King's College Hospital NHS Foundation Trust

AGENDA

Meeting	**Board of Directors**
Time of meeting	**15:30 – 17:30**
Date of meeting	**Thursday 08 December 2022**
Meeting Room	**The Board Room, Hambleden Wing, Denmark Hill**

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 29 September 2022	Chair	Enclosure	Approval	
5	Patient Story	Chief Nurse	Verbal	Discussion	**15.35**
	PERFORMANCE & STRATEGY				
6	Report from the Chief Executive	Chief Executive	Enclosure	Discussion	**15.55**
6.1	Integrated Performance Report	Site CEOs	Enclosure	Assurance	
6.2	Finance Performance Report	Chief Finance Officer	Enclosure	Assurance	
	QUALITY & SAFETY				
7	Safeguarding Adults Annual Report 2021/22	Acting Chief Nurse	Enclosure	Assurance	**16.35**
8	Maternity	Acting Chief Nurse	Enclosure	Assurance	**16.45**
8.1	Ockenden Assurance Visit Outcome	Acting Chief Nurse	Enclosure	Assurance	
8.2	Maternity Safe Staffing	Acting Chief Nurse	Enclosure	Assurance	
9	Safe Nurse Staffing Report	Chief Nurse	Enclosure	Assurance	**17.05**
	GOVERNANCE & ASSURANCE				
10	Standing Financial Instructions	Chief Finance Officer	Enclosure	Approval	**17.10**
11	Board Assurance Framework – Q3	Acting Dir of Corporate Affairs	Enclosure	Approval	**17.15**
12	CQC Statement of Purpose	Acting Chief Nurse	Enclosure	Approval	**17.20**
13	Council of Governors' Update	Lead Governor	Verbal	Information	**17.20**
Items for information– not scheduled for discussion unless notified in advance					
14	Board Committee – Highlight Reports	Committee Chairs	Enclosure	Assurance	
	OTHER				
15	Any other business	Chair	Verbal	Information	**17.25**
	DATE OF NEXT MEETING				
16	**The next public Trust Board meeting will be held TBC**				

Members:	
Charles Alexander	Trust Chair *(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
Clare Williams	Acting 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
Siobhan Coldwell	Acting Director of Corporate Affairs
Sara Harris	Interim Head of 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 9.30am on 29 September 2022, by MS Teams.

Members:

Sir Hugh Taylor	Trust Chair, Meeting Chair
Nicholas Campbell-Watts	Non-Executive Director
Prof Jonathan Cohen	Non-Executive Director
Prof Yvonne Doyle	Non-Executive Director
Dame Christine Beasley	Non-Executive Director
Prof Richard Trembath	Non-Executive Director
Steve Weiner	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:

Funmi Onamusi	Director of Equality, Diversity and Inclusion
Chris Rolfe	Director of Communications
Clare Williams	Deputy Chief Nurse
Prof William Bernal	Corporate Medical Director
Arthur Vaughan	Deputy Chief Finance Officer
Siobhan Coldwell	Associate Director, Corporate Governance (minutes)
Members of the Council of Governors	
Members of the Public	

Apologies:

Akhter Mateen	Non-Executive Director
Lorcan Woods	Chief Finance Officer

	Subject	**Action**
022/030	**Welcome and apologies**	

Apologies for absence were received from Akhter Mateen and Lorcan Woods.

022/031 **Declarations of Interest**

None.

King's College Hospital NHS
NHS Foundation Trust

	Subject	Action

022/032 Chair's Actions

There were no Chair's Actions to report.

022/033 Minutes of the last meeting

The minutes of the meeting held on 16th June 2022 were agreed.

022/034 Mortality Outcomes and Monitoring

The Chief Medical Officer introduced Prof William Bernal, Corp Medical Director. Prof Bernal reviews patient outcomes and mortality in order to ensure that Trust outcomes are at least in line with expectations. He provided the Board with a presentation that outlined Trust performance in relation to the Summary Hospital Level Mortality Indicator, noting the Trust is in line with expectation. In relation to Sepsis, King's observed deaths are lower than expected.

The Trust participates in 22 national audits and data can be broken down to consultant level. In respect of COVID-19, outcomes and hospital death rates were analysed over the three waves. The trend over time demonstrates improvements in treatments and the impact of vaccines. The Trust's outcomes compare very well with peers.

In relation to SHMI, the Board discussed the level of detail at which the team identify unexpected outcomes. Prof Bernal noted there are a series of metrics that trigger a review and data is at ward level. Changes to case mix is often the cause rather than lapses in quality of care. Nevertheless, the analysis is very focused and it is possible to identify wards under pressure and to put in additional support for staff as necessary.

The Board heard that there is a discussion at National Quality Board about which metrics should be used. Prof Bernal noted that mortality is important but cannot be seen in isolation. An understanding of the wider context, including morbidity and serious incidents is needed. The team at King's will triangulate data where it is available.

The Board noted there are some limitations. SHMI only identifies patients that have been discharged within 30 days. Community deaths are reviewed by the Medical Examiner and there are increasingly good links between the ME and the Trust's patient outcomes team.

The Board thanked Prof Bernal for his presentation, noting that Trust performance during the pandemic was remarkable.

022/035 The Report from the Chief Executive (including the Integrated Performance Report and the Finance Report)

The Board received a report from the Chief Executive, which highlighted a number of key developments since the Board last met. Professor Kay noted the pressures on the NHS were significant and King's was no different. Urgent care activity had been higher than anticipated as had COVID-19 numbers. COVID-19 cases have recently started to increase.

Since the Board last met, there have been a number of CQC unannounced inspections, which have highlighted some significant issues. The report into Orpington

Hospital has been published and the inspection has led to the site being downgraded to 'Requires Improvement'. A clear action plan is in place. The maternity inspection at DH was disappointing. Colleagues have responding quickly to the concerns raised and a Quality Assurance Group, led by the CEO has been established. This group, which includes Non-Executive Directors, receives weekly assurance on progress. It it is anticipated that all the concerns raised by CQC will be addressed by the end of September. In order to provide longer term assurance, a Strong Roots Quality Care programme is being implemented, and this will include focus on the importance of delivering the right standards of care.

The Trust received a PFD, in relation a patient who died in the community, but whose outpatient care was interrupted by the pandemic. Good progress is being made in addressing complaints performance and the Chief Nurse is working with Governors to ensure that the Trust learns from complaints. The Trust has implemented a number of initiatives aimed at improving patient experience including a new wheelchair scheme and the patient entertainment system is working well. The new national Patient Safety Incident Response Framework (PSIRF) has now been published and the Trust is working towards implementation in 2023. The Board discussed PSIRF, noting it will be a significant shift from current processes, and will have implications for assurance and governance. The Board will need to be trained and it will be important there is some consistency across the system so that benchmarking remains possible. Prof Kay noted that the ICS Performance and Quality Committee has identified this as a priority.

In respect of operational performance, the Trust is making good progress in elective recovery. There are no patients waiting more than 104 weeks and considerable effort is focused on maintaining this. The number of patients waiting more than 78 and 52 weeks respectively has also decreased. However, the Trust waiting list has 85k patients, and this is increasing by c300 patients per week. The Trust continues to improve its diagnostic performance, with the PRUH consistently meeting the national standard. This improved performance impacts positively on cancer pathways. The Board discussed whether patients could be transferred between DH and PRUH, nothing that certain procedures can only be undertaken at DH. There are also workforce constraints.

Performance against the Emergency Care Standard continues to be challenged at both sites and action plans are in place to drive improvement. There is considerable focus on minimising delays in ambulance handovers and meeting the 15-minute target. The Executive has approved a number of mitigations and London Ambulance Service (LAS) has just introduced a new IT system which should ensure better datasets. The Board discussed the challenges in reducing ambulance handover delays, noting that this is a system-wide issue. Workforce constraints are a particular issue at DH and for LAS. The frailty of the patient cohort is also a factor that impacts patient flow (length of stay and discharge).

The Board noted the M4 financial performance as outlined in the pack. The Deputy Chief Finance Officer updated that the M5 year to date deficit was £16.6m. The deficit could be explained in part by higher than expected COVID-19 (including staff sickness) and undelivered cost improvement programmes (CIP). The Trust is not an outlier compared to other Trusts. Analysis of expenditure indicates good cost control, but in order to achieve year end targets, £55M CIP is needed. The DCFO noted that the deficit impacts on the Trust's cash position and it is possible that a loan will be needed later in the year. This will be kept under review by the Finance and Commercial Committee (FCC). The Board noted that FCC had discussed the M4 forecast in detail at its November meeting. Whilst there is considerable uncertainty, inflation is being controlled and there has been prudent planning. However, more focus is needed to achieve better productivity and efficiency.

In relation to workforce, the Board noted there had been 400 nominations for the King's Stars Awards in November. The in-house Bank has been established and the supporting IT system is being rolled out in the coming months. Staff on Agenda for Change pay grades have received a national pay award. This has had a pension impact for some staff, and consideration is being given as to how they can be supported. A number of 'cost of living' initiatives have been implemented.

The Board welcomed the progress being made in delivering the Trust's equality, diversity and inclusion programme, noting particularly that all the graduates of the Project Search programme had found employment at the Trust.

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

Freedom to Speak Up Annual Report 2021/22

The Board considered the annual report from the Freedom to Speak Up Guardian. Reporting levels are high and there has been an emphasis on being more responsive over the past year. The levels of anonymous reporting is reducing, which allows the Guardian to better support staff. There are differences in the types of issues being reported at the PRUH and DH, and the impact of focused activity can be seen in the data. The Board noted that the data in relation to bullying and harassment has been reviewed in detail and appears to show a link to the use of performance management processes. The Board discussed the confidence in the system, noting that patient safety concerns are being raised through the CQC rather than FSUG. Staff need to feel confident that action will be taken and it is difficult to measure this. Nevertheless, Datix reporting (incidents) remains high, and there are multiple routes for staff to raise issues. The staff survey may give some indication of confidence, but the Trust engagement score has historically been low. Nicholas Campbell Watts, the Board's FSUG Champion, noted that the King's Ambassadors are being used to highlight the interventions that have been successful e.g. Renal and Theatres.

The Board **NOTED** the report and endorsed the approach being taken to deliver improvements in partnership with staff. The Board thanked Jacqui Coles, the Trust's Guardian for her support.

022/036 Safer Staffing Report

The Board received the quarterly review of nurse staffing levels from the Chief Nurse. Vacancy rates have increased, in part due to an increased establishment. The Trust has been proactive in attracting newly qualified nurses, with 53 joining the Trust in September, including 34 in paediatrics. Attracting Healthcare Assistants has been more difficult, given the wider workforce shortages, but there had been a successful jobs fair resulting in 45 offers being made. Apprenticeships are used to support HCAs, but more could be done, linked to the Trust's anchor institution programme. Whilst good progress is being made in addressing vacancies, turnover rates are high. The operational/clinical impact is being managed through use of bank staff. Agency spend is relatively low.

The Board **NOTED** the report, particularly the emerging paediatric issues.

022/037 Board Assurance Framework

The Associate Director of Corporate Governance presented the revised Board Assurance Framework, noting that FCC had agreed to raise the risk score on BAF risk 3 – financial sustainability. Whilst the committee is assured that costs are being controlled, there is less confidence that the CIP can be fully delivered and there are a number of external challenges, beyond the Trust's control.

The Board discussed the research risk, noting the wider contextual challenges.

The Board **APPROVED** the report.

022/038 **Report from the Governors**

Jane Allberry, Lead Governor, welcomed the increased engagement with the Trust, including the involvement of governors in the quality walkarounds. The governors continue to emphasise the importance of listening to patients and embedding change. The governors welcome the progress being made in elective recovery but are worried about the impact of winter pressures, including potential industrial action. The Governors welcomed concrete EDI activity being delivered.

022/039 **For Information**

The following items were received for information:

- Safeguarding Children Annual Report 2021/22
- Infection Prevention and Control Annual Report 2021/22
- Committee Highlight Reports:
  - Audit Committee July 2022
  - Finance and Commercial Committee July 2022
  - Quality, People and Performance Committee July 2022
  - Major Projects Committee June 2022.

022/040 **Any Other Business**

The Chair thanked everyone that had taken part in the King's Charity Great Hike. The event had been very successful and surpassed fundraising expectations.

The Chair noted that Prof Nicola Ranger will be leaving the Trust at the end of November. Prof Ranger had been a great champion for nursing and midwifery staffing and will be a significant loss to the Trust.

The Chief Executive thanked the Chair for the guidance and leadership he had provided both the Trust and the Board during his tenure. He had provided stability at a very difficult time and the Board owed him a debt of gratitude for his commitment to King's.

022/041 **Date of the Next Meeting**

3.30pm 8th December 2022

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8th December 2022
Report title:	Report from the Chief Executive	Item:	6
Author:	Siobhan Coldwell, Acting Director of Corporate Affairs	Enclosure:	
Executive sponsor:	Professor Clive Kay, Chief Executive Officer		
Report history:	n/a		

Purpose of the report

This paper outlines the key developments and occurrences since the last Board meeting held on 29th September that the Chief Executive wishes to discuss with the Board of Directors.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion	✓	Assurance	✓	Information	✓

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

Executive summary

The paper covers quality and safety, finance and performance as well as key workforce activities.

Strategy

Link to the Trust's BOLD strategy		Link to Well-Led criteria	
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*	✓	**Leadership, capacity and capability**
		✓	**Vision and strategy**
✓	**Outstanding Care:** *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*	✓	**Culture of high quality, sustainable care**
		✓	**Clear responsibilities, roles and accountability**
✓	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*	✓	**Effective processes, managing risk and performance**
		✓	**Accurate data/ information**
✓	**Diversity, Equality and Inclusion at the heart of everything we do:** *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*	✓	**Engagement of public, staff, external partners**
			Robust systems for learning, continuous improvement and innovation

	Person- centred	**Sustainability**		
	Digitally-enabled	**Team King's**		

Key implications	
Strategic risk - Link to Board Assurance Framework	The report outlines how the Trust is responding to a number of strategic risks in the BAF including: - Recruitment and retention - Culture and values - Financial sustainability - High quality care - Demand and capacity - Partnership working.
Legal/ regulatory compliance	n/a
Quality impact	The paper addresses a number of clinical issues facing the Foundation Trust.
Equality impact	The Board of Directors should note the activity in relation to promoting equality and diversity within the Foundation Trust.
Financial	The paper summarises the latest Foundation Trust financial position.
Comms & Engagement	n/a
Committee that will provide relevant oversight n/a	

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 Introduction

1.1 This paper outlines the key developments and occurrences since the last Board meeting on 29th September 2022 that I, the Chief Executive Officer (CEO), wish to discuss with the Board of Directors.

1.2 The NHS continues to be challenged and King's College Hospital NHS Foundation Trust ("the Trust") is no different. Operational demand and activity (both non-elective and elective) has been very high, exacerbated by COVID-19. The Trust has continued to work hard to recover its elective position. Demand for urgent and emergency care has been very significant and this continues to impact on our ability to meet the four-hour Emergency Care Standard. Our Emergency Departments are working hard to meet ambulance handover targets, but high inpatient bed occupancy means patient flow through the two sites is not as efficient as we would like.

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

2 Patient Safety, Quality Governance, Preventing Future Deaths and Patient Experience

Patient Safety

2.1 The Trust is working towards implementation of the new national Patient Safety Incident Response Framework (PSIRF). Multiple approaches to learning from Patient Safety Incidents are being developed and trialled to support proportionate and effective improvement. These will support an understanding of underlying system factors that make it challenging for staff to deliver safe care and to compassionately support affected people (patients, families and staff).

2.2 The Patient Safety Team continues to complete Thematic Reviews into the Trust's key patient safety risks. These triangulate multiple sources of insight into safety (e.g. complaints, claims, observations, external source) to provide recommendations to the organisation on potential system risks and areas for localised improvements.

2.3 Since the beginning of September 2022 the organisation has declared 41 Serious Incidents. This includes two Never Events (one retained swab and one use of a misplaced NG Tube), and one Maternal Death (referred to HSIB for investigation). Systems investigations are underway for all these cases, many utilising new system-based approaches referenced above to focus on learning and improvement.

2.4 Organisational performance on the completion of Serious Incident investigations has improved with 74 investigations completed in the same period. Duty of Candour performance for the initial two stages has recovered and is within the Trust tolerance levels (95%). Stage three sharing outcome remains challenged, largely due to the number of amber incidents (moderate) requiring completion of this stage within the cross-site Women's Health Care Group, Acute Medicine Care Group at DH and General Medicine at the PRUH.

King's College Hospital NHS Foundation Trust

Quality Governance

2.5 An announced Well-led inspection was conducted on the 15th and 16th of November 2022 by the Care Quality Commission (CQC). A member of staff from NHS England also assessed the Trust's financial governance as part of the Well-led inspection. The Trust has received initial feedback from the Inspection Team (see Annex 2).

2.6 As part of the Well-led inspection, the CQC also notified the Trust that unannounced inspections of at least one core service would be conducted prior to the Well-led inspection. On the 26th and 27th of October 2022 inspection teams arrived on site at Denmark Hill and inspected Child Health and two Care of the Elderly wards. Initial written feedback has been provided by the CQC pending the draft formal report.

2.7 Following the inspection of three medical wards at PRUH on 1 August 2022, the CQC published the final inspection report on 9 November 2022. The CQC did not rate the service as it was a focused inspection. However the previous rating of Good for PRUH Medical care (including older people's care) remains.

2.8 We have now received the draft report following the inspections of Maternity services at DH. The Trust received a draft report on Maternity services at the PRUH and responded to the factual accuracy request. The CQC have indicated that they intend to publish both Denmark Hill and PRUH reports at the same time.

2.9 The Trust's final scheduled update on progress against the Maternity CQC improvement action plan was shared with the CQC on 29 September 2022. The Trust has now moved to an approach of continuing to embed systems and processes to ensure compliance remains in place.

2.10 The CQC will be conducting announced inspections of King's Urgent Treatment Centre (UTC) provided by Greenbrook Healthcare between 6 and 9 December 2022. In preparation for the inspections, KFM, working together with the Quality Governance Team, will be submitting information about how we monitor Greenbrook UTC. The Trust is also supporting Greenbrook with provision of evidence as requested by the CQC.

Preventing Future Deaths (PFD) Reports

2.11 The Trust has not received any Prevention of Future Deaths Reports during the reporting period. During Q2, the Trust also received two post-inquest requests for statements, which are **not** PFDs but may be considered as a stage short of receiving one. We believe the prompt, positive engagement of colleagues with detailed responses to the requests reduced the risk of receiving PFDs in these instances.

Patient experience

2.12 Following a period of brief deterioration, performance in relation to the timeliness of complaint responses has continued to improve with 282 complaints responded to within a 10-weeks' period.

2.13 In July 2022, NHS England published a new statutory guidance on 'Working with people and communities'. The guidance extends the Trust's statutory duties to involve carers and communities and work is currently underway to map gaps in provision and enhance compliance.

2.14 On 29th September 2022, the CQC published the results of the inpatient survey. Patients were eligible to participate in the survey if they were aged 16 years or older and had spent at least one night in hospital during November 2021. Of those approached, 403 patients responded to the survey resulting in the response rate of 33.64%. Following decreases in 2018 and 2019, the Trust's overall patient experience score remained at 8.1 with improvements noted across several areas. It is worth highlighting that in 2019, King's College Hospital was rated in the bottom 20% of worst performing Trusts for 9 questions. In 2020, this number reduced to 6 with the latest survey demonstrating poorer performance against 1 question only.

2.15 Following receipt of updated guidance from NHS England, throughout October 2022, PLACE (Patient-led Assessments of the Care Environment) visits took place. 89 local people supported staff to assess how the environment at King's College Hospital supports the provision of clinical care, assessing such things as privacy and dignity, food, cleanliness, general building maintenance and the care of those with dementia or with a disability. Local results are currently being collated to be presented to the Patient Experience Committee in January 2023.

2.16 Working alongside King's College Hospital charity and colleagues in the Estates team, the Patient Experience Team led a patient engagement project to re-design the patient rooms across all children's wards to ensure that the new spaces meeting the needs of our patients and their parents and carers.

3.1 The Trust continues to operate against a backdrop of sustained heightened demand with a 1.69% increase in A&E attendances during October 2022 compared to October 2021. Overall bed occupancy in October 2022 was 97.12% with COVID-19 admissions occupying an average of 16.4 critical care beds and 166.6 general and acute beds across the month. Respectively, this reflects 13.9% of critical care beds and 12.5% of all general and acute beds occupied by COVID-19 positive patients. This demand on beds is set against increasing levels of patient acuity and increased volumes of medically fit patients who cannot be discharged from Trust beds as they require health or social care support. As a result the Trust has seen 315 patients with a length of stay above 21 days in October compared to 214 patients in October 2021.

Elective Recovery

3.2 The Trust continues to deliver ahead of plan on its elective recovery commitments, delivering one of the largest reductions in patients exceeding 52 weeks from Referral to Treatment (RTT) in England. At the end of October 2022 the Trust had 655 patients waiting >52 weeks, and was 35.1% ahead of its planned recovery position of 1,008. This is a reduction of 6,157 cases on the peak of 6,812 patients exceeding 52 weeks following the outbreak of COVID-19.

3.3 As per national recovery expectations, the Trust had zero >104 week waits from June this year and has maintained this. The next milestone in the national recovery programme is the elimination of all patients waiting >78weeks by the end of March 2023 and the Trust completed October with 54 patients in this cohort versus a plan of 126 (57.1% ahead of target).

3.4 As per RTT above, the Trust has delivered one of the most successful recovery programmes in the country. At the end of October 2.24% of patients were waiting more than 6 weeks for a diagnostic test compared to a peak of 40.16% following the first wave of COVID-19 in 2020. Benchmarking against nationally published

September data shows KCH to be ranked 12th among all reporting organisations nationally.

3.5 National reporting of Cancer data is a month in arrears of other elective access targets due to data complexities of shared pathways across multiple providers, and the inherent requirement to confirm cancer status via histology for some cases post treatment. September positions confirm continued delivery of 2-week wait targets for patients to be seen following a referral with suspected cancer. The 28-Day Faster Diagnosis standard was narrowly missed in month being 73.5% versus the target of 75%. Provisional data for October shows compliance has been restored to >75%. Targets relating to the volume of cancer treatments and backlog reduction have been met in 2022/23. Delivery of treatment of patients within 62 days of an urgent GP referral in September was 66.5%, with provisional October data showing improvement to 70.4%.

Urgent & Emergency Care

3.6 Set against the sustained attendance demand outlined above, compliance against the 4-hour Emergency Care Standard for patients to be admitted, transferred or discharged within 4 hours of arrival at the Emergency Department (ED) was 60.25% in October. During the month 494 patients conveyed to ED by ambulance waited more than 60 minutes for handover. This compares to 268 in the previous month, and reflects significant pressure relating to bed availability/patient flow on the PRUH site during the period. Robust action plans are in place to ensure that both in-hospital and wider health system flow is optimised and associated ambulance handover delays minimised. The Trust is also working closely with NHSE London Regional colleagues to deliver these plans and deploy any emerging areas of best practice nationally.

4 Acute Provider Collaborative (APC)

4.1 Colleagues will have received the most recent South East London Acute Provider Collaborative Board Update paper in September. As the lead CEO for the APC, I chair the monthly APC Executive meeting, which brings together the three acute CEOs and the APC's senior leaders to oversee the delivery of the APC's overarching goals and vision, as set by the Committee in Common. The elective and diagnostic recovery agenda, which is currently the core focus of the APC, remains very challenging, although London's elective backlogs and waiting times are overall lower than elsewhere in the country.

4.2 At the time of writing, South East London is currently overall the best performing ICS on elective, diagnostic and cancer recovery in London – but we know there is much more to do. Having succeeded in eliminating waits of over two years (104+ww), our next target, as reflected in the national operating framework for 2022/23, is to eliminate 18month waits (78+ww) by the end of March 2023. At the beginning of this financial year, we calculated that over 46,000 patients were at risk of waiting longer than 18 months by the end of March 2023 – this number now stands at around 4,300, a reduction of around 42,000, due to targeted work across the three trusts and specialty networks. With winter and potential strike action, we know it will be challenging to reduce this number to zero but we are closely managing the risks, and supporting challenged specialties through mutual aid, reallocation of capacity and of independent sector provision (both outsourcing and insourcing). At the same time, our clinical networks are working to achieve greater equity in waits, for example through single points of access and shared PTLs, as in Dental and Ophthalmology.

Further details will be provided in the next Board Update, which is due to be circulated end December/early January.

4.3 The APC Committee in Common will meet 9 December, attended for the first time by our new chair, Charles Alexander, and chaired for the first time by Mike Bell, the new chair of Lewisham & Greenwich NHS Trust. Both are strongly committed to furthering collaborative working - through the APC and other mechanisms – to ensure we are able to make best use of the resources we have to improve health outcomes for our population. There is also strong support from the SEL ICB in the ongoing running and future development of the APC.

5 Financial Performance (Month 7)

5.1 As at month 7, the Trust has reported a year to date deficit of (£19.8m) driven by:

- The cost of COVID numbers in excess of 25 beds in plan (£12m)
- Irish CAR-T and Liver income not having been recognised (£2.9m)
- Shortall in pay award (£2.5m)
- CIP shortfall (£2.4m).

5.2 The Trust plan includes £35m of cost improvement (£23.3m pay and £11.7m non-pay) and £20m of income improvement above block contracts. The program to date has identified (£43.2m) of schemes broken down as (£12.2m) in Red, (£1.3m) in Amber and (£29.7m) in Green which leaves an unidentified planning gap of (£11.7m). To address this gap, there are (£11.1m) of schemes currently in the pipeline which need further development by the care groups to ensure delivery.

5.3 The King's plan, in line with national assumptions for minimal COVID, assumed for 50 COVID beds and normalised staff sickness. Over the last three months King's has had on average 150+ COVID patients, 30 additional beds out of action due to the IPC requirements relating to these patients and sickness absence which is 3% above anticipated levels. This has led to incremental costs but also hampered the Trust's ability to over perform on ERF. At month 7 it is estimated the direct impact of excess COVID patients is c.£12m.

5.4 The month end Group Cash balance at 31 October 2022 was £69m. Overall cash levels are lower than in the previous year due to reducing outstanding levels of trade creditors and investment in capital projects (including the Apollo project and ongoing CCU build).

5.5 The Trust has spent £18.5m on capital projects and is forecasting to spend £68.8m by year end. Against the current envelope we are over committed by £1.6m, although some slippage is expected to mitigate this potential overspend.

5.6 I am pleased to be able to announce that at the Quality and Performance Committee of NHS England on 22 November 2022, NHSE approved the recommendation that the Trust should transition from segment 4 to segment 3 of the NHS Oversight Framework and so no longer needs the support of the Recovery Support Programme (RSP) (see appendix 2). The Trust was first put into Financial Special Measures in 2017, and then transitioned across to segment 4 when the new framework was introduced. This is a significant milestone for the Trust and reflects the huge efforts of staff across the Trust and particularly by finance colleagues led by Lorcan Woods (CFO) and Arthur Vaughan (DCFO). I am also grateful for the support of system partners in our discussions with NHS England throughout this process.

5.7 I am immensely proud of this achievement, but my executive colleagues and I are not complacent. The financial outlook remains challenged and we will not meet our year-end financial targets without a concerted focus on delivering our Cost Improvement Programme. We are committed to doing this and have strengthened our internal governance to ensure we remain on track and do not lose the grip and control we have established in recent years.

6 Workforce Update

Industrial Action

6.1 A number of healthcare unions are balloting their members in relation the 2021/22 national pay award. The majority of ballots close at the end of November/start of December. Members are being asked to vote on taking strike action or action short of a strike.

6.2 The Royal College of Nursing, (RCN), have confirmed that they have reached the required thresholds in terms of turnout and outcome for their members to take strike action at King's.

6.3 The RCN have confirmed their first wave of strikes have been set for 15 and 20 December. King's has not been selected as one of the Trusts where a strike will occur on those dates.

Cost of Living

6.4 The Trust has been working closely with the King's Charity to support two new initiatives to support staff during the cost of living crisis.

6.5 We have partnered with Meals in the NHS to install five fridges that provide staff with access to healthy, nutritious and affordable meals 24 hours per day. Following a successful pilot of the scheme in the Emergency Department, the fridges have now been installed across the Denmark Hill site. We will look to add further fridges in due course.

6.6 The Charity have generously funded the cost of a Blue Light Card to all staff in Agenda for Change Bands 2-5. The cards provide access to a range of discounts both on-line and in store.

6.7 We are also working with WageStream to provide staff with the option to draw down a set percentage of their accrued salary each month ahead of payday, avoiding the need for employees to take out costly payday loans. Wagestream also offer access to financial advice and a high interest savings account. There are multiple safeguards and alerts ensuring appropriate assurance in the system and it is already used in many other NHS Trusts nationally.

Staff Nursery

6.8 The Trust have been given notice by South London and the Maudsley (SLaM) that due to the development of their Denmark Hill site, the King's Nursery at Mapother House will close from August 2023. Work continues to evaluate the commercial feasibility of developing a new nursery in the Denmark Hill area following SLaM's decision.

Recruitment

6.9 The Trust's Vacancy rate has reduced to 13.51% in October from 15.42% in July. This was primarily due to 456 new starters joining the Trust in October. This is one of our largest monthly intakes of staff. Our Trust vacancy rate is now at its lowest level since November 2021. Our nursing & midwifery registered vacancy rate reduced from 15.71% in July to 13.85% in October, its lowest level since December 2021. Our Medical & Dental vacancy rate was 9.82% in October, down from 12.94% in July, and is also now at the lowest level it has been in over 12 months. Extensive local, national and international recruitment continues.

Board Changes

6.10 Two long-standing Board Members left the Trust at the end of November, our Chairman Sir Hugh Taylor, and our Chief Nurse and Executive Director of Midwifery, Nicola Ranger. I'm pleased to welcome Charles Alexander and Clare Williams, as Chairman, and Acting Chief Nurse and Executive Director of Midwifery, respectively, to the Board.

Temporary Staffing

6.11 On the 26 September the Trust completed work to bring the temporary staffing service in-house from the previous provider. The Trust has also introduced a new technology platform supported by Patchwork. Medical staff are already using this platform and this will be phased in for other staff groups in January and March 2023, subject to due diligence and testing.

Influenza and COVID-19 Vaccinations

6.12 Both our COVID-19 Booster and Influenza vaccination seasonal programmes commenced in September. Staff are able to choose to have the vaccines administered both at the same appointment and at two different times. Access is through a combination of vaccination clinics, pop up clinics and roaming vaccinators.

Learning and Organisational Development

6.13 We have maintained our performance against the 90% target for core skills compliance. Our compliance rate is currently 90.98% (September 2022). We have also met our target for non-medical appraisals for 2022.

6.14 We are embedding our King's Leaders programmes as part of our King's Kaleidoscope learning and development offer to staff. The first cohort of our new King's Leaders programme 'Essentials' concluded in September 2022 with cohort two currently underway. Cohort one of our 'Inspire' programme commenced in September 2022.

6.15 Nominations for the King's Ambassador Scheme, our new staff advocacy scheme, opened in July with the scheme due to be formally launched in January 2023.

6.16 In September we launched the new King's Admin Professionals Network, to support staff in our admin and clerical workforce. The network is making plans for a "Love Admin" week to take place in April 2023.

6.17 Our second cohorts of the King's Intern Project Search programme commenced across DH and PRUH. I am absolutely delighted that King's is supporting this wonderful initiative to provide support and mentorship for young adults with learning disabilities and autism.

King's Annual Star Awards

6.18 The Trust's annual Star Awards ceremony took place on 24 November. Given this was the first time we have been able to hold the event in three years, it was a real celebration of the best of King's.

7 Equality, Diversity and Inclusion

Developing our culture and skill

Race Equality Code

7.1 King's is the first London Trust to be awarded the RACE Equality Code - Quality Mark, which demonstrates our commitment and collective efforts to improving representation at boardroom and senior leadership.

7.2 The Quality Mark is formal recognition that we have the commitment and a set of tangible actions that are built on best practice and evidence-based that will aim to make a difference. The Quality Mark can now be displayed on all our internal and external channels to showcase our commitment to race equality.

EDI Training for our Staff

7.3 Over 1,200 colleagues have now participated in the award-winning 'Active Bystander' training, which gives staff the skills to challenge unacceptable behaviour. An evaluation of the training was recently undertaken, which established:

- 92% satisfactory experience of the training
- 87% of training participants feel more confident in calling out inappropriate behaviour
- 95% of participants would recommend the training to another colleague

7.4 The training is currently scheduled to continue fortnightly through March 2023. An evaluation of our fortnightly inclusive recruitment training is also underway and will be shared in the next CEO report. Over 300 colleagues have attended since June 2022.

Reciprocal Mentoring Programme Launch

7.5 We launched our Reciprocal Mentoring via a virtual event that was attended by over 160 King's staff. The programme enables staff to learn about the lived experiences of colleagues of different backgrounds, staff roles, bands, and departments. The main aspects currently included in the programme are: Race & Ethnicity, LGBTQ+ Identity at work, Women at work, Disability confidence, and Religion, Faith & Belief. The platform now has over 200 registered users, including 123 mentor and 120 mentee profiles.

Staff Network progress

7.6 The EDI team have continued to support staff networks by coordinating a development program for the Co-Chairs of all five networks.

7.7 Learning from this program has enabled **King's & Queers (over 600 members)** to update their Terms of Reference and to refine and develop their 'super objective'. King's participated in the first ever cohort of the NHS Rainbow Badge Assessment. The new scheme incorporates an assessment, as well as an accreditation model, to improve the experiences of our LGBT+ service users and colleagues.

7.8 King's assessment score (45 out of 166) was one level below 'bronze' (*the vast majority of participating NHS organisations also scored one level below bronze*). To achieve a bronze award, ten more points are required. Following on from this score the Rainbow Badge Assessment team have provided King's with a comprehensive long-term action plan.

7.9 There are also two notable events being planned before the end of the year. The first is Disability History Month **(King's Able membership is over 100**) and the EDI team have planned one event per week during the month. The second is International Day for the Elimination of Violence Against Women and there are stalls as well as an online event planned for the day. (**Women's Network membership is currently almost 600).**

7.10 **Black History Month -** supported King's BAME Network's annual conference (the theme was '*Time for Action NOT Words').* Topics included: supporting staff through challenging times, supporting overseas staff, turning adversity into action, and staff engagement. **BAME Network membership is now almost 600.** A webinar also occurred which covered the psychological impact of everyday racism.

7.11 **Interfaith & Belief Network -** We officially launched the Trust's first Interfaith and Belief Network, which was created to provide a space for King's staff to:

- Learn about other beliefs, faiths or life philosophies
- Celebrate King's diverse faiths, beliefs and life philosophies
- Safely explore and address sensitive issues of belief, faith or life philosophies
- Enable networking of like-minded colleagues to build an inclusive culture

Interfaith and Belief Network membership has now risen to over 300.

7.12 Total diversity staff network membership now stands at 2,174, this is an increase of 263 since our last report in August.

Becoming an Anchor/Community Partnerships

7.13 As part of our Black History Month activities, we ran a stall at Southbank University for the inaugural '*Dame Elizabeth Anionwu Lecture*'. The lecture was attended by over 150 delegates, primarily from nursing and EDI related professions, as well as a range of other local service providers.

7.14 King's EDI Team was highlighted as an official partner for the event, where we showcased our Roadmap to Inclusion projects to those in attendance, creating many new connections with external stakeholders (e.g. Sickle Cell Society). Subsequently, we met with RefuAid who also had representatives in attendance, and we are now in the process of establishing a collaborative project aimed at placing qualified refugees into clinical roles at King's.

7.15 Alongside Lambeth Public Health Team and King's Research Team, we have established an opportunity for 5th year medical students to undertake community placements at Wellbeing Hubs throughout Lambeth. Placements will provide students with an opportunity to gain direct experience of working with, and in, the community. This approach will help us shape our model for community engagement as part of our health inequalities programme. The first students have now been recruited and

placed for the pilot phase in November and we will look to scale up the programme in the early 2023.

Tackling Health Inequalities

7.16 We have established the governance structures for the delivery of the Health Inequalities programme. Three working groups have been set up and have been tasked with developing a programme of work as a specific priority area (Operationalising the Vital 5, Diversifying Research Participation and Developing a Health Inequalities Dashboard).

7.17 In November, we held initial meetings to identify their priority actions. Membership of the Health Inequalities Steering Group, which will provide oversight of the programme, has been agreed and will hold its first meeting in January 2023 to approve the working groups' priorities.

7.18 In parallel, the Programme team has identified three 'Golden Threads' (innovation, institutional mistrust, and data disclosure) and are taking a systematic approach to identifying evidence-based solutions that can be applied across the three work streams with a particular emphasis on community input, co-design and a new model for community engagement.

7.19 Additionally, we have commenced the development of a 'magazine', which will be used to showcase the range of projects underway across the Trust that aim to reduce disparity in access, experience and outcome for our diverse communities.

Our Next Steps

7.20 This section of the report showcases some of our key activities and projects from the Roadmap to Inclusion for the next reporting period of December 2022 to February 2023:

7.21 **Developing our Culture and Skill**

- Launch disability passport and reasonable adjustments policy - we will:
  - Create a 'Disability Passport' accompanied by guidance and training; designed to promote conversations and confidence around disability and adjustments.
  - Develop a Reasonable Adjustments policy, accompanied by processes and a centralised budget for accommodating reasonable adjustments.
- Publication of 2023 Inclusion Calendar - will spotlight events equip individuals, teams or managers with baseline knowledge to spark conversations, ideas and actions.
- Launch of Supporting Trans and Non-Binary Patient Guidance - guidance from internal and external stakeholders includes best practice for clinical areas and equitable access.
- Launch of EDI Toolkit - a 'one stop shop' that aligns to Roadmap to Inclusion projects.

7.22 **Build Community Partnerships & be an Anchor in the Community**

- Establishing Our Approach to Widening Participation - As part of the Trust's Anchor's programme and alongside colleagues from OD, we will convene and constitute the Widening Participation Steering Group. The role of the group will be to:
  - Increase recruitment from the local community into healthcare roles
  - Improve access to work for underrepresented groups to gain access to NHS careers
  - Engage with young people to promote career opportunities in the health care sector

7.23 **Tackling health inequalities**

Our Trust-wide health inequalities programme will shift from project planning to project delivery. We will also begin implementation of our stakeholder engagement plan and commence the establishment of our community engagement model, which will be the core driver of innovation for the programme. This will involve the development of new local partnerships and the recruitment of 'community champions' to our three working groups. Additionally, we will publish our 'health inequalities project magazine', which will showcase the broad range of activities already underway across the Trust.

8 Board Committee Meetings since the last Board of Directors Meeting (29th Sept 2022)

Audit Committee	3rd Oct 2022
Finance and Commercial Committee	17th Oct 2022
Quality, People and Performance Committee	30th Sept, 24th Nov 2022
Remuneration Committee	29th Sept 2022
Strategy, Research & Partnerships Committee	1st Dec 2022
Annual Members Meeting	29th Sept 2022
Board Development Session	20th Oct 2022
Council of Governors	18th Oct 2022
Governor Patient Safety and Experience Committee	13th Oct 2022

9 Good News Stories

9.1 **Sky News: King's College Hospital Charity Christmas appeal:** On 24 November, Sky News reported on King's patient Alan Raine, who donated part of his liver to save the life of his daughter, Lola-Rose after she experienced sudden liver failure. He's now calling on people to support the King's College Hospital Charity Christmas appeal for research, equipment, facilities and services for King's patients.

9.2 **The Guardian: Vaccine prolongs life of patients with aggressive brain cancer:** On 10 November, The Guardian reported on the ground-breaking results of a research trial held at King's for a new treatment for brain tumour patients. "The total results are astonishing," said Prof Keyoumars Ashkan, King's neurosurgeon and

European chief investigator of the trial. “The final results of this phase three trial … offer fresh hope to patients battling with glioblastoma.” ITV News and Channel 5 News also reported on the story.

9.3 **King’s Stars Awards evening:** In November, we celebrated the King’s Stars Awards evening. The event – generously supported by King’s College Hospital and hosted by BBC presenter Ros Atkins – was held at a central London venue, and attended by over 350 colleagues and supporters of the Trust. 10 awards were given out on the evening, with highlights from the event shared on our internal and social media channels.

9.4 **New Transitional Care Unit for babies opens at the PRUH**: A new Transitional Care Unit for newborn babies requiring extra monitoring and support opened at the PRUH in November. Rezi Morales, Neonatal Matron at the PRUH said: “Keeping mothers and babies together is a vital part of the care we provide, and the overall bonding process, so the opening of the Transitional Care Unit is a really positive step forward for the neonatal and maternity care we provide.”

9.5 **Health Service Journal (HSJ) award finalists**: King’s made the final short-list for three of this year’s Health Service Journal (HSJ) awards. Our teams were short-listed in three categories, namely NHS Comms Initiative of the year; NHS Race Equality Award; and Primary and Community Care Innovation of the year. Sadly, we were not victorious in any of the three categories on the night, but to have made the final short-list in these prestigious awards is a real achievement.

9.6 **Becoming an Anchor Institution – The Shelford Group blog**: Roxanne Smith, Director of Strategy at King’s, authored a blog on The Shelford Group’s website about our work to make King’s an ‘anchor institution’, so helping patients and communities beyond the confines of the hospital walls. Examples like Project SEARCH – and the development of the King’s Academy in Loughborough Junction – show that “we are committed to strengthening and deepening connections with our local community."

9.7 **Sky News – “There hasn’t been a downtime, it’s relentlessly busy.”**: In October, members of staff – including Dr Emer Sutherland, Clinical Director for Emergency Care; Professor Clive Kay, CEO; and Dr Oli Long, Site Medical Director, Denmark Hill spoke to Sky News about demand for our services, and the steps we are taking to reduce waiting lists for those patients needing routine care and treatment.

9.8 **Channel 4 News – Pressures on the NHS**: Also in October, staff spoke to Channel 4 News about the competing challenges of managing demand for our services, keeping patients safe, and reducing the waiting list backlogs. Lesley Powls, Director of Operations at Denmark Hill and Dr Jimstan Periselneris, Consultant Respiratory Physician, were among those interviewed.

9.9 **Mayor of London visits King’s to see youth violence prevention work:** Mayor of London Sadiq Khan visited our Emergency Department at Denmark Hill in October to meet with staff involved in helping young people affected by violence. Dr Emer Sutherland, Clinical Director for Emergency Medicine, was interviewed by regional media (including BBC and ITV London) as part of the visit.

9.10 **Secretary of State Visit to KCH:** On Thursday 1 December, Steve Barclay MP, Secretary of State for Health and Social Care, paid a visit to our Denmark Hill site to coincide with World AIDS Day. Mr Barclay visited colleagues based in our

Emergency Department, and virology service. He also visited our World AIDS Day stand in Golden Jubilee Wing. During his visit, he talked to Dr Emer Sutherland, Clinical Director for Emergency Care; Dr Oliver Mizzi, Consultant in Emergency Medicine; Dr Malur Sudhanva, Consultant Medical Virologist; and Dr Liz Hamlyn, Consultant Physician and HIV Clinical Lead. All patients having a blood test in Emergency Departments are now tested for HIV, unless they choose to opt out. This follows a successful pilot project launched at our Denmark Hill site in 2016, following funding from the Elton John AIDS Foundation. Since April 2022, ED HIV testing has been successfully rolled out across all London ED departments, with NHS funding. Our Emergency Department is also now offering ED patients routine testing for viral hepatitis, building on the success of the HIV testing initiative

AAC Date	Name of Post	Appointee	Post Type New / Replacement	Start Date
09/06/2022	Consultant in Oral Surgery	Mr Muneer Patel	New	03/10/2022
22/06/2022	Consultant Clinical Lead, Havens CYP Service	Dr Arlene Boroda	Replacement	03/10/2022
23/06/2022	Consultant Physician in Respiratory & GM, Sleep & Ventilation	Dr Marcus Pittman	New	03/10/2022
21/07/2022	Consultant Haematologist in General Haemato-Oncology	Dr Musab Omer	New	03/10/2022
10/08/2022	Consultant Obstetrics and Gynaecology, Interest in Urogynaecology	Mr George Andreas Araklitis	New	03/10/2022
13/09/2022	Consultant Obstetrics & Gynaecology, Interest in Fertility	Mr Venkatesh Subramanian	New	04/10/2022
28/04/2022	Consultant Diabetes & Endocrine	Dr Adrian Li	New	05/10/2022
28/06/2022	Consultant Urologist with Interest	Mr Kawa Omar	New	05/10/2022
26/09/2022	Consultant in Critical Care	Dr Theodoros Christoforatos	New	10/10/2022
04/08/2022	Consultant in Endocrinology & General Internal Medicine	Dr Shemitha Kollikkura Mohamed Rafique	New	12/10/2022
04/01/2022	Consultant Ophthalmologist with a special interest in Uveitis	Dr Neda Minakaran	Replacement	31/10/2022
28/06/2022	Consultant Urologist with Interest	Miss Francesca Kum	New	31/10/2022
21/07/2022	Consultant Haematologist with an interest in Lymphoid Malignancies	Dr Jin Shin	New	31/10/2022
07/07/2022	Consultant Anaesthetist with an Interest in Paediatric Anaesthesia	Dr Dominic Peter Douglas Nielsen	Replacement	14/11/2022

26/09/2022	Consultant in Critical Care	Dr Thomas David Costas Georgious	New	28/11/2022
11/10/2022	Consultant Chemical Pathology, Interest in Lipidology & Parenetal	Dr Ruvini Nilni Kumari Ranasinghe	New	09/01/2023
25/10/2022	Consultant in Medical Microbiology and Infection Sciences	Dr Anjaneya Bapat	New	10/04/2023
13/10/2022	Consultant Anaesthetist, Interest in General & Paediatric Anaesthesia	Dr Alexander James Stilwell Dr Bernadette Nzekwu	New	17/04/2023 TBC
15/11/2022	Consultant Diabetologist	Dr Martin Brunel Whyte	New	TBC
17/11/2022	Consultant Oral & Maxillofacial Surgeon (General) - 2 posts Consultant Oral & Maxillofacial Surgeon, Craniofacial Surgery Interest - 1 post	Mr Atheer Bedri Ujam (General) Mr Navin Vig (General) Dr Benjamin Ronald Robertson (Craniofacial)	Replacement	TBC TBC TBC
28/11/2022	Consultant Gastroenterologist, Interest in Nutrition, & Video Capsule Endoscopy	Ms Dominique Clement	New	TBC
29/11/2022	Consultant in Neuroanaesthesia	Dr Rachel Elizabeth Steele	Replacement	TBC
Honorary	Honorary Consultant	Dr Laura Crisan	Honorary	01/11/2022
Locum Consultant	Locum Consultant Trauma & Orthopaedic (Foot & Ankle)	Mr Syed Zaidi	Replacement	03/10/2022
Locum Consultant	Locum Consultant Paediatrician with an interest in Haematology/ Oncology	Dr Tamara Roberts	New	03/10/2022
Locum Consultant	Locum Consultant Respiratory Medicine	Dr Katherine Myall	Replacement	03/10/2022
Locum Consultant	Locum Consultant in Endodontics	Dr Neha Patel	Replacement	04/10/2022
Locum Consultant	Locum Consultant Anaesthetist	Dr Laura Alvaro-Gracia Heredero	New	17/10/2022
Locum Consultant	Consultant Trust Medical Examiner	Dr Shireen Amirali Kassam	Replacement	18/10/2022

Locum Consultant	**Locum Consultant Neonatologist**	**Dr Ana Serrano Llop**	**New**	**24/10/2022**
Locum Consultant	**Locum Consultant in Trauma & Emergency General Surgery**	**Dr Susana Fernandez-Diaz**	**New**	**31/10/2022**
Locum Consultant	**Locum in Oral and Maxillofacial Surgery**	**Dr Rutangi Hundia**	**Replacement**	**31/10/2022**
Locum Consultant	**Locum Consultant Anaesthetist**	**Dr Divya Harshan**	**New**	**02/11/2022**
Locum Consultant	**Locum Consultant Rheumatologist**	**Dr Asim Khan**	**New**	**14/11/2022**
Locum Consultant	**Locum Consultant Gynaecology & Obstetrics, Pregnancy Termination Interest**	**Dr Rahel-Ochido Odonde**	**Replacement**	**14/11/2022**
Locum Consultant	**Locum Consultant - Ophthalmology**	**Miss Caroline Louise Wilde**	**Replacement**	**18/11/2022**
Locum Consultant	**Consultant Haematologist - Diagnostics & Lymphoid Malignancies**	**Dr Prudence Jean Hardefeldt**	**New**	**28/11/2022**
Retire & Return	**Consultant Cellular Pathologist**	**Dr Nuzhat Akbar**	**Replacement**	**07/10/2022**
Retire & Return	**Consultant Urologist**	**Mr Gordon Hugh Muir**	**Replacement**	**07/11/2022**
Retire & Return	**Consultant Neurologist**	**Dr Thomas Cornelius Britton**	**Replacement**	**01/11/2022**

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

By email

Our reference:INS2-4261336011

Professor Clive Kay
Chief Executive
King's College Hospital NHS FT
Denmark Hill
London
SE5 9RS

28 November 2022

CQC Reference Number: INS2-14261336011

Dear Clive

Re: CQC inspection of King's College Hospital NHS FT -Well-led

Following your feedback Teams discussion with Stella Franklin today. I thought it would be helpful to give you written feedback as highlighted during this call.

This letter does not replace the draft report and evidence log we will send to you, but simply confirms what we fed-back on28 November and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report and evidence log, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you was:

- **We found a good level of Board unity, with a sense of the team working well together, with a healthy degree of challenge.**

- **It was clear there were positive changes in the governance arrangements and risks management. We recognised there was still work in progress related to these areas.**

- **We acknowledge the big piece of work around the strategy and, the strength of involvement with the wider staff group and stakeholders. This was achieved despite the additional pressures the Trust was facing. The ambitions to involve patients and what matters to them was clearly articulated in the strategy. We indicated the patient experience team as being invaluable in facilitating the strategic outcomes.**

- **Some good work has been done around EDI and the lead for this has contributed greatly.**

- **There are cultural issues in some areas, which still need to be resolved. Staff in some areas do not feel they are heard and when they raise matters or ask for information, do not always get a response or satisfactory resolution. HR activities did not always follow policy. There has been a concern in one area that issues raised have not been escalated, despite the seriousness.**

- **Complaints and incidents not always responded to as swiftly as expected, although we can see that measures have been put in place to improve these areas.**

- **The relationship between PRUH and King's sites has improved and there is greater sense of cohesion, improved by having the on-site executive team.**

Following the feedback, we discussed these points and you suggested the value in additional discussion with two members of the leadership team, which will be arranged. Additional documentation will also be sent where thought to be of benefit.

A draft inspection report will be sent to you once we have completed our due processes and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Mark Wood and Stephanie Coffey at NHS England and NHS Improvement.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

@BCL@A004ACBA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Stella Franklin

Inspection manager

c.c. Chair of Trust
Name of NHS Improvement representative
CQC regional communications manager

@BCL@A004ACBA

To:

Professor Clive Kay, Chief Executive Officer

Sir Hugh Taylor, Chair

King's College Hospital NHS Foundation Trust

Sir David Sloman
Chief Operating Officer
NHS England
Wellington House
London
SE1 8UG

29 November 2022

Dear Clive and Hugh,

Formal notice of transition to NHS Oversight Framework segment 3 and exit from the Recovery Support Programme

I have great pleasure in being able to confirm that the Quality and Performance Committee (QPC) of NHS England on **22 November 2022** approved the recommendation that King's College Hospital NHS Foundation Trust should transition from segment 4 to segment 3 of the NHS Oversight Framework and so no longer needs the support of the Recovery Support Programme (RSP). Please accept this letter as the formal notification of this decision.

I would like to thank you for all the hard work that you and your teams have contributed, to improve the quality of care to your patients in a sustainable way, and to make progress with the deep-seated and complex challenges that led to the decision to support your trust via the RSP.

I know that you will agree that there is still much that needs to be done to ensure that the improvement you have been achieving for your patients is fully embedded and sustained. The picture that you and the South East London Integrated Care Board (ICB) set out at the recent RSP review meeting convinced us that this joint approach to sustained improvement will be successful with delivery. The strong exit support

package and undertakings that have been agreed with the London regional team is also aimed to help with this sustained improvement.

I am convinced that the progress that has been achieved and that we saw at the RSP review meeting is to a large extent down to the personal, collaborative leadership that you have exhibited, as well of course to the immense hard work of all the clinical and non-clinical staff across your trust. I look forward to hearing how this story of improvement across a complex system continues over the forthcoming months and years and the difference that this will make for your patients.

Yours Sincerely,

Sir David Sloman
Chief Operating Officer
NHS England

Copy:

Professor Sir Stephen Powis, National Medical Director, NHS England
Andrew Ridley, Regional Director, London
Becky Chantry, Head of Intensive Support, London
Professor Mark Radford, National Director Intensive Support, ISCS, NHSE
Caroline Kurzeja, Regional SLT Lead, ISCS, NHSE
Hazel Doughty, Deputy Improvement Director, ISCS, NHSE
Richard Winter, SLT Regional Lead, ISCS, NHSE
Dr Nick Clarke, Deputy Director of Policy and Governance, NHSE
Andrew Bland, Chief Executive Officer, South East London ICB
Richard Douglas, Chair, South East London ICB

King's College Hospital NHS
NHS Foundation Trust

Integrated Performance Report

Month 7 (October) 2022/23

Board Committee

8 December 2022

King's College Hospital NHS
NHS Foundation Trust

Report to:	*Board Committee*
Date of meeting:	*8 December 2022*
Subject:	*Integrated Performance Report 2022/23 Month 7 (October)*
Author(s):	*Adam Creeggan, Director of Performance & Planning;* *Steve Coakley, Assistant Director of Performance & Planning;*
Presented by:	*Beverley Bryant, Chief Digital Information Officer*
Sponsor:	*Beverley Bryant, Chief Digital Information Officer*
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 October 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 2022/23 M7 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 7

QUALITY

- Summary Hospital Mortality Index (revised to NHS Digital index) has increased to 101.7 – which is above expected index of score of 100.
- **HCAI**:
  - ❑ Zero MRSA bacteraemia cases reported in October and the previous cases last reported in May and July 2022;
  - ❑ 7 new VRE bacteraemia cases reported in October and 39 cases reported year to-date.
  - ❑ E-Coli bacteraemia: 16 new cases reported in October and 97 cases year to-date which is above the target of 74 cases;
  - ❑ 11 new C-difficile cases reported in October and 75 cases year to-date which is above the target of 63 cases.
- FFT inpatient recommendation scores reduced by a further 0.3% in October to 93.7% and remains below the 96.0% target.
- FFT ED recommendation scores reduced by 0.2% to 60.2% and remains below the 86.0% Trust target.

PERFORMANCE

- Trust A&E/ECS compliance reduced from 62.75% in September to 60.25% in October. By Site: DH 58.08% and PRUH 63.06%.
- Cancer:
  - ❑ Treatment within 62 days of post-GP referral is not compliant but improved to 70.41% for October (target 85%).
  - ❑ Treatment within 62 days following screening service referral is not compliant at 84.00% for October (target 90%).
  - ❑ The two-week wait from GP referral standard reduced to 92.43% in October and is not compliant with the 93% target.
- Diagnostics: performance improved by 2.65% to 2.24% of patients waiting >6 weeks for diagnostic test in October (target <1%).
- RTT incomplete performance improved by 1.41% to 73.98% in October (target 92%).
- RTT patients waiting >52 weeks reduced by 38 cases to 655 cases in October, compared to 693 cases in September.

WORKFORCE

- The appraisal non-medical compliance rate of 93.31% has remained over the 90% target for the third consecutive month. The Medical & Dental rate of 91.08% has increased from last month and it is also over the 90% target for October.
- The sickness absence has increased from 3.98% in September to 4.64% in October.
- There were a total of 2,811 staff off sick during October.
- Statutory and Mandatory training compliance rate has decreased this month by 2.16% and it has not achieved the 90% target for the first time in 6 months.
- The Trust vacancy rate for this month has reduced from 14.52% in September to 13.51% in October.
- The Trust turnover rate has increased from 15.25% in September to 15.37% in October, and remains above the internal 14% target.

FINANCE

- Year to date the Trust reports a deficit of -£19.8m. This is predominantly driven by CIP non-achievement and incremental costs of reset and recovery and COVID as well as the following factors:
- **Operating Income**: £16.6m over performance against the plan due to prior year one off benefit for prior year Devices (£2.6m) received in M6 and prior year Drugs (£2.7m) received in M5, vaccination and standard COVID testing reimbursements of c£4m and recognition of E-plex tests for Q4.Income COVID testing contributes positively to YTD variance of £7.8m.
- **Employee Expenses (Pay)**: £5.3m overspend compared to plan is due to underachieving on CIPs, incremental COVID and reset and recovery.
- **Operating Expenses (Non Pay)**: £29.1m overspend compared to plan is mainly due to underachieving on CIPs and additional pressures including Drugs expenditure is significantly higher than budget (£8.2m YTD) partly offset by the income.

NHSi Dashboard - Strategic Oversight Framework

NHSi Dashboard

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
Domain	Indicator	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	13-Month Trend
A&E	A&E Waiting times - Types 1&3 Depts (Target: > 95%)	56.35 %	61.03 %	58.08 %	57.84 %	66.49 %	64.92 %	63.06 %	66.32 %	60.87 %	62.75 %	60.25 %	61.57 %	
RTT	RTT Incomplete Performance	74.46 %	75.72 %	78.03 %	74.69 %	72.08 %	71.20 %	71.40 %	71.97 %	73.50 %	73.98 %	75.39 %	73.68 %	
Cancer	2 weeks from referral to first appointment all urgent referrals (Target: > 93%)	96.15 %	92.60 %	91.88 %	94.20 %	96.37 %	94.47 %	93.25 %	94.96 %	96.24 %	93.39 %	92.43 %	94.51 %	
	2 weeks from referral to first appointment all Breast symptomatic referrals (Target: > 93%)					97.67 %	96.67 %	98.39 %	96.12 %	97.67 %	96.67 %	98.39 %	96.12 %	
	31 days diagnosis to first treatment (Target: >96%)	91.46 %	93.55 %	93.71 %	91.53 %	87.76 %	80.95 %	98.00 %	91.64 %	90.70 %	89.36 %	94.87 %	91.59 %	
	31 days subsequent treatment - Drug (Target: >98%)	100.00 %	86.67 %	100.00 %	95.63 %	100.00 %	100.00 %	100.00 %	100.00 %	100.00 %	87.88 %	100.00 %	96.04 %	
	31 days subsequent treatment - Surgery (Target: >98%)	97.37 %	80.77 %	83.33 %	87.98 %	33.33 %	0.00 %	100.00 %	56.25 %	92.68 %	75.00 %	84.09 %	85.71 %	
	62 days GP referral to first treatment (Target: >85%)	58.44 %	61.54 %	65.69 %	57.53 %	80.00 %	60.00 %	84.21 %	73.35 %	65.18 %	60.77 %	70.41 %	63.01 %	
	62 days NHS screening service referral to first treatment (Target: >90%)	58.14 %	85.42 %	77.78 %	74.85 %	100.00 %	75.00 %	100.00 %	81.01 %	63.27 %	81.94 %	84.00 %	76.02 %	
Patient Safety	Clostridium difficile infections	8	10	8	58	3	7	3	17	11	17	11	75	

A&E 4 Hour Standard

- A&E performance was non-compliant in October at 60.25%, below the national target of 95% and reducing by 2.50% compared to 62.75% performance achieved in September 2022.

Cancer

- The latest interim 62-day performance for patients referred by their GP for first cancer treatment improved by 9.64% from 60.77% reported for September 2022 to 70.41% in October, and below the national target of 85%.

RTT

- RTT performance is validated at 75.39% for October which is an improvement of 1.41% compared to 73.98% performance achieved in September.

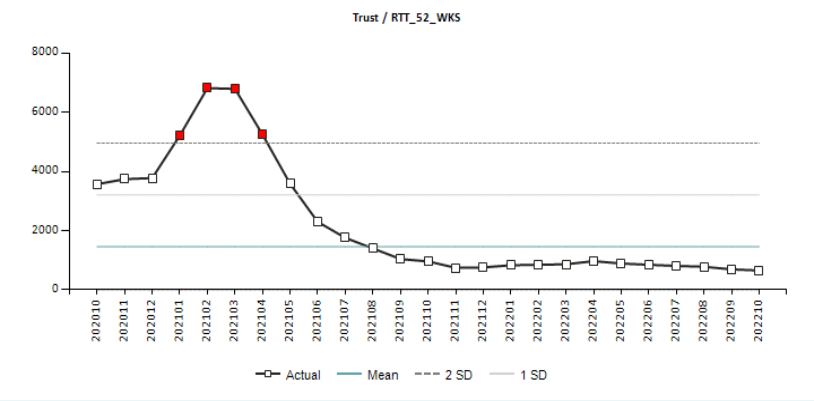
C-difficile

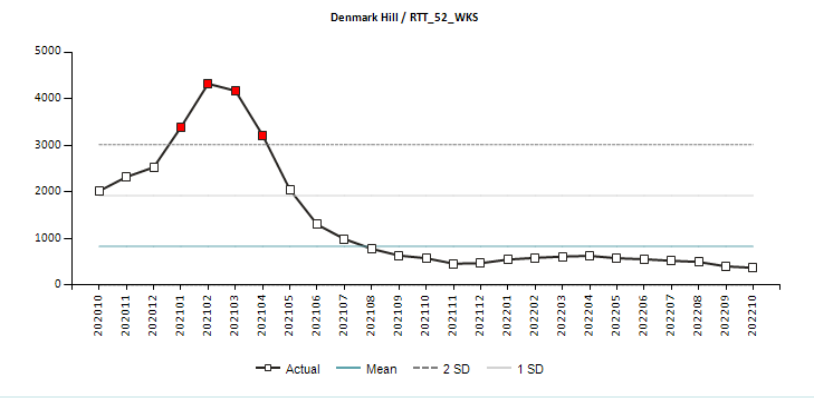
- There were 11 Trust attributed cases of C-Difficile in October 2022 and 75 cases year to-date which is above the cumulative target of 63 cases.

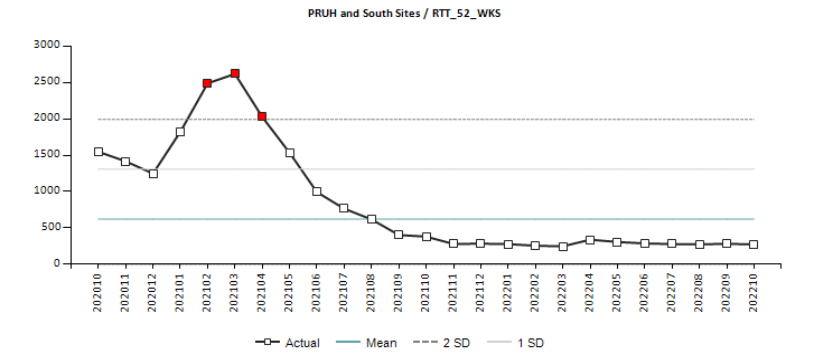
Selected Board Report NHSi Indicators

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

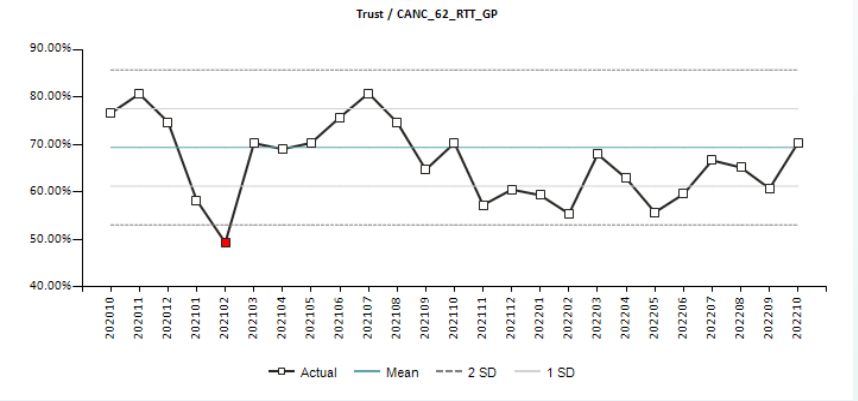
RTT Incomplete Pathways

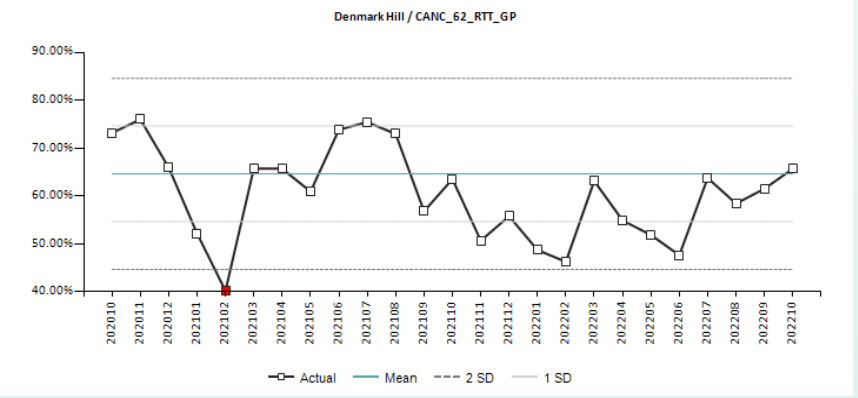


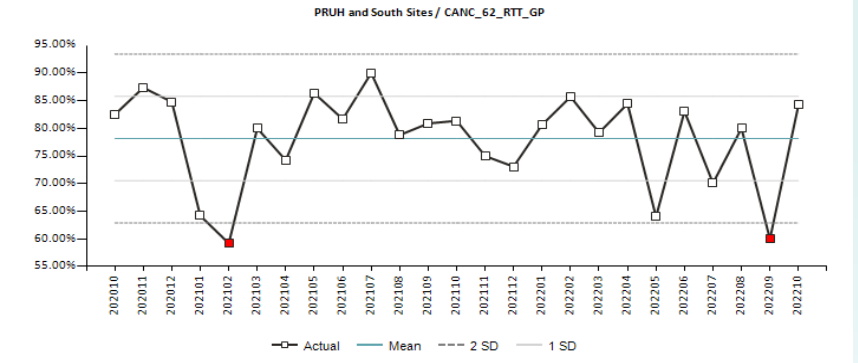




Cancer: 62 day standard

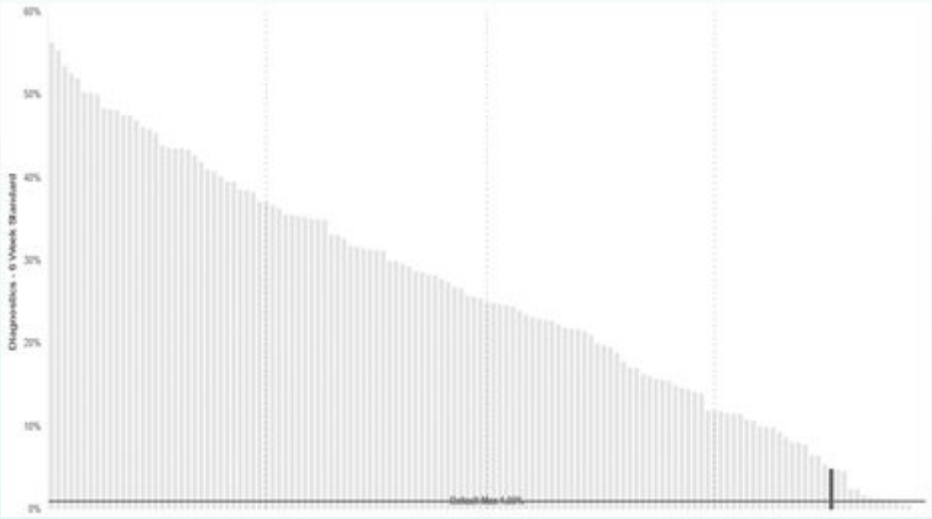




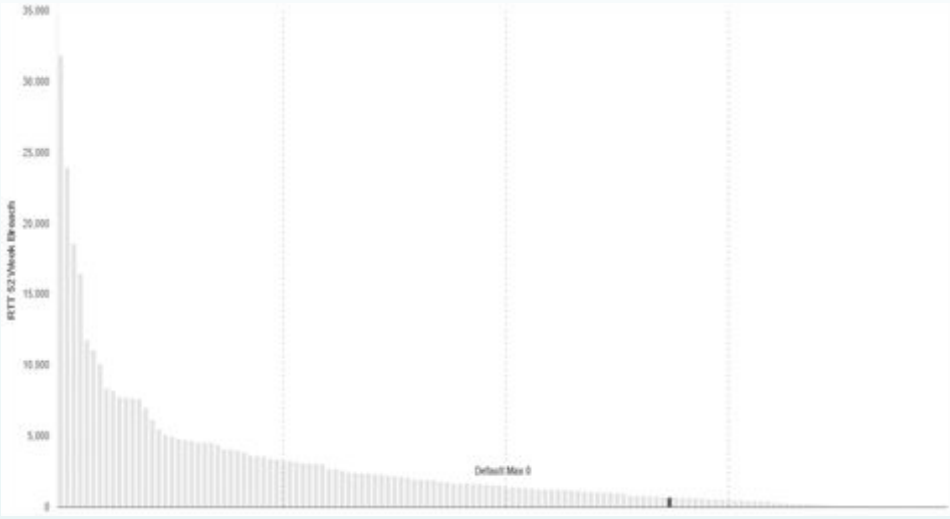


Selected Board Report NHSi Indicators

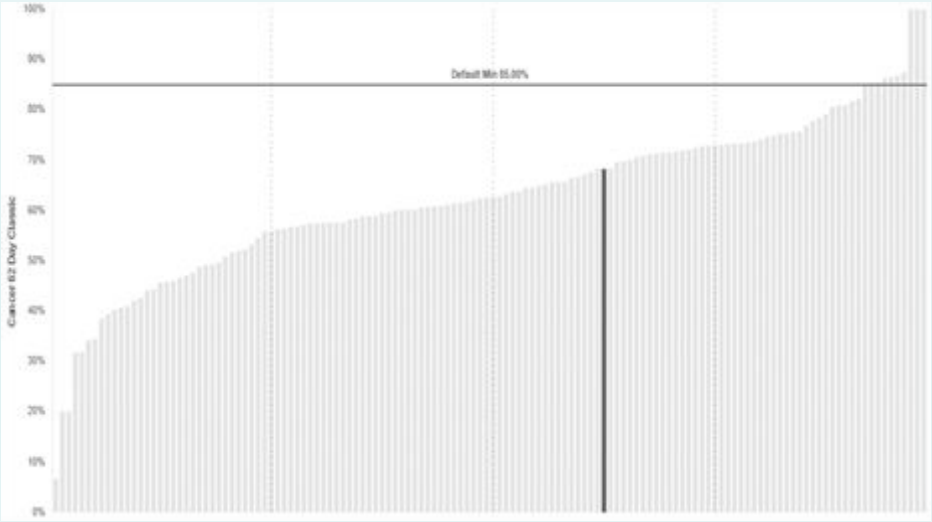
Based on data published from '*Public View*'



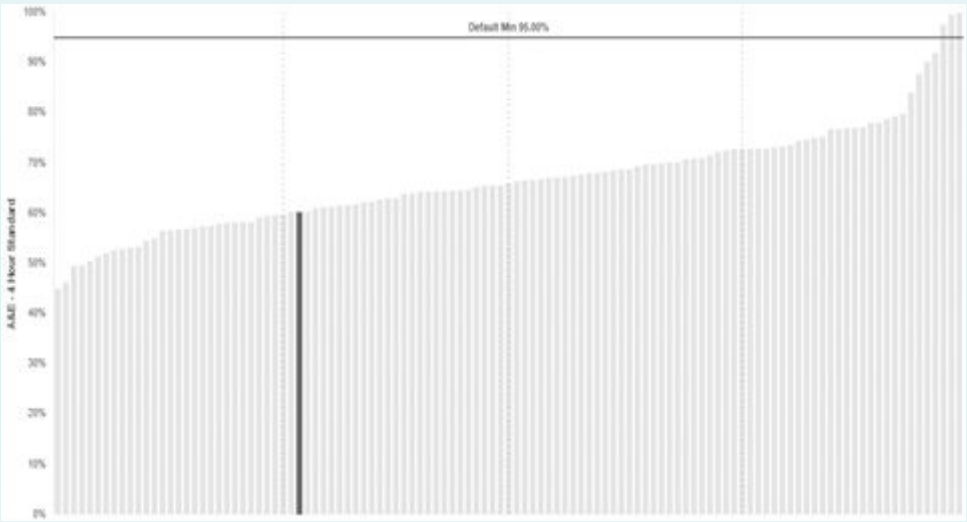
The chart above shows the national ranking against the DM01 diagnostic 6 week standard. Kings is ranked 15 out of 135 selected Trusts based on September 2022 data published.



The chart above shows the national ranking against the RTT 52 week standard. Kings is ranked 43 out of 136 selected Trusts based on latest September 2022 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 50 out of 134 selected Trusts based on latest September 2022 data published.



The chart above shows the national ranking against the 4 hour Emergency Care Standard. Kings is ranked 83 out of 113 selected Trusts based on latest October 2022 data published.

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Safety Dashboard

Safe

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	13 Month Trend
CQC level of inquiry: Safe														
Reportable to DoH														
2717	Number of DoH Reportable Infections	103	93	87	506	14	11	16	64	117	104	106	573	
Safer Care														
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.00	0.06	0.18	0.08	0.30	0.19	0.30	0.20	0.10	0.10	0.22	0.12	
1897	Potentially Preventable Hospital Associated VTE	2	3	0	9	3	0	0	9	5	3	0	18	
538	Hospital Acquired Pressure Ulcers (Grade 3 or 4)	1	0	1	5	0	0	0	0	1	0	1	5	
Incident Reporting														
520	Total Serious Incidents reported	6	3	14	47	1	5	5	37	7	8	19	84	
516	Moderate Harm Incidents	19	8	25	128	18	13	17	106	39	21	44	240	
509	Never Events	0	0	2	3	0	0	0		0	0	2	3	

HCAI

- There were no MRSA bacteraemia cases reported for October and the previous cases last reported in May and July 2022.
- 7 new VRE bacteraemia cases reported in October and 39 cases year to-date.
- E-Coli bacteraemia: 16 new cases reported in October and 97 cases year to-date which is above the cumulative target of 74 cases.
- 11 Trust attributed cases of c-Difficile in October and 75 cases year to-date which is above the target of 63 cases for the month.

Complaints

- The number of complaints reduced from 105 cases reported in September to 87 cases reported in October. The number of complaints not responded to within 25 days increased from 171 cases in September to 231 cases in October.

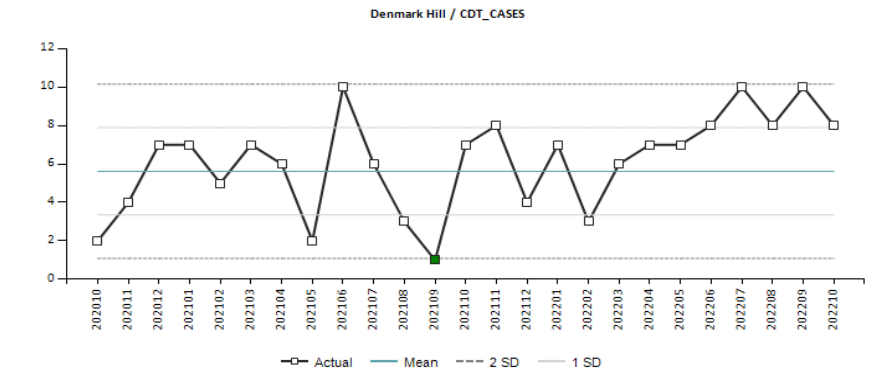
Inpatient Surgical Cancellations

- The number of inpatient surgical operations cancelled on the day increased from 42 in September to 47 in October, matching the Trust target of 47 cases.

HCAI

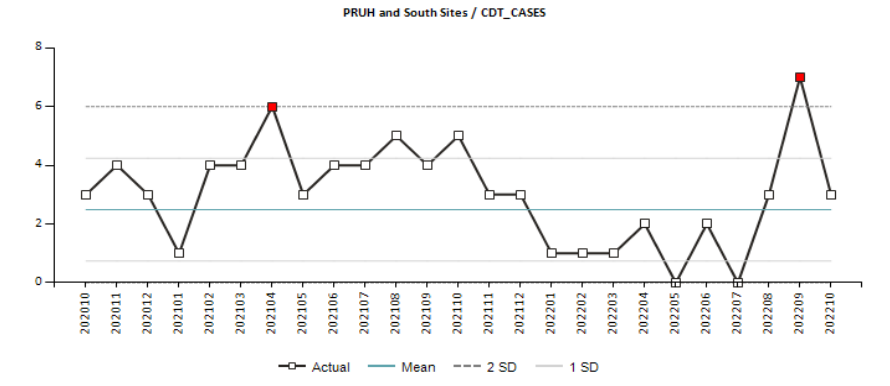
Denmark Hill performance:

- 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 were no MRSA bacteraemia cases reported for October and the previous cases reported on an Acute Medicine ward at Denmark Hill in July, and on a Haematology ward at Denmark Hill in May 2022.

VRE:

- 7 new VRE bacteraemia cases reported in October with 6 cases reported on the Denmark Hill site – including 2 cases reported on Critical Care wards, 1 case on each of an Acute Medicine ward, a General Medicine ward, a Cardiovascular ward and on a Child Health ward.
- There was 1 case reported on the PRUH site on Medical Ward 6.

E-Coli:

- E-Coli bacteraemia: 16 new cases reported in October and 97 cases year to-date which is above the cumulative target of 74 cases. There were 10 cases were reported at Denmark Hill.
- There were 6 cases reported at PRUH/South Sites.

C-Difficile:

- 11 Trust attributed cases of c-Difficile in October and 75 cases year to-date which is above the cumulative plan of 63 cases.
- There were 8 cases were reported on the DH site with 2 cases in Surgery wards, 2 cases in Haematology wards, 2 cases in a Renal ward, 1 case in an Acute Medicine ward and 1 case in a Cardiovascular ward.
- There were 2 c-Difficile cases reported on the PRUH site with 1 case reported on Medical Ward 8 and 1 case reported on Surgical Ward 8.
- There was also 1 case reported on Churchill ward at Orpington Hospital.

Patient Experience Dashboard

Caring

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	13 Month Trend
CQC level of inquiry: Caring														
HRWD														
422	Friends & Family - Inpatients	93.67 %	94.13 %	93.10 %	93.60 %	95.79 %	93.71 %	94.67 %	93.83 %	94.34 %	93.96 %	93.70 %	93.68 %	
423	Friends & Family - ED	60.32 %	58.42 %	54.16 %	60.26 %	71.81 %	62.77 %	67.63 %	68.11 %	66.95 %	60.36 %	60.19 %	64.19 %	
774	Friends & Family - Outpatients	90.15 %	89.46 %	89.87 %	90.05 %	90.42 %	89.98 %	89.68 %	89.75 %	90.26 %	89.67 %	89.79 %	89.93 %	
775	Friends & Family - Maternity	72.73 %	83.08 %	81.71 %	84.97 %	93.33 %	94.04 %	87.34 %	91.37 %	86.86 %	90.74 %	85.42 %	89.03 %	
Complaints														
619	Number of complaints	54	73	55	380	35	32	32	203	89	105	87	589	
Operational Engagement														
620	Number of complaints not responded to within 25 Days	21	110	151	495	10	61	80	268	31	171	231	770	
3119	Number of PALS enquiries – unable to contact department	8			73	12			84	20			161	
Incident Management														
660	Duty of Candour - Conversations recorded in notes	85.00 %	93.75 %	100.00 %	92.36 %	84.21 %	100.00 %	100.00 %	97.79 %	85.00 %	97.14 %	100.00 %	95.04 %	
661	Duty of Candour - Letters sent following DoC Incidents	92.00 %	100.00 %	94.44 %	89.36 %	82.35 %	95.24 %	89.47 %	95.59 %	88.10 %	97.22 %	91.89 %	92.47 %	
1617	Duty of Candour - Investigation Findings Shared	0.00 %	0.00 %	3.13 %	6.71 %	8.70 %	5.56 %	0.00 %	10.45 %	4.17 %	3.03 %	1.85 %	8.55 %	

- **FFT – Inpatient**: Trust score decreased by 0.3% to 93.7% recommendation rate in October. Please note from April 2022 the additional Quality Metrics nutrition, hydration and emotional support have been removed from our internal surveying programme.
- **FFT - A&E**: Overall Trust score decreased by 0.2% to 60.2% in October, remaining below target for the ninth consecutive month. A Trust-wide action plan based on the National CQC Urgent and Emergency Patient Experience Survey results has been drafted with local site action plans to complement. Patient feedback themes are now being sent monthly to the SMT at PRUH for incorporation into staff training within the department and to identify areas for improvement.
- **FFT – Outpatients**: Trust FFT score for outpatients increased marginally from 89.7% to 89.8% in October. Further cross-Trust conversations have begun around standardising patient communication within EPIC '*MyChart*' as part of the Apollo programme and work looking at a King's specific Communication and Engagement Plan has commenced.
- **FFT – Maternity (combined)**: Overall Trust combined FFT maternity score decreased by 5.3% to 85.4%. Feedback by SMS is now live for women across all key touchpoints; antenatal, labour and birth and community postnatal.

Performance Dashboard

Performance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	13 Month Trend
CQC level of inquiry: Responsive														
Access Management - RTT, CWT and Diagnostics														
364	RTT Incomplete Performance	74.46 %	75.72 %	78.03 %	74.69 %	72.08 %	71.20 %	71.40 %	71.97 %	73.50 %	73.98 %	75.39 %	73.68 %	
632	Patients waiting over 52 weeks (RTT)	501	405	375	3,578	277	283	276	2,054	781	693	655	5,647	
4997	Patients waiting over 78 weeks (RTT)	35	45	45	428	14	9	9	131	49	54	54	559	
4537	Patients waiting over 104 weeks (RTT)	0	0	0	5	0	0	0	3	0	0	0	8	
4557	RTT P2 Admitted Pathways	1,113	1,150	1,268	8,216	609	642	607	4,126	1,725	1,793	1,880	12,358	
4558	RTT P2 Admitted Pathways waiting >4 weeks	52.92 %	47.39 %	46.77 %	49.34 %	53.20 %	55.14 %	55.02 %	55.24 %	53.04 %	50.14 %	49.47 %	51.33 %	
412	Cancer 2 weeks wait GP referral	96.15 %	92.60 %	91.88 %	94.20 %	96.37 %	94.47 %	93.25 %	94.96 %	96.24 %	93.39 %	92.43 %	94.51 %	
413	Cancer 2 weeks wait referral - Breast					97.67 %	96.67 %	98.39 %	96.12 %	97.67 %	96.67 %	98.39 %	96.12 %	
419	Cancer 62 day referral to treatment - GP	58.44 %	61.54 %	65.69 %	57.53 %	80.00 %	60.00 %	84.21 %	73.35 %	65.18 %	60.77 %	70.41 %	63.01 %	
536	Diagnostic Waiting Times Performance > 6 Wks	6.61 %	5.64 %	2.63 %	5.75 %	0.43 %			0.18 %	5.76 %	4.89 %	2.24 %	5.02 %	
Access Management - Emergency Flow														
459	A&E 4 hour performance (monthly SITREP)	56.35 %	61.03 %	58.08 %	57.84 %	66.49 %	64.92 %	63.06 %	66.32 %	60.87 %	62.75 %	60.25 %	61.57 %	
Patient Flow														
399	Weekend Discharges	19.98 %	21.79 %	24.73 %	22.41 %	16.55 %	15.87 %	20.64 %	18.23 %	18.87 %	19.91 %	23.52 %	21.07 %	
404	Discharges before 1pm	14.90 %	16.89 %	14.91 %	15.91 %	15.54 %	16.28 %	19.22 %	17.35 %	15.04 %	16.65 %	16.15 %	16.44 %	
747	Bed Occupancy	90.84 %	91.53 %	92.58 %	91.79 %	95.56 %	96.40 %	95.90 %	95.26 %	92.48 %	93.21 %	93.73 %	92.99 %	
1357	Number of Stranded Patients (LOS 7+ Days)	410	400	420	2,727	255	256	238	1,595	666	657	660	4,337	
1358	Number of Super Stranded Patients (LOS 21+ Days)	199	216	218	1,327	92	100	96	590	292	317	315	1,931	
762	Ambulance Delays > 30 Minutes	526			2,451	143			1,221	669			3,672	
772	12 Hour DTAs	88	129	208	715	559	616	830	3,521	647	745	1,038	4,236	
Theatre Productivity														
801	Day Case Rate	76.61 %	75.89 %	77.93 %	76.53 %	73.06 %	71.76 %	73.56 %	72.81 %	76.23 %	75.13 %	77.22 %	76.05 %	

A&E 4 Hour Standard

- A&E performance was non-compliant in October at 60.25% which has reduced from 62.75% performance achieved in September.

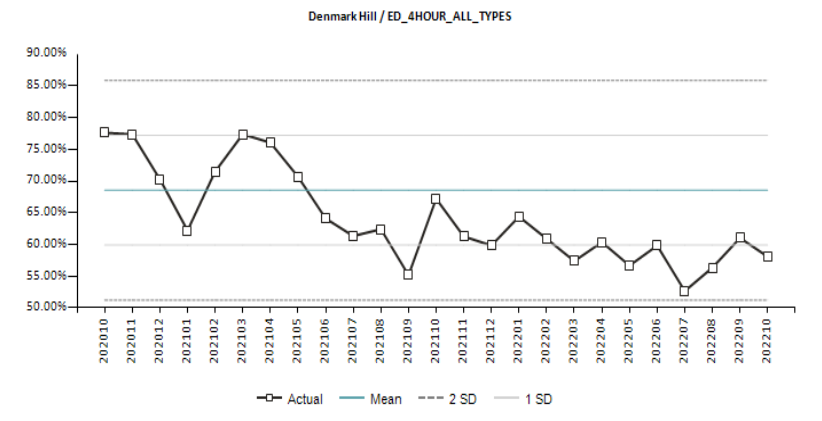
Cancer

- Treatment within 62 days of post-GP referral is not compliant – but improved to 70.41% for October (target 85%) compared to 60.77% in September.
- The two-week wait from GP referral standard reduced to 92.43% in October and is no longer compliant with the national 93% target, having exceeded 93% for the previous five months since May 2022.

Emergency Care Standard

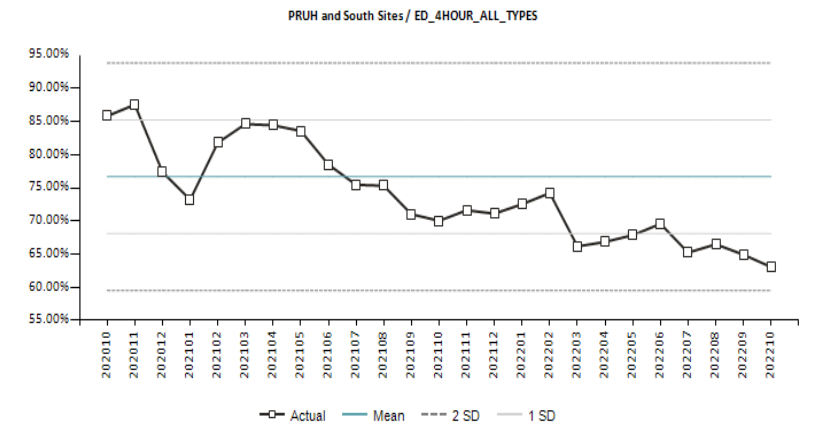
Denmark Hill performance:

- 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 494 ambulance delays >60 minutes and 684 ambulance delays waiting 30-60 minute delays in October (un-validated) compared to 262 delays >60 minutes and 552 delays >30 minutes reported in September.

DH Actions:

- Overall position has deteriorated with a significant and sustained increase in type 1 attends, with all type attends regularly over 3,000 per week.
- The Type 1 position remains challenged with nurse staffing and poor inpatient flow the main drivers for this.
- Type 3 performance and ambulance handover delays have improved with a renewed focus on LAS offload delays and escalation at senior level.

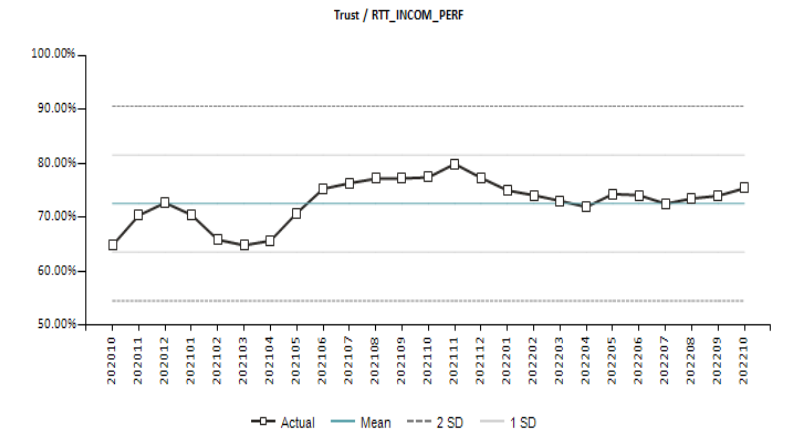
PRUH Actions:

- Work continues to improve flow and discharge across the Trust and with system partners through the Integrated Flow Board. Following a successful series of ward moves, we have created an augmented front-door capacity.
- We continue with LAS direct conveyance to MAU, implementing a refined Flow Navigator role and have agreed a plan for provision of discharge team/social care at the front door.
- A simplified proforma for expected discharge criteria has also been launched to further weekend discharges. The use of No Criteria to Reside patient level data is being embedded as part of the daily board round process.
- A review of the sub-acute area has been completed and an optimum staffing model developed – this will support improved Type 1 non-admitted performance, through improved time to first clinician and overall journey time. Pilot to be funded through system winter monies.

RTT

RTT Incomplete performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO



Background / target description:

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

Underlying issues:

- Reduction in on-the-day cancellations at both DH and PRUH – scoping the introduction of a text reminder system with Transformation team lead.

Current RTT Incomplete position:

- RTT performance improved to 75.39% for September compared to 73.98% performance achieved in September. Total PTL decreased by 1,064 to 80,663 pathways and the backlog reduced by 854 to 19,855 pathways.

DH Actions

- Theatres Improvement programme has defined a revised theatres reporting framework and supporting performance indicators for surgical pathways. New trending reports developed by BIU to show weekly and monthly trended activity and performance.

PRUH Actions

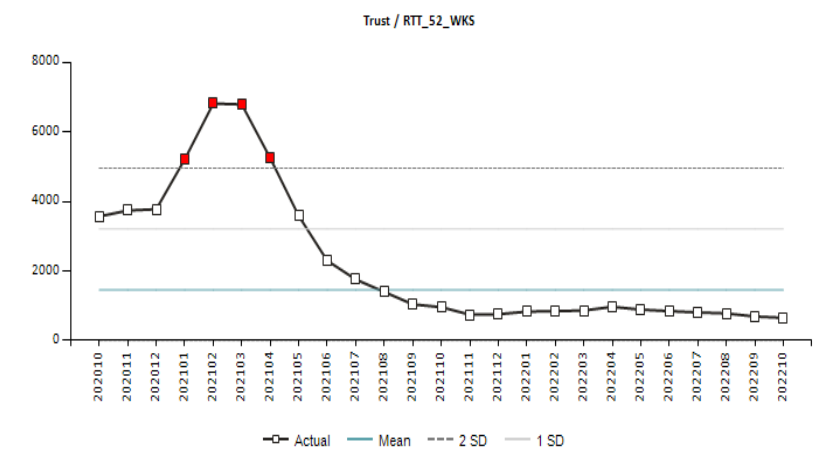
- The 'Enhanced Theatre Support Programme' continues with a daily Sitrep providing a forward and backward look of activity and sessions through all theatre complexes and a review of H1 effectiveness and trajectories for 52 week surgical specialties.
- Targeted work is underway to improve pre-assessment (POA) capacity and throughput. Focus on triage process and timely outcoming of all POA appointments. Workforce more stable with circa 400 slots per week now being delivered with time for outcoming assessments. Further external support has been identified in advance of winter, beginning 5 December to pilot triaging patients that will maximise the pool of potential elective patients.
- Focus on un-covered/dropped lists, annual leave cover in Main and Orpington theatres and minimising over Christmas and New Year, linked to ERF action plan, in particular with a focus on Urology, Gynaecology and Ophthalmology.

RTT – 52 Weeks

RTT Incomplete performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO

RTT 52+ Week waiters:



Background / target description:

- Zero patients waiting over 52 weeks.

52 Week position:

- Decrease of 38 breaches from 693 in September to 655 in October.
- The majority of the breaches are in General Surgery (98 patients), Bariatric Surgery (89 patients), T&O (78 patients) and Cardiology (50 patients).
- The number of 52 week breaches at Denmark Hill has decreased by 30 cases from 405 in September to 375 in October.
- The number of 52 week breaches at PRUH/South Sites reduced by 7 cases from 283 in September to 276 in October.

Actions:

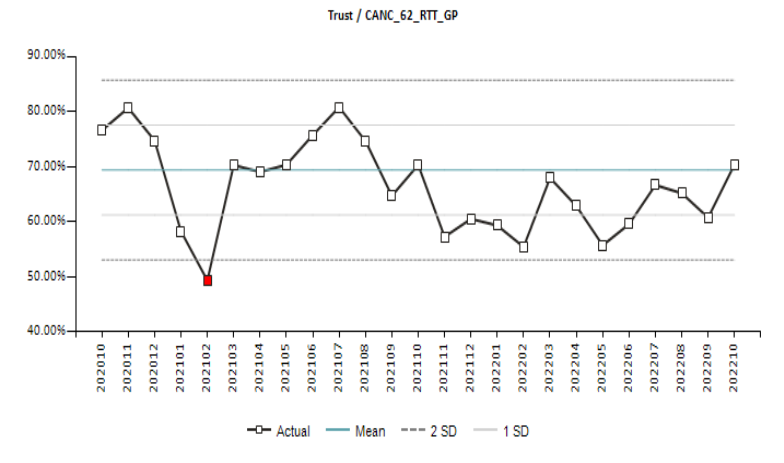
- **Allergy**: Recovery plans continue with enhanced clinical triage, pathway transfers to GSTT (343 YTD), and a new locum consultant post-holder. The number of 52+ week breaches reduced further in October, and we are forecasting a limited number of 52+ week breaches by January 2023. We have initiated discussions with GSTT around medium term solutions to ensure equitable and sustainable allergy waiting times in SEL.
- **Bariatrics**: Interim contracts with ISP providers have been agreed, and additional ad hoc capacity at Denmark Hill is under ongoing review (2x additional lists allocated in November). There is a significant ongoing risks from emergency pressures leading to elective cancellations pm the day of surgery, with the clinical prioritisation of patients superseding waiting time.
- **Cardiology**: The main challenges around AFO, PFO, and EP cohorts which had a delayed re-start following COVID and are capacity-constrained. The service are reviewing capacity options.
- Elective recovery plans are tracked through the Trust wide Elective Assurance and 52+ Week meetings.

- **104 Weeks (DH):** There were no patients waiting over 104 weeks at the end of October, and currently no identified November patient risks.
- **104 Week waits (PRUH)** – There were no patients waiting over 104 weeks by the end of October, and currently no identified November patient risks.

Cancer 62 day standard

62 days GP referral to first treatment performance:

- Executive Owner: Jonathan Lofthouse, Site Chief Executive
- Management/Clinical Owner: Emilie Perry, DOO



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:

- **Accelerated pathways** – implementation of accelerated pathways for prostate cancer. Notable improvement to 28-day performance at DH as a result. Challenges remain at PRUH due to workforce and operational challenges.
- **Pathology** – insufficient capacity Trust wide has impacted on 28-day FDS not being compliant in September 2022 as well as affecting some 62-day pathways. Multiple posts out to advert, highlighted at SEL executive group.
- **PET-CT** – 1 week reporting backlog (reduced from 4). One locum in place, insourcing underway, delay to second locum starting (advert not out). Clinical prioritisation process in place to reduce clinical harm but performance will continue to be affected for lower risk patients pending job planning for new consultant from December and second locum being put in place.

DH Actions

- **Colorectal** - increased tertiary capacity in place for SPEC service from October – SELCA funded fixed term post appointed on a pilot basis to reduce patient delays in diagnostic phase (postholder starting in January).
- **HpB** – Additional HCC consultant clinics in place from November 2022. Wider longer term review of regional pathways in place including tertiary referral processes.

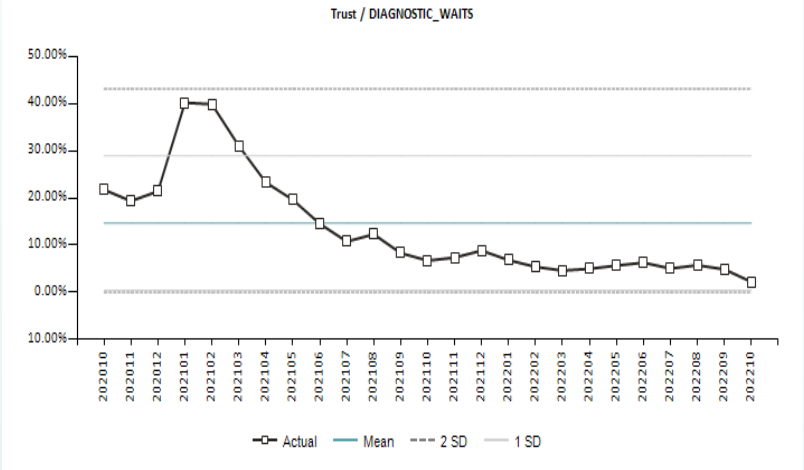
PRUH Actions

- **Colorectal -** streamlined pathways now in place for repeat diagnostics and pre-hab work up. Process for streamlined pre assessment to be implemented.
- **Upper GI** - challenges in workforce has impacted on 2WW triaging, outpatient and virtual clinics. Cancer funding has supported mitigation to the end of 2022/23 pending business case approval for additional consultants.

Diagnostic Waiting Times

DM01 performance:

- Executive Owner: Jonathan Lofthouse/Julie Lowe, Site Chief Executive
- Management/Clinical Owner: James Eales, DOO



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 581 in September to 265 in October which equates to 2.24% patients waiting <6 weeks.
- Performance for the Denmark Hill site group improved from 5.64% in September to 2.63% in October. Performance at the PRUH/South Sites site group remains at 0% for September and October with no breaches reported for PRUH/SS-run services. There were 10 breaches in DH-run Urology and Imaging services at PRUH.
- Cardiac MRI: The 6 week backlog reduced from 52 in September to 48 in October with the ongoing use of Independent sector providers to provide additional capacity. Workforce plans are under development between cardiology and radiology to reduce outsourced activity. The service is forecasting a growth in backlog at the end of Q3, with targeted DM01 compliance in Q4 22-23.

DH Actions

- GA Neuro MRI: The backlog reduced from 55 in September to 34 in October as recovery plan actions commenced with additional in week and weekend sessions. Capacity currently exceeds demand and the service is forecasting compliance in March 2023.
- Echo: The 6 week backlog reduced from 311 in September to 64 in October. Following the reduction in breaches, an extension of the short term actions has been agreed until January 2023 to support return to compliance, with medium term workforce planning to meet demand ongoing.

PRUH Actions

- Only one modality did not meet the standard – Urology Cystoscopy service with 10 breaches but is run by the DH site group.

Workforce Dashboard

Workforce

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Staff Training & CPD														
715	% appraisals up to date - Combined									90.59 %	90.90 %	92.90 %		
721	Statutory & Mandatory Training									90.97 %	90.98 %	88.82 %		
Staffing Capacity														
875	Voluntary Turnover %	15.06 %	14.98 %	14.98 %		15.45 %	15.78 %	16.25 %		15.18 %	15.25 %	15.37 %		
732	Vacancy Rate %	13.52 %	13.36 %	12.01 %		12.71 %	13.02 %	12.08 %		14.56 %	14.52 %	13.51 %		
Efficiency														
743	Monthly Sickness Rate	4.13 %	4.17 %	4.72 %		3.96 %	3.89 %	4.74 %		4.00 %	3.98 %	4.64 %		

Appraisals

- The appraisal non-medical compliance rate of 93.31% has remained over the 90% target for the third consecutive month.
- The Medical & Dental rate of 91.08% has increased from last month and it is also over the 90% target for October.

Sickness

- The sickness absence has increased from 3.98% in September to 4.64% in October.
- There were a total of 2,811 staff off sick during October.

Training

- Statutory and Mandatory training compliance rate has decreased this month by 2.16% and it has not achieved the 90% target for the first time in 6 months.

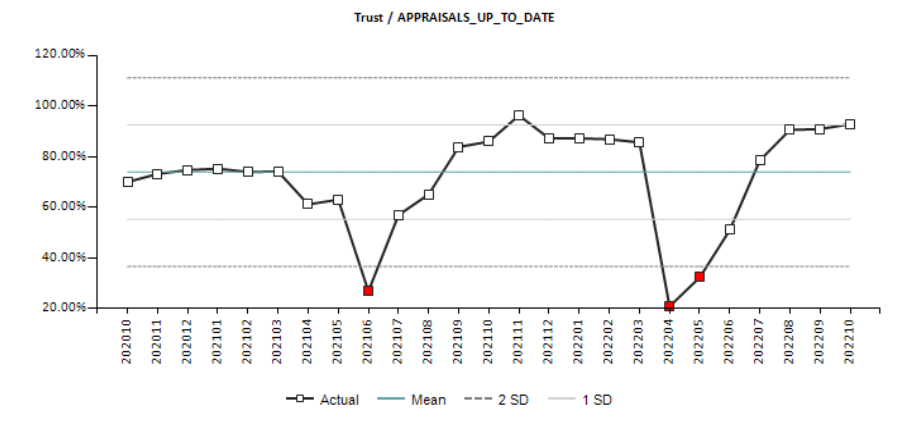
Staff Vacancy and Turnover

- The Trust vacancy rate for this month has reduced from 14.52% in September to 13.51% in October.
- The Trust turnover rate has increased from 15.25% in September to 15.37% in October.

Appraisal Rate

Appraisal Rate:

- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc



Performance Delivery:

- The appraisal non-medical compliance rate of 93.31% has remained over the 90% target for the third consecutive month.
- The Medical & Dental rate of 91.08% has increased from last month and it is also over the 90% target for October.

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 requirement for an appraisal session to be held is being well communicated within the Trust. Appraisal information is being circulated frequently to different forums across the Trust.
- Care Group and Corporate managers are receiving weekly lists of uncompliant staff in their areas, enabling them to clearly see this group and target their action.

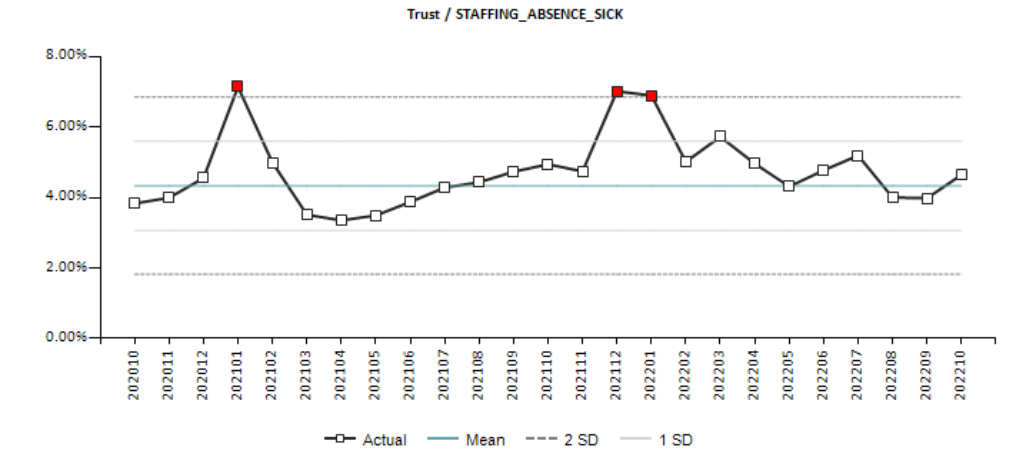
Medical:

- 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 appraise 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.

Sickness Rate

Sickness Rate:

- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc



Performance Delivery:

- There were a total of 2,811 staff off sick during October.
- The split of COVID-19 and other absences was 0.29% and 4.34% respectively in October. Whilst the COVID-19 figure has decreased by 0.01% from last month (0.30%), other absences have increased (0.66%).
- The three highest absence reasons based on the number of episodes excluding COVID-19 and unspecified were: Cold/Cough/Flu (28%) , Gastrointestinal problems (13%), and Other musculoskeletal problems, Anxiety/stress/depression/other psychiatric illness and Headache/migraine (all three 6%).

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.

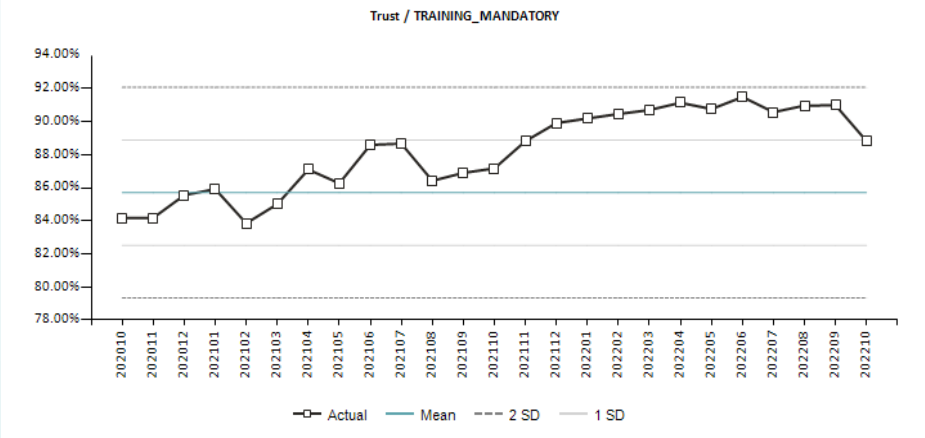
Actions to Sustain:

- Sickness rates are being monitored and managed. The ER Team Leader has fortnightly 1-2-1's with the ER Advisors 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.
- Increase in Psychological and pastoral support staff are now in place to support the management of absence.
- The ER Team is increasing awareness of the EAP service/OH offering and continuing to support managers to manage sickness cases. They 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, Chief People Officer
- Management/Clinical Owner: tbc



Performance Delivery:

- The rate has decreased this month by 2.16 percentage points and it has not achieved the 90% target for the first time in 6 months.
- The three topics with the highest rate in October were: Conflict Resolution (91%), Data Security IG (84.1%) and Equality & Diversity (96.9%).

Background / target description:

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

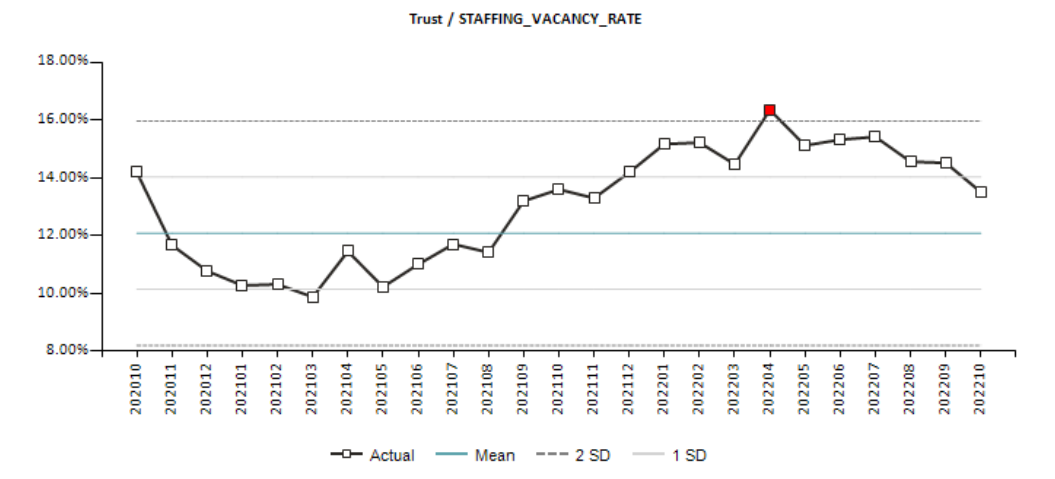
Actions going forward:

- We are continuing on work to improve LEAP, our learning management system
- 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, Chief People Officer
- Management/Clinical Owner: tbc



Performance Delivery:

- The significant rise in voluntary turnover over the past 12 months in addition to establishment increases has placed pressure on recruitment to lower the vacancy rate. Extensive recruitment continues, with a total of 456 new starters in October, of which:
  - 28 are IEN.
  - 48 are HCA & CSW,
  - 100 new N&M staff, which includes new qualified nurses.
  - 13 new M&D Consultants.
  - 28 AHP (Dietitians, Occupational Therapists, Orthoptists, Physiotherapists, Radiographers and Speech and Language Therapists)
- The high recruitment this month has resulted in decreases in all staff groups with the exception of Estates & Ancillary that has remain the same.

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:

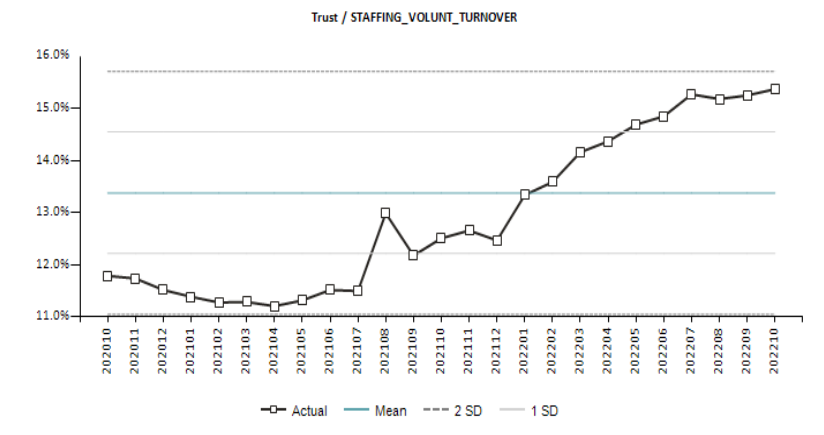
Priority areas of recruitment:

- 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.
- Extensive International recruitment and targeted nursing campaigns are in progress with several open day having taken place.
- International recruitment of midwives.
- 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.
- Extension of the 'Thank You' recruitment marketing campaign for all staff groups with an increase media presence both within our local communities and on-line. .

Turnover Rate

Turnover Rate:

- Executive Owner: Mark Preston, Chief People Officer
- Management/Clinical Owner: tbc



Performance Delivery:

- The Trust turnover rate has increased from 15.25% in September to 15.37% in October.
- The three main reasons for leaving voluntarily during September were: Promotion (23%), Relocation and Work life Balance (both 15%) and Retirement Age (5%).
- 26% of all voluntary leavers (191) left within 12 months of service at King's.

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.

Finance Dashboard

Finance

		Denmark Hill Site Group				PRUH/SS Site Group				Trust				
		Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	Aug 2022	Sep 2022	Oct 2022	F-YTD Actual	13 Month Trend
CQC level of inquiry: Well Led														
Overall (000s)														
895	Actual - Overall	(1,180)	16,018	2,424	27,783	(3,328)	4,956	2,518	13,335	1,442	5,845	5,902	37,792	
896	Budget - Overall	(4,794)	12,320	(2,161)	10,489	(1,172)	4,876	(273)	6,463	(89)	(150)	(163)	1,371	
897	Variance - Overall	(3,614)	(3,698)	(4,586)	(17,293)	2,155	(80)	(2,791)	(6,872)	(1,531)	(5,995)	(6,065)	(36,420)	
Medical - Agency														
602	Variance - Medical - Agency	(73)	(87)	142	(1,007)	(426)	(449)	(178)	(3,068)	(471)	(540)	(45)	(4,137)	
Medical Bank														
1095	Variance - Medical Bank	(1,109)	(1,069)	(1,177)	(7,309)	(393)	(441)	(589)	(3,026)	(1,503)	(1,510)	(1,772)	(10,346)	
Medical Substantive														
599	Variance - Medical Substantive	542	1,344	649	4,611	385	739	526	3,720	1,025	2,300	1,074	8,256	
Nursing Agency														
603	Variance - Nursing Agency	(434)	(617)	(451)	(2,860)	(157)	(189)	(160)	(992)	(606)	(832)	(645)	(3,997)	
Nursing Bank														
1104	Variance - Nursing Bank	(2,086)	(1,948)	(2,577)	(14,443)	(837)	(773)	(494)	(3,933)	(3,167)	(3,369)	(3,173)	(19,817)	
Nursing Substantive														
606	Variance - Nursing Substantive	2,168	3,996	2,295	17,037	767	1,553	593	6,571	3,097	5,790	2,765	24,503	

- **Operating income**: £16.6m over performance against the plan due to prior year one off benefit for prior year Devices (£2.6m) received in M6 and prior year Drugs (£2.7m) received in M5, vaccination and standard COVID testing reimbursements (c£4m) and recognition of E-plex tests for Q4.Income COVID testing contributes positively to YTD variance of £7.8m.
  - ❑ Income from Patient Care - a favourable variance of £5.3m against budget in month including Demand and Capacity Funding (£1.1m).
  - ❑ Other Operating Income – a favourable variance of £1.8m against budget mainly due to COVID income £1.2m (no income target against COVID income line).
- **Employee operation expenses (Pay):** £5.3m overspend compared to plan is due to underachieving on CIPs, incremental COVID and reset and recovery.
  - ❑ Planned cost improvement target of £23.3m has been phased equally across the year (£1.9m per month) and not yet achieved.
  - ❑ Staff sickness and COVID pressures have led to estimated cost pressure of £4.5-5m based on 1.5-2% increase in WTE and mass vaccination.
- **Operating expenses (Non pay)**: £29.1m overspend compared to plan is mainly due to underachieving on CIPs and additional pressures:
  - ❑ £8.2m of overspend due to COVID testing which is offset by income (£7.8m). (£0.4m) difference relates to antibody tests.
  - ❑ Planned cost improvement target of (£11.7m) has been phased equally across the year (£1.0m per month) and not yet fully achieved, so is reported as an overspend.

Domain 4: Finance

M7 (October) – Financial Performance

Surplus / (Deficit)

(£1.6m)	Actual M7
(£2.8m)	Average M1-7 22/23

Pay

(£76.5)	Actual M7
(£75.0)	Average M1-7 22/23

Non Pay

(£60.9)	Actual M7
(£59.6)	

COVID Costs

£12.4m	Actuals Total YTD
£4.1m	Pay YTD
£8.3m	Non Pay YTD

Payment Compliance

Debtor Days

16.8	Actual M7
15.9	Prior Month

Creditor Days

66.9	Actual M7
67.3	Prior Month

Capital

(£69.1m)
(£18.5m)

Key Metrics - IPR Summary

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

Trust (100)

Performance

		Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Month Target	F-YTD Actual
CQC level of inquiry: Responsive																
Access Management - RTT, CWT and Diagnostics																
364	RTT Incomplete Performance	77.41%	79.89%	77.32%	75.00%	74.10%	73.06%	71.93%	74.31%	74.11%	72.52%	73.50%	73.98%	75.39%	92.00%	73.68%
632	Patients waiting over 52 weeks (RTT)	962	745	760	832	847	865	971	890	848	809	781	693	655	0	5647
4997	Patients waiting over 78 weeks (RTT)	261	173	144	157	128	120	143	110	90	59	49	54	54	0	559
4537	Patients waiting over 104 weeks (RTT)	43	57	49	53	29	4	3	3	1	1	0	0	0	0	8
4557	RTT P2 Admitted Pathways	2221	2291	2214	2108	2047	1918	1888	1680	1706	1686	1725	1793	1880	2087	12358
4558	RTT P2 Admitted Pathways waiting >4 weeks	57.3%	52.2%	64.1%	62.6%	55.7%	52.7%	55.8%	46.6%	51.6%	52.4%	53.0%	50.1%	49.5%	56.1%	51.3%
412	Cancer 2 weeks wait GP referral	91.44%	94.49%	90.82%	90.59%	95.89%	94.92%	92.05%	95.11%	95.50%	96.58%	96.24%	93.39%	92.43%	93.00%	94.51%
413	Cancer 2 weeks wait referral - Breast	75.71%	87.50%	72.34%	68.18%	92.16%	95.83%	93.10%	100.00%	88.89%	95.56%	97.67%	96.67%	98.39%	93.00%	96.12%
419	Cancer 62 day referral to treatment - GP	70.32%	57.29%	60.53%	59.34%	55.45%	67.97%	62.87%	55.74%	59.59%	66.67%	65.18%	60.77%	70.41%	85.00%	63.01%
536	Diagnostic Waiting Times Performance > 6 Wks	6.73%	7.37%	8.86%	6.83%	5.41%	4.63%	5.01%	5.69%	6.31%	5.06%	5.76%	4.89%	2.24%	1.00%	5.02%
Access Management - Emergency Flow																
459	A&E 4 hour performance (monthly SITREP)	68.49%	65.87%	64.88%	68.01%	66.80%	61.22%	63.22%	61.57%	64.05%	58.27%	60.87%	62.75%	60.25%	95.00%	61.57%
Patient Flow																
399	Weekend Discharges	24.3%	19.8%	19.0%	23.3%	20.7%	18.0%	21.2%	20.7%	18.5%	24.7%	18.9%	19.9%	23.5%	20.8%	21.1%
404	Discharges before 1pm	15.1%	17.6%	16.2%	17.8%	17.0%	16.4%	16.0%	17.0%	17.1%	17.1%	15.0%	16.7%	16.2%	17.0%	16.4%
747	Bed Occupancy	90.8%	93.0%	88.6%	88.3%	91.4%	90.6%	92.3%	92.9%	93.9%	92.5%	92.5%	93.2%	93.7%	88.7%	93.0%
1357	Number of Stranded Patients (LOS 7+ Days)	537	590	584	534	574	600	565	569	610	610	666	657	660		4337
1358	Number of Super Stranded Patients (LOS 21+ Days)	214	257	252	248	252	261	251	253	253	250	292	317	315		1931
800	Delayed Transfer of Care Days (per calendar day)														0.0	
762	Ambulance Delays > 30 Minutes	617	593	636	614	515	818	821	759	664	759	669			0	3672
772	12 Hour DTAs	127	173	187	161	187	296	469	370	346	621	647	745	1038	0	4236
Theatre Productivity																
801	Day Case Rate	76.5%	75.4%	73.6%	76.8%	76.1%	76.2%	76.4%	76.1%	75.7%	75.7%	76.2%	75.1%	77.2%	78.3%	76.1%

Quality

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Created date: October 2019

BIU Business Intelligence Unit

Key Metrics - IPR Summary

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

Trust (100)

		Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Month Target	F-YTD Actual
CQC level of inquiry: Safe																
Reportable to DoH																
2717	Number of DoH Reportable Infections	83	63	62	66	50	54	55	57	60	74	117	104	106	66	573
Safer Care																
629	Falls resulting in moderate harm, major harm or death per 1000 bed days	0.17	0.15	0.15	0.11	0.14	0.17	0.13	0.08	0.15	0.06	0.10	0.10	0.22	0.19	0.12
1897	Potentially Preventable Hospital Associated VTE	4	2	2	0	2	1	3	4	2	1	5	3	0	0	18
538	Hospital Acquired Pressure Ulcers (Category 3 or 4)	1	0	0	2	2	0	0	1	1	1	1	0	1	0	5
945	Open Incidents			52			46			48			66			114
Incident Reporting																
520	Total Serious Incidents reported	19	16	8	11	15	14	10	19	14	7	7	8	19		84
516	Moderate Harm Incidents	33	38	41	31	32	36	37	42	32	25	39	21	44		240
509	Never Events	0	0	0	1	0	1	1	0	0	0	0	0	2	0	3
CQC level of inquiry: Caring																
Friends & Family Test																
422	Friends & Family - Inpatients	96.1%	94.5%	94.6%	96.4%	95.2%	94.5%	92.7%	94.0%	93.6%	93.3%	94.3%	94.0%	93.7%	96.0%	93.7%
423	Friends & Family - ED	72.9%	74.6%	72.2%	78.8%	73.7%	64.5%	66.8%	64.7%	66.1%	66.8%	67.0%	60.4%	60.2%	86.0%	64.2%
774	Friends & Family - Outpatients	87.2%	89.3%	90.3%	90.7%	90.7%	89.4%	90.0%	89.9%	90.1%	89.8%	90.3%	89.7%	89.8%	85.0%	89.9%
775	Friends & Family - Maternity	83.1%	87.5%	83.3%	89.2%	92.4%	87.2%	91.0%	92.4%	90.3%	88.0%	86.9%	90.7%	85.4%	94.0%	89.0%
Complaints																
619	Number of complaints	99	101	78	64	81	133	84	73	87	64	89	105	87	94	589
Operational Engagement																
620	Number of complaints not responded to within 25 Days	83	94	80	65	49	78	74	85	56	122	31	171	231	74	770
3119	Number of PALS enquiries – unable to contact department	42	36	42	29	25	35	28	40	38	35	20			35	161
Incident Management																
660	Duty of Candour - Conversations recorded in notes	90.6%	84.6%	81.1%	87.8%	91.7%	95.5%	94.7%	94.4%	97.9%	96.0%	85.0%	97.1%	100.0%	92.7%	95.0%
661	Duty of Candour - Letters sent following DoC Incidents	87.5%	61.9%	56.3%	79.6%	87.5%	92.1%	87.8%	92.0%	95.9%	95.8%	88.1%	97.2%	91.9%	86.4%	92.5%
1617	Duty of Candour - Investigation Findings Shared	17.1%	14.3%	26.0%	38.6%	25.6%	14.9%	16.0%	12.2%	5.6%	17.7%	4.2%	3.0%	1.9%	26.8%	8.6%
CQC level of inquiry: Effective																
Improving Outcomes																
831	Standardised Readmission Ratio	93.0	94.4	95.7	95.7	95.8	95.0	95.8	96.4	96.6					105.0	

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Key Metrics - IPR Summary

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

Trust (100)

436	HSMR	99.9	99.9	99.8	98.4	96.9	98.5	97.7	96.9	97.5	98.2				100.0	
4917	SHMI (NHS Digital)	101.5	102.0	101.6	101.8	100.7	101.7								105.0	
649	Patients receiving Fractured Neck of Femur surgery w/in 36hrs	91.2%	72.2%	71.1%	86.8%	80.0%	74.4%	83.3%	69.7%	89.3%	74.2%	76.0%	79.3%	94.4%	75.1%	80.0%
625	Diagnostic Results Acknowledgement	12.5%	12.1%	12.7%	12.7%	12.1%	11.5%	12.0%	13.2%	11.3%	10.7%	11.2%	10.4%	9.0%	12.2%	11.1%

Workforce

		Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Month Target	F-YTD Actual
CQC level of inquiry: Well Led																
Staff Training & CPD																
715	% appraisals up to date - Combined	85.96%	96.29%	87.25%	87.25%	86.89%	85.66%	20.96%	32.36%	51.08%	78.58%	90.59%	90.90%	92.90%	90.00%	
721	Statutory & Mandatory Training	87.17%	88.82%	89.91%	90.19%	90.46%	90.70%	91.14%	90.76%	91.49%	90.57%	90.97%	90.98%	88.82%	90.00%	
Staffing Capacity																
875	Voluntary Turnover %	12.5%	12.7%	12.5%	13.3%	13.6%	14.2%	14.4%	14.7%	14.9%	15.3%	15.2%	15.3%	15.4%	14.0%	
732	Vacancy Rate %	13.60%	13.30%	14.19%	15.17%	15.22%	14.47%	16.35%	15.12%	15.32%	15.42%	14.56%	14.52%	13.51%	10.00%	
Efficiency																
743	Monthly Sickness Rate	4.94%	4.74%	7.01%	6.89%	5.01%	5.72%	4.96%	4.31%	4.77%	5.19%	4.00%	3.98%	4.64%	3.50%	

Finance

		Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22	Month Target	F-YTD Actual
Overall (000s)																
895	Actual - Overall	842	6,807	7,923	9,030	30,633	22,029	10,277	2,457	6,021	5,848	1,442	5,845	5,902	(163)	37,792
896	Budget - Overall	(405)	(68)	(79)	(89)	(80)	298	4,388	4,388	5,406	(12,410)	(89)	(150)	(163)		1,371
897	Variance - Overall	(1,247)	(6,876)	(8,002)	(9,120)	(30,713)	(21,731)	(5,889)	1,932	(615)	(18,258)	(1,531)	(5,995)	(6,065)	0	(36,420)
Medical - Agency																
602	Variance - Medical - Agency	(716)	(672)	(577)	(718)	(710)	39	(563)	(652)	(875)	(991)	(471)	(540)	(45)	0	(4,137)
Medical Bank																
1095	Variance - Medical Bank	(1,495)	(1,018)	(929)	(1,948)	(1,110)	1,154	(1,379)	(1,550)	(1,347)	(1,284)	(1,503)	(1,510)	(1,772)	0	(10,346)
Medical Substantive																

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Key Metrics - IPR Summary

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

Trust (100)

599	Variance - Medical Substantive	610	1,185	1,027	965	842	2,754	706	1,301	1,065	784	1,025	2,300	1,074	0	8,256
Nursing Agency																
603	Variance - Nursing Agency	(421)	(424)	(492)	(495)	(538)	(496)	(422)	(471)	(488)	(533)	(606)	(832)	(645)	0	(3,997)
Nursing Bank																
1104	Variance - Nursing Bank	(2,611)	(2,322)	(2,895)	(4,115)	(2,435)	(3,866)	(2,484)	(2,867)	(2,261)	(2,496)	(3,167)	(3,369)	(3,173)	0	(19,817)
Nursing Substantive																
606	Variance - Nursing Substantive	3,507	3,137	3,147	1,863	3,644	3,658	3,152	3,400	3,200	3,099	3,097	5,790	2,765	0	24,503

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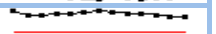
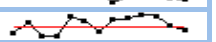
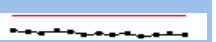
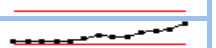
October 2022

Rolling 12mth	Trend
74.51%	
9696	
1281	
200	
22936	
54.2%	
94.09%	
91.58%	
61.90%	
5.65%	
63.06%	
20.7%	
16.7%	
91.9%	
7219	
3201	
	
6848	
5240	
75.9%	

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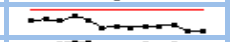
Rolling 12mth	Trend
868	
0.13	
25	
9	
212	
148	
418	
5	
94.2%	
68.0%	
90.0%	
88.6%	
1046	
1136	
328	
92.3%	
85.7%	
15.0%	
	

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	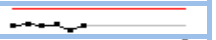
78.5%	
11.6%	

Rolling 12mth	Trend
	
	
	
	
	

Rolling 12mth	Trend
114,215	
1,353	
(112,862)	
(6,775)	
(14,198)	

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15,027	
(6,442)	
(35,451)	
39,953	

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Key Metrics - IPR Summary

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

Trust (100)

Item	Definition
364	The percentage of patients on an incomplete pathway waiting less than 18 weeks at the end of the month position. DOH submitted figures.
399	The number of patients discharged at the weekend expressed as a percentage of all patients discharged, excluding renal dialysis patients, patients discharged to other hospitals and ze
404	The number of patients discharged before 1pm expressed as a percentage of all patients discharged during the week, excluding renal dialysis patients, patients discharged to other hos
412	The percentage of pathways acheiving a maximum two week wait from an urgent GP referral for suspected cancer to DATE FIRST SEEN by a specialist for all suspected cancers
413	The percentage of pathways achieving a maximum two week wait from referral for breast symptoms (where cancer is not initially suspected) to DATE FIRST SEEN.
419	The percentage of pathways acheiving a maximum two month (62-day) wait from urgent GP referral for suspected cancer to First Definitive Treatment for all cancers
422	The Friends and Family survey net promoter score for Inpatients and Day Cases submitted to the DH via the Unify system for the reported month
423	The Friends and Family survey net promoter score for patients attending the A&E department, submitted to the DH via the Unify system for the reported month
436	The HSMR is a ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 dia methodology). This KPI is reported on a rolling 12-month position using HES (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
459	Percentage of all patients who are admitted, transferred or discharged within 4 hours of arrival at A&E: excluding any type 2 and external type 3 activity (Type 3 activity = QMS/Erith U
509	The number of never events recorded based on the reported date on the Datix system.
516	The number of incidents recorded on Datix that resulted in moderate harm to patients. Based on the reported date recorded on Datix.
520	Number of Serious Incidents declared to Commissioners. Based on the StEIS (Strategic Executive Information System) reported date on Datix.
536	% of patients waiting greater than 6 weeks for a diagnostic test
538	Number of hospital acquired pressure ulcers - Category 3 or Category 4
599	Total surplus(+ve) or deficit(-ve) generated by Medical Staff
602	Total surplus(+ve) or deficit(-ve) generated by Medical Staff - Agency Staff
603	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff - Agency Staff
606	Total surplus(+ve) or deficit(-ve) generated by Nursing Staff
619	The number of complaints received in the month.
620	The number of complaints not responded to within 25 working days .
629	Number of Inpatient slips, trips and falls by patients with moderate or major injury/ death reported based on the reported date recorded on Datix. Per 1000 bed days.
632	Number Patients waiting over 52 weeks (RTT). DOH submitted figures
649	Percentage of patients treated within 36hrs from the time of admission to the time that the patient was seen in theatre for a fractured neck of femur
660	The percentage of moderate/severe/death incidents where a Duty of Candour conversation was had following the incident. Based on the reported date recorded on Datix.
661	Percentage of Duty of Candour letters sent following moderate/severe/death incidents. Based on the reported date recorded on Datix.
715	Percentage of staff that have been appraised within the last 12 months (medical & non-medical combined).
721	Percentage of compliant with Statutory & Mandatory training.
732	The percentage of vacant posts compared to planned full establishment recorded on ESR
743	The number of FTE calendar days lost during the month to sickness absence compare to the number of staff available FTE in the same period.

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Key Metrics - IPR Summary

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

Trust (100)

747	The percentage occupancy of inpatient beds based on the midnight census
762	The number of times the LAS Arrival to Patient Handover Time is >30 mins during any calendar month
774	The Friends and Family survey net promoter score for Outpatients submitted to the DH via the Unify system for the reported month
775	The Friends and Family survey net promoter score for Maternity patients submitted to the DH via the Unify system for the reported month
800	Calculated by total delayed days during the month / calendar days in month.
801	Number of day cases divided by number of elective spells
831	The relative risk of 30 day emergency readmissions (ie: the ratio (multiplied by 100) of observed number of emergency readmissions to the expected number of 30 day readmissions). (Hospital Episode Statistics) data extracted from HED (Healthcare Evaluation Database)
875	The total number of voluntary leavers in a 12 month period as a percentage of the average headcount of staff in post in the same 12 month period. Note: Voluntary turnover is determined by the reason of leaving recorded on ESR. Voluntary turnover excludes 'Death in service', 'Dismissal', 'End of fixed-term contract and 'Redunda
945	All research related incidents which are open on Datix (note that this data is only available quarterly)
1095	Variance for Medical Bank
1104	Variance for Nursing Bank
1357	Number of stranded patients. Ie: any patient who is in the hospital for 7 days or more.
1358	Number of super stranded patients. Ie: any patient who is in the hospital for 21 days or more.
1617	The percentage of moderate/severe/death incidents where findings from the RCA were shared. Based on the reported date recorded on Datix.
1897	Number of hospital associated VTE during an admission/within 90 days of discharge associated with inadequate VTE prevention according to local guidance
2717	Combined total for all Department of Health reportable infections: MRSA bacteraemias, VRE bacteraemias, post 48-hr CDT cases, MSSA bacteraemias, E.Coli bacteraemias, Klebsiella s and Cabapenemase producing organisms (confirmed CPE/CPO)
4537	Patients waiting over 104 weeks (RTT)
4557	Number of P2 admitted RTT pathways
4558	Percentage of P2 Admitted pathways waiting longer than 4 weeks from their Decision To Admit date to treatment
4917	The national Summary Hospital Mortality Indicator (SHMI) is a risk adjusted mortality rate expressed as an index based on the actual number of patients discharged who died in hospit deaths. This KPI is reported on a rolling 12-month position using NHS Digital data extracted from HED (Healthcare Evaluation Database)
4997	Number Patients waiting over 78 weeks (RTT). DOH submitted figures

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ro LOS spells, based on discharging ward.
spitals and zero LOS spells, based on discharging ward.
gnosis groups in a specified patient group (as per HED
CC and 38% Beckenham Beacon)

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This KPI is reported on a rolling 12-month position using HES

ncy' (Compulsory)

pp. bacteraemias, Pseudomonas aeruginosa bacteraemias

al or within 30 days compared to the expected number of

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8th December 2022
Report title:	M7 Financial Position	Item:	6.2
Author:	Arthur Vaughan	Enclosure:	
Executive sponsor:	Lorcan Woods, Chief Finance Officer		
Report history:	King's Executive and Finance and Commercial Committee		

Purpose of the report

To provide an update on the M7 financial results.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion	✓	Assurance		Information	

The Board is asked to note the current financial position

Executive summary

As at month 7, the Trust has reported a year to date deficit of (£19.8)m.

The Trust plan includes £35m of cost improvement (£23.3m pay and £11.7m non-pay) and £20m of income improvement above block contracts. The program to date has identified (£43.2m) of schemes broken down as (£12.2m) in Red , (£1.3m) in Amber and (£29.7m) in Green which leaves an unidentified planning gap of (£11.7m).To address this gap, there are (£11.1m) of schemes currently in the pipeline which need further development by the care groups

The King's plan, in line with national assumptions for minimal COVID, assumed for 50 COVID beds and normalised staff sickness. Over the last three months King's has had on average 150+ COVID patients, 30 additional beds out of action due to the IPC requirements relating to these patients and sickness absence which is 3% above anticipated levels. This has led to incremental costs but also hampered the Trust's ability to over perform on ERF. At month 7 it is estimated the direct impact of excess COVID patients is c.£12m.

Driving the £19.8m deficit, are the following factors:

Operating Income

- £16.6m over performance against the plan due to prior year one off benefit for prior year Devices (£2.6m) received in M6 and prior year Drugs (£2.7m) received in M5, vaccination and standard COVID testing reimbursements (c£4m) and recognition of E-plex tests for Q4.Income COVID testing contributes positively to YTD variance of £7.8m.
- The Trust also received additional funding outside of the CCG core contract amounting to £3m (demand and capacity , Long Covid , Cardiac outpatient for Planned Medicine and £0.3m from NHS England for ECMO.
- £3m benefit YTD relating to in year drugs over performance.
- This is offset by non achievement of ERF (YTD figure £5.8m), Overseas (£2.9m YTD) and Commercial CIPs (£2.9m YTD). The Trust is likely to get confirmation of payment of Irish overseas income in month 8.

Employee Expenses (Pay)

- £5.3m overspend compared to plan is due to underachieving on CIPs, incremental COVID and reset and recovery.
    - Planned cost improvement target of £23.3m has been phased equally across the year (£1.9m per month) and not yet achieved.

King's College Hospital NHS Foundation Trust

- Staff sickness and COVID pressures have led to estimated cost pressure of £4.5-5m based on 1.5-2% increase in WTE and mass vaccination (funded).
- Unfunded reset and recovery costs of £2.7m has been incurred to deliver the elective recovery process.
- Unfunded pay award - £2.5m
- Budget for business cases/agreed cost pressures of £6.4m has been phased equally across the year (£0.7m per month), and partially mitigates the above overspends.

Operating Expenses (Non-Pay)

- £29.1m overspend compared to plan is mainly due to underachieving on CIPs and additional pressures :
  - (£8.2m) of overspend due to COVID testing which is offset by income (£7.8m). (£0.4m) difference relates to antibody tests
  - Planned cost improvement target of (£11.7m) has been phased equally across the year (£1.0m per month) and not yet fully achieved, so is reported as an overspend.
  - Drugs expenditure is significantly higher than budget (£8.2m YTD) partly offset by the income.
  - £2.8m overspend on Radiology (Medica) and Endoscopy (18 weeks support) outsourcing in Denmark Hill
  - £0.4m negative movement relates to PY Corporation Tax adjustment

In the plan, we have evenly phased the following items, for which we haven't yet seen the full impact of inflation nor cost improvement plans:

- £12m Non-Pay inflation (£1m per month)
- £7m Energy excess inflation (£0.6m per month)
- Business Cases not yet started £5.6m

Strategy

	Link to the Trust's BOLD strategy (Tick as appropriate)				**Link to Well-Led criteria** (Tick as appropriate)
	Brilliant People: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			✓	**Leadership, capacity and capability**
					Vision and strategy
	Outstanding Care: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*				**Culture of high quality, sustainable care**
				✓	**Clear responsibilities, roles and accountability**
	Leaders in Research, Innovation and Education: *We continue to develop and deliver world-class research, innovation and education*			✓	**Effective processes, managing risk and performance**
				✓	**Accurate data/ information**
	Diversity, Equality and Inclusion at the heart of everything we do: *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*				**Engagement of public, staff, external partners**
					Robust systems for learning, continuous improvement and innovation
✓	**Person- centred**	**Sustainability**			
	Digitally- enabled	**Team King's**			

King's College Hospital NHS Foundation Trust

Key implications	
Strategic risk - Link to Board Assurance Framework	Financial Sustainability
Legal/ regulatory compliance	
Quality impact	
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight **Finance and Commercial Committee**	

Month 07 – October 2022 Finance Report

Board of Directors

8th December 2022

KING'S HEALTH PARTNERS

An Academic Health Sciences Centre for London

Pioneering better health for all

Contents

Executive Summary

- As at month 7, the Trust has reported a year to date deficit of (£19.8)m. The Trust plan includes £35m of cost improvement (£23.3m pay and £11.7m non-pay) and £20m of income improvement above block contracts. The program to date has identified (£43.2m) of schemes broken down as (£12.2m) in Red , (£1.3m) in Amber and (£29.7m) in Green which leaves an unidentified planning gap of (£11.7m).To address this gap, there are (£11.1m) of schemes currently in the pipeline which need further development by the care groups

- The King's plan, in line with national assumptions for minimal COVID, assumed for 50 COVID beds and normalised staff sickness. Over the last three months King's has had on average 150+ COVID patients, 30 additional beds out of action due to the IPC requirements relating to these patients and sickness absence which is 3% above anticipated levels. This has led to incremental costs but also hampered the Trust's ability to over perform on ERF. At month 7 it is estimated the direct impact of excess COVID patients is c.£12m.

- The month end Group Cash balance at 31 October 2022 was £69m. Overall cash levels are lower than in the previous year due to reducing outstanding levels of trade creditors and investment in capital projects (including the Apollo project and ongoing CCU build).

- 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.

Summary of Year to Date Financial Position & Details

Summary of Year to Date Financial Position*

Year to date the Trust reports a deficit of £(19.8)m. This is predominantly driven by CIP non achievement and incremental costs of reset and recovery and COVID.

	Last 3 Months			Current Month				Year to Date				Run Rate
	M4	M5	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	133.1	140.5	141.1	132.9	132.5	139.6	7.1	899.3	927.5	944.1	16.6	(1.4)
Employee Operating Expenses	(74.3)	(74.0)	(81.4)	(71.7)	(74.8)	(76.5)	(1.7)	(487.8)	(520.0)	(525.3)	(5.3)	4.9
Operating Expenses Excluding Employee Expenses	(60.0)	(61.2)	(58.7)	(55.5)	(54.6)	(60.9)	(6.3)	(386.6)	(388.3)	(417.4)	(29.1)	(2.1)
Non Operating Expenses	(3.9)	(2.7)	(2.0)	(3.1)	(2.9)	(3.9)	(0.9)	(22.3)	(20.6)	(21.1)	(0.5)	(1.9)
Trust Total	**(5.0)**	**2.6**	**(1.1)**	**2.6**	**0.2**	**(1.6)**	**(1.8)**	**2.6**	**(1.4)**	**(19.8)**	**(18.4)**	**(0.6)**
Less Depr On Donated Assets	0.1	0.1	0.1	0.1	0.1	0.1	(0.0)	0.7	0.5	0.9	(0.3)	(0.0)
Less Donated Assets Income	(0.3)	0.3	(0.0)	(0.0)	(0.0)	(0.8)	0.8	(0.5)	(0.1)	(0.9)	0.8	(0.7)
Less Fixed Asset Impairments												0.0
Less Impairment, donated income	**(0.2)**	**0.4**	**0.1**	**0.1**	**0.1**	**(0.7)**	**0.7**	**0.2**	**0.4**	**(0.0)**	**0.5**	**(0.7)**
Operating Total (including ERF)	**(5.2)**	**3.0**	**(1.0)**	**2.7**	**0.2**	**(2.3)**	**(1.1)**	**2.8**	**(0.9)**	**(19.8)**	**(18.0)**	**(1.3)**
Less Elective Recovery Fund	(1.1)	(1.6)	(1.7)	(0.0)	(1.6)	(1.6)	0.0	(15.2)	(11.2)	(11.2)	0.0	0.1
Operating Total (excluding ERF)	**(6.3)**	**1.4**	**(2.7)**	**2.7**	**(1.4)**	**(3.9)**	**(1.1)**	**(12.4)**	**(12.1)**	**(31.0)**	**(18.0)**	**(1.2)**

Key Messages:

*The above figures include consolidation of KFM surplus's in non pay as a single line item.

As at month 7, the Trust has reported a year to date deficit of (£19.8)m. The Trust plan includes £35m of cost improvement (£23.3m pay and £11.7m non-pay) and £20m of income improvement above block contracts. The programme to date has identified (£43.2m) of schemes broken down as (£12.2m) in Red , (£1.3m) in Amber and (£29.7m) in Green which leaves an unidentified planning gap of (£11.7m).To address this gap, there are (£11.1m) of schemes currently in the pipeline which need further development by the care groups.

The King's plan, in line with national assumptions for minimal COVID, assumed for 50 COVID beds and normalised sickness. Over the last three months King's has had on average 150+ COVID patients, 30 additional beds out of action due to the IPC requirements relating to these patients and sickness absence which is 3% above anticipated levels. This has led to incremental costs but also hampered the Trust's ability to over perform on ERF. At month 7 it is estimated the direct impact of excess COVID patients is c.£12m.

Driving the £19.8m deficit, are the following factors:

Operating Income

- £16.6m over performance against the plan due to prior year one off benefit for prior year Devices (£2.6m) received in M6 and prior year Drugs (£2.7m) received in M5, vaccination and standard COVID testing reimbursements (c£4m) and recognition of E-plex tests for Q4.Income COVID testing contributes positively to YTD variance of £7.8m.
- The Trust also received additional funding outside of the CCG core contract amounting to £3m (demand and capacity , Long Covid , Cardiac outpatient for Planned Medicine and £0.3m from NHS England for ECMO.
- £3m benefit YTD relating to in year drugs over performance.
- This is offset by non achievement of ERF (YTD figure £5.8m), Overseas (£2.9m YTD) and Commercial CIPs (£2.9m YTD). The Trust is likely to get confirmation of payment of Irish overseas income in month 8.

Employee Expenses (Pay)

- £5.3m overspend compared to plan is due to underachieving on CIPs, incremental COVID and reset and recovery.
  - Planned cost improvement target of £23.3m has been phased equally across the year (£1.9m per month) and not yet achieved.
  - Staff sickness and COVID pressures have led to estimated cost pressure of £4.5-5m based on 1.5-2% increase in WTE and mass vaccination (funded).
  - Unfunded reset and recovery costs of £2.7m has been incurred to deliver the elective recovery process.
  - Unfunded pay award - £2.5m
  - Budget for business cases/agreed cost pressures of £6.4m has been phased equally across the year (£0.7m per month), and partially mitigates the above overspends.

Operating Expenses (Non-Pay)

- £29.1m overspend compared to plan is mainly due to underachieving on CIPs and additional pressures :
  - (£8.2m) of overspend due to COVID testing which is offset by income (£7.8m). (£0.4m) difference relates to antibody tests
  - Planned cost improvement target of (£11.7m) has been phased equally across the year (£1.0m per month) and not yet fully achieved, so is reported as an overspend.
  - Drugs expenditure is significantly higher than budget (£8.2m YTD) partly offset by the income.
  - £2.8m overspend on Radiology (Medica) and Endoscopy (18 weeks support) outsourcing in Denmark Hill
  - £0.4m negative movement relates to PY Corporation Tax adjustment

Detail (1/3) – Operating Income

Actuals	Last 3 Months			Current Month				Year to Date				Run Rate Change
	M4	M5	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
NHS England	49.1	50.6	55.3	51.1	48.4	49.2	0.8	313.4	344.7	348.6	4.0	(6.1)
Clinical Commissioning Groups	55.4	60.7	60.4	58.1	56.8	56.2	(0.6)	404.8	399.6	397.5	(2.1)	(4.1)
Pass Through Drugs Income	15.4	10.1	14.9	16.4	15.1	18.1	3.0	99.8	98.3	103.3	5.0	3.2
NHS Foundation Trusts	0.0	0.0	0.0			0.0	0.0	0.0		0.0	0.0	0.0
NHS Trusts	0.1	(0.1)	0.1	0.1	0.1	(0.0)	(0.1)	0.7	0.8	0.5	(0.4)	(0.1)
Local Authorities	0.3	0.3	0.3	0.4	0.3	0.3	(0.0)	1.8	2.2	2.2	(0.1)	(0.0)
NHS Other (Including Public Health England)	1.2	0.3	0.1	0.4	(1.7)	0.4	2.1	2.4	4.9	3.1	(1.8)	0.3
Non NHS: Private Patients	0.8	1.1	0.6	0.4	0.9	1.2	0.3	2.1	6.1	5.6	(0.4)	0.5
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To Patient)	0.4	0.7	0.3	0.3	0.3	0.2	(0.0)	2.3	2.1	2.2	0.1	(0.0)
Injury Cost Recovery Scheme	0.4	0.4	0.2	0.3	0.3	0.2	(0.1)	2.1	1.9	2.6	0.7	0.0
Non NHS: Other												0.0
Operating Income From Patient Care Activities	123.3	124.2	132.2	127.5	120.6	125.8	5.3	829.6	860.7	865.7	5.0	(6.3)
Research and Development	0.7	2.6	1.4	0.7	1.4	1.7	0.3	9.4	9.8	11.7	1.9	0.3
Education and Training	4.1	3.4	3.3	5.7	6.4	4.7	(1.7)	26.1	28.2	26.4	(1.8)	1.4
Cash Donations / Grants For The Purchase Of Capital Assets	0.3	(0.3)	0.0	0.0	0.0	0.8	0.8	0.5	0.1	0.9	0.8	0.7
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
Non-Patient Care Services To Other Non Wga Bodies	1.2	1.1	0.8	0.9	0.9	1.1	0.2	7.3	6.0	7.0	1.0	0.3
PSF, FRF, MRET funding and Top-Up	0.5	6.0	0.8	4.6		1.2	1.2	8.6		10.8	10.8	0.3
Income In Respect Of Employee Benefits Accounted On A Gross Basis	0.7	1.4	0.2	0.6	0.9	0.6	(0.3)	4.7	6.0	4.8	(1.2)	0.5
Rental Revenue From Operating Leases	0.1	0.1	0.1	0.1	0.1	0.2	0.1	0.6	0.7	0.7	(0.0)	0.2
Other (Operating Income)	2.3	2.1	2.2	(7.2)	2.3	3.5	1.2	12.6	16.0	16.1	0.1	1.3
Other Operating Income	9.8	16.4	8.9	5.4	12.0	13.8	1.8	69.8	66.8	78.4	11.6	4.9
Finance Income								(0.1)				0.0
Finance Income								(0.1)				0.0
Operating Income	133.1	140.5	141.1	132.9	132.5	139.6	7.1	899.3	927.5	944.1	16.6	(1.4)

1

Operating Income from Patient Care – a favourable variance of £5.3 m against budget in month

The main contributor for M7 over performance are :

- Demand and Capacity Funding of £1.1m,
- £0.9m Cardiac Outpatient funding for Planned Medicine,
- £ 0.35m HIV Testing, £0.15m - Smoking Cessation Funding and combined smaller amounts.
- £3m benefit YTD relating to in year drugs over performance

2

Other Operating Income – favourable variance of £1.8m against budget in month

The favourable variance is mainly due to COVID income £1.2m. (no income target against COVID income line)

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

Actuals	Last 3 Months			Current Month				Year to Date				Average Run Rate
	M4	M5	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Substantive Staff	(21.6)	(21.4)	(24.4)	(21.2)	(23.3)	(22.2)	1.1	(142.5)	(161.7)	(153.4)	8.3	2.3
Bank Staff	(1.3)	(1.5)	(1.5)	(1.5)	(0.0)	(1.8)	(1.8)	(9.4)	(0.1)	(10.5)	(10.3)	(0.3)
Agency / Contract	(1.1)	(0.5)	(0.6)	(0.8)	(0.1)	(0.1)	(0.0)	(5.1)	(0.5)	(4.7)	(4.1)	0.5
Medical Staff	(23.9)	(23.4)	(26.6)	(23.5)	(23.3)	(24.1)	(0.7)	(157.0)	(162.3)	(168.5)	(6.2)	2.5
Substantive Staff	(24.8)	(25.0)	(31.3)	(23.8)	(29.2)	(26.5)	2.8	(171.2)	(205.7)	(181.2)	24.5	4.8
Bank Staff	(3.3)	(3.5)	(4.1)	(3.3)	(0.9)	(4.1)	(3.2)	(20.7)	(5.0)	(24.8)	(19.8)	0.0
Agency / Contract	(0.6)	(0.7)	(0.9)	(0.5)	(0.1)	(0.8)	(0.6)	(4.3)	(0.8)	(4.8)	(4.0)	0.2
Nursing Staff	(28.7)	(29.2)	(36.2)	(27.6)	(30.2)	(31.3)	(1.1)	(196.2)	(211.5)	(210.8)	0.7	5.0
Substantive Staff	(12.1)	(11.8)	(6.6)	(10.8)	(11.8)	(11.1)	0.7	(70.8)	(84.9)	(76.8)	8.1	(4.4)
Bank Staff	(0.1)	(0.5)	(0.6)	(0.5)	(0.0)	(0.3)	(0.3)	(2.9)	(0.1)	(2.6)	(2.5)	0.2
Agency / Contract	(0.4)	(0.2)	(0.3)	(0.6)		(0.3)	(0.3)	(2.0)		(2.0)	(2.0)	0.1
Admin & Clerical	(12.6)	(12.4)	(7.5)	(11.9)	(11.8)	(11.7)	0.1	(75.8)	(85.0)	(81.4)	3.6	(4.1)
Substantive Staff	(8.2)	(8.3)	(10.2)	(8.0)	(9.2)	(8.7)	0.5	(55.6)	(67.6)	(59.9)	7.7	1.5
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	0.0	(0.1)	(0.2)	(0.1)	0.1	0.0
Bank Staff	(0.2)	(0.2)	(0.4)	(0.3)	(0.0)	(0.2)	(0.2)	(1.6)	(0.1)	(1.8)	(1.7)	0.2
Agency / Contract	(0.6)	(0.5)	(0.4)	(0.4)	(0.1)	(0.5)	(0.4)	(1.4)	(0.5)	(2.7)	(2.2)	(0.1)
Other Staff	(9.0)	(9.0)	(11.0)	(8.6)	(9.3)	(9.5)	(0.1)	(58.8)	(68.5)	(64.5)	3.9	1.6
CIP Target Pay					(0.2)		0.2		7.3		(7.3)	0.0
Pay Savings Target					(0.2)		0.2		7.3		(7.3)	0.0
Substantive Staff (Pension Charge)												0.0
Pay Reserves												0.0
Employee Operating Expenses	(74.3)	(74.0)	(81.4)	(71.7)	(74.8)	(76.5)	(1.7)	(487.8)	(520.0)	(525.3)	(5.3)	4.9
Substantive Staff Total	(66.7)	(66.4)	(72.6)	(63.8)	(73.6)	(68.4)	5.2	(440.2)	(512.8)	(471.4)	41.3	4.1
Bank Staff Total	(4.8)	(5.7)	(6.6)	(5.6)	(0.9)	(6.4)	(5.5)	(34.7)	(5.4)	(39.7)	(34.3)	0.1
Agency / Contract Total	(2.7)	(2.0)	(2.3)	(2.3)	(0.3)	(1.6)	(1.4)	(12.9)	(1.8)	(14.2)	(12.3)	0.6
Employee Operating Expenses	(74.3)	(74.0)	(81.4)	(71.7)	(74.8)	(76.5)	(1.7)	(487.8)	(520.0)	(525.3)	(5.3)	4.9

1

Medical – an adverse variance in month of £0.7m against budget

Across the Trust, pressures continue due to rota gaps, sickness, vacancies and COVID pressures. This is covered by Bank and Agency staff and so drives an adverse variance to budget.

3

A&C – a favourable variance in month of £0.1m against budget.

A&C spend are in line with the budget

Other – in month £0.1m minimal adverse variance which we will monitor going forward.

2

Nursing – an adverse variance in month of £1.1m against budget

Across the Trust, pressures continue due to rota gaps, sickness, vacancies and COVID pressures. This is covered by Bank and Agency staff and so drives an adverse variance to budget.

The biggest overspends in month are in Acute Medicine (DH) , Womens Health (DH) and Therapies Rehabilitation and Integrated Care Services (PRUH)

4

Looking across all categories after taking into account the pay award inflation, pay is broadly in line with the trend. However work needs to be done to start achieving CIPs, in order to meet the Trust's plan to breakeven.

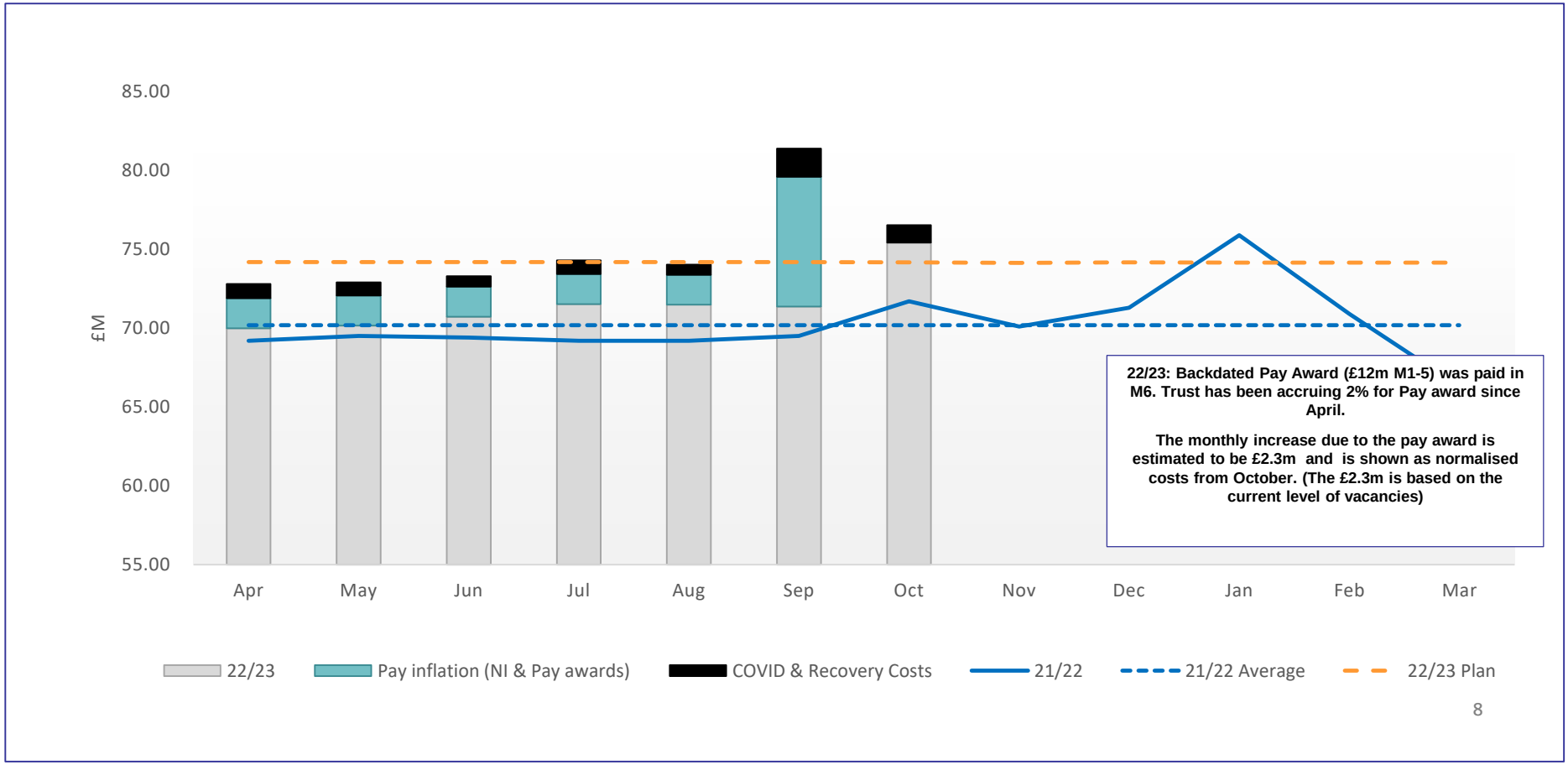
Pay includes YTD costs; reset & recovery (£2.7m), COVID (£5-6m) and mass vaccination (£1.1m).

Year to Date - Pay run rate

The Trust exited 2021/22 with a pay bill of £840.2m (excluding £31.2m year end pension adjustment, and also a £1.8m decrease to the annual leave provision) resulting in an average pay cost of £70m per month. The year on year increase is predominantly due to the pay inflation (1% NI, and 5.3% AfC and 3.5% Medical pay award).

Allowing for inflation, pay is in line with the 2021/21 average, £70m.

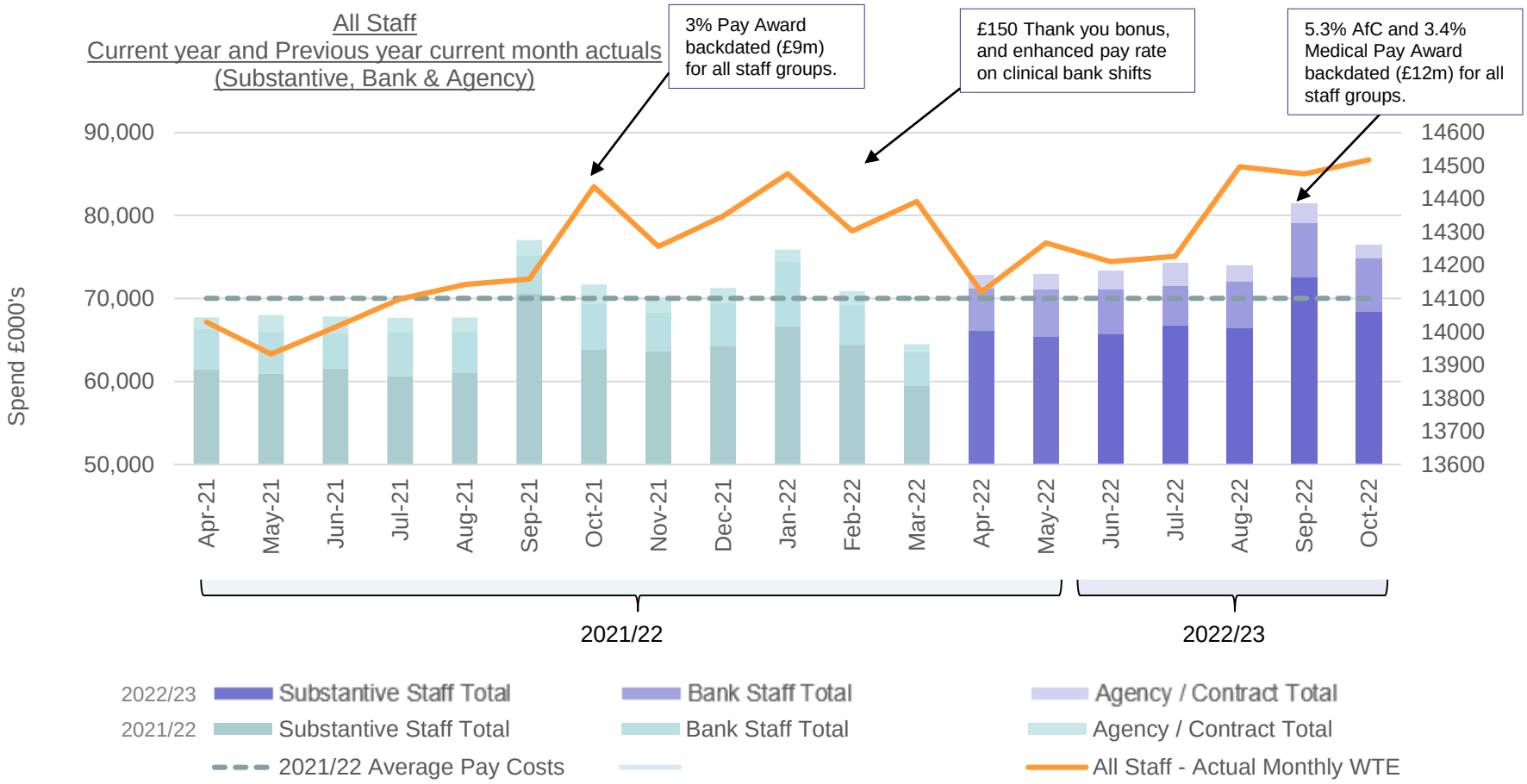
Pay includes YTD costs; reset & recovery (£2.7m), COVID (£4.5-5m) and mass vaccination (£1.1m).



Year on Year – Pay Review

The Trust's underlying pay run-rate was consistent over M01-12 of 2021/22. Overall, substantive recruitment has increased and this is being offset by reducing temporary staffing spend. In 22/23 underlying pay run-rate remain consistent averaging (£74.8m) per month.

- The increase in M01 of 2022/23 is due to pay inflation:
  - Employer's National Insurance contributions increased from 13.8% to 15.05% from April 2022
  - Pay award of 2% on substantive pay has been accrued (in previous years, it wasn't recognised until paid).
  - In M6 Trust paid backdated Pay Award (£12m) for all staff groups



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

Actuals	Last 3 Months			Current Month				Year to Date				Average Run Rate
	M4	M5	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Purchase Of Healthcare From NHS Bodies	(0.8)	(0.9)	(1.2)	(0.9)	(1.1)	(1.2)	(0.2)	(6.3)	(8.1)	(6.7)	1.4	0.0
Purchase Of Healthcare From Non-NHS Bodies	(15.3)	(16.1)	(15.3)	(16.1)	(15.5)	(16.0)	(0.5)	(110.8)	(108.1)	(108.5)	(0.3)	(0.6)
Non-Executive Directors												0.0
Supplies and Services - Clinical (Excluding Drugs Costs)	(2.6)	(2.8)	(2.1)	(3.1)	(1.4)	(2.7)	(1.3)	(17.6)	(10.1)	(18.4)	(8.3)	(0.7)
Supplies and Services - General	(0.1)	(0.1)	(0.0)	1.1	(0.1)	(0.2)	(0.1)	(3.7)	(0.6)	(0.7)	(0.1)	(0.1)
Drugs costs – on tariff	(2.3)	(2.3)	(2.3)	(4.5)	(2.1)	(2.2)	(0.1)	(27.5)	(14.7)	(16.5)	(1.8)	0.1
Pass Through Drugs Cost	(13.9)	(15.3)	(14.3)	(12.5)	(13.5)	(14.2)	(0.7)	(81.6)	(94.6)	(101.0)	(6.4)	0.1
Consultancy	(0.6)	1.5	(0.5)	(1.0)	(0.2)	0.4	0.6	(2.7)	(1.7)	(1.8)	(0.1)	0.9
Establishment	(1.1)	(1.1)	(1.1)	(0.9)	(0.9)	(1.3)	(0.4)	(7.2)	(6.6)	(7.6)	(1.0)	(0.2)
Premises - Business Rates Payable To Local Authorities	(0.6)	(0.2)	(0.5)	(0.4)	(0.4)	(0.4)	0.0	(2.7)	(2.7)	(2.7)	0.0	0.1
Premises - Other	(12.4)	(11.7)	(11.8)	(9.1)	(11.1)	(13.7)	(2.6)	(61.2)	(78.5)	(82.1)	(3.5)	(1.9)
Transport	(1.2)	(1.1)	(1.0)	(0.9)	(0.6)	(1.0)	(0.4)	(6.4)	(6.9)	(6.9)	0.0	(0.0)
Depreciation	(2.9)	(2.9)	(2.8)	(2.6)	(3.0)	(3.1)	(0.1)	(18.8)	(21.3)	(21.0)	0.3	(0.3)
Amortisation	(0.3)	(0.3)	0.5			(0.2)	(0.2)			(1.3)	(1.3)	(0.7)
Fixed Asset Impairments net of Reversals												0.0
Increase/(Decrease) In Impairment Of Receivables	(0.4)	(2.3)	(0.1)	(0.2)	(0.3)	(0.4)	(0.0)	(2.3)	(2.4)	(3.1)	(0.6)	(0.3)
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.0)	(0.2)	(0.1)	(0.2)	(0.1)	(0.0)
Clinical Negligence	(3.9)	(3.9)	(3.9)	(4.1)	(3.9)	(3.9)	(0.0)	(28.4)	(27.0)	(27.0)	0.0	0.0
Research and Development - Non-Staff	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(0.3)	(0.1)	(0.2)	(1.5)	(1.2)	0.3	(0.2)
Education and Training - Non-Staff	(0.5)	(0.3)	(0.1)	(0.5)	(0.5)	(0.7)	(0.2)	(2.7)	(4.0)	(3.1)	0.9	(0.5)
Operating Lease Expenditure (net)	(0.0)	(0.1)	(0.3)	(0.2)	(0.1)	(0.3)	(0.2)	(1.1)	(0.7)	(1.4)	(0.7)	0.0
Charges To Operating Expenditure For Ifric 12 Schemes (eg PFI / LIFT) On Ifrs Basis												0.0
Other	(1.0)	(1.0)	(1.3)	0.2	(1.3)	0.2	1.5	(5.1)	(9.5)	(6.5)	3.0	1.5
Operating Expenses Excluding Employee Expenses	(60.1)	(61.2)	(58.3)	(55.5)	(56.2)	(61.1)	(4.9)	(386.6)	(399.2)	(417.4)	(18.2)	(2.8)
CIP Target Non Pay	0.0	0.0	(0.4)	(0.0)	1.6	0.2	(1.4)	0.0	10.9	0.0	(10.9)	0.7
Non Pay Savings Target	0.0	0.0	(0.4)	(0.0)	1.6	0.2	(1.4)	0.0	10.9	0.0	(10.9)	0.7
Operating Expenses Excluding Employee Expenses	(60.0)	(61.2)	(58.7)	(55.5)	(54.6)	(60.9)	(6.3)	(386.6)	(388.3)	(417.4)	(29.1)	(2.1)

1

Operating expenses – an adverse variance in month of £6.3m against budget

Non-Pay costs are £2.2m higher than in month 6, and £6.3m overspend compared to budget.

The overspend in month 7 the main contributors for overspend are :

- £2.8m overspend on Radiology (Medica) and Endoscopy (18 weeks support) outsourcing in Denmark Hill
- £1.3m on supplies and services overspend relates to COVID testing
- £0.8m relates to Drugs overspend which £0.7m is pass though

In the plan, we have evenly phased the following items, for which we haven't yet seen the full impact of inflation nor cost improvement plans:

- £12m Non-Pay inflation (£1m per month)
- £7m Energy excess inflation (£0.6m per month)
- Business Cases not yet started £5.6m

Underlying Position

- The Trust's M1-7 normalised position is broadly an average deficit of £4.1m a month which extrapolated on a straight line would lead to a year end deficit of £49m.

- If the Trust was to remove other non recurrent items (COVID and redistributed elements of System top up) the average underlying deficit of £9.8m would lead to annual deficit of £118m which is c.£42m lower than the 2021-22 underlying deficit calculated on like for like basis. However, this is predominantly driven by £33m 22-23 ERF funding being assumed as recurrent in nature. Adjusting for this and the Trust has marginally improved its underlying position.

NHSI Category	M 1 £ M	M 2 £ M	M 3 £ M	M 4 £ M	M 5 £ M	M 6 £ M	M 7 £ M
Operating Income	125.9	132.0	1318	133.1	140.5	1411	139.6
Employee Operating Expenses	(72.8)	(73.0)	(73.3)	(74.3)	(74.0)	(814)	(76.5)
Operating Expenses Excluding Employee Expenses	(56.6)	(59.3)	(60.8)	(60.0)	(612)	(58.7)	(60.9)
Non Operating Expenses	(2.7)	(3.4)	(2.6)	(3.9)	(2.7)	(2.0)	(3.9)
Trust Total	**(6.2)**	**(3.7)**	**(4.9)**	**(5.1)**	**2.6**	**(1.1)**	**(1.6)**
Less Impairment, donated income	0.2	0.1	(0.1)	(0.2)	0.4	0.1	(0.7)
Operating Total (including ERF)	**(6.0)**	**(3.6)**	**(5.0)**	**(5.3)**	**3.0**	**(1.0)**	**(2.3)**
Normalising one off adjustments:							
Eplex	0.6	0.6	0.6	0.6	(4.2)		
Demand and Capacity Funding							(1.1)
Prior year drug over performance				(2.7)		(2.6)	
One off VAT costs	0.3	0.3	0.3	0.3	(13)		
One off COVID	0.1	0.1					
KHP Credits					(0.4)		
Pay award income	12	12	12	12	12	(5.9)	
Pay award costs	(0.6)	(0.6)	(0.6)	(0.6)	(0.6)	3.0	
Prior year commercial PFI benefits	(0.4)	(0.4)		0.2			
Deficit post normalising adjustments:	**(4.7)**	**(2.3)**	**(3.4)**	**(6.2)**	**(2.3)**	**(6.5)**	**(3.4)**
System non recurrent top up	(2.5)	(2.5)	(2.5)	(2.5)	(2.5)	(2.5)	(2.5)
System COVID funding	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)	(2.3)
Spec Comm CCU Funding	0.0	(17)	(0.8)	(0.8)	(0.8)	(0.8)	(0.8)
Underlying position	**(9.5)**	**(8.8)**	**(9.1)**	**(11.9)**	**(7.9)**	**(12.1)**	**(9.0)**

Average normalised deficit is £4.1m a month which equates to annualised deficit of c.£49.2m

Average normalised deficit is £9.8m a month which equates to annualised deficit of c.£118m

Inflation

- The Trust has been tracking inflation to understand the risk to date and going forward.

Crystalised Inflation

- Currently we have the following pressure YTD (FYE) which is broadly covered by the £7m incremental inflation funding we got at beginning of the year:
  - Non pay on clinical consumables - £1.0m (c.1%).
  - Pathology - £1.5
  - Energy – £4.5m
  - PFI - £1.5

2. Estimates of future pressure not in FOT

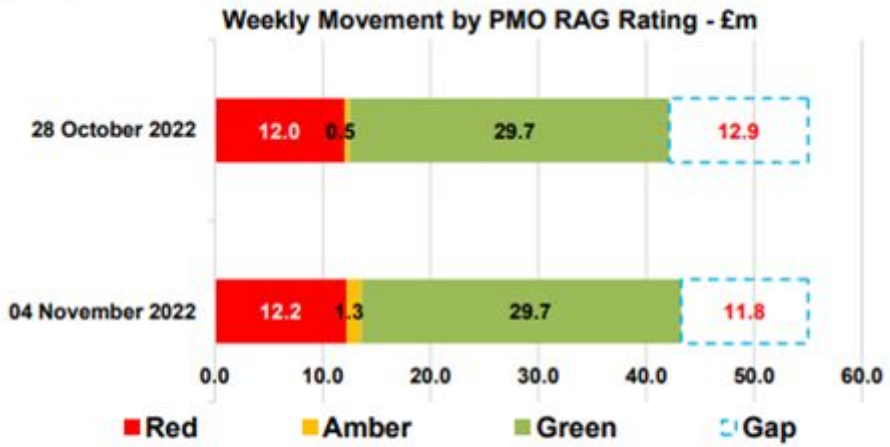
- In the FOT we have broadly assumed that there will be additional monies coming to cover inflation pressures. These pressures excluded from FOT are:
  - Pathology - £0.9m
  - Energy – £1.5m
  - PFI – £0.8m

The other risk which is being quantified is the impact on the gilt rate which significantly impacts the lease on Willowfield.

Scoping/Identification of schemes - The overall Trust Efficiency Programme has identified schemes to the total value of £43.2m of which £29.7m is in Green and ready for implementation

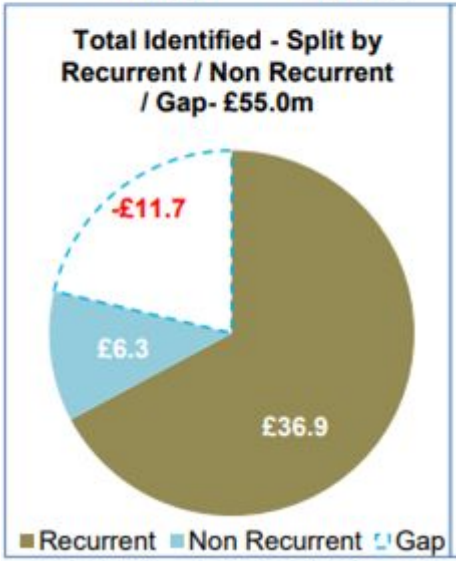
Headlines of schemes in scoping/identification stage:

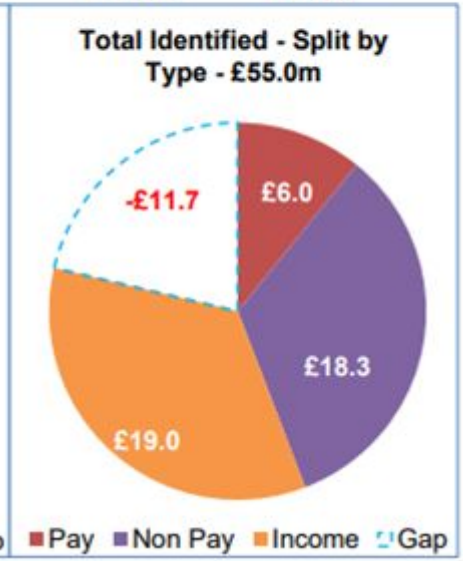
- The KCH Group Efficiency Programme target is £55m.
- The programme to date has identified £43.2m of schemes. This is broken down as £12.2m in Red, £1.3m in Amber and £29.7m in Green.
- The identified schemes are split Recurrent £36.9m and Non-Recurrent £6.3m.
- This leaves a £11.7m gap which is yet to be identified.
- To address and mitigate this gap, there are £11.1m of schemes currently in the pipeline to be matured, agreed and reflected. These schemes need further development by the site teams / care groups.

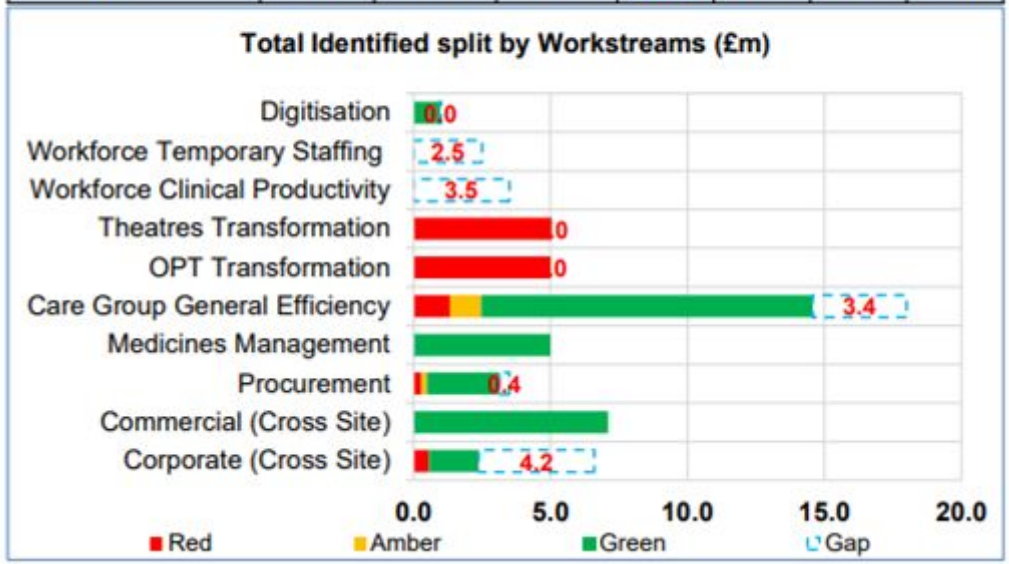


Total identification - Target vs. Identified

Site	Target	Pipeline Scheme	Identified	Gap	Red	Amber	Green
Denmark Hill	24.1	3.1	16.5	(7.7)	0.8	1.2	14.5
PRUH and South Sites	7.6	1.2	7.8	0.2	0.5	0.1	7.1
Corporate	4.2	1.5	4.7	0.5	0.1	0.0	4.6
Commercial	3.1	0.0	3.1	0.0	0.0	0.0	3.1
Centralised Schemes	16.0	5.3	11.2	(4.8)	10.8	0.0	0.3
Total	**55.0**	**11.1**	**43.2**	**(11.7)**	**12.2**	**1.3**	**29.7**







Delivery of schemes in Green - The overall Trust Efficiency Programme has delivered £14.5m of efficiency as at M7 and based on the schemes that are currently in Green are forecasting to deliver £27.4m by year end

Total Schemes in Implementation	In Month (M7)			YTD (M1-M7)			Full Year Forecast (M1-M12)		
Site	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Actual	Variance
Denmark Hill	2.0	0.7	(1.3)	14.1	4.5	(9.6)	24.1	12.4	(11.7)
PRUH and South Sites	0.6	0.4	(0.3)	4.4	4.8	0.4	7.6	6.8	(0.8)
Corporate	0.3	0.4	0.1	2.4	2.2	(0.3)	4.2	4.6	0.4
Commercial	0.3	0.0	(0.2)	1.8	2.7	0.9	3.1	3.1	0.0
Centralised Schemes	1.3	0.1	(1.2)	9.3	0.4	(9.0)	16.0	0.4	(15.6)
Total	**4.6**	**1.7**	**(2.9)**	**32.1**	**14.5**	**(17.6)**	**55.0**	**27.4**	**(27.6)**

The plan values reported above are as per our financial plan. The total 55.0m has been profiled equally throughout the year. The actual values are based on all schemes that are currently in the green category only. This does not reflect schemes which are in red or amber stages of the programme.

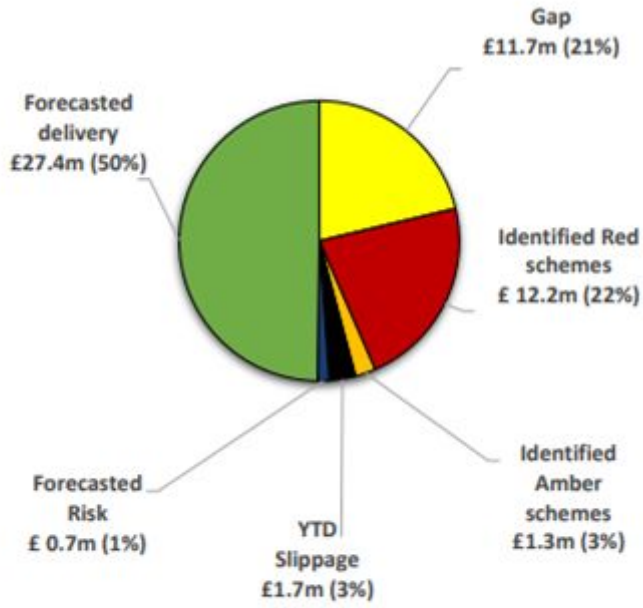
M7 Efficiency Reporting Headlines:

- As at M7 reporting, the Trust has delivered a total of £14.5m of efficiency. Against the YTD planned position (where the efficiency is evenly phased across the year), the Trust is £17.6m behind plan.
- Based on the schemes that are in green (£29.7m), the Trust is forecasting year end delivery of £27.4m. The slippage between the green value and the year end forecast (£2.3m) is owing to a combination of slippage and risks identified on delivery of some schemes.
- The risk to the programme displayed by the chart to the right, reflects a YTD slippage of £1.7m (3%) and a forecasted risk to the programme of £0.7m (1%). These percentages are based on the full year target of £55m, resulting in a gap of £25.3m (46%) of schemes to identify over the coming weeks.
- The YTD slippage and forecasted risk totals £2.3m; 4% collectively. The main schemes that are a contributing to the YTD slippage and risk include **(1)** £0.4m Alliance refund to KCH which is at risk as debt being disputed **(2)** £0.4m Endoscopy insourcing due to a delay in recruitment therefore resulting in continued insourcing costs **(3)** £0.2m Modernising Medicine due to delayed implementation.
- In order to bridge the gap to the total target of £55m, Denmark Hill are required to still convert £11.7m, PRUH £0.8m and centralised schemes £15.7m.

Key Actions for Remainder of the Year:

- Convert the schemes sitting in red and amber into implementation to help bridge the current gap
- Denmark Hill site to identify the remainder site gap to help bridge the overall gap of the programme, specifically focusing on recurrent expenditure reduction
- Sites to focus on delivery of schemes that are currently in the programme
- Sites to mitigate any slippages and forecast risks for schemes in delivery
- Continue to push discussions with NHSE for CAR-T payment
- Monitor the impact of patchwork and continue to drive bank/agency reductions alongside vacancy reviews

Breakdown of Delivery against the £55m Target



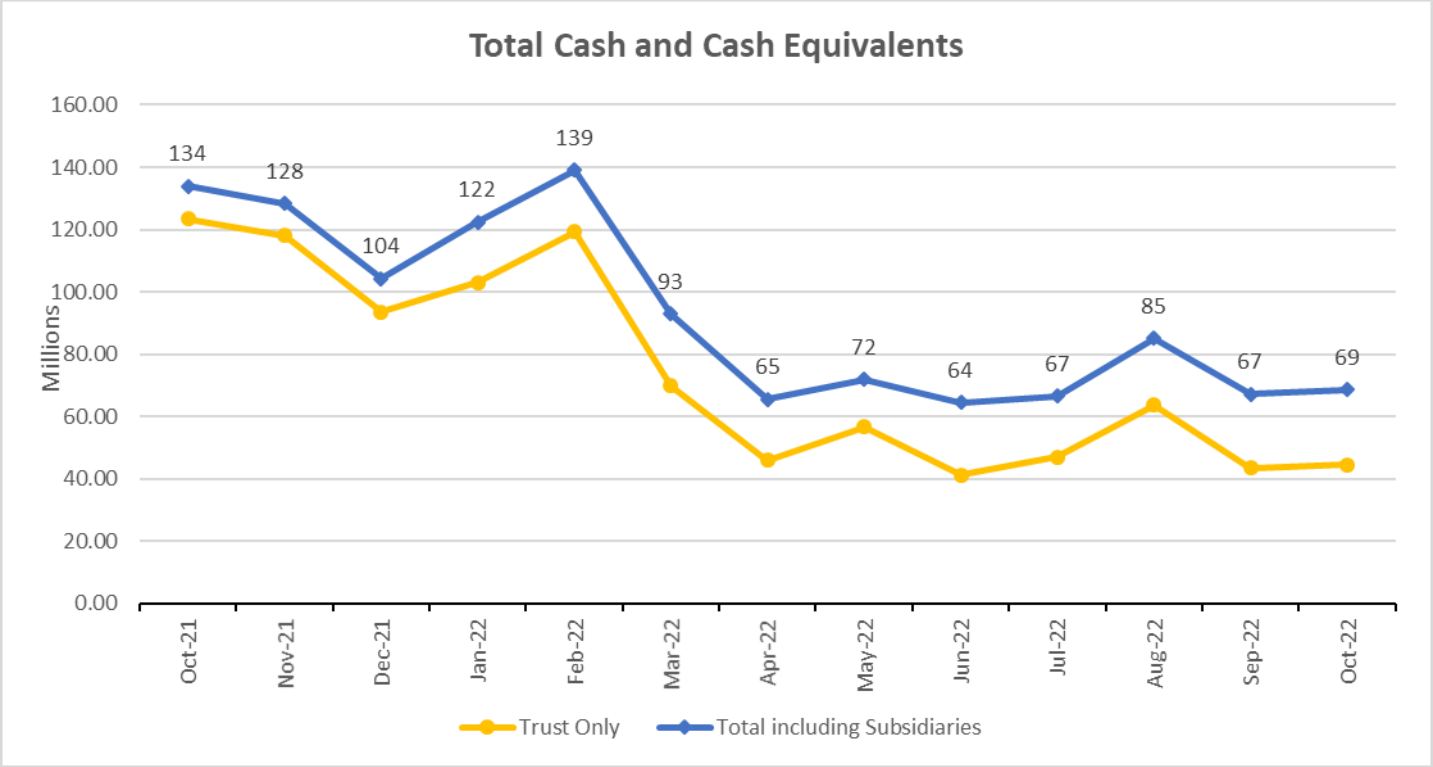
Cash Flow & Revenue Support - Debtors and Creditors

Better Payment Practice Code

Better payment practice code	YTD Number	YTD £'000
Non NHS		
Total bills paid in the year	141,413	708,126
Total bills paid within target	102,955	600,743
Percentage of bills paid within target	**72.8%**	**84.8%**
NHS		
Total bills paid in the year	1,622	25,659
Total bills paid within target	872	10,705
Percentage of bills paid within target	**53.8%**	**41.7%**
Total		
Total bills paid in the year	**143,035**	**733,785**
Total bills paid within target	**103,827**	**611,448**
Percentage of bills paid within target	**72.6%**	**83.3%**

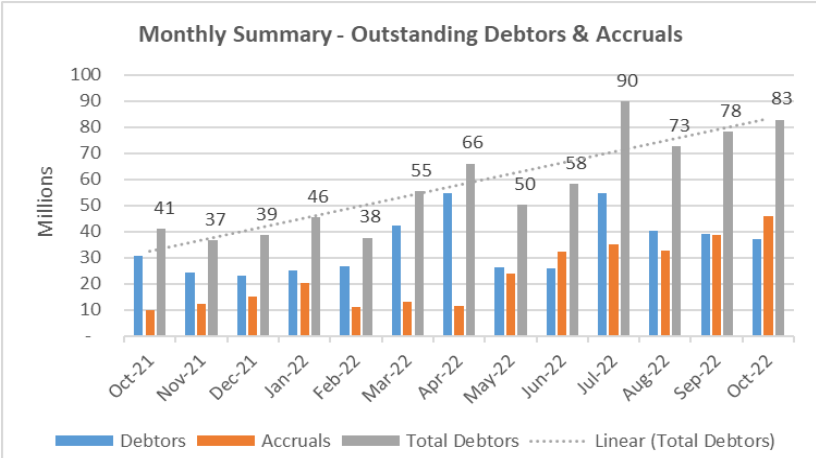
- The Better Payment Practice Code target is to pay all NHS and non-NHS trade payables within 30 calendar days of receipt of goods or a valid invoice (whichever is later) unless other payment terms have been agreed
- Compliance against this target is for at least 95% of invoices to be paid within the 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
- 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.

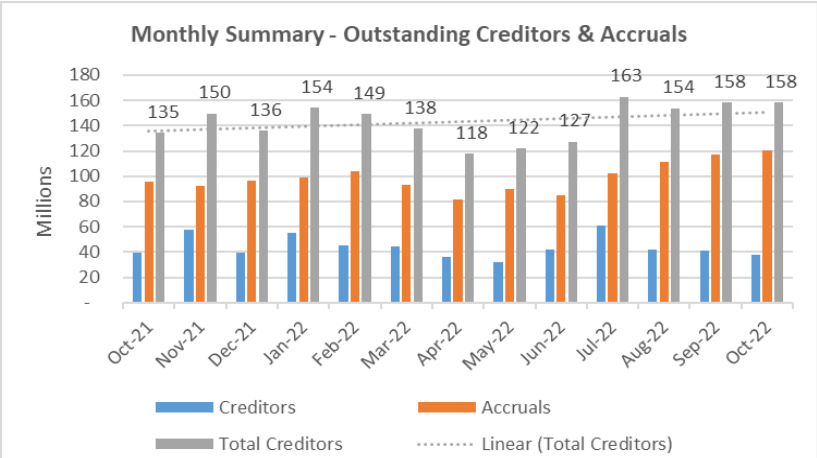
Cash and Cash Equivalents

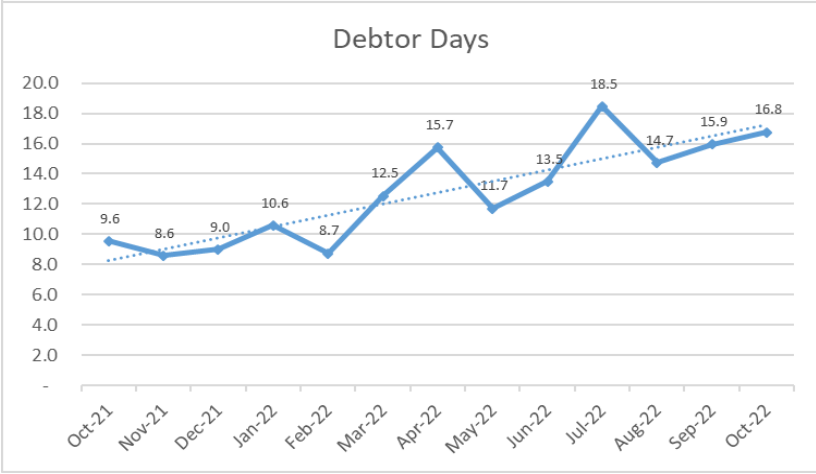


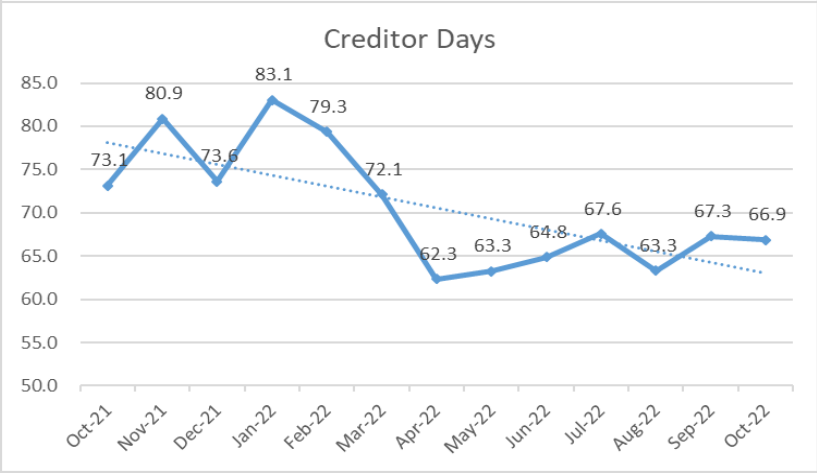
- The month end Group Cash balance at 31 October 2022 was £69m.
- Overall cash levels were higher in the previous year but have reduced due to reducing outstanding levels of trade creditors and investment of capital projects (including the Apollo project and ongoing CCU build) in March 2022.
- While currently holding at a consistent level, cash balances are forecast to remain under pressure for the remainder of the financial year. The Group and Trust cash balances are monitored on an ongoing basis to manage the impact of this.
- 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



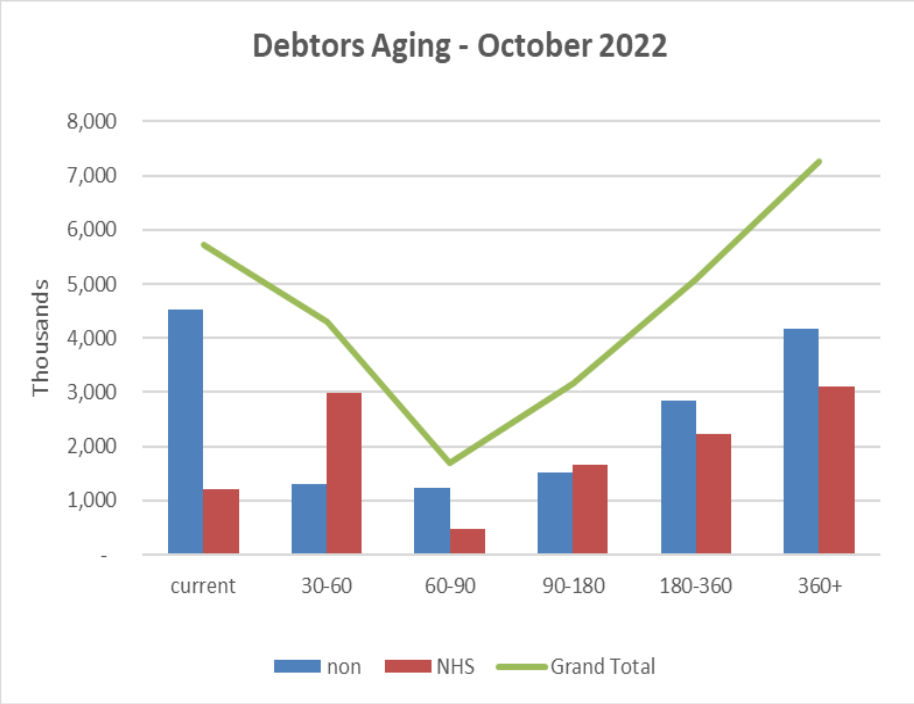


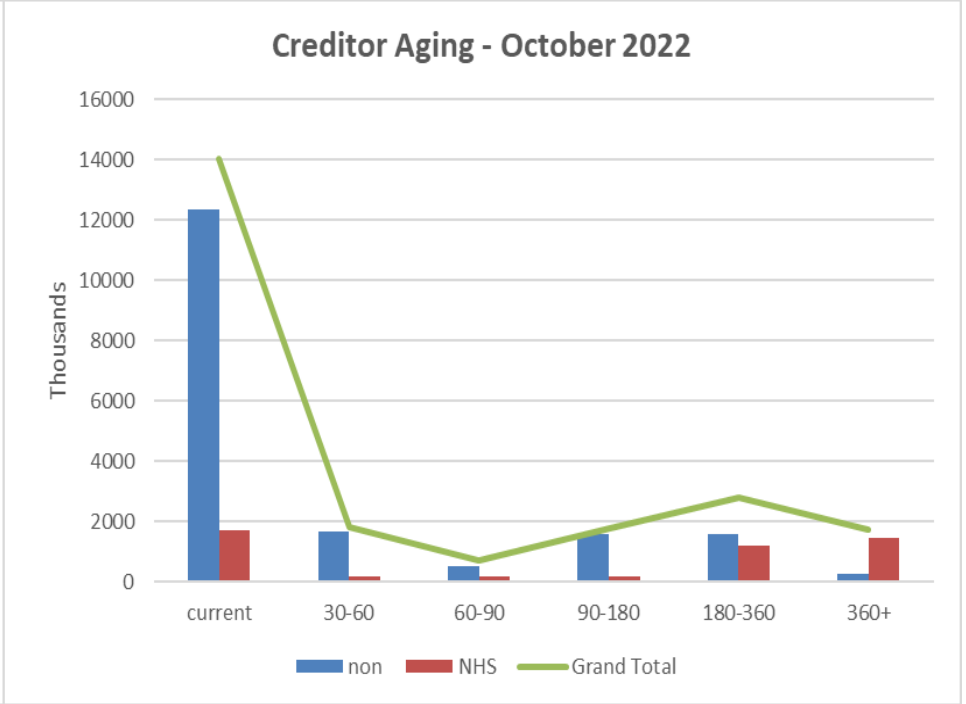




- Debtor Days have increased in month 7 to 16.8 days primarily due to an increase in income accruals in month 7. The Trust continues to focus on debt recovery and collection of aged debt.
- The Trust receives monthly contract payments on the 15th of each month from NHSEI and local CCGs.
- Creditor payment days have decreased to 66.9 days in month 7 also 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 although the Trade Creditors now has a very current profile.

Debtor and Creditor Ageing Update





- Aged creditors show a highly current profile, particularly with Non-NHS debt, which is the correct direction of travel for moving towards achieving compliance with BPPC.
- 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

1.1 Run Rate Detail – Operating Income

12 Months Rolling Run Rate	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
NHS England	43.0	48.2	45.1	45.7	77.4	44.9	49.2	50.4	49.1	50.6	55.3	49.2	607.9
Clinical Commissioning Groups	60.3	55.8	56.1	56.8	53.8	67.3	46.1	51.4	55.4	60.7	60.4	56.2	680.2
Pass Through Drugs Income	13.3	13.5	15.0	14.3	16.5	0.0	25.6	19.1	15.4	10.1	14.9	18.1	175.9
NHS Foundation Trusts	0.0	0.0	(0.2)	0.0	0.1	0.0	0.0	(0.0)	0.0	0.0	0.0	0.0	(0.0)
NHS Trusts	0.2	(0.0)	0.1	(0.0)	(0.5)	1.0	(0.8)	0.1	0.1	(0.1)	0.1	(0.0)	0.2
Local Authorities	0.2	0.3	0.8	0.3	(0.4)	0.3	0.2	0.4	0.3	0.3	0.3	0.3	3.4
NHS Other (Including Public Health England)	0.2	0.1	(0.1)	0.8	(0.8)	0.1	0.6	0.3	1.2	0.3	0.1	0.4	3.4
Non NHS: Private Patients	0.4	0.7	0.3	1.0	0.9	0.6	0.9	0.4	0.8	1.1	0.6	1.2	8.9
Non-NHS: Overseas Patients (Non-Reciprocal, Chargeable To	0.2	0.4	0.3	0.2	0.3	0.2	0.2	0.2	0.4	0.7	0.3	0.2	3.6
Injury Cost Recovery Scheme	0.2	0.3	0.3	0.2	0.3	0.2	0.9	0.3	0.4	0.4	0.2	0.2	3.9
Non NHS: Other	0.0	0.0	0.0	0.0	2.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.1
Operating Income From Patient Care Activities	**118.0**	**119.3**	**117.6**	**119.2**	**149.8**	**114.6**	**123.0**	**122.6**	**123.3**	**124.2**	**132.2**	**125.8**	**1,489.7**
Research and Development	1.4	2.4	2.2	2.1	1.1	2.7	1.6	1.1	0.7	2.6	1.4	1.7	20.9
Education and Training	3.4	3.4	3.2	3.9	4.6	3.6	3.6	3.6	4.1	3.4	3.3	4.7	45.1
Cash Donations / Grants For The Purchase Of Capital Assets	0.1	0.0	2.5	0.1	3.4	(0.1)	0.0	0.2	0.3	(0.3)	0.0	0.8	7.1
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	0.9	1.0	1.0	1.1	0.9	1.1	0.8	0.9	1.2	1.1	0.8	1.1	11.9
PSF, FRF, MRET funding and Top-Up	1.5	2.1	1.2	3.8	1.6	0.9	0.8	0.6	0.5	6.0	0.8	1.2	21.0
Income In Respect Of Employee Benefits Accounted On A Gross	0.2	0.5	1.1	0.4	1.1	0.9	0.4	0.6	0.7	1.4	0.2	0.6	8.2
Rental Revenue From Operating Leases	0.2	0.1	0.1	0.1	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.2	1.5
Other (Operating Income)	2.4	1.1	1.9	1.4	7.3	2.2	1.7	2.1	2.3	2.1	2.2	3.5	30.3
Other Operating Income	**10.1**	**10.6**	**13.3**	**13.0**	**20.4**	**11.4**	**9.0**	**9.2**	**9.8**	**16.4**	**8.9**	**13.8**	**145.9**
Finance Income	0.0	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0
Finance Income	**0.0**	**0.0**	**0.0**	**0.0**	**2.0**								**2.0**
Operating Income	**128.1**	**129.9**	**131.0**	**132.2**	**172.2**	**125.9**	**132.0**	**131.8**	**133.1**	**140.5**	**141.1**	**139.6**	**1,637.5**

1.2 Run Rate Detail – Employee Expenses

12 Months Rolling Run Rate	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Substantive Staff	(20.9)	(21.0)	(21.2)	(21.0)	(19.5)	(21.4)	(21.2)	(21.2)	(21.6)	(21.4)	(24.4)	(22.2)	(257.1)
Bank Staff	(1.0)	(1.0)	(2.0)	(1.1)	1.1	(1.4)	(1.6)	(1.4)	(1.3)	(1.5)	(1.5)	(1.8)	(14.5)
Agency / Contract	(0.7)	(0.6)	(0.8)	(0.8)	(0.0)	(0.6)	(0.7)	(1.0)	(1.1)	(0.5)	(0.6)	(0.1)	(7.7)
Medical Staff	**(22.7)**	**(22.6)**	**(24.0)**	**(23.0)**	**(18.4)**	**(23.4)**	**(23.5)**	**(23.6)**	**(23.9)**	**(23.4)**	**(26.6)**	**(24.1)**	**(279.2)**
Substantive Staff	(24.6)	(24.7)	(26.1)	(24.4)	(24.1)	(24.7)	(24.6)	(24.4)	(24.8)	(25.0)	(31.3)	(26.5)	(305.1)
Bank Staff	(3.0)	(3.5)	(4.7)	(3.1)	(4.5)	(3.1)	(3.5)	(3.3)	(3.3)	(3.5)	(4.1)	(4.1)	(43.6)
Agency / Contract	(0.5)	(0.6)	(0.6)	(0.6)	(0.6)	(0.5)	(0.6)	(0.6)	(0.6)	(0.7)	(0.9)	(0.8)	(7.7)
Nursing Staff	**(28.1)**	**(28.7)**	**(31.4)**	**(28.1)**	**(29.2)**	**(28.3)**	**(28.7)**	**(28.4)**	**(28.7)**	**(29.2)**	**(36.2)**	**(31.3)**	**(356.4)**
Substantive Staff	(10.0)	(10.3)	(10.8)	(10.9)	(7.7)	(11.8)	(11.4)	(12.0)	(12.1)	(11.8)	(6.6)	(11.1)	(126.4)
Bank Staff	(0.5)	(0.4)	(0.8)	(0.4)	(0.3)	(0.4)	(0.4)	(0.4)	(0.1)	(0.5)	(0.6)	(0.3)	(5.0)
Agency / Contract	(0.3)	(0.4)	(0.0)	(0.1)	(0.2)	(0.2)	(0.3)	(0.4)	(0.4)	(0.2)	(0.3)	(0.3)	(3.1)
Admin & Clerical	**(10.8)**	**(11.1)**	**(11.6)**	**(11.4)**	**(8.2)**	**(12.4)**	**(12.0)**	**(12.7)**	**(12.6)**	**(12.4)**	**(7.5)**	**(11.7)**	**(134.5)**
Substantive Staff	(8.2)	(8.3)	(8.5)	(8.2)	(8.1)	(8.2)	(8.2)	(8.1)	(8.2)	(8.3)	(10.2)	(8.7)	(101.2)
Substantive Staff (Apprentices)	(0.0)	(0.0)	(0.0)	(0.0)	(2.8)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(2.9)
Bank Staff	(0.2)	(0.2)	(0.4)	(0.2)	(0.4)	(0.3)	(0.3)	(0.2)	(0.2)	(0.2)	(0.4)	(0.2)	(3.2)
Agency / Contract	(0.3)	(0.2)	0.0	(0.1)	(0.1)	(0.2)	(0.2)	(0.3)	(0.6)	(0.5)	(0.4)	(0.5)	(3.4)
Other Staff	**(8.6)**	**(8.8)**	**(8.9)**	**(8.5)**	**(11.3)**	**(8.7)**	**(8.7)**	**(8.6)**	**(9.0)**	**(9.0)**	**(11.0)**	**(9.5)**	**(110.7)**
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	0.0	0.0	0.0	(31.2)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(31.2)
Pay Reserves					**(31.2)**								**(31.2)**
Employee Operating Expenses	**(70.1)**	**(71.3)**	**(75.9)**	**(70.9)**	**(98.5)**	**(72.8)**	**(73.0)**	**(73.3)**	**(74.3)**	**(74.0)**	**(81.4)**	**(76.5)**	**(912.0)**
Substantive Staff Total	(63.6)	(64.3)	(66.7)	(64.4)	(93.5)	(66.1)	(65.5)	(65.7)	(66.7)	(66.4)	(72.6)	(68.4)	(823.9)
Bank Staff Total	(4.7)	(5.1)	(7.8)	(4.8)	(4.0)	(5.2)	(5.7)	(5.4)	(4.8)	(5.7)	(6.6)	(6.4)	(66.2)
Agency / Contract Total	(1.8)	(1.8)	(1.4)	(1.7)	(1.0)	(1.6)	(1.8)	(2.2)	(2.7)	(2.0)	(2.3)	(1.6)	(21.9)
Employee Operating Expenses	**(70.1)**	**(71.3)**	**(75.9)**	**(70.9)**	**(98.5)**	**(72.8)**	**(73.0)**	**(73.3)**	**(74.3)**	**(74.0)**	**(81.4)**	**(76.5)**	**(912.0)**

1.3 Run Rate Detail – Operating Expenses

12 Months Run Rate	Nov-22	Dec-22	Jan-22	Feb-22	Mar-22	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Total
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Purchase Of Healthcare From NHS Bodies	(1.0)	(1.1)	(1.2)	(0.7)	(0.0)	(0.7)	(0.9)	(0.9)	(0.8)	(0.9)	(1.2)	(1.2)	(10.6)
Purchase Of Healthcare From Non-NHS Bodies	(17.8)	(18.8)	(19.8)	(14.6)	(36.7)	(15.3)	(15.4)	(15.0)	(15.3)	(16.1)	(15.3)	(16.0)	(216.1)
Non-Executive Directors	0.0	0.0	0.0	0.0	(0.2)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.2)
Supplies and Services - Clinical (Excluding Drugs Costs)	(3.3)	(3.2)	(2.9)	(3.1)	(6.3)	(2.9)	(2.6)	(2.6)	(2.6)	(2.8)	(2.1)	(2.7)	(37.1)
Supplies and Services - General	(0.2)	(0.3)	(0.5)	0.1	(0.6)	(0.2)	(0.0)	(0.1)	(0.1)	(0.1)	(0.0)	(0.2)	(2.3)
Drugs costs – on tariff	(4.6)	(4.2)	(3.7)	(2.9)	(3.7)	(3.7)	(1.2)	(2.5)	(2.3)	(2.3)	(2.3)	(2.2)	(35.7)
Pass Through Drugs Cost	(11.1)	(11.9)	(12.1)	(13.1)	(13.0)	(11.0)	(17.8)	(14.5)	(13.9)	(15.3)	(14.3)	(14.2)	(162.3)
Consultancy	0.7	(0.2)	(0.1)	(3.6)	1.8	(1.6)	(0.2)	(0.8)	(0.6)	1.5	(0.5)	0.4	(3.3)
Establishment	(0.9)	(0.9)	(2.4)	(0.2)	(0.6)	(1.0)	(0.7)	(1.3)	(1.1)	(1.1)	(1.1)	(1.3)	(12.6)
Premises - Business Rates Payable To Local Authorities	(0.4)	(0.4)	(0.4)	(0.4)	(0.5)	(0.4)	(0.4)	(0.0)	(0.6)	(0.2)	(0.5)	(0.4)	(4.7)
Premises - Other	(10.3)	(5.2)	(3.6)	(10.7)	74.3	(10.6)	(9.6)	(12.3)	(12.4)	(11.7)	(11.8)	(13.7)	(37.6)
Transport	(1.0)	(0.9)	(0.9)	(0.9)	(0.7)	(1.0)	(0.8)	(0.9)	(1.2)	(1.1)	(1.0)	(1.0)	(11.4)
Depreciation	(2.8)	(2.7)	(4.6)	(1.8)	(2.3)	(3.2)	(3.6)	(2.4)	(2.9)	(2.9)	(2.8)	(3.1)	(35.2)
Amortisation	0.0	0.0	0.0	0.0	(2.0)	0.0	0.0	(0.9)	(0.3)	(0.3)	0.5	(0.2)	(3.3)
Fixed Asset Impairments net of Reversals	0.0	0.0	0.0	0.0	(6.0)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(6.0)
Increase/(Decrease) In Impairment Of Receivables	0.5	(0.3)	(0.1)	(0.2)	0.2	0.3	(0.1)	(0.2)	(0.4)	(2.3)	(0.1)	(0.4)	(2.9)
Audit Fees and Other Auditor Remuneration	(0.0)	(0.0)	(0.0)	(0.0)	0.0	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.0)	(0.1)	(0.2)
Clinical Negligence	(4.1)	(4.1)	(4.1)	(1.8)	(3.6)	(3.7)	(3.7)	(4.2)	(3.9)	(3.9)	(3.9)	(3.9)	(44.5)
Research and Development - Non-Staff	(0.1)	(0.1)	(0.0)	(0.5)	0.2	(0.3)	(0.2)	0.0	(0.1)	(0.1)	(0.1)	(0.3)	(1.7)
Education and Training - Non-Staff	(0.5)	(0.4)	(0.8)	(0.7)	0.1	(0.6)	(0.6)	(0.4)	(0.5)	(0.3)	(0.1)	(0.7)	(5.4)
Operating Lease Expenditure (net)	(0.1)	(0.1)	(0.1)	(0.3)	(6.2)	(0.2)	(0.2)	(0.2)	(0.0)	(0.1)	(0.3)	(0.3)	(8.2)
Charges To Operating Expenditure For Ifric 12 Schemes (E.G. PFI / LIFT) On Ifrs Basis	0.0	0.0	0.0	0.0	(68.3)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(68.3)
Other	(0.9)	(0.5)	(0.6)	(1.0)	1.8	(0.4)	(1.6)	(1.5)	(1.0)	(1.0)	(1.3)	0.2	(7.8)
Operating Expenses Excluding Employee Expenses	**(57.9)**	**(55.2)**	**(57.9)**	**(56.4)**	**(72.3)**	**(56.6)**	**(59.4)**	**(60.8)**	**(60.1)**	**(61.2)**	**(58.3)**	**(61.1)**	**(717.3)**
CIP Target Non Pay	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	(0.4)	0.2	0.0
Non Pay Savings Target	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.1**	**0.0**	**0.0**	**0.0**	**(0.4)**	**0.2**	**0.0**
Operating Expenses Excluding Employee Expenses	**(57.9)**	**(55.2)**	**(57.9)**	**(56.4)**	**(72.3)**	**(56.6)**	**(59.3)**	**(60.8)**	**(60.0)**	**(61.2)**	**(58.7)**	**(60.9)**	**(717.2)**
Finance Expense	(3.0)	(3.2)	(3.2)	(3.2)	(7.3)	(3.3)	(3.3)	(3.3)	(4.5)	(3.5)	(3.4)	(3.8)	(45.0)
Gains/(Losses) On Disposal Of Assets	0.0	0.0	0.0	0.0	(0.2)	0.0	0.0	0.0	0.0	(0.0)	0.0	(0.0)	(0.2)
Share Of Profit/ (Loss) Of Associates/ Joint Ventures	0.0	0.0	0.0	0.0	0.0	0.6	(0.0)	0.7	0.6	0.7	1.4	0.3	4.3
Corporation Tax Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(0.4)	(0.4)
Non Operating Expenses	**(3.0)**	**(3.2)**	**(3.2)**	**(3.2)**	**(7.5)**	**(2.7)**	**(3.4)**	**(2.6)**	**(3.9)**	**(2.7)**	**(2.0)**	**(3.9)**	**(41.2)**
Non Operating Expenses	**(3.0)**	**(3.2)**	**(3.2)**	**(3.2)**	**(7.5)**	**(2.7)**	**(3.4)**	**(2.6)**	**(3.9)**	**(2.7)**	**(2.0)**	**(3.9)**	**(41.2)**
Finance Expense	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					**0.0**								**0.0**
Obsolete Subjective Codes (since Dec-16)					**0.0**								**0.0**
Trust Total	**(3.0)**	**0.2**	**(6.0)**	**1.7**	**(6.0)**	**(6.2)**	**(3.6)**	**(4.9)**	**(5.0)**	**2.6**	**(1.1)**	**(1.6)**	**(32.9)**
Less Depr On Donated Assets	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.4
Less Donated Assets Income	(0.1)	(0.0)	(2.5)	(0.1)	(3.4)	0.1	0.0	(0.2)	(0.3)	0.3	(0.0)	(0.8)	(7.0)
Less Fixed Asset Impairments	0.0	0.0	0.0	0.0	6.0								6.0
Less Impairment, donated income	**(0.0)**	**0.1**	**(2.4)**	**(0.0)**	**2.8**	**0.2**	**0.1**	**(0.1)**	**(0.2)**	**0.4**	**0.1**	**(0.7)**	**0.4**
Operating Total (including ERF)	**(3.0)**	**0.3**	**(8.4)**	**1.7**	**(3.3)**	**(6.0)**	**(3.5)**	**(4.9)**	**(5.2)**	**3.0**	**(1.0)**	**(2.3)**	**(32.5)**
Less Elective Recovery Fund	(3.4)	0.0	(0.7)	(0.2)	(0.2)	(1.7)	(1.7)	(1.7)	(1.1)	(1.6)	(1.7)	(1.6)	(15.6)
Operating Total (excluding ERF)	**(6.4)**	**0.3**	**(9.1)**	**1.5**	**(3.4)**	**(7.7)**	**(5.2)**	**(6.7)**	**(6.3)**	**1.4**	**(2.7)**	**(3.9)**	**(48.1)**

Site Summaries

Summary of Year to Date Financial Position – DENMARK HILL

Denmark Hill Site has reported a £8.3m surplus for M7, resulting in a YTD surplus of £46.4m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	**M6**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**M7 vs M6**
NHSI Category	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	986.8	77.7	85.7	84.2	83.2	(1.0)	545.0	563.6	564.2	0.7	5.6
Employee Operating Expenses	(575.6)	(57.5)	(46.6)	(48.1)	(50.3)	(2.2)	(320.0)	(335.8)	(344.6)	(8.8)	7.2
Operating Expenses Excluding Employee Expenses	(281.2)	(25.1)	(25.4)	(23.3)	(24.6)	(1.3)	(165.6)	(164.3)	(173.2)	(8.9)	0.5
DENMARK HILL Total	**130.0**	**(4.9)**	**13.7**	**12.8**	**8.3**	**(4.5)**	**59.3**	**63.4**	**46.4**	**(17.0)**	**13.2**

Key Messages:

The Denmark Hill site recognised an in-month surplus of £8.3m and YTD surplus of £46.4m, which was adverse against plan by £4.5m in month and £17.0m YTD

Income:

Income overall is better than plan YTD by £0.7m YTD. The main drivers for over-performance are pass through drugs, and increased day case activity of £1.4m and outpatient New activity of £1.6m, offset by an under performance in critical care (closed beds) and Acute Medicine non-elective.

Pay:

Pay was overspent by £2.2m in month and £8.8m overspent YTD. The YTD overspend is driven by £2.4m in ERF costs and £6.1m of unidentified CIP target, offset by unfilled vacancies. The medical overspend is related to a budget misalignment and gaps in deanery rotas being filled with higher cost bank/agency.

Non Pay:

Non-Pay was over spent by £1.3m in M07 and £8.9m YTD vs budget. The YTD variance was driven by the unachieved CIP target (£2.3m), ERF recovery spend (£2.0m) and pass-through drug expenditure (£4.2m).

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

PRUH & South Sites have reported a £0.1m deficit for M7, resulting in a YTD surplus of £3.3m

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	304.6	23.7	24.9	26.2	23.8	(2.5)	160.9	174.7	165.6	(9.0)	0.1
Employee Operating Expenses	(224.7)	(21.8)	(17.5)	(18.5)	(18.7)	(0.2)	(119.7)	(130.4)	(129.2)	1.2	3.1
Operating Expenses Excluding Employee Expenses	(52.4)	(4.5)	(4.2)	(4.7)	(5.2)	(0.5)	(30.3)	(30.6)	(33.0)	(2.4)	(0.7)
DENMARK HILL Total	**27.5**	**(2.6)**	**3.2**	**3.0**	**(0.1)**	**(3.2)**	**10.9**	**13.6**	**3.3**	**(10.3)**	**2.5**

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 and Physics*; (iii) Corporate functions reporting to PRUH Site CEO: Business Intelligence Unit*. (*predominantly non income generating with YTD costs totalling £21mYTD).*

Income:

£2.5m adverse in month which is driven by (i) Non-Elective Income £1.3m (General Medicine £0.5m, General Surgery £0.3m and Respiratory £0.3m), (ii) £0.6m within Elective Inpatients across Orthopaedics and within Surgery, (iii) £0.4m within Ophthalmology outpatient procedures. The site is underperforming against plan in Ophthalmology (£0.8m) as a result of 5 month recruitment delay for BC2515-Ophthlamology Service Sustainability SEL Diagnostic Hubs and in General Medicine (£0.6), Elective Inpatient plan includes DH Bariatric procedures which the service have not elected to do within PRUH despite capacity being made available.

Pay:

£19m in month. The pay run rate is increasing in line with expectation from recruitment to significant business cases within both cross site care groups (Cancer, Ophthalmology) and PRUH based care groups (STAE and Specialty Medicine). The in month position has seen a 14% decrease vs M6 however this is driven by £3m backdated pay relating to pay awards across all substantive staffing grades.

Medical pay is overspent by £0.24m in M7 and £2.4m YTD, predominantly within General Medicine and Adult Medicine. This is driven by responding to emergency department pressures, and response to vacancies across the sites (Medical 64 wte). Agency spend has reduced in month due to successful recruitment to Junior Doctor posts within General Medicine against approved business case. Focus remains on reduction of temporary staff pay as a percentage of the growing substantive pay to below 10%, with continuing efforts on substantive recruitment.

Non pay:

Non pay is overspent £0.5m in month due to costs being transferred from KFM associated with equipment for Theatre 4 at Orpington. Business Case funding was allocated for this, but has not been made available to draw down. YTD overspend of £2.4m YTD, chiefly attributable to pass through drugs, which is offset by income.

CIPs:

Care groups have worked up detailed plans to deliver the £7.6m PRUH and South Sites envelope. The PRUH had identified £7.7m, of which £7.1m (92%) rated as Green as at 28th October 2022.

The PRUH's position is net of CIP of £5.3m transacted YTD.

Summary of Year to Date Financial Position – CORPORATE

Corporate Directorate have reported a £14.5m deficit for M7, resulting in a YTD deficit of £98.4m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	17.9	1.7	2.7	1.7	1.7	0.0	10.7	10.9	11.7	0.8	0.1
Employee Operating Expenses	(73.2)	(5.9)	(5.7)	(5.9)	(5.6)	0.3	(36.9)	(42.6)	(38.0)	4.6	0.3
Operating Expenses Excluding Employee Expenses	(109.6)	(10.3)	(10.9)	(7.9)	(10.6)	(2.7)	(71.5)	(61.7)	(72.1)	(10.4)	(0.3)
CORPORATE Total	**(164.9)**	**(14.6)**	**(14.0)**	**(12.1)**	**(14.5)**	**(2.4)**	**(97.7)**	**(93.3)**	**(98.4)**	**(5.1)**	**0.1**

Key Messages:

Income: Overall is reporting a breakeven position in month and YTD over performance position of £0.8m. The main drivers YTD continues to be; Executive Nursing £0.12m mainly due to Health Care Support worker winter Funding, and CEF division reported £0.7m - over-achievement of Patient Transport from Clinical Commissioning Groups.

Pay: Reporting a favourable in month by £0.3m and YTD by £4.6m mainly due to vacancies across the divisions. The main under spent areas are driven primary in IG and Management £1.05m and Apollo £0.78m, Finance £0.47m, ICT £0.4m, Workforce Development £0.37m, Trust Wide £0.2m, Operations £0.2m, Executive Nursing £0.46m and Medical Director mainly in Post Grad £0.3m. Total vacant post in M7 271 WTE. This represents 20% vacancy rate.

Non Pay: Over spent (£10.4m) YTD mainly due to Finance Unallocated CIP (£9.6m), Trust Wide Programmes mainly International Recruitment and accommodation (£1.6m). Theses adverse movements are offset by favourable movement in Underspend on HEE training YTD of HEE £0.8m.

Key movements from last month include

Operating Income: in month reporting a breakeven position.

Pay: reporting a favourable in month variance of £0.27m, mainly due to vacancies across many divisions. Apollo £0.1m and Operations Directorate IG and Management £0.16m. In month pay run rate improved by £0.3m due to Trust pay award arrears paid in M6.

Non-Pay: reported a (£2.7m) adverse position in month largely due to Finance Unallocated CIP (£1.4m). Outside of the unidentified CIP, Patient Transport also reported an overspend of (£0.43m) which is mostly offset by over performance in clinical income. International Recruitment (£0.44m) and Taxi And Other Vehicle Hire (£0.4m) due to CIPs identified being actioned in M7.

Summary of Year to Date Financial Position – COMMERCIAL

Commercial Division have reported a £9.3m deficit for M7, resulting in a YTD deficit of £58.0m.

Commercial	Annual	Run Rate	Current Month				Year to Date				Run Rate Change
NHSI Category	**Budget**	**M6**	**Last Year**	**Budget**	**Actual**	**Variance**	**Last Year**	**Budget**	**Actual**	**Variance**	**M7 vs M6**
	£ M	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**	**£ M**
Operating Income	15.3	1.0	1.1	1.3	1.6	0.3	8.3	8.9	9.1	0.2	0.5
Employee Operating Expenses	(1.5)	(0.1)	(0.2)	(0.1)	(0.1)	0.0	(0.9)	(0.9)	(0.7)	0.2	(0.0)
Operating Expenses Excluding Employee Expenses	(119.1)	(10.3)	(6.4)	(9.9)	(11.1)	(1.2)	(59.3)	(69.5)	(70.7)	(1.3)	(0.8)
Non Operating Expenses	8.0	1.4		0.7	0.3	(0.3)		4.7	4.3	(0.3)	(1.0)
Commercial Total	**(97.3)**	**(8.0)**	**(5.5)**	**(8.1)**	**(9.3)**	**(1.2)**	**(52.0)**	**(56.8)**	**(58.0)**	**(1.2)**	**(1.3)**

Key Messages:

Income:

Run rate: Favourable, due to retrospective depreciation & interest recharges following updated valuations. Additionally in month position benefits from realignment of PFI variable recharges (Corporate to Commercial division).

Variance: Favourable in month & YTD due retrospective depreciation & interest recharges following updated valuations. Additionally in month position benefits from realignment of PFI variable recharges (Corporate to Commercial division, related targets to be retrospectively realigned in M8). YTD position includes a one-off Compass Ltd credit (186k). Overall favourable position is partially reduced by IVF activity/income shortfall.

Pay:

Run rate: Breakeven

Variance: Favourable in month & favourable YTD, due to vacancies primarily within KHP Haematology portfolio.

Non Pay:

Run rate : Adverse, primarily due to KFM retrospective charges for above core contract activity overspend plus reduction in KFM profit share.

Variance: Adverse in month & breakeven YTD, driven by reduced KFM profit share, KFM retrospective charges for above core contract activity overspend, plus PFI RPI, payawards & energy costs. Overall costs are partially reduced by Medirest contract loan credit & reduction in equipment service charges.

Summary of Year to Date Financial Position – R&D

Research and Development have reported a £0.2m deficit for M7, resulting in a YTD deficit of £0.0m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	15.6	1.3	0.6	1.3	1.6	0.3	9.0	9.1	11.3	2.2	0.3
Employee Operating Expenses	(13.2)	(1.4)	(1.2)	(1.1)	(1.3)	(0.2)	(8.2)	(7.7)	(8.8)	(1.1)	0.1
Operating Expenses Excluding Employee Expenses	(3.8)	(0.1)	0.1	(0.3)	(0.5)	(0.2)	(1.1)	(2.2)	(2.5)	(0.3)	(0.4)
RESEARCH & DEVELOPMENT Total	**(1.4)**	**(0.2)**	**(0.6)**	**(0.1)**	**(0.2)**	**(0.2)**	**(0.3)**	**(0.8)**	**(0.0)**	**0.7**	**0.0**

Key Messages:

Income:

Income is £2.2m YTD over-achieving due to one-off (£0.5m) 21/22 CRN deferred income released in M01, (£0.1m) 21/22 CTU income raised as a result of reconciliation in M07, (£0.4m) Grant funding received to off-set overspend on Pay and Non-pay and also release of £1.2m deferred income as a result of M05 income reconciliation.

Pay:

Pay is over spend by (£1.1m) YTD against plan partly due to pay arrears and CRN pay reconciliations in M06 , however in line with funding received.

Non Pay:

Non pay (£0.3m) YTD Adverse movement largely relates to Bad debt provision for unpaid invoices and one-off costs of external data contract.

Key movements from last month include

Income increased by £0.3m due to Grant funding received to off-set overspend and 21/22 CTU income raised as a result of reconciliation between M06 and M07. Bad debt provisions dropped as more invoices have now been settled.

Summary of Year to Date Financial Position – GUTHRIE

Guthrie have reported a £0.3m surplus for M7, resulting in a YTD surplus of £2.6m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	12.7	0.9	0.7	1.1	1.1	0.0	4.4	7.3	7.4	0.1	0.2
Employee Operating Expenses	(2.5)	(0.2)	(0.1)	(0.2)	(0.1)	0.1	(0.9)	(1.5)	(0.9)	0.5	0.1
Operating Expenses Excluding Employee Expenses	(12.4)	(0.6)	(0.4)	(1.0)	(0.6)	0.4	(1.0)	(7.3)	(3.8)	3.4	(0.1)
GUTHRIE Total	**(2.3)**	**0.1**	**0.2**	**(0.2)**	**0.3**	**0.5**	**2.5**	**(1.4)**	**2.6**	**4.0**	**0.2**

Key Messages:

Income:

Over all Guthrie Income is breakeven YTD.
• Although as at M07, Private Patient has carried out 1 CAR-T & 4 Transplants procedures, income is still under achieving, which is mainly due to £3.1m YTD CIP target.
• Overseas Visitors however is achieving £0.1m YTD, mainly driven by over performance of activities as per the KCH/Jersey agreement.

Pay:

• Pay is underspend by £0.5m YTD, mainly due to (15 wte) vacancies and unspent 22/23 B&A funding.
• Pay Run rate is expected to remain the same for the rest of the financial year.

Non Pay:

• Favourable Non pay YTD variance of £3.4m, largely relates to Overseas Bad debt provision (£0.5m), Staff Consultant & Support fee (£1.6m), External Contracts - Financial Services (£0.8m), Internal Recharges for activities between PP & Division (£0.2m).
• All NP under spend is due to less Guthrie activities as a result of unavailable PP beds.

Key movements from last month include

Overall M07 YTD surplus is mainly due to Non-pay underspend and is forecasted to continuously remain under spend month on month for the rest of the year.

Summary of Year to Date Financial Position – PBU

PBU have reported a £3.4m deficit for M7, resulting in a YTD deficit of £24.4m.

	Annual	Last Month	Current Month				Year to Date				Run Rate
	Budget	M6	Last Year	Budget	Actual	Variance	Last Year	Budget	Actual	Variance	M7 vs M6
NHSI Category	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M	£ M
Operating Income	12.0	2.0	1.9	1.0	2.6	1.6	13.7	7.0	15.7	8.7	0.6
Employee Operating Expenses	(0.9)	(0.0)	0.0	(0.1)	(0.0)	0.0	0.0	(0.5)	(0.4)	0.2	(0.0)
Operating Expenses Excluding Employee Expenses	(53.1)	(5.4)	(6.7)	(4.4)	(5.9)	(1.5)	(40.2)	(31.0)	(39.7)	(8.8)	(0.5)
PATHOLOGY BUSINESS UNIT Total	**(42.0)**	**(3.5)**	**(4.7)**	**(3.5)**	**(3.4)**	**0.1**	**(26.5)**	**(24.5)**	**(24.4)**	**0.1**	**0.1**

Key Messages:

Income:

In M7 there were favourable variances of £1.6m in the month and £8.7m year to date. The favourable variance in Income in M7 was driven by Direct Access income of £0.5m which was backdated from previous months, plus Covid 19 income of £1m, which was slightly higher than M6 due to actual activity being higher than estimated. Covid 19 income is offset by Covid expenditure. Overall though, Covid activity is falling.

Pay:

Pay costs consist of KCH PBU management staffs as well as 50% of GSTT staff costs. In-month & YTD under spend is due to vacant posts in which some are currently been covered through agency staff. There are two vacant posts covered by agency staff and the managing director's post is also vacant. The general manager's post was vacant for around six weeks but has now been filed.

Non Pay:

Non-pay is showing an in-month adverse variance of £1.5m & YTD of £8.8m, this mostly consists of the Covid 19 expenditure costs which have no budget (accounting for £1.3m and £8.2m respectively) but which are offset by Covid 19 income.

PBU Management is £0.2m favourable YTD as there was no spend on operating expenses but we will rephrase the budget in M8 as these costs are anticipated to come in later in the year.

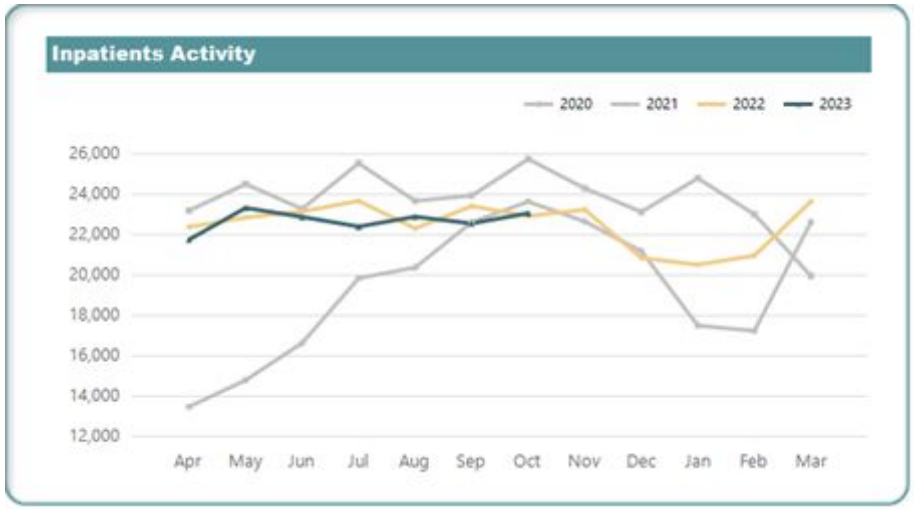
Pathology JV Contract was £0.3m unfavourable in M7 and £0.7m YTD due to over performance against contract by Synnovis and new tests performed by them for which we need to request additional budget.

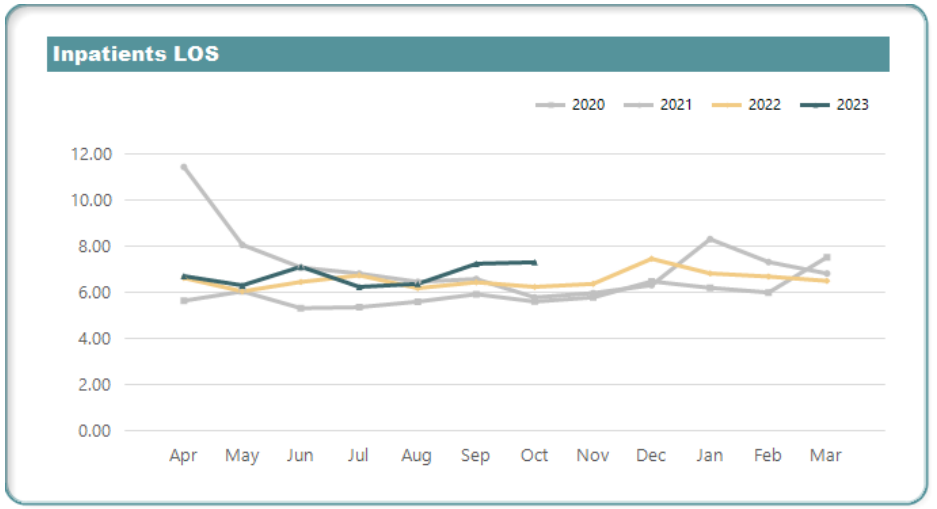
Key movements from last month include

Income –Direct Access income of £0.5m backdated from previous months received in M7.
Non Pay – New tests – Hepatitis B and C £0.15m accrued for. Disputed invoices with Synnovis of £0.1m. Direct Access invoices £0.15m.

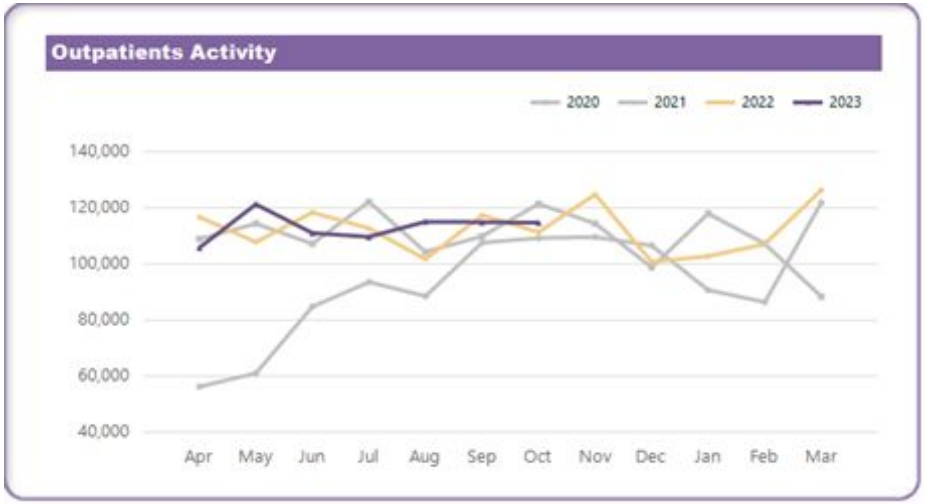
Appendices
Activity Trends

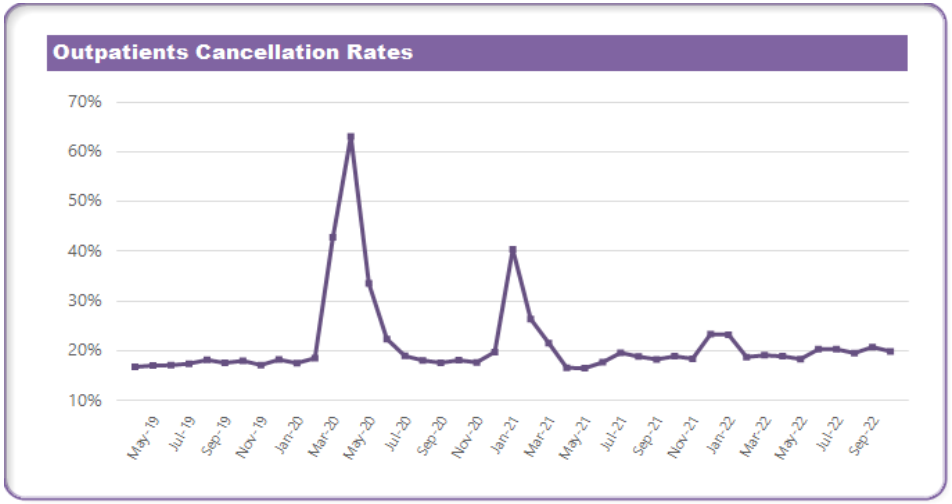
Appendix 3.1 - Activity Summary - Inpatients

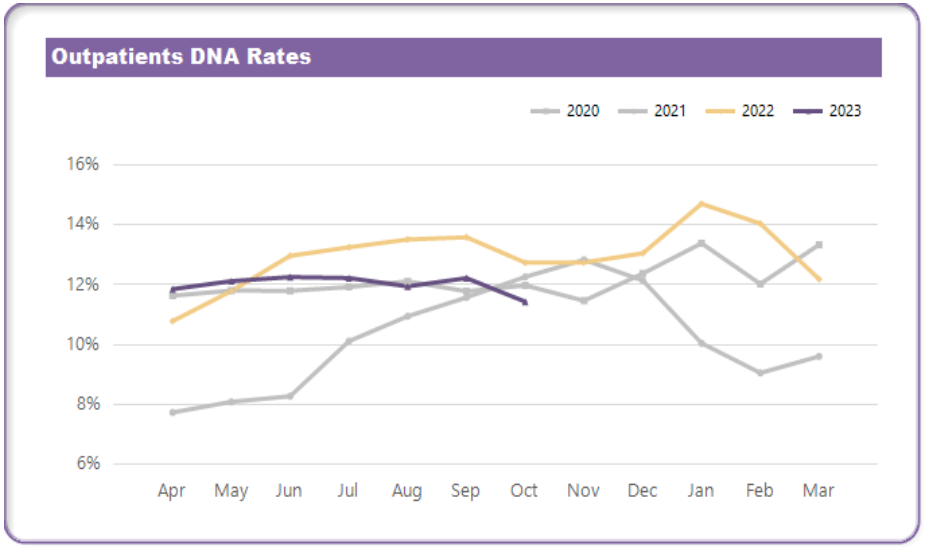




Appendix 3.2 - Activity Summary - Outpatients







King's College Hospital NHS
NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8th December
Report title:	Safeguarding Adults Annual Report 2021/22	Item:	7
Author:	David Glover, Head of Safeguarding Adults	Enclosure:	
Executive sponsor:	Clare Williams, Acting Chief Nurse and Executive Director of Midwifery		
Report history:	Annual Reporting Requirement		

Purpose of the report

This report provides detail of the Safeguarding Adult activity for 2021/2022 including compliance with safeguarding requirements outlined in the Care Act 2014.

Board/ Committee action required (please tick)

Decision/ Approval		Discussion		Assurance	x	Information	

The Board is asked to note the Safeguarding Adult activity for 2021/2022 and the associated key risks.

Executive summary

This report evidences key safeguarding activity for 2021/2022 and highlights the challenges, risks and priorities for 2022/2023.

The Adult Safeguarding Service (ASG) continues to work closely with the Child Safeguarding service and together the services promote the 'Think Family' ethos. Adult Safeguarding has adapted to new ways of working to ensure business continuity through the pandemic; this has included access to remote working and daily virtual meetings to discuss critical business.

The ASG service was affected by Covid-19 related long term sickness and vacancies during 2021-22. However, business continuity has been maintained.

During 2021-22 the Adult service supported:
- 1893 safeguarding concerns,
- 951 Deprivation of Liberty Safeguards (DoLS) applications
- 582 learning disability notifications

Learning disability and DoLS activity has increased relative to previous years whilst safeguarding referrals have seen a slight decrease of approximately 1% (variance of 27 referrals).

Safeguarding training compliance continues to improve with all training now above 90% target.
Key risks identified are:
- Robustness of domestic abuse service provision
- Restraint; previously added to the trust risk register while the policy was being revised in late 2020. It remains on the risk register while the trust continues to work towards embedding least restrictive practices.
- Gaining information on safeguarding referrals outcomes from the relevant Local Authority remain challenging.

Key priorities for 2022/2023 are:
- Resume planning for the implementation of the Liberty Protection Safeguards
- Complete audits in key services areas; including Mental Capacity Act and restraint

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• Focus on disseminating and embedding lessons learned from local and national Multi-agency reviews • Resume work on the Safeguarding and Learning Disability Strategy

Strategy					
Link to the Trust's BOLD strategy				**Link to Well-Led criteria**	
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*				**Leadership, capacity and capability**
					Vision and strategy
✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			✓	**Culture of high quality, sustainable care**
					Clear responsibilities, roles and accountability
✓	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*			✓	**Effective processes, managing risk and performance**
					Accurate data/ information
✓	**Diversity, Equality and Inclusion at the heart of everything we do:** *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*			✓	**Engagement of public, staff, external partners**
				✓	**Robust systems for learning, continuous improvement and innovation**
	Person- centred	**Sustainability**			
	Digitally- enabled	**Team King's**			

Key implications	
Strategic risk - Link to BAF	BAF7 - High Quality Care
Legal/ regulatory compliance	The report highlights the potential risk of non-compliance with the Liberty Protection Safeguards due to lack of government guidance. It includes position against statutory safeguarding requirements outlined in the Care Act 2014.
Quality impact	Patient Safety learning and improvement
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight Patient Safety Committee/Quality, People and Performance	

King's College Hospital NHS
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Safeguarding Adults Annual Report 2021/22

Introduction

Safeguarding adults remains a key priority for KCH under the leadership of the Deputy Chief Nurse and the executive responsibility of the Chief Nurse. The Adult Safeguarding Service (ASG) service is closely aligned with the Child Safeguarding Service. The teams work closely together to promote the 'Think Family' approach. KCH is committed to working in partnership with key stakeholders to ensure that adults at risk in the local boroughs are identified early and protected from harm.

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

The Safeguarding Adults Service includes Specialists for Safeguarding Adults, Learning Disabilities, Deprivation of Liberty Safeguards and a Safeguarding Administrator. The team is multi-professional and includes a social worker, which brings a huge benefit to the team's skillset. In 2021/22 the service has benefitted from the support of a new specialist safeguarding education role that has significantly improved the quality of safeguarding education across the organisation.

Affiliated with the service is the Independent Domestic Abuse Advocates who are employed by Victim Support. The service has close affiliation with other internal departments who support the delivery of safeguarding activity, this includes the Trust employed social workers, the Trust homeless team, drug & alcohol services, psychiatric liaison and the hospital discharge team.

The service works across all of KCH sites.

The quarterly Adult and Child Safeguarding Committee advises the Quality, People and Performance Committee and the Trust Board on how its statutory obligations are met.

The purpose of this report is to:

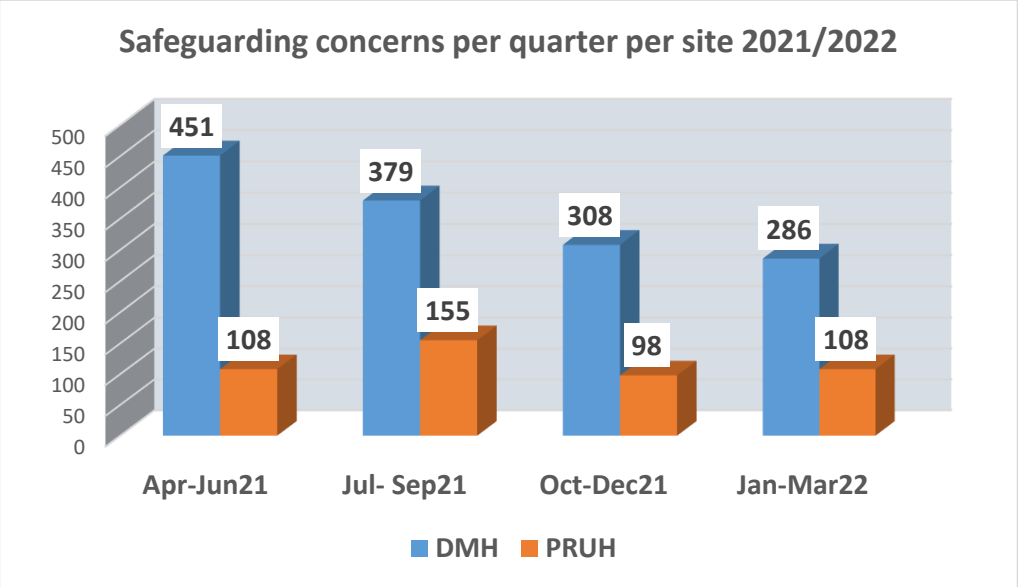
- Provide an overview of the Trust's safeguarding activity during 2021/2022,
- Provide assurance that the organisation is compliant with its safeguarding duties and,
- Outline the safeguarding risks and priorities for the 2022/2023.

This report was drafted by the former Head of Adult Safeguarding however has been finalised by the Head of Social Work & Interim Head of Adult Safeguarding who commenced in post in September 2022.

Safeguarding Adults Activity

During the reporting period, the Adult Safeguarding Service (ASG) received 1893 safeguarding concerns from services across the Trust. There has been a slight decrease (27 referrals- approximately 1%) reported into the ASG than the previous year. (Please see figures 1 and 2.)

Figure1: Total number of concerns raised per quarter per site in 2021/22



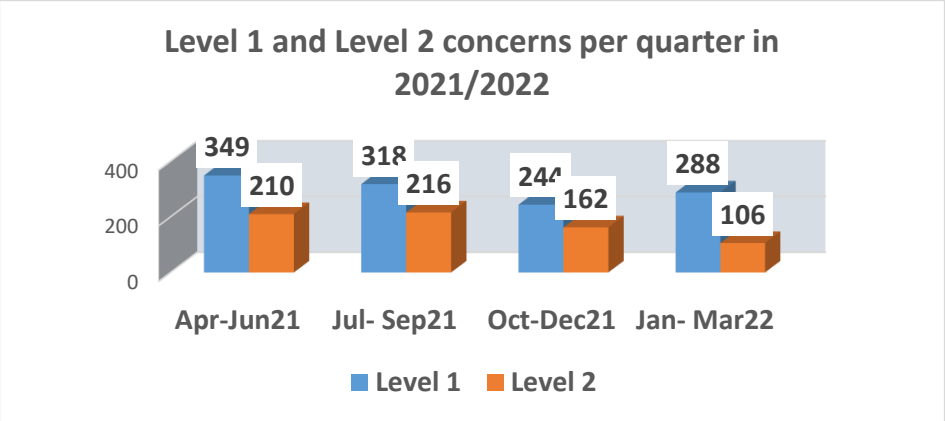
During the course of 2021/22 the ASG service has been closely monitoring the safeguarding referral numbers from the PRUH site. The concern, that there was a disproportionately low referral rate, was added to the risk register in October 2019. Figure 1 shows a total of 469 referrals, in total, came from the PRUH which is a significant increase of 137 referrals compared with 332 referrals made in 2020/21 – a 41% increase in referrals in the year. This is the second year running that the ASG service has reported an increase in referrals from the PRUH. The ASG services continues to work closely with the PRUH to support referrals into the service.

Of the total referrals to the service, 37% referrals (n=694) were triaged as a level 2[1] and referred on to the relevant local authority to be considered for a Section 42 enquiry and 63% (n=1199) were categorised as level 1[2] concerns.

Figure 2: Showing Level 1 and Level 2 per quarter 2021/22

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

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



Categories of Abuse

The KCH referral data shows the three main abuse groups are neglect, self-neglect and domestic abuse. This position reflects the same for the previous year.

- 356 self-neglect – 18%
- 335 neglect – 17%
- 146 domestic abuse – 7%

Domestic abuse and self-neglect were included under adult safeguarding abuse categories for the first time with the introduction of the Care Act 2014. These are considered 'new' areas of work within the field of adult safeguarding and there is a lack of national guidance on how these cases should be managed. Additionally, there remains a considerable volume of cases where abuse is not identified and the case is subsequently managed under complex care management as part of discharge pathways. This constitutes 20% of the overall casework in this area.

The Safeguarding Adults service has excellent relations with our partner boroughs – Lambeth, Bromley and Southwark. There is a complex case pathway that has been created that allows improved management and responses to persons with complex needs who may not sit under the traditional framework of safeguarding.

Making Safeguarding Personal (MSP) is another key area of national focus. This relates to having conversations with people about how to respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. The Care Act 2014 advocates a person-centred rather than process-driven approach. MSP is critical work for the SGA service and frontline staff are asked to seek the service user's views and wishes on the concerns identified where possible. The team aims to ensure that all patients' wishes are obtained when we consider our safeguarding responses.

It is essential that outcomes from safeguarding cases are shared by the relevant local authority, with the ASG service. Historically it has been difficult to obtain outcomes and the ASG service has experienced this issue again during the reporting period. Establishing the outcome of Section 42 enquiries is an area of improvement and will receive targeted work with our local system partners to improve the quality of referral outcomes.

KCH implicated referrals

Within the reporting period there has been 48 KCH implicated safeguarding referrals. This is similar to the previous year where 49 cases were reported.

Of the 48 cases an outcome of investigation remains outstanding on 18 cases from the local authority. Of the 48 cases, 10 relate to hospital acquired illness, 25 relate to discharge concerns or care management at the point of leaving hospital. There were also 7 reports of physical abuse involving King's staff and 3 unexplained bruises on patients. The service is waiting for the outcomes for 18 cases.

The pandemic has affected the completion on investigations in some cases, many statutory services remain working from home and this has reduced the visibility of the statutory intervention and our ability to obtain responses.

Domestic Abuse

Domestic violence and abuse (DVA) is a serious safeguarding issue for both adults and children. King's has a partnership with Victim Support, an external charity. This allows for the provision of three full time independent domestic violence advocates (IDVA'S) who provide cross cover across the two King's sites. There is no funded in house dedicated provision.

The IDVA has provided bespoke training for staff including teaching on the level 3 safeguarding training throughout 2021-22. The IDVA team also returned to onsite working in 2021/22 which has seen an improvement in our ability to identify patients who are potentially suffering DVA.

Prevent

Prevent is part of the Government's strategy for counter terrorism (CONTEST) and seeks to reduce the risks and impact of terrorism on the UK. Health is a key partner in the Prevent agenda and raising awareness of Prevent among front line staff providing health care is crucial. There have been no Prevent cases in 2021-2022. The Trust is compliant with the target for all Prevent training.

The Aim of the prevent duty is to protect those who are vulnerable to exploitation from those who seek to get people to support or commit acts of violence, by preventing the radicalisations of vulnerable adults and children. It is inclusive of all forms of terrorism – international extremism and those in the UK who are inspired by it, and domestic activity such as those from the far right and far left.

Prevent training is included within the mandatory level 1 and 2 safeguarding adults training and is therefore completed by all staff. This is at 98% and 91% respectively. The compliance with level 3 Prevent training is also at 90%.

The head of adult safeguarding is the named professional lead for Prevent within the organisation and attends Prevent meetings on behalf of the trust throughout 2021-2022.

Learning Disability

The Adult Safeguarding service is responsible for the Learning Disability Clinical Nurse Specialist (CNS) role and the learning disability liaison role. Learning disabilities and autism remains a priority of the NHS Long-Term Plan.

The CNS service covers paediatric and adult patients within planned and unplanned care. The priority of the learning disability CNS role is to ensure patients accessing the hospital have access to timely equitable care and that the trust prioritises reasonable adjustments. The CNS team aim to focus on the development of a learning disability strategy to improve the visibility of the role and the overall standards of care provided to persons with learning disability and autism.

Training remains a priority, to improve staff knowledge and skills, which will increase on-site expertise in order to provide person centred care.

Bespoke training is delivered by the learning disability CNS, to a number of clinical groups in the hospital, including the occupational therapy team, speech and language therapy team, junior A&E doctors and ophthalmology.

The Oliver McGowan training has now been approved by parliament and learning disability and autism awareness training is now mandatory for all NHS and social care staff. The code of practice and training academies are now in the process of being developed. Therefore, the training package is unlikely to be rolled out until quarter two in 2023.

The department has seen a slight decrease in the number of referrals made into the learning disability service in 2021-22. This is not considered to be linked to any decrease in the numbers of patients with this diagnosis presenting to the hospital, and therefore there is a risk that patients with learning disabilities who require reasonable adjustments are not being identified. It is important for the department to consider how the CNS role can become more embedded within clinical areas to ensure we make best use of this specialist function.

The learning disability CNS will continue to raise awareness of learning disabilities and autism within the hospital and highlight the need for reasonable adjustments and person centred care.

Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DoLS) and Liberty Protection Safeguards (LPS) Activity

The Mental Capacity Act 2005 is currently used in the care of patients in determining their capacity to make a decision related to their care/ being in the hospital environment to receive care and treatment.

Where capacity is lacking a Deprivation of Liberty Safeguard (DoLS) may have to be considered for them. This is a legal authorisation that allows the Trust to deprive someone, aged 18 years or older, of their liberty in order to receive that care and treatment. The organisation where a patient is receiving care can self-authorise a DoLS for an initial seven-day period (Urgent) followed by an extension for a further seven days pending formal assessment by the supervising local authority (Standard).

A large proportion of DoLS applications will not be authorised by the local authority due to:

• Patient's need for deprivation may be short-lived due to patient recovering from a delirium

• Patient may be discharged or RIP

• Best interest assessor may not consider the deprivation justified

There are national challenges in relation to the completion of DoLS assessments by local authorities. This is attributed to the *Cheshire West* case law which significantly changed the parameters and legal requirements of persons being eligible for DoLs. This has had a significant impact on the Trust - driving an increasing number of DoLs remaining subject to urgent authorisations. Given this increase, the SGA has initiated a review of the way urgent deprivations are overseen. This will include a move away from an administrative process to create a process that ensures additional safeguards are provided for those awaiting the independent best interest assessment process by the local authority.

The DoLs data for the year is recorded as 951 requests relating to a person being deprived of their liberty. There were additionally 95 DoLs requests received but not processed. This may be due to there being no deprivation, the patient being discharged or deceased.

Due to the delays attributed to the Covid-19 pandemic, the implementation of the Liberty Protection Safeguards (LPS) legislation continues to be pushed back by the government.

It is anticipated that LPS will have an impact on staff and roles, as training will need to take place and staff will need to be identified to take roles as assessors. An LPS lead nurse has been appointed by NHSE, and there is now a London LPS lead to help ensure the smooth compliance. London LPS implementation meetings have commenced and the Head of Safeguarding has secured membership into the relevant key decision making forums

Partnership working

The ASG Service works closely and is well supported by the Designated Nurses from Bromley, Southwark and Lambeth CCGs.

Maintaining engagement with the Safeguarding Adults Boards and associated sub-groups has continued during the reporting period, where possible. KCH has membership of Bromley, Southwark and Lambeth SABs and the ASG service has active membership of the associated subgroups.

The Head of Adult Safeguarding has previously chaired the Bromley Performance, Audit and Quality subgroup and deputises for the Chair of the Lambeth Performance and Quality sub-group when required.

Close networking, particularly through the pandemic has been critical to support internal safeguarding practice.

In addition to formal board membership, the Head of Adult Safeguarding has regular meetings throughout the year with the designated safeguarding nurses across the London boroughs of Lambeth, Southwark and Bromley respectively.

Multi-agency reviews

The ASG service supports and coordinates a number of multi-agency reviews, namely Safeguarding Adult Reviews (SARS), Domestic Homicide Reviews (DHRS) and Learning Disabilities Mortality Review (LeDeR) reviews. The adult safeguarding team is working in partnership with the newly established medical examiner officer roles situated within the bereavement team in the creation of a new Structured Judgement Review (SJR) pathway to allow for the internal reviewing of deaths of persons with Learning Disabilities. This will enhance our engagement with the LeDeR processes. The trust learning disability nurses are in regular contact with the South East London LeDeR network.

LeDeR meetings have been attended throughout the year and feedback from the deaths of persons with learning disabilities has related to

- DNACPR process not following correctly. With medical teams not making efforts to discuss these decisions with care providers or friends/family/advocates
- Discharge planning not involving the MDT
- Lacking insight into the importance of involvement of AHP roles to improve standards of care.

Some of this work required stepping down during the pandemic. However, it has since returned to pre-pandemic operational standards.

Over the last year the Trust has participated in 15 Domestic Homicide Reviews that involve coordination with a range of London boroughs. The main recommendations from DHR's include the continued recommendation that frontline staff in the emergency and outpatient departments make routine enquiries about domestic abuse during all patient contact. The trust is also ensuring that our IDVA service is available for the entire workforce with staff also being able to access confidential safety planning if they have concerns about a relationship or life outside of work.

Training

Following the development of the safeguarding education strategy, the education programme continues to grow with delivery of safeguarding education across the organisation. We have also seen a number of collaborative education initiatives with our health and social care partners throughout the year.

We have been working in partnership with our Learning and Development (L&D) leads to ensure our local safeguarding training matrix is fully aligned with the RCN intercollegiate national recommendations.

Now that the Director of L&D is in post, we are driving changes forward and preparing to launch the new Training Needs Analysis. This will affect the number of health and social care professional learners across the organisation required to complete statutory and mandatory level 3 safeguarding children and adults. Once we have the new accurate number for our local audience, we plan to roll this out across the trust this year.

The adult safeguarding team delivered two pilots for the safeguarding adult's level 3 virtual course day. The team are hoping to launch the course via our internal learning management system (LEAP). Due to team capacity and job vacancies this project is currently on hold. We are aiming to implement the adult safeguarding level 3 course day over the next year. This will also align our health and social care professional learners to the updated training matrix that is currently in process and ensure that professionals are updated with the statutory and mandatory training requirements.

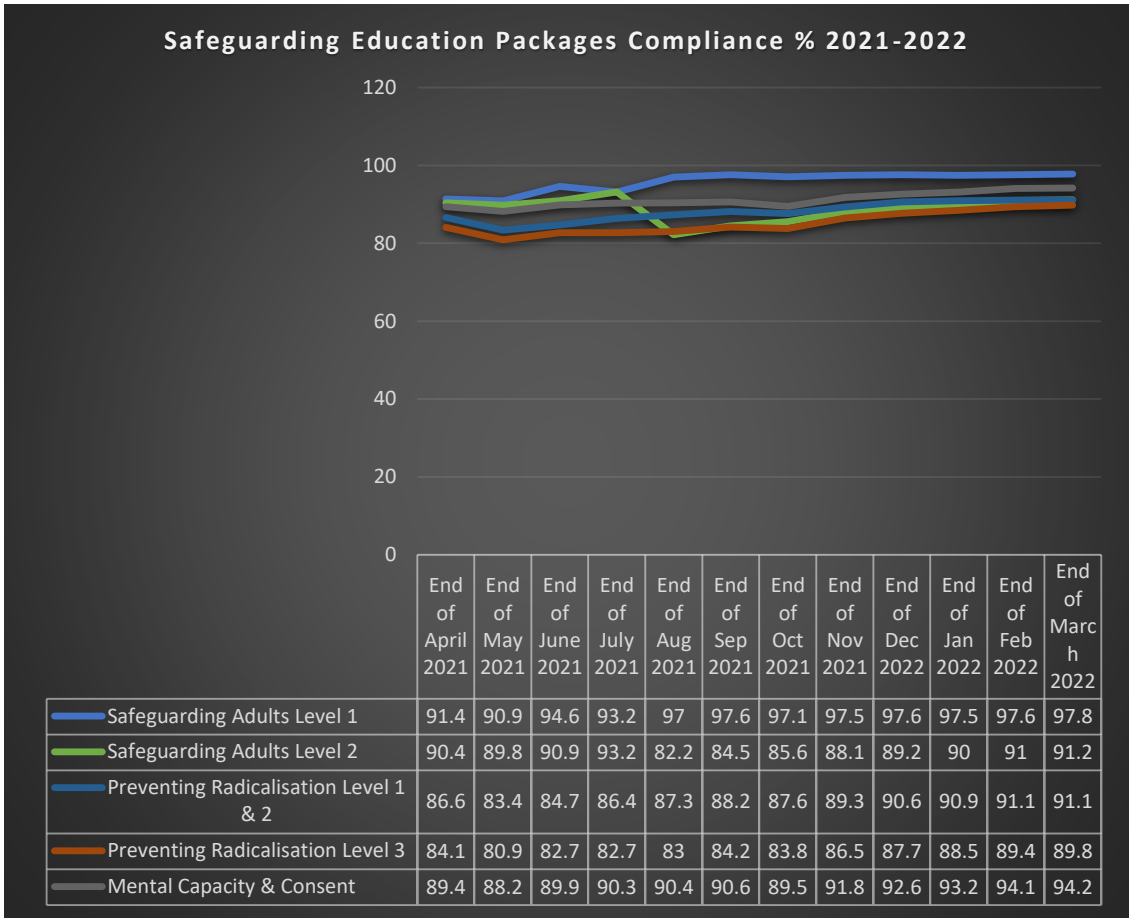
Our SPRINT programme has continued to grow and engage a large number of health and social care professional over the last year (1034 in total). Evaluations remain positive with and overarching 4.4* out of 5* for delivery. We have also incorporated a quarterly safeguarding talking space session in collaboration with our psychology team to support staff through safeguarding restorative multi-professional group supervision. These sessions are currently averaging a 4.1* out of 5*, we will continue to monitor progress over the next year. Our abstract was submitted and accepted by the NET Conference, and our work will be shared with multi-professional colleagues delivering education in health.

The safeguarding team have delivered a number of additional education events over the last year. This includes the impact of Covid-19 on Safeguarding Adults, Young People and Children webinar, the adult safeguarding awareness week, learning disabilities awareness week, Covid-19 Response: Safeguarding Education Webinars, 'How are things at home' domestic abuse virtual live education event and the NAI Masterclass with the MET Police. Our health and social care partner joined our faculty and collaborated with us to deliver the education updates across the organisation. For example, this included CAMHS, Social Care Leads, GAIA Centre, Standing Together and IDVA Teams.

Our IDVA leads have engaged and supported a number of education events across the trust. This includes IDVA virtual webinars, CSG3, SPRINT teaching, our local DV virtual event and face to face sessions on the ED Bite-Size programme. The IDVA leads have played a vital role in championing education updates on what constitutes domestic abuse and advising multi-disciplinary team learners on the tools, management and referrals of domestic violence.

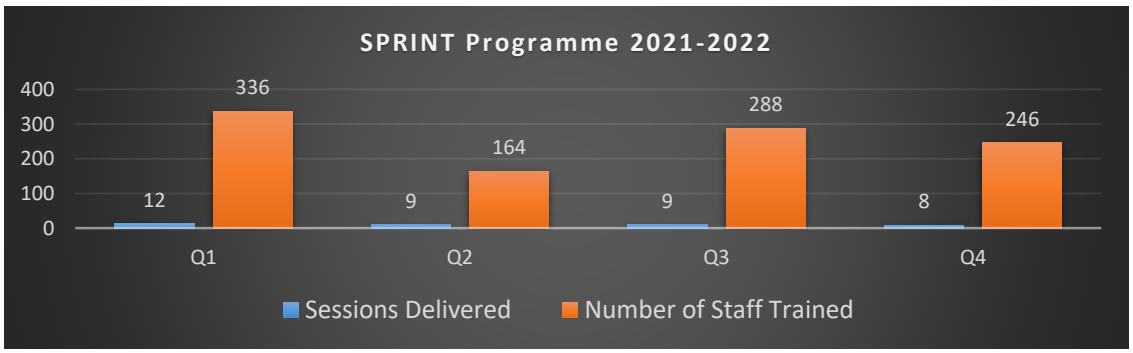
Education & Training Compliance Percentage April 2021-March 2022

All education packages compliance percentage are currently >90%.



	End of April 2021	End of May 2021	End of June 2021	End of July 2021	End of Aug 2021	End of Sep 2021	End of Oct 2021	End of Nov 2021	End of Dec 2022	End of Jan 2022	End of Feb 2022	End of March 2022
Safeguarding Adults Level 1	91.4	90.9	94.6	93.2	97	97.6	97.1	97.5	97.6	97.5	97.6	97.8
Safeguarding Adults Level 2	90.4	89.8	90.9	93.2	82.2	84.5	85.6	88.1	89.2	90	91	91.2
Preventing Radicalisation Level 1 & 2	86.6	83.4	84.7	86.4	87.3	88.2	87.6	89.3	90.6	90.9	91.1	91.1
Preventing Radicalisation Level 3	84.1	80.9	82.7	82.7	83	84.2	83.8	86.5	87.7	88.5	89.4	89.8
Mental Capacity & Consent	89.4	88.2	89.9	90.3	90.4	90.6	89.5	91.8	92.6	93.2	94.1	94.2

Safeguarding PRoactive INtensive Teaching (SPRINT) Programme



Covid -19

The service has continued to be delivered throughout the pandemic -no staff were redeployed at any stage. The team continue to adapt a mix of remote and onsite working however there is daily presence across sites. The team have acknowledged the impact of Covid-19 in the day to day management of safeguarding cases. A key area has been the lack of accessible services and local authorities remaining off site, with crucial departments such as housing and adult social care remaining closed to visitors. The service has seen an increase in complex cases that require extensive input from safeguarding practitioners.

Assurance

In February 2022, the service participated in an internal audit undertaken by the Trust's audit partners – KPMG. The report concluded that within their sample testing, the trust was discharging its statutory duties with regard to safeguarding and the report offered significant assurance (with minor improvement opportunities) to the organisation.

The report concluded with recommendations relating to the improvement of pathways aimed to establish outcomes of safeguarding enquiries.

The report identified one medium priority, described as a potentially significant weakness in the system which related to the outcomes of s.42 referrals not being obtained which has already been described earlier in the report.

Risks and challenges

The risk register is reviewed and updated at the quarterly safeguarding committee meeting. Current risks are:

- Robustness of domestic abuse service provision
- Restraint; previously added to the trust risk register while the policy was being revised in late 2020. It remains on the risk register while the trust continues to work towards embedding least restrictive practices.
- Gaining information on safeguarding referrals outcomes from the relevant Local Authority remain challenging.

Priorities for 2022/2023

This annual report demonstrates that safeguarding our patients and staff remains a key priority for the organisation.

The programme of work has been delivered which has resulted in :

- Robust governance with senior management oversight of cases, named professionals in post, good standards of partnership working
- Compliant with policies and procedures
- Referrals and incidents monitored
- Consistent engagement with system partners in the form of borough committees, safeguarding adult boards and liberty protection safeguard implementation groups

The following areas are key priorities for the service in the next year and will inform the work plan for the 2022-2023.

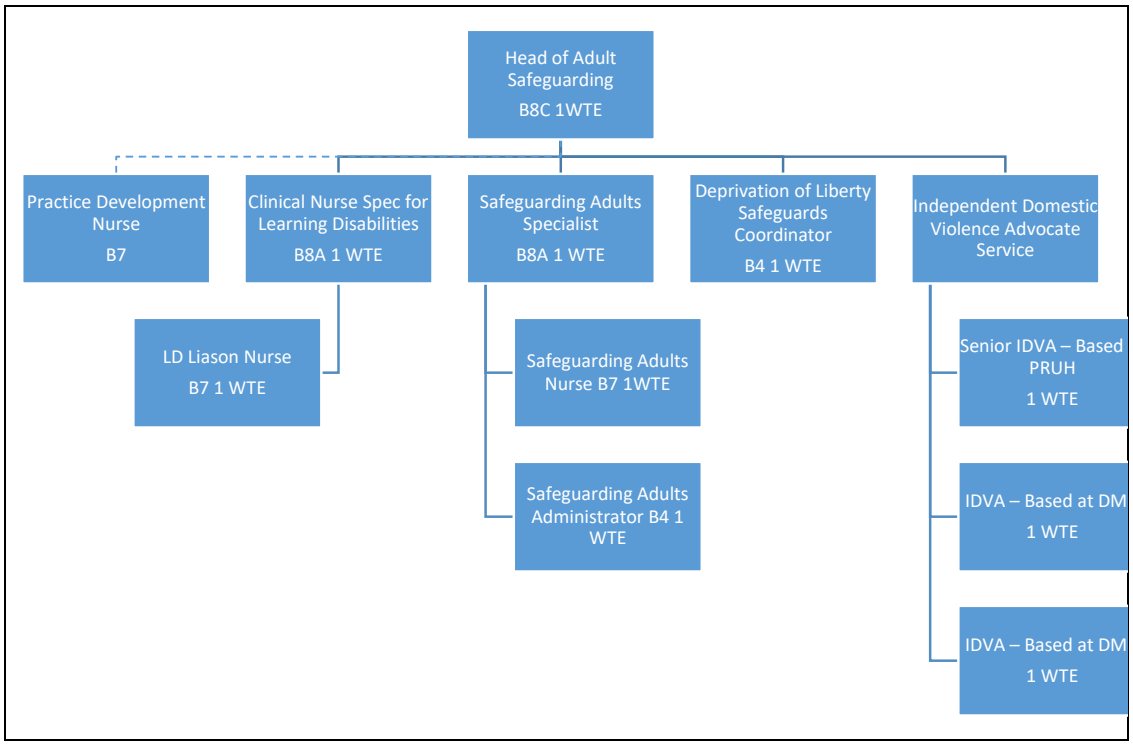
- Resume planning for the implementation of the Liberty Protection Safeguards steering group
- To continue to strengthen safeguarding processes and systems with a focus on reducing the KCH implicated discharge activity and the outcomes of Section 42 processes
- To enhance the care of those with a learning disability who attend the trust with increased staffing levels for the trust learning disability nursing team
- To continue to improve our collaboration with key internal and external safeguarding partners
- To identify quality improvement in accordance with the Learning Disability Improvement Standards for NHS Trusts, the LeDeR functions and LeDeR mortality review programme
- Complete audits in key services areas; including MCA, restraint and work in partnership with the new violence and aggression matron

- Focus on disseminating lessons learned from local and national Multi-agency reviews
- Resume work on the Safeguarding and Learning Disability Strategies
- Focused reviews and policy updates on domestic abuse and managing allegations involving professionals

This report has identified areas for further strengthening and improvement with clear objectives for 2022/23. Thus assurance is provided that the trust continues to meet its statutory safeguarding duties.

David Glover
Head of Social Work & Interim Head of Adult Safeguarding

Appendix 1: Safeguarding Adults Service Organogram 2021/2022



King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8th December.2022
Report title:	Ockenden Assurance visit outcome	Item:	8.1
Author:	Tracey MacCormack – Director of Midwifery	Enclosure:	
Executive sponsor:	Clare Williams - Chief Nurse and Executive Director of Midwifery Julie Lowe – Site Chief Executive		
Report history:			

Purpose of the report

Following Donna Ockenden's reports stating the findings from Shrewsbury and Telford Hospitals NHS Trust published in December 2020 and March 2022; King's maternity team have been working towards meeting the required immediate and essential actions (IEAs) set out in the reports. Following multiple assurance processes, the Ockenden quality assurance team visited the Trust on 10th October 2022. This visits was based on the 7 IEAs set out in the first report. The report following this visit has now been published and can be found in annex 1.

Board/ Committee action required (please tick)

Decision/ Approval		**Discussion**		**Assurance**	✓	**Information**	✓

Executive summary

This independent review of maternity services at Shrewsbury & Telford NHS Trust was commissioned by NHSE at the request of the then Secretary of State Jeremy Hunt in 2017. This was in response to concerns about the safety and quality of maternity services at the Trust from affected families.

Donna Ockenden was appointed Chair of this review which over the intervening years has extended far beyond the original 23 cases. The final review spans the years 2000-2019 and the total number of families included are 1,486. The review findings identified that there were avoidable maternal deaths (9), avoidable baby deaths (131 stillbirths, 70 neonatal deaths) and avoidable brain damage to babies (84).

The review suggested repeated patterns of poor care, repeated failures in governance and leadership, a lack of learning from incidents and multiple missed opportunities to act to improve services.

Trusts are being asked to provide assurance that IEAs are adhered to so as to improve safety in maternity services

Strategy

Link to the Trust's BOLD strategy			**Link to Well-Led criteria**	
✓	**Brilliant People**: *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*		✓	**Leadership, capacity and capability**
				Vision and strategy
✓	**Outstanding Care**: *We deliver excellent health outcomes for our*			**Culture of high quality, sustainable care**

King's College Hospital NHS Foundation Trust

	patients and they always feel safe, care for and listened to			✓	**Clear responsibilities, roles and accountability**
	Leaders in Research, Innovation and Education: *We continue to develop and deliver world-class research, innovation and education*			✓	**Effective processes, managing risk and performance**
					Accurate data/ information
✓	**Diversity, Equality and Inclusion at the heart of everything we do:** *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*			✓	**Engagement of public, staff, external partners**
					Robust systems for learning, continuous improvement and innovation
	Person- centred	**Sustainability**			
	Digitally-enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	High Quality Care
Legal/ regulatory compliance	None
Quality impact	Quality of maternity care
Equality impact	None
Financial	Staffing implications of question 46
Comms & Engagement	Internal comms and engagement
Committee that will provide relevant oversight Women's Health Board/Quality, People and Performance	

Assurance processes followed by the care group

All assurance measures to date have been against the first report. There are 7 IEAs plus workforce, therefore 49 questions in total. All the ratings gained have been issued by the Maternity transformation team.

1. February 2021- paper presented to QPPC outlining the cross site department's benchmark against the 7 IEAs.

2. February 2021 - following approval from QPPC and sign off from CEO, the benchmark tool was submitted to NHSE (maternity transformation program-MTP).

3. February 2021- virtual meeting with regional chief midwife, director of midwifery peer reviewer, service user peer review, obstetric peer reviewer and project manager. The purpose of the meeting was to clarify position against the 7 IEAs based on the information provided. King's was the first hospital in London to undergo this process. In attendance from KCH- Director of Midwifery and PRUH labour ward lead.

4. June 2021- Evidence in support of the benchmark against the 7 IEAs was submitted via an NHSE portal for external ratification.

5. September 2021-Benchmark received from NHSE. 5 IEAs at 100%, 5 IEAs requiring work.

6. January-March 2022- NHSE requested further benchmark against the 7, IEAs and any updates since last benchmark. Request for further information received and documents embedded and returned. Paper presented to board.

7. March 2022- 2nd report published but the MTP advised that no work should be done against this until informed otherwise. King's decided to do benchmark exercise against the new 15 IEAs. This was an internal process and not required by NHSE so not submitted.

8. April 2022- NHSE advised that further information could be submitted regard LMNS processes with executive sign off.

9. June 2022- Ockenden benchmark returned to Trust.

10, October 2022 – Ockenden quality assurance visit.

Ockenden Quality assurance visit

The quality assurance team made up of NHSE staff and peer reviewers visited both maternity departments on 10th October 2022.

The preliminary feedback from the visit was that the department was one on a journey and was aware of the areas of improvement.

The full visit report was published on 21st November 2022 and showed that of the 49 questions within the 7 immediate and essential actions, there was still work to be done in 8. These 8 questions have been rated amber and an action plan is in appendix 2.

NHSE have advised that the Trust is not an outlier with regards to outstanding compliance.

Actions for the Trusts

Further recommendations and guidance regarding maternity and neonatal services is expected to follow as other reviews are published. Actions will eventually be consolidated into a national delivery plan.

The Trust Board is asked to review the action plan for the 8 amber IEAs and support the care group in achieving full compliance against these.

The care group is seeking permission to share the visit report with the ICB and to publish it on the website in keeping with Trust across London.

The care group will update the Trust Board on progress against the 8 amber IEAs quarterly.

NHS England London

Kings College Hospital NHS Foundation Trust

Maternity Services – Overview findings of Regional Ockenden Assurance Visit

Date: 10th October 2022

Purpose

An assurance visit to King's College Hospital NHS Foundation Trust's maternity services was completed on 10 October 2022.

The purpose of the visit was to provide assurance against the 7 immediate and essential actions from the interim Ockenden report (December 2020). The assurance visit team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Conversations were held with several members of the board, maternity senior leadership team, front line staff and students in a range of job roles. Emerging themes from conversations were organised under the immediate and essential actions.

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Visit team members

Regional maternity team

Nina Khazaezadeh Deputy Regional Chief Midwife, NHS England - London

Olivia Houlihan, Regional Transformation Lead, NHS England - London

Sarah Espenhahn Maternity Service User Voice Lead for London

Miss Susie Crowe, Regional Lead Obstetrician for London, NHS England - London

Peer reviewers

Abiola Jinadu, Director of Midwifery/ Divisional Nurse for Women's Health, Barking, Havering and Redbridge University Hospitals NHS Trust

Miss Antoinette Johnson, Consultant Obstetrician and Gynaecologist, Epsom and St Helier University Hospitals NHS Trust

Jacqui Kempen, Head of Maternity Programme, NHS South East London Integrated Care System

Miss Jessica Moore, Clinical Director for Women's Services, St George's University Hospitals NHS Foundation Trust

Manjit Roseghini, Deputy Chief Nurse and Director of Midwifery, Croydon Health Services NHS Trust

Mayani Muthuveloe, Co-Chair for Whittington Maternity Voices Partnership

Miss Muna Noori, Clinical Director, Imperial College Healthcare NHS Trust

Miss Natasha Singh, Clinical Director for Obstetrics, Chelsea and Westminster Hospitals NHS Foundation Trust

Nicole Callender, Associate Director of Midwifery, North Middlesex University Hospital NHS Trust

Priti Patel, NMC Lead Midwife for Education, London South Bank University

Miss Sonji Clarke, Consultant Obstetrician and Clinical Lead for Maternity, Guy's and St Thomas' NHS Foundation Trust

Sue Chatterley, Head of Midwifery (Queen Elizabeth site), Lewisham and Greenwich NHS Trust

Key headlines

- The visiting team would like to thank the Trust for the warm reception, hospitality, time and effort that went into managing the complexities a visit brings.
- The Trust demonstrated that they have an insight and a shared understanding across all levels of the issues that face their maternity service, which the CQC also recognised.
- The recent CQC inspection raised a number of concerns about the estates and equipment, as well as some concerns around governance processes. Whilst the senior maternity team views the report as an opportunity to improve the care and services, on reflection, staff feel strongly that some of the concerns raised could have been addressed earlier with the right level of communication and support from the executive team. The Trust needs to review how the floor to Board messages are communicated to ensure a shared understanding of the concerns with robust feedback processes to close the loop.
- Of note, the purpose of this visit was to assess the service against the Immediate and Essential Actions in the interim Ockenden report and overall safety culture and therefore had a different focus.
- The service is on an improvement journey to address its issues whilst building on many established achievements.
- The Trust board are very engaged and invested in maternity and supporting the maternity leadership through their improvement journey to realise their vision.
- The recently appointed midwifery leadership team and the Non-Executive Director will provide well-needed stability and is welcomed by the wider maternity team.
- The staff at Kings College Trust are dedicated and motivated to achieve the best for the women, birthing people and families they care for. However, the challenges of the vacancy rates in midwifery and challenges with their estate are taking a toll on the morale of some of the teams, something which the leadership teams are acutely aware of and working hard to resolve.

Key headlines

- Despite these challenges, staff described good multidisciplinary team working that is respectful and supportive, with the exception of Labour ward at the Denmark Hill site. A concern acknowledged by all from ward to Board.
- There have been recent changes in midwifery leadership across the services and to strengthen leadership further, the Trust is reviewing its structure in the Maternity Care Group. The triumvirate at each site works well together and is highly committed to delivering the improvements needed.
- The senior maternity team will need support and guidance to develop into their roles, with clear lines of accountability and will need to ensure maternity remains visible at the Trust Board whilst ensuring visibility to the rest of the staff.
- The historical financial challenges faced by the Trust are still imprinted in staff minds which resulted in an inability to unlock resources for maternity services. There is therefore a perception by some of the team that their concern related to resources will not be acted upon deterring them from escalating. The Director of Midwifery (DoM) and the General Manager are working hard to address the challenge of this misconception.
- Overall, the staff felt able to escalate concerns to the senior maternity team but were not confident that their concerns had been noted or acted on due to a lack of response in the past. They expressed a desire for better open dialogue and feedback processes.
- Following the visit, the Trust demonstrated compliance across three of the seven Immediate and Essential Actions outlined in the Ockenden interim report.
- The visiting team would like to extend their thanks to all the staff who, on the day of the visit, gave time to share their thoughts, experiences and aspirations for their services.

IEA 1: Enhanced safety

- The executive leadership demonstrated great insight and understanding of the issues facing their maternity service and saw themselves as part of the solution with respect to support and leadership.
- Obs and Gynae trainees described a well-functioning debrief process following serious incidents. They are invited to attend SI meetings and contribute towards investigations.
- The Board level safety champion (the Chief Nurse) is known to staff across both sites by name and was described to be supportive.
- The Director of Midwifery reports to the Chief Nurse and attends the Trust board together with the Clinical Director from the Denmark Hill site - presenting an expert clinical voice in discussions on maternity, ensuring maternity is represented by the whole MDT. This is an excellent practice that should be modelled across London.
- The service has two full time bereavement lead midwives (one for each site) who lead on PMRT, supported by an obstetric lead. The service engages across the sector for mutual review and support.
- The governance team consists of Cross site, a Band 8B Quality, Safety and Governance Lead covering maternity and Gynaecology, 1.5 wte Patient Safety Manager, and a site-specific Flow safety leads.
- The Trust has significantly reduced the backlog of the SIs and datixes, using temporary additional resources. The visiting team heard that there are still a backlog of eight SIs and 206 open datixes and 65 with open actions to be completed. This indicates a need for additional permanent resource in the governance team to ensure a timely review of SIs and datixes.
- The cross-site safety huddles take place daily twice daily via MS Teams. The huddles are led by the Flow Matron and mainly operationally focused. Although there is an open invite for the MDT to attend the huddles, they are mainly attended by the midwifery staff. There is an opportunity to encourage wider MDT attendance to improve oversight and MDT working.

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA 1: Enhanced safety (continued)

- The service is engaged with the Healthcare Safety Investigation Branch and all Sis are taken to Trust board and the executives are sighted on risk and issues across both sites.
- Although a clear governance structure to share safety intelligence from the ward to board was described, the staff illustrated a disconnect in the communication flow and lack of shared understanding of the issues. The visiting team heard that some staff perception was that messages reached the Board only when raised via the Freedom to Speak U Guardian, rather than via the maternity management structure. This may be attributed to the lack of feedback to staff and the new channels of communication, e.g., "Messages of the Week“ and "Patient Safety Summit“ are a positive way to address the disconnect. However, the effectiveness of these initiatives requires a close review.

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA 2: Listening to women and families

- The Non-Executive Director (NED) for Maternity has recently taken over the role. Despite being new, the NED has good insight into the challenges for the services and is keen to think about how the role can be fully utilised. This includes working with the Maternity Voices Partnerships to regularly hear the voices of women, birthing people and families. The NED has met some of the MVP chairs and is planning to attend the next MVP meeting.
- The Trust is associated with three strong MVPs: Kings MVP, PRUH MVP (previously Bromley MVP) and Bexley MVP, who all have links to local community groups. All the MVP chairs are known in some areas, although not throughout the units, and it would be helpful to increase the visibility of the MVPs to staff and service users. They feel welcomed, and it is impressive that some of the chairs are members of the Women's Health Board, but they are not always fully included in key issues and activities.
- The MVPs are well funded, both from baseline funding and being supported to apply for additional funding for specific activities, for example, Black History Month. Claims are now easy to make and paid within an appropriate timescale.
- Service users are able to give feedback in a variety of ways, including through the Friends and Family, PALS and via the MVPs who invite feedback in a variety of ways, sharing it directly with the Heads of Midwifery at the Women's Health Board, and through the MVP meetings. The Trust welcomes the feedback but could consider how to better close the feedback loop with the MVPs and service users.
- In addition, it would be worth planning to move towards more co-production and joint working, rather than inviting input during the later stages of a project, which is sometimes the current mode of working.
- The Trust and MVPs want to focus on those voices which are not regularly heard from within the local population. Starting with building awareness of who is not being heard, and working with the communication midwife will be a great help with this.

IEA2	RAG
Q9 – Advocate role	N/A
Q10 – Advocate role	N/A
Q11 – NED	
Q12 - PMRT	
Q13 – Service user feedback	
Q14 – Bimonthly safety champ meetings	
Q15 – Service user feedback	
Q16 – NED	

IEA 3: Staff training and working together

- Staff reported good multi-disciplinary team (MDT) working in parts of the service, the variability was attributed to the labour ward on Denmark Hill site and between Midwifery and medical colleagues at the PRUH site. The issues at the Denmark Hill site is compounded by a lack of clarity on the role of Health Care Assistants (HCAs).
- Breakdown in communication and incivility by some HCAs in the clinical areas, negatively influencing the Maternity Care Assistants (MCAs) refusing a request for help, and lack of stock available in the clinical rooms were some examples described by staff to highlight the safety issues and the extent of the problem. Although this concern is acknowledged and shared by the senior leadership team, engagement with the MCAs and the staff to address this should be prioritised.
- The service has a robust MDT training schedule, supported by the education leads - delivered through a hybrid model at the Princess Royal University Hospital (PRUH), and face to face at Denmark Hill site. The PRUH is planning to return to face-to-face training in November 2022.
- PROMPT and CTG masterclasses are available and timetabled in advance to enable the trainees to attend. The senior team has set expectations and advocates for junior colleagues and trainees, enabling them to participate in PROMPT, and is congratulated on setting this standard.
- Staff have access to additional education training including audit half day, informed choice forums and in situ training with London Ambulance Service.
- The labour ward consultants are present on site every day until 21:00 and ward rounds take place at 07:15 and 19:15.
- The bereavement, PMA and education teams were widely praised as being supportive, visible and valued by staff.

IEA3	RAG
Q17 – MDT Training	
Q18 – Cons. Ward Rounds	
Q19 – Ring-Fenced Funding	
Q20 – workforce planning	
Q21 – 90% MDT Training	
Q22 – Cons Ward Rounds	
Q23 – MDT Training Schedule	

IEA 4: Managing complex pregnancy

- There are three midwives in the bereavement team, one band seven for each site, and Denmark Hill site has an additional band six midwife. There is an obstetric consultant lead for bereavement for each site with 0.75 PA. There is no interaction across the two sites on PMRT, which is a missed opportunity and an area for consideration.
- There is a good link with the gynaecology team at the Denmark Hill site, and the team provides support for women from 16 weeks gestation. Although a lack of criteria/guidance for supporting the gynae patients resulted in inequity of service provision and additional workload without adequate resources in the team to meet the women's needs. The bereavement team was clearly committed and performing an effective women-centred service, albeit without structured, regular psychological supervision. Holding PMRT as an open session with the significant junior doctor and band 5+6 midwifery presence is a commendable initiative.
- The Trust has made a great stride towards achieving full compliance across all elements of the Saving Babies' Lives Care Bundle and is fully compliant with four elements. However, the service is not offering Co monitoring at 36 weeks gestation to all women/birthing people, and the lack of smoking cessation services in Bromley hampering expectant women/birthing peoples' ability to receive support from a trained stop smoking specialist service. Therefore, this element will remain amber until the Trust is able to demonstrate that it can fulfil all the criteria pertaining to element one.
- The PRUH site has a dedicated bereavement room for antenatal and postnatal care. In contrast, the Denmark Hill site has an agreement to build a dedicated bereavement room. It is of note that there is no dedicated bereavement room in labour ward at either site.

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA 4: Managing complex pregnancy (continued)

- The Trust has recently appointed an obstetric physician and offers a twice weekly obstetric medicine ward round at each site, which has positively contributed to care. The obstetric medical pathways are well supported at Demark Hill site, but less so at the PRUH and this needs further attention.
- There are well-established joint maternal medicine and obstetric medicine clinics across both sites, a pre-pregnancy counselling clinic as well as a new monthly clinic for epilepsy in pregnancy.
- The Trust offers 24/7 phone and email support to service users as part of the South East London Maternal Medicine Network. The Obstetric medicine pathway is well supported at Denmark Hill but less so at the PRUH, and there is an opportunity to share the learning and ensure equal access for women and birthing people across both sites.

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA 5: Risk assessment throughout pregnancy

- The maternity service at Denmark Hill site implemented Birmingham Symptom-specific Obstetric Triage System (BSOTS) a couple of weeks prior to the team visiting; however, the estate hampers the success in creating the right environment, and a lack of adequate midwifery staffing provides a further challenge. It was noted that BSOTS had been successfully implemented at the PRUH site and there is an opportunity for cross-site learning.
- The maternity team is confident that midwives are carrying out risk assessments throughout the whole pathway, but the assessments are not documented consistently. A recent audit of risk assessment at each antenatal contact undertaken at the PHUH indicate a reduction from 90% to 63% in a documented risk assessment between Q2 & Q3. Therefore, this element will remain amber until the Trust is able to demonstrate that it can fulfil all the criteria pertaining to Q30.
- The Maternity Assessment Unit (MAU) at Denmark Hill is located outside the hospital site in the Harris Birthright building. There are no doctors in MAU before 14:00, presenting risk, as women requiring urgent review will need to be transferred to Denmark Hill via ambulance. This has been identified as a safety issue and features on the maternity risk register. There is a SOP for women requiring transfer to Denmark Hill site and work is underway to repurpose an area. The expected completion date is April 2023.
- Triage at PRUH is collocated with the MAU. There is no dedicated telephone line or a ward clerk and inadequate midwifery resources to meet the demand. Equally, triage at the PRUH site was highlighted for similar reasons. This presents an opportunity to review the resource requirements for both triage services.

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

IEA 5: Risk assessment throughout pregnancy (continued)

- Another concern raised by staff was related to the lack of robust communication between clinicians and inequity in the antenatal scan pathway, particularly for women and birthing people booked at the PRUH site. All scans are undertaken in the Harris Birthright building. Where clinical issues are identified at the scan, women or birthing people are referred to MAU without informing the MAU staff. The inequity in the pathway affects the women and birthing people booked at PRUH, as they need to travel back to the MAU at the PRUH site for review by the medical team. A proportion of women who require antenatal admission for conditions such as severe early onset of hypertension at 26 weeks gestation then have to travel back to the Denmark Hill site. The pathway needs a review, with input from the MVP.
- Furthermore, the environment at the PRUH requires urgent attention, as the MAU has no designated waiting area. Women and birthing people are expected to sit in a corridor whilst waiting to be reviewed. There is no oversight from the clinical team or direct access to midwives, and there is no 24-hour receptionist service. The staff described a near-miss delivery in the corridor. The senior leadership is aware of this safety risk and are working on a proposal to repurpose an underutilised bathroom. The senior leadership team need to be supported to proceed with their plans. This is suboptimal care and needs to be prioritised.
- Staff also raised concern about the estate at Orpington Hospital, which hosts the antenatal clinic for the PRUH (moved into the community temporarily during the pandemic). There is no toilet within the clinic area, with little space for waiting. There is concern that if someone collapsed in the waiting room or toilet, staff would not immediately be aware. The leadership are aware of this concern, and have some ideas, but this situation needs urgent improvement.

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

IEA 6: Monitoring fetal wellbeing

- Midwifery Practice Facilitators (MPF) were reported to be supportive, approachable and responsive to students' needs, creating opportunities for students via weekly drop-in skills sessions. Student midwives reported that reduced capacity in the MPF team has been detrimental to their experience and retention, as their rota is only available at short notice impacting their ability to manage their competing priorities such as part-time working and caring responsibilities.
- There is a full-time fetal monitoring midwife at each site and site-specific obstetric leads for fetal surveillance with 1 PA . The fetal monitoring midwives attend ward rounds with doctors and support staff in the clinical area and are reported to be excellent.
- A great deal of effort has gone into improving CTG training and practices over the years. Training has evolved from half a day to one day, using NICE guidelines for CTG training, incorporating human factors and understanding physiological changes resulting in CTG changes. The team uses the same teaching material across both sites and has a robust process to access learning needs and support packages, including K2, should they require additional training support. Staff involved in any risk issues related to CTG interpretation are invited to CTG meetings to participate in discussions.
- There is central fetal monitoring using Badgernet maternity information system at the Denmark Hill site, however there is no central monitoring at the PRUH site. The Trust is moving to a new maternity information system (EPIC) in October 2023 and will be procuring central monitoring system in preparation.
- Overall, the fetal monitoring team are well connected with the wider fetal monitoring networks through their Local Maternity and Neonatal System and PRUH is participating in the Intermittent Auscultation Avoiding Brain Injury in Childbirth (ABC) study.

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	

IEA 7: Informed consent

- Both Kings and PRUH websites provide limited amounts of information as women and birthing people are encouraged to access information via Badgernet; however, service users found that leaflets and information are not always up to date on this system either. The new communication midwife is leading on improving access to information, but currently the websites do not provide sufficient information about all care pathways, particularly choice of place of birth and how to ask for a caesarean; and while there is a leaflet about induction of labour on the Kings website, there is nothing on the PRUH website. Therefore, Q39 and Q40 are currently rated amber.
- The PRUH website does not include a translation facility while the Kings website does, although the self-referral form is a word document, so isn't translatable. Similarly, there was little information displayed in other languages at the PRUH, although the Kicks Count posters were observed in several at the antenatal clinic at Orpington. While there were welcome signs in several languages, as well as signs letting women know they could ask for an interpreter at Denmark Hill. This visibility of translated material and interpretation services should be available across both sites.
- The maternity service provides virtual antenatal education workshops for expectant parents in Spanish and is about to start a Portuguese language session too, both of which are excellent initiatives supporting particular parts of the diverse population.
- The service is determined to address health inequalities in its local population. Following collaboration with the FiveXMore Charity, the maternity service developed and piloted "*Five X More colourful birth wallets",* a successful initiative that has now been funded by the Local Maternity and Neonatal System for implementation across their footprint.

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

IEA 7: Informed consent (continued)

- Signage at both sites was not always clear, especially around the MAU at the PRUH, and to the antenatal clinic at Orpington. In addition, it could be confusing that the birth centre at the PRUH is the midwifery-led unit (MLU), while the Nightingale Birth Centre at Denmark Hill includes both the labour ward and the two "home from home" rooms (the MLU).
- While the birth centre at the PRUH has generally remained open, the visiting team heard that the staffing challenges since the pandemic have led to frequent closure of the MLU rooms at the Denmark Hill site. The lack of staff confidence and enthusiasm for facilitating birth in the MLU was noted by students, resulting in a limited choice of place of birth at the Denmark Hill site. Additionally, impacting student midwives' ability to gain clinical skills and experience in an MLU setting. An area requiring attention.
- Community midwives reported that out-of-criteria homebirths were a major safety issue as well as a source of significant psychological distress for them. They felt that the preparation and support to facilitate these births was wholly inadequate and that senior members of staff signing off on place of birth plans were entirely disconnected from their reality.
- Student midwives described observing poor standards of consenting for epidural analgesia with a lack of information concerning the benefits and potential risks in the obstetric-led unit at Denmark Hill. This requires urgent attention to ensure women and birthing people are able to make fully informed choice about pain relief in labour.
- Feedback shared with the team about support for decision making was mixed, including some having experienced pressure to accept induction of labour, and others having their request for a caesarean birth supported.

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

Workforce planning and guidelines

- The Trust received its latest Birthrate plus midwifery workforce assessment report in May 2021. The Birthrate plus assessment indicated a deficit in midwifery establishment of -21.27 wte. The Trust has implemented several initiatives to reduce the midwifery vacancy rate and has recruited 48.76 wte additional midwives who are joining the service between now and early 2023. However, the Trust is not funded to meet the recommended midwifery establishment based on their last Birthrate plus report; as such question 46 has been downgraded to amber, until the Trust is able to demonstrate that it can fulfil all the criteria.
- Student midwives expressed a mixed view on their intention to seek employment at the Trust. While they reported good continuity of mentors across both sites, they described that the lack of midwifery staffing has limited their learning opportunities. They also cited an observed lack of preceptorship support for newly qualified midwives and inappropriate culture in the labour ward at the Denmark Hill site as contributing factors to their decision.
- In contrast, trainees feel well supported by the consultant body, particularly the Clinical Director and the Labour Ward Lead. They described the consultant body as supportive and approachable, and identified that there is a good induction programme in place. Some trainees requested to work at Denmark Hill site as it offers great training opportunities, e.g., pathology and has an excellent reputation.
- Most gynaecology is based at the PRUH site, and the trainees have to travel to the PRUH site to operate. However, their rota and the cross-site working limits their ability to follow up on postoperative patients, resulting in poor continuity of care and a lack of gynaecology operation opportunities for trainees at the Denmark Hill site.

Workforce planning and guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Workforce planning and guidelines (continued)

- Community staff across both sites described feeling overstretched - a constant large volume of visits, related paperwork admin and following up appointments without protected time. This is exacerbated by information technology connectivity issues. All of which results in the community staff feeling burnt out and stressed. Staff have highlighted this as an issue as it has led to delays in arranging timely obstetric appointments. Capacity of the community staff requires an urgent review.
- There is a perception amongst some of the band 6 midwives and MCAs that the senior maternity team has no interest in their well-being. They described the sickness absence monitoring as punitive with no management continuity.
- Whilst staff felt able to escalate safety concerns, they expressed a desire for timely feedback to help them understand that their insight has been considered as part of the service improvement process. The lack of or delay in feedback has left some staff feeling "invisible" and disengaged. It was acknowledged that the CQC feedback sessions had good staff engagement, but staff reported an imbalance in the feedback as there was little focus on the PRUH site. Overall, the Trust's new initiatives to improve engagement and feedback mechanisms are welcomed by the staff but need monitoring to ensure information reaches all clinicians.
- There is a shared understanding around workforce being a key challenge across both sites. There is a sense of community and caring for each other, demonstrated by the midwives' comments at the PRUH*:"We are busy, but we also have a laugh".*
- The staff at the PRUH site raised concerns about delays in obstetrics reviews /care, including reviewing patients and writing prescription. This is attributed to a shortage of registrar and SHO grade doctors at the site leading to cross cover, including: gynae, A&E, MAU, and inpatient ward areas.

Workforce planning and guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Workforce planning and guidelines (continued)

- The visiting team also heard that lack of equipment and inability to cover breaks on the labour ward and inpatient areas due to high workload is an issue.
- The Trust has invested in the Professional Midwifery Advocate (PMA) team to ensure sufficient staff support and is congratulated on their approach. There is a well-resourced PMA team, with a full-time PMA for each site and sessional PMAs with 11.5 hours per month. Six additional PMAs are starting training in January 2023, working towards a 1:20 ratio. Each student midwife is allocated a PMA.
- The Trust is aware of staffing challenges and has implemented a number of initiatives to support midwifery staffing and skill mix, including having a dedicated PDM cross-site for maternity support workers, and supporting the 32 apprenticeships. It is engaged in international recruitment of midwives and has already recruited four midwives and a dedicated retention lead on each site working with preceptorship midwives; however close monitoring of the impact of these initiatives and continued engagement with staff is key to retaining staff.
- The Trust has implemented the Capital Midwife preceptorship framework and obtained the kite mark. The preceptors at the PRUH site reported positive experiences, and staff expressed an awareness of the Pan London escalation policy and knew how to escalate concerns. In contrast, some of the matrons at the Denmark Hill site were unaware of the Pan London escalation policy. Still, they felt they were embedded in the Trust site rep meeting and supported by the general side and the site nurse practitioners when required.
- Matrons and specialist midwives work clinically to support the team. A “flow matron" is a new role recently introduced to support flow through the service and offer additional support to staff.

Workforce planning and guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Workforce planning and guidelines (continued)

- There are three consultant midwives, all working cross-site; however one consultant midwife has been on long-term sick. They described having a large portfolio with management responsibilities and covering other roles, therefore being unable to fulfil their role effectively. This correlates with the junior midwifery teams' perception that the consultant midwives are not very visible in the clinical areas. They also reported that their banding is not aligned with their counterparts within the system, and have been waiting a promised review of their banding since February 2022.
- Midwives and maternity support workers expressed a desire for more senior leadership visibility, including HoM, DoM, consultant midwives and the risk team. However, the matrons' experience was different in this regard, and they reported having adequate access to the HoM and DoM across both sites. There has been instability in the senior midwifery leadership, with three HoMs in one year. The recently appointed HoM at the PRUH and substantive HoM at the Denmark Hill site returning from maternity leave will provide well needed stability. In response to staff feedback, the senior leadership is commencing a new initiative called a" peer review senior team walkabout" in October 2022, one of many initiatives to create an open culture and engage staff.
- Staff across both sites described dissatisfaction with the lack of flexible working. The visiting team also heard about a perceived unfair recruitment process and lack of career conversations as barriers to career progression for some staff. There was an expressed desire to introduce a fair and transparent recruitment policy and flexible working to support work-life balance.

Workforce planning and guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Workforce planning and guidelines (continued)

- 89% of the maternity guidelines are up to date. The remaining seven guidelines are currently under review and expected to be completed in October 2022; the maternity service has not been able to submit the evidence demonstrating full compliance due to workforce issues. Therefore, question 49 remains amber until the audit is submitted to demonstrate full compliance with the guidelines.
- The consultant workforce at the Denmark Hill site described an increasing complexity of their population, with half a day caesarean section list insufficient to cover the workload.
- There are 33 consultants at Denmark Hill site, 24 contribute to maternity service and 14 participate in the on-call rota which runs a frequency of 1:12.
- Although all consultants have been job planned and clinical obstetric cover is always maintained, there is a feeling amongst the obstetric consultant body at the DH site that the demand for both clinical and leadership works outstrips current capacity. This is compounded by the large workload in gynaecology due to surgical backlog. This needs to be further explored with the team.

Workforce planning and guidelines	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Other points of note

- The maternity service is committed to research and evidence-based practice, a strong feature in their strategy. The service has invested in a research team, including three midwives 1.5 wte and a band 8A research midwife lead (this post is currently vacant).
- There is a large body of research undertaken at the fetal medicine centre, including international research collaborations.
- Denmark Hill site has a tertiary medical and surgical neonatal unit and is a member of the London Operational Delivery Network. It serves a community of over one million in Southeast London. It is closely linked to the Harris Birth right fetal medicine unit. In contrast PRUH has a level two Neonatal unit that serves Bromley's local population. Transitional Care was launched at the PRUH last month, enabling babies to have IV antibiotics in the postnatal ward to further improve the care pathway and experience for women and birthing people.
- A notable comment made by many was related to estates and the environment. The community footprint within GP practices has been reduced as a consequence of the pandemic. Antenatal clinics are provided across three sites in the community. Two venues, namely Orpington and Beckenham Beacons, were reported by staff as poorly equipped and unsuitable. The senior leadership team acknowledged the estate problem in the community on both sites and is working to resolve the issue.
- The trust is to congratulated on appointing a communication midwife who used to be a journalist and sits within maternity whilst working closely with the trust comms team with the focus on improving patient information, working with the MVP, and ensuring key messages around safety and initiatives are delivered to staff in a timely manner that is accessible to them.
- The Trust has commenced a number of initiatives, such as monthly listening events with Freedom to Speak Up Guardian (FTSUG) in response to an anonymous whistle-blowing letter in October 2021. The FTSUG took over the monthly forums in June 2022 to listen to staff, aiming to foster an open culture and improve engagement with staff from ward to board. Whilst these initiatives are excellent and will support the service to realise its ambition, they are still in their infancy and will require close monitoring and attention to thrive and ensure engagement of the junior clinicians.
- Both the Oasis Birth Centre at the PRUH and the Home from Home rooms at Denmark Hill have spacious and welcoming rooms, with lots of birth aids including pools and balls. The labour ward rooms at both sites included elements to support physiological birth and create a relaxed environment, such as birth balls and “galaxy” lights. These steps to make the labour ward rooms more inviting are to be commended.

Recommendations / points for consideration

- The student midwives reported a number of challenges impacting their learning experience and their intention to seek employment at the Trust following qualification, all of which should be attended to urgently.
- The MPF team are highly valued by the student midwives. However, the lack of capacity in the MPF team was raised as a concern, impacting student midwives' experience. This requires an urgent review.
- Lack of admin support for community staff adds an enormous burden to their busy workload and detracts from midwifery time and clinical care. This is compounded by a lack of IT connectivity, resulting in community staff feeling overwhelmed and moving towards burnout - an area that needs attention to release time for midwives to provide clinical care.
- The lack of clarity of roles and responsibilities and incivility in the HCAs and MCAs was recognised by the maternity team as a safety concern. This requires urgent attention to ensure this group of professionals receive the correct level of support, training, managerial support and supervision to contribute to caring for women and birthing people.
- Out of criteria homebirths were raised as a significant source of concern for midwives, as the senior midwifery team agreed upon new plans with no engagement from midwives providing the homebirth care; as such, midwives felt ill-prepared, which resulted in psychological distress. There is an opportunity to develop an MDT approach to birth choices option that involves obstetric as well as midwifery expertise and includes midwives providing homebirth in the birth planning discussions whilst ensuring the choice of place of birth for women and birthing people.
- Staff need to be supported to build their confidence and enthusiasm for caring women and birthing people in the Home from Home rooms at Denmark Hill site to ensure that service users have a genuine choice.
- Staff reported poor planning and inadequate recruitment practices lead to senior/ specialist roles being left permanently unfilled, resulting in a major source of concern. The long-term gaps in senior/specialist roles contributed significantly to staff morale, necessitating a transparent recruitment practice to improve staff awareness and career conversations.

Recommendations / points for consideration (continued)

- Equally, a lack of flexible working was raised as an issue impacting staff work-life balance. There is a need to have an open dialogue with staff, supporting them whilst ensuring operational safety.
- The bereavement team at Denmark Hill is dedicated and provides an excellent service; however, the team highlighted the need for structured, regular psychological supervision support in their role to promote retention and prevent burnout. Formalised arrangements for cross-site working and attention to how learning from incidents can be disseminated down to frontline staff would further benefit the service.
- There is no interaction across the two sites on PMRT, which is a missed opportunity and an area for consideration.
- Student midwives described observing poor standards of care on consenting for epidural analgesia with a lack of information concerning the benefits and potential risks in the obstetric-led unit at Denmark Hill site. This requires urgent attention to ensure women and birthing people are able to make a fully informed choice about pain relief in labour.
- A common theme noted by many of the teams spoken to was the lack of key administrative support. This results in teams using clinicians to administer paperwork in a way which restricts their ability to fulfil their appointed roles effectively and results in delay in clinical appointments being made. This needs to be reviewed.
- Women and birthing people are invited to attend Harris Birthright for their scans irrespective of where they are booked, which presents an inequity in access and creates a complex antenatal pathway should they require a review by the obstetric team at the PRUH site. There is an opportunity to offer a satellite scanning clinic at the PRUH site to improve care and experience and this should be considered with support from the MVP.
- The lack of a waiting area in the MAU at the PRUH sites presents a safety risk and the senior leadership needs to be supported to operationalise their proposed solutions.

Recommendations / points for consideration (continued)

- The consultant Midwives' portfolios and banding are pending review. This presents an opportunity to align their banding with their counterparts in across the system, enable them to fulfil their function and better meet the needs of staff by being visible and supporting the midwives.
- Obstetric consultant capacity at the Denmark Hill site requires a review - to ensure they are able to meet the needs of women and birthing people with multiple complexities and the increased elective activity such as caesarean section and gynae operational list.
- The obstetric medical pathways are well supported at Denmark Hill site but less so at the PRUH and this needs further attention.
- Equally there is need to review the doctors' capacity, roles and responsibilities at the PRUH site to ensure timely and appropriate response to escalations.
- There is an opportunity to learn from the BSOTS implementation from the PRUH team and review the estate and resource requirements needed for a successful implementation at Denmark Hill site.
- Triage across both sites is highlighted as an area of risk requiring an urgent review - to ensure adequate resources and estate to deliver safe care. Considerations should be given to adding triage to the maternity risk register with appropriate mitigations.
- The Trust is investing in the need to listen more to staff and has appointed a Communication Midwife to improve the dissemination of information. This role is innovative and learning from their implementation should be shared across both the system and London.
- Currently both websites do not provide sufficient information about all care pathways, particularly choice of place of birth and how to ask for a caesarean.
- The Senior leadership team are aware of the challenges around the community estates (Orpington and Beckenham Beacons); however, there is a need to prioritise solutions related to the estates in the community, ensuring the antenatal clinic and community teams are able to provide care in the right environment with appropriate resources.

Recommendations / points for consideration (continued)

- The Trust has invested in the governance team; however, the outstanding backlog of SIs and datixes indicates a need to resource the team further to ensure a timely review of cases, dissemination and speed up any learning.
- The cross-site twice daily safety huddles, like many services in London, have been a welcome product of the pandemic and are highly valued and embedded in the service. Nonetheless, it is mainly attended by the midwifery staff, and there is an opportunity to encourage attendance by the obstetric and neonatal colleagues to strengthen MDT working.

Offers of support

- The regional transformation lead will be happy to support the digital leads as they work on the need for developing maternity information systems.
- The Service User Voice Lead for London will support the MVP chair(s) through established meetings and networks.
- Matrons are invited to attend the recently established London Matron Forum for opportunities for networking and support.
- The regional team can signpost to resources to improve both clinical escalation and psychological safety.

Appendix 1:
15 Steps-style survey

For background please see the full 15 Steps for Maternity Toolkit:

https://www.england.nhs.uk/publication/the-fifteen-steps-for-maternity-quality-from-the-perspective-of-people-who-use-maternity-services/

Where to focus

For the assurance visits, we aim to visit the first 3 areas listed below, which tie in with the Ockenden priorities, and possibly more, depending on time and the layout of the unit:

triage waiting area

the antenatal clinic waiting room

postnatal ward

scanning waiting area

day assessment unit (or equivalent) waiting area

If there is time, you could visit other areas as well.

Aim to spend a maximum of 20-30 minutes in each area, depending on the overall time available, and observe what is happening (rather than talking to service users, or discussing with staff other than to say hello and why you're here).

All participants can take notes on paper/electronically, and then share so that both the MVP chair(s) on the assurance team and the local MVP chair(s) can use this information.

Use the following in the "Observed?" column:

Key:	✓✓✓	✓✓	✓	0	N/O	NA
	excellent/ always	good/ mostly	Could be better/ occasionally	poor/ never	Not observed	Not relevant

Alongside the overall impression, where possible make specific notes on what is working well and could be shared eg "excellent wall display with up-to-date information and showing a diverse group of service users", as well as specific things that could be improved.

Denmark Hill: Antenatal Clinic

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	✓✓✓	We were buzzed in quite quickly after pressing the buzzer
Are reception staff welcoming and kind?	✓	They were lukewarm. The receptionist did not take his eyes of his screen when we introduced ourselves. Later when talking to another member of staff about the translation tower he seemed warmer but on greeting he seemed distracted
Does the space feel welcoming?	✓	The space is quite tired compared to the rest of the Kings maternity clinics/wards. They had just taken in a delivery and the boxes were in the waiting area. Although they were to one side and not blocking the seats it did make the space feel like a storage area.
Is the atmosphere calm and peaceful?	✓	Not really, you could hear the radio playing from behind reception and with the boxes in the waiting area it ruined any calm and peaceful atmosphere
Are there enough seats? Are they comfortable	✓✓	Yes – there are 7 seats and from conversation there is not more than a few women at a time in the waiting room. The seats were clean and comfortable
Do appointments seem to be on time?	✓✓✓	Yes – neither lady had been waiting long and both were called in while we were there
Is water available to drink?	✓✓	Yes
Safety		
Does the area feel safe? (Why/ why not?)	✓✓✓	Yes as entrance to the building has a buzzer and the waiting room is in view of the reception desk
Is hand gel/hand washing available?	✓✓✓	Yes – hand gel on the wall of the waiting room
Are masks available?	0	None out at the visit but when asked staff said they would usually be on the reception
Staff		
Are staff calm and friendly in general?	✓✓	Yes
Are staff calm and friendly when calling someone for an appointment?	✓✓✓	Yes very – midwife was professionally friendly when they greeted their next appointment
Do staff introduce themselves?	✓✓	One midwife introduced herself to the pregnant person and the other seem to know her pregnant person well, suggesting that they had met previously.
Do staff seem caring of each other?	✓✓	The reception staff did to one another. I did not see them interact with the midwife
Are staff kind (to service users and each other)?	✓✓	Yes
Is there information about who the staff in the area are?	✓✓	There was information of the antenatal midwives but it did not include the reception staff
Do staff communicate waiting times etc?	N/O	

Denmark Hill: Antenatal Clinic

Element	Observed?	Notes
Cleanliness & accessibility		
Is the area clean?	✓✓	It is clean but the building is tired and not the same as the rest of the maternity unit
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?	✓	Step free access. For those with a physical disability I think the door to the toilet is fairly heavy and the corridor down to the consultation rooms seemed quite tight to navigate if in a wheelchair or with a walking aid
Is there access to translation/ interpretation services?	✓✓	Yes there is a translator tower, although there was no signs highlighting this
Are cultural needs taken into account or acknowledged?	N/O	No I did not see anything
Are the toilets clean?	✓✓	Yes, they were clean
Are the toilets accessible?	✓	Once past the heavy door yes they are accessible
Toilets for partners/support people too?	✓✓	There was not a separate toilet to the main ones in the clinic
Are baby change facilities available?	✓✓✓	Yes, there was a change table in one of the toilets

Denmark Hill: Antenatal Clinic

Element	Observed?	Notes
Information		
Is the signage clear and well placed?	✓✓	
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)	 ✓ ✓	The main notice board is good and similar to the board seen on the postnatal ward. This board is well laid out with the information however the placement of the board in the antenatal clinic was behind the seating area so if someone was sat there it would be hard for another to read without feeling they are in someone else's space
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters	 ✓	There was information on infant feeding and information for antenatal and postnatal classes but I did not see anything regarding choice for the place of birth, mode of birth and personalising birth space
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		Did not see information specific to this
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	 ✓ ✓ ✓ ✓ ✓	There is information about staff, trust values, classes, PALS and MVP (although these leaflets to one side of the waiting area that happened to have the boxes delivered to)

Denmark Hill: Antenatal Clinic

Element	Observed?	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	 ✓ ✓	 domestic violence posters in the toilet and skin to skin information in the waiting room
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction**		

Denmark Hill: Triage

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	N/O	Did not have to wait for long as we were let in by the security guard
Are reception staff welcoming and kind?	✓✓	Yes the reception staff were warm and welcoming, omce we passed the security guards
Does the space feel welcoming?	✓	Yes, it is a bit of a windowless corridor waiting area but it is pleasant in the space
Is the atmosphere calm and peaceful?	✓✓	
Are there enough seats? Are they comfortable	✓✓	There are enough seats, but could be awkward moving between seats (with back to triage rooms) when heavily pregnant
Do appointments seem to be on time?	N/O	
Is water available to drink?	✓✓	Water is available in the reception area; so once returning to reception to get water you would need to be allowed back into the triage waiting area
Safety		
Does the area feel safe? (Why/ why not?)	✓✓	The area does feel safe once you get past the security on the door. The security guard did make you feel safe but also asks the question why they need security.
Is hand gel/hand washing available?	✓✓✓	Yes they are on the walls
Are masks available?	0	Masks are meant to be available on the reception desk but there was none there
Staff		
Are staff calm and friendly in general?	✓✓	Yes they were to us and when talking to each other
Are staff calm and friendly when calling someone for an appointment?	N/O	
Do staff introduce themselves?	N/O	
Do staff seem caring of each other?	✓✓	Yes, the midwifes seemed supportive of one another in discussion
Are staff kind (to service users and each other)?	N/O	
Is there information about who the staff in the area are?	✓	There is a board with photos of staff but no names or names of people in charge
Do staff communicate waiting times etc?	N/O	(Staff said that this would happen after they had been triaged with BSOTS)
Cleanliness & accessibility		
Is the area clean?	✓✓✓	Extremely clean - sparkling
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?	✓✓✓	It is a for those with physical disabilities. Midwife said that they would have a plan in place for people with a mental or learning disability based on what it is the need in advanced.
Is there access to translation/ interpretation services?	✓✓	Translation tower visible, but no notice to direct service users to ask for this is they need it
Are cultural needs taken into account or acknowledged?	0	None that I could see
Are the toilets clean?	✓✓✓	Extremely clean
Are the toilets accessible?	✓✓✓	Yes
Toilets for partners/support people too?	✓✓✓	Yes
Are baby change facilities available?	N/A	No

Denmark Hill: Triage

Element	Observed?	Notes
Information		
Is the signage clear and well placed?	✓✓✓	
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)	 ✓ ✓ ✓	The noticeboard was along the wall of the seating area as the seating was set out in a theatre style it could be hard to read the information depending on where you are sitting and/or who was sat in the way.
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters	 ✓	Could not see any information specific to this in triage In waiting room
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		Could not see any information specific to this in triage
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	 ✓ ✓ ✓	There was a staff board with photos but no names. Trust values were on the notice board along with details for PALS

Denmark Hill: Triage

Element	Observed?	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	 ✓ ✓	In the toilet there was a poster of domestic violence and in the waiting area there were posters of infant feeding and skin to skin in the waiting area
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction** It is confusing that you enter the triage in through an entrance named the Nightingale Birth Centre which leads on to the labour ward. There are only two rooms at the end of the Nightingale Birth Centre (the labour ward) that are midwife led while the rest of the rooms are the labour ward.		

Denmark Hill: Postnatal ward

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	✓✓✓	Only a few moments. Service users would not have to wait as they would be with the labour ward midwife who will be bring them to their bed
Are reception staff welcoming and kind?	✓✓	Yes they are, although feels less welcoming with the security guard at the door.
Does the space feel welcoming?	✓✓✓	Yes very
Is the atmosphere calm and peaceful?	✓✓✓	So calm and peaceful. Maybe all the babies were in their golden hour but it felt like such a lovely place to start your journey as a parent.
Are there enough seats? Are they comfortable	N/A	
Do appointments seem to be on time?	N/A	
Is water available to drink?	✓✓✓	Water fountain but also HCA bring jugs around & fills them up at meal times
Safety		
Does the area feel safe? (Why/ why not?)	✓✓	Feels safe once away from the entrance and security guard. The bays are also not far away from the midwife station as it is in the centre of the ward
Is hand gel/hand washing available?	✓✓✓	Yes on the wall
Are masks available?	✓	None, but when asked a box was placed on reception desk where they are meant to be
Staff		
Are staff calm and friendly in general?	✓✓	Yes they are
Are staff calm and friendly when calling someone for an appointment?	N/O	
Do staff introduce themselves?	N/O	
Do staff seem caring of each other?	✓✓	Yes
Are staff kind (to service users and each other)?	✓✓	Yes
Is there information about who the staff in the area are?	✓✓	Yes there is a board with who is on duty and in charge, though not updated
Do staff communicate waiting times etc?	N/O	
Cleanliness & accessibility		
Is the area clean?	✓✓✓.	Sparklingly clean
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?	✓✓	Midwife said that side rooms might be used depending on their needs which they would know in advance from antenatal
Is there access to translation/ interpretation services?	✓✓	Translation tower but no signs informing service users of this should they want to ask
Are cultural needs taken into account or acknowledged?	✓	
Are the toilets clean?	✓✓✓	Very clean
Are the toilets accessible?	✓✓✓	Yes, & the signs stand out with an image for those who can't read English or can't read
Toilets for partners/support people too?	✓✓✓	Yes toilets are towards the front of the ward
Are baby change facilities available?	✓	None, expected that babies are changed in the bay. But no facilities for siblings

Denmark Hill: Postnatal ward

Element	Observed?	Notes
Information		
Is the signage clear and well placed?	✓✓	Toilet signs are very clear and well placed
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)	 ✓ ✓ ✓	Really good notice board at the front of the ward which is clearly laid out. It is a preprinted white board which means there is unformed space for the information. Most information was up to date
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters	 N/A N/A N/A N/A ✓ N/A	There is information on infant feeding, safe sleeping, milk production.
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services	 N/O	Did not see this
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	 ✓ ✓ ✓ ✓	These is information on classes (including for Spanish and Portuguese speakers which is reflective of their community) staff, trust values, and PALS feedback. There was not information on birth reflections or MVP

Denmark Hill: Postnatal ward

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	 ✓ ✓ ✓	There are posters on domestic violence, safe sleep, skin to skin
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction** The main notice board is excellent and has all information that a service user might need, rather than it being lost on a piece of paper or small posters on a tired board. The MVP have a standing slide in the antenatal classes who join so that all service users know of them. Security guards: now understand why they are placed on the door but only after questioning why they were there.		

Orpington Hospital: Antenatal Clinic

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	N/A	No locked doors
Are reception staff welcoming and kind?	✓✓	
Does the space feel welcoming?	✓✓	
Is the atmosphere calm and peaceful?	✓	Too small, feels like you are sitting on top of next person
Are there enough seats? Are they comfortable	✓	6 chairs in tiny waiting area. Staff confirmed sometimes have to wait in narrow corridor
Do appointments seem to be on time?	N/O	
Is water available to drink?	✓✓	Fountain in office
Safety		
Does the area feel safe? (Why/ why not?)	✓	No; tiny waiting area not very visible from reception desk, although service users can be seen arriving as they walk past the open office door. Phlebotomy room too small & hot to close door. Scales in corridor.
Is hand gel/hand washing available?	✓✓	At hospital entrance
Are masks available?	✓✓	At hospital entrance
Staff		
Are staff calm and friendly in general?	✓✓	
Are staff calm and friendly when calling someone for an appointment?	✓✓	
Do staff introduce themselves?	N/O	
Do staff seem caring of each other?	✓✓✓	
Are staff kind (to service users and each other)?	✓✓	
Is there information about who the staff in the area are?	N/O	
Do staff communicate waiting times etc?	N/O	
Cleanliness & accessibility		
Is the area clean?	✓✓	
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?	✓	Waiting area and some clinic rooms are tiny, while some clinic rooms very spacious.
Is there access to translation/ interpretation services?	✓✓	Yes, but no signs letting service users know
Are cultural needs taken into account or acknowledged?	✓	
Are the toilets clean?	N/O	Toilets for service users in adjoining part of hospital (X-ray)
Are the toilets accessible?	N/O	
Toilets for partners/support people too?	✓	On the way from the hospital entrance
Are baby change facilities available?	N/O	

Orpington Hospital: Antenatal Clinic

Element	Observed?	Notes
Information		
Is the signage clear and well placed?	✓	
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)	 ✓ ✓ ✓ ✓	Sometimes easy to read, but also often behind seats in waiting area – not much choice as space to small. Sometime writing small so wouldn't be easy to read unless very close. