstances, given existing controls	Once a year	1% - 10%
Rare (1)	Not expected to occur given existing controls	Once in >2 years	> 1%

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RISK MATRIX (risk score calculation)

LIKELIHOOD	CONSEQUENCE 1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain Will occur given existing controls	5	10	15	20	25
4 Likely Will probably occur given existing controls	4	8	12	16	20
3 Possible Could occur given existing controls	3	6	9	12	15
2 Unlikely Not expected to occur except in exceptional circumstances given existing controls	2	4	6	8	10
1 Rare Not expected to occur given existing controls	1	2	3	4	5

Appendix A (continued)

Risk Level	Risk treatment, communication and review frequency based on risk priority
High (Red) (15-25)	Treatment: Immediate action required - risk cannot be accepted or tolerated. Create an initial action plan or modify an existing treatment plan no later than 2 weeks after identification. Communication: Notify Executive Director and senior operational group or committee. Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. Review: At least every 2 months, no longer. Review and update monthly or sooner if circumstances change. Review at appropriate risk register level.
Moderate (Orange) (8-12)	Treatment: Action required to reduce risk to as low as reasonably possible considering cost versus benefits. Risk may be managed at service or department level. Create an initial action plan, or modify an existing treatment plan no later than 3 weeks after identification. Communication: Notify Directorate Management Team for information. Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. Review: Review and update quarterly or sooner if circumstances change. Review at appropriate risk register level.
Low (Green) (1-6)	Treatment: action required – implement quick easy measures when resources are available. Risk may be managed at service or department level. Create an initial, or modify an existing treatment plan no later than one month after identification. **If at 1 -3 there may be not action required as acceptable risk requiring no further treatment** Communication: Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. Review: Review and update six monthly or sooner if circumstances change. Review at appropriate risk register level.

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Appendix B:

Risk Appetite Statement

The Board recognises that it is impossible and not always appropriate to eliminate all risks. Systems of control must be balanced in order that innovation and the use of limited resources are supported when applied to healthcare. The Board also recognises the complexity of risk issues in decision-making and that each case requires the exercise of judgement. However, the Risk Appetite Statement can be used to inform decision-making in connection with risk and what limits may be deemed as outside their tolerance.

The Risk Appetite Statement does not negate the opportunity to potentially make decisions that result in risk taking that is outside of the risk appetite however these instances would usually be required to be referred to the Board.

The Trust recognises that its long-term sustainability depends upon the delivery of its strategic objectives and its relationships with its patients, staff, the local community and strategic partners.

The lowest risk appetite relates to safety and compliance objectives, including employee health and safety, with a higher risk appetite towards strategic, reporting, and operations objectives. This means that reducing to reasonably practicable levels the risks originating from various clinical systems, equipment, and our work environment, and meeting our legal obligations will take priority over other business objectives.

As such, the Trust has a minimal appetite for risks that impact on quality of care, specifically anything that compromises or has the potential to compromise its ability to be safe and effective in providing a positive patient experience. Interrelated, the Trust has a minimal risk appetite relating to regulatory non-compliance.

The Trust has significant appetite to pursue innovation and challenge current working practices in pursuance of its commitment to clinical excellence, providing that patient safety and experience is not adversely affected.

The Trust has a moderate appetite to take considered risks in terms of their impact on financial stability and reputation in terms of its willingness to take opportunities where positive gains can be anticipated, within the constraints of the regulatory environment.

Similarly, the Board has only a moderate appetite to risks associated with the development of its people and demonstrating effective leadership recognising that both of these elements are key to ensuring quality service and care to patients and achieving the Trust objectives.

The Board has greatest appetite in seeking strategic transformation of healthcare across South East London, as well as developing wider effective partnerships, alliances and commercial ventures where positive gains can be anticipated, providing they are done so within the regulatory environment in which we operate.

The Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high in comparison to the potential severity of the risk and the likelihood of it occurring.

In implementing the Trust's risk appetite, target risk scores have to be determined for each risk based on the appetite described.

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Appendix C

Risk Register Escalation/De-escalation Form

Please escalate a risk to the next level Risk Register once all possible controls have been implemented to reduce to the target rating.

Request to escalate the following risk to	
Request to de-escalate the risk or close	
Initial Risk Register holder (e.g. Care Group)	

Risk ID	
Date risk opened	
Risk owner	
Current rating	
Target rating	
Risk description	
Controls in place	
Actions remaining to reduce the risk	
Supporting Evidence (Control Effectiveness) Evidence to support the effectiveness of controls and justify the current risk rating. E.g. KPI's or outcome measures. Frequency issue occurred and evidence of impact	

Rationale for escalation/ de-escalation (please give assurance all possible controls are in place and why the outstanding/required actions cannot be achieved by the current register holders):

Committee/Group Decision

Accept the risk onto the higher level risk register as a new risk and completely remove from the lower risk register;	
Accept the risk as part of an existing higher level risk but the risk remains with the current holders with a clear link to the higher level risk (ID number linked);	
Accept the delivery of a particular action and include in the committee action tracker with the risk remaining at existing level;	
Not accept the risk or action and request further controls, actions or review of current and target rating by the requesting risk holder.	
Agreement to de-escalate or close the risk	

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Appendix D. Equality Impact Assessment Tool

Name of Person carrying out Equality Impact Assessment	*Ashley Parrott*	*Department of assessor*	*Executive Nursing*
1. Name of the strategy / policy / clinical practice	*Risk Management Strategy*	*Date last reviewed or created*	*Jan 2021*
2. What is the aim, objective or purpose of the strategy / policy / clinical practice	*The purpose of this strategy is to describe the arrangements for effective risk management in support of the organisation's vision and objectives and to meet relevant standards imposed by legislation and our regulators.*		
3. Who implements the strategy / policy / clinical practice	*The Board of Directors, Executive Nursing (Risk Team), senior managers and department leads (including Care Groups). All staff with responsibility for assessing or managing risk*		
4. Who is intended to benefit from this strategy / policy / clinical practice and in what way?	*Patients, staff and management through the reduction of risk to patients, staff and visitors and compliance with key regulatory requirements*		
5. Is the strategy/ policy / clinical procedure applied uniformly throughout the Trust?	*Yes*		
6. Who are the main stakeholders in relation to the strategy / policy / clinical procedure (for example certain groups of staff, patients, visitors etc)?	*All staff have a duty to identify risks to self and others. The key stakeholders to the strategy are the Board, senior managers and department leads (including Care Groups).*		
7. What data are available to facilitate the screening of this strategy / policy / clinical procedure	*Profile of relevant staff*		
8. Is there any evidence of higher or lower participation, uptake or exclusion by the following characteristics?			
Race (Evidence)	*No*		
Gender (Evidence)	*No*		
Disability (Evidence)	*No*		
Sexual Orientation (Evidence)	*No*		
Age (Evidence)	*No*		
Religious Belief (Evidence)	*No*		
Carers or those with dependants (Evidence)	*No*		
9. In the context of the preceding sections are there any groups which you believe should be consulted?	*No*		
10. What data are required in the future to ensure effective monitoring?	*Not applicable*		
11. Considering all information please indicate areas where a differential impact occurs or has the potential to occur. Please specify and give reasons.	*None: Strategy can be available in different languages and formats on request.*		
Potential for differential impact?	*None*		*Recommended for full impact assessment?* *No*
Signed *A. Parrott*	*Date of assessment* *14/1/2021*		

King's College Hospital NHS Foundation Trust

Risk Management Policy

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Ratification Date	
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Responsible Executive Director	Risk and Governance Committee
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Consideration of counter fraud, corruption or bribery measures was given	Consideration given
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Relevant External Requirements	Care Quality Commission, Health and Safety Executive

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King's College Hospital NHS Foundation Trust

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Index

King's College Hospital NHS Foundation Trust

1. Introduction

This document supports the trust Risk Management Strategy which outlines the risk principles, framework and process. This policy focusses on the risk process and the identification, assessment and management of risk. The risk matrix for assessing and evaluating risk is included within this document. There are 4 main types or risk;

- Compliance risks (these could be mandatory or regulatory)
- Hazard risks (known as pure risks) – e.g. staff or patient safety
- Control risks (uncertain of the outcome such as a project or transformation)
- Opportunity risks (speculative or risk for a positive return)

2. Definitions

Risk Management: *Coordinated activities to direct and control the organisation with regard to risk* (ISO 31000:2018 Risk Management – Guidelines). This is the systematic process of the identification, analysis, evaluation and control of actual and potential risks to patients, visitors, staff, contractors, property and to the achievement of the Trust's strategic priorities.

Risk: *Is the combination of the probability of an event and its consequence. The consequence can range from positive to negative. (Institute of Risk Management – IRM)* This is the likelihood (probability) that an event with adverse consequences or impact (hazards) will occur in a specific time period, or as a result of a specific situation. This event may cause harm to patients, visitors, staff, property, or have an impact on the Trust reputation, corporate objectives, stakeholders or assets.

Hazard: Is something that has the potential to cause harm, such as substances, equipment, methods of work, and other aspects of work organisation.

Event: *The occurrence or change of a particular set of circumstances, this could be expected or unexpected* (ISO 31000:2018 Risk Management – Guidelines).

Likelihood: *Is the chance of something happening* (ISO 31000:2018 Risk Management – Guidelines).This is measured by the frequency of exposure to the hazard or the probability of an event occurring on a scale of 1 to 5.

Consequence (impact): *Is the outcome of an event affecting objectives* (ISO 31000:2018 Risk Management – Guidelines). This can be measured as the level of harm that has, or may be suffered (Trust scale of 1 to 5.

Risk Level (rating): The likelihood of a risk occurring (on a scale of 1-5) multiplied by its impact (also on a scale of 1-5) to give a score out of 25. The higher the score the more serious the risk to the organisation, see **Appendix 1**.

Controls: Are arrangements and systems that are intended to maintain and or modify the risk such as minimise the likelihood or severity of a risk. An effective control will always reduce the probability of a risk occurring. If this is not the case, then the control is ineffective and needs to be reconsidered. Controls are intended to improve resilience.

Controls Assurance: Is the means by which the organisation, Board of Directors, trust senior leadership, manager, or clinical lead knows that the controls designed to manage/ mitigate risks are effective and being properly implemented.

Gap in Assurance/control: Is deemed to exist where adequate controls are not in place or where collectively they are not sufficiently effective. A negative assurance (a poor internal audit report for example) highlights gaps in control.

The Risk Register: Is a management tool that allows the Trust to understand its comprehensive risk profile through accessing the various risks. The Trust has different risk register levels which are Department/Specialty, Care Group, Site, Corporate or Board Assurance Framework.

Board Assurance Framework (BAF): The BAF provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting their objectives and deliverables outlined in the Trust strategy.

Inherent or Initial Risk: Is the risk linked to the activity itself without the application of controls i.e. when first identified.

Current or Residual Risk Rating: Is the risk remaining after the controls put in place to mitigate the inherent or initial risk are fully effective. The current risk status can be changed at any time if and when the controls change.

Target Risk Rating: The level of risk the department, Care Group or Trust is willing to accept once all the controls are in place. This is set depending on the risk appetite for the risk type. When a risk has been managed to its target level, the remaining risk reflects that all reasonable and additional controls have been applied and are known to be effective.

Managed (Tolerable) Risk: Is the remaining risk when all reasonable and additional controls have been applied and the risk is at its target rating.

Health and Safety Risk Assessment: Is proactive examination of the risks arising from work. This includes risks from activities, processes, workplaces, equipment and people at particular risk. Health and safety risk assessments inform the risk register where a risk has been identified which is unable to be controlled to as low as reasonably practicable (i.e. the control measures identified in the risk assessment are unable to be implemented locally) and could have a wider impact or a high impact in the relevant department. The risk must be entered onto the risk register in this instance. The Health and Safety risk assessments are stored on the Datix system.

