King's College Hospital NHS Foundation Trust

AGENDA

Meeting	**Board of Directors**
Time of meeting	**15:30 – 17:30**
Date of meeting	**Thursday 10 March 2022**
Meeting Room	**MS Teams**
Site	**N/A**

No.	Agenda item	Lead	Format	Purpose	Time
	STANDING ITEMS				
1	Apologies for absence	Chair	Verbal	Information	15.30
2	Declarations of Interest	Chair	Verbal	Information	
3	Chair's Actions	Chair	Verbal	Approval	
4	Minutes of the Meeting held 9 December 2021	Chair	Enclosure	Approval	
5	Patient story	Chief Nurse	Verbal	Information	15.35
	QUALITY & PERFORMANCE				
6	Report from the Chief Executive	Chief Executive	Enclosure	Information	15.50
7	Integrated Performance Report – Month 10 (January) 2022	Site CEOs	Enclosure	Assurance	
8	Finance Report – Month 10 (January) 2022	Chief Finance Officer	Enclosure	Assurance	
9	Maternity Services 9.1 Ockenden Review Update 9.2 Maternity Staffing	Chief Nurse	Enclosure	Assurance	16.30
10	Safe Nurse Staffing Report	Chief Nurse	Enclosure	Assurance	16.50
	GOVERNANCE & ASSURANCE				
11	Board Assurance Framework	Director of Corporate Affairs	Enclosure	Approval	17.05
12	Report from the Governors	Lead Governor	Verbal	Information	17.15
Items for information – not scheduled for discussion unless notified in advance					
13	Committee minutes • Quality, People and Performance 19/11/2021 • Audit Committee 25/11/2021 • Strategy Research and Partnerships 9/9/2021	Committee Chairs	Enclosure	Assurance	
	OTHER ITEMS				
14	Any other business	Chair	Verbal	Information	17.25
	DATE OF NEXT MEETING				
15	The next public Trust Board meeting will be held on Thursday 16 June 2022 at 15:30				

Members:	
Sir Hugh Taylor	Trust Chair *(Chair*)
Sue Slipman	Non-Executive Director *(Deputy Chair)*
Prof Jonathan Cohen	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Steve Weiner	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Akhter 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	Chief Medical Officer
Mark Preston	Chief People Officer
Julie Lowe	Site CEO – Denmark Hill
Jonathan Lofthouse	Site CEO – PRUH and South Sites
Beverley Bryant	Chief Digital Information Officer
Attendees:	
Funmi Onamusi	Director of Equality, Diversity and Inclusion
Chris Rolfe	Director of Communications
Sophie Whelan	Director of Corporate Affairs
Siobhan Coldwell	Associate Director – Corporate Governance (Minutes)
Circulation List:	
Board of Directors & Attendees	

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 9th December 2021, by MS Teams.

Members:

Sir Hugh Taylor	Trust Chair, Meeting Chair
Akhter Mateen	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Sue Slipman	Non-Executive Director
Steve Weiner	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Prof Nicola Ranger	Chief Nurse and Executive Director of Midwifery
Dr Leonie Penna	Chief Medical Officer
Julie Lowe	Site Chief Executive - Denmark Hill
Jonathan Lofthouse	Site Chief Executive – PRUH and South Sites
Lorcan Woods	Chief Financial Officer
Beverley Bryant	Chief Digital Information Officer
Mark Preston	Chief People Officer

In attendance:

Siobhan Coldwell	Associate Director, Corporate Governance (minutes)
Funmi Onamusi	Director of Equality, Diversity and Inclusion
Chris Rolfe	Director of Communications
Sophie Whelan	Director of Corporate Affairs
Members of the Council of Governors	
Members of the Public	

	Subject	Action

021/63 Apologies

There were no apologies for absence. Prof Richard Trembath joined the meeting at 4pm.

021/64 Declarations of Interest

None.

021/65 Chair's Actions

There were no Chair's Actions to report.

King's College Hospital NHS
NHS Foundation Trust

Subject **Action**

021/66 Minutes of the last meeting

The minutes of the meeting held on 9th September 2021 were agreed.

021/67 Reducing Violence and Aggression

The Chief Nurse provided the Board with a summary of the work the Trust is doing to support and protect staff from violent or aggressive patients. The ambition is for them to be supported, protected and confident. There has been a significant increase in the number of recorded incidents over recent years and the Trust staff survey results show that the Trust scores comparatively poorly in providing a safe environment to staff. The data shows that the majority of incidents are in the emergency departments (ED) on both sites, with Denmark Hill having nearly twice as many incidents as the PRUH.

Dr Jacqui Butler, a consultant from the Denmark Hill ED, joined the meeting to outline the experiences of staff in her department. The behaviour ranges from rudeness and verbal abuse to extreme violence (although this is relatively rare). There can be a numbers of drivers including intoxication and withdrawal, mental distress and crisis, and physical ill-health e.g. head injury. Frustration with long waits and processes can also be a contributing factor. Regardless of the reasons for the behaviour, the impact on staff can be devastating and fortunately the most serious incidents are relatively rare. She noted the Trust provided excellent support to staff affected by violent incidents. The Trust also has an excellent security team that supports clinical teams during and after incidents.

A programme is in place to improve the Trust's approach to supporting staff. Listening events were held with staff and a new nursing team is now in place, led by Joe Hague, Deputy Chief Nurse, to work with clinical teams to enable staff to live the Trust values and provide them with the tools needed to be confident to de-escalate situations when they arise. Current policy and process including acceptable behaviour agreements and banning orders will be reviewed and improved. A flagging system is in place, and this is now being more actively managed. A robust training programme will be delivered to all staff, with further customised training available to staff in high-risk areas. The Board discussed the importance of ensuring this is integrated into the student education programme at an early stage. The approach is evidence based and will be piloted before being rolled out more widely. Short and medium term outcome measures have been agreed, so the impact of the programme can be evaluated.

The Board welcomed the Trust's commitment to supporting and protecting staff and the breadth of activity being delivered. The Board has previously heard about the impact violent and aggressive behaviour from patients and their families can have on wards and it is important to ensure that the patient voice is considered in all strands of activity. The Board noted the importance of the physical environment in preventing situations from escalating and where possible actions are in place to improve the estate.

In concluding the discussion the Chair thanked the team for their thoughtful contribution and the sensitive approach being taken to improve staff and patient safety and experience.

King's College Hospital NHS
NHS Foundation Trust

Subject **Action**

021/68 The Report from the Chief Executive

The Board considered a report from the Chief Executive, which highlighted the key developments in a number of areas since the Board last met. On behalf of the Board, he expressed his gratitude to the Trust's staff for the excellent contribution they continue to make despite ongoing difficult circumstances.

The Board noted the following points:

- The number of patients being treated for COVID-19 has increased in recent weeks and currently stands at 128. This is putting increasing pressure on ED, patient flow and critical care beds. The vaccination programme is progressing well. The vaccines minister visited the Denmark Hill vaccination centre in early December. Vaccination will become a condition of deployment for patient facing staff in April 2022 (assuming legislation is passed as planned) and the Trust is preparing to ensure it is compliant.
- The Government announced new COVID-19 restrictions on 8th December. The Trust is considering the implications, particularly in relation to home-working. Most staff are unable to do this, and the Trust is ensuring that the work environment is as COVID-19 secure as possible, through the use of PPE and infection prevention and control.
- In respect of quality, safety and risk, the Trust has received the report on the DH ED CQC inspection that took place in July. The Trust has also received a Coroner's Section 28 notice in respect of the treatment of a patient who died earlier in 2021. The complaints backlog has reduced considerably since the Board last met and there has been one never event in that period.
- The Trust continues to meet RTT recovery targets and all patients that have waited for more than 104 weeks will have been treated by the end of March 2022. Cancer performance is mixed but there are funded plans in place to drive improvement. Diagnostics performance has also improved ahead of targets. Emergency care performance at both sites is below target.
- A number of workforce initiatives have been implemented since the Board last met, aimed at embedding Trust values and raising awareness of the 'Brilliant People' strand of the Trust Strategy. The Trust 'thank you' campaign has won a national recruitment award.
- Work continues on the delivery of the equality, diversity and inclusion roadmap. The Board held an excellent session on EDI in November.
- Helen Hayes MP, held an adjournment debate in the House of Commons on 3rd December 2021, recognising how hard staff have worked to recover from the impact of the pandemic.

The Board noted that the number of incidents of hospital associated infection had increased in recent months and sought assurance that this was being addressed. There has been some analysis of the causes. Hand hygiene and line management have been identified as areas for improvement. The Board agreed to review this in detail in the next Quality, People and Performance Committee.

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King's College Hospital NHS
NHS Foundation Trust

Subject **Action**

021/68 cont.. **The Report from the Chief Executive cont…..**

The Board discussed 'winter preparedness'. Plans are in place, with key partners including the London Ambulance Service and relevant local authorities. Routine elective activity will stop for a short period (7 days) over Christmas and New Year. This allows essential maintenance to take place and reflects patient choice. Resilience will be a challenge over the winter period, but the Board was reassured that preparation has been appropriate.

In concluding the discussion, the Chair welcomed the achievements over recent months and thanked staff for their ongoing contribution.

The Board **NOTED** the report from the Chief Executive.

021/69 **Safer Staffing Report**

The Board received the quarterly review of nurse staffing levels from the Chief Nurse. Vacancy levels are generally low and turnover has reduced and the focus is on staff wellbeing and retention. This includes a focus on education and flexible working. Whilst the vacancy levels at the PRUH appear to be high, in some areas this is due to new posts being established. Nevertheless, there are a number of hotspots including in the emergency department. The Trust will be welcoming a number of overseas nurses in December and a programme of support is in place. There is an ongoing programme of support and education for healthcare assistants including promotion of pathways to becoming registered nurses.

The staffing model in midwifery has been changed to improve the management of high rates of maternity leave and there has been a focused effort to reduce staff sickness. The Board welcomed the work to improve student retention post-qualification and to improve nurse retention more generally.

The Board **NOTED** the report.

021/70 **Report from the Governors**

Jane Allberry, Lead Governor, welcomed the discussion at the recent governor strategy committee on the delivery of the Trust strategy and looks forward to further engagement. A numbers of issues were discussed at the governor patient safety and experience committee including learning from complaints. The Governors remain keen to help and support the Trust on behalf of patients and the public. The Governors recognise the ongoing COVID-19 challenge, but noted that in some areas remote engagement, particularly through the Cancer Board has been excellent.

021/71 **For Information**

The minutes of the following meetings were received for information:

- Finance and Commercial 22nd June and 27th Sept 2021
- Audit Committee 1st July and 16th September 2021
- Major Projects Committee 22nd July 2021

King's College Hospital NHS
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	Subject	Action

021/72 **Any Other Business**

There were no items of any other business.

021/73 **Date of the Next Meeting**

3.30pm 10 March 2022

DRAFT

King's College Hospital NHS Foundation Trust

Report to:	The Board of Directors
Date of meeting:	10 March 2022
Subject:	Report from the Chief Executive Officer
Author(s):	Siobhan Coldwell, Associate Director, Corporate Governance
Presented by:	Professor Clive Kay
Sponsor:	Chief Executive Officer
History:	N/A
Status:	Discussion

Background/Purpose

This paper outlines the key developments and occurrences since the last Board meeting held on 9 December 2021 that the Chief Executive wishes to discuss with the Board of Directors.

Action required

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

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 of Directors 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 of Directors is asked to note the strategic implications of the vision.
Workforce:	The Board of Directors 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 on 9 December 2021 that the Chief Executive Officer (CEO) wishes to discuss with the Board of Directors.

1.2. At the time of the last Board of Directors meeting, the number of COVID-19 in-patients had started to increase, in line with the expectations laid out in our winter plans, and the Foundation Trust ("the Trust") had made progress on elective recovery, balancing the care of the smaller cohort of COVID-19 patients whilst working across South East London (SEL) to recover our own, and our partners', waiting lists. Since then, the Trust has dealt with a further wave of COVID-19 primarily due to the Omicron variant which resulted in increased admissions and more significantly, high levels of staff absence, which impacted on our ability to deliver non-urgent planned care across the Trust.

1.3. I would like to commend all of our teams for their incredible hard work and dedication in continuing to deliver compassionate care to all our patients despite of the very significant operational pressures we continue to face as an organisation.

2.0 Quality, Patient Experience and Safety

Patient Safety

2.1 There has been one Never Event in the Trust since the start of 2022. The incident involved wrong site surgery in our Dermatology service whereby a patient had a biopsy undertaken of the wrong lesion. Both lesions were on the patient's left cheek. An investigation is underway to understand and address the causes. This is the third Never Event in dermatology services (across all sites) in the last 12 months and the investigation will therefore include an assessment of common causes and themes to ensure that effective steps are taken to prevent any further incidents.

2.2 We continue to work collaboratively with colleagues in the Healthcare Safety Investigation Branch (HSIB) particularly in relation to significant maternity and neonatal patient safety incidents. There have been no incidents requiring referral to the HSIB in 2022. There are currently three HSIB investigations open and ongoing.

2.3 Work is underway to prepare the Trust for the transition to the new NHS Patient Safety Incident Response Framework. This is a key component of the NHS Patient Safety Strategy and will significantly change all aspects of the management of patient safety incidents. The dates have not been confirmed nationally, but it is expected that formal implementation in South East London should begin in Summer 2022.

Patient Experience

2.4 The Trust's progress in addressing the backlog of complaints accumulated during the pandemic peaks has been negatively affected by the third wave of Coronavirus (COVID-19). The number of overdue complaints has risen to 109. The Trust has plans currently under development to improve the Trust's position.

2.5 In January 2022, 96.3% of our inpatients reported a positive experience and 90.2% of our outpatient reported a positive experience. Whilst the Friends and Family Test (FTT) scores have not reached the levels we are aiming for across all areas, qualitative analysis of patient feedback indicates that patients are appreciative of the compassion, competency and support offered by staff. However, delays and communication challenges have negatively affected their experience. As a result, plans to support improvements have been developed and are being driven by the patient experience function.

2.6 The Care Quality Commission's (CQC) survey focussing on Urgent and Emergency Care (UEC) was recently published and this revealed that our patients' experience is broadly comparable with the national picture. Patients rated their experience as '*significantly better'* in relation to six questions including quicker waiting times for patients attending via ambulance; getting a member of nursing/medical staff to help them; and that the environment was clean and tidy. Importantly, there were no areas in which we achieved a '*significantly worse'* score. We also saw improved patient experience scores on all questions in which we were previously rated as '*significantly worse'*. Plans to further improve patient experience in UEC are currently being implemented.

2.7 The CQC's inpatient survey has also been recently published. We were pleased to note that the Trust's scores improved against 18 of 45 questions, where direct comparison could be made. This included access to drinks, quality of food and pain relief. A detailed review of the benchmarking data informed the development of an action plan that will focus on co-designing patient information, improving patients' experience of discharge and communication skills for doctors.

2.8 In February 2022, the CQC also published the Maternity patient survey. This has shown some deterioration in our patient experience scores and relates to feedback from women who gave birth in February 2021. Work is already underway to understand the causes and instigate improvement plans. This includes a briefing pack for staff which will help start a process of co-designing the experience improvement plans.

2.9 The highly anticipated roll-out of the patient entertainment portal, generously supported by the King's College Hospital Charity, has commenced with the public launch scheduled for week commencing 21 March 2022. The launch will take a form of a roadshow, led by Prof Nicola Ranger, Chief Nurse and Executive Director of Midwifery, and Beverley Bryant, Chief Digital Information Officer, to promote the service to patients and staff.

Quality Governance

2.10 The Trust is currently running a project in collaboration with the Good Governance Institute which is aiming to standardise and enhance the quality governance structures at care group level. The project is currently in the final phase, which includes 'hands on' support for care groups over the course of three of their local governance meetings to help, to effectively embed key changes.

2.11 The Trust has worked with colleagues in the CQC to host a number of focus groups with our maternity staff on both sites. These took place in February 2022. Focus groups are a useful way for the information to be gathered by the CQC to help to

inform their risk-based approach to inspection. They are also an opportunity for the Trust to obtain valuable feedback about staff views and concerns.

2.12 Following an inquest into the death of a patient from an isolated pancreatic injury, an investigation was undertaken. This identified that there had been missed opportunities in the identification and escalation of her deterioration. The death was also the subject of an inquest on 25 February 2022, and the Coroner reached the same conclusions. We accept the Coroner's findings and we are working through an action plan to enhance the safety of paediatric patients in our care, and address the concerns set out by the Coroner in the Reg.28 report to Prevent Future Deaths. We have apologised to the family and they remain very much in our thoughts.

3.0 Operational Performance for the period M1 to M10 inclusive

3.1 Due to the increasing number of COVID-positive in-patients, as well a significant COVID-19 related staff sickness during December '21 and January '22, the King's Executive took a decision again to temporarily suspend non-urgent elective, outpatient, and diagnostic activity across all of our sites from the middle of December '21 until the middle of January '22. This decision was agreed across the South East London Acute Provider Collaborative.

3.2 The Trust saw a rapid growth in COVID-19 admissions during December culminating in 347 COVID-positive patients in our beds at the end of December, with 327 patients in General and Acute beds and 32 patients in Intensive Care Unit beds. The peak period during the third COVD-19 wave occurred on 5 January 2022, there were 387 COVID-positive patients in our beds including 355 patients in General and Acute beds and 32 patients in Intensive Care Unit beds. Thankfully, the associated conversion to critical care demand was much reduced during this third COVID-19 wave, and the median length of stay for COVID-positive patients reduced to 4 days compared to the 7.5 days observed during the second and first COVID-19 waves.

3.3 Our elective recovery programme resumed from the middle of January despite having 227 COVID-positive patients across our acute sites at that point. Although Emergency Department (ED) attendances were lower during December and January compared to pre-pandemic levels, emergency demand has meant that overall adult bed occupancy throughout January remained above 95%.

3.4 Elective inpatient activity has increased towards the end of January with weekly activity achieving over 78% BAU levels by the week-ending 6 February. Elective day case activity has also increased week-on-week during January achieving over 82% BAU activity levels by the final week of January. Outpatient attendances have remained consistently above historic BAU activity levels. Diagnostic activity in imaging modalities such as CT and MRI has exceeded pre-pandemic activity levels throughout January and February, although endoscopy activity has been more variable on a weekly basis during the same period delivering between 80-87% BAU activity levels.

Referral to Treatment (RTT)

3.5 By the end of December 2021, the number of patients waiting more than 52 weeks had reduced to 760. While this increased to 832 by the end of January 2022 due to the enforced cessation of elective activity, this still represents a reduction of 5981 cases (-87.79%) on the February 2021 peak of 6,813.

3.6 The Trust has committed to eliminate any patient waits of more than 104 weeks by March 2022. At the time of writing this report, there are 51 patients requiring completion of their treatment by the end of March 2022 who are either currently waiting, or will have waited, more than 104 weeks by the end of this financial year. There are three patients who are yet to be booked for an outpatient appointment on their pathway. There are also 42 patients waiting for day case or inpatient treatment of whom all but three patients have a booked admission date before 31 March. There is one patient booked for admission on 1 April 2002 due to patient choice.

3.7 During February 2022, referrals have returned to pre-Christmas levels. The overall Patient Tracking List (PTL) size has increased by 10% over the previous 18 weeks with 77,144 patients currently waiting. With this overall increase there has been a 7.7% growth in the number of patients waiting 0-30 weeks, and a 35.4% increase in the number of patients waiting over 30 weeks. This change in the number of patients waiting across our PTL waiting time groups, presents a significant risk to sustainable long wait reduction. In collaboration with our NHS partners in South East London (SEL) our first draft operational plan activity and Referral to Treatment Time (RTT) forecasts for the next financial year have been completed and will be incorporated into the SEL Integrated Care System (ICS) Operating Plan submission due by April. These plans include a number of elective activity expansion schemes to mitigate waiting list growth in 2022/23.

Emergency Care Standard

3.8 A&E attendance volumes between June to October this year have been higher than 2019/20 baseline year activity levels. However, due to the impact of the third COVID-19 wave, ED and Urgent Care attendances were 11.5% lower in December ‘21 and 4.5% lower in January ‘22 compared to pre-COVID-19 baseline levels.

3.9 Performance at Trust level (all attendance types):

- 68.01% in January 2022 compared to 64.88% in December 2021 (95% target).

3.10 Performance at site level (all attendance types):

- 64.39% in January 2022 compared to 59.84% in December 2021 at Denmark Hill.
- 72.54% in January 2022 compared to 71.11% in December 2021 at PRUH.

Diagnostic waiting times

3.11 The percentage of patients waiting more than six weeks for a diagnostic test reduced to 6.83% by the end of January 2022 compared to 8.86% reported at the end of December 2021. This represents a reduction in the total number of patients waiting

over six weeks of 3,717 cases (-82.78%) from the 4,490 peak waiting immediately after COVID-19 Wave 2 (March 2021) to 773 waiting at the end of January 2022.

3.12 Performance at site level:

- 7.42% in January 2022 compared to 9.92% in December 2021 at Denmark Hill.
- 2.74% in January 2022 compared to 1.35% in December 2021 at PRUH. Prior to December, PRUH had reported performance compliant with the national 1% target for two consecutive months at 0.35% in October 2021 and 0.52% in November 2021.

Cancer

3.13 Delivery of the two week wait standard for attendance following an urgent GP referral for a suspected cancer diagnosis, was 90.59% in January (93% target), with 90.93% and 90.12% delivered at Denmark Hill and PRUH/SS sites respectively. The two week wait standard was last achieved in November 2021 at 94.49%.

3.14 The Trust's aggregate performance for patients receiving first treatment following an urgent GP referral was 59.33% (85% target). The Trust's aggregate position comprised of 48.74% delivered at Denmark Hill, and 80.65% at PRUH/SS sites.

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

4.0 COVID-19

Vaccination as a Condition of Deployment

4.1 The Secretary of State confirmed on 31 January 2022, that there would be a consultation on the Vaccination as a Condition of Deployment (VCOD) regulations which required those aged 18 and over working in frontline NHS roles to have received two doses of an approved COVID-19 vaccination (unless medically exempt) by 31 March 2022. The national consultation closed on 16 February and the Government confirmed that "*subject to the outcome of the consultation, the regulations will be revoked ahead of 1 April 2022*". On 2 March 2022, the Government announced that it has formally cancelled plans to make vaccination a condition of deployment for NHS staff. We understand how challenging this issue has been for some of our staff, and we are doing all we can to support them.

Living with COVID-19

4.2 On 23 February 2022, the Prime Minister set out plans for how we will live with and manage the COVID-19 virus. The most significant step announced by the Government was that, from Thursday 24 February, the legal requirement to self-isolate following a positive test result ended. Routine contact tracing has also ended.

4.3 The Prime Minister also made clear that the NHS is best placed to decide which measures it needs to retain after Thursday 24 February. Whilst further changes are likely in the future, the Trust will continue to apply a range of measures in our hospitals for the time being. Keeping our staff and patient safe remains our number one priority.

- **Self-isolation for COVID-19:** members of staff must continue to self-isolate after 24 February if they return a positive lateral flow test. The minimum self-isolation period is five days.

- **Lateral flow tests:** staff should continue to undertake lateral flow tests twice a week. These are particularly important for people working in a healthcare setting, as they help identify cases of COVID-19 in people who may have no symptoms, but are still infectious. The Government has confirmed that people can continue to order lateral flow tests for free until the end of March. We are awaiting further information about the supply and availability of lateral flow tests for NHS staff from 1 April onwards.

- **Face masks:** Everyone (including patients, staff and visitors) will still need to wear a face mask as soon as they enter any of our clinical buildings, and we expect this policy to remain in place for some time. Our wards have posters detailing what PPE needs to be worn, and these must be followed at all times. Inpatients should also wear face masks during their stay unless clinically indicated.

- **Visiting arrangements:** As of23 February, we have introduced further changes to arrangements for visitors, the most significant of which is that patients on our wards will now be allowed two visitors each day rather than one. Updated visiting guidance is on our website- and whilst some restrictions still apply, I am confident the new arrangements will be welcomed by patients, visitors, and colleagues on our wards.

- **Working from home:** From 28 February, everyone was expected to return to their on-site place of work, unless they have already agreed and formalised an on-site/home working arrangement with their line manager. We fully support hybrid working, and many teams already have well-established practices and rotas in place that enable colleagues to combine on-site and home working.

- **Social distancing** will continue to apply in our hospitals.

Vaccinations

4.4 The Trust continues to run vaccination centres at both Denmark Hill and Bromley Civic Centre and we continue to work with colleagues to promote the benefits of vaccination.

5.0 SOUTH EAST LONDON(SEL) ACUTE PROVIDER COLLABORATIVE (APC)

5.1 I have updated the Board of Directors previously regarding the work of the Acute Provider Collaborative (APC) in South East London (SEL) through the pandemic, and the work we have been collectively doing to ensure all our patients across South East London are seen in as timely a manner as possible. The APC consists of the three

acute providers in SEL – Guy's and St Thomas', King's College Hospital, and Lewisham and Greenwich.

In my role as APC CEO Lead, I have been working with colleagues to further formalise structures and governance for the APC. These were presented to the three Boards during January and February 2022. As you know, we have been working on developing the APC governance document for some months, and I recognise that getting Trust agreement to this new governance model is only the first step. A formal Governance structure involving a Committee in Common, a CEO Committee, and a number of executive-led committees, now formalise the ongoing collaborative work already in place. There is a lot of hard work ahead in order to implement the proposals and bring them to life across the APC. I look forward to working with partners to continue to refine and evolve the APC, and similarly for the APC to play its part in supporting the wider system.

5.2 The APC Chief Executives, and various executive groups, continue to meet on a regular basis and as noted above, elective recovery progress across South East London is positive. The APC has been instrumental in supporting mutual aid across the three providers during and following the pandemic surges.

6.0 Finance

Summary of the Financial Position (Month 10)

6.1 The Trust achieved a breakeven position for the first half of the year and submitted a breakeven plan for months 7-12 which it is on track to achieve.

6.2 During the M7-12 planning process, a gap of £36m was identified based on NHS income allocations, current expenditure run rates and known cost pressures (largely relating to winter and recovery costs).

6.3 A review of the mitigations at month 10, indicated that the Trust had between £35-45m of mitigations identified to bridge the gap.

6.4 Year to date the Trust is reporting a £(8.2)m deficit (£[8.4]m in H2), £16.0m favourable to the pre mitigation plan. The Trust has realised £20.4m of the mitigations the Trust had identified and the M10 forecast is to breakeven.

6.5 The Trust has carried out a detailed capital reforecast at M9 to understand the planned expenditure on the major and regular portfolio programmes of work. As at M10 the Trust is forecasting to achieve the planned spend of £86.8m (inclusive of £24m for the Apollo Electronic Patient Record System).

6.6 Further details can be found in the **Integrated Performance Report** later in this set of papers.

7.0 WORKFORCE UPDATE

People and Culture Strategy

7.1 The Trust's new People and Culture strategy has been finalised and we are developing plans to embed this across the Trust. There are five key themes which underpin the strategy: *Belonging to King's; Being our best; Looking after our people; Inspiring Leadership; Ensuring our people thrive*. The strategy places a focus on personal and professional development, empowerment and engagement, and the individual needs of our people.

7.2 We are keen that all of our people are involved in the delivery of the strategy so that this makes a real difference to the way they work and the experience they have at King's, ensuring the Trust develops as a real exemplar in people-based practice.

Recruitment

7.3 The Trust continues to run a number of recruitment campaigns locally, nationally and internationally. We have received additional funding from NHSE/I to support the recruitment of Health Care Support Workers and for Internationally Educated Nurses (IENs). In the current financial year, the Trust is on target to have deployed c.350 IENs.

7.4 The Trust's overall vacancy rate is 15.17% as at the end of M10. Whilst this is higher than the planned trajectory, there are a number of factors that have contributed to this, including a higher number of externally-funded posts added to the establishment to support winter pressures and the continued deployment of the Mass Vaccination centre. The Trust does however continue to make net gains on starters over leavers.

National Staff Survey

7.5 The Trust has received the benchmarked National Staff Survey results for the 2021 survey. These are embargoed until 30 March, however we will be using this time to analyse the results to highlight where we have achieved positive outcomes and identify areas for improvement. We will develop action plans that support improvement and real change across the Trust.

Events in the Ukraine

7.6 We have been very much saddened by recent events in the Ukraine and given the diversity of our teams, we are mindful that we will have people in the organisation who will be affected both directly and indirectly by this. We have developed and promoted an offer of support for King's people. This includes access to health and wellbeing support (including occupational health) and the employee assistance programme.

Staff Health and Wellbeing

7.7 As part of the Trust's response to Vaccination as a Condition of Deployment (VCOD), we have hosted a number of webinars and reflective sessions for people who have been affected and requested support in regard to this issue. The webinars have been

particularly helpful for the Trust to understand how we better communicate with our people.

7.8 The development of our hospital well-being hubs at Denmark Hill, PRUH and Orpington continue, and we are planning that these will be open in April. These will provide our people with a permanent space for us to support their well-being and we look forward to these opening.

8.0 EQUALITY, DIVERSITY AND INCLUSION

8.1 This section of the report will describe the achievements to date under the diversity and inclusion-related priority areas embedded in our *Strong Roots, Global Reach* strategy.

Leading the way by developing our culture and skill - We have:

- Produced a guidance document to help ensure effective practice for managers supporting and facilitating provisions for Muslim team members wishing to pray.
- Co-ordinated more Active Bystander training sessions, with another 238 attendees across 7 sessions.
- Procured and uploaded more than 20 new EDI interactive/video modules onto LEAP.
- Supported Chaplaincy celebrating World Interfaith Harmony Week and ratified an Interfaith & Belief network Terms of Reference (TOR).
- Marked LGBT+ History Month with communications, campaigns, flag raising, bake sales, a virtual event and transgender awareness training.
- Delivered a Race Equality Week webinar with almost 200 attendees with a range of speakers who shared how staff could take practical steps to increase race equality.
- Ratified King's new Women's Network TOR ahead of the launch on 8 March to mark International Women's Day.
- Finalised development of the staff EDI policy and Staff Networks policy, which aligns to a business case to embed protected time for our staff networks

Being an anchor in the community and Building Community Partnerships

- We re-established a link to Brixton-based college, *'Southbank UTC'*, and are now in the process of organising work experience placements for their Healthcare BTEC students at the Trust.
- We planned a joint project with a Youth Centre in Lambeth, *Marcus Lipton*, which focusses on employability and wellbeing for vulnerable young people. The project will be launched in April and will connect participants to relevant professionals at the Trust.

- We participated in the launch and subsequent first meeting of the London Anchor Strategy and Change Network.

- We continued to support the implementation of South Central 1 (SC1) Employment and Skills workstream, and contributed to the development of their first stage research proposal.

Tackling Health Inequalities

- We submitted a proposal to the Executive Team for taking an organisational approach to '*Tackling Health Inequalities'* that was developed collaboratively with key stakeholders from across the Trust.

- We have supported the procurement of hearing loops for Outpatient receptions at Denmark Hill and are in the process of organising the implementation of a wheelchair hire scheme, '*Wheelshare*' at Denmark Hill.

- We continued to support the configuration of the Epic patient health record system (Apollo) through our ongoing contributions to two working groups.

- We responded to requests from Sickle Cell, End of Life, Cancer and Dementia services, and we are supporting these departments and specialists to create targeted actions plans to address health inequalities.

Next Steps

- Now that we have received extensive feedback on our Equality, Diversity and Inclusion (EDI) Roadmap, we will submit our final draft to King's Executive and the Quality, People and Performance Committee in March. Assuming approval is received, we will publish the final version and communicate our ambitions to our internal and external stakeholders in April.

- We will develop a detailed project plan for our health inequalities work and initiate our first stage, data and gap analysis.

9.0 Board Committee Meetings since the last Board of Directors Meeting (9 December 2021)

Quality People and Performance Committee	20 Jan 2022
Audit Committee	27 Jan 2022
Strategy, Research and Partnerships	3 Feb 2022
Major Projects Committee	10 Feb 2022
Governor Strategy Committee	10 Feb 2022
Governor Patient Experience and Safety Committee	24 Feb 2022

10.0 GOOD NEWS STORIES

10.1 **Accreditation for our Occupational Health team** Our Occupational Health (OH) team recently secured full Safe, Effective and Quality Occupational Health Service

(SEQOHS) accreditation. The service is now listed as accredited on the SEQOHS website, having demonstrated “values of engagement, experience and partnership”. Throughout SEQOHS’s accreditation report, our Occupational Health team were recognised for their excellent service delivery.

10.2 **King’s Virologist recognised in New Year's Honours** Dr Malur Sudhanva, Consultant Virologist at the Trust, was made an Officer of the British Empire (OBE) in the New Year's Honours list. Dr Sudhanva, who has been a consultant at King's since 2004, was recognised for his services to healthcare science, particularly during the COVID-19 pandemic. I am sure you will join me in extending my sincere congratulations to Malur.

10.3 **Amanda Pritchard and Sajid Javid visit Denmark Hill site** In early January, Amanda Pritchard, Chief Executive of NHS England, visited our Denmark Hill site to talk to staff, and thank everyone for their efforts during the pandemic. She met with members of our neurosurgery team on Kinnier Wilson ward, and talked to staff and volunteers based in our vaccination centre. Sajid Javid, Secretary of State for Health and Social Care, visited our Denmark Hill the same week, and met with staff in our vaccination centre, and in intensive care.

10.4 **Ministerial and Royal visits in February** In February, we welcomed a number of other visitors to services across the Trust, including Mike Freer, Equalities Minister, who visited the Camberwell Sexual Health Centre, and the Duchess of Cornwall and Mayor of London Sadiq Khan, who met staff in The Haven sexual assault referral centre. The Attorney General, Rt Hon Suella Braverman QC MP also visited The Haven on 24 February.

10.5 **Professor Clive Kay, Chief Executive interviewed on BBC Radio 4** I was interviewed on BBC Radio 4’s Today programme in January about the Trust’s Omicron response. You can listen to the interview in full at the following link: https://www.bbc.co.uk/sounds/play/m001326h. The interview with me starts at 1 hour, 52 minutes. I was also interviewed for the BBC News Channel on the same morning (3 January).

10.6 **Professor Clive Kay, Chief Executive interviewed for** BBC One’s Sunday Morning Show Sophie Raworth interviewed me about the challenges presented by the Omicron variant, and the lasting impact on King’s staff. The BBC presenter also spoke to me about the COVID-19 vaccination mandate for NHS staff, and the impact this was likely to have on staff. The interview was covered extensively by national broadcast and print media, including pieces in BBC online, The Guardian, Mirror Online, Daily Mail.

10.7 **Lesley Powls interviewed for BBC Radio 4's The Briefing Room** In January, Lesley Powls, Head of Clinical Site Operations and Emergency Planning at the Trust was interviewed for BBC Radio 4's The Briefing Room. The 30-minute podcast, which takes an in-depth look at the latest issues, focussed on the challenges presented by the Omicron variant. Lesley talked about how King's prepared for the Omicron variant, and how it differed from previous strains.

10.8 **New treatment for patients with cystic fibrosis** Earlier this month, seven-year-old Kate Farrer who lives with cystic fibrosis spoke to ITV News about her new treatment at King's. Kate received the drug Kaftrio this month, after it was approved for patients aged 12 and above by the UK's drug regulator, MHRA. ITV News also interviewed Dr Cara Bossley, paediatric respiratory consultant at King's, about how the drug – which needs to be taken twice a day for the rest of a patient's life – helps to manage the condition.

10.9 **New treatment for sickle cell patients** In February, our Haematology Team at Denmark Hill became one of the very first hospitals in the country to administer a new treatment called Crizanlizumab for patients with sickle cell disease. We are a specialist centre for the treatment of sickle cell – in both adults and children – so it' isreally pleasing to see our patients benefiting from this new treatment, which reduces the likelihood of a sickle cell crisis occurring in adult patients.

King's College Hospital NHS Foundation Trust

APPENDICES

Appendix 1: List of Consultant appointments

AAC Date / Locum Consultant / Honorary	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
Honorary	Honorary Consultant in Obstetrics and Gynaecology	Ms Lama Daher	Honorary	07/02/2022	07/02/2024
Locum Consultant	Acute Frailty Consultant	Dr Nermeen Abdelfattah Abdelaziz Hassan	New	31/01/2022	30/01/2023
Locum Consultant	Locum Obstetrician and Gynaecologist Consultant	Dr Mohamed Maged Refat Hosni	New	01/02/2022	31/07/2022
Locum Consultant	Locum Consultant in Obstetrics and Gynaecology	Mr Alexander Steshenko	Replacement	01/02/2022	31/07/2022
Locum Consultant	Locum Consultant Urologist	Dr Yasmin Abu-Ghanem	Replacement	10/02/2022	09/02/2023
Locum Consultant	Locum Cardiac Consultant Anaesthetist	Dr Dmitrii Borisovich Bragin	Replacement	14/02/2022	13/02/2023
Locum Consultant	Locum Consultant in Emergency Medicine	Dr Yashar Deylamipour	Replacement	21/02/2022	20/02/2023
Locum Consultant	Locum Consultant Anaesthetist	Dr Merate Kristos Place	Replacement	21/02/2022	20/08/2022
Locum Consultant	Locum Consultant in Paediatric Anaesthesia	Dr Charis Ern Huey Khoo	Replacement	21/02/2022	20/02/2023
13/01/2022	Consultant Nephrologist with a special interest (10 PAs Dialysis & 6 PAs Transplant)	Dr Theodoros Kasimatis	Replacement	01/02/2022	N/A

King's College Hospital NHS Foundation Trust

AAC Date / Locum Consultant / Honorary	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
16/12/2021	Consultant in Paediatric Intensive Care	Dr Christina Balnta	Replacement	01/02/2022	N/A
07/12/2021	Consultant in Neuroanaesthesia	Dr Ian Jonathan Davis	Replacement	01/02/2022	N/A
14/12/2021	Consultant Anaesthetist with Special Interest in Major/High Risk Surgery	Dr Bethan Jane Ikponmwosa	Replacement	01/02/2022	N/A
08/10/2021	Consultant Haematologist with a Specialist Interest in Bone Marrow Failure and Myeloid Disease	Dr Roochi Trikha	Replacement	01/02/2022	N/A
24/08/2021	Consultant in Medical Microbiology and Infection	Dr Caoimhe Nic Fhogartaigh	Replacement	01/02/2022	N/A
17/08/2021	Consultant in Critical Care	Dr Carole Jackie Dangoisse	New	01/02/2022	N/A
12/11/2020	Palliative Care Consultant	Dr Natalie Gemma Webber	New	01/02/2022	N/A
14/12/2021	Consultant Anaesthetist with Special Interest in Major/High Risk Surgery	Dr Lucy Dancy	Replacement	02/02/2022	N/A
09/09/2021	Consultant Radiologist	Dr Siok Li Chung	New	02/02/2022	N/A
09/09/2021	Consultant Radiologist	Dr Nikhil Rasik Patel	New	07/02/2022	N/A
07/02/2022	Consultant Haematologist with a special interest in Plasma Cell Dyscrasias and Stem Cell Transplantation	Dr Katharine Elizabeth Bailey	Replacement	21/02/2022	N/A
09/12/2021	Consultant in Palliative Medicine	Dr Helen Louise McGee	Replacement	21/02/2022	N/A
24/08/2021	Consultant in Medical Microbiology and Infection	Dr Aileen Elizabeth Boyd	Replacement	21/02/2022	N/A

AAC Date / Locum Consultant / Honorary	Name of Post	Appointee	Post Type New / Replacement	Start Date	End Date
09/02/2022	Consultant in Emergency Medicine	Dr Tahseen Ansari	Replacement	28/02/2022	N/A
08/02/2022	Consultant Rheumatologist	Dr Chris Wincup	Replacement	TBC	N/A
09/02/2022	Consultant in Emergency Medicine	Dr Tahseen Ansari Dr Qadir Adebowale Adelasoye	Replacement	28/02/2022 TBC	N/A
16/02/2022	Consultant in Anaesthesia x 4	Dr Swinda Esprit Dr Marouf Dhar- Locum (6months) Dr Marta Cabana Dr Sylvia Martin	Replacement	TBC 09/03/2022 TBC TBC	N/A
17/02/2022	Consultant Gynaecologist with a Special Interest Colposcopy (Lead)	Dr Efthalia Tsachalina (12 Months FTC)	Replacement	TBC	N/A
22/02/2022	Consultant in Clinical Neurophysiology With special interest in EEG telemetry	Dr Ioannis Stavropoulos	Replacement	TBC	N/A
22/02/2022	Consultant in Endodontics	Mr Mohammadreza Aryafar	Replacement	TBC	N/A
23/02/2022	Consultant Radiologist with a Special Interest Breast Imaging	Dr Charlotte Longman Dr Adam Harry Brown	Replacement	TBC TBC	N/A

King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 10 (January) 2021/22

Board Committee

9 March 2022

King's College Hospital NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*9 March 2022*
Subject:	*Integrated Performance Report 2021/22 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 2022 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 Committee is asked to approve the latest available 2021/22 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 2021/22 Month 10

QUALITY

- Summary Hospital Mortality Index (SHMI) increased to 106.1 – which is above the expected index of score of 100.
- **HCAI**:
  - ❑ Zero MRSA bacteraemia cases reported in January and 4 cases reported YTD;
  - ❑ 8 new VRE bacteraemia cases reported in January, 65 cases YTD which is below the target of 68 cases;
  - ❑ E-Coli bacteraemia: 9 new cases reported in January, 99 cases YTD which is just below the target of 100 cases;
  - ❑ 8 new C-difficile cases reported in January, 92 cases YTD which is above the quota of 85 cases.
- FFT inpatient recommendation scores improved by 1.7% in January to 96.3% and is better than the 94.9% target.
- FFT ED recommendation scores improved by 6.6% to 78.8% and are better than the 74.8% Trust target.

PERFORMANCE

- Trust A&E/ECS compliance improved from 64.88% in December to 68.01% in January. By Site: DH 64.39% and PRUH 72.54%.
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant and reduced to 59.34% for January (target 85%).
  - ❑ Treatment within 62 days following screening service referral is not compliant at 69.44% for January (target 90%).
  - ❑ The two-week wait from GP referral standard reduced to a non-compliant position of 90.59% (target 93%) for January.
- Diagnostics: performance improved by 2.03% to 6.83% of patients waiting >6 weeks for diagnostic test in January (target <1%).
- RTT incomplete performance reduced by 2.32% to 75.00% in January (target 92%).
- RTT patients waiting >52 weeks increased by 72 cases to 832 cases in January, compared to 760 cases in December.

WORKFORCE

- 85.61% people in non-medical roles have had an appraisal since 1 April compared to a target of 90%. Compliance for medical staff has increased to 93.57% which includes Deanery doctors.
- There was a further decrease in the monthly non-COVID sickness absence rate to 3.69% in January compared to 4.01% in December. COVID related sickness increased slightly from 3.00% to 3.20%.
- Statutory and Mandatory Training compliance achieved its 90% target for the first time at 90.18% in January, an increase of 0.28% from December.
- The Trust vacancy rate has risen from 14.19% to 15.17%. This is due to the unexpected large increase in the Trust establishment in both December 2021 and January 2022.
- The Trust voluntary turnover rate was 13.34% in January which is an increase from 12.47% in December, set against a target of 13%.

FINANCE

- The Trust has recorded a deficit of -£8.4m in month 10, £2.3m adverse to the H2 plan (pre mitigations). Year to date the Trust is reporting a £6.1m deficit (-£6.2m in H2), and £18.2m favourable to plan. The Trust has realised £20.4m of the mitigations the Trust had identified for closing £36m H2 planning gap. The Trust is on target to breakeven.
- Overall Income is £6.0m favourable in month compared to the M10 NHSI plan, and is £21.9m favourable in H2.
- Employee Expenses (Pay) is £5.1m adverse variance to plan in month (£5.8m adverse in H2) predominantly driven by £2.3m cost of the £150 '*Thank You*' bonus awarded to all staff in January pay (DH £1.5m, PRUH £0.6m, Corporate £0.2m), and £2.7m increase in Bank Pay cost in month.
- Operating Expenses (Non Pay) is £0.9m adverse variance to plan in month (£1.4m favourable in H2) largely due to £1.7m backdated depreciation of KFM assets, previously in progress and capitalised in M10 and -£0.8m benefit in month on KFM profit share.

NHSi Dashboard - Strategic Oversight Framework

NHSi Dashboard

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
Domain	Indicator	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	13-Month Trend
A&E	A&E Waiting times - Types 1 & 3 Depts (Target: > 95%)	61.26%	59.84%	64.39%	64.14%	71.62%	71.11%	72.54%	75.42%	65.87%	64.88%	68.01%	69.33%	
RTT	RTT Incomplete Performance	78.95%	76.50%	73.88%	74.45%	81.31%	78.52%	76.58%	76.54%	79.89%	77.32%	75.00%	75.30%	
Cancer (Please note that all Cancer indicators show interim, unvalidated positions for the lastest month (Feb-21) in this report)	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	92.76%	89.30%	90.93%	92.66%	96.96%	93.23%	90.12%	90.46%	94.49%	90.82%	90.59%	91.69%	
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: > 93%)				75.00%	87.50%	72.34%	68.18%	83.40%	87.50%	72.34%	68.18%	83.27%	
	31 days diagnosis to first treatment (Target: >96%)	92.20%	88.49%	84.93%	87.54%	97.78%	92.50%	83.61%	92.46%	93.58%	89.44%	84.54%	88.88%	
	31 days subsequent treatment - Drug (Target: >98%)	89.29%	96.30%	83.33%	91.60%	100.00%		100.00%	85.71%	89.66%	96.30%	85.71%	91.30%	
	31 days subsequent treatment - Surgery (Target: >98%)	85.37%	93.75%	66.67%	79.01%	83.33%	100.00%	40.00%	75.61%	85.11%	94.12%	63.64%	78.66%	
	62 days GP referral to first treatment (Target: >85%)	50.71%	55.80%	48.74%	61.42%	75.00%	73.08%	80.65%	80.33%	57.29%	60.53%	59.34%	67.82%	
	62 days NHS screening service referral to first treatment (Target: >90%)	87.50%	89.47%	59.26%	71.35%	100.00%	100.00%	100.00%	84.21%	90.00%	93.10%	69.44%	74.30%	
Patient Safety	Clostridium difficile infections (Year End Target: xx)	8	4	7	54	3	3	1	38	11	7	8	92	

A&E 4 Hour Standard

- A&E performance was non-compliant in January at 68.01%, below the national target of 95% but improving by 3.13% compared to 64.88% performance achieved in December 2021.

Cancer

- The latest interim 62-day performance for patients referred by their GP for first cancer treatment reduced by 1.19% from 60.53% reported for December 2021 to 59.34% in January, and below the national target of 85%.

RTT

- RTT performance is validated at 75.00% for January which is an reduction of 2.32% compared to 77.32% performance achieved in December.

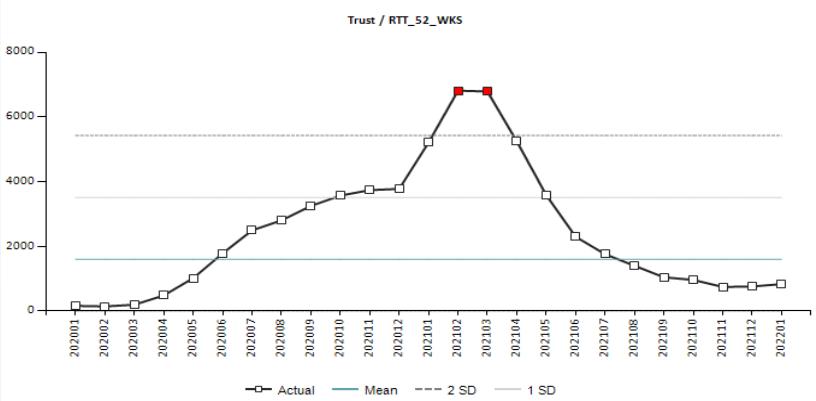
C-difficile

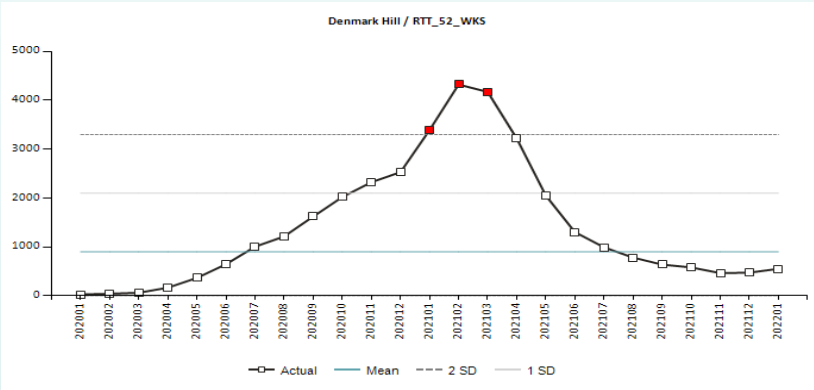
- There were 8 Trust attributed cases of C-Difficile in January 2022, 92 cases YTD which is above the cumulative YTD target of 85 cases.

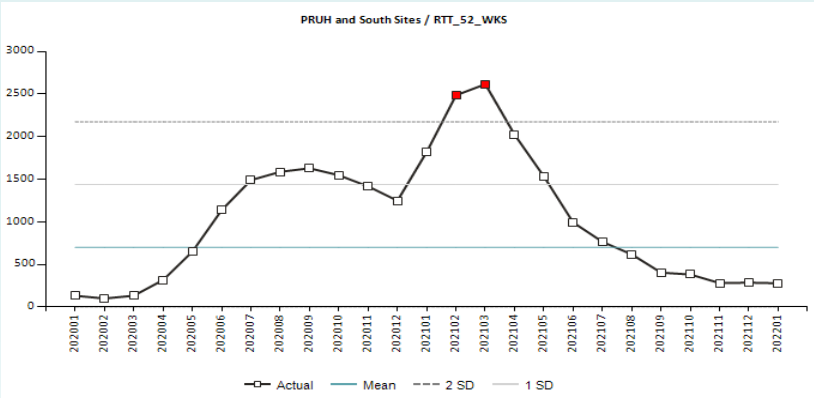
Selected Board Report NHSi Indicators

Statistical Process Control Charts for the last 25 Months Jan-20 to Jan-22

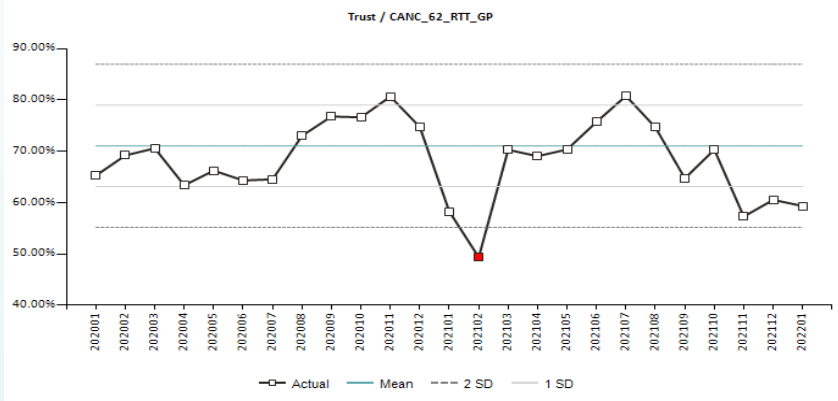
RTT Incomplete Pathways

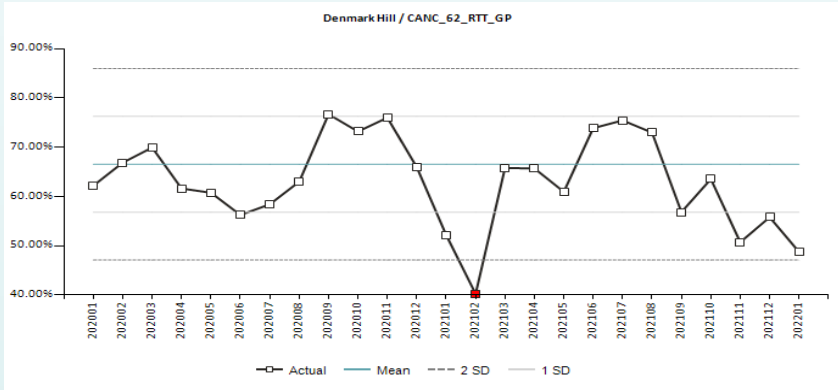


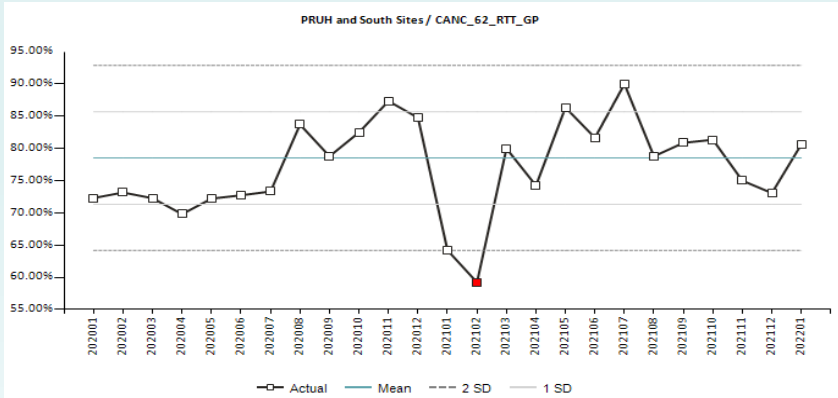




Cancer: 62 day standard

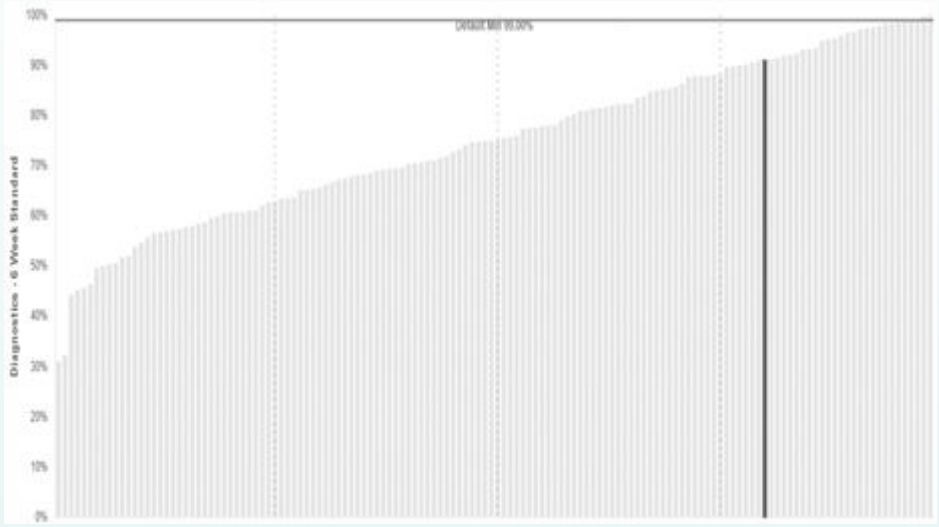




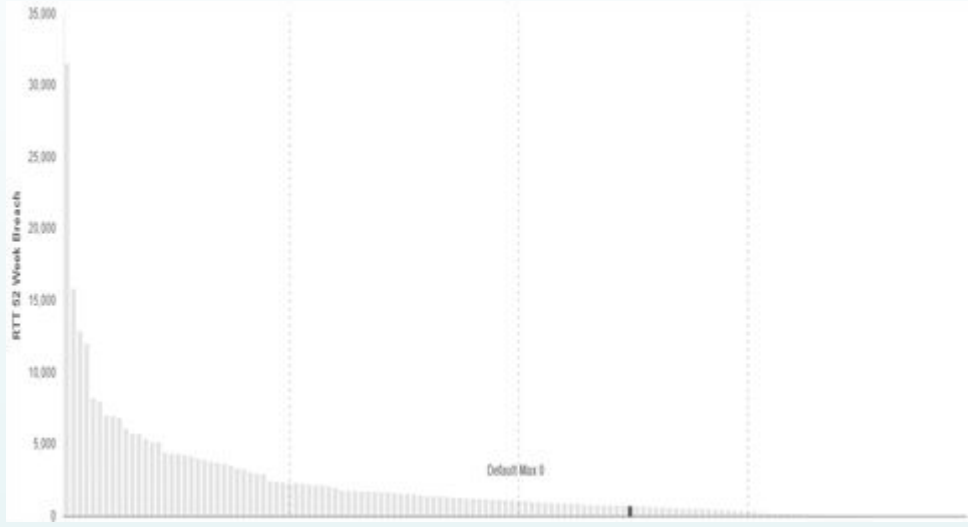


Selected Board Report NHSi Indicators

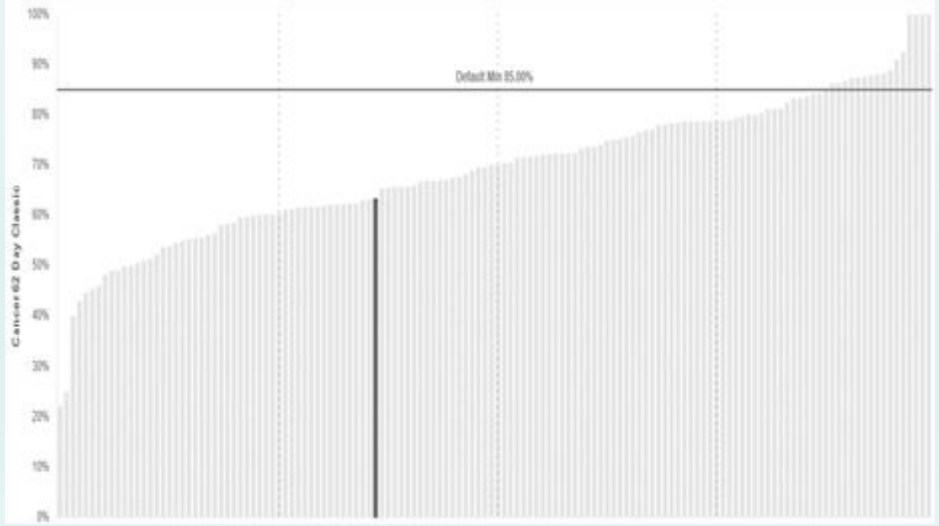
Based on data published from '*Public View*'



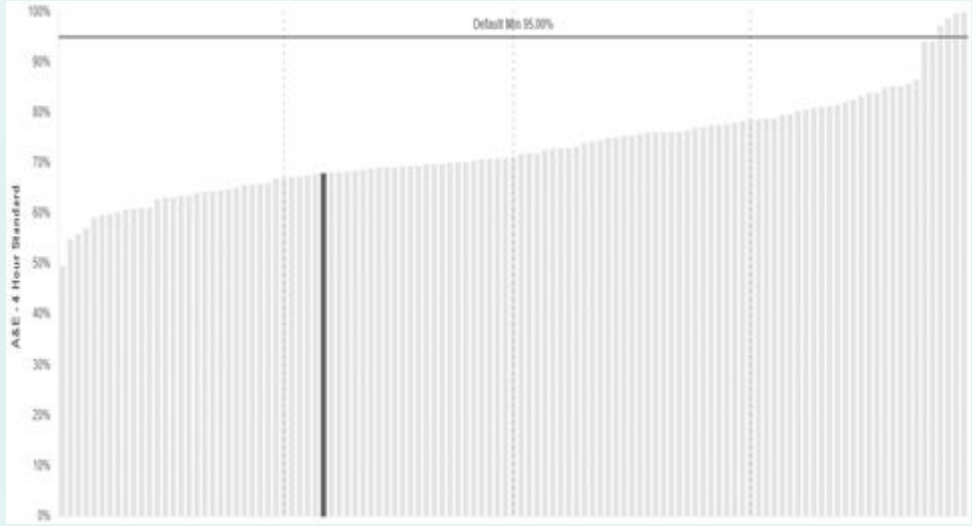
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. Kings is ranked 27 out of 138 selected Trusts based on latest December 21 data published.



The chart above shows the national ranking against the RTT 52 week standard. Kings is ranked 52 out of 138 selected Trusts based on latest December 2021 data published.



The chart above shows the national ranking against the cancer standard for patients receiving first definitive treatment within 62 days of an urgent GP referral. Kings is ranked 87 out of 136 selected Trusts based on latest December 2021 data published.



The chart above shows the national ranking against the 4 hour Emergency Care Standard. Kings is ranked 82 out of 115 selected Trusts based on latest January 2022 data published.

8

Safety Dashboard

Safe

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	13-Month Trend
CQC level of inquiry: Safe														
Reportable to DoH														
2717	Number of DoH Reportable Infections	55	52	61	593	8	10	3	85	63	62	66	683	
Safer Care														
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.03	0.10	0.10	0.06	0.37	0.25	0.19	0.28	0.15	0.17	0.13	0.14	
1897	Potentially Preventable Hospital Associated VTE	0	1	1	8	2	1	0	14	2	2	1	22	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	0	0		0	0	0		0	0	0		
945	Open Incidents										52		124	
Incident Reporting														
520	Total Serious Incidents reported	8	2	3	49	7	6	8	77	17	8	12	132	
516	Moderate Harm Incidents	21	20	19	170	16	16	14	143	38	41	33	328	
509	Never Events	0	0	0	1	0	0	1	2	0	0	1	3	

HCAI

- There were no MRSA bacteraemia cases reported for January with 4 cases reported YTD.
- 8 new VRE bacteraemia cases reported in January and there are now 65 cases YTD which is above the target of 68 cases.
- E-Coli bacteraemia: 9 new cases reported in January, 99 cases YTD which is below the cumulative target of 100 cases.
- 8 Trust attributed cases of c-Difficile in January, 92 cases YTD which is above the cumulative target of 85 cases.

Complaints

- The number of complaints received rated as high/severe increased from 16 cases in December to 22 cases received in January - with 13 reported at Denmark Hill and 8 cases reported at PRUH/South Sites. The number of complaints reduced to its lowest level reported per month to 73 for December, which is also below the target of 85 cases.

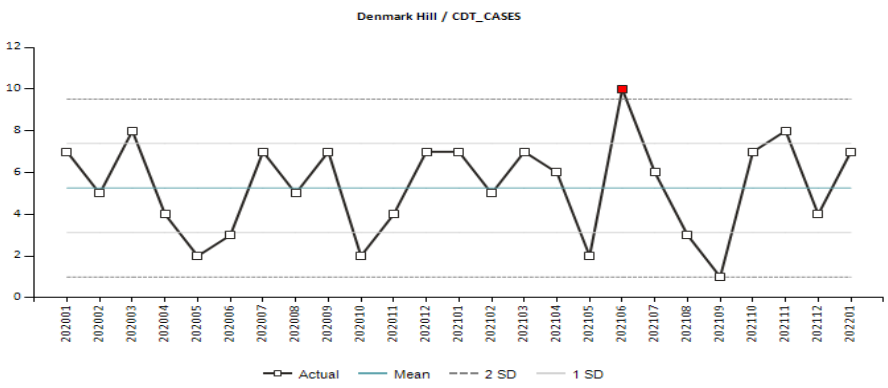
SHMI Summary Hospital Mortality Index)

- The latest SHMI index has increased to 106.1 (above expected) based on the latest rolling 12-month data available to September 2021. We have also received a mortality alert for acute myocardial infarction which is being investigated by the Mortality Monitoring Committee.

HCAI

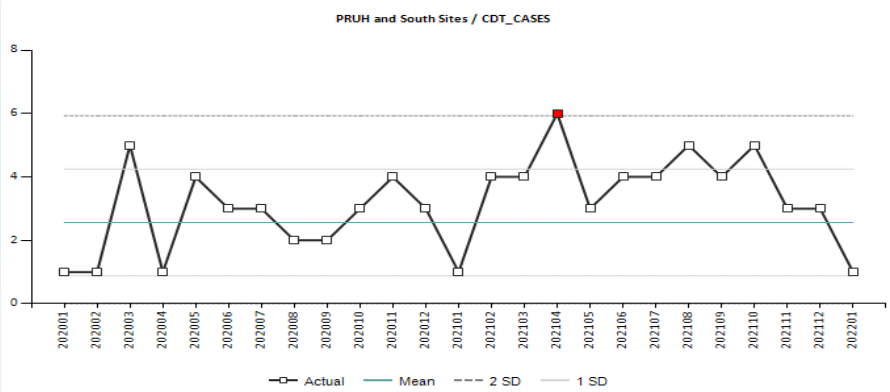
Denmark Hill performance:

- Executive Owner: Nicola Ranger, Chief Nurse & Executive Director of Midwifery
- Management/Clinical Owner: Ashley Flores, Director of Infection Prevention & Control



PRUH performance:

- Executive Owner: Nicola Ranger, Chief Nurse & Executive Director of Midwifery
- Management/Clinical Owner: Ashley Flores, Director of Infection Prevention & Control



MRSA:

- There was no MRSA bacteraemia cases reported for January. This means there has been 4 cases reported this financial year, all reported on the Denmark Hill site. One case in a Cardiac ward and the other 3 cases in critical care units so far this financial year.

VRE:

- 8 new VRE bacteraemia cases reported in January which includes 5 cases reported in critical care and 1 case reported in Haematology, Acute Medicine and Surgery wards, all on the Denmark Hill site. There were no cases reported at PRUH/South Sites. There are now 65 cases YTD which is below the cumulative target of 68 cases.

E-Coli:

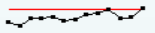
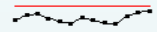
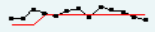
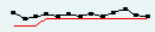
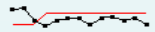
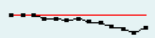
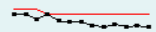
- E-Coli bacteraemia: 9 new cases reported in January, 99 cases YTD which is below the cumulative target of 100 cases. There were 8 cases reported at Denmark Hill and 1 case reported at PRUH/South Sites.

C-Difficile:

- 8 Trust attributed cases of c-Difficile in January, of which 7 were reported on the DH site and 1 case reported at the PRUH site. 92 cases YTD which is above the cumulative target of 85 cases.
- At the PRUH site there were 1 case reported in Adult Medicine (in Medical Ward 1).
- At the DH site there were 2 cases in Cardiovascular wards and Acute Medicine, and 1 case in each of Haematology, Liver and Womens Health wards.

Patient Experience Dashboard

Caring

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	13-Month Trend
CQC level of inquiry: Caring														
HRWD														
422	Friends & Family - Inpatients	93.9%	94.4%	95.8%	94.6%	95.8%	94.9%	97.3%	95.5%	94.5%	94.6%	96.3%	94.9%	
423	Friends & Family - ED	73.3%	67.3%	79.5%	75.0%	76.1%	77.1%	78.0%	74.4%	74.6%	72.2%	78.8%	74.8%	
774	Friends & Family - Outpatients	89.6%	90.6%	91.1%	89.0%	89.0%	89.8%	90.2%	88.1%	89.3%	90.3%	90.7%	88.7%	
775	Friends & Family - Maternity	85.0%	80.3%	84.4%	89.2%	88.5%	86.2%	93.9%	91.7%	87.5%	83.3%	89.2%	90.5%	
Complaints														
619	Number of complaints	68	56	44	615	23	18	27	256	93	81	73	902	
Operational Engagement														
620	Number of complaints not responded to within 25 Days	58	51	45	499	33	17	16	212	94	70	66	736	
3119	Number of PALS enquiries – unable to contact department									36	41	28	355	
Incident Management														
660	Duty of Candour - Conversations recorded in notes	69.6%	69.6%	76.9%	84.0%	100.0%	100.0%	86.4%	96.5%	81.4%	75.5%	81.3%	87.4%	
661	Duty of Candour - Letters sent following DoC Incidents	69.6%	69.6%	69.2%	82.0%	100.0%	100.0%	100.0%	99.5%	81.4%	75.5%	83.3%	87.6%	
1617	Duty of Candour - Investigation Findings Shared	0.0%	0.0%	3.9%	17.5%	10.5%	19.1%	4.6%	20.0%	4.7%	8.2%	4.2%	18.3%	

- **FFT - A&E**: Overall Trust score improved by 6.6% to 78.8% in January which is above the 74.8% internal target. The DH score improved by 12.2% to 79.5% and the PRUH score improved by 0.9% to 78.0% in January.
- **FFT – Inpatient**: Trust score improved by 1.7% to 96.3% recommendation rate in January. DH score improved by 1.4% to 95.8% and PRUH improved by 2.4% to 97.3%, with both sites achieving target.
- **FFT – Outpatients**: Trust FFT score for outpatients improved by 0.4% to 90.7% in January. DH scores improved by 0.5% to 91.1% and PRUH scores improved by 0.4% to 90.2%.
- **FFT – Maternity combined**: Overall Trust combined FFT maternity score improved by 5.9% to 89.2%. DH scores improved by 4.1% to 84.4% in January. PRUH scores have improved further by 7.7% to 93.9% in January, above the 91.4% target.

Performance Dashboard

Performance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	13-Month Trend
CQC level of inquiry: Responsive														
Access Management - RTT, CWT and Diagnostics														
364	RTT Incomplete Performance	78.95%	76.50%	73.88%	74.45%	81.31%	78.52%	76.58%	76.54%	79.89%	77.32%	75.00%	75.30%	
632	Patients waiting over 52 weeks (RTT)	464	473	552	11048	281	286	279	7565	745	760	832	18618	
412	Cancer 2 weeks wait GP referral	92.76%	89.30%	90.93%	92.66%	96.96%	93.23%	90.12%	90.46%	94.49%	90.82%	90.59%	91.69%	
413	Cancer 2 weeks wait referral - Breast				75.00%	87.50%	72.34%	68.18%	83.40%	87.50%	72.34%	68.18%	83.27%	
419	Cancer 62 day referral to treatment - GP	50.71%	55.80%	48.74%	61.42%	75.00%	73.08%	80.65%	80.33%	57.29%	60.53%	59.34%	67.82%	
536	Diagnostic Waiting Times Performance > 6 Wks	8.18%	9.92%	7.42%	10.11%		1.35%	2.74%	24.51%	7.37%	8.86%	6.83%	12.18%	
Access Management - Emergency Flow														
459	A&E 4 hour performance (monthly SITREP)	61.26%	59.84%	64.39%	64.14%	71.62%	71.11%	72.54%	75.42%	65.87%	64.88%	68.01%	69.33%	
Patient Flow														
399	Weekend Discharges	20.6%	20.2%	23.8%	22.1%	18.0%	16.5%	22.0%	18.8%	19.8%	19.0%	23.2%	21.0%	
404	Discharges before 1pm	17.2%	15.7%	18.0%	16.6%	18.6%	17.2%	17.4%	17.8%	17.6%	16.2%	17.9%	17.1%	
747	Bed Occupancy	90.8%	86.4%	87.2%	86.4%	96.4%	92.4%	89.6%	91.2%	92.8%	88.6%	88.1%	88.1%	
1357	Number of Stranded Patients (LOS 7+ Days)	384	373	345	3420	205	211	193	1988	589	584	538	5410	
1358	Number of Super Stranded Patients (LOS 21+ Days)	194	182	187	1607	61	69	64	623	255	251	251	2232	
762	Ambulance Delays > 30 Minutes	485			3773	108			739	593			4512	
772	12 Hour DTAs	28	69	48	346	145	118	113	685	173	187	161	1031	
Theatre Productivity														
801	Day Case Rate	76.0%	73.7%	76.8%	77.4%	70.4%	68.6%	73.2%	77.2%	75.4%	73.6%	76.9%	78.7%	

A&E 4 Hour Standard

- A&E performance was non-compliant in January at 68.01% which has improved from 64.88% performance achieved in December.

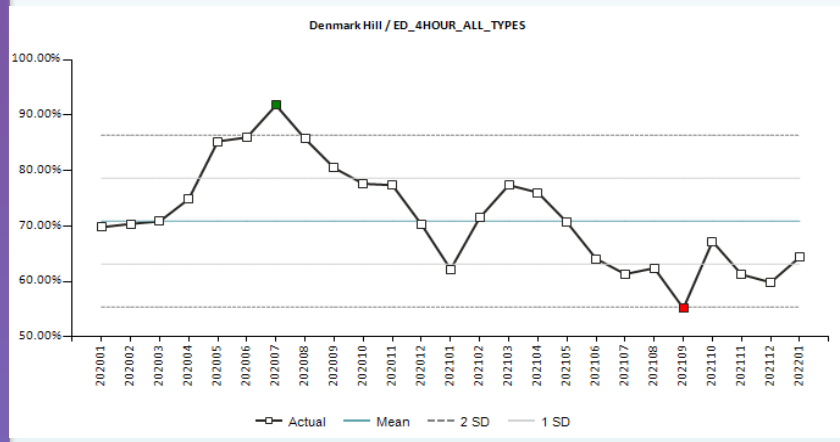
Cancer

- Treatment within 62 days of post-GP referral is not compliant - reducing to 59.34% for January (target 85%) compared to 60.53% in December.
- The two-week wait from GP referral standard reduced to 90.59% in January compared to 90.82% achieved in December. The national target of 93% was last achieved in November at 94.49%.

Emergency Care Standard

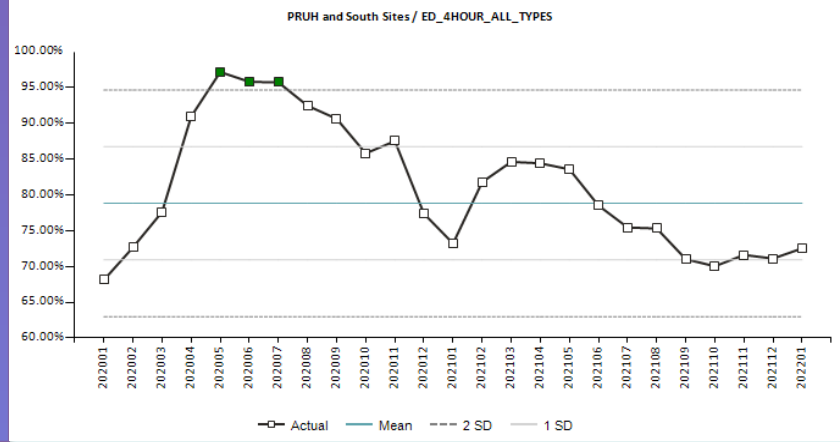
Denmark Hill performance:

- Executive Owner: Julie Lowe, Site Chief Executive
- Management/Clinical Owner: Emer Sutherland, CD



PRUH performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: tbc



Background / target description:

- Ensure at least 95% of attendees to A&E are admitted, transferred or discharged within 4 hours of arrival.

Underlying issues:

- There were 141 ambulance delays >60 minutes and 516 ambulance delays waiting 30-60 minute delays in January (un-validated) compared to 188 delays >60 minutes and 470 delays >30 minutes reported in December.

DH Actions:

- Performance has remained static with Greenbrook Urgent Treatment Centre (UTC) has remained static for the last 2 weeks in January.
- The phased start of paediatric urgent care to Greenbrook UTC went live in January.
- ED medical and nursing staffing sickness has stabilised but there is still a sizeable level of nursing staffing vacancies. This is being address in the ED Project plan which was submitted to Kings Executive for review and approval on 21st February.

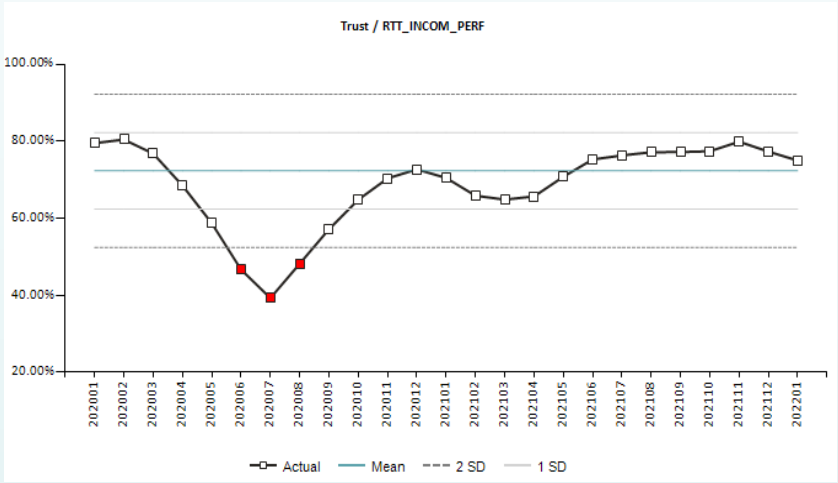
PRUH Actions:

- **ED Capacity**: High ambulance conveyances continue to be a challenge, with batching of conveyances. An ambulance cohort area was mobilised in January, supported by LAS for use at times of peak conveyances and ED occupancy, however LAS continue to struggle to staff the area.
- **Frailty**: The Acute Frailty Assessment Unit opened w/c 22 November providing 14 dedicated spaces for patients identified as suitable for a frailty pathway, with the aim of avoiding the need for admission. This service continues to expand as recruitment progresses, with a full mobilisation by the end of March.
- **Mental Health**: The Oxleas Mental health Assessment Unit opened in December with four dedicated assessment rooms for patients presenting in mental health crisis.

RTT

RTT Incomplete performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: Palmer Winstanley, DOO



Background / target description:

- Ensure 92% of patients are treated within 18 weeks of referral.

Underlying issues:

- Suspension of non-urgent elective activity enacted from the middle of December until 17 January 2022.

Current RTT Incomplete position:

- RTT performance of 75.00% for January compared to 77.32% performance achieved in December. Total PTL increased by 2,227 to 72,255 pathways and the backlog increased by 2,186 to 18,065 pathways.

DH Actions

- Elective services resumed from 17 January as planned.
- Pre-op assessment slot expansion is on-hold pending office moves due to take place for the Dental team. The Estates team have indicated that they expect to be ready for the last week in February.

PRUH Actions

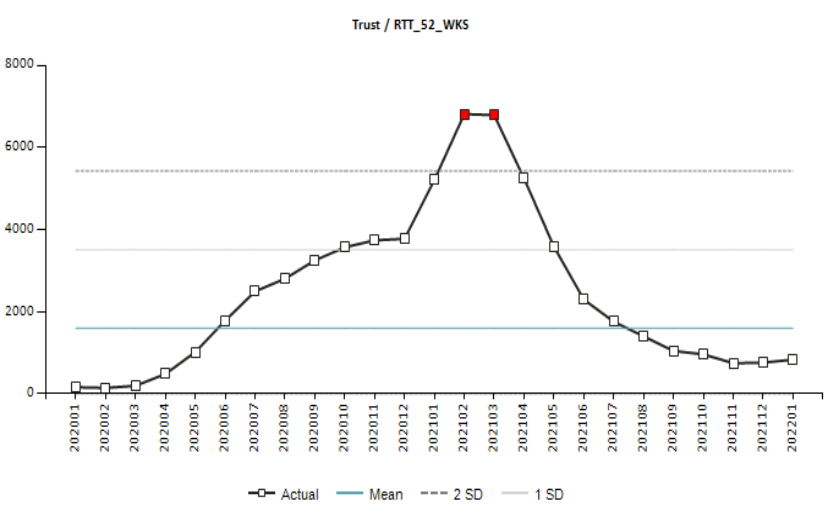
- Elective services resumed from 17 January as planned.
- Theatre staffing is an on-going challenge in terms of recruitment and
- retention. Mitigating actions taken include:
    - Revised budget 22% uplift to be applied to then support a skills mix to
    - support career progression.
    - Regular adverts to be reviewed in line with developments at PRUH.
    - sites to renew interest.
    - Development of rotational posts across theatre suites.
    - Development of training opportunities and team based developments.

RTT – 52 Weeks

RTT Incomplete performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: Palmer Winstanley, DOO

RTT 52+ Week waiters:



Background / target description:

- Zero patients waiting over 52 weeks.

Underlying issues:

- From the week commencing 13 December most routine activity was cancelled across all sites. The only activity undertaken was screening, P1/P2 urgent and cancer work and other chronic conditions whereby cancelling would cause an increase Emergency attendances. Normal services resumed from 17 January 2022.

52 Week position:

- Increase of 72 breaches from 760 in December to 832 in January due to enforced activity cessation.
- The majority of the breaches are in T&O (153 patients), General Surgery (132 patients), Neurosurgery (98 patients), Bariatric Surgery (66 patients) and Ophthalmology (51 patients).
- The number of 52 week breaches at Denmark Hill has increased by 79 cases from 473 in December to 552 in January.
- The number of 52 week breaches at PRUH/South Sites reduced by 7 cases from 286 in December to 279 in January.

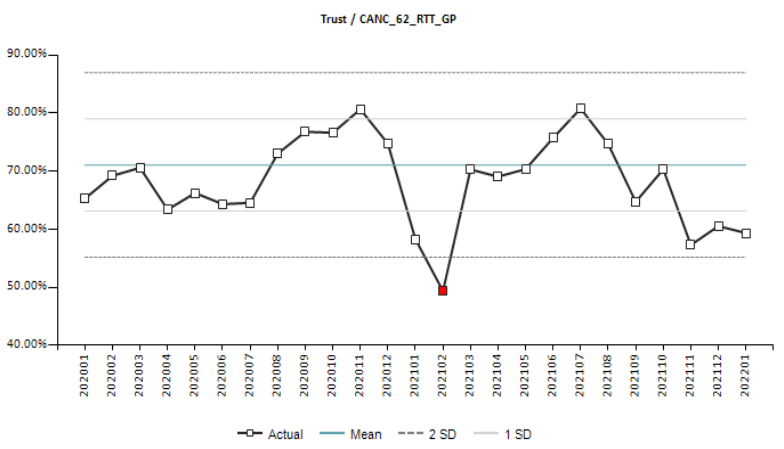
Actions

- All elective services resumed as planned from 17 January.
- **104 Weeks (DH):** There are 30 admitted patients waiting in the year-end 104+ weeks risk cohort with only 2 admitted patients un-booked (in Bariatric Surgery and Neurosurgery). There is 1 patient waiting for an outpatient yet to be booked.
- **Theatres (PRUH):** DSU connection building work schedule may result in up to 3 weeks of reduced activity in March 2022 – and the PRUH team are working with the project team to minimise impacts.
- **104 Week waits (PRUH) –** There are 7 admitted patients waiting in the year-end 104+ weeks risk cohort with only 1 admitted patient un-booked in Ophthalmology. There are 3 patients waiting for an outpatient yet to be booked in ENT and Urology.

Cancer 62 day standard

62 days GP referral to first treatment performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: tbc



CANCER SITE	TARGET	CASES	BREACHES	NO BREACH	PERF
Breast	85%	16.0	1.0	15.0	93.8%
Colorectal	85%	10.0	4.0	6.0	60.0%
Gynaecology	85%	1.5	0.5	1.0	66.7%
Haematology	85%	3.0	1.0	2.0	66.7%
Lung	85%	1.5	0.5	1.0	66.7%
Skin	85%	3.0	0.0	3.0	100.0%
Upper GI - HPB	85%	1.0	1.0	0.0	0.0%
Urology	85%	15.5	8.5	7.0	45.2%

Background / target description:

- That 85% of patients receive their first definitive treatment for cancer within 62 days of an urgent GP (GDP or GMP) referral for suspected cancer.
- That 90% of patients receive their first definitive treatment for cancer within 62 days of referral from an NHS cancer screening service.

Underlying issues:

- **Specialist PET-CT scans** – GSTT to support with pharmaceutical demand for D-PETs (for NET cancers) and PSMA PET-CT (prostate cancers) from Q1 2022/23.
- **Oncology** - long term expansion of oncology services from business case approval in 2022/23. Additional uro-oncologist to commence cross site in March 2022. PRUH colorectal clinical fellow to start in March 2022. Additional DH breast oncologists to start in Q1.
- **Accelerated pathways** – implementation of accelerated pathways for prostate, gynaecology and lung cancers (workshops held, funding agreed with prostate – recruitment commenced in February 2022).

DH Actions

- **HpB** – review outpatient timetables to ensure post MDM clinics are within 1 working day of MDMs (long term plan, new service management team to start in Feb 2022). Additional HCC clinic needed pending business case funding/approval.
- Additional theatre capacity to be considered for DH breast and urology (kidney) – may require regional support.

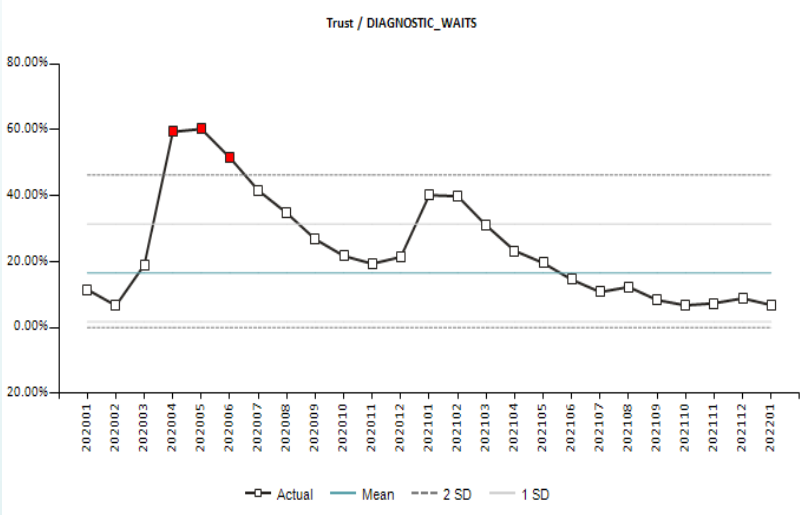
PRUH Actions

- **Head & Neck** – Develop 1-stop clinic for PRUH patients – service to write business case in Q1 2022/23.
- **Rapid Diagnostic Centre** – Implementation of rapid diagnostic centre underway on PRUH site (from Q1 2022/23) to reduce waiting times to diagnosis for complex pathways.
- **PRUH pathology** - pathology reviewing and redesigning laboratory processes to improve turnaround time for 2WW pathology reporting – complete for gynaecology, go live for Head & Neck in March, now GI being reviewed.

Diagnostic Waiting Times

DM01 performance:

- Executive Owner: Jonathan Lofthouse/Julie Lowe, Site Chief Executive
- Management/Clinical Owner: tbc



Background / target description:

- The percentage of patients not seen within six weeks for 15 tests reported in the DM01 diagnostic waiting times return.

Underlying issues:

- The number of diagnostic DM01 breaches reduced from 1,009 in December to 773 in January which equates to 6.83% patients waiting <6 weeks.
- This position has improved with the resumption of our elective programme from the middle of January following the third COVID-19 wave where routine test were temporarily suspended from the middle of December.
- Performance at Denmark Hill improved from 9.92% in December to 7.42% in January. Performance at the PRUH/South Sites improved from 3.99% for December to 1.35% for January.

DH Actions

- All diagnostic services resumed as planned from 17 January.
- Performance for January is broadly on trend with November/December due to downtime with capacity.
- Additional capacity is coming online with further insourcing and outsourcing capacity, funded from the Elective Recovery Fund monies.

PRUH Actions

- All diagnostic services resumed as planned from 17 January.
- Recovery plans are underway to return to compliance across all modalities, with a March 2022 target date.
- Sleep studies had the highest number of patients waiting >6 weeks at 30 patients, due to unexpected short notice staff shortages – the DH team are currently supporting where possible.

Workforce Dashboard

Workforce

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	13-Month Trend
CQC level of inquiry: Well Led														
Staff Training & CPD														
715	% appraisals up to date - Combined									96.29%	87.25%	87.25%		
721	Statutory & Mandatory Training									88.82%	89.91%	90.19%		
Staffing Capacity														
875	Voluntary Turnover %	12.7%	12.5%	13.4%		13.1%	12.8%	13.4%		12.7%	12.5%	13.3%		
732	Vacancy Rate %	11.23%	11.91%	13.54%		13.85%	15.29%	15.90%		13.30%	14.19%	15.17%		
Efficiency														
743	Monthly Sickness Rate	4.81%	7.44%	7.05%		4.44%	6.57%	7.05%		4.74%	7.01%	6.89%		

Appraisals

- 85.61% people in non-medical roles have had an appraisal since 1st April against a target of 90%. This year, we have amended the appraisal process to incorporate a Reflect and Reconnect conversation as part of our wider post-COVID staff recovery programme.
- Medical compliance has increased from M9 to 93.57% which includes Deanary doctors.

Sickness

- In January, the monthly non-COVID sickness rate decreased to 3.69% compared to the previous month (4.01%). This trend towards reduction has been seen since October 2021. There has been a slight increase in COVID-related sickness in January to 3.20% from 3.00%.

Training

- Statutory and Mandatory Training compliance achieved its 90% target for the first time at 90.18% in January, an increase of 0.28% from December.

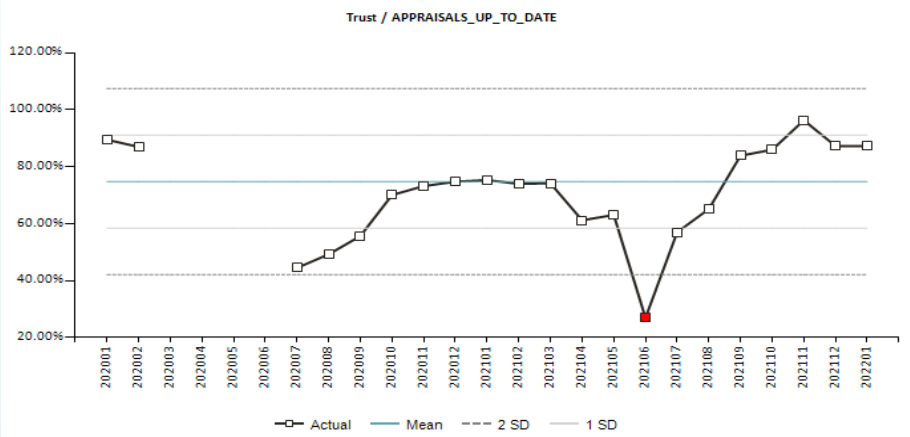
Staff Vacancy and Turnover

- The Trust vacancy rate has risen from 14.19% to 15.17% due to the unexpected large increase in the Trust establishment in both December and January. The Trust voluntary turnover rate was 13.34% in January which is an increase from 12.47% in December, set against a target of 13%.

Appraisal Rate

Appraisal Rate:

- Executive Owner: Mark Preston
- Management/Clinical Owner: tbc



Performance Delivery:

Non-Medical:

- 85.61% people in non-medical roles have had an appraisal since 1st April against a target of 90%.
- This year, we have amended the appraisal process to incorporate a Reflect and Reconnect conversation as part of our wider post-COVID staff recovery programme.
- The revised 2022 process for Appraisals will be communicated over the next couple of months.

Medical:

- Compliance has increased from December to 93.57which includes Deanary doctors.

Background / target description:

- The percentage of staff that have been appraised within the last 12 months (medical & non-medical combined)

Actions to Sustain:

Non-Medical:

- The Reflect and Reconnect sessions are being well communicated within the Trust. Senior Management across the Trust are being contacted to ensure they have completed the appraisals for their teams and request this be cascaded down. Appraisal information is being circulated frequently to different forums across the Trust.

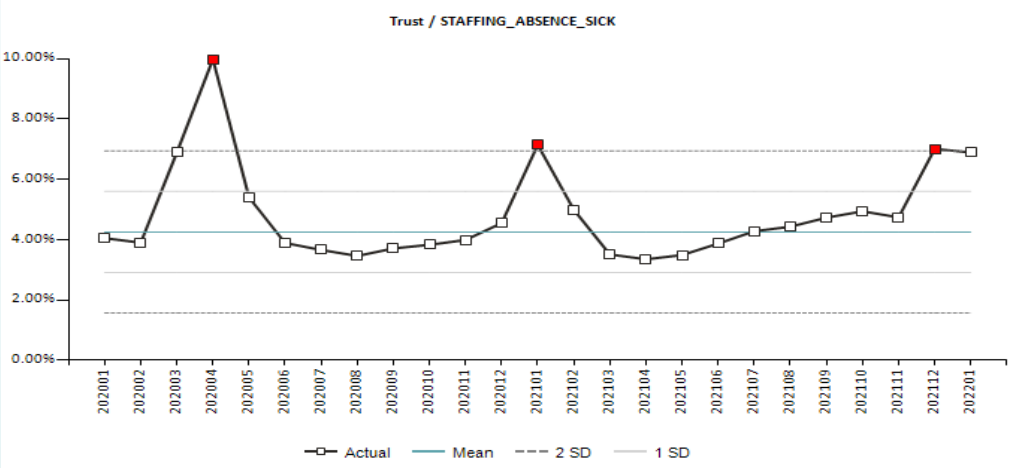
Medical:

- Monthly appraisal (weekly job planning) compliance report (by Care Group) is sent to CD's , Site MDs, HRBP's, and General managers. CD's and Site MD's also have access to SARD to view and monitor appraisal (and job planning) compliance in real time.
- Appraisal reminders are sent automatically from SARD to individuals at 3, 2, and 1 month prior to the appraisal due date (including to those overdue with their appraisal, i.e.12-15 month non-compliant).
- Review 12-15 month non compliant list and escalate to CD's and Site MD's.
- Regular review of submitted appraisals on SARD pending sign-off - chase appraiser and appraisee to complete relevant sections of the appraisal.
- CD's to provide support to colleagues in their Care Group who have difficulty identifying an appraiser.
- Monthly meeting with Chief Medical Officer, Responsible Officer, Trust Lead for Appraisal and Revalidation and Site Medical Directors to monitor/address appraisal compliance.
- Appraisal (and Job Planning) compliance now linked to LCEA award eligibility (consultants only).

Sickness Rate

Sickness Rate:

- Executive Owner: Mark Preston
- Management/Clinical Owner: tbc



Performance Delivery:

- In January 2022, the monthly non-COVID sickness rate decreased to 3.69% compared to the previous month (4.01%). This trend towards reduction has been seen since October 2021.
- There has been a slight increase in COVID-related sickness in January to 3.20% from 3.00%.
- The proportion of sickness absence due to psychiatric illness increased in January to 8% from 6%.
- Looking at the 12 months rolling figures (4.65%), long term sickness absence accounted for a loss of 2.34% of available working time, whilst short-term absence accounts for 2.31%. The rolling (12 months) sickness rate is slightly higher at DH 4.68% than at PRUH 4.65%.
- The Employee Relations team will continue to work with Occupational Health and the Health and Well-being team to support managers and staff.

Background / target description:

- The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.

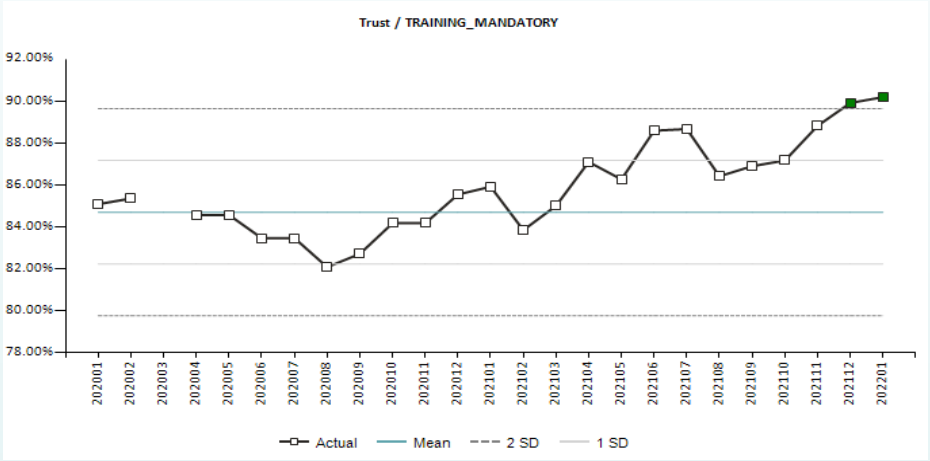
Actions to Sustain:

- Comments have been received and work continues on the latest version of the sickness policy.
- 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.
- The Health & Wellbeing business case has been signed off and the plan is being mobilised. This will provide an increase in Psychological and pastoral support available to staff .
- The ER Team is increasing awareness of the EAP service / OH offering and continue to support managers to manage sickness are currently reviewing all long term sickness absence to ensure the appropriate support is in place for individuals.

Statutory and Mandatory Training

Statutory and Mandatory Training

- Executive Owner: Mark Preston
- Management/Clinical Owner: tbc



Performance Delivery:

- January 2022 saw the Trust hit its target for the first time with 90.18% compliance. This remains reassuringly static throughout the month. This is an increase on the previous month of 0.28%.
- Eight out of thirteen topics are exceeding the 90% target and nine topics are currently below 79%. (This includes each Safeguarding course separately).
- SGC3 saw an increase in January 2022 with a 1.1% improvement. In relation to sites, R&D have seen the biggest improvement on the previous month by 0.6%.
- We continue to improve staff engagement, communication and access to training.
- There has been a particular focus on departments and topics with the low compliance. The Core Skills team is working with the subject matter experts and senior managers in care groups and directorates to improve performance in the worst performing topics.

Background / target description:

- The percentage of staff compliant with Statutory & Mandatory training.

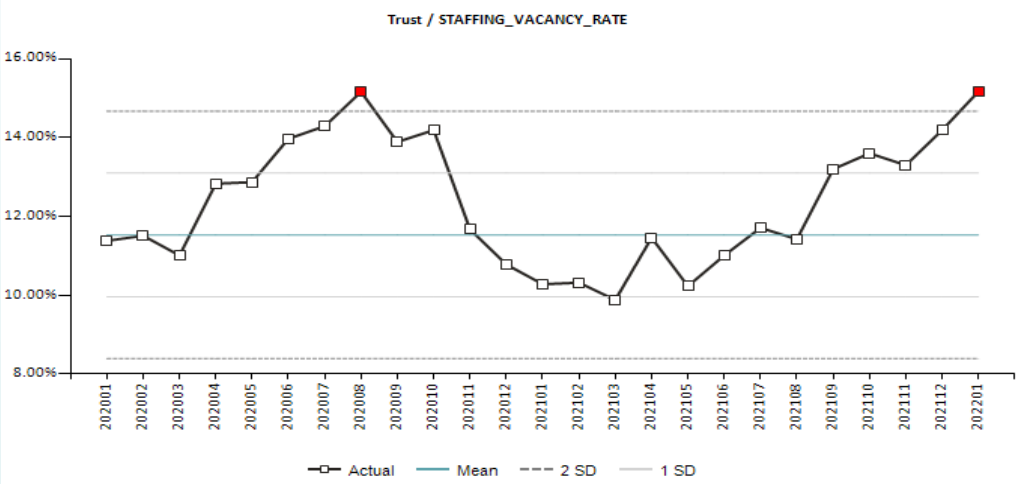
Actions to Sustain:

- We are continuing on work to improve LEAP, our learning management system. Improvement projects include:
  - improving the user experience;
  - enhanced reporting capabilities;
  - enhancing self service options that allow people to self-certify against topics they have completed elsewhere providing they can provide valid proof. These projects will make the platform easier and quicker to use;
  - A new Head of Core Skills is reviewing current processes to identify opportunities to improve performance and efficiencies;
- Care groups to focus on lowest compliance, HRPB's are targeting areas with low compliance, fortnightly meetings with the HRBP's/L&OD to monitor.

Vacancy Rate

Vacancy Rate:

- Executive Owner: Mark Preston
- Management/Clinical Owner: tbc



Performance Delivery:

- The Trust vacancy rate has risen from 14.19% to 15.17%. This is due to the unexpected large increase in the Trust establishment in both December 2021 and January 2022. Despite a net increase of starters compared with leavers in December, this is not been sufficient to prevent the vacancy increase.
- An increase in voluntary turnover, particularly at the PRUH and South Sites has also contributed to an increase in vacancies.
- Additional contributing factors in the vacancy increase include. The planned TUPE transfer for the Viapath staff being delayed, and the funding of the Mass Vaccination Centre. It was originally part of the Operating Plan that this service would stop at the end of December 2021.
- The Nursing & Midwifery vacancy rate has increased from 12.55% to 14.03% and remains an area of intense recruitment effort. Vacancy rate for AHPs has reduced between 15.47% in December to 14.75% in January.

Background / target description:

- The percentage of vacant posts compared to planned full establishment recorded on ESR.

Note: When the actual FTE is higher than the establishment FTE the vacancy % is displayed as zero.

Actions to Sustain:

Strategy and future action:

- Continuing to work with Airline Industry, Retail and the Hospitality Industries to encourage interest in NHS roles in our Trust.
- Working with local DWP, Lambeth College and Lambeth Local authority to offer work experience placements to their disability network (Project Search). 8 placements have been made for Denmark Hill and a similar campaign is being set up for the PRUH and South Sites.

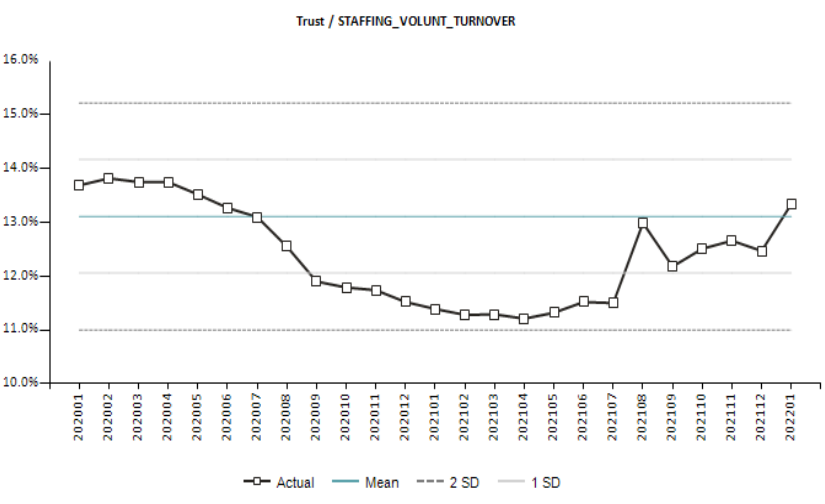
Priority areas of recruitment:

- 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 TMP at the PRUH and is helping to reduce vacancies.
- AHP – continual adverts with talent pooling at band 5 & 6 level, promotion of more specialised posts on Social media, conversion of bank/agency staff.
- International Recruitment and deployment (of IEN's) between August 27th 2021 and March 2022.

Turnover Rate

Turnover Rate:

- Executive Owner: Mark Preston
- Management/Clinical Owner: tbc



Background / target description:

- The percentage of vacant posts compared to planned full establishment recorded on ESR

Note: When the actual FTE is higher than the establishment FTE the vacancy % is displayed as zero.

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.

Performance Delivery:

- The Trust voluntary turnover rate was 13.34% in January 2022, which is an increase from 12.47% in December 2021, set against a target of 13%. This is the first time it has exceeded the target in the last twelve consecutive months.
- Turnover is above target at both DH (13.39%) and the PRUH (13.45%). Our gross turnover rate is 19.73% for January 2021 (this is includes both voluntary and non-voluntary turnover).
- In January 2022, there were 178 voluntary leavers - an increase of 67 compared to December 2021. The top three reasons for leaving were promotion, work life balance and relocation. There were 39 voluntary leavers with less than one years service, an increase of 18, with the top reasons being promotion and work life balance.

Finance Dashboard

Finance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	Nov 21	Dec 21	Jan 22	F-YTD Actual	13-Month Trend
Overall (000s)														
895	Actual - Overall	15,875	10,593	19,841	118,799	6,371	3,748	9,253	56,459	6,807	7,923	9,030	44,245	
896	Budget - Overall	8,807	8,587	10,203	78,289	4,841	5,288	5,227	50,891	(68)	(79)	(89)	(7,352)	
897	Variance - Overall	(7,068)	(2,006)	(9,638)	(40,510)	(1,530)	1,539	(4,026)	(5,568)	(6,876)	(8,002)	(9,120)	(51,597)	
Medical - Agency														
602	Variance - Medical - Agency	(145)	(51)	(321)	(1,614)	(519)	(502)	(374)	(4,853)	(672)	(577)	(718)	(6,591)	
Medical Bank														
1095	Variance - Medical Bank	(742)	(732)	(1,526)	(9,475)	(273)	(193)	(412)	(3,538)	(1,018)	(929)	(1,948)	(13,087)	
Medical Substantive														
599	Variance - Medical Substantive	640	520	485	8,728	485	503	538	4,505	1,185	1,027	965	13,162	
Nursing Agency														
603	Variance - Nursing Agency	(285)	(313)	(328)	(3,454)	(110)	(136)	(125)	(1,269)	(424)	(492)	(495)	(4,969)	
Nursing Bank														
1104	Variance - Nursing Bank	(1,538)	(1,852)	(2,625)	(16,806)	(609)	(699)	(943)	(6,827)	(2,322)	(2,895)	(4,115)	(25,663)	
Nursing Substantive														
606	Variance - Nursing Substantive	1,945	2,076	1,111	19,166	997	861	563	8,234	3,137	3,147	1,863	29,582	

- **Operating income**: £6.0m favourable to plan in month (£21.9m favourable in H2) predominantly driven by:
  - ❑ £2.5m increase in donated assets income, £2.9m received in relation to Coldharbour Works (contribution towards costs of capital works to building) less deferral of £0.4m.
  - ❑ £1.1m CCG surplus income recognised in month (this mitigation was previously identified; a total of £3.3m CCG surplus dispersed to Trusts, recognised equally across Q4). £0.7m additional ERF in relation to H1
- Employee operation expenses (Pay): is £5.1m adverse variance to plan in month (£5.8m adverse in H2)predominantly driven by:
  - ❑ £2.3m cost of the £150 'Thank You' bonus awarded to all staff in January pay (DH £1.5m, PRUH £0.6m, Corporate £0.2m)
  - ❑ £2.7m increase in Bank Pay cost in month.
- **Operating expenses (Non pay)**: £0.9m adverse variance to plan in month (£1.4m favourable in H2)largely due to:
  - ❑ £1.7m backdated depreciation of KFM assets, previously in progress and capitalised in M10
  - ❑ -£0.8m benefit in month on KFM profit share

Domain 4: Finance

M10 (January) – Financial Performance

Surplus / (Deficit)

(£6.0m)	Actual M10
(£0.0m)	Average M1-9 21/22

Pay

(£75.9m)	Actual M10
(£69.9m)	Average M1-9 21/22

Non Pay

(£57.9m)	Actual M10
(£55.5m)	Average M1-9 21/22

COVID Costs

£17.5m	Actuals Total YTD
£6.2m	Pay YTD
£11.3m	Non Pay YTD

Payment Compliance

Debtor Days

10.6	Actual M10
9	Prior Month

Creditor Days

77.6	Actual M10
73.6	Prior Month

Capital

(£88.0m)	Annual Plan 21/22
(£42.1m)	Actual YTD 21/22

Key Metrics - IPR Summary

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

Trust (100)

January 2022

Performance

		Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Responsive																		
Access Management - RTT, CWT and Diagnostics																		
364	RTT Incomplete Performance	70.47%	65.87%	64.84%	65.68%	70.79%	75.27%	76.32%	77.16%	77.21%	77.41%	79.89%	77.32%	75.00%	92.00%	75.30%	73.75%	
632	Patients waiting over 52 weeks (RTT)	5212	6813	6788	5242	3582	2295	1757	1400	1043	962	745	760	832	0	18618	32219	
4537	Patients waiting over 104 weeks (RTT)	3	7	10	17	15	25	46	44	43	43	57	49	53	0	392	409	
4557	RTT P2 Admitted Pathways				1687	1906	2220	2136	2147	2147	2221	2291	2214	2108		21077	21077	
4558	RTT P2 Admitted Pathways waiting >4 weeks				55.2%	51.5%	50.5%	57.7%	58.1%	55.1%	57.3%	52.2%	64.1%	63.0%		56.5%	56.5%	
412	Cancer 2 weeks wait GP referral	89.39%	90.97%	96.49%	89.71%	93.21%	94.38%	92.46%	87.99%	91.07%	91.44%	94.49%	90.82%	90.59%	93.00%	91.69%	91.69%	
413	Cancer 2 weeks wait referral - Breast	75.00%	75.00%	94.03%	74.00%	94.23%	100.00%	82.89%	88.24%	90.48%	75.71%	87.50%	72.34%	68.18%	93.00%	83.27%	83.27%	
419	Cancer 62 day referral to treatment - GP	58.28%	49.37%	70.29%	69.05%	70.35%	75.72%	80.79%	74.65%	64.73%	70.32%	57.29%	60.53%	59.34%	85.00%	67.82%	67.82%	
536	Diagnostic Waiting Times Performance > 6 Wks	40.16%	39.83%	30.98%	23.28%	19.60%	14.53%	10.76%	12.31%	8.33%	6.73%	7.37%	8.86%	6.83%	1.00%	12.18%	16.35%	
Access Management - Emergency Flow																		
459	A&E 4 hour performance (monthly SITREP)	67.38%	76.44%	80.85%	80.00%	76.72%	70.78%	67.90%	68.50%	62.57%	68.49%	65.87%	64.88%	68.01%	95.00%	69.33%	69.33%	
Patient Flow																		
399	Weekend Discharges	24.6%	20.0%	19.0%	18.7%	24.6%	19.2%	20.8%	21.4%	19.2%	24.3%	19.8%	19.0%	23.2%	20.9%	21.0%	20.8%	
404	Discharges before 1pm	15.3%	15.9%	16.3%	16.9%	17.8%	17.8%	17.8%	16.0%	17.7%	15.1%	17.6%	16.2%	17.9%	16.7%	17.1%	16.9%	
747	Bed Occupancy	80.5%	79.8%	79.2%	82.8%	86.1%	87.1%	87.8%	86.9%	90.7%	90.6%	92.8%	88.6%	88.1%	78.2%	88.1%	86.7%	
1357	Number of Stranded Patients (LOS 7+ Days)	539	502	540	495	490	590	513	526	550	535	589	584	538		5410	6452	
1358	Number of Super Stranded Patients (LOS 21+ Days)	202	190	204	207	207	221	202	197	229	212	255	251	251		2232	2626	
800	Delayed Transfer of Care Days (per calendar day)														0.0			
762	Ambulance Delays > 30 Minutes	650	346	321	405	444	550	640	617	646	617	593			0	4512	5179	
772	12 Hour DTAs	245	74	70	36	29	63	95	38	122	127	173	187	161	0	1031	1031	
Theatre Productivity																		
801	Day Case Rate	84.8%	83.6%	83.7%	81.8%	80.8%	80.8%	80.2%	79.4%	80.8%	76.5%	75.4%	73.6%	76.9%	80.0%	78.7%	79.4%	

Quality

		Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Safe																		
Reportable to DoH																		
2717	Number of DoH Reportable Infections	72	87	55	46	53	82	65	89	74	83	63	62	66	63	683	825	
Safer Care																		
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.15	0.05	0.16	0.14	0.24	0.09	0.15	0.15	0.04	0.17	0.15	0.17	0.13	0.19	0.14	0.14	
1897	Potentially Preventable Hospital Associated VTE	7	3	2	3	3	1	2	0	4	4	2	2	1	0	22	27	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	0	0	0	3	0	0	1	1	0	1	0	0	0	0			

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

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)

945	Open Incidents			17			36			36			52			124	141	
Incident Reporting																		
520	Total Serious Incidents reported	4	21	18	17	15	9	12	14	7	21	17	8	12		132	171	
516	Moderate Harm Incidents	22	31	34	37	31	20	29	33	30	36	38	41	33		328	393	
509	Never Events	0	1	2	0	1	0	0	0	1	0	0	0	1	0	3	6	
CQC level of inquiry: Caring																		
HRWD																		
422	Friends & Family - Inpatients	93.8%	93.0%	94.3%	94.5%	94.6%	93.9%	94.3%	95.1%	95.3%	96.1%	94.5%	94.6%	96.3%	96.0%	94.9%	94.8%	
423	Friends & Family - ED	84.9%	85.7%	84.8%	81.2%	79.3%	73.0%	71.3%	72.8%	66.3%	72.9%	74.6%	72.2%	78.8%	86.0%	74.8%	76.7%	
774	Friends & Family - Outpatients	88.2%	89.7%	89.8%	88.8%	87.9%	87.4%	88.8%	88.2%	87.5%	87.2%	89.3%	90.3%	90.7%	92.0%	88.7%	88.8%	
775	Friends & Family - Maternity	92.1%	0.0%	97.7%	95.0%	93.2%	91.9%	90.1%	87.2%	96.3%	83.1%	87.5%	83.3%	89.2%	94.0%	90.5%	90.7%	
Complaints																		
619	Number of complaints	75	77	100	90	83	96	101	81	106	98	93	81	73	85	902	1079	
Operational Engagement																		
620	Number of complaints not responded to within 25 Days	80	58	65	74	67	75	67	77	66	80	94	70	66	60	736	859	
3119	Number of PALS enquiries – unable to contact department	56	60	36	25	36	40	39	27	41	42	36	41	28	49	355	451	
Incident Management																		
660	Duty of Candour - Conversations recorded in notes	91.9%	100.0%	100.0%	95.2%	95.1%	96.0%	90.0%	88.4%	88.9%	88.6%	81.4%	75.5%	81.3%	97.8%	87.4%	89.5%	
661	Duty of Candour - Letters sent following DoC Incidents	100.0%	100.0%	100.0%	95.2%	95.1%	92.0%	95.0%	90.7%	88.9%	84.1%	81.4%	75.5%	83.3%	99.7%	87.6%	89.7%	
1617	Duty of Candour - Investigation Findings Shared	59.5%	62.2%	41.0%	59.5%	31.7%	24.0%	25.0%	11.6%	2.8%	15.9%	4.7%	8.2%	4.2%	60.1%	18.3%	24.0%	
CQC level of inquiry: Effective																		
Improving Outcomes																		
831	Standardised Readmission Ratio	87.9	88.5	89.5	89.1	89.0	89.1	89.1	88.8	89.1	89.5				105.0			
436	HSMR	93.5	94.9	93.5	92.1	93.9	94.6	96.6	97.3	98.2	99.1	98.7			100.0			
433	SHMI	101.8	102.1	99.7	98.8	100.1	101.6	103.6	104.7	104.9	106.1				105.0			
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	86.8%	85.4%	69.2%	73.8%	83.7%	56.8%	73.0%	80.4%	57.8%	91.2%	71.4%	73.5%	94.1%	77.2%	74.5%	74.5%	
625	Diagnostic Results Acknowledgement	13.5%	13.3%	14.3%	13.0%	14.9%	13.5%	13.7%	13.6%	13.5%	12.2%	11.0%	11.0%	9.9%	13.4%	12.7%	12.8%	

Workforce

		Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Month Target	F-YTD Actual	Rolling 12mth	Trend
CQC level of inquiry: Well Led																		
Staff Training & CPD																		
715	% appraisals up to date - Combined	75.29%	73.98%	74.17%	61.19%	63.06%	26.93%	57.00%	65.14%	83.86%	85.96%	96.29%	87.25%	87.25%	90.00%			
721	Statutory & Mandatory Training	85.92%	83.85%	85.01%	87.10%	86.27%	88.59%	88.67%	86.42%	86.90%	87.17%	88.82%	89.91%	90.19%	90.00%			
Staffing Capacity																		
875	Voluntary Turnover %	11.4%	11.3%	11.3%	11.2%	11.3%	11.5%	11.5%	13.0%	12.2%	12.5%	12.7%	12.5%	13.3%	14.0%			
732	Vacancy Rate %	10.28%	10.32%	9.88%	11.46%	10.23%	11.01%	11.71%	11.42%	13.20%	13.60%	13.30%	14.19%	15.17%	10.00%			
Efficiency																		
743	Monthly Sickness Rate	7.14%	4.99%	3.51%	3.35%	3.49%	3.87%	4.28%	4.43%	4.73%	4.94%	4.74%	7.01%	6.89%	3.50%			

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Key Metrics - IPR Summary

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Trust (100)

Finance

		Jan 21	Feb 21	Mar 21	Apr 21	May 21	Jun 21	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Month Target	F-YTD Actual	Rolling 12mth	Trend
Overall (000s)																		
895	Actual - Overall	(5,965)	9,310	109,461	(5,195)	(598)	(1,853)	1,888	24,132	1,268	842	6,807	7,923	9,030	(89)	44,245	163,016	
896	Budget - Overall	28,683	22,115	23,811	(1,189)	(1,189)	(1,189)	(619)	(1,623)	(902)	(405)	(68)	(79)	(89)		(7,352)	38,573	
897	Variance - Overall	34,648	12,805	(85,650)	4,007	(591)	664	(2,507)	(25,756)	(2,170)	(1,247)	(6,876)	(8,002)	(9,120)	0	(51,597)	(124,442)	
Medical - Agency																		
602	Variance - Medical - Agency	(459)	(268)	(339)	(315)	(779)	(597)	(779)	(742)	(696)	(716)	(672)	(577)	(718)	0	(6,591)	(7,198)	
Medical Bank																		
1095	Variance - Medical Bank	(1,171)	(3,569)	(1,604)	(1,480)	(1,561)	(1,132)	(1,635)	(976)	(913)	(1,495)	(1,018)	(929)	(1,948)	0	(13,087)	(18,260)	
Medical Substantive																		
599	Variance - Medical Substantive	2,095	(24)	(2,479)	1,248	1,349	1,459	2,090	1,322	1,907	610	1,185	1,027	965	0	13,162	10,659	
Nursing Agency																		
603	Variance - Nursing Agency	(430)	(449)	(553)	(492)	(542)	(828)	(402)	(420)	(452)	(421)	(424)	(492)	(495)	0	(4,969)	(5,971)	
Nursing Bank																		
1104	Variance - Nursing Bank	(3,274)	(3,260)	(4,849)	(2,483)	(2,086)	(1,953)	(2,183)	(2,669)	(2,346)	(2,611)	(2,322)	(2,895)	(4,115)	0	(25,663)	(33,772)	
Nursing Substantive																		
606	Variance - Nursing Substantive	2,722	3,083	2,387	3,040	2,944	2,623	3,327	2,867	3,127	3,507	3,137	3,147	1,863	0	29,582	35,052	

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Created date: October 2019

Month 10 – January 2022
Finance Report

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Contents

Executive Summary

- The Trust has recorded a deficit of £(8.4)m in month 10, £2.3m adverse to the H2 plan (pre mitigations).

- Year to date the Trust is reporting a £(6.1)m deficit (£(6.2)m in H2), £18.2m favourable to plan. The Trust has realised £20.4m of the mitigations the Trust had identified for closing £36m H2 planning gap. The Trust is on target to breakeven.

- The month end Trust Cash balance at 31 January 2022 was £103.1m. The increased cash balance from December 2021 is due to the receipt of Annual Leave funding, donated capital income and additional capital PDC funding.

- Cash balances decreased on average by c£5.1m per month from Jul-20 to Dec-21. The reduction in cash balances is expected to increase over the remainder of the year as the Trust will be utilising available cash reserves to fund £31.5m of capital expenditure in 21-22 rather than obtaining cash-backed emergency capital funding from NHSI. The year to date reduction in cash balances have resulted from the Trust's effort to reduce creditor payment days and payment of non-recurrent loan items to subsidiaries and associates.

- The special payment arrangements in place for the Covid-19 response, have helped keep the cash balance above average year to date, but the Trust cash forecast for the remainder of the financial year reflects a monthly reduction in cash balance and a requirement to borrow funds in early 2022/23 if the current trend continues.

Summary of Year to Date Financial Position & Details

Summary of Year to Date Financial Position

The Trust has recorded a deficit of £(8.4)m in month 10, £2.3m adverse to the H2 plan (pre mitigations).**
Year to date the Trust is reporting a £(8.2)m deficit (£(8.4)m in H2), £16.0m favourable to plan. The Trust has realised £20.4m of the mitigations the Trust had identified for closing £36m H2 planning gap. The Trust is on target to breakeven.

	Last 3 Months			Current Month		Year to Date		Run Rate*	H2 Plan** - HTD		
	M7	M8	M9	Last Year	Actual	Last Year	Actual	CM vs YTD	Plan	Actuals	Variance
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	132.9	128.1	129.9	121.7	131.0	1,196.1	1,288.4	2.4	500.0	521.9	21.9
Employee Operating Expenses	(71.7)	(70.1)	(71.3)	(66.5)	(75.9)	(656.8)	(705.1)	(6.0)	(283.2)	(289.0)	(5.8)
Operating Expenses Excluding Employee Expenses	(55.5)	(57.9)	(55.2)	(41.4)	(57.9)	(521.3)	(557.7)	(2.4)	(228.0)	(226.6)	1.4
Non Operating Expenses	(3.1)	(3.0)	(3.2)	(3.3)	(3.2)	(33.1)	(31.7)	(0.0)	(13.2)	(12.5)	0.7
Trust Total	**2.6**	**(3.0)**	**0.2**	**10.5**	**(6.0)**	**(15.1)**	**(6.1)**	**(6.0)**	**(24.4)**	**(6.2)**	**18.2**
Less Impairment, donated income	0.1	(0.0)	0.1	2.1	(2.4)	20.8	(2.1)	2.4		(2.2)	(2.2)
Operating Total (including ERF)	**2.7**	**(3.0)**	**0.3**	**12.6**	**(8.4)**	**5.7**	**(8.2)**	**(3.6)**	**(24.4)**	**(8.4)**	**16.0**
Less Elective Recovery Fund	(0.0)	(3.4)			(0.7)		(19.3)	(1.4)		(4.1)	(4.1)
Operating Total (excluding ERF)	**2.7**	**(6.4)**	**0.3**	**12.6**	**(9.1)**	**5.7**	**(27.5)**	**(5.0)**	**(24.4)**	**(12.5)**	**11.9**

*run rate change – takes the average of M01-9 actuals and compares against the current month actuals (M10).

**See appendices for summary of H2 Plan in month and HTD

Key Messages:

Operating Income - £6.0m favourable to plan in month (£21.9m favourable in H2)

Overall Income is £6.0m favourable in month compared to the M10 NHSI plan predominantly driven by:

- £2.5m increase in donated assets income, £2.9m received in relation to Coldharbour Works (contribution towards costs of capital works to building) less deferral of £0.4m.
- £1.1m CCG surplus income recognised in month (this mitigation was previously identified; a total of £3.3m CCG surplus dispersed to Trusts, recognised equally across Q4)
- £0.7m additional ERF in relation to H1
- £0.6m increase in salary recharges relating to retrospective invoicing and new SLA's started in M10 on the DH site (£0.2m Acute Medicine, £0.2m Neuro, £0.2m Haematology and Liver).
- £0.2m received in month in relation to funding of Education and Training expenses

The Trust have realised £12m of mitigations in H2 in relation to drugs and devices over performance. This plus the £4.1m ERF and £1.1m CCG surplus is driving the £21.9m H2 favourable variance.

Employee Expenses (Pay) - £5.1m adverse variance to plan in month (£5.8m adverse in H2)

Pay is £5.1m adverse to the H2 plan, predominantly driven by:

- £2.3m cost of the £150 'Thank You' bonus awarded to all staff in January pay (DH £1.5m, PRUH £0.6m, Corporate £0.2m)
- £2.7m increase in Bank Pay cost in month, due to a combination of factors including: pay rate uplift for clinical staff (£0.8m), bank holiday pay relating to December paid in January (£0.3m), winter funding initiatives at PRUH (£0.2m) increased vacancies and sickness (£0.3m), and retrospective shifts (£0.5m).

Operating Expenses (Non Pay) - £0.9m adverse variance to plan in month (£1.4m favourable in H2)

Non pay is £0.9m adverse to plan in M10 largely due to:

- £1.7m backdated depreciation of KFM assets, previously in progress and capitalised in M10
- £(0.8)m benefit in month on KFM profit share

In month 10 the Trust realised a further £1.8m (£1.1m CCG surplus plus £0.7m ERF) of identified mitigations (£20.4m year to date).

Review of the mitigations identified during planning to close the £36.5m gap has indicated that the Trust has between £35-40m.

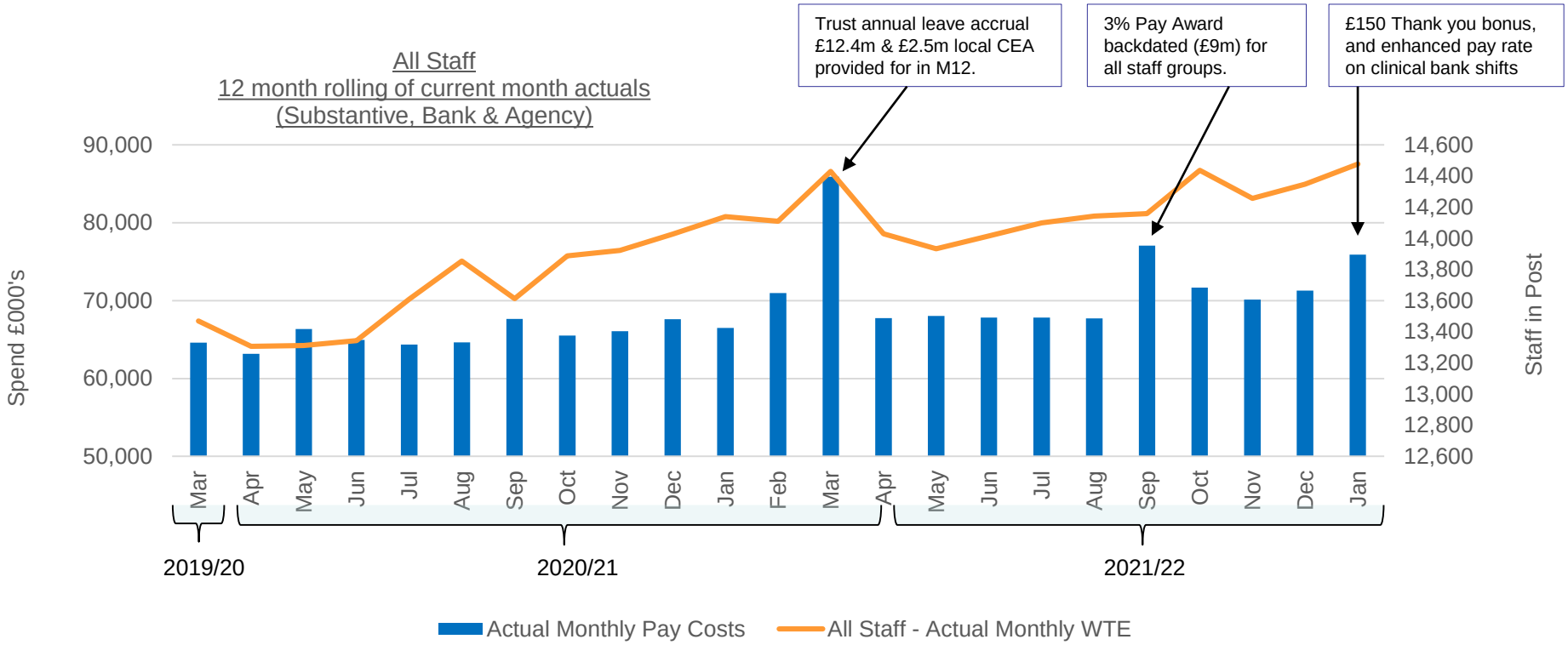
This provides sufficient headroom to achieve the breakeven plan.

Bridging the gap	£m
Realised	
Drugs and Devices over performance M4-M6	12.0
Higher income for pay award than £9.0m accrued in H1	0.5
ERF H1 received in M8 (£3.4m) and M10 (£0.7m)	4.1
CCG surplus disseminated to Trusts (1/3 recognised in M10)	1.1
PFI - Revenue to Capital	1.5
Pathology accrual release M9	1.2
Total mitigations realised M7-M10	**20.4**
Potential items likely to be realised	
Drugs and Devices over performance H2	3.0
H1 ERF held by ICS	0.6
CCG surplus disseminated to Trusts (2/3 still to be recognised)	2.2
M9 balance sheet	10-15
Potential mitigations M11-M12	**16-21**
Total (realised + potential) mitigations H2	**35-40**

Year on Year – Pay Review

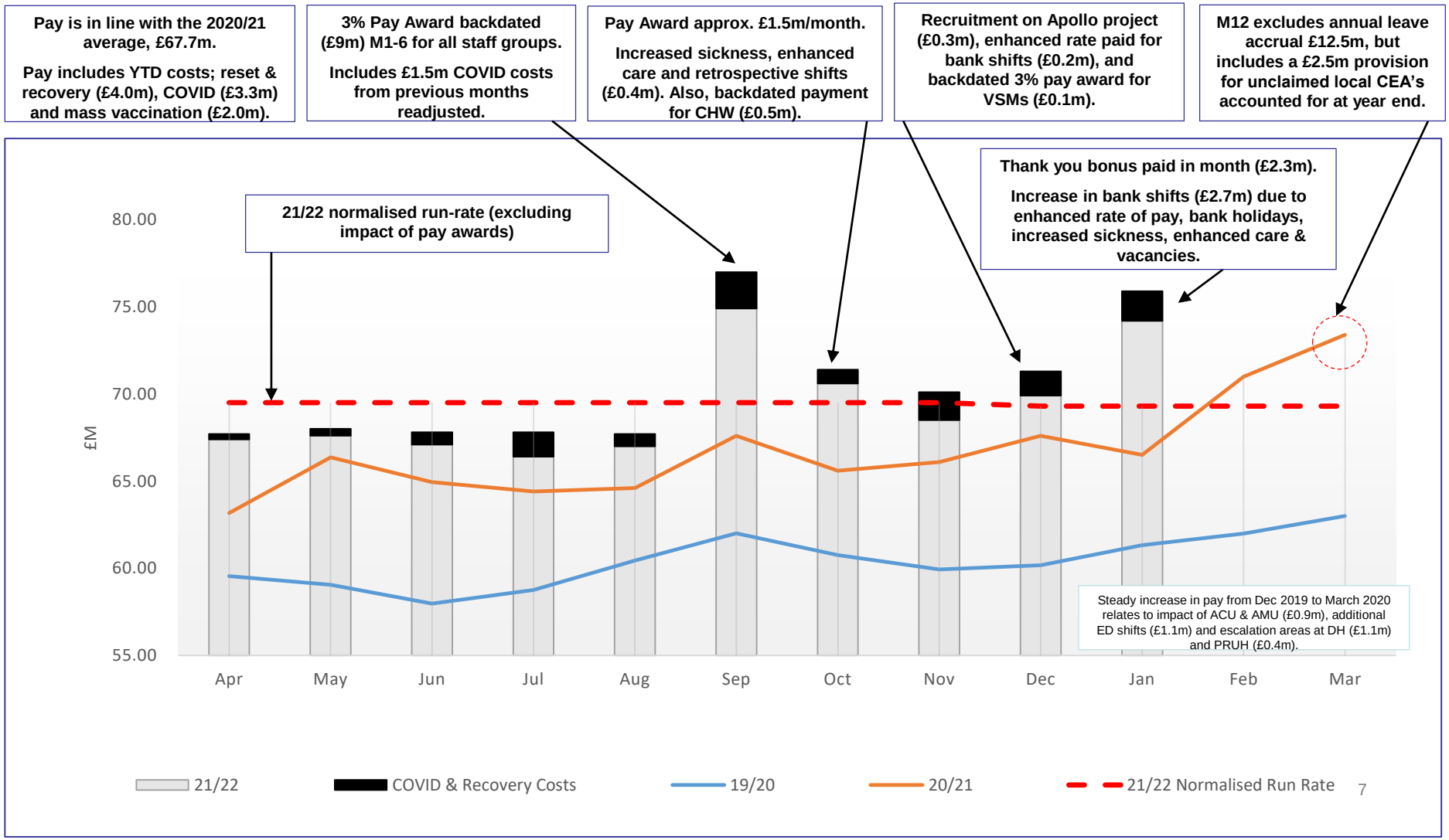
The Trust's underlying pay run-rate is consistent over M01-10 of this year. Overall, substantive recruitment has increased and this is being offset by reducing temporary staffing spend.

- The increase in M06 is due to the 3% pay award being implemented as per the Governments announcement for all NHS staff. Medical clinical excellence awards this year have been frozen and replaced with this pay award.



Year to Date - Pay run rate

The Trust exited 2020/21 with a pay bill of £813m (excluding £12.5m annual leave provision) resulting in an average of £67.7m. The current year average is £69m (pre-pay award) but is expected to increase in line with plans for reset & recovery and winter.



Detail (1/3) – Operating Income

Actuals	Last 3 Months			Current Month		Year to Date		Run Rate Change	
	M7	M8	M9	Last Year	Actual	Last Year	Actual	M10 to Ave	M10 to M09
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
NHS England	51.1	43.0	48.2	41.1	45.1	494.5	449.7	0.1	(3.1)
Clinical Commissioning Groups	58.1	60.3	55.8	61.4	56.1	466.7	577.0	(1.7)	0.4
Pass Through Drugs Income	16.4	13.3	13.5	11.4	15.0	103.9	141.6	0.9	1.5
NHS Foundation Trusts		0.0	0.0	0.0	(0.2)	(0.0)	(0.2)	(0.2)	(0.2)
NHS Trusts	0.1	0.2	(0.0)	0.0	0.1	0.7	1.0	0.0	0.1
Local Authorities	0.4	0.2	0.3	0.2	0.8	2.9	3.1	0.5	0.5
NHS Other (Including Public Health England)	0.4	0.2	0.1	0.5	(0.1)	2.7	2.6	(0.4)	(0.3)
Non NHS: Private Patients	0.4	0.4	0.7	0.7	0.3	5.2	3.6	(0.1)	(0.4)
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	0.3	0.2	0.4	0.2	0.3	4.2	3.2	(0.0)	(0.1)
Injury Cost Recovery Scheme	0.3	0.2	0.3	0.2	0.3	2.9	3.0	0.0	0.0
Non NHS: Other				0.0		0.0			
Operating Income From Patient Care Activities	127.5	118.0	119.3	115.9	117.6	1,083.9	1,184.6	(0.9)	(1.7)
Research and Development	0.7	1.4	2.4	1.2	2.2	15.5	15.4	0.8	(0.1)
Education and Training	5.7	3.4	3.4	3.6	3.2	36.3	36.2	(0.4)	(0.2)
Cash Donations / Grants For The Purchase Of Capital Assets	0.0	0.1	0.0	0.0	2.5	0.0	3.2	2.4	2.5
Charitable and Other Contributions To Expenditure	0.0	(0.0)		0.0	0.0	0.1	(0.0)	0.0	0.0
Non-Patient Care Services To Other Non Wga Bodies	0.9	0.9	1.0	0.3	1.0	2.7	10.2	(0.0)	0.0
PSF, FRF, MRET funding and Top-Up	4.6	1.5	2.1		1.2	35.1	13.4	(0.1)	(0.9)
Income In Respect Of Employee Benefits Accounted On A Gross Basis	0.6	0.2	0.5	0.8	1.1	7.1	6.6	0.5	0.6
Rental Revenue From Operating Leases	0.1	0.2	0.1	0.1	0.1	0.8	1.0	(0.0)	(0.0)
Other (Operating Income)	(7.2)	2.4	1.1	(0.1)	1.9	14.7	18.0	0.1	0.8
Other Operating Income	5.4	10.1	10.6	5.9	13.3	112.2	103.9	3.3	2.7
Finance Income					0.0		(0.1)	0.0	0.0
Finance Income					0.0		(0.1)	0.0	0.0
Operating Income	132.9	128.1	129.9	121.7	131.0	1,196.1	1,288.4	2.4	1.0

1

Operating Income from Patient Care – a deterioration of £1.7m against last month

In month 10, we received £2.2m of additional income as follows:

- £1.1m CCG surplus income recognised in month (1/3 of £3.3m CCG surplus)
- £0.7m additional ERF in relation to H1
- £0.4m increase in Local Authority activity

In month 9, we received an additional £4.3m of income relating to high cost drugs over performance in month 6. This was previously identified as a potential income item within the Trust's mitigations.

Overall income is £21.9m ahead of NHSI plan largely due to over performance against high cost drugs and devices and ERF. As the NHS England guidance here is unclear, we can expect further over performance to continue and help bridge the £36m Trust gap.

2

Other Income – an improvement of £2.7m against last month

This month, the improvement is predominantly driven by income received against the category Cash Donations / Grants For The Purchase Of Capital Assets. This is due to £2.9m received in month as a contribution towards the costs of capital works on Coldharbour Works building, following an amendment to the lease contract (extension to term from 15 to 25 years). Less £0.4m of deferred income.

3

In month 9, £0.7m of income previously coded to 'Other (Operating Income)' was reclassified to 'PSF, FRF, MRET funding and Top-Up', as it relates to COVID income. M10 shows normalised monthly values.

Detail (2/3) – Employee Expenses (Pay)

Actuals	Last 3 Months			Current Month		Year to Date		Run Rate Change		
	M7	M8	M9	Last Year	Actual	Last Year	Actual	M10 to Ave	M10 to M9	
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	
Substantive Staff	(21.2)	(20.9)	(21.0)	(18.5)	(21.2)	(189.0)	(205.6)	(0.7)	(0.2)	
Bank Staff	(1.5)	(1.0)	(1.0)	(1.2)	(2.0)	(14.0)	(13.3)	(0.7)	(1.0)	1
Agency / Contract	(0.8)	(0.7)	(0.6)	(0.6)	(0.8)	(6.3)	(7.3)	(0.1)	(0.1)	
Medical Staff	(23.5)	(22.7)	(22.6)	(20.3)	(24.0)	(209.3)	(226.3)	(1.5)	(1.3)	
Substantive Staff	(23.8)	(24.6)	(24.7)	(23.1)	(26.1)	(227.3)	(246.5)	(1.6)	(1.4)	
Bank Staff	(3.3)	(3.0)	(3.5)	(3.9)	(4.7)	(30.9)	(31.9)	(1.7)	(1.3)	2
Agency / Contract	(0.5)	(0.5)	(0.6)	(0.5)	(0.6)	(6.9)	(6.1)	0.0	(0.0)	
Nursing Staff	(27.6)	(28.1)	(28.7)	(27.6)	(31.4)	(265.0)	(284.4)	(3.3)	(2.7)	
Substantive Staff	(10.8)	(10.0)	(10.3)	(9.8)	(10.8)	(96.5)	(101.9)	(0.7)	(0.5)	
Bank Staff	(0.5)	(0.5)	(0.4)	(0.2)	(0.8)	(2.9)	(4.6)	(0.3)	(0.3)	
Agency / Contract	(0.6)	(0.3)	(0.4)	(0.4)	(0.0)	(1.8)	(2.7)	0.3	0.3	
Admin & Clerical	(11.9)	(10.8)	(11.1)	(10.3)	(11.6)	(101.2)	(109.2)	(0.7)	(0.5)	
Substantive Staff	(8.0)	(8.2)	(8.3)	(7.9)	(8.5)	(76.0)	(80.6)	(0.5)	(0.2)	
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)	(0.2)	(0.0)	(0.0)	3
Bank Staff	(0.3)	(0.2)	(0.2)	(0.1)	(0.4)	(1.7)	(2.4)	(0.1)	(0.1)	
Agency / Contract	(0.4)	(0.3)	(0.2)	(0.3)	0.0	(3.4)	(1.9)	0.2	0.2	
Other Staff	(8.6)	(8.6)	(8.8)	(8.4)	(8.9)	(81.3)	(85.2)	(0.4)	(0.1)	
CIP Target Pay								0.0	0.0	
Pay Savings Target								0.0	0.0	
Employee Operating Expenses	(71.7)	(70.1)	(71.3)	(66.5)	(75.9)	(656.8)	(705.1)	(6.0)	(4.6)	
Substantive Staff Total	(63.8)	(63.6)	(64.3)	(59.3)	(66.7)	(589.0)	(634.8)	(3.5)	(2.3)	
Bank Staff Total	(5.6)	(4.7)	(5.1)	(5.4)	(7.8)	(49.5)	(52.3)	(2.9)	(2.7)	4
Agency / Contract Total	(2.3)	(1.8)	(1.8)	(1.8)	(1.4)	(18.3)	(18.0)	0.4	0.4	
Employee Operating Expenses	(71.7)	(70.1)	(71.3)	(66.5)	(75.9)	(656.8)	(705.1)	(6.0)	(4.6)	

1

Medical – a deterioration of £1.3m against last month

Thank you bonus for medical staff paid in month 10 totalled £0.4m.

In month increase in bank pay is due to a number of factors including: pay rate uplift for clinical shifts (£0.3m) and retrospective shifts booked (£0.5m). At PRUH, an increased cost of £0.2m was incurred due to winter funding which is expected to continue for the rest of the year.

Generally, pressures continue due to rota gaps, sickness and vacancies (£0.2m).

2

Nursing – a deterioration of £2.7m against last month

Thank you bonus for nursing staff paid in month 10 totalled £1.1m.

In month, we have incurred a cost of £0.5m due to the pay enhancement rates offered for bank shifts for January. In addition, we have incurred £0.3m for bank holiday pay (December), and increased sickness & vacancies (£0.2m).

YTD continues to be driven by vacancies Planned Care, Children's and Critical Care.

3

A&C – a deterioration of £0.5m against last month

Thank you bonus for admin staff paid in month 10 totalled £0.5m.

Other – a deterioration of £0.1m against last month

Thank you bonus for admin staff paid in month 10 totalled £0.2m.

4

Overall, pay is £5m above trend this month, due to the £2.3m thank you bonus paid in January, and the £2.7m increase in bank pay costs.

Pay includes YTD costs; reset & recovery (£4.7m), COVID (£4.0m) and mass vaccination (£2.3m).

Detail (3/3) – Operating Expenses (Non-Pay)

Actuals	Last 3 Months			Current Month		Year to Date		Run Rate Change	
	M7	M8	M9	Last Year	Actual	Last Year	Actual	M10 to Ave	M10 to M9
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	(0.9)	(1.0)	(1.1)	1.8	(1.2)	(9.4)	(9.6)	(0.2)	(0.1)
Purchase Of Healthcare From Non-NHS Bodies	(16.1)	(17.8)	(18.8)	(15.2)	(19.8)	(145.2)	(167.1)	(3.4)	(1.0)
Supplies and Services - Clinical (Excluding Drugs Costs)	(3.1)	(3.3)	(3.2)	(0.8)	(2.9)	(12.5)	(27.0)	(0.2)	0.3
Supplies and Services - General	1.1	(0.2)	(0.3)	(0.1)	(0.5)	(1.1)	(4.8)	(0.0)	(0.2)
Drugs costs – on tariff	(4.5)	(4.6)	(4.2)	(3.5)	(3.7)	(27.6)	(40.1)	0.3	0.5
Pass Through Drugs Cost	(12.5)	(11.1)	(11.9)	(11.2)	(12.1)	(98.3)	(116.7)	(0.5)	(0.2)
Consultancy	(1.0)	0.7	(0.2)	5.9	(0.1)	2.9	(2.3)	0.2	0.1
Establishment	(0.9)	(0.9)	(0.9)	(0.2)	(2.4)	(7.1)	(11.4)	(1.4)	(1.5)
Premises - Business Rates Payable To Local Authorities	(0.4)	(0.4)	(0.4)	(0.5)	(0.4)	(4.6)	(3.9)	(0.0)	(0.0)
Premises - Other	(9.1)	(10.3)	(5.2)	(6.4)	(3.6)	(85.8)	(80.3)	5.0	1.7
Transport	(0.9)	(1.0)	(0.9)	(0.8)	(0.9)	(9.4)	(9.3)	(0.0)	0.0
Depreciation	(2.6)	(2.8)	(2.7)	(2.3)	(4.6)	(23.3)	(28.9)	(1.9)	(2.0)
Fixed Asset Impairments net of Reversals				(2.0)		(20.0)		0.0	0.0
Increase/(Decrease) In Impairment Of Receivables	(0.2)	0.5	(0.3)	(0.3)	(0.1)	(5.0)	(2.2)	0.2	0.2
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)	(0.3)	0.0	0.0
Clinical Negligence	(4.1)	(4.1)	(4.1)	(2.7)	(4.1)	(43.8)	(40.5)	0.0	0.0
Research and Development - Non-Staff	(0.0)	(0.1)	(0.1)	(0.0)	(0.0)	(0.5)	(0.4)	(0.0)	0.0
Education and Training - Non-Staff	(0.5)	(0.5)	(0.4)	(0.5)	(0.8)	(4.1)	(4.4)	(0.4)	(0.4)
Operating Lease Expenditure (net)	(0.2)	(0.1)	(0.1)	(0.0)	(0.1)	(1.9)	(1.4)	0.0	(0.0)
Other	0.2	(0.9)	(0.5)	(2.5)	(0.6)	(24.3)	(7.2)	0.1	(0.1)
Operating Expenses Excluding Employee Expenses	(55.5)	(57.9)	(55.2)	(41.4)	(57.9)	(521.3)	(557.7)	(2.4)	(2.7)
CIP Target Non Pay	(0.0)		0.0			0.0	0.0	(0.0)	(0.0)
Non Pay Savings Target	(0.0)		0.0			0.0	0.0	(0.0)	(0.0)
Operating Expenses Excluding Employee Expenses	(55.5)	(57.9)	(55.2)	(41.4)	(57.9)	(521.3)	(557.7)	(2.4)	(2.7)
Finance Expense	(3.1)	(3.0)	(3.2)	(3.3)	(3.2)	(33.1)	(31.7)	0.0	(0.0)
Gains/(Losses) On Disposal Of Assets	0.0	0.0	0.0	0.0		0.0	0.0	(0.0)	(0.0)
Non Operating Expenses	(3.1)	(3.0)	(3.2)	(3.3)	(3.2)	(33.1)	(31.7)	(0.0)	(0.0)
Non Operating Expenses	(3.1)	(3.0)	(3.2)	(3.3)	(3.2)	(33.1)	(31.7)	(0.0)	(0.0)
Trust Total	**2.6**	**(3.0)**	**0.2**	**10.5**	**(6.0)**	**(15.1)**	**(6.1)**	**(6.0)**	**(6.3)**

1

Operating expenses – a deterioration of £2.7m against last month

1 Movements in month 10 include:

- Increased depreciation charges of £2m, £1.7m of which was due to an increase in capital spend by KFM, and capitalisation of previous assets resulting in backdated depreciation charges.
- Establishment costs incurred of £1.6m for international recruitment, majority of which relates to prior years which was partially provided for at year end (£0.4m).
- Additional cost of £4.8m for the KFM H2 ISFA, however this was offset by an in month KFM profit share of £5.6m (YTD £8.2m), so overall we saw a benefit in month of £0.8m.
- £0.6m benefit for a credit note received in month relating to pathology underperformance at DH site from April-August 2021.
- In month 9, PBU released £1.2m of prior year provisions that related to Viapath, following their financial year end in December.

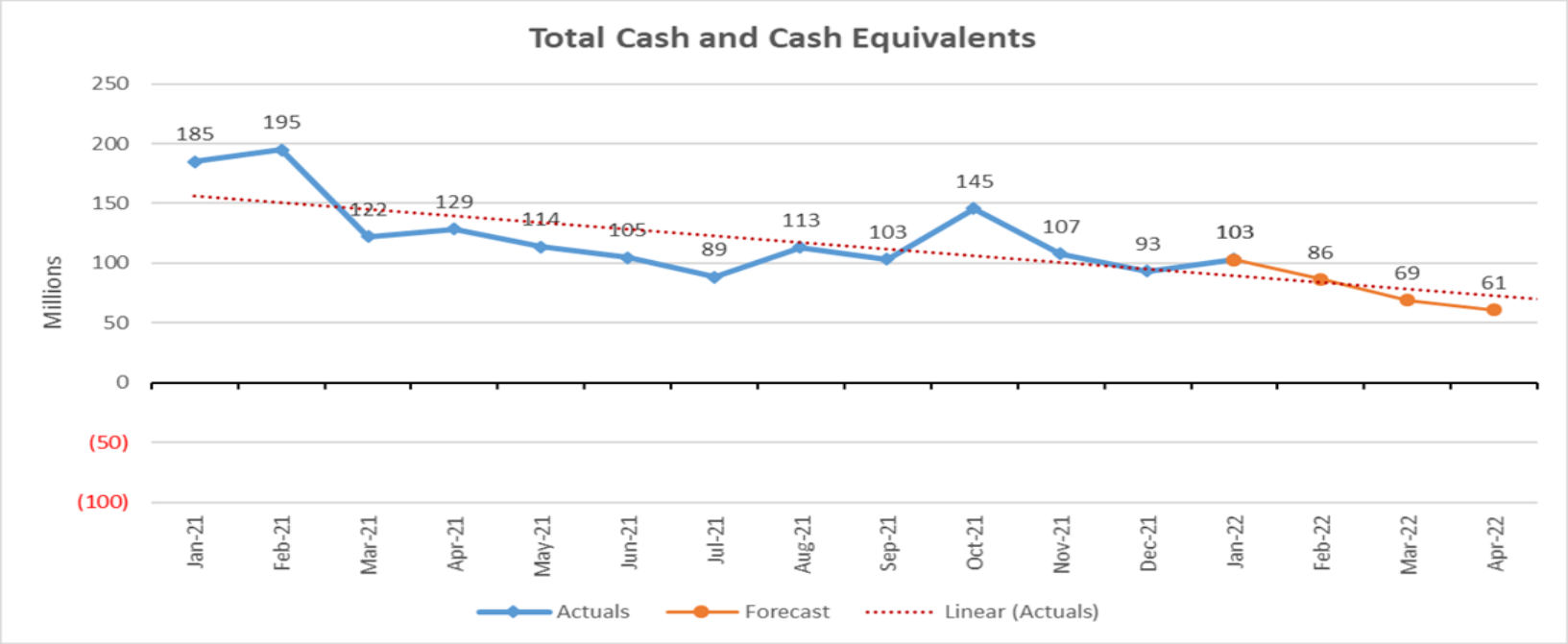
Underlying position

High level analysis of the Trust's underlying position indicates an average H2 underlying deficit of £24m a month (£290m annualised) once you adjust for normalising adjustments and non recurrent items. The £20m deterioration in the underlying deficit from £270m identified in H1 is largely driven by H2 efficiency factor (1.5-2%) which has not been offset by run rate reducing CIP. The current planning envelopes suggests a further 2% efficiency will be required next year.

NHSI Category	M7 £ M	M8 £ M	M9 £ M	M10 £ M
Operating Income	132.9	128.1	129.9	131.0
Employee Operating Expenses	(71.7)	(70.1)	(71.3)	(75.9)
Operating Expenses Excluding Employee Expenses	(55.5)	(57.9)	(55.2)	(57.9)
Non Operating Expenses	(3.1)	(3.0)	(3.2)	(3.2)
Trust Total	**2.6**	**(3.0)**	**0.2**	**(6.0)**
Less Impairment, donated income	0.1		0.1	(2.4)
Operating Total (including ERF)	**2.7**	**(3.0)**	**0.3**	**(8.4)**
Normalising adjustments:				
H1 Pay award income higher than accrual	(0.5)			
H1 drug overperformance	(3.4)		(4.3)	
H1 HCTED Devices overperformance	(3.3)			
PFI - Cap to Rev	(1.5)			
H1 ERF		(3.4)		(0.7)
CCG surplus income				(1.1)
UTC Contract	(0.4)	0.4		
Prior year Pathology provision release			(1.2)	
Non recurrent pay award (£150 thank you bonus)				2.3
H2 Drugs and Devices over performance estimate (not in numbers due to uncertainty over the baseline)	0.5	0.5	0.5	0.5
Deficit post normalising adjustments:	**(5.9)**	**(5.5)**	**(4.7)**	**(7.4)**
Backlog recovery costs	0.8	0.8	0.8	0.8
System top up (excluding PFI support)	(13.9)	(13.9)	(13.9)	(13.9)
System COVID funding	(5.3)	(5.3)	(5.3)	(5.3)
Winter Funding	(0.8)	(0.8)	(0.8)	(0.8)
Winter Costs	0.5	0.5	0.5	0.5
Underlying position	**(24.6)**	**(24.2)**	**(23.4)**	**(26.1)**

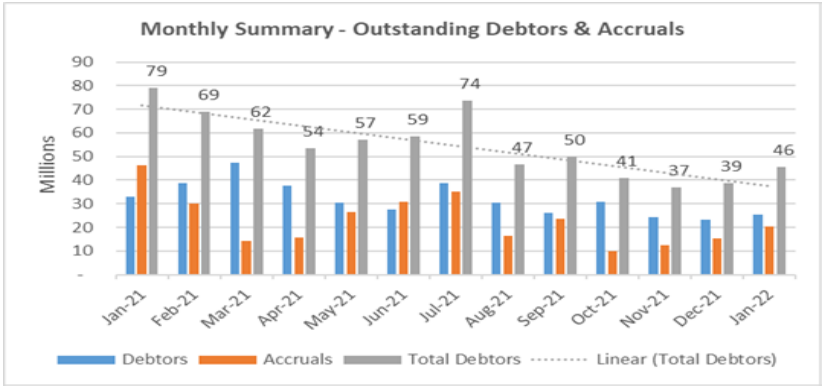
Cash Flow & Revenue Support - Debtors and Creditors

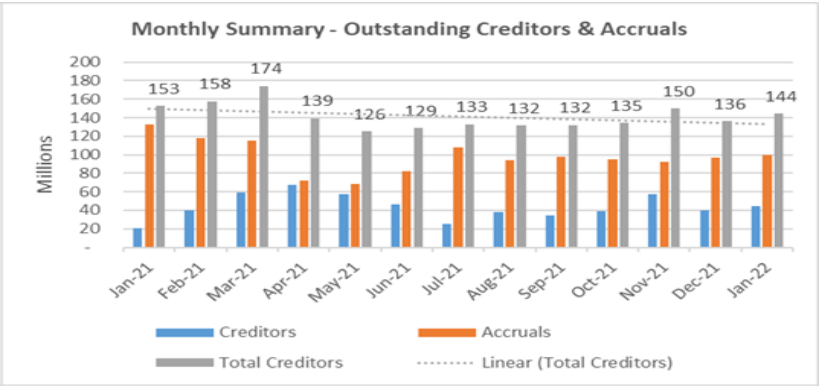
Cash and Cash Equivalents

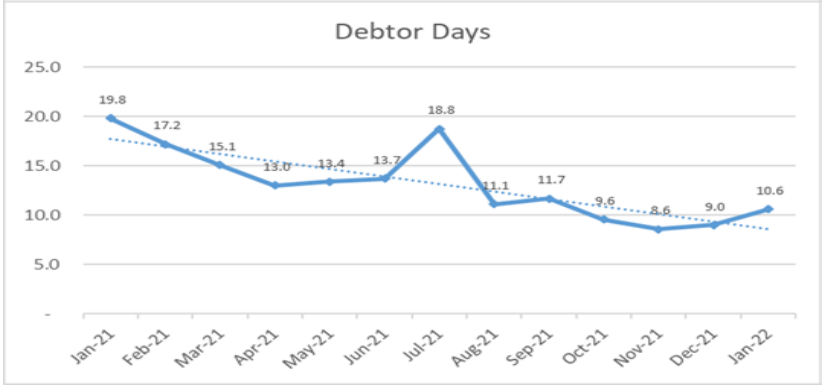


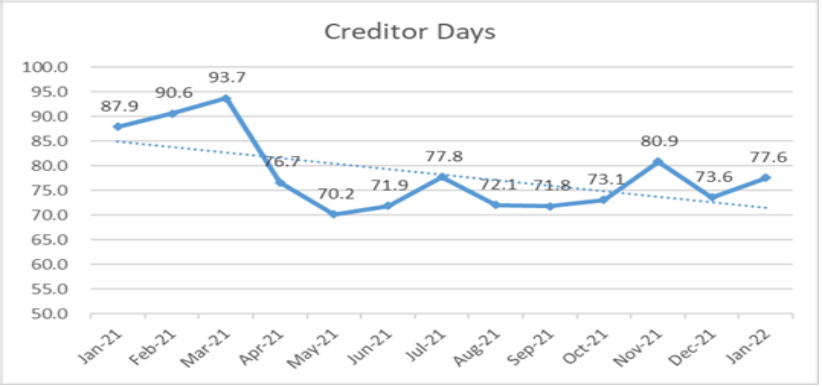
- The month end Trust Cash balance at 31 January 2022 was £103.1m. The increased cash balance from December 2021 is due to the receipt of Annual Leave funding, donated capital income and additional capital PDC funding.
- Cash balances decreased on average by c£5.1m per month from Jul-20 to Dec-21. The reduction in cash balances is expected to increase over the remainder of the year as the Trust will be utilising available cash reserves to fund £31.5m of capital expenditure in 21-22 rather than obtaining cash-backed emergency capital funding from NHSI.
- The year to date reduction in cash balances have resulted from the Trust's effort to reduce creditor payment days and payment of non-recurrent loan items to subsidiaries and associates. Additional funding received for ERF and Covid-19 increased the cash balance as at October 21.
- The special payment arrangements in place for the Covid-19 response, have helped keep the cash balance above average year to date, but the Trust cash forecast for the remainder of the financial year reflects a further monthly reduction in cash balance and a requirement to borrow funds in early 2022/23 if the current trend continues.
- The expectation is that the Trust maintains a minimum cash balance of £3m. Due to timing of receipts and payments, actual balances will fluctuate throughout the month.

Debtors and Creditors Summary









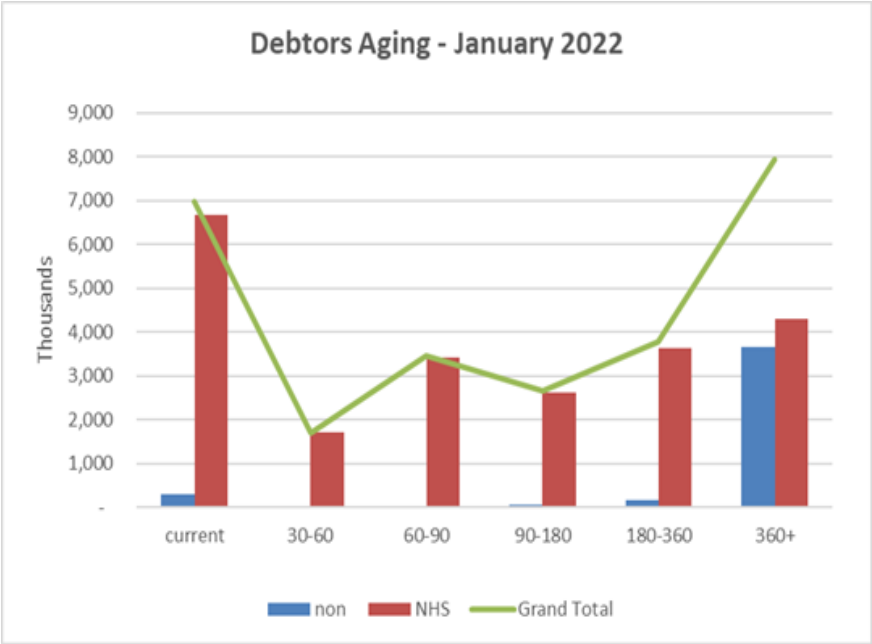
- Debtor Days have increased in month 10 to 10.6 days resulting from increased accruals.
- The Trust receives payments monthly on the 15th of each month from NHSEI and local CCGs.
- In 2020-21, the Trust was receiving these monthly payments 15 days in advance; from April 2021, this reverted to payment within 15 days of invoice date.
- Creditor payment days have increased in month 10 due to an increase in creditor accruals.
- In response to the increased emphasis on the Better Payment Practice Code, the Trust is focusing on further reducing its aged outstanding invoices on the Accounts Payable ledger.
- The reversion to payments from NHSEI and CCGS being received on the 15th of the month is resulting in a reduced a cash in bank balance month on month and creditor payments will need to monitor to take account of this reduction in coming months.

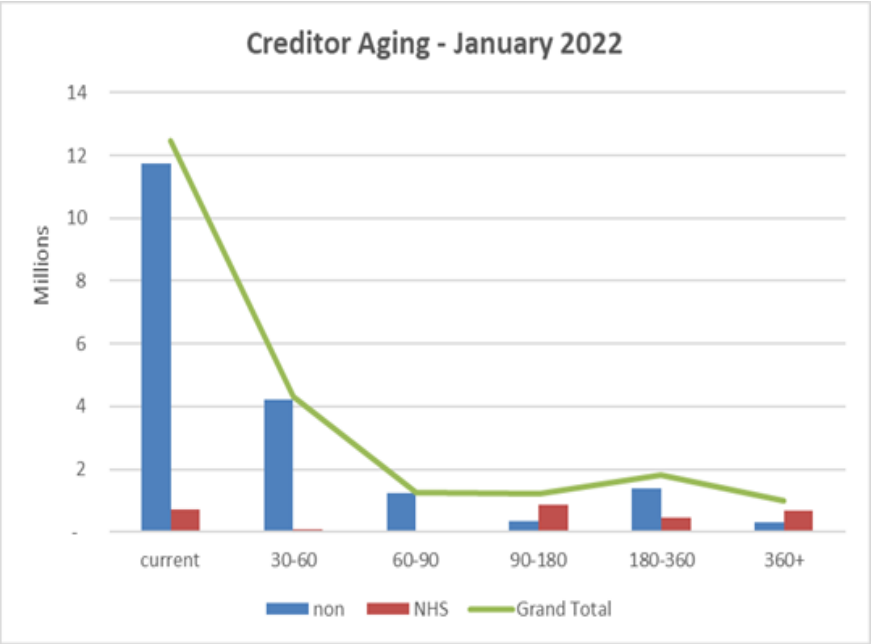
Better Payment Practice Code

Better payment practice code	YTD Number	YTD £'000
Non NHS		
Total bills paid in the year	180,402	876,493
Total bills paid within target	125,027	707,528
Percentage of bills paid within target	**69.3%**	**80.7%**
NHS		
Total bills paid in the year	4,009	60,208
Total bills paid within target	1,091	38,530
Percentage of bills paid within target	**27.2%**	**64.0%**
Total		
Total bills paid in the year	**184,411**	**936,701**
Total bills paid within target	**126,118**	**746,058**
Percentage of bills paid within target	**68.4%**	**79.6%**

- The Better Payment Practice Code target is to pay all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed
- Compliance against this target is for at least 95% of invoices to be paid within the thirty days or within agreed contract terms.
- The Trust is not currently meeting this target and has identified the following areas affecting this performance which are being addressed.
- Time taken to process invoices through the Pharmacy Department (high invoice volume and impact of COVID pressures on the team).
- Delayed payment of Agency invoice due to delayed processing and approval of timesheets
- Continued work to resolve historic balances on supplier accounts. The effects of this work can be seen in reducing creditor balances but this adversely impact the BPPC measure.
- Delays in approval processes for low value NHS invoices.
- However it should be noted that the measure of Creditor Days has reduced significantly indicating continued improvement in this area.

Debtor and Creditor Ageing Update





- Aged creditors show a highly current profile which is the correct direction of travel for moving towards achieving compliance with BPPC. The current creditors include invoices of c£15m due to KFM and paid in the first week of February.
- Balances held which are aged are largely for GSTT and KCL where separate discussions take place regularly to review both AP and AR balances (usually similarly sized). These transactions have a higher number of queries and disputes and can take longer to reach payment agreement.
- The aged debt profile is more even, although additional work in reviewing older balances is underway. A high proportion of older debts relates to positions with KCL and GSTT (as above).

Appendices

Run Rate Details - Trend across Income, Pay and Non-Pay

Appendix 1.1 – Run Rate Detail – Operating Income

12 Months Current Month Run Rate	Feb-21	Mar-21	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
NHS England	41.9	74.3	43.9	42.5	43.4	42.6	45.5	44.4	51.1	43.0	48.2	45.1	565.8
Clinical Commissioning Groups	50.6	53.8	69.3	51.8	57.5	62.2	48.4	57.4	58.1	60.3	55.8	56.1	681.3
Pass Through Drugs Income	13.2	15.4	0.0	24.8	16.7	16.8	13.6	11.6	16.4	13.3	13.5	15.0	170.2
NHS Foundation Trusts	(0.1)	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)	(0.2)
NHS Trusts	0.1	(0.4)	0.1	(0.1)	0.3	0.0	0.2	0.1	0.1	0.2	(0.0)	0.1	0.8
Local Authorities	0.3	0.3	0.3	(0.1)	0.3	0.3	0.3	0.3	0.4	0.2	0.3	0.8	3.7
NHS Other (Including Public Health England)	0.2	0.4	0.1	1.1	0.3	0.5	(0.0)	0.0	0.4	0.2	0.1	(0.1)	3.2
Non NHS: Private Patients	0.5	0.6	0.2	0.2	0.2	0.6	0.3	0.3	0.4	0.4	0.7	0.3	4.7
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To	0.6	0.8	0.4	0.2	0.3	0.3	0.5	0.3	0.3	0.2	0.4	0.3	4.6
Injury Cost Recovery Scheme	0.4	0.3	0.3	0.2	0.4	0.2	0.4	0.3	0.3	0.2	0.3	0.3	3.7
Non NHS: Other	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Operating Income From Patient Care Activities	**107.7**	**145.4**	**114.5**	**120.6**	**119.4**	**123.6**	**109.3**	**114.8**	**127.5**	**118.0**	**119.3**	**117.6**	**1,437.7**
Research and Development	1.8	1.8	1.5	1.2	1.4	1.2	1.5	1.8	0.7	1.4	2.4	2.2	18.9
Education and Training	3.8	4.9	4.3	4.4	4.1	0.0	3.7	3.8	5.7	3.4	3.4	3.2	44.9
Cash Donations / Grants For The Purchase Of Capital Assets	0.3	1.8	0.0	0.4	0.1	0.0	0.1	0.0	0.0	0.1	0.0	2.5	5.3
Charitable and Other Contributions To Expenditure	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	(0.0)	0.0	(0.0)	0.0	0.0	(0.0)
Non-Patient Care Services To Other Non Wga Bodies	0.5	0.7	0.3	1.9	1.1	1.0	1.0	1.0	0.9	0.9	1.0	1.0	11.4
PSF, FRF, MRET funding and Top-Up	4.5	0.7	1.0	1.0	0.9	1.0	(3.8)	3.9	4.6	1.5	2.1	1.2	18.6
Income In Respect Of Employee Benefits Accounted On A Gross	0.7	0.7	0.7	0.7	0.5	0.6	1.0	0.7	0.6	0.2	0.5	1.1	8.0
Rental Revenue From Operating Leases	0.1	0.4	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.1	1.5
Other (Operating Income)	4.2	27.4	1.1	1.6	2.0	2.5	2.2	10.4	(7.2)	2.4	1.1	1.9	49.6
Other Operating Income	**15.9**	**38.3**	**9.0**	**11.3**	**10.1**	**6.6**	**5.9**	**21.7**	**5.4**	**10.1**	**10.6**	**13.3**	**158.0**
Finance Income	0.0	0.1	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Finance Income		**0.1**	**(0.1)**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Operating Income	**123.6**	**183.8**	**123.5**	**131.8**	**129.5**	**130.1**	**115.1**	**136.5**	**132.9**	**128.1**	**129.9**	**131.0**	**1,595.7**

Appendix 1.2 – Run Rate Detail – Employee Expenses

12 Months Current Month Run Rate	Feb-21	Mar-21	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff	(20.4)	(22.8)	(19.9)	(19.9)	(19.9)	(19.6)	(20.0)	(22.0)	(21.2)	(20.9)	(21.0)	(21.2)	(248.8)
Bank Staff	(3.6)	(1.6)	(1.5)	(1.6)	(1.2)	(1.7)	(1.0)	(0.9)	(1.5)	(1.0)	(1.0)	(2.0)	(18.6)
Agency / Contract	(0.4)	(0.5)	(0.4)	(0.9)	(0.7)	(0.9)	(0.8)	(0.8)	(0.8)	(0.7)	(0.6)	(0.8)	(8.2)
Medical Staff	**(24.4)**	**(24.9)**	**(21.8)**	**(22.3)**	**(21.7)**	**(22.1)**	**(21.9)**	**(23.7)**	**(23.5)**	**(22.7)**	**(22.6)**	**(24.0)**	**(275.6)**
Substantive Staff	(23.9)	(23.6)	(23.6)	(23.8)	(24.1)	(23.8)	(23.9)	(28.1)	(23.8)	(24.6)	(24.7)	(26.1)	(293.9)
Bank Staff	(3.9)	(5.5)	(3.1)	(2.7)	(2.6)	(2.8)	(3.3)	(3.0)	(3.3)	(3.0)	(3.5)	(4.7)	(41.3)
Agency / Contract	(0.5)	(0.6)	(0.6)	(0.7)	(0.9)	(0.5)	(0.5)	(0.6)	(0.5)	(0.5)	(0.6)	(0.6)	(7.3)
Nursing Staff	**(28.3)**	**(29.7)**	**(27.3)**	**(27.1)**	**(27.6)**	**(27.1)**	**(27.8)**	**(31.7)**	**(27.6)**	**(28.1)**	**(28.7)**	**(31.4)**	**(342.4)**
Substantive Staff	(9.9)	(21.4)	(10.1)	(9.7)	(9.8)	(9.7)	(9.5)	(11.2)	(10.8)	(10.0)	(10.3)	(10.8)	(133.2)
Bank Staff	(0.3)	(0.8)	(0.1)	(0.5)	(0.4)	(0.5)	(0.5)	(0.4)	(0.5)	(0.5)	(0.4)	(0.8)	(5.7)
Agency / Contract	(0.1)	(0.4)	(0.2)	(0.3)	(0.2)	(0.2)	(0.2)	(0.3)	(0.6)	(0.3)	(0.4)	(0.0)	(3.1)
Admin & Clerical	**(10.3)**	**(22.6)**	**(10.4)**	**(10.5)**	**(10.4)**	**(10.3)**	**(10.3)**	**(12.0)**	**(11.9)**	**(10.8)**	**(11.1)**	**(11.6)**	**(142.0)**
Substantive Staff	(7.8)	(8.2)	(7.9)	(7.6)	(7.7)	(7.6)	(7.5)	(9.2)	(8.0)	(8.2)	(8.3)	(8.5)	(96.7)
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.2)
Bank Staff	(0.2)	(0.2)	(0.2)	(0.2)	(0.2)	(0.4)	(0.2)	(0.2)	(0.3)	(0.2)	(0.2)	(0.4)	(2.8)
Agency / Contract	(0.1)	(0.3)	(0.1)	(0.2)	(0.3)	(0.2)	(0.1)	(0.2)	(0.4)	(0.3)	(0.2)	0.0	(2.2)
Other Staff	**(8.0)**	**(8.7)**	**(8.2)**	**(8.1)**	**(8.2)**	**(8.1)**	**(7.8)**	**(9.7)**	**(8.6)**	**(8.6)**	**(8.8)**	**(8.9)**	**(101.9)**
CIP Target Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Pay Savings Target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Substantive Staff (Pension Charge)	0.0	(29.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(29.1)
Pay Reserves		**(29.1)**											**(29.1)**
Employee Operating Expenses	**(71.0)**	**(115.1)**	**(67.7)**	**(68.0)**	**(67.9)**	**(67.7)**	**(67.7)**	**(77.0)**	**(71.7)**	**(70.1)**	**(71.3)**	**(75.9)**	**(891.1)**
Substantive Staff Total	(62.0)	(105.2)	(61.5)	(61.0)	(61.6)	(60.7)	(61.1)	(70.6)	(63.8)	(63.6)	(64.3)	(66.7)	(801.9)
Bank Staff Total	(8.0)	(8.1)	(4.9)	(5.0)	(4.2)	(5.3)	(5.0)	(4.6)	(5.6)	(4.7)	(5.1)	(7.8)	(68.4)
Agency / Contract Total	(1.1)	(1.8)	(1.3)	(2.0)	(2.1)	(1.7)	(1.6)	(1.8)	(2.3)	(1.8)	(1.8)	(1.4)	(20.8)
Employee Operating Expenses	**(71.0)**	**(115.1)**	**(67.7)**	**(68.0)**	**(67.9)**	**(67.7)**	**(67.7)**	**(77.0)**	**(71.7)**	**(70.1)**	**(71.3)**	**(75.9)**	**(891.1)**

Appendix 1.3 – Run Rate Detail – Operating Expenses

12 Months Current Month Run Rate	Feb-21	Mar-21	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-22	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Purchase Of Healthcare From NHS Bodies	(2.8)	(6.1)	(0.9)	(1.0)	(0.6)	(1.0)	(0.9)	(1.0)	(0.9)	(1.0)	(1.1)	(1.2)	(18.5)
Purchase Of Healthcare From Non-NHS Bodies	(16.6)	(10.1)	(15.3)	(15.3)	(15.1)	(18.3)	(14.8)	(15.8)	(16.1)	(17.8)	(18.8)	(19.8)	(193.9)
Non-Executive Directors	0.0	(0.1)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.1)
Supplies and Services - Clinical (Excluding Drugs Costs)	(1.5)	(16.6)	(0.9)	(3.6)	(1.9)	(2.1)	(3.5)	(2.5)	(3.1)	(3.3)	(3.2)	(2.9)	(45.1)
Supplies and Services - General	(0.1)	(0.2)	(0.1)	(0.4)	0.1	(0.1)	(0.1)	(4.2)	1.1	(0.2)	(0.3)	(0.5)	(5.1)
Drugs costs – on tariff	(3.8)	(22.6)	(4.0)	(3.5)	(4.1)	(2.8)	(4.1)	(4.5)	(4.5)	(4.6)	(4.2)	(3.7)	(66.5)
Pass Through Drugs Cost	(12.7)	(12.2)	(12.1)	(9.5)	(12.9)	(13.1)	(10.8)	(10.7)	(12.5)	(11.1)	(11.9)	(12.1)	(141.6)
Consultancy	(0.4)	(6.8)	(0.3)	(0.5)	(0.6)	(0.5)	0.2	(0.2)	(1.0)	0.7	(0.2)	(0.1)	(9.5)
Establishment	(1.1)	(1.7)	(1.1)	(1.0)	(1.0)	(1.1)	(0.9)	(1.1)	(0.9)	(0.9)	(0.9)	(2.4)	(14.2)
Premises - Business Rates Payable To Local Authorities	(0.0)	0.1	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(0.4)	(3.8)
Premises - Other	(7.5)	1.6	(9.0)	(8.5)	(8.9)	(9.7)	(9.9)	(6.1)	(9.1)	(10.3)	(5.2)	(3.6)	(86.2)
Transport	(0.5)	(1.4)	(1.2)	(0.6)	(0.9)	(0.9)	(0.9)	(1.0)	(0.9)	(1.0)	(0.9)	(0.9)	(11.1)
Depreciation	(2.4)	(6.2)	(2.8)	(2.4)	(2.6)	(3.0)	(2.1)	(3.3)	(2.6)	(2.8)	(2.7)	(4.6)	(37.5)
Fixed Asset Impairments net of Reversals	(2.0)	(40.6)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(42.6)
Increase/(Decrease) In Impairment Of Receivables	(0.4)	4.5	(1.0)	(0.5)	0.5	(0.2)	(0.3)	(0.7)	(0.2)	0.5	(0.3)	(0.1)	1.9
Audit Fees and Other Auditor Remuneration	(0.1)	0.0	(0.0)	(0.1)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.3)
Clinical Negligence	0.0	0.1	(3.9)	(4.0)	(4.0)	(4.2)	(4.2)	(4.1)	(4.1)	(4.1)	(4.1)	(4.1)	(40.4)
Research and Development - Non-Staff	0.0	(0.0)	(0.1)	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.1)	(0.0)	(0.4)
Education and Training - Non-Staff	(0.4)	(2.4)	(0.4)	(0.3)	(0.4)	(0.4)	(0.3)	(0.4)	(0.5)	(0.5)	(0.4)	(0.8)	(7.3)
Operating Lease Expenditure (net)	(0.1)	(0.1)	(0.2)	(0.1)	(0.2)	(0.1)	(0.2)	(0.1)	(0.2)	(0.1)	(0.1)	(0.1)	(1.5)
Other	(0.9)	2.6	(0.7)	(1.1)	(0.6)	(0.9)	(1.1)	(0.8)	0.2	(0.9)	(0.5)	(0.6)	(5.5)
Operating Expenses Excluding Employee Expenses	**(53.1)**	**(118.1)**	**(54.6)**	**(52.8)**	**(53.5)**	**(59.0)**	**(54.3)**	**(56.9)**	**(55.5)**	**(57.9)**	**(55.2)**	**(57.9)**	**(728.9)**
CIP Target Non Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0
Non Pay Savings Target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**(0.0)**	**0.0**	**0.0**	**0.0**	**0.0**
Operating Expenses Excluding Employee Expenses	**(53.1)**	**(118.1)**	**(54.6)**	**(52.8)**	**(53.5)**	**(59.0)**	**(54.3)**	**(56.9)**	**(55.5)**	**(57.9)**	**(55.2)**	**(57.9)**	**(728.8)**
Finance Expense	(3.1)	(0.2)	(3.3)	(3.3)	(3.2)	(2.7)	(3.1)	(3.5)	(3.1)	(3.0)	(3.2)	(3.2)	(35.0)
Gains/(Losses) On Disposal Of Assets	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Non Operating Expenses	**(3.1)**	**(0.2)**	**(3.3)**	**(3.3)**	**(3.2)**	**(2.7)**	**(3.1)**	**(3.5)**	**(3.1)**	**(3.0)**	**(3.2)**	**(3.2)**	**(34.9)**
Non Operating Expenses	**(3.1)**	**(0.2)**	**(3.3)**	**(3.3)**	**(3.2)**	**(2.7)**	**(3.1)**	**(3.5)**	**(3.1)**	**(3.0)**	**(3.2)**	**(3.2)**	**(34.9)**
Trust Total	**(3.5)**	**(49.5)**	**(2.1)**	**7.6**	**4.9**	**0.7**	**(10.0)**	**(1.0)**	**2.6**	**(3.0)**	**0.2**	**(6.0)**	**(59.1)**
Less Depr On Donated Assets	0.1	0.2	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.3
Less Donated Assets Income	(0.3)	(0.4)	0.0	(0.4)	(0.1)	0.0	(0.1)	(0.0)	(0.0)	(0.1)	(0.0)	(2.5)	(3.9)
Less Fixed Asset Impairments	2.0	36.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	38.1
Less Impairment, donated income	**1.8**	**35.8**	**0.1**	**(0.3)**	**0.1**	**0.1**	**(0.0)**	**0.1**	**0.1**	**(0.0)**	**0.1**	**(2.4)**	**35.4**
Operating Total (including ERF)	**(1.8)**	**(13.7)**	**(2.0)**	**7.4**	**4.9**	**0.8**	**(10.0)**	**(0.9)**	**2.7**	**(3.0)**	**0.3**	**(8.4)**	**(23.7)**
Less Elective Recovery Fund			0.0	0.0	(12.4)	(10.4)	7.6	0.0	(0.0)	(3.4)	0.0	(0.7)	(19.3)
Operating Total (excluding ERF)	**(1.8)**	**(13.7)**	**(2.0)**	**7.4**	**(7.4)**	**(9.6)**	**(2.4)**	**(0.9)**	**2.7**	**(6.4)**	**0.3**	**(9.1)**	**(43.0)**

Site Summaries

Summary of Year to Date Financial Position – DENMARK HILL

Denmark Hill Site has reported a £0.6m deficit for M10, resulting in a YTD surplus of £73.3m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M9**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**Change**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	946.5	80.2	66.2	76.9	72.9	(4.0)	644.2	788.9	771.8	(17.1)	(4.8)
Employee Operating Expenses	(545.5)	(46.1)	(44.2)	(46.0)	(49.9)	(3.9)	(425.8)	(454.0)	(459.4)	(5.4)	(4.4)
Operating Expenses Excluding Employee Expenses	(264.1)	(24.7)	(23.1)	(21.6)	(23.6)	(2.0)	(206.5)	(220.6)	(239.1)	(18.5)	0.3
DENMARK HILL Total	136.9	9.4	(1.1)	9.3	(0.6)	(9.9)	11.9	114.3	73.3	(41.0)	(8.8)

Key Messages:

Income:

Clinical income is £4.0m underperforming in month, which represents a £4.8m worsening against the month 1-9 run rate. The bank holidays, mandated break in elective activity and the impact of sickness related to Covid are the key factors in the dip in activity vs December and previous months in 2021. The in month and YTD positions are net of a favourable Pass through Drugs position of £3.2m and £25.1m respectively. Activity OLAP reports for Inpatients and Outpatients for January indicate 77% and 87% respectively compared to 2019/20 activity.

Pay:

Pay for Month 10 has had an increase in run rate of £4.3m vs the M1-9 trend, mainly in nursing (£2.2m) and medical (£1.4m). This run rate increase is mainly driven by the 'Thank You Bonus' (£1.5m), an increase in bank costs related to the bank holiday and enhanced nursing rates (£0.6m), and additional temporary staff costs required due to the impact of Covid.

Non-Pay:

Non-pay costs run rate is in line with the previous 9 months, 0.3m / 1% improvement compared to M1-9 run rate.

Summary of Year to Date Financial Position – PRUH & South Sites

PRUH & South Sites have reported a £2.7m deficit for M10, resulting in a YTD surplus of £10.8m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M9**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**Change**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	279.6	24.9	20.9	22.9	20.1	(2.8)	187.8	231.6	229.0	(2.6)	(3.1)
Employee Operating Expenses	(208.4)	(17.6)	(16.1)	(17.5)	(18.2)	(0.8)	(161.7)	(172.8)	(174.1)	(1.3)	(0.9)
Operating Expenses Excluding Employee Expenses	(50.9)	(4.6)	(4.1)	(4.3)	(4.6)	(0.4)	(39.9)	(42.5)	(44.1)	(1.6)	(0.3)
PRUH AND SOUTH SITES Total	20.3	2.7	0.7	1.1	(2.7)	(3.9)	(13.7)	16.3	10.8	(5.5)	(4.2)

PRUH and South sites budget is inclusive of (i) PRUH & South Sites led care groups of General Medicine, Adult Medicine, Specialty Medicine, Surgery, and PRUH Site Ops; (ii) Cross site led care groups of Orthopaedics,, Ophthalmology, Cancer Network, Therapies*, and Medical Engineering*; (iii) Corporate functions reporting to PRUH Site CEO: Business Intelligence Unit*. (*predominantly non income generating with costs totalling £25.4m).*

Key Messages:

Income:

YTD income includes £1.5m in respect of reimbursed costs due from staffing the Mass Vaccination Centre in Bromley which has delivered >155,000 vaccines YTD. Therefore, excluding vaccination reimbursement, income is tracking £4.1m behind plan YTD.

Income from CCGs is underperforming by £5.2m YTD driven by Ophthalmology (£4.3m), Orthopaedics (£2.8m) and Therapies (£1.5m). Underperformance partially offset by an over performance in General Medicine (£4.5m YTD).

M10 is £4.6m down on M9 driven by Outpatients £1.8m (Ophthalmology, Orthopaedics and Rheumatology), Elective £1.8m (Orthopaedics, General Surgery & Ophthalmology) & Non-Elective Income £0.4m (General Medicine and Geriatric Medicine), largely as a result of pause of elective activity due to Omicron and winter pressures.

Pay:

Pay presents a YTD variance of £1.3m but the business as usual budget excludes costs of mass vaccination centre (£1.5m YTD) which are reimbursed and pay costs attributed to elective recovery schemes (£1.5m YTD). Additional pay spend in month of £0.6m due to the Trust wide Thank You payment in January 22.

The Therapies care group is underspent by £0.2m in month and £2.5m YTD (9.7%) due to vacancies across staff groups. Within the General Medicine and Adult Medicine care groups, due to consultant vacancies and staffing rotas to compliant levels there remains a reliance on locum and agency doctors. This has resulted in an overspend of £2.2m YTD in General Medicine and £1.6m YTD in Adult Medicine. Medical cover has been provided to a number of wards supporting medical outliers, along with cover for ambulatory gaps, weekend discharge and POD rota backfill, and Junior Doctor vacancies. Work has been completed in January to realign rotas in line with HEE action plan.

A recruitment campaign utilising external experts previously successfully engaged by the Trust is underway to attract Consultants to vacancies, particularly within Geriatrics.

Nursing pay of £68m YTD is against plan, despite incurring additional nursing costs of staffing the Mass Vaccination centre (£0.8m). Nursing pay includes enhanced care costs £0.7m YTD. Enhanced bank rates for Nursing staff effective 17 Dec 21 has resulted in an additional £0.2m pressure.

Non-Pay:

Non pay expenditure relating to recovery schemes is predominantly within Endoscopy (£1m), Cardiology (£0.2m) and Dermatology (£0.1m) which corresponded to compliance with the DM01 diagnostic performance in these areas prior to December increase in COVID presentations.

Recovery (Trust earned ERF income in H1 not reported in site positions)

38 recovery schemes were submitted and are being tracked across Ophthalmology, Medical Engineering, Orthopaedics, Specialist Medicine, & Surgery. The costs of this additional activity for M10 YTD is £2.9m: £1.5m Pay (predominantly Ophthalmology £0.9m) and £1.4m Non Pay (predominantly Endoscopy £1m).

Summary of Year to Date Financial Position – COMMERCIAL

Commercial Division have reported a £6.3m deficit for M10, resulting in a YTD deficit of £70m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M9**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**Change**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	12.7	1.2	1.2	1.1	1.2	0.2	11.2	10.6	11.7	1.1	0.1
Employee Operating Expenses	(1.5)	(0.1)	(0.1)	(0.1)	(0.1)	0.0	(1.4)	(1.3)	(1.1)	0.2	0.0
Operating Expenses Excluding Employee Expenses	(95.0)	(7.6)	(3.3)	(7.9)	(7.5)	0.5	(81.3)	(79.2)	(80.6)	(1.4)	0.7
COMMERCIAL Total	(83.9)	(6.5)	(2.2)	(7.0)	(6.3)	0.7	(71.4)	(69.9)	(70.0)	(0.1)	0.7

Key Messages:

Income:

Run rate on trend.

Favourable in month & YTD due to (1) IVF activity over performance £0.4m (2) PFI rental income £0.7m – income target yet to be allocated.

Pay:

Run rate on trend.

Breakeven in month & YTD £0.2m favourable, due to vacancies primarily within KHP Haematology portfolio. Favourable run rate expected to shrink in future months following a restart of programme activities.

Non-Pay:

Run rate : Improvement in run rate resulting KFM share of Profit

Favourable in month c£0.5m mainly driven by KFM share of profit. Overall YTD £1.4m adverse variance relates primarily to KFM contract incl. H1&H2 adjustment, COVID costs, warehouse storage, MRI scanner rental, ophthalmology rental units, historical costs. Costs are partially offset by KFM share of profit and savings from successful contract re-negotiations, challenges & revised costings across Commercial portfolio (ACU, Pharmacy, Decontamination).

Summary of Year to Date Financial Position – CORPORATE

Corporate Directorate have reported a £15.9m deficit for M10, resulting in a YTD deficit of £143.5m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M9**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**Change**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	16.6	1.5	1.3	1.3	1.5	0.2	10.8	14.2	15.8	1.6	(0.0)
Employee Operating Expenses	(71.3)	(5.5)	(5.1)	(6.1)	(5.8)	0.3	(53.8)	(59.1)	(55.0)	4.1	(0.3)
Operating Expenses Excluding Employee Expenses	(118.6)	(10.0)	(7.9)	(9.9)	(11.7)	(1.8)	(108.8)	(98.4)	(104.3)	(5.9)	(1.4)
CORPORATE Total	(173.2)	(13.9)	(11.7)	(14.6)	(15.9)	(1.2)	(151.8)	(143.3)	(143.5)	(0.2)	(1.7)

Key Messages:

Income:

Corporate Income overall is over performing in month by £0.2m and YTD £1.6m.The main drivers YTD are: CEF division reported £1m- over-achievement of transport income due to increased activity. £0.2m which relates to 3 one-off incomes relating to prior years phone masts, Rooftop lease and Dental Building utility recharges, with no income target, Finance Acute Provider Collaboration and APC Diagnostics £0.3m.

Pay:

Pay is under spend YTD by £4.1m mainly due to vacancies across the divisions. The main areas Admin & Clerical: Apollo project £0.643m, CQUIN £0.35m, Workforce Development £0.45m, Thank You Bonus (£0.381m). Medical Staff: ICT £0.117m, Trust Wide Programmes £0.187m, Corporate Services £0.151m. and Thank You Bonus (£0.381m). Nursing Staff: Executive Nursing £0.263m, Nurse Education £0.216m, Operations £0.232m, Thank You Bonus (£0.064m). and Trust Wide Programmes £0.62m. Other Staff: Workforce Development £0.169m, Thank You Bonus (£0.037m).

Non-Pay:

Non-Pay is over spent (£5.9m) mainly due to Trust Wide (£2.9m) Iconica International recruitment isolation and the increase in numbers. Of which is(£0.8m) is either old year or not invoices relating to us) (0.35m credits in month 11)

(£0.63m) legal cases in Commercial; (£1.2m) patient Transport partly offset by over achievement in income. SPS courier services (£0.4m) overs spend due to KFIM pharmacy not able to be recharged out. (£0.28m) COVID, Salary sacrifice (offset by vehicle leases costs in transport (£1m), (£1.1m) Feasibility studies in CEF which should be recharged to Capital once project go live. In month (£0.2m) Trust Wide International recruitment fees (£1.6m) largely due to back log invoicing for recruitment of international nurses. Also Executive Nursing (training) - no budget drawn down yet (£0.4m)

Key movements from last month include:

Income YTD average Run Rate run rate has improved by £0.15m mainly due to HEE income received for Executive Nursing.

Pay remains pretty static. The main movement relates to the continue recruitment of staff for the Apollo project in ICT. Staff Thank You Bonus (£0.426m)

Non Pay has increased largely due to (£1.6m) KCH Mgt invoices (international recruitment), Executive Nursing (0.430m) costs - need to draw down funding in M11.

Summary of Year to Date Financial Position – GUTHRIE

Guthrie have reported a breakeven position for M10, resulting in a YTD surplus of £2.8m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M9**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**Change**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	7.4	1.0	0.9	0.6	0.6	(0.0)	9.3	6.2	6.6	0.4	(0.1)
Employee Operating Expenses	(2.5)	(0.1)	(0.1)	(0.2)	(0.1)	0.1	(1.3)	(2.1)	(1.3)	0.8	(0.0)
Operating Expenses Excluding Employee Expenses	(15.4)	(0.4)	(0.5)	(1.3)	(0.4)	0.9	(4.7)	(12.8)	(2.5)	10.3	(0.2)
GUTHRIE Total	(10.4)	0.4	0.3	(0.9)	0.0	0.9	11.5	(8.7)	2.8	11.5	(0.3)

Key Messages:

Income:

£0.4m YTD favourable income movement is as a result of 1 CAR-T activity and one-off increased activities for KCH/Jersey.

Pay:

Pay is under spend by £0.8m YTD, mainly due to (12.26wte) vacancies and unspent 21/22 B&A funding. Future months run rate expected to remain the same.

Non-Pay:

YTD favourable Non Pay variance of £10m, largely relates to Pass Through Drugs (£2m), Bad debt provision (£0.9m), Consultant fee (£2.9m), External Contracts - Financial Services (£1.4m), Internal Recharges & M1-5 Bed days benefit (£2.1M).

All Non Pay under spend is due to less Guthrie activities as a result of Covid-19.

Key movements from last month include:

Non-pay continuously under spend month on month and will remain same till the year end.

Summary of Year to Date Financial Position – PBU

PBU have reported a £3.5m deficit for M10, resulting in a YTD deficit of £38.4m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M9**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**Change**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	12.0	2.0	2.1	1.0	2.0	1.0	7.1	10.0	19.6	9.6	0.1
Employee Operating Expenses	(0.3)	(0.1)	0.0	(0.0)	(0.0)	(0.0)	0.0	(0.3)	(0.3)	(0.0)	(0.0)
Operating Expenses Excluding Employee Expenses	(50.7)	(5.1)	1.4	(4.2)	(5.5)	(1.3)	(31.2)	(42.2)	(57.8)	(15.5)	0.3
PATHOLOGY BUSINESS UNIT Total	(39.0)	(3.1)	3.5	(3.2)	(3.5)	(0.3)	(24.1)	(32.5)	(38.4)	(6.0)	0.4

Key Messages:

PBU financial position is showing a YTD adverse variance of £6m. This largely relates to an increase in COVID-19 test price for Rapid ePlex PCR tests requested by clinicians from the ED department at DH & PRUH sites. The assumption is that the current level of demand would likely continue until end of this Financial Year. PBU finance team will review the ePlex activity and pricing with Synlab in M12 for further negotiation of price reduction.

Income:

YTD favourable operating income variance of £9.6m is mainly in relation to COVID-19 funding from NHSE/I. *Note: Covid income target & expenditure budget not yet allocated by planning team.* COVID-19 *expenditure of £14.2m is partly offset against the Covid income of £10m leaving a YTD cost pressure of £4.2m.*

Non-Pay:

YTD adverse Non pay variance of £15.5m is largely relating to COVID-19 expenditure from Viapath (£14.2m), majority of this expenditure has been claimable from NHSE and offset against Income.

Other unfunded costs included in the position total £3.6m (i.e. *Over performance £2.35m, New Tests & CCNs £1.2m) and non-recurrent consultancy costs (£0.4m) also contribute to PBU's adverse financial position. However, this overspend is partly offset against the benefit from release of prior year accruals of £1.8m*.

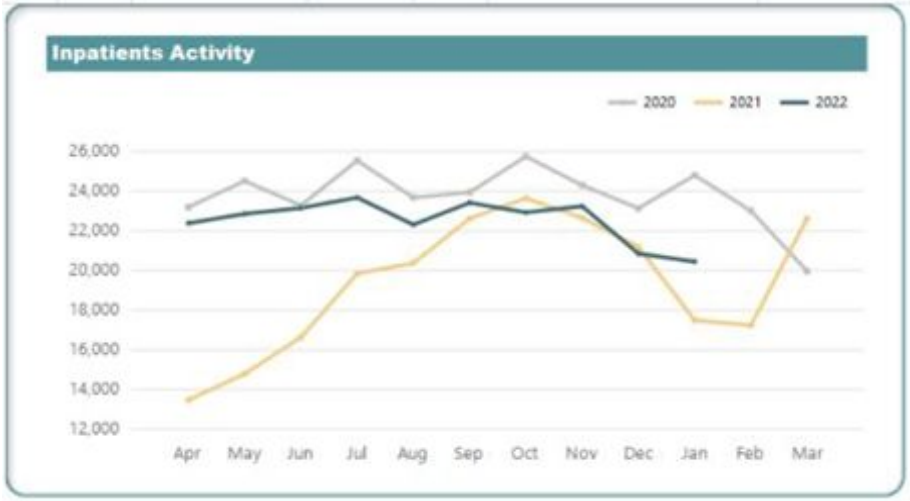
Key movements from last month include:

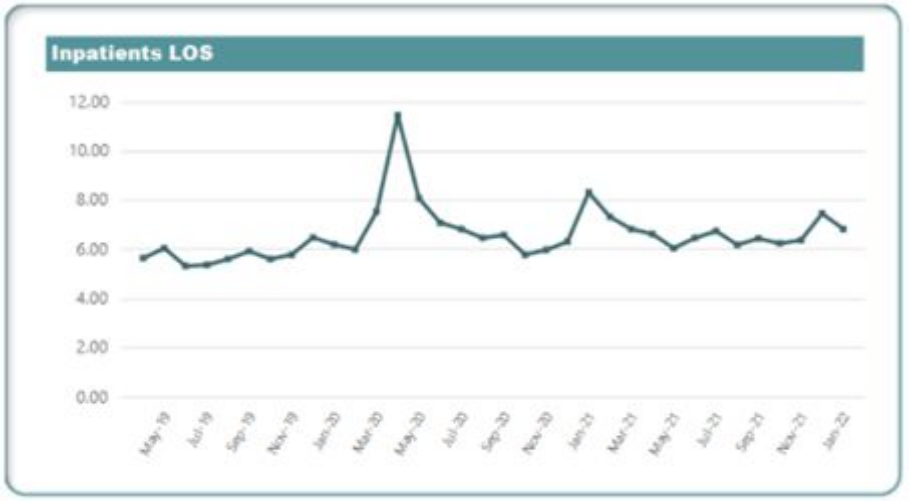
M10 operating income is in line with the previous month, with TSA/CSA and Non-Pay recharges normalised from M05 and COVID-19 income and activity similar to the previous month

Non-Pay run rate further dropped in month due to a credit note received from Synlab (£521k) to adjust previous months baseline contract billing. However, COVID-19 cost and Genomes costs are still in line with previous month's trend.

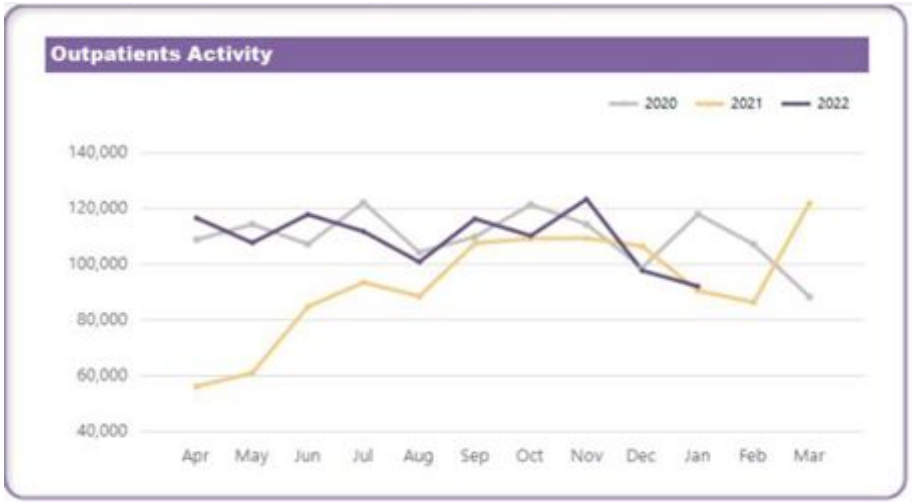
Appendices
Activity Trends

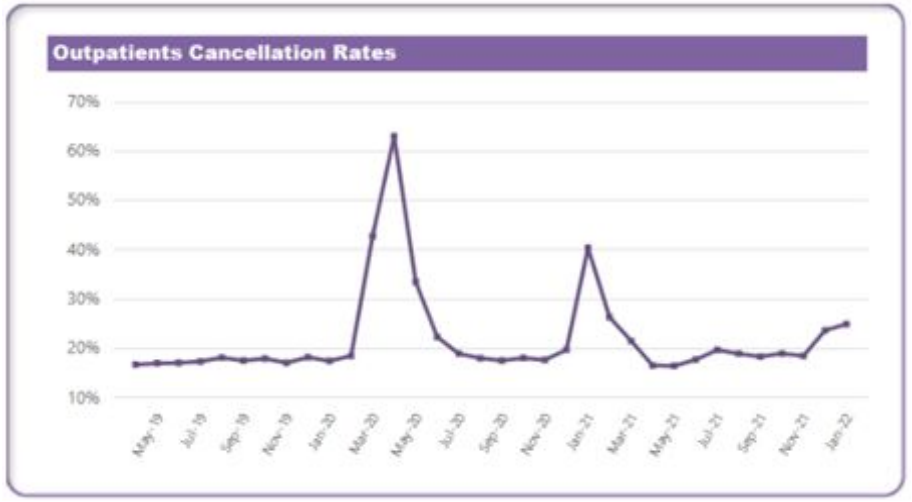
Appendix 3.1 - Activity Summary - Inpatients

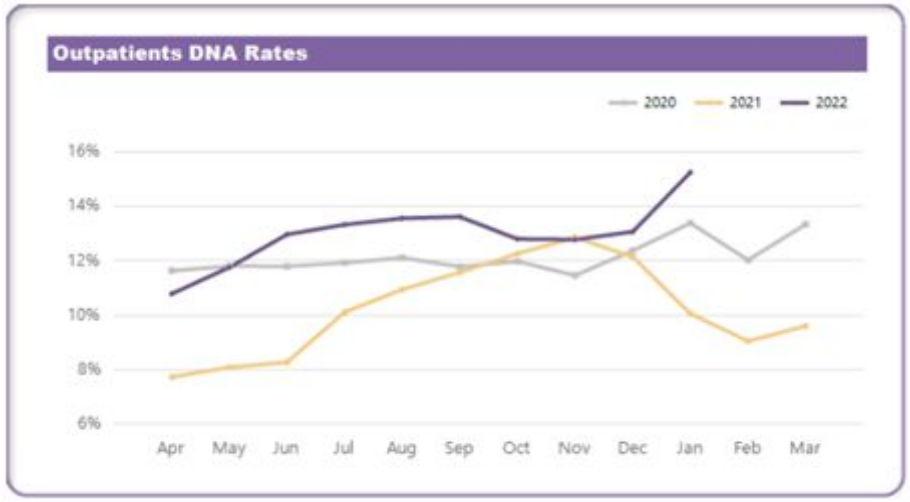




Appendix 3.2 - Activity Summary - Outpatients







Appendix 4.0 – Glossary

Glossary of Terms

OLD (Aptos)		NEW (NEP Oracle)	
FOM Type	**FOM Summary**	**NHSI Type**	**NHSI Category**
Income	NHS Clinical Contract Income Private Patient & Overseas Income Other Non-NHS Clinical Income	Operating Income	Operating Income from Patient Care Activities
	Other Operating Income		Other Operating Income
Pay	Medical Staff Nursing Staff Admin & Clerical Other Staff	Employee Operating Expenses	Medical Staff Nursing Staff Admin & Clerical Other Staff
Non Pay	Drugs Clinical Supplies External Services Other Non-Pay Capital	Operating Expenses Excluding Employee Expenses	Operating Expenses Excluding Employee Expenses
Financing	Finance Expense Gains/(Losses) on Disposal of Assets	Non Operating Expenses	

a few examples:	**FOM Lookup**	**NHSI Sub Type**
	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)
	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 Foundation Trust

Report to:	Board of Directors
Date of meeting:	10 March 2022
Subject:	Maternity Ockenden Review
Author(s):	Tracey MacCormack, Director of Midwifery and Maxine Vassell, Quality, Safety and Governance Lead midwife
Presented by:	Prof Nicola Ranger
Sponsor:	Prof Nicola Ranger, Chief Nurse and Executive Director of Midwifery
History:	KE/QPPC
Status:	Assurance

1. Summary of Report

Following Donna Ockenden's report stating the findings from Shrewsbury and Telford Hospitals NHS Trust; King's maternity team have since been working towards meeting the required standards set out in the report. The attached assurance tool is an overview of what the team have achieved thus far.

- The first stage peer review was completed in February 2021. Upon completion of the peer review (of the 47 standards), maternity was fully compliant with 47% (n=22) and 2% (n=1) partially compliant; the remaining 24 was found to be non-compliant at the time.

- The second stage review was completed in June 2021. Evidence was submitted to give assurance of the maternity unity compliance with the standards. Upon completing the second review, the maternity unit was compliant with 85% (n=40) of the 47 standards. 15% (n=7) remain the same, improve or went down.

- The midwifery team aims to have a monthly meeting to review the Ockenden standards and track any outstanding actions. February 2022, a self-review was carried out to benchmark ourselves against the standards. Upon completing the self-review, we are compliant with 98% (n=46) of the 47 standards. 2% (n=1) remain the same.

2. Action required

The Board is asked to note and discuss the attached assurance tool.

3. Key implications

Legal:	
Financial:	
Assurance:	This report provides an update on the progress being made against the Ockenden recommendation.

Clinical:	
Equality & Diversity:	
Performance:	
Strategy:	
Workforce:	
Estates:	
Reputation:	Yes
Other:(please specify)	

Main Report:

See attached

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

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?
Action 2: Are you submitting data to the Maternity Services Dataset to the required standard?
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?

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 we are learning at system and trust level?	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?
• Quarterly reporting to Women's Health board using the perinatal quality surveillance model. • All Si's are presented to the Trust serious incident committee. HSIB action plans are also reviewed at SIC	Meeting minutes and action log monitoring	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board Regular update, review and trouble shooting at CNST/Ockenden review meeting	Request regular board assurance and accept paper at Trust board	Chief Nurse and Executive Director of Midwifery	Nil resources required	Presentation at QPPC

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.

- Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.
- 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.
- 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.

Link to Maternity Safety actions:
Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?
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?
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?

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.
(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.

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 advocate not in place. Awaiting national guidance on this • NED safety champion in place • Good links with MVP and ongoing coproduction. Work streams ongoing to improve service user feedback • Regular walk around with Exec team and NED	Meeting minutes and action log monitoring Feedback gained	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board Regular update, review and trouble shooting at CNST/Ockenden review meeting	Request regular board assurance and accept paper at Trust board	Chief Nurse and Executive Director of Midwifery	Nil resources required	Presentation at QPPC

Immediate and essential action 3: Staff Training and Working Together
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.
- 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.
- Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only.

Link to Maternity Safety actions:

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

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?
• 96 hour consultant presence on labour ward • Vacant consultant posts recruited to • PROMT training monthly	Meeting minutes and action log monitoring Workforce data PROMPT training records	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board Regular update, review and trouble shooting at CNST/Ockenden review meeting	Request regular board assurance and accept paper at Trust board Anaesthetic involvement at PROMPT	Chief Nurse and Executive Director of Midwifery Lead Anaesthetist	Nil resources required	Presentation at QPPC

Immediate and essential action 4: Managing Complex Pregnancy
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.

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

Link to Maternity Safety Actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

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?
A named consultant is allocated at booking and KHP are working closely to develop maternal medicine pathways and there is a consultant midwife also leading on this.	Compliance is audited quarterly.	Women's Health board audit review and update annually.	Request regular board assurance and accept paper at Trust board	Director of Midwifery	Nil resources required	Presentation at QPPC

Immediate and essential action 5: Risk Assessment Throughout Pregnancy
Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.

- 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
- Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Link to Maternity Safety actions:

Action 6: Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?

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.

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?
These are completed on the Badgernet system and there is now a quarterly audit in place to assess compliance. This data is presented once a year at the care group audit committee.	Meeting minutes and action log monitoring	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board	Request regular board assurance and accept paper at Trust board Liaising with LMNS regarding use of mother and baby app and how to capture PCP across LMNS	Chief Nurse and Executive Director of Midwifery	Nil resources required	Presentation at QPPC

Immediate and essential action 6: Monitoring Fetal Wellbeing

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?
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?

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.

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?
The 5 elements of the bundle are reviewed at the fortnightly CNST/Ockenden meeting and any actions fed back to the wider team.	Spreadsheet log and action log monitoring	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board CNST submission of compliance. SBLCB quarterly audit compliance spreadsheet	Request regular board assurance and accept paper at Trust board	Chief Nurse and Executive Director of Midwifery	Nil resources required	Presentation at QPPC

Immediate and essential action 7: Informed Consent 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. 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 Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care Women's choices following a shared and informed decision-making process must be respected
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.

What do we have in place currently to meet all requirements of IEA 7?	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?
• Heads of Midwifery meet with the MVP chairs monthly. • Postnatal feedback sessions and an education sessions co-produced with MVP • Quarterly MVP meetings • Co-production meetings to support development of new initiatives	Meeting minutes and action log monitoring (The monthly meetings are not currently minted)	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board (MVP update at board) Regular update, review and trouble shooting at CNST/Ockenden review meeting	Request regular board assurance and accept paper at Trust board	Chief Nurse and Executive Director of Midwifery	Resources required for maternity's website update and department welcome videos. The website was poorly reviewed by our MVP last year. Cost is £10,000	Presentation at QPPC

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?**
We have robust processes in place for this IEA	Training needs analysis and core competency framework will be reviewed and submitted annually	Quarterly surveillance reporting to LMS Scheduled reporting at governance and Women's Health board Regular update, review and trouble shooting at CNST/Ockenden review meeting	Request regular board assurance and accept paper at Trust board	Chief Nurse and Executive Director of Midwifery	Nil resources required	Presentation at QPPC

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

The Director of Midwifery is responsible and accountable to the Chief Nurse.

Compliance with Strengthening midwifery leadership: a manifesto for better maternity care is embedded

Q48 Royal College of Midwives in Strer

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?**
There is currently a maternity guideline group that review internal guidelines at a monthly meeting. All guidelines have to be reviewed at least every three years. There are very few guidelines that include sections that deviate from NICE guidance.	Any guidelines which include non-evidenced based sections clearly state this on the front sheet of the guideline. We report this at approval and ratification	All guidelines are reviewed by an expert in the topic and also have a peer review and then are approved at the maternity guidelines meeting and ratified by the maternity governance meeting. Peer review comments are recorded. The rationale for any deviation is carefully reviewed and critiqued prior to approval and ratification.	Currently we have a robust process in place for updating and reviewing guidelines. Where this is not possible this is escalated at the maternity quality governance meeting or the Women's health board meeting	The individual who is updating the guideline would report any deviation from the NICE guidance with rationale. This update is given at the maternity guideline group meeting prior to approval.	At present none	This is not applicable as all guidelines are meeting NICE guidance (standards) or above.

		KCH - cross site Ockenden 2022 review against 2021 benchmark	1st stage (Feb 21) Peer review RAG	2nd stage (June 21) Evidence Review RAG	Update and comments - February 2022
IEA 1	Q1	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		↔	The LMNS dashboard is now submitted quarterly. This started in July 2021.Reporting is now tabled at the quarterly quality surveillance meeting. The first meeting was in December 2021.
IEA 1	Q2	External clinical specialist opinion from outside the Trust (but from within the region), must be mandated for cases of intrapartum fetal death,		↔	Ongoing work - standard maintained
IEA 1	Q3	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,		↑	Ongoing work - standard maintained
IEA 1	Q4	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		↔	Ongoing work - standard maintained
IEA 1	Q5	Are you submitting data to the Maternity Services Dataset to the required standard?		↔	Ongoing work - standard maintained
IEA 1	Q6	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?		↔	Ongoing work - standard maintained
IEA 1	Q7	A plan to implement the Perinatal Clinical Quality Surveillance Model		↔	This has now been implemented and a template created. First Maternity Surveillance Group meeting was on was on 14/1/22. Next 10/12/22. Template review steering group is on 1/3/22
IEA 1	Q8	All maternity SIs are shared with Trust boards at least monthly and the LMS, in addition to reporting as required to HSIB		↑	Ongoing work - standard maintained
IEA 2	Q9	Trusts must create an independent senior advocate role which reports to both the Trust and the LMS Boards.			
IEA 2	Q10	The advocate must be available to families attending follow up meetings with clinicians where concerns about maternity or neonatal care are			
IEA 2	Q11	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.		↓	This is now in place. We have monthly safety champion meetings. In attendance - NED safety champion - Sue Slipman, ED safety champion - Nicola Ranger, Obstetric safety champion - Lisa Long, Maternity safety champion - Tracey MacCormack. Nicola Ranger and Sue Slipman are co-chairs of the bimonthly Women's Health board. There is also a monthly operational meeting which safety champions attend with the senior women's health team to discuss safety challenges in the care group.
IEA 2	Q12	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?		↔	Ongoing work - standard maintained
IEA 2	Q13	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your		↑	Ongoing work - standard maintained
IEA 2	Q14	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?		↓	This is in place. Bimonthly Women's Health board since September 2021. The monthly safety champions meeting is not minuted so no evidence - this will be implemented going forward
IEA 2	Q15	Evidence that you have a robust mechanism for gathering service user feedback, and that you work with service users through your Maternity		↑	Ongoing work - standard maintained
IEA 2	Q16	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		↓	This was in place since April 2021 but the NED job description did not reflect the additional responsibilities. This has updated.
IEA 3	Q17	Trusts must ensure that multidisciplinary training and working occurs and must provide evidence of it. This evidence must be externally		↑	Ongoing work - standard maintained
IEA 3	Q18	Multidisciplinary training and working together must always include twice daily (day and night through the 7-day week) consultant-led and		↔	Ongoing work - standard maintained
IEA 3	Q19	Trusts must ensure that any external funding allocated for the training of maternity staff, is ring-fenced and used for this purpose only (e.g.		↔	Ongoing work - standard maintained
IEA 3	Q20	Can you demonstrate an effective system of clinical workforce planning to the required standard?		↔	Ongoing work - standard maintained
IEA 3	Q21	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies		↑	Ongoing work - standard maintained
IEA 3	Q22	Implement consultant led labour ward rounds twice daily (over 24 hours) and 7 days per week.		↔	Ongoing work - standard maintained
IEA 3	Q23	The report is clear that joint multi-disciplinary training is vital, and therefore we will be publishing further guidance shortly which must be		↔	Ongoing work - standard maintained
IEA 4	Q24	Through the development of links with the tertiary level Maternal Medicine Centre there must be agreement reached on the criteria for those	Yes/Partial	↑	Ongoing work - standard maintained
IEA 4	Q25	Women with complex pregnancies must have a named consultant lead		↔	Ongoing work - standard maintained
IEA 4	Q26	Where a complex pregnancy is identified, there must be early specialist involvement and management plans agreed between the woman and		↔	Ongoing work - standard maintained
IEA 4	Q27	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?		↑	Ongoing work - standard maintained
IEA 4	Q28	All women with complex pregnancy must have a named consultant lead, and mechanisms to regularly audit compliance must be in place.		↑	Ongoing work - standard maintained
IEA 4	Q29	Understand what further steps are required by your organisation to support the development of maternal medicine specialist centres		↔	Ongoing work - standard maintained
IEA 5	Q30	All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropr		↔	Ongoing work - standard maintained
IEA 5	Q31	Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.		↑	Ongoing work - standard maintained
IEA 5	Q32	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?*Links to CNST safety action 6*		↑	Ongoing work - standard maintained
IEA 5	Q33	A risk assessment must be completed and recorded at every contact. This must also include ongoing review and discussion of intended place		↔	Risk assessments and place of birth discussions are carried out at each visit and documented on Badgernet. Regular audits of compliance have not been completed. These are now scheduled to occur quarterly
IEA 6	Q34	All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champi		↑	Ongoing work - standard maintained
IEA 6	Q35	The Leads must be of sufficient seniority and demonstrated expertise to ensure they are able to effectively lead on: - Improving the practice of		↑	Ongoing work - standard maintained
IEA 6	Q36	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?*Links to CNST safety action 6*		↑	Ongoing work - standard maintained
IEA 6	Q37	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies tra		↑	Ongoing work - standard maintained
IEA 6	Q38	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 ident		↑	Ongoing work - standard maintained
IEA 7	Q39	All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode		↑	Ongoing work - standard maintained
IEA 7	Q40	All maternity services must ensure the provision to women of accurate and contemporaneous evidence-based information as per national guid		↑	Ongoing work - standard maintained
IEA 7	Q41	Women must be enabled to participate equally in all decision-making processes and to make informed choices about their care		↔	Ongoing work - standard maintained
IEA 7	Q42	Women's choices following a shared and informed decision-making process must be respected		↔	Ongoing work - standard maintained
IEA 7	Q43	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Mate		↑	Ongoing work - standard maintained
IEA 7	Q44	Every trust should have the pathways of care clearly described, in written information in formats consistent with NHS policy and posted on the		↑	Ongoing work - standard maintained
WF	Q45	Can you demonstrate an effective system of clinical workforce planning to the required standardBased on a Birthrate Plus assessment taken p		↑	Ongoing work - standard maintained
WF	Q46	Can you demonstrate an effective system of midwifery workforce planning to the required standard?Based on a Birthrate Plus assessment take		↑	Ongoing work - standard maintained
WF	Q47	Please confirm that your Director/Head of Midwifery is responsible and accountable to an executive director		↔	Ongoing work - standard maintained
WF	Q48	Describe how your organisation meets the maternity leadership requirements set out by the Royal College of Midwives in Strengthening midwif		↔	Ongoing work - standard maintained
WF	Q49	We are asking providers to review their approach to NICE guidelines in maternity and provide assurance that these are assessed and impleme		↓	There is a robust review process . All guidelines are reviewed and amended by MDT and presented for sign off at maternity guidelines committee. All approved guidelines are then ratified at the governance meeting before being uploaded onto the Trust portal. A compliance audit is ongoing Where guidance does not comply with NICE, appropriate derogation is sought.

Classification: Official

Publication approval reference: PAR807

Maternity services system learning
Maternity self-assessment tool

Version 6, 19 July 2021

Where updates have been made to the content of this document since the previous version was published (version 5, February 2020), they have been highlighted in yellow.

Introduction

This Safety Self-assessment tool has been designed for NHS maternity services and private maternity providers to allow them to self-assess whether their operational service delivery meets national standards, guidance, and regulatory requirements. Organisations can use the tool to inform the trust's maternity quality improvement and safety plan and so keep the trust board and commissioners aware of their current position.

The tool has been developed in response to national review findings, and recommendations for good safety principles within maternity services. This version of the tool has been further influenced by the findings of the Ockenden review, 7 features of safety culture and the emerging themes from services on the safety support programme and the areas CQC found to be outstanding in other maternity services across England.

Please use this tool to as a benchmark for your organisation in the core principles of good safety standards within Maternity services.

The tool

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
Directorate/care group infrastructure and leadership	**Clinically-led triumvirate**	Trust and service organograms showing clinically led directorates/care groups	Green	
		Equal distribution of roles and responsibilities across triumvirate to discharge directorate business such as meeting attendance and decision-making processes	Green	
	Director of Midwifery (DoM) in post **(current registered midwife with NMC)**	DoM job description and person specification clearly defined	Green	
		Agenda for change banded at 8D or 9	Green	
		In post	Green	
	Direct line of sight to the trust board	Lines of professional accountability and line management to executive board member for each member of the triumvirate	Green	
		Clinical director to executive medical director	Amber	
		DoM to executive director of nursing	Green	
		General manager to executive chief operating officer	Amber	
		Maternity services standing item on trust board agenda as a minimum three-monthly Key items to report should always include: • SI Key themes report, Staffing for maternity services for all relevant professional groups • Clinical outcomes such as SB, NND HIE, AttAIN, SBLCB and CNST progress/Compliance. • Job essential training compliance • Ockendon learning actions	Amber	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	Red	
		Monthly review of maternity and neonatal safety and quality is undertaken by the trust board [Perinatal quality surveillance model]	Red	
		There should be a minimum of three PAs allocated to clinical director to execute their role	Green	
	Collaborative leadership at all levels in the directorate/ care group	Directorate structure and roles support triumvirate working from frontline clinical staff through to senior clinical leadership team	Amber	
		Adequate dedicated senior human resource partner is in place to support clinical triumvirate and wider directorate Monthly meetings with ward level leads and above to monitor recruitment, retention, sickness, vacancy and maternity leave	Amber	
		Adequate senior financial manager is in place to support clinical triumvirate and wider directorate	Green	
		Monthly meetings with all ward level leaders and above to monitor budgets, ensure updated and part of annual budget setting for each area	Green	
		Adequate senior operational support to the delivery of maternity services in terms of infrastructure and systems that support high quality service delivery aligned with national pathways	Green	
		From governance and senior management meetings that all clinical decisions are made collaboratively by multiprofessional groups	Green	
		Forums and regular meetings scheduled with each professional group are chaired by the relevant member of the triumvirate, eg senior midwifery leadership assembly	Amber	
		Leadership culture reflects the principles of the '7 Features of Safety'.		
		Trust-wide leadership and development team in place	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Leadership development opportunities	In house or externally supported clinical leadership development programme in place	Green	
		Leadership and development programme for potential future talent (talent pipeline programme)	Green	
		Credible organisations provide bespoke leadership development for clinicians/ frontline staff and other recognised programmes, including coaching and mentorship	Green	
	Accountability framework	Organisational organogram clearly defines lines of accountability, not hierarchy	Green	
		Organisational vision and values in place and known by all staff	Amber	
		Organisation's behavioural standards framework in place: Ensure involvement of HR for advice and processes in circumstances where poor individual behaviours are leading to team dysfunction. [Perinatal Surveillance model]	Amber	
	Maternity strategy, vision and values	Maternity strategy in place for a minimum of 3–5 years	Amber	
		Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children's chapter of the NHS Long Term Plan	Red	
		Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	Amber	
		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 [Ockenden Assurance]		
		Maternity strategy aligned with trust board LMNS and MVP's strategies	Amber	
		Strategy shared with wider community, LMNS and all key stakeholders	Red	
		Non-executive director appointed as one of the board level maternity safety champions and is working in line with national role descriptor	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Non-executive maternity safety champion	Maternity and neonatal safety champions to meet the NED and exec safety champion to attend and contribute to key directorate meetings in line with the national role descriptor	Green	
		All Safety champions lead quality reviews, eg 15 steps quarterly as a minimum involving MVPs, service users, commissioners and trust governors (if in place)	Amber	
		Trust board meeting minutes reflect check and challenge on maternity and neonatal services from non-executive safety champion for maternity services	Amber	
		A pathway has been developed that describes how frontline midwifery, neonatal, obstetric and Board safety champions share safety intelligence from floor to Board and through the local maternity system (LMS) and MatNeoSIP Patient Safety Networks. [MIS]	Amber	
Multiprofessional team dynamics	**Multiprofessional engagement workshops**	Planned schedule of joint multiprofessional engagement sessions with chair shared between triumvirate, ie quarterly audit days, strategy development, quality improvement plans	Amber	
		Record of attendance by professional group and individual	Amber	
		Recorded in every staff member's electronic learning and development record	Amber	
	Multiprofessional training programme	Annual schedule of job essential maternity-specific training and education days, that meet the NHS England and NHS Improvement Core Competency framework as a minimum published and accessible for all relevant staff to see	Green	
		A clear Training Needs analysis in place that identifies the minimum hours of training required for each professional group and by grade/ seniority	Green	
		All staff given time to undertake mandatory and job essential training as part of working hours	Green	
		Full record of staff attendance for last three years	Green	
		Record of planned staff attendance in current year	Green	
		Clear policy for training needs analysis in place and in date for all staff groups		
		Compliance monitored against training needs policy and recorded on roster system or equivalent	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Education and training compliance a standing agenda item of divisional governance and management meetings	Green	
		Through working and training together, people are aware of each other's roles, skills, and competencies (who does what, how, why and when) and can work effectively together, thus demonstrating "collective competence". [7 Steps]	Green	
		Individual staff Training Needs Analysis (TNA) aligned to professional revalidation requirements and appraisal		
	Clearly defined appraisal and professional revalidation plan for staff	All job descriptions identify individual lines of accountability and responsibility to ensure annual appraisal and professional revalidation	Green	
		Compliance with annual appraisal for every individual	Amber	
		Professional validation of all relevant staff supported by internal system and email alerts	Green	
		Staff supported through appraisal and clearly defined set objectives to ensure they fulfil their roles and responsibilities	Green	
		Schedule of clinical forums published annually, eg labour ward forum, safety summit, perinatal mortality meetings, risk and governance meetings, audit meetings	Amber	
	Multiprofessional clinical forums	HR policies describe multiprofessional inclusion in all processes where applicable and appropriate, such as multiprofessional involvement in recruitment panels and focus groups	Green	
	Multiprofessional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	Amber	
		Multiprofessional inclusion in clinical and HR investigations, complaint and compliment procedures	Green	
		Standard operating procedure provides guidance for multiprofessional debriefing sessions following clinical incidents or complaints	Amber	
		Debriefing sessions available for all staff groups involved following a clinical incident and unusual cases in line with trust guideline and policy	Amber	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Schedule of attendance from multiprofessional group members available	Amber	
	Multiprofessional membership/ representation at Maternity Voices Partnership forums	Record of attendance available to demonstrate regular clinical and multiprofessional attendance.	Green	
		Maternity Voice Partnership involvement in service development, Quality Improvement, recruitment and business planning through co-production and co-design	Green	
		Quality improvement plan (QIP) that uses the SMART principle developed and visible to all staff as well as Maternity Voice Partnership/service users	Red	
	Collaborative multiprofessional input to service development and improvement	Roles and responsibilities in delivering the QIP clearly defined, ie senior responsible officer and delegated responsibility	Red	
		Clearly defined and agreed measurable outcomes including impact for women and families as well as staff identified in the QIP	Red	
		Identification of the source of evidence to enable provision of assurance to all key stakeholders	Red	
		The organisation has robust repository for collation of all evidence, clearly catalogued and archived that's has appropriate shared access	Red	
		Clear communication and engagement strategy for sharing with key staff groups	Red	
		QIP aligned to national agendas, standards and national maternity dataset and national maternity quality surveillance model requirements	Red	
		Weekly/monthly scheduled multiprofessional safety incident review meetings	Green	
	Multiprofessional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Red	
		Positive and constructive feedback communication in varying forms	Green	
		Debrief sessions for cases of unusual or good outcomes adopting safety 2 approach	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Senior members of staff make sure that more junior staff have opportunities to debrief and ask questions after experiencing complex clinical situations, and that they learn from theirs and others' experience. [7 steps to safety]	Amber	
		Schedule of focus for behavioural standards framework across the organisation		
	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	Green	
		Unsafe or inappropriate behaviours are noticed and with HR support corrected in real time, so they don't become normalised. [7 steps]	Amber	
		All policies and procedures align with the trust's board assurance framework (BAF)		
Governance infrastructure and ward-to-board accountability	**System and process clearly defined and aligned with national standards**	Governance framework in place that supports and promotes proactive risk management and good governance	Green	
		Staff across services can articulate the key principles (golden thread) of learning and safety	Amber	
		Staff describe a positive, supportive, safe learning culture	Amber	
		Robust maternity governance team structure, with accountability and line management to the DoM and CD with key roles identified and clearly defined links for wider support and learning to corporate governance teams	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Maternity governance structure within the directorate	Maternity governance team to include as a minimum: Maternity governance lead (Current RM with the NMC) Consultant Obstetrician governance lead (Min 2PA's) Maternity risk manager (Current RM with the NMC or relevant transferable skills) Maternity clinical incident leads Audit midwife Practice development midwife Clinical educators to include leading preceptorship programme Appropriate Governance facilitator and admin support	Green	
		Roles and responsibilities for delivery of the maternity governance agenda are clearly defined for each team member	Green	
		Team capacity able to meet demand, eg risk register, and clinical investigations completed in expected timescales	Amber	
		In date maternity-specific risk management strategy, as a specific standalone document clearly aligned to BAF	Amber	
	Maternity-specific risk management strategy	Clearly defined in date trust wide BAF	Amber	
	Clear ward-to-board framework aligned to BAF	Perinatal services quality assurance framework supported by standardised reporting requirements in place from ward to board	Amber	
		Mechanism in place for trust-wide learning to improve communications	Amber	
	Proactive shared learning across directorate	Mechanism in place for specific maternity and neonatal learning to improve communication	Amber	
		Governance communication boards	Red	
		Publicly visible quality and safety board's outside each clinical area	Red	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Learning shared across local maternity system and regional networks	Amber	
		Engagement of external stakeholders in learning to improve, eg CCG, Strategic Clinical Network, regional Director/Heads of Midwifery groups	Green	
		Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	Green	
		Multi-agency input evident in the development of the maternity specification	Amber	
Application of national standards and guidance	**Maternity specification in place for commissioned services**	Approved through relevant governance process	Green	
		In date and reflective of local maternity system plan	Green	
		Full compliance with all current 10 standards submitted	Green	
	Application of CNST 10 safety actions	A SMART action plan in place if not fully compliant that is appropriately financially resourced.	Green	
		Clear process defined and followed for progress reporting to LMS, Commissioners, regional teams and the trust board that ensures oversights and assurance before formal sign off of compliance	Green	
		Clear process for multiprofessional, development, review and ratification of all clinical guidelines	Green	
	Clinical guidance in date and aligned to the national standards	Scheduled clinical guidance and standards multiprofessional meetings for a rolling 12 months programme.	Green	
		All guidance NICE complaint where appropriate for commissioned services	Green	
		All clinical guidance and quality standards reviewed and updated in compliance with NICE	Green	
		All five elements implemented in line with most updated version	Green	
		SMART action plan in place identifying gaps and actions to achieve full implementation to national standards.	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Saving Babies Lives care bundle implemented	Trajectory for improvement to meet national ambition identified as part of maternity safety plan	Green	
		All four key actions in place and consistently embedded	Green	
	Application of the four key action points to reduce inequality for BAME women and families	Application of equity strategy recommendations and identified within local equity strategy	Amber	
		All actions implemented, embedded and sustainable	Amber	
	Implementation of 7 essential learning actions from the Ockendon first report	Fetal Surveillance midwife appointed as a minimum 0.4 WTE	Green	
		Fetal surveillance consultant obstetrician lead appointed with a minimum of 2-3 PAs	Green	
		Plan in place for implementation and roll out of A-EQUIP	Green	
	A-EQUIP implemented	Clear plan for model of delivery for A-EQUIP and working in collaboration with the maternity governance team	Green	
		Training plan for transition courses and succession plan for new professional midwifery advocate (PMA) A-EQUIP model in place and being delivered	Green	
		Service provision and guidance aligned to national bereavement pathway and standards	Green	
	Maternity bereavement services and support available	Bereavement midwife in post	Green	
		Information and support available 24/7	Amber	
		Environment available to women consistent with recommendations and guidance from bereavement support groups and charities	Amber	
		Quality improvement leads in place	Amber	
	Quality improvement structure applied	Maternity Quality Improvement Plan that defines all key areas for improvement as well as proactive innovation	Red	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Recognised and approved quality improvement tools and frameworks widely used to support services	Red	
		Established quality improvement hub, virtual or otherwise	Amber	
		Listening into action or similar concept implemented across the trust	Amber	
		Continue to build on the work of the MatNeoSip culture survey outputs/findings.	Amber	
	MatNeoSip embedded in service delivery	MTP and the maternity safety strategy well defined in the local maternity system and quality improvement plan	Amber	
	Maternity transformation programme (MTP) in place	Dynamic maternity safety plan in place and in date (in line with spotlight on maternity and national maternity safety strategy)	Amber	
Positive safety culture across the directorate and trust	**Maternity safety improvement plan in place**	Standing agenda item on key directorate meetings and trust committees	Amber	
		FTSU guardian in post, with time dedicated to the role	Green	
	Freedom to Speak Up (FTSU) guardians in post	Human factors training lead in post	Amber	
	Human factors training available	Human factors training part of trust essential training requirements	Green	
		Human factors training a key component of clinical skills drills	Green	
		Human factors a key area of focus in clinical investigations and formal complaint responses	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		Multiprofessional handover in place as a minimum to include Board handover with representation from every professional group: • Consultant obstetrician • ST7 or equivalent • ST2/3 or equivalent • Senior clinical lead midwife • Anaesthetist And consider appropriate attendance of the following: • Senior clinical neonatal nurse • Paediatrician/neonatologist? • Relevant leads form other clinical areas eg, antenatal/postnatal ward/triage.	Red	
	Robust and embedded clinical handovers in all key clinical areas at every change of staff shift	Clinical face to face review with relevant lead clinicians for all high-risk women and those of concern	Green	
		A minimum of two safety huddles daily in all acute clinical areas to include all members of the MDT working across and in maternity services as well as the opportunity to convene an urgent huddle as part of escalation process's	Amber	
	Safety huddles	Guideline or standard operating procedure describing process and frequency in place and in date	Red	
		Audit of compliance against above	Red	
		Annual schedule for Swartz rounds in place	Amber	
	Trust wide Swartz rounds	Multiprofessional attendance recorded and supported as part of working time	Amber	
		Broad range of specialties leading sessions	Green	
		Trust-wide weekly patient safety summit led by medical director or executive chief nurse	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
	Trust-wide safety and learning events	Robust process for reporting back to divisions from safety summit	Green	
		Annual or biannual trust-wide learning to improve events or patient safety conference forum	Green	
		Trust board each month opened with patient story, with commitment to action and change completed in agreed timeframes	Green	
		In date business plan in place	Green	
Comprehension of business/ contingency plans impact on quality. **(ie Maternity Transformation plan, Neonatal Review, Maternity Safety plan and Local Maternity System plan)**	**Business plan in place for 12 months prospectively**	Meets annual planning guidance	Green	
		Business plan supports and drives quality improvement and safety as key priority	Green	
		Business plan highlights workforce needs and commits to meeting safe staffing levels across all staff groups in line with BR+ or other relevant workforce guidance for staff groups	Green	
		Consultant job plans in place and meet service needs in relation to capacity and demand	Amber	
		All lead obstetric roles such as: labour ward lead, audit lead, clinical governance lead and early pregnancy lead are in place and have allocated PAs in job plans	Green	
		Business plans ensures all developments and improvements meet national standards and guidance	Green	
		Business plan is aligned to NHS 10-year plan, specific national initiatives and agendas.	Green	
		Business plans include dedicated time for clinicians leading on innovation, QI and Research	Green	

Area for improvement	Description	Evidence	Self-assessed compliance (RAG)	Evidence for RAG rating
		That service plans and operational delivery meets the maternity objectives of the Long Term Plan in reducing health inequalities and unwarranted variation in care. Note the Maternity and Neonatal Plans on Pages 12 & 13.	Amber	
Meeting the requirements of Equality and Inequality & Diversity Legislation and Guidances.	**That Employment Policies and Clinical Guidances meet the publication requirements of Equity and Diversity Legislation.**	Assess service ambitions against the Midwifery 2020: Delivering expectations helpfully set out clear expectations in relation to reducing health inequalities, parts 3.1, 4.1 and 4.3 of the documents.	Green	
		Refer to the guidance from the Royal College of Midwives (RCM) Stepping Up to Public Health, (2017). Utilise the Stepping up to Public Health Model, Table 10 as a template.	Green	

Key lines of enquiry	Kirkup recommendation number
Leadership and development	2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18
Governance: Covers all pillars of Good governance	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Quality Improvement: application of methodology and tools	5, 6, 9, 12, 13, 15, 16, 17, 18
National standards and Guidance: service delivery	2, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Safety Culture: no blame, proactive, open and honest approach, Psychological safety	2, 3, 4, 5, 7, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Patient Voice: Service user involvement and engagement through co-production and co-design. MVP and wider	6, 9, 11, 12, 13, 15, 17, 18

Staff Engagement: Harvard System two leadership approach, feedback and good communication tools	2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18
Business Planning: aligned with LMNS plans and the National Maternity Transformation agenda, Maternity safety strategy and the Long term plan	8, 9, 10, 14, 15, 16, 17, 18

Key supporting documents and reading list

1. NHS England National Maternity review: Better Births. February 2016; https://www.england.nhs.uk/wp-content/uploads/2016/02/national-maternity-review-report.pdf

2. Royal College of Obstetricians and Gynaecologists Maternity Standards 2016; https://www.rcog.org.uk/globalassets/documents/guidelines/working-party-reports/maternitystandards.pdf

3. NHS England NHS Long Term Plan: January 2019; https://www.longtermplan.nhs.uk/

4. Report of the Investigation into Morecambe Bay March 2015; https://www.gov.uk/government/publications/morecambe-bay-investigation-report

5. Royal College of Midwives. Birth-rate plus tools; https://www.rcm.org.uk/media/2375/working-with-birthrate-plus.pdf

6. Royal College of Midwives State of Maternity Services 2018; https://www.rcm.org.uk/media/2373/state-of-maternity-services-report-2018-england.pdf

7. NHS England. Spotlight on Maternity: Safer Maternity care. 2016; https://www.england.nhs.uk/signuptosafety/wp-content/uploads/sites/16/2015/11/spotlight-on-maternity-guide.pdf

8. Department of Health Safer Maternity care. The National Ambition. November 2017; https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/560491/Safer_Maternity_Care_action_plan.pdf

9. NHS Resolution. Maternity Incentivisation Scheme 2019/20; https://resolution.nhs.uk/services/claims-management/clinical-schemes/clinical-negligence-scheme-for-trusts/maternity-incentive-scheme/

10. NHS staff survey. (2018); https://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/

11. Maternity Picker Survey. 2019; https://www.picker.org/wp-content/uploads/2014/10/Maternity-4-pager-for-website-ARe-V2-18122018.pdf

12. National Maternity Perinatal Audit. (NMPA) report; https://www.hqip.org.uk/resource/national-maternity-and-perinatal-audit-nmpa-clinical-report-2019/#.XdUiX2pLFPY

13. Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK. (MBRACE) report; https://www.npeu.ox.ac.uk/mbrrace-uk

14. Organisations Monthly Maternity Dashboards; https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/maternity-services-data-set/maternity-services-dashboard

15. Organisational Maternity and Neonatal Cultural Score Survey; https://improvement.nhs.uk/documents/5039/Measuring_safety_culture_in_matneo_services_qi_1apr.pdf

16. NHS England Saving babies lives Care bundle. V2 March 2019; https://www.england.nhs.uk/wp-content/uploads/2019/07/saving-babies-lives-care-bundle-version-two-v5.pdf

17. 7 Features of safety in maternity services framework; https://for-us-framework.carrd.co/

18. Ockendon Report: investigation into maternity services at Shrewsbury and |Telford NHS hospitals 2020; https://www.gov.uk/government/publications/ockenden-review-of-maternity-services-at-shrewsbury-and-telford-hospital-nhs-trust

19. Perinatal Surveillance Model; https://www.england.nhs.uk/wp-content/uploads/2020/12/implementing-a-revised-perinatal-quality-surveillance-model.pdf

20. Maternity Incentive Scheme; https://resolution.nhs.uk/wp-content/uploads/2021/03/Maternity-Incentive-Scheme-year-3-March-2021-FINAL.pdf

King's College Hospital NHS
NHS Foundation Trust

Report to:	Board of Directors
Date of meeting:	10 March 2022
Subject:	Maternity Staffing
Author(s):	Tracey MacCormack, Director of Midwifery
Presented by:	Prof Nicola Ranger
Sponsor:	Prof Nicola Ranger, Chief Nurse and Executive Director of Midwifery
History:	KE/QPPC
Status:	Assurance

1. Background/Purpose

A requirement of the Maternity Incentive Scheme Year 4 (CNST), Safety action 5 is that a midwifery staffing oversight report that covers staffing/safety issues is presented to the Trust board every 6 months within the reporting period (August 2021-June 2022). This is a follow up to the first paper presented in November 2-21 and outlines progress against the recommendations as per the CNST requirements.

This report outlines the current progress in ensuring safe midwifery and support worker staffing levels at King's College Hospital NHS Foundation Trust. The recommendations within this document are modelled using the nationally recognised tool Birthrate. Birthrate + (Ball & Washbrook, 1996) is the only recognised maternity-specific workforce planning tool which has been endorsed by NICE (2016), The Kings Fund (2012) and the Royal Colleges (2007). The Birthrate+ Midwifery Workforce Planning system is based upon the principles of providing one-to-one care during labour and delivery to all women and includes additional midwifery hours for women in the higher clinical needs categories.

A full Birthrate + review was completed against December 2020- January 2021 staffing and the findings were reported to QPCC in November 2021.

- This report provides the committee with an update in relation to King's maternity staffing
- The report outlines progress being made to address workforce shortages in maternity in line with national guidance

2. Action Required

- The Board of Directors is asked to note the data presented in this report and associated recommendations for information.

King's College Hospital NHS
NHS Foundation Trust

3. Key implications

Legal:	NA
Financial:	Addition staffing needs identified
Assurance:	Steps are being taken to ensure staffing is in line with acuity within the department
Clinical:	Provision of quality care in safely staffed maternity units
Equality & Diversity:	NA
Performance:	NA
Strategy:	NA
Workforce:	Ensure adherence to CNST and national recommendations and safe staffing ratios in the department
Estates:	NA
Reputation:	NA
Other:(please specify)	NA

Background

The Maternity Incentive scheme year 4, published in August 2021, Safety Action 5 asks – "Can you demonstrate an effective system of midwifery workforce planning to the required standard??"

The standards to achieve for this safety action are outlined below:-

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed.

b) The midwifery coordinator in charge of labour ward must have supernumerary status; (defined as having no caseload of their own during their shift) to ensure there is an oversight of all birth activity within the service

c) All women in active labour receive one-to-one midwifery care

d) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months, during the maternity incentive scheme year four reporting period.

The departments are working towards the aims and objectives for maternity as set out by the NHS Long Term Plan, which states that the NHS will accelerate action to achieve 50% reductions in stillbirth, maternal mortality, neonatal mortality and serious brain injury by 2025. A recommendation in achieving this aim is Continuity of Carer teams being developed to ensure women are cared for by the same midwife throughout their pregnancy, during birth and post-natally.

Continuity of Care

Women who receive continuity of carer are 16% less likely to lose their baby, 19% less likely to lose their baby before 24 weeks and 24% less likely to experience pre-term birth. The aim is for this care provision to be targeted towards women from ethnic minority groups and those living in deprived areas, for whom midwifery-led continuity of carer is linked to significant improvements in clinical outcomes. The national team is currently reviewing the continuity of care framework in responses to challenges from senior midwifery leaders across the country. The maternity department value the benefits of continuity and are

continuing to support a slow upscale to meet the needs of women and birthing people. Percentages of continuity of care offered in the last quarter range between 4% and 10.7%.

Safer Staffing levels in Maternity – Birthrate plus Staffing App – Maternity

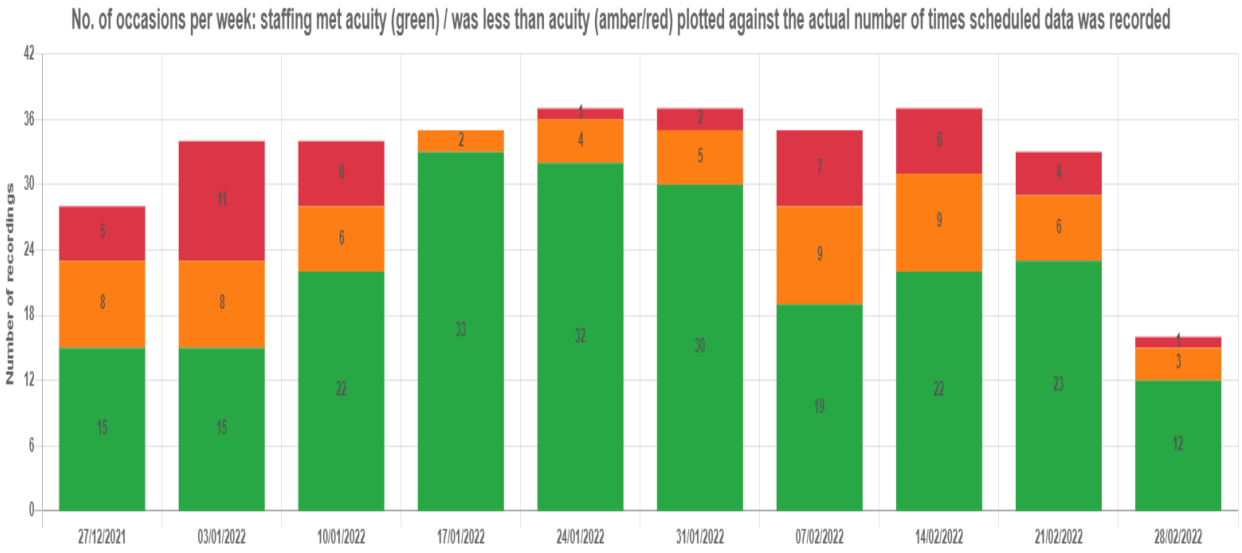
The inpatient activity focused on 1:1 care in labour, red flags and reasons for these are shown below.

Birthrate plus is a national tool that the maternity units have adopted to assess the clinical needs of the women on the ward and match them against the staff available due to the fluid nature of the workload.

Data collection covers all women in the unit, who are classified according to their clinical and social needs. Data is collected every four hours and calculates the staff hours needed based upon the client need and compares them with the staff hours available on that shift.

The following tables highlight the recorded staffing requirement based on the clinical and social needs of the women on the unit from – 01/01/22 – 28/02/22.

Labour Ward – Denmark Hill



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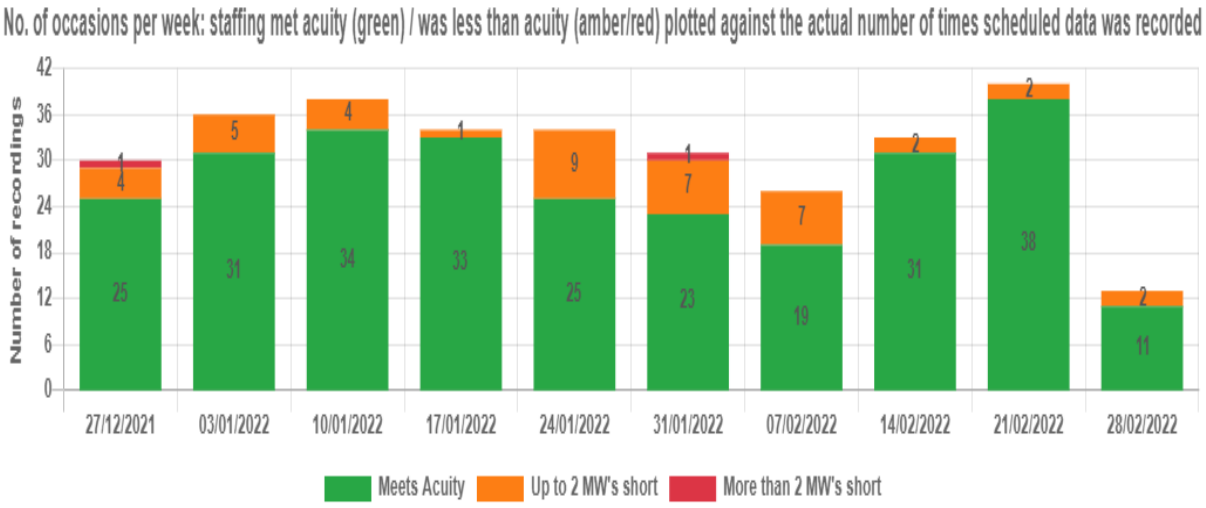
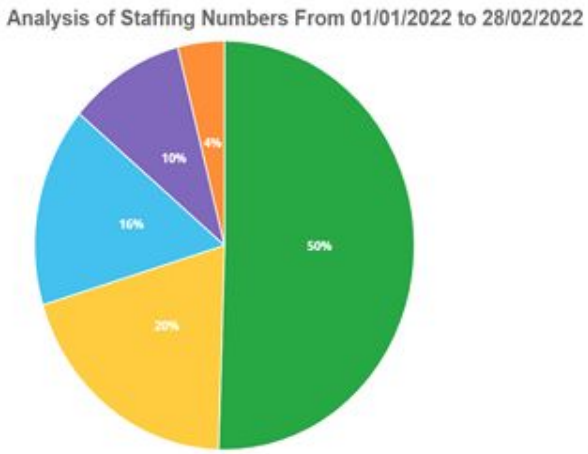
Labour Ward – PRUH



Red – More than 2 midwives short / **Amber** – Up to 2 midwives short / **Green** – staffing levels meets acuity

The following pie charts focus on the inpatient areas and show the percentage of shift recorded

William Gillatt



Green – Positive: Yellow – Up to 1 staff short: Blue – Up to 2 staff short: Purple – Up to 3 staff short: Orange – Up to 4 staff short: Red – > 4 staff short:

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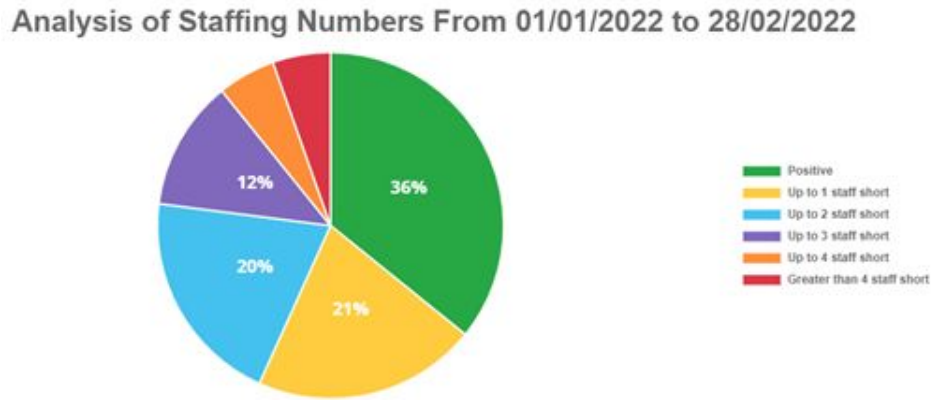
Maternity ward - PRUH



Birthrate + recommendations

Headlines from the Birthrate + report are outlined below.

Site	% Case mix I,II,III 2020	% Case mix IV-V 2020	% Case mix I,II,III 2015	% Case mix IV-V 2015
DH	**18.2**	**81.8**	**39**	**61**
PRUH	**32.9**	**67.1**	**41.2**	**58.8**

There have not been any changes in the level of complexity within the case mix since the departments were last fully reviewed in 2015. The generic case mix at KCH indicates that over 80% of women are in the two higher categories IV and V. This is noticeably higher than the average for England of 58%, based on 55 maternity units from a wide range of sizes and locations. The generic case mix at the PRUH is also above average at 67.1%. This increase in complexity of the women and birthing people seen has impacted on the staffing required to safely provide care within both departments.

	Current staffing band 3-8	Birthrate + recommendation	Staffing variance	Midwife: Support worker ratio
PRUH	193.89	207.81	13.92	90:10
DH	263.43	270.78	7.35	88:12
Total			21.27	

Birth rate overview and ethnic minority percentages

Year – 2021	Births	% ethnic minority
Denmark Hill	4388	34.09
PRUH	3988	22.8%

Whilst the birth rate has fallen nationally, the complexity of women seen has increased within both departments. In addition, the ethnic minority percentages, which have remained constant at DH are increasing at PRUH. As complexity and care pathways for ethnic minorities are key factors for the provision of care in accordance with the long term plan, the department agrees with the findings of Birthrate + and requests that the staffing increases proposed within the document are taken into consideration by QPPC in order to provide safe care to all our women and birthing people.

Current staffing levels

Current midwifery establishment: 429.58 (including Ockenden) .Vacancy rate in February 2022 was 9.62% for Midwifery and 13.22% for support staff. There is ongoing recruitment and most of the vacant midwifery posts have been filled. There is an advert out currently for support staff recruitment.

Recruitment plans

Cross site rolling recruitment is now embedded with recruitment plans for the coming year outlined below.

Opens	Closes	Interviews
14th March	27th March	WC 4th April
9th May	22nd May	WC 30th May
4th July	17th July	WC 25th July
29th August	11th September	WC 19th September

Workforce action plan

Issue	Plan	Timescale
Recruitment	Cross site rolling recruitment implemented for Band 6's on an 8 weekly cycle. Additional recruitment cycles added timed specifically to capture Band 5 midwives at point of qualification (April/September) International recruitment commenced – 10 midwives recruited in initial cycle to start in post April-July 2022. Refugee recruitment being scoped as potential recruitment option	Ongoing April-July 2022

Issue	Plan	Timescale
Retention	Posts added to the Education Team to provide clinical and pastoral support: 1.2 WTE Band 6 Clinical Practice Facilitators per site working in a supernumerary capacity to support the work of the PDM in the clinical area. Working alongside individual midwives to support them in specific clinical skills and offering clinical skills teaching sessions. 1 WTE Retention support midwife per site to work with a focus on clinical and pastoral support of early career midwives including preceptees, Return to Practice (RTP) midwives, and internationally educated midwives. Career development pathways being developed for each Band and career clinics being set up. Local exit interview process being commenced PMA team recruited, trained & launched to support staff and student practice and wellbeing Strengthening staff training and development processes – see below	March 2022 March 2022 June 2022 December 2021

Issue	Plan	Timescale
Education	Review of Education Team structure to ensure fit for purpose. Addition of new Education Team roles as above. Work with Corporate Nursing team to write trust-wide CPD process ensuring standardised transparent approach to allocation of CPD monies – will commence from April 2022 Midwifery education mapped against NHSE Core Competency Framework & 3 year plan developed. Annual TNA developed to inform CPD spend – commissioned courses agreed due to both service and professional development needs.	Ongoing Ongoing April 2022 Plan complete, implementation ongoing March 2022

Current pipeline

- 18 new midwives recruited in March
- PRUH Fetal Surveillance mw – March appointment
- Inpatient matron team restructure finalised in March
- Practice development midwife team extension – March recruitment
- Capital Midwife consortium – international recruitment – 10 midwives April-June 2022

Ockenden Maternity award and staff utilisation

21.27WTE was requested in the Ockenden maternity safety bid submitted on 6th May 2021 .The Trust was awarded 11.1 WTE which has now been added to the budgets for ongoing recruitment.

There is still a staffing deficit of 10.17 WTE .The department have submitted business cases to support safety and wellbeing within the care group and these, if approved will account for this deficit.

The department is also looking at more creative work patterns and on call arrangements to ensure robust staffing for community and labour ward and post-natal.

The department will seek to continue provide 6 monthly assurance to QPPC that, safe staffing levels and retention strategies are implemented and monitored.

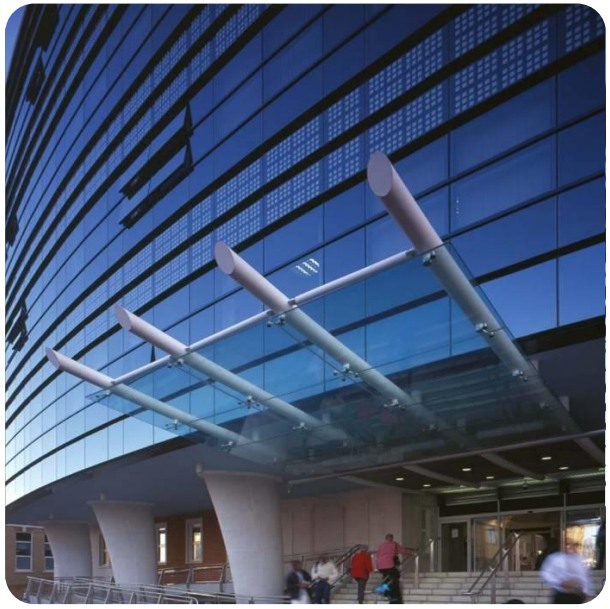
King's College Hospital NHS
NHS Foundation Trust

3 Monthly Safer Staffing Report for Nursing and Midwifery

November 2021 – January 2022

Trust Board March 2022

Nicola Ranger
Chief Nurse



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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 (relaunched post COVID in June 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 80 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 2022, the most recent data currently available on BIU (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
89%	93%	87%	102%	7.2	3.1	10.2

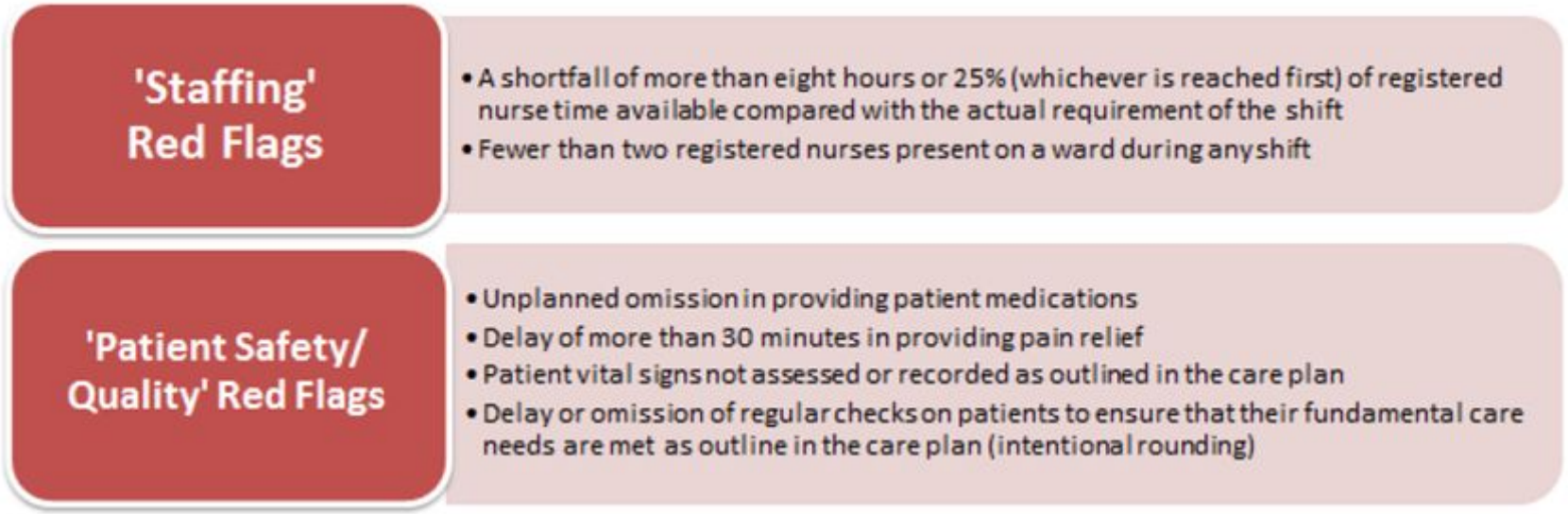
- Total CHPPD at 10.2 is reasonable although lower RN/Midwives fill rates are noted due to some clinical areas not achieving planned staffing levels due to vacancies/sickness and raised levels of maternity leave particularly due the to Omicron spike over the festive period. Staffing levels are maintained through relocation of staff, use of bank staff and where necessary agency staff to ensure safety.
- There is a raised unregistered Care Staff fill rate for nights due to ongoing 1:1/specialing needs. Work to address this is included as part of the ongoing N&M workforce reviews in collaboration with Heads of Nursing and the Associate Director of Nursing for Mental Health. It should also be noted this continued to reduce from 105% at the last 3 month review and 110% prior.

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.

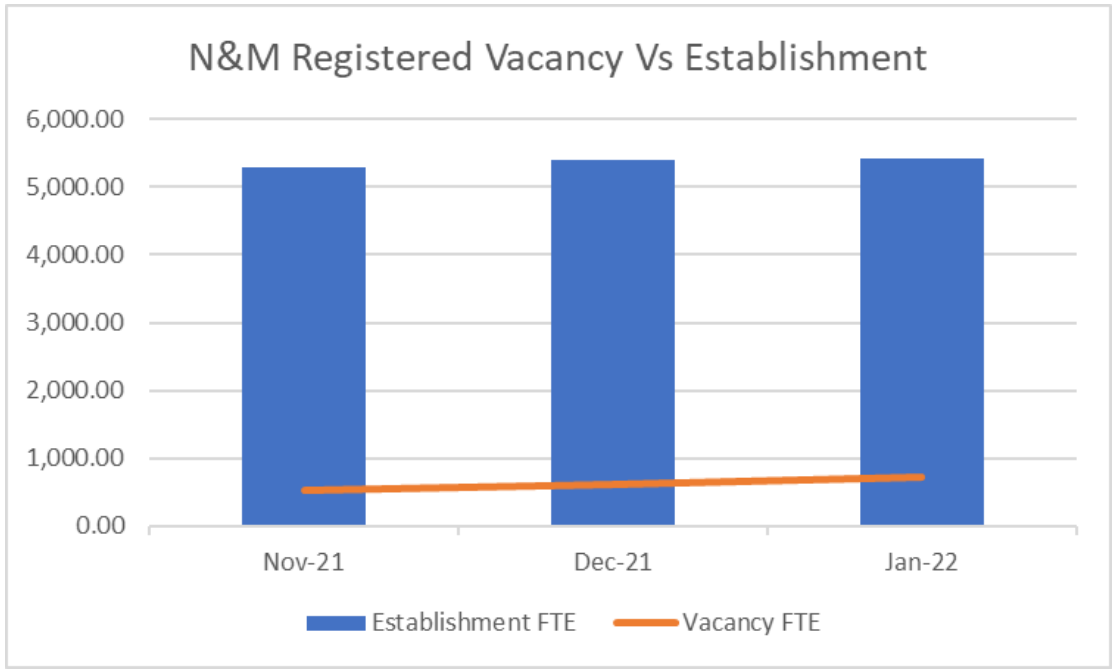


- The purpose of a Red Flag being raised is to identify those times where either essential nursing care has not been delivered, or where there is a risk that the quality of patient care may be impacted. If clinical areas do not have enough nurses on duty with the right skills to safely meet the needs of your ward/unit, they will raise a Red Flag. This data is accessed and validated by the HoNs and shared at N&M Workforce Governance.
- <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

Registered N&M Vacancies

King's College Hospital NHS Foundation Trust

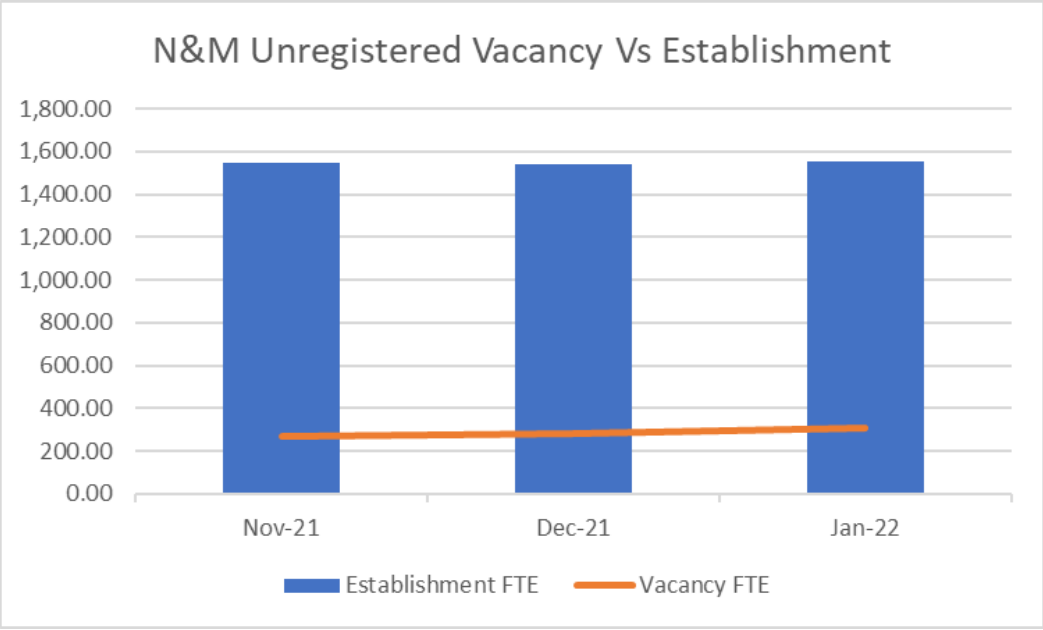
- The current vacancy for January 2022 is 13.48% for registered Nursing and Midwifery staff.
- The Trust's national N&M recruitment campaign (with TMP) fully launched in Nov 20-Jan 21. This award-winning campaign is now in the process of being revised and relaunched with new images and targeted print and media adverts in late spring 2022
- **Registered vacancies have risen slightly between Nov-21 – Jan-22:**
  - Post Wave 1 of COVID-19 we have seen the return of the Trust's usual international recruitment activity however, there are still some restrictions in place which has marginally affected the vacancy rate and will continue to do so until these are fully lifted.
  - Local NQN recruitment has also been impacted by Covid-19 as clinical placements were deferred/interrupted – a wider wave of NQN's throughout spring/summer 2022 is expected rather than the singular peak in usual years



HCA & CSW Vacancies

King's College Hospital NHS Foundation Trust

- The current vacancy for January 2022 is 17.5% (272.03 FTE) for unregistered Nursing and Midwifery staff bands 2-3.
- **Unregistered vacancies have risen slightly between from Nov-21 – Jan-22:**
  - HCA advertising, recruitment centers and widening participation work has been increased in line with the national drive to reduce Health Care Support Worker vacancies to 0%.
  - The Trust has commenced on NHSI/E direct support programme for the recruitment of health care support workers
  - Following benchmarking with local trusts Maths and English pre-assessment has now been removed and a focus on values-based recruitment implemented alongside increased post recruitment educational support
  - Following these improvements a pipeline of 102 positions were recruited in January 2022 with 18 commencing in the organisation in February. An 3 additional inductions planned for march to accelerate onboarding of these candidates.

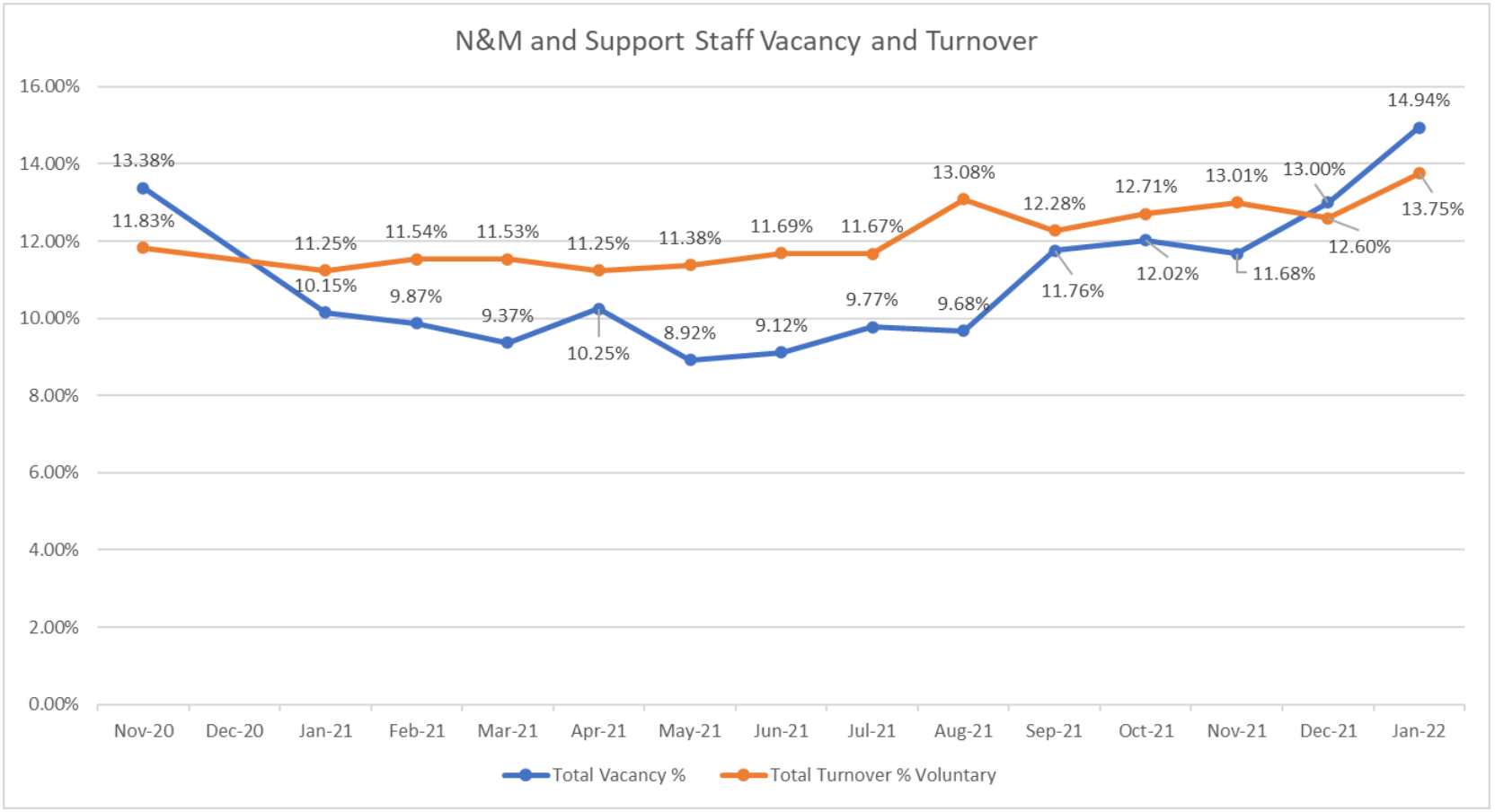


Nursing and Midwifery Turnover

King's College Hospital NHS Foundation Trust

As of January 2022, the voluntary turnover for registered nursing and midwifery staff is 12.55% and is currently 17.97% for the unregistered workforce. The monthly Trust wide N&M Workforce Governance meeting will monitor vacancies alongside care group-specific recruitment and retention work plans with the aim to reduce registered vacancies below 10% and reduce total voluntary turnover to 10% by the end of 2022.

The graph below outlines the current position:



7

Recruitment Hotspot & Next Steps

King's College Hospital NHS Foundation Trust

The aggregate nursing and midwifery staff vacancy for January 2022 is 14.94%. This represents an increase from November 2021. The current N&M hotspots are outlined below, plans for these areas are being actioned departmentally with support from the divisional recruitment partners and will be flagged at monthly site based recruitment meetings.

As of January 2022 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 several department with a total vacancy rate above 20%

Inpatient areas with a vacancy rate above 20% are listed below:

- **DH:** Guthrie Ward (28.23%)
- **DH:** CCU Sam Oram Ward (20.12%)
- **DH:** Children Surgical Ward (21.74)
- **DH:** Adult ED Nurses (28%)
- **DH:** Paediatric ED Nurses (23.23%)
- **DH:** Katherine Monk ASU (22.65%)
- **PRUH:** Frank Cooksey Rehab Unit (21.44%)
- **PRUH:** Churchill Ward (22.52%)
- **PRUH:** Elizabeth Escalation Ward (20.13%)
- **PRUH:** Medical Units 4 (22.88%)
- **PRUH:** Stroke Ward PRUH (20.50%)
- **PRUH:** ED PRUH Nursing (26.01%)
- **PRUH:** Medical 7 PRUH (25.76%)
- **PRUH:** Chartwell CDU PRUH (27.83%)

The Trust wide N&M Workforce Governance 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
- There are robust divisional-specific recruitment plans to support hot spot areas, pipelines have been created for each care group with a number of Bands 2-7 staff currently on-boarding waiting to fill Trust 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 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 2022

Recruitment:

- Increased HCA interview dates and revised interview questions in line with values based recruitment saw positions 68 offered in January 2022 via rolling recruitment
- Undertaking the NHSI/E HCSW direct support programme to support the accelerated recruitment of HCSW into our vacancies
- Workforce transformation: Planned revision and relaunch of NA programme in September with planned cohort of 30 positions and targeted cluster placement of trainees to ensure their roles are embedded into everyday clinical workforce
- International nurse recruitment: recent IEN deployments Dec – 21 IENs, Jan – 7 IENs, Feb – 34 IENs. In addition, 21 IENs took their OSCE in Feb with 11 passing on 1st attempt – we have also recruited 6 refugee nurses as part of new NHSEI programme
- Recruitment events & widening participation
- HR and N&M teams attending face-to-face recruitment events following relaunch post easing of COVID-19 restrictions
- Widening participation work ongoing in the local community with organized visits to Sixth Form Colleges & Job Centres
- HCA Recruitment event at the Oval on 26th February saw 98 attendees, 83 on the day interviews and approx. 40 job offers – next recruitment event is planned at the PRUH for Saturday 4th April
- 50+ Non host NQNs are scheduled for interview in coming weeks and revised recruitment and onboarding process commences in March for our 123 host NQN's who have already accepted conditional job offers to join us in Q2/3

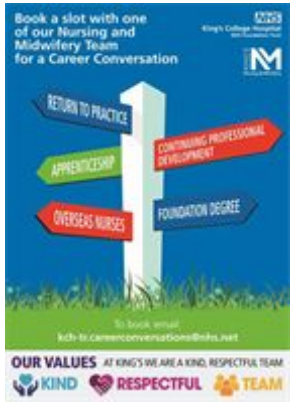
Recruitment & Retention Next Steps

King's College Hospital NHS
NHS Foundation Trust

Target - 10% vacancy RN and HCA turnover by the end of 2022

Retention:

- Career conversations, have been relaunched with a focus on widening access and flexible digital delivery to N&M staff at all clinical levels
- Career taster evenings are planned for late spring early summer to offer our registered nurses insights into some of the wider career opportunities they can access within the organisation outside of the traditional ward structure
- drop-in clinics and Local Faculty Groups are ongoing with our unregistered and newly registered practitioners cross site which feedback into the local education boards
- Preceptorship: Preceptorship team are working with IEN team to launch a dedicated IEN Preceptorship programme which focuses on helping orientate them to the NHS while crediting their extensive experience as healthcare practitioners
- Education and training: Revised application process with increased transparency to apply for funding is now in place and a reworked KAM model is being used to ensure improved dialogue with academic partner institutions
- IEN's Following the success of IEN graduations biannual dates are being planned to act as both a celebration of their accomplishment but also as conference dates for CPD
- Starting with the December 2021 cohort increasing pastoral care has been made available to onboarding IEN's with a focus on increased weekend and on call support during their pre-OSCE period



King's College Hospital NHS Foundation Trust

Report to:	**Board of Directors**
Date of meeting:	**10 March 2022**
Author:	**Sophie Whelan, Director of Corporate Affairs**
Executive Sponsor:	**Professor Clive Kay, Chief Executive**
Subject:	**Development of the Board Assurance Framework (BAF)**

This report is for (tick as appropriate):			
Decision	**Discussion**	**Assurance**	**Information**
x	**x**		

Executive summary

The Trust's Board Assurance Framework (BAF) has been refreshed following a series of Board strategic risk sessions to align the BAF with the Trust's *Strong Roots, Global Reach* strategy and to strengthen board level oversight of strategic risk.

The refreshed BAF, as at Quarter 3 2021/22, is included for review and approval.

Introduction

The BAF connects an organisation's strategic objectives to risk management and assurance arrangements. It summarises the potential risks impacting the achievement of the organisation's strategic objectives and the key controls and processes in place to manage the key risks. A good BAF supports the Board's understanding of the effectiveness of the key controls and mitigations in place to manage strategic risk and, as a result, supports oversight of the delivery of the Trust's strategic objectives.

Development of the KCH BAF

The launch of the Trust's *Strong Roots, Global Reach 2021-2026* strategy in 2021 and the development of the supporting delivery plan provided an opportunity for the Board to review the strategic risks facing the Trust and its risk appetite.

In November 2021, a 'Next Steps' paper was developed to identify a series of actions to review and refresh the Trust's BAF reporting arrangements to reflect the *Strong Roots, Global Reach* strategy and strengthen board level oversight of strategic risk.

A Board strategic risk session was held in December 2021 to support the delivery of the actions identified.

The format of the BAF has been refreshed and the detail for each of the ten strategic risks has been developed to:

- map the Trust's key controls and sources of assurance to each strategic risk;
- identify the current risk scoring based on the Trust's likelihood/ consequence framework;
- identify any gaps in controls and/or assurances; and
- identify the actions required to address any significant gaps in controls and/or assurances – this work is ongoing in line with the continued development of the Trust's strategy delivery & implementation plan.

There are currently 10 strategic risks included on the BAF. Four of the 10 risks are rated 'Red' at 20 or 16 including:

- Recruitment & Retention (BAF 1);
- Financial Sustainability (BAF 3);
- Maintenance and Development of the Trust's Estate (BAF 4); and
- Demand and Capacity (BAF 9).

Review and oversight of the BAF

The Trust's internal processes have also been refreshed to support the ongoing development of the BAF. The key controls, assurance and actions for each of the strategic risks will be reviewed regularly and any changes will be reported to the Executive Risk and Governance Committee for review.

The BAF and a summary of any significant amendments will be presented to the Trust Board on a quarterly basis.

Recommendation

The Board of Directors is asked to receive and approve the refreshed Board Assurance Framework.

King's College Hospital NHS Foundation Trust

Board Assurance Framework

Summary - Q3 2021/22

Ref	Risk Summary	Executive Lead(s)	Assurance Committee	Current risk (LxC)	Change from previous quarter	Target Risk Score*
1	**Recruitment & Retention** If the Trust is unable to recruit and retain sufficient staff with the appropriate skills, this will affect our ability to deliver our services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience	Chief People Officer	Quality, People & Performance	**20 (5 x 4)**	↔	12
2	**King's Culture & Values** If the Trust does not implement effective actions to develop the 'Team Kings' culture and embed the Trust values, staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other	Chief People Officer & Director of Equality, Diversity & Inclusion	Quality, People & Performance	**12 (3 x 4)**	↔	9
3	**Financial Sustainability** If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver our investment priorities and improve the quality of services for our patients in the future	Chief Finance Officer & Executive Director of CEF	Finance & Commercial	**16 (4 x 4)**	↔	8
4	**Maintenance and Development of the Trust's Estate** If the Trust is unable to maintain and develop the estate sufficiently, our ability to deliver safe, high quality and sustainable services will be adversely impacted	CFO & Executive Director of CEF	Major Projects	**16 (4 x 4)**	↔	8
5	**Apollo Implementation** If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised	Chief Digital Information Officer	Major Projects	**12 (3 x 4)**	↔	9
6	**Research & Innovation** If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre	Chief Medical Officer	Strategy, Research & Partnerships	**9 (3 x 3)**	↔	6
7	**High Quality Care** If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm	Chief Nurse & Executive Director of Midwifery	Quality, People & Performance	**12 (3 x 4)**	↔	6
8	**Partnership Working** If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities	Chief Executive	Strategy, Research & Partnerships	**9 (3 x 3)**	↔	9
9	**Demand and Capacity** If the Trust is unable to restore services (as a result of the COVID-19 pandemic) and sustain sufficient capacity to manage increased demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm	Site Chief Executive DH & Site Chief Executive PRUH/SS	Quality, People & Performance	**16 (4 x 4)**	↔	9
10	**IT Systems** If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems and/or the loss of data	Chief Digital Information Officer	Audit	**12 (3 x 4)**	↔	4

- **Current risk –** the risk remaining after the controls put in place to mitigate the gross (inherent) risk have been applied. The risk score is calculated by multiplying the likelihood score (1 to 5) by the consequence/ impact score (1 to 5).

- **Target risk –** the acceptable risk score based on the Trust's risk appetite for the risk type

- **Change from previous quarter:**

Change	Description
↑	The current risk score has increased since previous quarter
↓	The current risk score has decreased since previous quarter
↔	The current risk score is consistent with previous quarter

BAF 1				20
If the Trust is unable to recruit and retain sufficient staff with the appropriate skills, this will affect our ability to deliver our services and future strategic ambitions which may adversely impact patient outcomes and staff and patient experience				
Executive Lead	Chief People Officer	Assurance Committee	Quality, People & Performance Committee	
Executive Group	People and Culture Committee	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred		Link to BAF & CRR	SR2 – Culture & Values 3866- Medical Staffing Vacancies 3941 – Delay to treatment in ED 5209 – Vaccination as a condition of deployment
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			5		↔	5	12
Consequence			4			5	
Risk Score			20			25	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Dedicated recruitment campaigns for specific services e.g. Cancer services • International recruitment programme • Nursing Workforce Governance Group oversight • Temporary staffing arrangements – working with external partners as required • Working from Home policy to support flexible working arrangements • Redeployment programme (temporary support) • King's Stars – reward and recognition programme • Staff health and wellbeing programme (See BAF 2) • Engagement in ICS and APC workforce groups • Engagement in King's Health Partners (KHP) – training and development opportunities •	• Safer staffing reporting to QPP and Trust Board • Quarterly Guardian of Safe Working report to QPPC • Integrated Performance Report –staff turnover rate, vacancy rates, and appraisals metrics reviewed by KE, QPPC and Trust Board • Annual National Staff Survey results • Quarterly Staff Pulse Survey results
Gaps in controls & assurances	
• Talent management and succession planning • Leadership development • People and Culture enabling strategy • Vaccination as a Condition of Deployment (VCOD)	

Actions planned

Action	Lead	Due date	Progress update
Develop a People & Culture enabling strategy	CPO	March 2022	Draft strategy developed

Develop a plan to manage the operational delivery of VCOD and identify risks to service provision	CPO	January 2022	VCOD plan developed to deliver proposed legal requirements and identify risk to delivery of the service
Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2)	CPO	TBC	
Review and refresh of appraisal, talent management and succession processes	CPO	TBC	Draft plans to develop the 2022 appraisal process created
Development of leadership development programme and leadership coaching offer	CPO	TBC	
Establish an Apprenticeship Steering Group to support launch of Apprenticeship Strategy	CPO	Q4 2021/22	
Establish a training academy for KCH nursing and midwifery staff	CNO/CFO	TBC	A business case to establish a training academy has been approved

BAF 2				12
If the Trust does not implement effective actions to develop the 'Team Kings' culture and embed the Trust's values, staff engagement and wellbeing may deteriorate, adversely impacting our ability to provide compassionate and culturally competent care to our patients and each other				
Executive Lead	Chief Executive & Chief People Officer	Assurance Committee	Quality, People & Performance Committee	
Executive Group	People and Culture Committee	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred	✓	Link to BAF & CRR	SR1 - Recruitment & Retention 3942 – Bullying & Harassment
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do	✓	Team King's	✓		

Risk Scoring							
Quarter	Q1	Q2	Q3	Q4	Change	Gross risk	Target risk*
Likelihood			3		↔	4	9
Consequence			4			4	
Risk Score			12			16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• EDI training programmes e.g. Active Bystander • EDI activity plan 2021/22 and WRES/ WDES action plan • EDI - Staff networks • Staff wellbeing programme and site Wellbeing Hubs • Wellbeing Guardian and Champions network • FTSU Guardian and Ambassador network • Equality Risk Assessment Framework	• EDI quarterly progress reporting to QPPC • FTSU reporting to QPPC and Trust Board • National Staff Survey results • Trust Pulse Survey results • WRES & WDES scores • Progress reporting against the Model Employer goals 2028 (NHS People Plan)
Gaps in controls & assurances	
• EDI road map to align activity planning and our longer term strategic ambitions • People and Culture enabling strategy (see BAF 1)	• Composite culture measure • Health & Wellbeing Framework

Actions/ Activities planned

Action	Lead	Due date	Update
Develop an Inclusion Calendar for 2022	Director of EDI	February 2022	Inclusion calendar published w/c 24 January 2022
Develop an EDI roadmap to set out our longer terms plan for ensuring	Director of EDI	Q1 2022/23	Draft roadmap has been developed

diversity, equality and inclusion is “at the heart of everything we do”			
Review and refresh of workforce policies to embed our new values (See BAF 1)	Chief People Officer/ Director of EDI	TBC	
Develop an EDI reporting dashboard	Director of EDI	Q1 2022/23	
Develop a framework to better measure our culture and staffs’ sense of belonging	Director of EDI	TBC	
Development of violence and aggression reduction programme to support staff	Chief Nurse	TBC	The Trust has appointed a Violence Reduction Matron to support the design and implementation

BAF 3				16
If the Trust is unable to improve the financial sustainability of the services it provides, then we may not achieve our financial plans, adversely impacting our ability to deliver our investment priorities and improve the quality of services for our patients in the future.				
Executive Lead	Chief Financial Officer	Assurance Committee	Finance and Commercial Committee	
Executive Group	King's Executive	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	3943- Financial recovery targets
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability	✓		
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			4		↔	5	8
Consequence			4			4	
Risk Score			16			20	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Annual integrated activity and workforce financial plan • Capital prioritisation process – 2021/22 • Key financial system controls framework • Investment Board review and challenge of revenue and capital business cases. Board-level review of business cases >£1m • Financial performance review meetings – at Care Group and Site level • Vacancy/Pay controls incl. temporary staffing controls • ESR and Ledger reconciliations • SOF 4 Exit plan • Financial forecasts • Transformation & improvement programme – efficiency and productivity • Budget holder training	• Performance reporting – KE, FCC & Board • Achievement of break-even H1 plan and on-track to achieve H2– 2021/22 • SOF 4 Exit progress updates • Clean External Audit accounts and VFM opinion – 2020/21 • Internal audit reports 2020/21 including COVID-19 Financial Governance (*significant assurance with minor improvement opportunities*) • External Counter Fraud reports
	• Underlying financial position – c.(£268)m for 21/22
	• Internal audit reports 2021/22 - Financial planning / budgetary responsibility
Gaps in controls & assurances	
• The Trust is awaiting confirmation of 2022/23 financial allocations and future funding framework. • Longer-term financial planning (as above)	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Review and refresh of Scheme of Delegation and SFIs	CFO/ DCA	Q4 2021/22	
Engagement with APC and ICS partners & Finance Leads	CFO	Ongoing	
SOF 4 dialogue with national, region and ICS	CFO	Q1 2022/23	
22/23 plan development (£, activity, WTE and efficiency)	CFO	April 2022	Planning guidance issued, draft plan to be submitted in March 22.

BAF 4				16
If the Trust is unable to maintain and improve the estate sufficiently, our ability to deliver safe, responsive, high quality and sustainable services will be adversely impacted				
Executive Lead	Chief Finance Officer	Assurance Committee	Major Projects Committee	
Executive Group	Investment Board/ Risk & Governance	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	4191 – Non-compliance Health & Safety at Work Act 4472 – Nosocomial CV-19 infections 4524 – Fire Safety 4975 – Infection control (estate) 5017 – Ventilation and air handling
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability	✓		
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			4		↔	5	8
Consequence			4			5	
Risk Score			16			25	

Controls and Assurance	
Key controls & mitigations	**Assurances**
Maintenance • Estates/IPC ward-level risk assessment and prioritisation • Fire Risk Assessments • Water safety management service arrangements • IPC Committee – risk and governance arrangements • IPC audits and sampling • Bi-monthly Health & Safety Committee – review of estates H&S risks **Development** • Capital planning and prioritisation process 21/22 • Modernising Medicine programme and capital build schemes in progress – to increase support patient flow and increase physical site capacity	• Estate risk assessment progress reported to Risk & Governance and QPP • H&S training compliance • IPC BAF • Internal audit 21/22 – Infection, Prevention & Control • Quarterly capital programme progress updates reported to Major Projects Committee • Estate (site) compliance report • Internal audit review 20/21 – Estate safety and compliance • Backlog maintenance log – funding requirement • Internal audit 21/22 – Infrastructure investment
Gaps in controls & assurances	
• Future capital and estate planning - capital funding allocation not confirmed for 22/23	

Actions planned

Action	Lead	Due date	Update

Implementation of external review recommendations	CFO	Multiple	
Development of 2022/23 capital & estates plan	CFO	TBC	

BAF 5				12
If the Trust fails to deliver the Apollo Electronic Patient Record (EPR) transformation programme effectively then the clinical and operational benefits may not be realised				
Executive Lead	Chief Digital Information Officer	Assurance Committee	Major Projects Committee	
Executive Group	Digital Technology Board	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	
	Outstanding Care	✓	Digitally- enabled	✓		
	Leaders in Research, Innovation & Education	✓	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			3		↔	4	9
Consequence			4			4	
Risk Score			**12**			16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Dedicated programme team and programme office • Executive SRO • Full Business case outlining the strategic case for change developed • Project plan – key milestones identified • Programme Governance arrangements in place e.g. Apollo Programme Board • Benefits realisation methodology developed • Clinical engagement in programme scoping	• Joint Executive Oversight Group (GSTT & KCH) reporting • Apollo Programme Board reporting • Programme status updates reported to Board via Major Projects Committee • External assurance through periodic gateway reviews
Gaps in controls & assurances	
• Final Board approval of the FBC following Joint Investment Committee approval – January 2022 • Benefits realisation plan	

Actions planned

Action	Lead	Due date	Update
Trust Board review of updated FBC	CDIO	Jan 2022	The FBC has been approved by the Trust Board.
Develop benefits realisation plan	CDIO	TBC	

BAF 6				9
If the Trust fails to capitalise on innovative and pioneering research opportunities, this may affect our ability to support the development of new treatments and technologies for patients now and in the future, adversely impacting the Trust's ambitions as a world-leading research and innovation centre				
Executive Lead	Chief Medical Officer	Assurance Committee	Strategy, Research & Partnerships Committee	
Executive Group	King's Executive	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	
	Outstanding Care		Digitally- enabled			
	Leaders in Research, Innovation & Education	✓	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			3		↔	4	6
Consequence			3			3	
Risk Score			**9**			12	

Controls and Assurance	
Key controls & mitigations	**Assurances**
• KCH Research & Innovation Strategy 2019-2024 and annual plans • Engagement in King's Health Partners (KHP), Academic Health Science Network and KHP Institutes • Action plans to improve the diversity of research participants and increase awareness and engagement in research design and delivery within our local community • Research & Innovation governance and risk management structure	• Annual strategy progress update reported to SRP Committee – progress aligned to key aims • Research progress metrics reported to SRP – e.g. number of approved commercial studies and trends • COVID research participation and participant diversity in vaccine trials
Gaps in controls & assurances	
• Physical capacity to participate in drug trials and trials requiring clinical research facilities • Longer-term research workforce model (linked to funding and investment planning)	

Actions planned

Action	Lead	Due date	Progress update
Develop plans to increase the Trust's accredited research capacity	CMO	TBC	

BAF 7				12
If the Trust does not have adequate arrangements to support the delivery and oversight of high quality care, this may result in an adverse impact on patient outcomes and patient experience and lead to an increased risk of avoidable harm				
Executive Lead	Chief Nurse	Assurance Committee	Quality, People & Performance Committee	
Executive Group	Patient Safety Committee	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	2919 – Failure to recognise the deteriorating patient 4460 – Harm from patient falls 4914 – Quality compliance
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			3		↔	5	6
Consequence			4			4	
Risk Score			12			20	

Controls and Assurance	
Key controls & mitigations	**Assurances**
• Risk management policy and procedures • Incident management policy and procedures • Quality governance and reporting structure • Site performance reviews to support oversight and escalation • Serious Incident Review group to oversee the investigation of and learning from incidents • Care group quality governance development programme 2021/22 - to support care groups progress governance and risk management arrangements • Corporate induction and programme of mandatory training for all staff • Appraisal, CPD and revalidation arrangements for registered professionals • Development of quality dashboards to provide real-time information to support decision-making • Apollo EPR programme (See BAF 5)	• CQC ED reports (DH and PRUH)– 2021 and action plan progress updates • CQC patient survey reports • Quality performance reporting to KE, QPPC and Board • Safe staffing reports presented to Public Board • Quarterly patient outcome reporting to QPPC • GGI reports – Review of Risk Management (October 2021) • Internal Audit reports 2021/22 – PALs (*Significant assurance with minor improvement opportunities*)
	• Incident reporting backlog • Outstanding complaints backlog
	• Internal Audit reports 2021/22 – Risk Management • External service reviews
Gaps in controls & assurances	
• Implementation of external review actions • Quality improvement assurance	

BAF 8				9
If the Trust does not collaborate effectively with key stakeholders and partners to plan and deliver care, this may adversely impact our ability to improve services for local people and reduce health inequalities				
Executive Lead	Chief Executive	Assurance Committee	Strategy, Research & Partnership Committee	
Executive Group	King's Executive	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF& CRR	BAF 9 – Demand and Capacity
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do	✓	Team King's	✓		

Risk Scoring (Current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			3		↔	4	9
Consequence			3			4	
Risk Score			9			16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• Trust relationship leads identified for key partnerships to ensure that the Trust is represented and engaged in relevant ICS and APC forums • Engagement and leadership of place-based partnerships e.g. One Bromley, Lambeth Together • KCH CEO is designated CEO lead for SEL APC • Active role in existing APC and ICS clinical and operational forums e.g. Clinical, Strategy & Operations, APC Finance • Engagement in SEL ICS and APC recovery programmes (See BAF 9)	• Regular updates to SRP and Trust Board regarding emerging ICS and APC governance arrangements and the Trust's role as a partner • APC Committee-in-Common progress reports • SEL APC Elective recovery performance • External Well-Led Review – March 2021
Gaps in controls & assurances	
• APC governance and decision-making arrangements are in development – target completion Q4 2021/22 • System planning arrangements – 2022/23	

Actions planned			
Action	**Lead**	**Due date**	**Update**
SEL APC governance framework to be development and agreed	CEO	March 2022	Draft proposals have been developed for review and approval

Establish a 'Trust Anchors' programme to align with ICS Anchors initiative and coordinate current 'anchor institution activities	Director of Strategy	TBC	

BAF 9				16
If the Trust is unable to restore services (as a result of the COVID-19 pandemic) and sustain sufficient capacity to manage increased demand for services, patient waiting times may increase, potentially resulting in an adverse impact on patient outcomes and experience and/or patient harm				
Executive Lead(s)	Site Chief Executives	Assurance Committee	Quality, People & Performance Committee	
Executive Group	King's Executive	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to CRR	270 – Elective waits 597 – Theatre capacity (Neurosurgery) 1178 – Care of MH patients 2679 - Ophthalmology demand and capacity 2739 – Theatre capacity (emergency) 3941 – Delay to Treatment DH ED 4297 – Non-delivery of ECS 5005 – Further COVID-19 waves
	Outstanding Care	✓	Digitally- enabled			
	Leaders in Research, Innovation & Education	✓	Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (Current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			4		↔	5	9
Consequence			4			5	
Risk Score			16			25	

Actions/Activities planned	
Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Command and Control arrangements to support COVID-19 incident management response – arrangements can be activated as required (i.e. in the event of further COVID waves) • Clinical prioritisation of waiting lists and patient engagement and status checks whilst on waiting list to minimise risk to patient safety • Use of virtual and telephone appointments • Use of outsourcing arrangements for some clinical services • Engagement in SEL ICS and APC recovery programmes e.g. theatre productivity • Modernising Medicine Programme - to create additional capacity and improve non-elective flows across the DH site • Estate programmes to increase physical capacity across sites e.g. Orpington Theatres • Workforce and recruitment planning to support increased workforce capacity (see BAF 1)	• Monthly Elective Assurance Group • Quarterly/ Monthly Site-Care Group reviews • IPR - performance metrics are routinely reported to KE, QPPC and Trust Board e.g. number of patients waiting > 52+/104+ weeks • Patient Outcomes report – quarterly presented to QPP • SEL APC elective recovery performance
	• IPR - performance metrics are routinely reported to KE, QPPC and Trust Board e.g. ECS
	• Internal Audit Review 21/22 – Site Governance • Internal Audit Review 21/22 – Discharge
Gaps in controls & assurances	
• Additional site and workforce capacity	

Action	Lead	Due date	Update
Complete an internal review of response to Omicron wave – further to the work completed following COVID Wave 1 and 2	Site CEOs	Q1 2021/22	
Capital investment and estate planning to support further decompression of the DH site and increased physical capacity across all sites	Site CEOs/CFO	TBC	Coldharbour Works – operational January 2022 See BAF Risk 4 (Estate maintenance and development)
Workforce planning and recruitment activities to support increased workforce capacity	CPO	Multiple – See BAF 1	See BAF Risk 1 – Recruitment & Retention
Engagement with APC/ ICS partners to develop and progress further plans to maximise use of system resources	Site CEOs	TBC	

BAF 10				12
If the Trust's IT infrastructure is not adequately protected systems may be comprised, resulting in reduced access to critical patient and operational systems, service disruption and/or the loss of data.				
Executive Lead	Chief Digital Information Officer	Assurance Committee	Audit Committee	
Executive Group	Risk & Governance	Latest review date	Q3 2021/22	

Strategy and Risk Register						
Link to Strategy	Brilliant People		Person- centred		Link to BAF & CRR	2956 – Data and Cyber security 4562 – Malware
	Outstanding Care		Digitally- enabled	✓		
	Leaders in Research, Innovation & Education		Sustainability			
	Diversity, Equality & Inclusion at the heart of everything we do		Team King's			

Risk Scoring (current)							
Quarter	Q1	Q2	Q3	Q4	Change from previous quarter	Gross risk	Target risk*
Likelihood			3		↔	4	4
Consequence			4			5	
Risk Score			12			20	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• Cyber security strategy • Cyber security & IT Use policies • Risk and governance arrangements - ICT Security Group and Information Governance Steering Group, chaired by the Chief Digital Information Officer • Mandatory data security and protection training for staff • Communication initiatives to increase staff awareness and understanding of potentials threats e.g. Phishing • Firewall perimeter covers all systems and application within the Trust Network • Automatic patch updates	• Information governance reports to Audit Committee • Data security and protection training compliance – c.93.3% completed at Dec 2021 • Cyber Security Internal Audit Review 2021/22 – *Significant assurance with minor improvement opportunities* • DSP toolkit assessment Internal Audit Review 2021/22 – *Significant assurance with minor improvement opportunities*
Gaps in controls & assurances	
Internal audit recommendations	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Implementation of internal audit recommendations	CDIO	Q1 2022/23	

King's College Hospital NHS Foundation Trust

Quality, People and Performance Committee
Minutes of the Quality, People and Performance Committee (QPPC) Meeting
Thursday 18 November 2021 at **09:30 – 13:15hrs**
MS Teams, Video Conference

Present:

Nicholas Campbell-Watts	Non – Executive Director (Chairing)
Dame Christine Beasley	Non – Executive Director
Professor Yvonne Doyle	Non – Executive Director (Part Meeting)
Sir Hugh Taylor	Trust Chairman
Professor Clive Kay	Chief Executive (Part Meeting)
Julie Lowe	Site Chief Executive Officer, Denmark Hill
Dr Leonie Penna	Chief Medical Officer
Mark Preston	Chief People Officer
Professor Nicola Ranger	Chief Nurse & Executive Director of Midwifery

In attendance:

Siobhan Coldwell	Associate Director of Corporate Governance
Diane-Kareen Charles	Assistant Director of Patient Safety
Patricia Mecinska	Assistant Director of Patient Experience
Roisin Mulvaney	Director of Quality Governance
Funmi Onamusi	Director of Equality, Diversity and Inclusion
Claire Palmer	Head of Patient Outcomes
Emilie Perry	Director of Operations, PRUH & South Sites
Adam Creeggan	Director of Planning and Performance
Sophie Whelan	Director of Corporate Affairs
Shereen Cameron	Head of Midwifery, PRUH
Dr Nitish Narvekar	Clinical Director in Women's Health
Jacqueline Coles	Freedom to Speak Up Guardian
Sonia Colwill	South East London CCG (Observer)
Hillary Entwistle	Southwark Governor (Observer)
Tara Knight	Corporate Governance Officer (Minutes)

Apologies:

Professor Jonathan Cohen	Non – Executive Director (Chair)
Jonathan Lofthouse	Site Chief Executive Officer, PRUH & South Sites

Item	Subject	Action

21/111 Introduction and Apologies

Apologies were received and noted for Professor Jonathan Cohen, Non – Executive Director and Chair of QPPC and for Jonathan Lofthouse, Site Chief Executive Officer, PRUH & South Sites.

The Chair welcomed Dame Christine Beasley and Professor Yvonne Doyle as new Non-Executive Directors to the Committee.

21/112 Declaration of Interests

No interests were declared.

21/113 Chair's Action

There were no actions for the Chair.

Item	Subject	Action

21/114 Minutes of Previous Meetings

The Committee noted the minutes of the previous meeting held on 30.09.2021 and accepted them as an accurate record of the meeting.

21/115 Action Tracker/Matters Arising

The Committee reviewed the action tracker and received a number of updates, which have been reflected on the tracker.

21/116 Immediate Items for Information

Higher Education England (HEE) Visit
HEE visited the PRUH in May, shortly after COVID Wave 2. HEE triangulate with the GMC survey, which has been deteriorating at the PRUH. Improvement areas included rostering – understaffing, redeployment and supervision. The Trust has since moved to a new rostering system, however further work is required Work has commenced to recruit Physician's Associates.

HEE has begun another inspection within Medicine at the PRUH today to review the training doctors receive there. A significant amount of work has been completed to improve training at the PRUH. HEE will be interviewing trainee doctors and provide feedback tomorrow afternoon.. The Chief Medical Officer and Chief Executive Officer will be presenting to HEE tomorrow. The Committee will be updated on the feedback received. **L Penna**

Ambulance Handovers
There has been significant interest in ambulance handover times from NHS England. There is real concern that some patients that are assessed as requiring an ambulance are waiting very long times for an ambulance to arrive. NHS England have notified organisations to implement a zero tolerance approach in order to release LAS staff to respond to emergencies and bring waiting times more in line with expected standards. Both sites have submitted action plans.

Delays with handover from LAS staff are caused when there are either extended delays in ED staff attending to receive the patient, or when patients are unable to be moved from the vehicle because there is no trolley or cubicle available in ED for the patients to be transferred to.

The Trust has participated in recent pilots with LAS where postcodes are assigned to hospital locations with the view of making it easier to offload. Thirty and sixty minute handover delays will be routinely included in the IPR so that the data is more visible to the Executive team and the Board. The Trust has also agreed with the Chief Executive Lead for South East London to complete a wider piece of work from a system perspective. **J Lowe**

21/117 COVID-19/Vaccination Programme Update

The Site Chief Executive for Denmark Hill updated the Committee on the COVID-19 status and the Vaccination Programme at the Trust. The following was noted:

- The number of COVID-19 cases at the Trust remains fairly stable. There is, however, a Critical Care Unit and 2 wards of COVID-19 patients on both sites.
- Whilst those patients that are vaccinated are less unwell, there has been a small number of patients that are double/triple vaccinated but have still

Item	Subject	Action

required admission. The Trust continues to encourage social distancing and has recently issued guidance on festive gatherings.

- The COVID-19 vaccine will be mandatory for certain groups of NHS staff from April 2022, which will mean that staff affected will need to have their first dose by February 2022. The Trust will not force any staff member to take the vaccine, however it will become a legal requirement to have the vaccine for certain roles. Currently, it is unclear which staff groups will be mandated to have the vaccine.
- The vast majority of staff have had the vaccine, however, there is a significant minority who have not. Rates are higher amongst black African staff and those in junior grade posts, specifically, Healthcare Assistants and Midwives. The Trust is in the process of formalising an impact assessment.
- It is also currently unclear as to whether contractors (cleaners, porters) will be mandated to take the vaccine.

Action: An update on the staff groups that will be legally required to have the COVID-19 vaccine will be circulated to the Committee once guidance has been published. — **J Lowe, M Preston**

The Chief People Officer provided the following update to the Committee:

- There are currently around 1300 staff members that have not taken up the COVID-19 vaccine. In Social Care, following the implementation of mandatory COVID-19 vaccines, the uptake increased significantly.
- There may be a significant group of around 500/600 staff members that may choose to remain unvaccinated and will need to be redeployed. Challenges are expected in finding suitable alternative employment, particularly for highly skilled professionals. A shared redeployment job process has been discussed at ICS level.
- If the Trust is unable to redeploy staff, the next stage will be dismissal. This process will begin from February as staff will need to have had their first dose by then in order to be double vaccinated by April 2022. NHSE/NHSI are yet to formally publish guidance on what the process will look like.
- The Trust continues to encourage staff to take up the vaccine.

Action: In relation to mandatory COVID-19 vaccinations, an impact assessment will be provided to the Committee once the data becomes available and is finalised. — **M Preston**

QUALITY

21/118 Maternity Service Review

The Committee received and noted the Maternity Staffing report. The head of Midwifery at the PRUH updated the Committee on the following:

- The report outlines the current progress in maintaining safe midwifery and staffing levels at the Trust and performance against national objectives to improve outcomes in relation to maternity care. The Trust uses the nationally recognised tool Birthrate Plus, which provides national benchmarking data as well as data that may be harder to calculate, for example, woman with social needs, women with mental health problems and enhanced neonatal care needs.
- The tool provides the data for regular activity reports, which enables the service to carry out local analysis, staffing reviews and provides guidance for developing escalation pathways.

Item	Subject	Action

- The last full scale staffing review was completed in 2015. The current report shows that, since then, at both Sites, the acuity and complexity of women has increased significantly to levels higher than the national average acuity need. At Denmark Hill, there has been as increase by 20% and at the PRUH Site, 10%.
- Both departments have remained short staffed with a shortfall of 21 midwives across both sites. The Trust has now received funding for 11 full time equivalent Midwives. Recruitment has started for 9 Midwives at Denmark Hill and 8 Midwives at the PRUH. Due to the current number of vacancies, the establishment will be reviewed.
- It has been particularly challenging to recruit experienced Midwives, which makes staff retention and the support of newly qualified Midwives a priority. The Preceptorship Programme for Midwives has been reviewed and is likely to be extended. The Trust has taken on the maximum number of students. There is also a national programme to recruit international Midwives and the Trust is part of a pilot to recruit 10 international Midwives.

Action: The Committee requested that future reports include risks related to staffing issues within the Service and how they are being managed. **N Ranger**

The Clinical Director for Women's Health and the Head of Midwifery at the PRUH presented an update, giving the Committee an overview of risks, patient outcomes and Serious Incidents within the Service. The Committee discussed ensuring that Serious Incident data reporting includes whether the incidents lead to any harm.

21/119 CQC Update – Denmark Hill Emergency Department

The Committee received and noted the update on the CQC feedback following an inspection of the Emergency Department at Denmark Hill.

An updated, detailed action plan, which sets out timescales for delivery, has been submitted to the CQC. This action plan has oversight from the CQC Operational Committee, which meets on a monthly basis.

Monthly Quality Walk Abouts have now been introduced as part of a structured framework with Site Executives and Clinical Leads. The Walk Abouts review compliance around environment as well as providing a forum for leadership to speak with patients and staff.

21/120 Patient Safety/Duty of Candour Report – Quarter 2

The Committee received and noted the Patient Safety Report for quarter 2.

There will be a presentation to the Board on the 9th December regarding the action plan to reduce incidents relating to violence and aggression. Work is taking place with the BIU team to further understand the reporting around security. Further work continues in order to contextualise Serious Incident data in terms of mortality and patient outcomes. Early discussions are being held with the Shelford Group regarding benchmarking data in this area.

Duty of Candour performance has declined in quarter 2. There remains delays in CCG sign off who have an action plan to address the backlog.

21/121 Patient Experience Report – Quarter 2

The Committee received and noted the Patient Experience Report for quarter 2.

Item	Subject	Action

The Chief Nurse and Committee commended the Assistant Director of Patient Experience and the team for the work that has taken place to reduce the complaints backlog and improve patient experience.

21/122 Quality Account Priorities – Progress Report

The Director of Quality Governance presented an update to the Committee on progress with the Quality Accounts. The following was noted:

- **Reducing Harm to Deteriorating Patients**: There has been a change in leadership with the recruitment of an Assistant Director of Nursing for Patient Safety to focus the approach and align with the Patient Safety Framework. There has been some progress in terms of identifying the key data points and developing a training package to support staff. A task and finish group has been set up with the new leadership team with a view to restarting the Deteriorating Patients Committee.

- **Long COVID**: The teams continues to see a significant number of patients in clinic. The outcomes data for these patients is currently being collected and teams will be in a better position to report on the data in quarter 3 and 4.

- **Improving Patient Experience for Inpatients**: The Trust has been successful in compliance with the action to improve the score for patients receiving emotional support from staff. The Trust has also achieved the action to attain 96% on the Friends and Family Test recommendation rate across all inpatient services. Work continues to increase the Friends and Family Test response rate to 20%. It is expected that the new entertainment system roll out will begin by the end of quarter 3.

- **Reducing Violence & Aggression**: The focus has been on enhancing learning and development pathways for staff. The Trust has been working closely with SLaM to roll out training to manage complex patients. The team has been liaising with front line staff, particularly in hotspot areas, in order to tailor the training and support available. A full update on the work taking place to reduce violence and aggression will be presented to the Board next month.

21/123 Patient Outcomes Report – Quarter 2

The Head of Patient Outcomes presented the Patient Outcomes Report for quarter 2.

The high level Trust outcomes, mortality and risk adjusted readmissions, are within the expected range or better than expected range. The National Stroke Audit poor result is driven by the percentage of patients admitted to a stroke unit within four hours. The NHSE/NHSI annual quality HASU review highlighted the issue but concluded that overall care for patients with strokes was very good. Detailed action plans are in progress on both sites to address the issue. The outcomes for stroke, in terms of risk adjusted mortality, are better than expected. This process indicator impacts negatively on patient experience but not in terms of mortality.

The audit shows that the Trust should meet the Thrombolysis targets at both sites, which very few units in the UK achieve. This is probably one of the significant reasons why the Trust is seeing good outcomes and is indicative that patients are receiving the right treatment in ED.

Item	Subject	Action

Two external outlier alerts were received in relation to bowel cancer. The reviews have now been completed and no significant quality of care issues were identified. The alert that was raised for the PRUH site was withdrawn by the National Audit as it was driven by a data error on their part.

The Committee acknowledged the Trust's excellent outcomes data and recommended that this good news story should be consistently promoted.

21/124 Bone Marrow Transplant Service Review

The Chief Medical Officer presented an Executive Summary following an external review of the Bone Marrow Transplant Service.

The Royal College of Physicians undertook an invited review of the Haematology Service in March 2020. One of the recommendations was to commission a further external quality review of the Bone Marrow Transplant Service. This review took place earlier this year and identified no significant quality issues. The final report is yet to be published, however, no material changes are expected in the full report.

Reviewers commented on the physical environment of the lab, which will require medium to long term investment. This will be raised through the appropriate channels. The specific recommendations highlighted under the quality governance framework and shared care and patient pathways should be also be pursued.

Action: The Chair of QPPC will write to the Chair of the Haematology Programme Board to confirm that the QPPC Committee has reviewed the report and is satisfied. The Committee recommends that the Haematology Programme Board move forward with the recommendations from the review at pace. — **J Cohen, L Penna**

21/125 King's Dubai Quality Review

This Committee received the summary report of the findings of the September 2021 quality visit to KCH Dubai. Site visits were suspended during the pandemic, and the September 2021 marks the first visit since November 2019.

KCH Dubai have their own quality management system and JCI accreditation. No significant quality concerns were identified and work has started towards obtaining the 7th edition of the JCI accreditation standards.

The Committee discussed the reporting and assurance arrangements in relation to the Trust's commercial activities.

Action: The Chair of QPPC, Chair of the Finance and Commercial Committee (FCC) and the Chief Financial Officer are to make a decision as to whether the King's Dubai Quality Reviews will go to FCC or QPPC in future. — **J Cohen, S Slipman, L Woods**

Break 11:25 – 11:40am

GOVERNANCE

21/126 Red Risk Review: 52-Week Wait List

The Director of Planning and Performance presented an update on the long waiter delivery strategy. The Committee noted the following:

Item	Subject	Action

- A number of different initiatives have been implemented to help recover from the two significant waves of COVID admissions, ensuring long waiters are treated in the right place and in the right order. The Trust has achieved the largest volume and percentage of 52 week reduction across the country.
- The Director of Planning and Performance highlighted the participation of the Trust as a system partner with the provision of physical and clinical capacity and mutual aid. The Trust provided a huge amount of support to partners on validation and access management systems.
- The Trust is committed to eradicating the 104 week wait list by March 2022 and managing clinical risk to ensure the cohort of patients that could become part of the 104 week list are treated before 104 weeks.
- The critical risk remains and will create pressure into next year. The Trust is working on a number of ways to mitigate that.

Action: The Director of Planning and Performance to arrange for the presentation on RTT Long Waiters to be circulated to the Committee. **A Creeggan**

21/127 Red Risk Register

The Committee received an overview of the open red risks that sit under the auspices of QPPC. The report sets out the current high level description of the risks, the current risk level and the Committee which has the responsibility for monitoring the risk.

Many of the risks on the register reflect unmitigated positions when there are, in fact mitigations in place. A significant amount of work is taking place with the Care Group Leadership in relation to risk ownership and ensuring the register is used appropriately.

The Board Assurance Framework is currently under development to align it with the new Strategy. Once completed, the strategic risks can be assigned to the appropriate assurance Committees.

PEOPLE

21/128 Workforce Metrics

The Committee received the Workforce Performance Report for Month 6. The Trust has won two awards recently for the recruitment campaign - RAD award and the 2021 recruitment marketing award for internal communications. The Chief People Officer thanked and congratulated the team.

The following highlights were noted:

- **Vacancy Rates**: Vacancies have slightly increased, however still on trajectory given recruitment plans to meet the target by year end.
- **Sickness Absence**: The sickness absence rate has increased by a small percentage, which is expected during the winter period. The Trust continues to promote the COVID vaccine as well as the Flu vaccine.
- **Appraisals**: Work continues to follow up on outstanding appraisals.
- **Employee Relations**: The average time to resolve cases has been reduced from 12 weeks to 9 weeks. The team continues to see an increase in informal resolution.

Item	Subject	Action

21/129 Winter Staff Support Response

The Committee received and noted the update on staff support over the winter period. Throughout the pandemic, additional staff support initiatives were developed, including psychological support. This has led to a renewed focus and mandate across the NHS to do more to support and improve the health and wellbeing for staff.

Initiatives that will be taken forward include additional leave, REACT Mental Health training, recognition programmes, the 'Feel Good' funds, the Schwarz round and the reflect and reconnect discussions, which is now built into the appraisal process.

Communication around what wellbeing support is available at the Trust, as well as regionally and nationally, is being strengthened. Work continues to progress the wellbeing hospital hubs as a permanent feature. At the moment, the wellbeing hubs are mainly being used as rest and recovery rooms and somewhere to access refreshments rather than to access the wellbeing interventions on offer. This speaks to the availability and quality of break out rooms for staff, which is often limited due to the estate. The team is working to ensure the new hubs continue to offer a sense of community and promote good culture and values.

21/130 Freedom to Speak Up Guardian Report

The Committee received the Freedom to Speak Up report and noted that there has been an increase in cases. Anonymous reporting has also decreased, which indicates that staff feel more confident to speak up. The majority of speaking up issues relate to bullying and harassment by managers and poor working relationships. This is in line with the national picture. The Freedom to Speak Up Guardian highlighted that some members of staff have been seeking to access FTSU inappropriately and have been signposted back to their line managers or leadership team.

Work is taking place to raise the profile of the Freedom to Speak Up Guardian across all sites. The National Guardians Office have published guidance on the role of FTSU ambassadors, which is primarily to raise the profile of freedom to speak up rather than to manage cases. The Trust has a diverse team of 52 FTSU ambassadors.

Formal listening and support work with the EDI team in particular Services with historical cultural issues is in progress.

21/131 Equality, Diversity & Inclusion Update

The Committee received and noted the Equality, Diversity & Inclusion Update. The Director of Equality, Diversity & Inclusion updated the Committee on the key areas of focus:

- Raising the profile of EDI as a function and department within the Trust.
- Developing of people though specific, tailored EDI training offers including training for Board members.
- EDI collaboration with existing structures and frameworks, particularly in HR processes and employment relations.
- Culture review; taking an MDT approach to reviewing cultural related issues in targeted areas and developing recommendations and actions for leadership. Support will be sought from the Communications team to appropriately communicate progress with actions to staff throughout the organisation.

Item	Subject	Action

- The EDI team will review objectives and effectiveness, monitoring the impact of any initiatives and actions taken.
- The WRES and WDES data for the Trust was submitted in August. An action plan has been developed and is monitored by the Executive team.
- An EDI road map will be developed and integrated into the Trust Strategy rather than having a standalone EDI Strategy.

PERFORMANCE

21/132 Integrated Performance Report

The Chief Executive Officer for Denmark Hill presented the IPR for Month 6. The Committee noted the following:

- The ED performance remains the greatest area of performance concern on a daily basis. There are action plans in progress at both sites.
- The Trust moved from using the Hurley Group to Greenbrooks to provide UCC support at Denmark Hill. Greenbrooks is also the provider at the PRUH, although the contract arrangement is slightly different. At the PRUH the contract is held by the CCG. The Trust is working to equalise and balance Greenbrooks performance between the sites.
- In the first few weeks, Denmark Hill ED saw a significant improvement in performance. Since then Greenbrooks have been unable to prioritise Denmark Hill and the performance is far less than expected. Attendances at the ED have been considerably higher than expected. Extremely long waits have been mostly resolved, however.
- Greenbrooks have been unable to take on Paediatrics and it is likely that this will be delayed.
- The Acute Frailty Unit will open on Monday at the PRUH, which will have a positive impact on the number of patients that may require admission at Denmark Hill.

The Chief Executive thanked the Chief Executive for Denmark Hill, the Chief Medical Officer and the Chief Nurse for their efforts to improve staff morale in the Denmark Hill ED.

21/133 London Breast Screening Recovery: Update on Clinical Risk

At the last meeting, the Committee requested an update on the clinical risks associated with the backlog within the Breast Screening Service. The Chief Medical Officer presented a verbal update to the Committee on progress with the recovery performance.

The tier 4 patient backlog has been significantly reduced, and good progress is being made to reduce the number of patients whose appointments have been delayed. It has been acknowledged nationally that it is extremely difficult to assess harm. A national process is under development.

The highest risk women have been prioritised and have all been invited for screening. The Trust will use Datix to identify any issues and implement any national recommendations once they are published.

A borough led task and finish group will be assessing the equality impact, as women are now being invited to book an appointment rather than being offered an appointment.

Item	Subject	Action

FOR INFORMATION/REPORTING & DISCUSSION BY EXCEPTION

21/134 Sub-Committee Minutes:

The Committee noted the minutes from the following meetings:

- Health & Safety Committee, 16.09.2021
- Equality, Diversity & Inclusion Delivery Group, 08.09.2021

COMMITTEE GOVERNANCE

21/135 QPPC Annual Work-Plan 2022

The Director of Corporate Affairs informed the Committee that final work plan is likely to be impacted by the work taking place to align the governance structure with the new strategy. Also, the annual review of the Committee's terms of reference and the Committee's self-assessment, which informs the Board overall effectiveness work, will take place at the end of this year and early next year.

21/136 ANY OTHER BUSINESS

An independent inquiry has been launched by the Health Secretary following an incident at two Kent Hospital mortuaries. NHS England have issued guidance and actions that organisations should take and an update will be circulated to the Committee by the end of next week. **N Ranger J Lowe**

DATE OF NEXT MEETING
Thursday 20th January 2022
09:30am – 3:00pm

King's College Hospital Audit Committee
Minutes of the meeting of the Audit Committee held on Thursday 25 November 2021 at 9.10am
via MS Teams

Present:

Akhter Mateen	Non-Executive Director (Chair)
Jon Cohen	Non-Executive Director

In attendance:

Sir Hugh Taylor	Trust Chair
Steve Weiner	Non-Executive Director
Prof Clive Kay	Chief Executive
Beverley Bryant	Joint Chief Digital Information Officer - (CDIO)
Lorcan Woods	Chief Financial Officer (CFO)
Prof Nicola Ranger	Chief Nurse
Dr Mairi Bell	Director of Financial Operations
Sophie Whelan	Director of Corporate Affairs and Trust Secretary
Nina Martin	Assistant Board Secretary *(Minutes)*
Siobhan Coldwell	Assoc Director, Corporate Governance
Paul Dossett	External Audit (Grant Thornton)
Ellen Millington	External Audit (Grant Thornton)
Gareth Norris	External Audit (Grant Thornton)
Alex Barrington	Internal Audit (KPMG)
Charles Medley	Internal Audit (KPMG)
Roisin Mulvaney	Director of Quality Governance
Jane Allberry	Lead Governor – Observer (part)
Adam Creegan	Head of Planning and Performance ***(item 4.1)***

Apologies:

Sue Slipman	Non-Executive Director
Neil Hewitson	Internal Audit (KPMG)

Item	Subject	Action
	2. STANDING ITEMS	
021/103	**Welcome and Apologies** The Chair welcomed all to the meeting. Apologies were noted from Sue Slipman, Non-Executive Director and Neil Hewitson, KPMG	
021/104	**Declarations of Interest** No interests were declared.	
021/105	**Chair's Action** There were no Chair's actions to report since the last Committee.	
021/106	**Minutes of the Previous Meeting** The minutes of the meeting held on 16 September, 2021 were approved.	
021/107	**Action Tracker and Matters Arising** All the Items were either closed or on the meeting agenda.	

Item	Subject	Action

3. RISK AND RISK MANAGEMENT

021/108 Data Quality Assurance Report

The Head of Performance and Planning presented a report that aimed to provide the Committee with assurance around the Trust's data quality framework and gives an overview of the Data Quality Strategy and supporting process, systems, training, validation and audits in place. It also highlighted perceived key current risks and included Secondary Uses Service (SUS) data quality dashboard which summarises the accuracy of key data fields in terms of accuracy, validity, reliability, timeliness, relevance and completeness

The Contracts Information and Data Quality Team shares a large amount of data on a rolling 3-month programme. The Trust runs a proactive process to review the data to ensure that all data quality items are proactively identified in advance of any commissioning challenge.

The Data Quality Steering Group provides organisational oversight and regular scrutiny of internal and external data quality including the monthly SUS+ Data Quality dashboard reports.

As ethnicity coding was not mandatory, this data was not routinely captured. Additionally, with no formal training in this area, there was a level of hesitancy amongst staff in gathering this data.

It was noted that a smooth migration to EPIC would support data quality particularly as it would reduce the reliance on manual data collection and entry. The Committee received assurance that the move to EPIC would not necessarily increase the number of data entry points.

A historical organisational risk has been the number of local data systems in use and for which there had been very little local oversight. ICT had audited the numbers of systems in use along with their owners. The Trust aim is to monitor and establish corporate oversight of all data systems. Migration to EPIC would limit the number of data owners.

KPMG had not carried out an overarching data quality review for some time and expressed a level of assurance with today's report.

021/109 GGI Risk Management Review and Action Plan

The Chief Nurse and Director of Quality, updated the Committee on the final GGI report following its review over the summer. The findings gave good assurance of progress made and showed there was an understanding of the risk management responsibilities locally. There remained the challenge of understanding the risk escalation process. There seemed to be good understanding within the care groups of their risk management practice.

The identified gaps in the understanding of the risk escalation/management process within the care groups could be addressed with the training of senior managers This training had started in November.

The GGI action plan would be brought to and discussed at the Risk and Governance Committee.

Item	Subject	Action
	There had been good progress regarding the identification of metrics for the risk profile of the organisation and with the individual metrics and KPIs for each of the corporate risks. The draft KPIs would be presented to the Risk and Governance Committee next week. In response to a query it was confirmed that there were timelines for completion of the recommendations which extend to Feb/March 2022 and these were aligned with the launch of the risk management module on Datix. A balance between flexibility and standardisation was needed in respect of site governance arrangements. The Committee heard that the present governance model was flexible but a standardised risk escalation process would be developed. It was noted that while risk identification and assessment was important there needed to be an equal focus on risk mitigation, the overall risk profile and understanding how many are being mitigated.	
	Action: Further to the discussion, it was agreed that: • **The Trust's prioritisation of risk management needed to be communicated organisation wide and not limited to the clinical areas.** • **A process to include non-clinical areas in the Board walk-around would be developed.** • **Future reporting should include a summary of how the Trust is progressing with the recommendations and design of the risk management process. It should also include a summarised view of the operational part of risk management showing the maturity of level of care groups in terms of risk assessment and mitigation.**	**Assc Dir, Corp Gov/Dir Corp Aff** **Dir, Quality Gov/Chief Nurse**
021/110	**Risk Management Assurance and Implementation Update** The Committee considered a report that provided an update on the implementation of the risk management strategy and policy. The report provided an overview of the overall risk profile of the Trust as well as compliance with the Trust policy. A short summary of ongoing work to further support the implementation of the strategy. The Committee noted the report. There were 629 open risks on the Trust's risk register. Of these, 108 were red rated and this was inclusive of the current corporate risk register. The report shows the risk profile is viewed. This was done at site level, by care group governance and by the timeliness of reviews. There was assurance that two thirds of the red risks have had timely reviews. Staff risk training should include developing the confidence to challenge the risk score.	
	Action: Further to the discussion, the Committee proposed developing planned next steps around the identified catastrophic risks. The Committee observed that some of these may be misclassified and proposed carrying out a validation exercise.	**Dir, Quality Gov/Chief Nurse**
	Alongside the work around Risk Assurance, the Chief Executive acknowledged that work would soon start on reviewing the Committee meeting cycles. An outcome from this would be the standardising of the reporting relationship between the Risk and Governance Committee, the Audit Committee and the Board of Directors. This would support the reduction of duplicate and/or repetitive discussions. **Action: The Committee will receive a progress report on this piece of work at the January Committee.**	**Dir Corp Affairs**

Item	Subject	Action
021/111	**Board Assurance Framework (BAF)** The Director of Corporate Affairs updated the Committee. Over the last few weeks actions plans to address the recommendations from external governance reviews had been developed. A gap analysis against the well-led framework had also been completed to inform the broader corporate governance work plan. Additionally there had been a number of discussions at Board Development sessions about the implementation of the Trust strategy and the opportunity this presents to review the governance and decision making structures. A paper is being developed which would include timescales to refresh the BAF as well arrangements on overseeing the BAF going forward. **Action: The revised BAF would be presented to the January Audit Committee.**	**Dir Corp Affairs**
021/112	**Risk and Governance Committee Update** The Chief Executive provided the Committee with a summary of the most recent Risk and Governance Committee, noting that in future there will be a formal report. At the 9 November meeting the Committee: • Reports from KPMG were received. These included the recommendation tracker and the counter fraud progress report from the Internal Auditors both of which were on today's AC agenda. • The Committee received and noted the latest iteration of the external visits register. Two visits had been added. These were the British Society for Blood and Marrow Transplantation & Cellular Therapy. The Human Tissue Authority Visit will take place in January 2022. A process to improve the logging and follow up of reviews was needed to ensure any patient safety issues raised were addressed. • The final report from the GGI review and action plan was discussed. • The Committee received and discussed the Data Quality Assurance framework • An update on the learning from legal claims within neuroscience was received and discussed by the Committee. It was clarified that the Audit Committee does not have oversight over the Risk and Governance Committee. The Audit Committee's remit was to ensure there was an adequate process for risk management within the Trust. **Action: A process for the follow up of external reviews would be developed and presented at the next AC.**	**Dir Corp Affairs**
021/113	**Better Payment Practice (BPP) Improvement Plan Update** The Committee noted the report and the Director of Financial Operations provided the key updates. In September, the Trust had been asked to put in place an improvement plan to move closer to the overall target figure of 95% of invoices paid. Today's report sets out progress made to date in improving this measure. In the October month end reporting, the Trust had reported an improved position for its YTD performance in BPPC for non-NHS invoices, measured by both number and invoice value, as compared to the previous month end. The progress made was noted by the Committee and the aim now would be to sustain the improvement. The push is to bring the organisation to carry out the payment process properly from the start of the payment process	

Item	Subject	Action
	The Trust had updated the Centre that there would be a plan to improve payments but had not formally responded that we would attain the 95% compliance target. The immediate target for the Trust was to get to the high 80% and above threshold. The Committee heard that the Centre had changed its data collection form which would mean it would have sight of the Trusts' BBPC figures on a monthly basis.	
021/114	**Accounting Update - IFRS16 Impact** The accounting standard governing the treatment of leases would change for the financial year 2022-23 for NHS organisations (following deferral from the original planned implementation date of April 2020 due to the Covid-19 Pandemic), with information required to be calculated during the current year setting out the expected impact of the change on the organisation's accounts from 1st April 2022. An impact assessment would need to be submitted to the Centre in January and the Trust was confident that it would make this deadline as it had started the process two years ago. There was a meeting scheduled with the external auditors next Monday to plan the 21/22 audit. This discussion would include the Trusts' and the auditors approach to the IFRS 16. A review of the SFIs will come to the January Committee and this would address the Trusts' approach to lease agreements. Regarding the impact on the Trusts' capital plans, the CDEL allowance will only impact leases existing on implementation by 01 April, 2022. After this date there was likely to be an impact on capital spend as it would involve utilising CDEL for projects previously outside its scope. Further guidance was needed from the Centre on how additional CEDL would be addressed.	
	Action: The Committee proposed conducting an operational impact assessment of this ahead of any potential planning guidance in November/December. The Trust had so far focussed on the impact on capital spend but revenue budgets could also be impacted.	**Dir, Fin Ops**
	EXTERNAL ASSURANCE	
021/115	**Internal Audit Progress Report (inc recommendations tracker)** Some of the planned reviews had not yet been approved by the Risk and Governance Committee, so these would not be presented at today's Committee. With the new reporting process and timelines there were some concern that there could be a back-up of reports in the New Year. The Auditors however assured that they will remain on track to complete the head of internal audit opinion as planned. Two recommendations were overdue, two had over optimistic timelines and was being reviewed and two were proposed to be closed as the actions or all that could be done had been carried out. The CDIO updated that the digital strategy had been completed but its communication and implementation was delayed until EPIC funding had been received.	
	Action: The Committee asked that more narrative be added to the status of the IT strategy recommendation and the CDIO will work with colleagues to ensure fuller status updates are presented on the tracker.	**Joint CDIO**

Item	Subject	Action
	It was noted that the changing of dates and any amendment or closing of actions has to be discussed and confirmed at the Integrated Risk and Governance Committee.	
021/116	**Counter Fraud Progress Report** Trust wide counter fraud awareness sessions continued across the Trust. There had been some delay in the field work with the overseas patients' proactive review. This review would now come to the January Committee. Referrals were coming in and this was hopefully a reflection of staff engagement and confidence to raise concerns.	
021/117	**Subsidiaries Audit Progress Report** The financial statements of the companies had been completed and signed off last week. Regarding KCH Management Ltd, the key item was the PIK note valuation. The Auditors were comfortable with the valuation of the PIK note, financial statements and the data used in its calculation. During the course of the audit another bank account had been identified with transactions which had not been posted to the ledger during the year. Managers had adjusted for these transactions in the accounts which introduced half a million of receivables and corresponding entries. An internal control recommendation was raised around this. The Committee received assurance that based on correspondence from the Trust bankers no other bank accounts were identified. Regarding KCS Ltd, the auditors expressed assurance around the accounting treatment of Viapath. The plan had been to complete the companies' accounts alongside the Trust main audit but there had been slippage driven by delays in the timely receipt of information. A timetable for the 21/22 audits would be developed and agreed with management to support a timely signing off of these accounts. The Auditors informed that additional time had been spent on the audit which can likely impact the fees to the Trust for the audit work.	
021/118	**Audit Progress Report and sector update** The Committee noted the update. The plans for next year's audit includes timeline for bringing the formal reporting to the Audit Committee. Next year auditors report should be alongside the financial statement. Clarification around the guidelines for the climate change component for public sector organisations was yet to be received. Once received, the impact on audit timelines would be assessed to avoid any unforeseen delays due to this	
021/119	**Any other Business** No other business was highlighted.	
021/120	**Date and time of next Meeting -** The next meeting was scheduled for 27 January 2022, 9-12.	

King's College Hospital NHS Foundation Trust – Strategy, Research and Partnership Committee

Minutes of the Strategy, Research and Partnership Meeting held on Thursday 09 September 2021 via MS Teams

Present:

Sir Hugh Taylor	Trust Chair (Chair)
Prof Richard Trembath	Non-Executive Director
Nicholas Campbell-Watts	Non-Executive Director
Sue Slipman	Non-Executive Director
Akhter Mateen	Non-Executive Director
Prof Clive Kay	Chief Executive Officer
Julie Lowe	Site Chief Executive, DH
Mark Preston	Chief People Officer (CPO)

In attendance:

Funmi Onamusi	Director of Equality, Diversity and Inclusion (EDI)
Nina Martin	Assistant Board Secretary (minutes)
Siobhan Coldwell	Associate Director of Corporate Governance
Ann-Marie Murtagh	Director of Research and Innovation/Head of Nursing
Sophie Whelan	Director of Corporate Affairs

Apologies:

Steve Weiner	Non-Executive Director

Item	Subject	Action
021/09	**Introductions and Apologies for Absence** All introductions were made and apologies for absence noted.	
021/10	**Declarations of Interest** There were no declarations of interest.	
021/11	**Chair's Action** There were no Chair's action to report.	
021/12	**RESEARCH** The Director Research and Innovation/Head of Nursing provided an update on the Trust's research programme, including key achievements and milestones in Covid-19 research. It was noted that KCH DH was among the top 5 sites for the number of COVID portfolio studies opened in the UK. In terms of non-Covid-19 research, KCH was one of the top recruiting trusts in the UK in 2021/22 with over 5000 recruited participants. A key limitation remained appropriate facilities to conduct research activity, particularly at the PRUH.	

Item	Subject	Action

There were further research opportunities at the PRUH which were worth pursuing. Through funding from the PRUH two co-leads had been appointed. This would help the Trust to link into community/primary care. The aim is also to better link the work of PRUH and DH and so grow and expand the Trust's research portfolio

There were potential ophthalmology research opportunities at the Sidcup site.

The Chief Executive queried if the highlighted new ways of working due to the pandemic would continue. It was confirmed that they would:

- Remote consents had been helpful and the hope was that this would remain ongoing;
- The Trust was now able to use non-qualified staff to follow up
- Docusign is now in use which reduced administrative workload and negated the need for printing out masses of paper

The Committee commended the level of commercial contract recruitment and asked for clarity around the Haematology contract where the value was very high despite the low recruitment numbers. This was due largely to the complexity of haematology studies. The requirement would only be for 2-3 patients but due to the complexity of the research trials, the pay rate would be high.

The Committee commended progress with the diversity of research recruits.

PARTNERSHIPS

021/13 Acute Provider Collaborative (APC)/Integrated Care System (ICS)

The Chief Executive provided on overview of key developments in relation to the APC and ICS. Ahead of legislation, NHSE/I had published guidance and design frameworks outlining expectations on the structure of ICS Boards and Provider Collaboratives. Over the summer work progressed to develop proposals for agreement by partners. Shadow arrangements will likely be in place by January 2022, with new legislation enacted by April 2022.

The national framework proposes a requirement for an Integrated Care Partnership (ICP) and a NHS ICS Body. The ICP is a partnership between the NHS and local authorities and other community stakeholders in the system. The Integrated Care Board is a statutory body with more prescription in relation to its membership and structure.

With the ICP there were a number of options on how this would be governed. The SEL ICP will be jointly chaired by the ICS Chair and a local authority leader. Richard Douglas will continue to be the ICS Chair designate for south east London.

Discussions on the composition of the ICB were ongoing. Determining the membership was proving a challenge as the function of the Board was yet to be clarified.

The Board would be supported by an ICS executive. The advertisement for the posts of Chief Executives had gone out. There will also be a number of senior and area leads on ICS staff.

Item	Subject	Action

The Acute Provider Collaborative (APC) was established in May last year and good progress had been made in the last few months. The leadership team of the APC had been refreshed. Fiona Howgego had been appointed as the Managing Director. A Director of Elective Recovery had also been appointed and work was ongoing to build a system wide elective access team to support elective recovery. Jonathan Lofthouse was appointed the new diagnostic SRO.

The APC was trying to ensure network activity was appropriately coordinated. A governance review of the APC was done, following which a next step document was produced last May. The plan now is to address the recommendations made and prepare a draft proposal for the three Chief Executives to approve hopefully by the end of October. Following which this would go to our respective Boards to review by November. The ICS will also need to approve the proposed governance arrangement.

The Chair added that until funding was clear there remained a level of uncertainty with the proposed arrangements.

The wider implications of the arrangements and emergent funding would be discussed more fully at the next Board away day. It was noted that Trust governance model will be put under great strain. KCH and GSTT were placed to lead and influence the work.

The ICS planned approach to research, education and training would also be a useful future discussion.

021/14 KHP Governance Review

KHP Governance Review was launched early in the year in response to the external landscape. The review led to a number of recommendations.

- At Board level, KHP would be returning to an independent Chair model and Professor Ajay Kakkar had been appointed to this role from 1st September. Reviewing the role of the other non-independent members of the Board would be one of his first key priorities.
- A System Innovation forum would meet about twice a year to identify and oversee the implementation of innovation.
- The Board was now supported by an expanded KHP Executive with representation from university health faculties and some non-health faculties. It would also include Trust Medical Directors and Directors of Strategy. The aim was to develop within KHP the structures that would support the delivery of individual refreshed Trust strategies

Innovation District - SC1 had been established. Lord Kakker and Prof Lechler were co-chairing this Board which reports into KHP for oversight and continuity.

BRC leadership - Director Matt Brown was leaving to Genomics England. Robin Ali, Deputy Director with support from Professor Trembath would take up the role until a substantive appointment is made.

Professor Ajay Shah had been appointed the Executive Dean of the School of Life Sciences and Medicine.

There had been concern that student recruitment would be a challenge in the last year. However, in practice KCL had over recruited student nurses by over 100 – a very positive outcome. Partner Trusts had responded well to the demand for extra student placements.

021/15 Any Other Business

No other business was highlighted.

021/16 Date of next meeting

The next meeting was scheduled for 02 November, 2021, 9-11am.