Patient Risk Assessments: These are clinical assessments conducted by clinicians to ensure the safe care of patients, recorded and stored within the health record.

Risk Appetite: Is the amount of risk exposure, or potential adverse impact from an event, that the organisation is willing to accept / retain. Once the risk appetite threshold has been breached, risk management treatments and business controls are implemented to bring the exposure level back within the accepted range. The risk appetite may vary according to risk type.

3. Purpose and Scope

3.1 This document should be read in conjunction with the Trusts Risk Management Strategy 2021-2023

3.2 The overall purpose of the document is to describe the risk assessment process through which risks are *identified*, *recorded, evaluated/analysed, and actioned to manage the risk* to improve safety, quality and performance across King's College Hospital Foundation Trust (The Trust).

3.3 The Trust uses Datix as its Risk Management database. This document is not a Datix user guide for the risk module. For advice on the Datix system please contact the Risk and Datix Team or access the Risk and datix page on KWIKI.

4. Duties

4.1 Chief Executive

Has overall responsibility for ensuring Risk Management is robust within the Trust to cover all of its activities. The Chief Executive is required to sign the Annual Governance Statement on behalf of the Board of Directors to provide stakeholders with an assurance that the Trust has met its governance responsibilities.

4.2 Executive Lead

Wherever possible each risk on the system will be assigned to an Executive Director to ensure they are aware of any new current rated risk of 15 or above and that their directorate is managing risks in line with the Risk Management Strategy and related policies, procedures, guidelines and terms of reference.

4.3 Chief Nurse

The executive accounting officer responsible for risk management on behalf of the Trust Board.

4.4 Risk Owner

Every risk has a risk owner responsible for implementing and/or coordinating the identified actions planned to reduce the risk and for escalating when actions are not being progressed in a timely manner.

4.5 Director of Quality Governance

Delegated responsibility from accountable officer for ensuring the risk management principles, framework and process are embedded within the trust and the ownership of the risk strategy and this policy.

4.6 Director of Corporate Affairs

The Director of Corporate Affairs, supported by the Trust Secretary is responsible for producing, populating, updating and maintaining the Board Assurance Framework and ensuring it is scrutinised and used by the Trust Board as part of normal business, embedding into practice.

4.7 Head of Risk

The Head of Risk will ensure there is support and guidance for risk owners and committees, operational groups when required. This will also include oversight of all risks and management of the Corporate Risk Register, ensuring risks are escalated appropriately and reviewed within the timescales.

4.8 Each Operational Group, Committee, Care Group and department (including corporate services).

The department and clinical leaders, chairperson of committees are responsible for ensuring risk is embedded within the team, service, committee or governance meetings and that consideration is given to current and potential risks to the objectives or business of the relevant area and risks are escalated where required. Each meeting should be aware of the top 3 risks to their business/objectives and the control or further actions required to mitigate. This will raise risk awareness and focus teams on the core issues to address.

4.9 Risk and Governance Committee

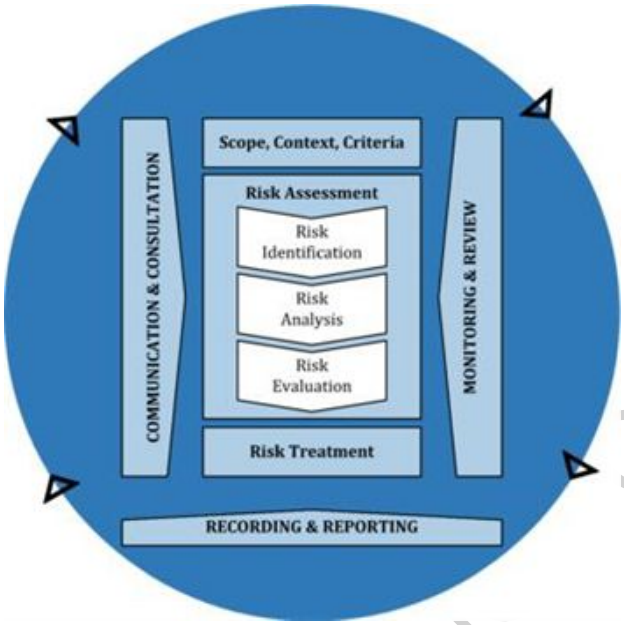
This committee will ensure the trust corporate risks (corporate risk register) are reviewed and updated and escalated to the Board Assurance Framework where impact on key strategic objectives. The committee will review and accept or remove risks from the corporate risk register.

4.10 All staff

All staff must comply with this policy and contribute to risk assessments and risk mitigation activities. Where staff feel worried about raising a risk or believe that it will not be effective, they are encouraged to follow the Trust's Raising Concerns (whistle blowing) guidance or access the Freedom to Speak up Guardian.

5. The Risk Process

The figure below from the Standard ISO 31000:2018 Risk management – Guidelines outlines the risk process the trust will follow.



6. Identifying Risks

6.1 Risks are identified from a variety of proactive and reactive sources such as:

- Incidents, complaints, claims and inquests
- Performance management
- Horizon scanning and external reports, reviews and commissioning landscape
- Safety Alerts
- Regulation and standards and guidance/best practice
- Audit outcomes (internal and external)
- Reviews and inspections (regulatory, professional bodies etc.)
- Projects, transformation and strategic planning.

6.2 When identifying risks individuals, groups or committees should in addition to the above consider what can impact on achieving the organisation, department, project or task objectives.

6.3 Risks and issues that can be easily and immediately resolved do not need to be added to the risk register.

7. Recording Risks

7.1 The Trust uses Datix to record and manage its risks. A project risk register could be held locally by a department but any principle (overarching) risk to people or the

organisation should be recorded on Datix and aligned to the relevant committee and or department.

7.2 Subject matter risk assessment forms i.e. Health and Safety will be recorded and stored locally in accordance with their associated Standing Operating Procedure.

7.3 Risks should generally be recorded on Datix by the Risk Owner however it is the responsibility of the recorder to ensure the Risk Owner is notified a risk has been recorded and that they are in agreement. All new risks must be reviewed and discussed at the relevant committee, department at appropriate level (see risk framework in the Risk Strategy – section 7)

7.4 Once identified the description of the risk must include the risk event (the event that could happen), the cause (the facts) of this risk and the impact (e.g. safety, compliance) it could have. Therefore it must be written on the system as “There is a risk…. Caused by….. That could impact on……”. (In simple terms, IF x THEN y).

7.5 To ensure the assessment is robust the process should be done collectively as this enables different opinions to be considered, reducing the possibility or a biased and/or unbalanced outcome. If not possible the first review at the committee, team or governance meeting should confirm the assessment.

7.6 The following minimum dataset must be completed on the Datix system when recording the risk;

Risk ID	Datix will automatically produce
Opened date	Date risk identified
Risk title	Maximum of 6 words – e.g. Generator failure
Risk description	There is a risk of… caused by… could impact on….
Inherent risk score	The risk score before controls (see risk matrix)
Controls in place	The controls to reduce likelihood or impact of the risk
Adequacy of controls (strong, moderate, weak)	This is a control effectiveness rating see section 8 of this document
Current rating (with the controls in place) including the current likelihood and consequence (impact) score	Assessment of risk score with controls – use risk matrix
Actions (required to reduce the risk)	Clear “SMART” actions to reduce risk to target rating by identifying and establishing further robust controls
Target risk rating	Based on risk appetite (see risk strategy) what is the risk score that will make this risk acceptable (safe) and controlled

Target risk completion/closure date	When is this risk likely to be resolved/reduced to acceptable level
Risk owner	Who is responsible to check and update risk and ensure actions developed
Executive lead	The Executive Director responsible for the workstream (it may not always be one executive)
Risk type	Choose from dropdown e.g. patient safety
Risk plan (4T's of hazard response	Tolerate, treat, transfer, terminate
Monitoring committee	The committee aligned to the risk e.g. fire risk - Fire Safety group
Location/department	The area the risk (event) could occur
Risk register level	Level of control/ownership – e.g. Specialty or Care Group

7.7 Once entered onto the Datix system the risk can remain in draft form for Risk Team to review and or for the owner to discuss the risk with senior team members, committee or relevant governance meeting. This enables the risk to be refined and confirmed and changed to open or if deemed appropriate, rejected.

8. Risk analysis (evaluation) and assessment

8.1 All assessments must consider the Risk Scoring Matrix (**Appendix A**) when evaluating the inherent risk score (before any controls), the current score (once controls in place) and the target score which is the level of risk the trust will accept. The score (rating) is derived from likelihood x impact (consequence) = risk score (rating)

8.2 The inherent score is the risk rating at the first identification of the risk with the existing controls in place (if there are any controls).

8.3 When determining the target risk score the following is a guide based on the trust risk appetite;

Risks impacting on safety (patients, staff and visitors), compliance to regulation and standards, quality of care – the target risk level rating must be low as the trust has a low appetite (acceptable level) for any such risk.

Risks impacting on finance and staffing opportunities where the gains could be beneficial to the services (so long as no harm to staff) – the target rating must be moderate or below as the trust has a moderate appetite for these risks.

Risks impacting on innovation and strategic transformation where there are opportunities to pursue clinical excellence or develop external partnerships, but no

harm to patient safety or experience – the target risk rating can be higher as the trust has the greatest risk appetite for these opportunities and potential gains for the organisation and the people it serves.

8.4 The risk controls are critical to evaluating a risk and considering the current risk rating (score). Controls are the specific measures in place to reduce the likelihood of the risk occurring or in some cases reducing the impact. There are 4 main types of controls:

Preventative - e.g. pre-employment screening or substitution of the hazard for something less of a risk (e.g. cooler water)

Corrective (responsive) – e.g. limitation on hours worked or passwords or increased staffing to manage a system

Directive – e.g. training and supervision or personal protective equipment or policy/procedure

Detective – e.g. audits, key performance indicators, surveillance (health)

The controls in place must be documented as part of the evaluation and then the current risk rating can be assessed and recorded.

8.5 Adequacy of controls

Once the controls have been documented an assessment to the effectiveness (adequacy) of these must be completed and recorded (this should be done after the addition of new controls). It is important to consider how controls will be measured for effectiveness. For example are there key performance indicators that would track the effectiveness of a policy such as hand hygiene audit? The following table is the guide to determine the adequacy;

Control Rating	Definition – Assessment
Strong (3)	Control(s) operating effectively to manage current risk rating
Moderate (2)	Some deficiencies in the control(s) have been identified however there are compensating controls to cover identified faults. Further controls required to ensure control of risk at current rating.
Weak (1)	Significant control deficiencies have been identified and more robust controls required to manage risk at current rating

8.6 Controls Assurance and Gaps in Assurance

Effective management of a risk is to ensure there is assurance to the adequacy of the controls in place to mitigate the risk. There are four levels of assurance (also known as lines of defence);

- First line:
  The way risks are managed and controlled day-to-day. Assurance comes directly from those responsible for delivering specific objectives or processes. It may lack independence but its value is that it comes from those who know the business, culture and day-to-day challenges. For example - following procedures, wearing PPE, two person checking process.

- Second line:
  The way the organisation oversees the control framework so that it operates effectively. The assurance provided is separate from those responsible for delivery, but not independent of the management chain, such as risk and compliance functions. For example – internal performance targets, central committee monitoring and performance figures, surveys.

- Third line:
  Objective and independent assurance from internal audit or central governance teams providing reasonable (not absolute) assurance of the overall effectiveness of governance, risk management and controls. The level and depth of assurance provided will depend on the size and focus of the internal audit function and management's appetite for internal audit assurance. For example – internal audit, peer reports, national audits and surveys.

- Fourth line:
  Assurance from external independent bodies such as the external auditors and other regulatory bodies. External bodies may not have the existing familiarity with the organisation that an internal audit function has, but they can bring a new and valuable perspective. Additionally, their outsider status is clearly visible to third parties, so that they can not only be independent but be seen to be independent. For example - Commission/Regulator/ Accreditation reports, accreditation.

9. Managing the risk (risk treatment)

9.1 When reviewing a risk it is essential the Datix field 'Date Current Assessment' is updated to indicate a review and update has taken place. Please note this is not an automated function. This should be completed by the risk owner but should be done in collaboration (can be done separately but must inform and share) with the committee or team/department/governance meeting to ensure all aware of the risk status.

9.2 Risks and or risk registers shared at any committee or any meeting must contain the minimum dataset listed in section 4.5 above to ensure the appropriate

information is available for suitable discussion and risk awareness. The key questions to ask by the committee, operational group or department meeting are:

- Is the description still appropriate?
- Are the current controls strong?
- Is the current rating correct?
- What is the progress on actions (what is required to provide further controls to reduce the risk)?
- What else needs to be done?
- Is this risk controlled and can we resolve at our level of authority/accountability?

9.3 All risks recorded on Datix must have a current status using the options and workflow as below:

- **Draft** – Should the person recording the risk need to obtain advice from the Risk Team, further information or confirmation from committees, governance meetings, the proposed owner, or senior manager it should stay as draft. It must not be in draft for longer than 10 working days. An open risk can still be amended once reviewed and approved by committee etc.
- **Open** – Denotes the risk is open and has usually be confirmed as accurate and appropriate. Once open status it is visible on the system and within the relevant risk registers.
- **Target Met, Periodic Review** – Not all risks will be suitable to close once risk target level has been achieved. The owner and appropriate risk register level owners (e.g. a Care Group or committee) may agree to monitor the risk for a period of time to ensure it remains controlled to target level. These risks will require a minimum of an annual review but will not routinely feature on the 'Business As Usual' (open risks) risk registers. A separate report will be required for the review of these.
- **Closed** – These are risks that have been reduced to target rating with effective controls or the risk has been eliminated. Approval to close must be by the owner but also the Operating Group, Committee or Forum (department, governance meeting).
- **Rejected** – These are risks that were placed on the system but following initial review they were not required or the risk was already resolved, or entered in error or a test for training or system checks.

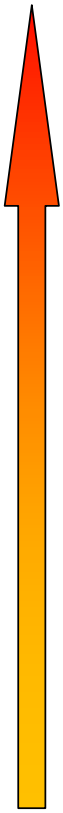
9.4 Risk Actions to reduce/mitigate the risk

The actions and timescale required to reduce the risk must be recorded within the risk action summary section on Datix. The action description must be succinct with the completion date included. The action should increase the controls and therefore reduce the risk rating. Once an action has been completed it should then move and become a control – therefore the controls section will require updating to reflect this. Once action complete, and controls amended the current rating can be considered.

9.5 Risk Escalation

The Risk Strategy provides full detail of risk escalation and assurance for managing risks through operational management and trust wide committees. The following provides a brief overview of the process to ensure risks are managed and escalated appropriately. See also Appendix A “Risk Matrix and Action Guide”;

Operational Risk Escalation	**Trust wide risk assurance and escalation**	**Urgent Risk Escalation for a high risk that cannot be controlled with major or catastrophic impact**
Trust Board Board Assurance Framework (BAF)		
Board Committees – Risk Assurance		
Risk and Governance Committee for acceptance to Corporate Risk Register		
Site Team meeting / quality reviews/ governance meeting	Executive Oversight Committees	King’s Executive Committee
Care Group or Corporate Service Team /Governance meeting	Operational groups/committees	Executive Director responsible for the
Department or Specialty		Risk Owner or any operational group or trust wide committee



The committee or operational group agrees whether to escalate to the next risk register level based on the current rating and whether the risk is controlled sufficiently. The escalation and subsequent transfer of a risk to the next level will only be accepted if it cannot be controlled and if the risk is deemed to have a

greater and or wider impact. A high risk for a department may not be significant for the Site or Trust. It may be the risk remains at the initial level with a specific escalated action for the risk. The risk escalation template (**Appendix B**) can be used for escalation.

The decision to escalate a risk to the next level should be based on the following;

- The severity of actual harm it could cause to people or the trust;
- How well controlled the risk is likely to be by the current owners?
- Have all possible controls been put in place to mitigate?
- Can the actions required to mitigate be delivered by the current group/committee?

The proposed new risk register holders will review the request and following discussion will agree to one of the following;

- Accept the risk onto the higher level risk register as a new risk and completely remove from the lower risk register;
- Accept the risk as part of an existing higher level risk but the risk remains with the current holders with a clear link to the higher level risk (ID number linked);
- Accept the delivery of a particular action and include in the committee action tracker with the risk remaining at existing level;
- Not accept the risk or action and request further controls, actions or review of current and target rating by the requesting risk holder.
- Agree to de-escalation or risk closure
- The risk owner may change when escalated or de-escalated

All risks on the trust register are aligned to a trust wide committee to ensure there is oversight of risks and aggregation should there be a number of similar risks across different departments. Any risk can be escalated to a trust wide committee and or through the organisational structure. A risk can go straight to the Corporate Risk Register if required and approved by the relevant Executive Lead and the risk and Governance Committee.

9.6 Risk Aggregation

Individual areas will face similar risks, but correctly identify these as moderate or low with actions underway to mitigate them, or could be a risk for periodic review. Individually these risks will not have a significant impact on the objectives of the Trust, but when considered collectively a different picture could emerge, potentially resulting in a risk that should be escalated to higher levels within the organisation. The Risk Team and the trust wide committees will review these and monitor the risks (committees risks assigned to their activity, and Risk Team all risks) and escalate a risk theme. This may become a higher level risk linked to the individual

risks within operational groups or committees. The appropriate committee will manage this aggregated risk (in most cases it will be the Corporate Risk Register).

9.7 Risk review timescales

The risk register (open risks) for each operational risk group should be reviewed every 2 months but this is the overall risk register and not an in-depth analysis of each risk. The specific risk (open) must be reviewed as a minimum to these timescales;

High risks (15-25) – review every 2 months

Moderate risks (8-12) – reviewed quarterly

Low risks (6 or less) – reviewed every 6 months

9.8 Corporate Risk Register

All risks added or removed from the Corporate Risk Register must be approved by the Risk and Governance Committee. The risk escalation form in **Appendix B** of this policy must be used for adding risks onto or removing from the Corporate Risk Register.

10. Monitoring Compliance and Policy Implementation

Please refer to the Trust Risk Management Strategy

This policy will be implemented through support to departments, specialties, committees and care groups and through the risk training to the appropriate staff.

11. Associated Documents

The Trust Risk Management Strategy 2020-2023

12. References

- HM Government – The Orange Book, Management of Risk - Principles and Concepts
- ISO 31000:2018. Risk management – Guidelines
- Institute of Risk Management (IRM)

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Appendix A - Risk Scoring Matrix and Action Guide

CONSEQUENCE TABLE: GUIDANCE ONLY – USE ONLY THE MOST APPROPRIATE ATTRIBUTES

	ATTRIBUTE	Negligible (1)	Minor (2)	Moderate (3)	Major (4)	Extreme (5)
PEOPLE	**Patient safety**	No obvious injury/harm	Minor non-permanent injury/harm. Increase in length of hospital stay by 1-3 days.	Semi–permanent injury/harm (up to 1 year,) e.g.: • Medication error due to wrong drug, wrong patient, wrong dose, wrong route, wrong time/omission, wrong frequency, wrong diluent or wrong infusion volume/rate • Adverse drug/blood reaction e.g. any untoward reaction to the blood transfused or correct drug administered such as allergic/anaphylactic reactions, skin rash, nausea and vomiting, etc. • Equipment failure e.g. cylinder runs out of oxygen while transporting patient; laser or diathermy burns; etc. • Patient falls e.g. from bed, stretcher, chair, toilet, etc. • Adverse outcome of procedure, e.g. perforation of bowel following peritoneal dialysis catheter insertion	Incidents involving major permanent injury/harm or any of the following: • Infant Abduction • Infant Discharged to Wrong Family • Mismatch (Haemolytic) Blood Transfusion • Rape or serious assault • Surgery on Wrong Patient or Wrong Body Part • Wrong radiological or laboratory results causing wrong treatment or procedure being carried out when it is not necessary or may even cause morbidity to the patient	Death e.g.: • Death resulting from 'medical error' • Death following adverse outcome of procedure • Any fatal cardiac or respiratory arrest that occurs intra-operative or in recovery room Any event that impacts on a large number of patients.
	Clinical effectiveness	No significant impact on clinical outcome	Minor impact on clinical outcome, readily resolvable	Unsatisfactory clinical outcome related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory clinical outcome related to poor treatment/care resulting in long term effects, less than 10 patients affected.	Unsatisfactory clinical outcome related to poor treatment/care resulting in long term effects, more than 10 patients affected.
	Patient experience	No significant impact on patient experience	Unsatisfactory patient experience related to treatment/care given, e.g. inadequate information or not being treated with honesty, dignity and respect - readily	Unsatisfactory patient experience related to poor treatment/care resulting in short term effects (less than 1 week).	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, less than 10 patients affected.	Unsatisfactory patient experience related to poor treatment/care resulting in long term effects, more than 10 patients affected.

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			resolvable.			
	Staff safety	No harm. Injury/ill health resulting in less than 7 days absence from work.	Short term / non-permanent injury/ill health. > 7 days to 1 month absence from work. (RIDDOR reportable)	Medical treatment required, i.e. fracture, penetrating eye injury. > 1 month absence from work. (RIDDOR reportable)	Permanent or extensive injury/ ill health / permanent disability or loss of limb. (RIDDOR reportable)	Death
	Staff morale	No significant impact on staff morale	Minor short-term staff discontent – readily resolvable	Moderate staff discontent causing short term staff turnover	Major staff discontent causing some short-medium term staff turnover	Extreme, prolonged staff discontent resulting in high staff turnover
	Public safety	No significant impact on public (e.g. visitor) safety	Minor non-permanent injury or ill health	Semi-permanent injury or ill health (up to 1 year)	Major permanent injury or ill health	Death

	ATTRIBUTE	Negligible	Minor	Moderate	Major	Extreme
ORGANISATION	**Objectives**	No significant impact	Minor impact on objectives.	Moderate impact on objectives	Gross failure to meet some of key objectives.	Gross failure to meet most or all of key objectives.
	Compliance e.g. standards, policies/protocols, targets, contracts, etc.)	No significant non-compliance	Single failure to meet internal standards or follow protocol. Minor recommendations that can be easily addressed by local management	Repeated failure to meet internal standards or follow protocols. Important recommendations that can be addressed with an appropriate management action plan.	Repeated failure to meet external standards. Important recommendations that can be addressed with an appropriate management action plan.	Gross failure to meet external standards. Repeated failure to meet national norms and standards/regulations.
	Service impact	Insignificant interruption of service(s) which does not impact on the delivery of patient care or the ability to continue to provide service	Short term disruption to service(s) with minor impact on patient care	Some disruption to service(s) provision with unacceptable short-term impact on patient care. Temporary loss of ability to provide service(s).	Sustained loss of service which has serious impact on patient care resulting in major contingency plans being involved.	Permanent loss of core service or facility.
	Information governance	No significant breach of data confidentiality	*Potentially* serious breach of data confidentiality	Serious breach of data confidentiality with up to 100 people affected.	Serious breach of data confidentiality involving either particular sensitivity (e.g. sexual health) or up to 1000	Serious breach of data confidentiality with potential for ID theft or over 1000 people affected.

					people affected.	
	Adverse publicity/ reputation	No significant adverse publicity or impact on reputation	Local media coverage – short term Some public concern. Minor effect on staff morale/public attitudes	Local media – adverse publicity. Significant effect on staff morale & public perception of the organisation. Public calls (at local level) for specific remedial actions. Review/investigation necessary.	National media/adverse publicity. Public confidence in King's seriously undermined. Use of resources questioned. Need to report to SHA/Monitor etc.	Total loss of public confidence. Political intervention.
	Finance	Small loss, e.g. less than 1 % budget or less than £1k	Minor loss, less than 5% budget up to £100k	Moderate loss,20% of budget up to <£1m	Major loss, 30-40% budget or up to £1M-£10M	Extreme loss greater than 40% total budget or > £10M
ENVIRONMENT	**Environmental impact**	No significant damage to environment	Short-term minor pollutant release to air or water. Non-damaging. Includes noise and fire pollution.	Short-term minor pollutant release to air or water on-site causing some non-lasting damage	Major spill of toxic/hazardous substance(s) with potential to seriously affect people, animals and/or plants life	Major spill of toxic/hazardous substance(s) causing harm/damage to people, animals and/or plant life

LIKELIHOOD TABLE

	Actual frequency	Will occur:	Probability
Almost certain (5)	Will occur given existing controls	Daily	> 90%
Likely (4)	Will probably occur given existing controls	Weekly	50% - 90%
Possible (3)	Could occur given existing controls	Monthly	10% - 50%
Unlikely (2)	Not expected to occur, except for in exceptional circumstances, given existing controls	Once a year	1% - 10%
Rare (1)	Not expected to occur given existing controls	Once in >2 years	> 1%

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RISK MATRIX (risk score calculation)

LIKELIHOOD	CONSEQUENCE 1 Negligible	2 Minor	3 Moderate	4 Major	5 Extreme
5 Almost Certain Will occur given existing controls	5	10	15	20	25
4 Likely Will probably occur given existing controls	4	8	12	16	20
3 Possible Could occur given existing controls	3	6	9	12	15
2 Unlikely Not expected to occur except in exceptional circumstances given existing controls	2	4	6	8	10
1 Rare Not expected to occur given existing controls	1	2	3	4	5

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Risk Level	Risk treatment, communication and review frequency based on risk priority
High (Red) (15-25)	**Treatment:** Immediate action required - risk cannot be accepted or tolerated. Create an initial action plan or modify an existing treatment plan no later than 2 weeks after identification. **Communication**: Notify Executive Director and senior operational group or committee. Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. **Review:** At least every 2 months, no longer. Review and update monthly or sooner if circumstances change. Review at appropriate risk register level.
Moderate (Orange) (8-12)	**Treatment:** Action required to reduce risk to as low as reasonably possible considering cost versus benefits. Risk may be managed at service or department level. Create an initial action plan, or modify an existing treatment plan no later than 3 weeks after identification. **Communication:** Notify Directorate Management Team for information. Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. **Review:** Review and update quarterly or sooner if circumstances change. Review at appropriate risk register level.
Low (Green) (1-6)	**Treatment:** action required – implement quick easy measures when resources are available. Risk may be managed at service or department level. Create an initial, or modify an existing treatment plan no later than one month after identification. If at 1 -3 there may be not action required as acceptable risk requiring no further treatment **Communication:** Escalate upwards from the organisation level in which risk was identified if risk cannot be managed within existing resources or requires Trust wide approach. **Review:** Review and update six monthly or sooner if circumstances change. Review at appropriate risk register level.

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Appendix B

Risk Register Escalation/De-escalation Form

Please escalate a risk to the next level Risk Register once all possible controls have been implemented to reduce to the target rating.

Request to escalate the following risk to	
Request to de-escalate the risk or close	
Initial Risk Register holder (e.g. Care Group)	

Risk ID	
Date risk opened	
Risk owner	
Current rating	
Target rating	
Risk description	
Controls in place	
Actions remaining to reduce the risk	
Supporting Evidence (Control Effectiveness) Evidence to support the effectiveness of controls and justify the current risk rating. E.g. KPI's or outcome measures. Frequency issue occurred and evidence of impact	

Rationale for escalation/ de-escalation (please give assurance all possible controls are in place and why the outstanding/required actions cannot be achieved by the current register holders):

Committee/Group Decision

Accept the risk onto the higher level risk register as a new risk and completely remove from the lower risk register;	
Accept the risk as part of an existing higher level risk but the risk remains with the current holders with a clear link to the higher level risk (ID number linked);	
Accept the delivery of a particular action and include in the committee action tracker with the risk remaining at existing level;	
Not accept the risk or action and request further controls, actions or review of current and target rating by the requesting risk holder.	
Agreement to de-escalate or close the risk	

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Appendix C

Equality Impact Assessment

Name of Person carrying out Equality Impact Assessment	*Ashley Parrott*	*Department of assessor*	*Executive Nursing*
1. Name of the strategy / policy / clinical practice	*Risk Management Policy*	*Date last reviewed or created*	*Jan 2021*
2. What is the aim, objective or purpose of the strategy / policy / clinical practice	*The purpose of this policy is to describe the process for effective risk management in support of the trust Risk Management Strategy.*		
3. Who implements the strategy / policy / clinical practice	*The Board of Directors, Executive Nursing (Risk Team), senior managers and department leads (including Care Groups). All staff with responsibility for assessing or managing risk.*		
4. Who is intended to benefit from this strategy / policy / clinical practice and in what way?	*Patients, staff and management through the reduction of risk to patients, staff and visitors and compliance with key regulatory requirements*		
5. Is the strategy/ policy / clinical procedure applied uniformly throughout the Trust?	*Yes*		
6. Who are the main stakeholders in relation to the strategy / policy / clinical procedure (for example certain groups of staff, patients, visitors etc)?	*All staff have a duty to identify risks to self and others. The key stakeholders to the policy are the Risk & Governance Committee, senior managers and department leads (including Care Groups).*		
7. What data are available to facilitate the screening of this strategy / policy / clinical procedure	*Profile of relevant staff*		
8. Is there any evidence of higher or lower participation, uptake or exclusion by the following characteristics?			
Race (Evidence)	*No*		
Gender (Evidence)	*No*		
Disability (Evidence)	*No*		
Sexual Orientation (Evidence)	*No*		
Age (Evidence)	*No*		
Religious Belief (Evidence)	*No*		
Carers or those with dependants (Evidence)	*No*		
9. In the context of the preceding sections are there any groups which you believe should be consulted?	*No*		
10. What data are required in the future to ensure effective monitoring?	*Not applicable*		
11. Considering all information please indicate areas where a differential impact occurs or has the potential to occur. Please specify and give reasons.	*None: Policy can be available in different languages and formats on request.*		
Potential for differential impact?	*None*		*Recommended for full impact assessment? No*
Signed A. Parrott	*Date of assessment 14/1/2021*		

King's College Hospital NHS Foundation Trust

Appendix D

Policy Checklist

Check		If No, why?
Is the font Arial size 12 throughout?	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	Yes	
• 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	
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	
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	

King's College Hospital NHS Foundation Trust – Finance & Commercial Committee

Minutes of the Finance and Commercial Committee Meeting held on Thursday 26 November at 9.00am, via MS teams videoconference

Present:

Sue Slipman	Non-Executive Director (Chair)
Prof Richard Trembath	Non-Executive Director
Akhter Mateen	Non-Executive Director
Sir Hugh Taylor	Trust Chair
Steve Weiner	Non-Executive Director
Professor Clive Kay	Chief Executive
Lorcan Woods	Chief Financial Officer (CFO)
Julie Lowe	Interim Site CEO, DH
Jonathan Lofthouse	Site Chief Exec, PRUH and south sites
Dr Leonie Penna	Acting Chief Medical Officer
Beverley Bryant	Chief Digital Information Officer/SIRO

In attendance:

Nina Martin	Assistant Board Secretary (minutes)
Lauren Gable	Dir of Commercial & Contracting
Siobhan Coldwell	Trust Secretary and Head of Governance
Rachael Wood	Dir Financial Management, Information and Analysis
Paul Cosh	Governor Observer
Carole Olding	Governor Observer
Vimala Jayaraman	Director of Finance and Commercial, KFM, *part*
Andy Lockwood	Managing Director, KFM, *part*
Giles Peel	External Governance Observer

Apologies:

Prof Nicola Ranger	Chief Nurse and Executive Director of Midwifery

Item	Subject	Action

020/74 Introductions and Apologies for Absence
All introductions were made and apologies noted.

020/75 Declarations of Interest
Steve Weiner declared his interest in Mediclinic and would leave the meeting for the KCS discussions.

020/76 Chair's Action
No Chair's action was reported.

020/77 Minutes of previous meeting - 24 September 2020
The minutes of the previous meeting was agreed. The title of "interim" to be removed from the PRUH and south sites Chief Executive designation.

020/78 Matters Arising and Action tracker

Med Tech JV Update – Shadow Board meetings had taken place as the approval process is still ongoing. Tim Irish had been agreed as the Chair. He is presently the Vice Chair of NICE. SLAM would become a party after the signing of the JV.

IN YEAR FINANCIAL REPORTING

020/79 Month 07 – Finance Report

For the first 6 months of 2020 /21 the Trust was given retrospective top up funding to help it reach a broadly breakeven position. For months 7-12, the Trust's funding arrangements have moved to a system block with the Trust receiving a block income of £107.6 m each month until the end of this financial year. This includes a system top of £15m each month and £ 5m COVID top up each month. This income will help the Trust breakeven for the last 6 months of the year based on the month 5 forecast submitted to the ICS. This improvement was supported by the reduction in bank and agency spend and a fall in drug spend.

The Trust was expecting to exit 2020 /21 with an exit run rate of £155m as per the pre-covid control total. To achieve its objective, the Trust would need to reduce its monthly pay by c£5.3m to an exit monthly run rate of £59.9m, representing a 8.2 % reduction on current spend.

The Committee queried whether as previously discussed a review of business cases would form part of the approach to managing pay spend. A review of business cases had been undertaken, so there should be no surprises.

An increase in critical care beds had been approved but as yet confirmation on the release of funding was still being awaited from the centre.

There was agreement that KCH should also keep abreast of ICS financial performance. While a formal ICS update had not been seen, the Trust had a good rapport with partner colleagues. GSTT and KCH finance teams regularly worked together and other partners are involved at different times.

Service level expenditure commitment especially around workforce should be closely monitored to support the Trust remaining on a positive financial trajectory next year.

020/80 <u>New Financial System</u>

The Trust had identified the Oracle Cloud system provided by NEP (hosted by Northumbria NHS Foundation Trust) as the most suitable for its needs. Following a detailed implementation process, the Trust went live with the new system on 1st October 2020, and has now completed its first month end reporting cycle on the Oracle system. The change was progressing well and another review would be undertaken in a few months. The team were congratulated on the successful introduction.

020/81 <u>Capital Plan Update</u>

The CFO updated the Committee on the key points of the capital programme. The internal capital programme was forecasting to spend £42m against the funding envelope of £52.8m. Although certain elements

of funding were ring-fenced, a significant underspend of £10.9m remained a concern. The plan was to repurpose the underspend on other strategic projects.

Significant funds had been received for investing in modular buildings. This was a major project and included plans for a 4 story modular building alongside the Normandy building as well as a three story modular structure at the side of ED. The business case for this would be ready by February 2021 but construction was not anticipated to start until July.

The Committee asked for assurance on the level of resource to take forward the capital spend. While KCH had much less capacity than GSTT, the CFO expressed confidence in the recently appointed Site Capital and Finance Director, Eric Monroe's approach to assessing capital expenditure and investment.

Action: The Committee proposed inviting Eric Munro to update at a future FCC or Major Projects Committee.

USE OF RESOURCES

020/82 Greening King's

The Committee noted the report which outlined the proposal to develop King's approach to sustainability. It was noted that the Trust lagged behind its counterparts on the green agenda. This agenda was linked to the Trust's role as an Anchor organisation. King's executives were keen to take this forward as this would be a good opportunity to increase the level of staff engagement.

This work would need to be effectively formalised and the governance arrangements agreed. The convening of a Sustainability Committee with the CFO as the executive lead and a NED lead would need to be decided. A team is being recruited to achieve progress in key areas that are most relevant to King's which would hopefully include governors, and senior clinical leaders.

The Chair asked that the sustainability work be cognizant of supply chains and align with community initiatives. Historical work on sustainability carried out jointly with Lambeth Council should also be revisited and inform the agenda.

Regarding governance, it was proposed that the Sustainability Committee report into the Strategy, Research and Partnership Committee on some issues of the wider sustainability agenda, but will retain an overlap with the FCC. The level of overlap should be addressed though the Committee's ToR.

Embedding sustainability would require a Trust wide culture shift. To effectively achieve this, there needed to be active engagement of the Trust's Communications team.

SUBSIDIARIES

020/83 **King's Facilities Management (KFM)** – The Committee noted the report. The Managing Director highlighted the following:

- Financially, KFM was on budget or possibly over-performing
- KFM Digital Automation was progressing
- KFM sustainability statement is on their website, and KFM looking forward to being part of KCH sustainability group.
- There are some issues with the outpatients pharmacy location
- Some progress on electronic prescribing adoption (increased from 60% to 72%)
- Outpatients pharmacy stock controls reviewed and an improvement plan was in place
- Intense work on vaccination programme logistics and storage.
- KCH contract expiry in June 2021 was causing challenges with suppliers, employees (recruitment and retention) and potential partners.
- The Customer satisfaction survey showed a good level of satisfaction in the services provide

A key update was the proposal to introduce KCH contractual KPIs. This was a reflection of the symbiotic relationship between KCH and KFM. The Trust was being asked to commit to the KPIs to support improved service delivery of its subsidiary. The Committee also noted the PTS procurement waiver proposal.

The Site Chief Executive, DH asked for more time to consider both proposals and asked for a meeting between KFM leads and the KCH Site Chief Executives to get further clarity. Regarding the PTS waiver further assurance around the level of clinical engagement would form part of these conversations.

020/84 REDACTED COMMERCIALLY SENSITIVE

020/85 **Board Assurance Framework**

The Trust Secretary updated that there had been no significant changes since the last update to the Committee. The two main risks were around the management of pay cost and capacity to deliver the Trust's capital programme. The Committee asked for more narrative and analysis going forward on how the risks manifest, ownership and plans for mitigation.

020/86 **ANY OTHER BUSINESS**

The CFO updated as follows:

Critical Care Unit –The Trust was successful in the recent adjudication process. The contractors were deemed responsible for the design of the unit and will be working with the Trust to take the work forward.

Viapath – All parties have signed up to an initial contract. The aim now was to deal with the integration with Synlab. A lead had been assigned to take forward the transformation work.

020/87 **DATE OF NEXT MEETING**

Thursday 28 January, 2021 (09:00-11:00) via MS Teams.

King's College Hospital NHS Foundation Trust – Additional Finance & Commercial Committee

Minutes of the Additional Finance and Commercial Committee Meeting held on Thursday 17 December at 9.00am, via MS teams videoconference

Present:

Sue Slipman	Non-Executive Director (Chair)
Prof Richard Trembath	Non-Executive Director
Akhter Mateen	Non-Executive Director
Sir Hugh Taylor	Trust Chair
Steve Weiner	Non-Executive Director
Professor Clive Kay	Chief Executive
Lorcan Woods	Chief Financial Officer (CFO)
Julie Lowe	Interim Site CEO, DH
Jonathan Lofthouse	Site Chief Exec, PRUH and south sites
Prof Nicola Ranger	Chief Nurse and Executive Director of Midwifery

In attendance:

Nina Martin	Assistant Board Secretary (minutes)
Siobhan Coldwell	Trust Secretary and Head of Governance

Apologies:

Dr Leonie Penna	Acting Chief Medical Officer
Beverley Bryant	Chief Digital Information Officer/SIRO

Item	Subject	Action

020/88 Introductions and Apologies for Absence

All introductions were made and apologies noted.

020/89 Declarations of Interest

No declarations were made

020/90 Chair's Action

No Chair's action was reported.

020/91 Development of Denmark Hill clinical and office Hubs

The Committee noted the update and the CFO highlighted the key points. The main projects are the UEC projects at DH (Modernising Medicine and SDEC) and the PRUH. At both sites the Trust needs to decant and move staff off site in order to free up clinical space. This is mainly non clinical staff but at DH, the Therapies gym will move from 1st floor Golden Jubilee Wing to offsite.

The Committee was asked to approve the "Development of DH Clinical & Office Hub" by entering into a 15 year lease on "Coldharbour Works" at Loughborough Junction.

The cost is £1.3m a year although £0.4m of rent is avoided on the On Call building and 161 DH which the Trust has to vacate. The Trust had been aware of the need to vacate the on-call building and premises at 161 and had been looking

for alternative venues for about two years. Nothing suitable had been found until Coldharbour Works two months ago. The Trust had moved at pace to seize the opportunity. The other option of reconfiguring present buildings was not considered feasible.

There was concern that the scale of the estate capacity challenges at DH and the required investment had not been flagged sooner to the Board. The CFO updated that in February the modernising medicine business case which had proposed allocating the first floor of jubilee wing to modernising medicine was discussed at the Board. Feedback from the Board had been to ensure the logistics around decanting staff was incorporated in the planning process as this can be a challenge. This was proving true as there were complex decant requirements for the Modernising Medicine project on the 1st floor of Golden Jubilee Wing, some of which are suitable to move off campus but need to be in close proximity for efficient staff movement.

The pace, costings and governance process around the decisions and proposals were the key concerns expressed by the Committee. Given the cost and scale of the proposals, there needed to be more rigorous scrutiny at the Major Projects Committee.

The CFO felt that there had been adequate scrutiny of the modernising medicine business plan which came to the February board. Additionally, there had been a further review at the October MPC.

It was noted that the costings presented today was higher than what had previously been discussed. The increased costings related to a review undertaken by Eric Munro of the modernising medicine business plan. Mr Munro shared that the previous costings for the refurbishment of the first floor Golden Jubilee Wing had focussed on works cost. His review allowed for factors such as professional fees, VAT, etc. The core cost had not changed.

The Chair reminded of historical financial issues which had led to NHSI investigations. In light of this, the learning from this should have seen a full business case presented with proposed changes and rationale to provide assurance around the governance.

The Trust Chair did not recall the plan submitted in February to the Board including decanting, or capital costs for modernising medicine. Nor did the October MPC highlight the capital costs. Inadequate business case preparation and scrutiny had contributed to the Trust's past financial challenges.

The Chief Executive accepted there were gaps in the governance process for which there was collective executive responsibility. It was agreed that full business case on modernising medicine would be prepared for Board discussion and scrutiny in mid-January. With the rising number of Covid cases, the business plan would need to be cognizant of the impact of ward conversions on the financials.

There was assurance that only minor refurbishment was needed for Coldharbour Works and no delays were anticipated. Teams should be able to move in January. IT issues were also in hand and being address by the IT team.

Staff had responded positively when viewing the premises and were enthusiastic about the move. This will be a move to flexible, agile working and it was noted that

communications and engagement with teams needed to be prioritised ahead of the move.

Going forward, it was important that the Trust estates teams clearly highlight the stages in outline and full business cases brought to committees. This would give committees a greater level of assurance when asked to approve financial decisions. Teams also needed to develop the discipline and culture of clearly writing identified risks as it's not enough to articulate these verbally at meetings.

Before agreeing the proposals, the Committee wanted more assurance around the governance and scrutiny and asked that a full business case for Modernising Medicine and modular builds to come to either FPC or MPC in January.

The CFO agreed this as a way forward but asked for approval to proceed with the Coldharbour refurbishments and move. Regarding the modular builds, the business case would be presented in January but CFO asked for approvals to book production costs to be able to capitalise this as work in progress in year.

Approval to proceed with the Coldharbour Works was given.

Action: A plan providing assurance around timelines, staff engagement, HR involvement and business continuity plans for these works should be drafted for the Committee.	**L Woods**
The Committee deferred decision on the Modernising Medicine and SDEC programmes until the full business cases are presented and discussed at either the Major Projects or Finance and Commercial Committees in January. They gave approval to book production costs before then.	**L Woods**

020/92 Radiology Waiver

Board approval was required for two waivers associated with Radiology enabling works for 2 MRI and 1 CT replacement scanners with works needing to be completed by 31st March 2021. The scanners are being sourced from Siemens and therefore Siemens will hold the primary contract for enabling works to allow the project to be done on a design & build / turnkey basis. Siemens have approached three suppliers to get quotes and had chosen the lowest of the quote.
The Committee approved the waiver.

020/93 Capital Programme Update

The Committee noted the update. These were presented to give context and assurance that modernising medicine and SDEC could be taken forward within the capital envelope in year and next year. This will further be demonstrated within the business case and will be shared with the APC and ICS.
The Trust Chair asked for clarity around the link with capitalising for Coldharbour works and 21/22 capital spend to give assurance that the Committee was not approving more than has been put into the plan. The Committee asked that it be noted that the capital expenditure for Coldharbour works was anticipated and budgeted for in the forecast set out in the capital plan presented to the Board.

020/94 DATE OF NEXT MEETING

Thursday 28 January, 2021 (09:00-11:00) via MS Teams.

King's College Hospital NHS Foundation Trust

Quality, People and Performance Committee
Minutes of the Quality, People and Performance Committee (QPPC) Meeting
Thursday 3rd December 2020 at **09:30am – 13:15pm**
MS Teams, Video Conference

Present:

Professor Jonathan Cohen	Non – Executive Director (Chair)
Nicholas Campbell-Watts	Non – Executive Director
Professor Ghulam Mufti	Non - Executive Director
Sir Hugh Taylor	Trust Chairman
Clive Kay	Chief Executive Officer
Leonie Penna	Acting Chief Medical Officer
Nicola Ranger	Chief Nurse & Executive Director of Midwifery

In attendance:

Siobhan Coldwell	Trust Secretary & Head of Corporate Governance
Claudette Elliott	Director of Equality, Diversity and Inclusion
Samantha Gradwell	Head of Patient Safety
Keith Loveridge	Acting Director of Workforce
Ashley Parrott	Director of Quality Governance
Claire Palmer	Head of Patient Outcomes
Michael Bewick	DCO Partners Ltd, Governance Advisory Practice
Kirsty Alexander	Patient Governor (Observer)
Billie McPartlan	Patient Governor (Observer)
Victoria Silvester	Southwark Governor (Observer)
Tara Knight	Corporate Governance Officer (Minutes)

Part Meeting:

Louise Clark	Acting Chief People Officer
Jonathan Lofthouse	Site Chief Executive Officer, PRUH & South Sites
Professor Will Bernal	Corporate Medical Director

Apologies:

Julie Lowe	Interim Site Chief Executive, Denmark Hill

Item	Subject	Action

20/119 Introduction and Apologies

Apologies for absence were received and noted from Julie Lowe, Site Chief Executive Officer for Denmark Hill.

The Chair informed the Committee that the Chief Nurse & Executive Director of Midwifery is now the executive lead for the Quality, People and Performance Committee.

The Chief Executive Officer introduced Michael Bewick as an observer, who is working with Giles Peel to support the well-led work stream. The Committee were informed that they will be working with the Trust to further review gaps and strengths and provide feedback to the Trust Board.

20/120 Declaration of Interests

No interests were declared.

Item	Subject	Action

20/121 Chair's Action

There were no actions for the Chair.

The Committee were advised that two 'focused' sessions will be added to the QPPC standing agenda:

- Highlight Report: Areas of concern from papers.
- The scrutiny/deep dive of one or two red risks at each meeting that the lead Executive will speak to in order to provide assurance to the Committee that the risk is being appropriately managed and is scored appropriately in light of the evidence.

20/122 Minutes of Previous Meetings

The Committee noted the minutes of the previous meeting held on 01.10.2020 and accepted them as an accurate record of the meeting.

20/123 Action Tracker/Matters Arising

The action tracker was reviewed and the following updates were received:

- **Action 20/75-4: Immediate Items for Information - Maternity Inquest**
  Suggested that date for updating the Committee is changed to first meeting of 2021 as the case is deferred pending the application for judicial review that the inquest was not heard by a jury, and the scope of the inquest did not include unlawful detention. There has been no further update since the last meeting.

- **Action 20/75-5: Immediate Items for Information - Child Safeguarding Incident**
  The case is going to a formal safeguarding review. Elements of the reporting process have been reviewed and changed in response. Once the review is concluded, findings will be shared with the Committee.

- **Action 20/56: Safeguarding Children Quarterly Report** **J Lowe**
  The Committee requests an update on the strategy for addressing the issues around adolescents and CAMHS care in A&E for the next meeting.

20/124 Immediate Items for Information/COVID-19 Update

The Chief Medical Officer updated the Committee on the current COVID-19 status at the Trust.

There are currently 75 inpatients who are COVID-19 positive across the Trust, which has essentially been a static position over the last 10 days. There has been a slight increase in the number of COVID patients in critical care, which includes a small cohort of patients that have cared for themselves at home and then presented at ED in extremis.

The Trust is making preparation should pressure arise from the sector in relation to critical care as other areas on London have higher numbers of critical care patients. The higher rates in Kent and surrounding areas has meant a reduction in their elective activity. The surge hubs have responded by asking the Trust to be prepared should this affect our specialist elective activity.

Item	Subject	Action

Regular self-testing for asymptomatic staff has been implemented. Around 3000 kits have been collected by staff. There is now a working group to develop an implementation plan for the roll out of a vaccination programme for the organisation.

QUALITY

20/125 Patient Safety Report – Quarter 2

The Committee received the Patient Safety Report for quarter 2 and noted the following:

- The Patient Safety Team experienced significant levels of sickness in October which has affected the delivery of routine work, including the duty of candour and Serious Incidents work.
- There remains a significant backlog of amber reports both in the moderate harm category and the low/no/prevented harm category.
- The number of reported incidents has reduced since last quarter, which reflects a reduction in reporting during the peak of the COVID-19 pandemic.
- Violence and aggressions continue to be the highest rate of incidents.
- The Trust is one of the highest reporting organisations across the country for medication safety incidents.
- Priority is being given to the backlog of Serious Incidents which has increased since the start of the pandemic.
- An interim appointment has been made until January to specifically lead on addressing the backlog.
- The SI policy is being updated to include nursing staff in the role of leading serious incident investigations so there will be an increase in resource.

The Committee expressed concern about the high number of medication safety incidents. A new lead has been appointed who will be reviewing themes and learning to develop an action plan.

Action: The Committee requested a paper on the processes in place relating to medication safety, and the plans to address any gaps. — **N Ranger, L Penna**

20/126 Acute Myocardial Infarction Mortality Review

Professor Bernal updated the Committee on action 18/129, which related to an apparent decline in performance in the national cardiac arrest audit at the PRUH Site. Upon investigation, it was found that this was in fact a data collection and submission issue which related to a lack of resuscitation officer staffing. The PRUH was forced to withdraw from the national cardiac arrest audit but has started to submit data again since April. A nurse has been recruited to start in March and will be responsible for the data submission.

The Committee received and noted the Acute Myocardial Infarction mortality review. The investigation was not triggered by any external mortality alert but rather as a consequence of the Trusts internal monitoring. Key findings of these investigations include:

- Signals arise from the Denmark Hill site, reflecting its status as a Heart Attack Centre (HAC).
- Opportunity to improve coding.
- Cardiology was the primary care team as opposed to general medical cases of acute myocardial infarction.

Item	Subject	Action

- On case note review, decision making was appropriate and procedural complications were rare.
- Quality of care issues were very uncommon.

The issues appear to be a combination of low level coding issues and case mix issues. The deaths that have been identified have mostly been out of hospital cardiac arrests or structural complications of acute myocardial infarction or myocardial infarction in very frail patients. The predicted model that is being used is perhaps inaccurate for the Trusts' case mix (a problem that has also been observed in some other London centres). The Trust hopes to combine data and views of other HACs (St George's and GSTT) and make a joint submission to NHS Digital to request a review and refinement of the model.

The Committee thanked Prof Bernal for the excellent reports provided by his group.

20/127 Patient Outcomes Report

The Committee received the Patient Outcomes report for quarter 2 and noted the following:

- The majority of indicators are rated green. KCH is in the top quartile in relation to Summary Hospital-level Mortality Indicator (SHMI) data and Mortality is better than expected or within the expected range.
- Survival of lung cancer is much better than the national average.
- Outcomes for children and young people with Type 1 diabetes is now similar to national average on both sites. The PRUH had previously been identified by CQC as an outlier for this indicator.
- Reporting red for one of the stroke process indicators which relates to the Trusts Hyper Acute Stroke Units (HASU) on both sites. This is mainly driven by capacity issues and delays in admitting patients to the Stroke Unit.
- Capacity concerns in relation to HASU beds is a commissioning issue and is under national review. The issue has been recorded in the Risk Register and is under review.

The Committee agreed that the Trusts' outcome data is a good news story that should be promoted, however, the significant HASU capacity issues should be raised at APC and ICS level.

Action: The Chief Executive to raise the HASU capacity issues with the APC and ask the Clinical Strategy and Operations Group to review the HASU capacity and facility across South East London and prepare a proposal. **C Kay**

20/128 NICE Guidelines Implementation Plan

The acting Chief Medical Officer presented the NICE Guidelines implementation plan to the Committee.

It has been identified that the Trust's compliance with NICE guidance, and the assurance processes to ensure quality, requires improvement. An action plan is in place which includes agreed rolling audit programmes with the Care Groups. The new Clinical Director Leadership structure provides greater oversight and the ability to call Clinical Directors to account. An update on progress with the plan will be provided at the next meeting. **L Penna**

Item	Subject	Action

20/129 Patient Experience Report

The Committee received and noted the Patient Experience Report for quarter 2.

Following the inpatient survey results, the team are working on improving the observance of mealtimes. The new Patient Property Policy has been agreed and bedside furniture will help to standardise where property is kept. Colour coded property bags are being rolled out – e.g. for soiled clothes, property of bereaved patients.

There is currently a backlog of complaints. The Complaints policy is under review and will be revised to ensure that the Trust is able to meet the agreed targets and improve learning. There have been challenges with the responsiveness of the PALS service. The IT issues have now been resolved and the phones are being answered. The office space at Denmark Hill is currently being reviewed to enable face to face visits from patients and carers to be reinstated.

Results of the National Cancer Patient Experience Survey have improved. Data will be shared with each specialty so that each team can work on specific areas that require improvement.

Doctors speaking in front of patients as if they were not there was due to be taken up as an improvement project for year 5 doctors as part of their training. This has been delayed due to the response to the COVID-19 pandemic, however, there is a new intake of junior doctors in February. A teaching video is also being created with the Communications team.

Joint work with GSTT will be carried out to review patient feedback on virtual consultations. Work is also to be conducted to review virtual consultations more generally and assess whether patients who should be seen face to face are being adversely affected.

20/130 Quality Account Priorities – Update on Progress

The Chief Nurse and Executive Director of Midwifery presented an overview on the progress with the quality priorities. Reducing harm to deteriorating patients is a top risk on the risk register. A deep dive into this area will be presented at the next meeting.

Improving inpatient experience is linked to the trust wide Connected Leadership programme for ward leaders. The implementation of the patient experience improvement plan also continues to progress.

The key area of slight concern is the progress in improving outcomes for patients with COPD. Because of the pandemic, the Trust has been unable to engage with the British Lung Foundation which has hindered progress.

Governors are required to comment on the Quality Account Priorities annually. It was suggested that Governors would be in a better position to comment if they could engage and be involved in committees or working groups that progress the quality priorities.

20/131 Maternity Service Briefing

The Committee received and noted the Maternity Safety Briefing. The Chief Nurse and Executive Director of Midwifery informed the Committee that the Maternity

Item	Subject	Action
	Board now has been strengthened with new membership and greater oversight and scrutiny.	
	Tracey MacCormack has been appointed as Director of Midwifery and will start in early 2021. The Chief Nurse requested a meeting with the NEDs and the new Director of Midwifery to agree areas of scrutiny in maternity for the Quality, People and Performance Committee.	**N Ranger J Cohen**
	Virtual clinics in maternity is an area of concern for patients. A review is required to ensure the safeguarding of vulnerable women.	
20/132	**Duty of Candour Compliance Update**	
	The Patient Safety Manager presented the Duty of Candour compliance update to the Committee. There has been a decline in compliance due to staffing pressures over the last month at the Denmark Hill site. There has been good improvement at the PRUH and South Sites as the Site Chief Executive has been working with the Care Groups to incorporate duty of candour onto the integrated performance cards. This allows for Clinical Directors to be called into account.	
	The policy is to be reviewed and simplified to allow for other members of the MDT, who are not doctors, to lead on duty of candour.	
	The Committee expressed dissatisfaction with the continued deterioration in compliance.	
	Action: The Chief Executive Officer will meet with the Chief Nurse and Chief Medical Officer to agree and produce a trajectory on compliance with the duty of candour so that progress can be monitored by the Committee.	**C Kay N Ranger L Penna**
20/133	**Quality Account 2019/20**	
	The Chief Nurse and Executive Director of Midwifery requested that all comments on the quality account should be sent to her directly.	
	In relation to the 52 week data, as a South East London APC, there is a clear trajectory to reduce the waiting list by the end of March. The Trust has two large dental hospitals that use aerosol generating procedures which accounts for a large percentage of those waiting for treatment over 52 weeks. The Trust is an outlier in Outpatients partly due to the focus on inpatients during the pandemic and partly because improvement is required in validating patients on the waiting list.	
	The Committee suggested that an explanation for the varying data on learning from deaths should be included in the report.	
20/134	**Clinical Governance Arrangements**	
	The Chief Executive Officer and Chief Nurse updated the Committee on the clinical governance arrangements since the implementation on the new Care Group Structure.	
	The Site CEOs are working with the Chief Nurse and Chief Medical Officer to identify a robust plan for clinical governance, strengthening ward to Board leadership. Quality improvement is a key focus and patient safety is a priority. The exec team are exploring structured training and support for new Clinical Directors and the leadership triumvirate for good outcomes and experience for patients. The	

Item	Subject	Action

plans to become a well-led, clinically led organisation are yet to be finalised and discussions with external parties are still ongoing. An update will come to the next meeting.

BREAK: The Committee took recess from 11:25 – 11:35am

GOVERNANCE

20/135 Red Risk Review:

- **Risk 3865: Risk of Harm to Staff - Violence, Aggression & Bullying from Patients/Visitors**
  The Chief Nurse and Executive Director of Midwifery gave a presentation to the Committee on the work to reduce violence and aggression towards staff.

  The national staff surveys for the last two years has demonstrated that King's College Hospital is among the worst Trust for staff experiencing violence and aggression in the workplace and data shows that it is increasing. It is documented on the Trust's Risk Register and the impact of violence and aggression on staff safety and morale has been recorded. A programme of work is being led by the Deputy Chief Nurse using a quality improvement (QI) approach and frontline staff have been engaged with through listening events to identify the causes of violence and aggression and ideas on what the Trust can do to tackle the problem.

  Work has already begun to implement changes to training and staff education as well as improvements to the environment and entertainment for inpatients. The reporting of violent and aggressive incidents will be aligned with new governance structures and the Trust is in the process of agreeing methods of escalating serious violent or aggressive incidents through Gold Command with members of the Executive team.

  The Committee enquired about learning from listening to patients and whether messaging to patients around violence and aggression was adequate. Currently, there is no structured way of receiving feedback from patients. The policy is being reviewed to ensure the process on banning patients that have been violent and/or aggressive is more stringent and is a last resort.

20/136 Board Assurance Framework (BAF)

The Committee received the Board Assurance Framework and noted the following:

- **People and Culture**: The vacancy rate is driven by an increase in establishment. Work is taking place to refresh the people and culture strategy and the values and behaviours for the Organisation. Once these have been embedded, there should be an improvement in metrics. Training and appraisal levels have been impacted by COVID-19.

- **Operational Performance**: This domain remains an area of concern. Performance in the 52 week target has deteriorated which is directly affected by the COVID-19 pandemic. There has, however, been some improvement in the cancer and diagnostic performance.

- **Quality**: Patient outcomes analysis presents a good news story. Work with the Care Groups and Patient Safety Team should yield progress in patient safety performance over the new year.

Item	Subject	Action
	Action: The BAF should cross reference issues relating to patient safety raised in the Internal Audit Report. The BAF should also be updated to factor in the Acute Provider Collaborative, which means there is a certain amount of risk sharing across South East London for some of the performance indicators and another layer of assurance.	**S Coldwell**

PEOPLE

20/137 Workforce Metrics

The Director of Workforce presented the Workforce Performance report and the Committee noted the following:

- **Establishment**: There has been quite a significant increase in establishment mainly due to business cases.
- **Turnover**: The Trust is reporting a consistent downward trend in turnover, although the rate is still higher than comparative organisations.
- **Sickness absence**: The sickness absence rate remains above target, which is mainly affected by COVID-19 related sickness.
- **Statutory and Mandatory Training**: Compliance is poor in this area which is driven by cultural and infrastructure issues. Level 3 Safeguarding Children training is now available as an online/virtual package. 60 places have been scheduled for this month and another session is available in January.
- **Appraisal**: Compliance rates are low and plans are in place to ensure targets are met by the end of March. The GMC have made changes to the appraisal and revalidation requirements for appraisals that were due during the peak of the COVID-19 pandemic. This has led to some confusion. In addition, there have been no meetings which has affected CPD portfolios. Appraisals are then being delayed to try to ensure CPD portfolios are not incomplete.
- **Consultant Job Planning**: Compliance with the job planning rate is still significantly under target. Activity was suspended for five months and programmes were restarted in September. Data is regularly sent to Clinical Directors to engage them with job planning activity.

20/138 Employee Relations Update

The Committee received and noted an analysis of Trust disciplinary cases between April and September 2020, following findings from the WRES data that a disproportionate number of staff from BAME communities are subject to formal disciplinary procedures.

The Director of Workforce presented the report to the Committee and the following was noted:

- BAME employees account for 50% of the workforce; however, they account for 65% of all employees entering the disciplinary process during this period.
- The data shows that BAME staff in pay bands 2 and 4 are disproportionally represented entering the disciplinary process.
- The Employee Relations Team continue working with managers to explore and embed informal/early resolution solutions when concerns are raised.
- Following the introduction of a Triage panel and Oversight group, chaired by the Chief People Officer, 47% of disciplinary cases have been resolved without the need to commission a formal investigation.
- The Director of Equality, Diversity and Inclusion and Chief People Officer are seeking to develop a course on managing diverse teams for managers.

Item	Subject	Action

- Work is taking place to refresh the people and culture strategy and the values and behaviours for the Trust.
- NHSE Guidance has been circulated today reminding Trusts to ensure that their review of all disciplinary procedures, against recommendations made following a review at Imperial College Healthcare NHS Trust last year, is completed by the end of March and then subsequently on an annual basis.

20/139 Equality, Diversity and Inclusion Update

The Committee received an update on equality, diversity and inclusion.

Despite challenges in equality, diversity and inclusion, staff are committed to the organisation and have been enthusiastic with engagement in the work that has started to refresh the Trust values. Work has already begun to implement some of the recommendations set out in the report and a new Head of EDI will be starting on with the organisation next week to lead on implementing, at pace, the actions within the improvement plan.

Future reports will be explicit in providing assurance that processes are robust in the area of EDI. The prospect of having Associate Board Members was discussed and it was agreed that the Trust should have aspirations and achievable trajectories for more diversity and inclusivity in the Board membership.

PERFORMANCE

20/140 Integrated Performance Summary Report

The Site Chief Executive for PRUH and South Sites presented the Committee with the key performance metrics. The following highlights were noted:

- **Emergency Care Standard**: Challenge remains at both sites, although compliance is poorer at the Denmark Hill site. Weekly reviews with Site Chief Executive and relevant leads are taking place to address the poor performance and monitor progress. There was a decline in performance at the PRUH in October but this has since improved. In relation to the 4-hour emergency access standard, changes will be implemented to provide additional physical space and accommodation as part of the winter solution.

- **Cancer/Diagnostics**: In order to deliver the cancer standard, the Trust must improve performance against diagnostic standards. At both sites there has been consistent improvement in compliance with the 2 week and 62 day cancer standards. This can be directly linked to improvement in performance in diagnostics. In terms of volume throughput, the Organisation is the highest performing Endoscopy Centre in South East London. As a result, in November, the PRUH has achieved the national standard in relation to the 2 week cancer standard. New metrics on the 28 day cancer standard will be provided in the next report.

- **RTT**: The areas of concern regarding poor compliance with the 52 week standard are Ophthalmology, Oral Surgery and General Surgery. The Orthopaedic Service is now starting to show improvement with more activity arranged through SEL. A range of orthopaedic and bariatric activity has been migrated between sites which has helped to manage the overall waiting list.

Item	Subject	Action
	COMMITTEE GOVERNANCE	
20/141	**Terms of Reference – Annual Review**	
	The Committee reviewed the Terms of Reference and the following was discussed: • **Paragraph 3:11 – Periodically receiving reports on nutrition** The Committee will receive updates from the operational working group if any concerns arise. • **Paragraph 3:12 - Inquests and litigation reports** The Chief Nurse will work with the CEO and Trust Secretary to ensure greater oversight on inquests and litigation and decide if QPPC is the appropriate Committee to provide scrutiny.	**N Ranger** **C Kay** **S Coldwell**
	Discussions are to be had to decide whether this Committee could, periodically, hear directly from patients/staff. The Board already hears directly from patients as there is a standing patient story slot on the agenda. Practical concerns were also raised about expanding the agenda in terms of the length of the meeting.	**N Ranger**
20/142	**QPPC Annual Work Plan**	
	The Committee received and noted the annual work plan for QPPC.	
	FOR INFORMATION/REPORTING & DISCUSSION BY EXCEPTION	
20/143	**CQC Response & Action Plan Update**	
	The Committee received and noted the CQC summary update.	
20/144	**Sub-Committee Minutes**	
	The Committee noted the minutes from the following groups: – Cancer Board Denmark Hill, October 2020 – Health & Safety Committee, November 2020 – Medication Safety Committee, October 2020	
20/145	**ANY OTHER BUSINESS**	
	– **Professor Ghulam Mufti Retires as Non-Executive Director** This is the last QPPC meeting for Professor Ghulam Mufti as he will step down as Non-Executive Director on the Trust Board at the end of this year. The Committee thanked and commended his leadership and contribution to the Organisation and this Committee over the years.	
	– **New Performance Reporting Metrics: Revised Care Groups** In light of the new care group structure, there are additional metrics that the Committee might want to be sighted on. A meeting to be arranged to discuss and agree.	**S Coldwell** **J Lofthouse** **J Cohen**

DATE OF NEXT MEETING
Thursday 4th February 2021, 09:30am – 3:00pm
Venue TBC

King's College Hospital NHS Foundation Trust

Audit Committee – Minutes

Minutes of the meeting of the Audit Committee held on Thursday 19 November 2020 at 9.05am via MS Teams

Present:

Akhter Mateen	Non-Executive Director (Chair)
Sue Slipman	Non-Executive Director
Jon Cohen	Non-Executive Director

In attendance:

Sir Hugh Taylor	Trust Chair
Steve Weiner	Non-Executive Director
Lorcan Woods	Chief Finance Officer
Prof Nicola Ranger	Chief Nurse and Executive Director of Midwifery
Dr Mairi Bell	Director of Financial Operations
Nina Martin	Assistant Board Secretary *(Minutes)*
Jane Allberry	Lead Governor
Jonathan Gooding	External Audit (Deloitte)
Angus Fish	External Audit (Deloitte)
Neil Hewitson	Internal Audit (KPMG)
Charles Medley	Internal Audit (KPMG)
Alexander Barrington	Internal Audit (KPMG)
Paul Dossett	External Audit – Observer, (Grant Thornton), part

Apologies:

Siobhan Coldwell	Trust Secretary and Head of Corporate Governance

Item	Subject	Action
	2. STANDING ITEMS	
020/109	**Welcome and Apologies** The Chair welcomed all to the meeting	
020/110	**Declarations of Interest** No declarations were declared.	
020/111	**Chair's Action** There were no Chair's action to report to the Committee.	
020/112	**Minutes of the Previous Meeting** The minutes of the meeting held on 17 September, 2020 were approved.	
020/113	**Action Tracker and Matters Arising** Since the September Committee, there had been a change in executive leadership. The Executive Director of Integrated Governance risk management and implementation remit was now under the Chief Nurse and Executive Director of Midwifery. Consequently it had been agreed that the risk management action updates would be deferred to the January Committee. There was concern around further slippage in progressing the Risk	

Item	Subject	Action

Management Strategy and its implementation. The Chair, CFO and Chief Nurse would meet to discuss the strategy and the risk action updates ahead of the January Audit Committee.

The CFO updated on the interim arrangements for the risk management work and the new governance reporting lines. The Chief Nurse and Executive Director of Midwifery portfolio would lead on this portfolio. There were plans to create and recruit to the role of Director of Corporate Affairs who would lead on the Trust's risk management work.

All other actions were either completed or on the meeting's agenda.

3. RISK MANAGEMENT

020/114 **Risk and Governance Committee update**

The Chief Finance Officer updated on the two Risk and Governance Committee since the last Audit Committee. The 23 September committee discussed the Care group governance and risk management. The Chief Nurse would be leading the re-launch of the care group structure and clarifying governance arrangements. A review of the approach to risk identification, management and closure would be undertaken. The ToR for care group governance meetings, duty of candour and NICE guidelines compliance were also discussed at this Committee.

KPMG had attended the 4 November meeting and presented the internal audit progress report and recommendation tracker. The Committee also reviewed the external visits register and agreed the policy on policies and the conflict of interest policy. There had been good attendance and engagement from executives at both meetings.

A key concern of the Audit Committee was the increase in the numbers of overdue responses to internal audit recommendations and the failure to update on overdue recommendations.

The CDIO apologised to the Committee on slippage with the Information Governance recommendations adding that it would take some time to get all on trajectory but that this would be progressed. The Committee discussed the importance of embedding clinical engagement with the risk management process and viewing it as relevant and effective. Given the demands on their time the process should be straightforward to support their engagement. Extra support would also be needed to help clinicians. A mechanism to appropriately align Datix with the care groups was also needed

Mr Cohen added that clinical risks was an ongoing item at the QPPC meetings. For additional assurance, he had been invited by the Chief Executive to attend the Risk and Governance committee to ensure alignment between both committees.

At the NED/Auditor pre-meet, the committee had heard that compared to other Trusts, KCH was an outlier regarding the volume of overdue recommendations. The Committee proposed the development of milestones to support the monitoring of recommendations to bring them back and keep them on trajectory. Realistic timelines to prevent actions going overdue was needed but these should not be too long especially for high priority recommendations.

Action: The Committee asked for clarity on the risk management strategy for the new care structure and how it would inform the BAF. An update from executives would come to the January Committee. **Chief Nurse**

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The CDIO added that there were plans to recruit extra capacity to support the monitoring of recommendations.

020/115 INFORMATION GOVERNANCE

The Committee noted the report and the CDIO presented the key updates. This was the first of a quarterly report to the Audit Committee:

- The Trust had submitted its 2019/20 self-assessment in March 2020 showing full compliance with the requisite DSPT standards, with the exception that further work was required to meet the DSPT target of 95% of Trust staff having completed their IG training. This compares with a Trust target for statutory and mandatory training completion of 80%. During Quarter 1 and the first wave of the COVID-19 pandemic, IG training trust-wide was paused even though executives had proposed this continue.
- An important element of the work during COVID-19 had been the maintenance of a register of all data flows agreed under the COPI Notice issued by the Secretary of State for Health and Social Care. The Notice ends 31 March 2021 and work will be undertaken beforehand to ensure that all data flows have a valid legal basis after that date. Confirmation was needed on whether there was likely to be an extension to this in order to support the diversion of limited resources.
- From 1 January 2021, the UK will become a non-trusted country and last minute legislation from the UK was expected.
- Like all trusts, King's cyber security was open to risk. Presently, KCH does not have a single IT system which makes it harder to patch when things go wrong. However, a benefit of this was that it was a harder target for cyber criminals. The implementation of a single system through EPIC, would make the repair of breaches easier but would also increases the risk of cyber attack.
- There was good FTO compliance despite Covid pandemic.

Mr Cohen commended the report and asked for assurance around processing and ownership of pathology data. The Committee heard that each subsidiary had its own staff to support data process and that the Synlab system would be transferred to the Trust's EPR system. The CDIO would liaise with the Trust's EDI Executive lead to determine the drivers behind the Trust's low performance on ethnicity recording.

The Committee asked that the IG risk report be shorter and suggested it take the format of a dashboard with key points flagged.

4. EXTERNAL ASSURANCE

020/116 Internal Audit – Progress Report (incl counter fraud)

KPMG were on trajectory with the delivery of the 20/21 programme of work. During fraud awareness week a survey was carried out to determine the level of awareness.

The Committee noted the high value of suspected fraud case and queried how the Trust compared with other Trusts. While the Trust had a higher volume of fraud referrals compared to its counterparts, this value was driven by a small number of high value cases particularly relating to overseas patients.

The Committee queried the executive plan to manage this going forward. The Trust was working with the overseas team to review their processes and would take forward the recommendations coming out of this review.

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020/117 Recommendation tracker

There were 82 live recommendations on the tracker, 24 of these had exceeded the agreed deadline for implementation. Twenty one of the twenty-four had no revised timelines allocated to them. Three of the recommendations were high priority. Six further recommendations will fall due by the January Audit Committee.

The Chief Finance Officer commented that while the right processes were in place, more needed to be done by way of monitoring and oversight of the implementation of the recommendations within the required timeframes.

KFM KPIs and contract was in the process of being agreed and the Chief Nurse was now on the KFM Board. The contract and KPIs would be reviewed with the Executive team. The Committee looked forward to seeing an improvement with the recommendations.

020/118 Freedom to Speak Up and Whistleblowing

This review was amber/green RAG rated. The main areas for improvement related to the Freedom to Speak up policy and governance arrangements.

Ms Slipman had helped to develop the freedom to speak up policy and updated that the policy had changed the guardianship from a NED to an accessible and trusted member of staff. There would be a NED lead to support staff where the concern raised related to an executive staff member. Nicholas Campbell-Watts was the NED Freedom to Speak up lead.

A dedicated Guardian had been appointed and a review of the governance arrangements was ongoing. Ms Slipman would work with the relevant leads to support this review.

The Committee proposed that the KPMG review be followed up at the Quality, People and Performance Committee. The Trust Chair proposed benchmarking best practice processes against other Trusts could also form part of the review process.

020/119 Incident Reporting

This review was amber/red rated which was driven by control weaknesses and structural changes. The Committee raised concerns around the availability of resources to address these issues and the impact on already stretched clinical capacity. The strain could negatively impact on the quality of the reporting. Capacity had been impacted by high level of sickness and the Trust was working hard to get staff back to work.

Good quality handover and the timely review of incidents were key to addressing the challenges around incident reporting.

020/120 Counter Fraud

Declaration of Interests – The Committee noted the review. There was a policy in place, however, there were significant issues around implementation. The Committee queried whether the challenges were driven by resource, system or compliance issues and heard that all three were drivers. The effective management of the drivers should support a revision of the timelines which seemed very long.

The Committee asked for assurance on how the register would be used to mitigate against fraud particularly in the area of procurement. The Registers should form part of procurement decision making processes. It was proposed the CF Team consider how to

Item	Subject	Action

take this forward and some suggestions included audit samples of procurement decisions to assess any conflict.

The CFO suggested this may be very difficult to take forward and added that the present process was that anyone involved in tenders was required to declare any known or potential conflict. There was a need for a robust register for estates and procurement teams.

The Committee noted the importance of a functioning COI system and the challenge to embed the process The onus was on individuals to make declarations and to be clear on the impact of non-disclosure. A culture of transparency in decision making needed to be embedded.

Action: The CFO and KPMG agreed to meet and reframe the responses to the review recommendations as well as the timelines for implementation and present at the January Committee.

Pre-employment checks - The Committee noted the review. Compliance was in alignment with NHSE guidance. There were recommendations made around the need for developing and implementing more Trust specific policies.

020/121 External audit

The Chair updated the Committee that following the tender process, Grant Thornton had been appointed as the new Trust external auditors. Paul Dossett from Grant Thornton was present for part of today's meeting as an observer prior to formal handover.

Deloitte was finalising the 2019/20 subsidiary audits and this should be completed in the next few weeks.

The Committee's thanks to Deloitte were recorded for their work for the Trust over the last few years. Deloitte also thanked the Committee and the Trust and expressed disappointment that they would not be continuing as external auditors.

FINANCE REPORT

020/122 Financial System Update

The Director of Financial Operations presented this update. The system was implemented on 1st October 2020 in line with the plan. All modules were fully implemented and operational, and the Trust had now completed a full month's cycle using the new system. Key activity since the last update to Audit Committee had focussed on training end user requisitioners within the business and training the wider management accounting teams.

020/123 Any other business

No other business were highlighted.

020/124 Date of next meeting

The next meeting was scheduled for 21 January, 2021, 9am via MS Teams.

King's College Hospital NHS Foundation Trust

Audit Committee – Minutes

Minutes of the meeting of the Audit Committee held on Thursday 21 January 2021 at 9.05am via MS Teams

Present:

Akhter Mateen	Non-Executive Director (Chair)
Sue Slipman	Non-Executive Director
Jon Cohen	Non-Executive Director

In attendance:

Sir Hugh Taylor	Trust Chair
Steve Weiner	Non-Executive Director
Lorcan Woods	Chief Finance Officer
Dr Mairi Bell	Director of Financial Operations
Nina Martin	Assistant Board Secretary *(Minutes)*
Jane Allberry	Lead Governor
Siobhan Coldwell	Trust Secretary and Head of Corporate Governance
Neil Hewitson	Internal Audit (KPMG)
Charles Medley	Internal Audit (KPMG)
Ellen Millington	External Audit (Grant Thornton)
Paul Dossett	External Audit (Grant Thornton)

Item	Subject	Action
	2. STANDING ITEMS	
021/01	**Welcome and Apologies** The Chair welcomed all to the meeting	
021/02	**Declarations of Interest** No interests were declared.	
021/03	**Chair's Action** The decision had been made to have a shorter meeting which would cover external assurance, so senior executive could continue to focus on the COVID response. The external and internal auditors confirmed that other Trusts were either doing the same or deferring their AC meetings because of COVID.	
021/04	**Minutes of the Previous Meeting** The minutes of the meeting held on 21 November, 2020 were approved.	
021/05	**Action Tracker and Matters Arising** Some actions were deferred due to the pandemic response and demand on management time. **Declaration of Interest review** – As agreed, the CFO and IA had a discussion following which a revised proposal which included making some recommendations more pragmatic	

Item	Subject	Action

was submitted to the CFO the day before. The finalised review would come to the March Committee.

4. EXTERNAL ASSURANCE

021/06 Internal Audit – Progress Report (incl counter fraud)

KPMG were on trajectory with the delivery of the 20/21 programme of work and updates on the remaining 20/21 reviews would be brought to the March Committee.

Work remained ongoing on the live counter fraud cases and the Committee heard that there were no new cases to flag. It was recognised that the COVID pressures provided potential opportunities for fraud and so work was continuing to promote fraud awareness.

An update on the 21/22 IA plan would be brought to the next Committee. The usual approach to engagement with management on the reviews would need to be adapted given the present pressures on their time. The IA team would meet with the Chief Nurse and CFO and then bring the discussion to the wider KE. The AC chair would then be engaged to get NED input.

The Data quality review had been deferred and remains a document in draft. IA would want executive feedback before commenting on the status and findings of the review.

021/07 Recommendation Tracker

A number of recommendations were overdue for report/implementation and a number of these had no updates. Some of the recommendations were marked closed but KPMG had yet to see the evidence. It was acknowledged that implementation of many of the recommendations inevitably was delayed because of COVID and the pressure of the response, but it was important for the tracker to be kept up to date and for recommendation owners to provide updates, even if it to say that COVID pressures was the cause of the delay.

Action: KPMG to work with the Trust Secretary and CFO to ensure fuller updates in plenty of time for the March meeting and to ensure realistic timelines for recommendations be set for moving forward.

The Committee was asked to note that most of the actions had progressed but not recorded due to the Covid response.

The Trust Secretary updated that Ashley Parrott and Nicola Ranger were progressing the risk management recommendations and work.

The subsequent updates to the tracker which had been circulated highlighted progress with the IT actions.

021/08 Ledger Review (Oracle System)

The Committee noted the report. There were no major governance gaps to flag and there had been good compliance with the risk processes in place. The recommendations made were largely in the form of lessons learnt.

A dedicated project manager and the input of KPMG at project meetings had helped with the transition and smooth implementation. The CFO asked that IA review be amended to include that that there had been HR presence at the project meetings.

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The Committee commended the smooth implementation and looked forward to further assurance once EA carried out their review.

021/09 External Audit

Grant Thornton updated briefly on their start at King's, key issues that they are likely to be looking at going forward and some of the changes in audit procedures which would affect the external audit process. Their other key updates included:

- No risks to the audit work had as yet been identified from the impact of the pandemic but this will be continually monitored.
- Further clarity and details around the new Value for Money requirements would come to the March Committee.
- Assessing going concern status would need to be planned proactively given the Covid pressures.
- It had been confirmed that the Quality Report won't be audited this year.

021/10 EA Progress Report

EA had attended a number of Trust meetings. They hoped to soon confirm an approach to the stock take. Grant Thornton would liaise with the previous auditors to get any learning from the previous year's approach. While most of their work will be carried out remotely, Grant Thornton will take a flexible approach if needed to take forward this year's stock take.

021/11 Finance Reports

These discussions would be deferred to the next Committee. The Committee noted the waivers report. The Chair added that it would be helpful to include the names of the suppliers and the nature of their business to the waiver report.

021/12 Date of next meeting

The next meeting was scheduled for 4 March 2021, 9am via MS Teams.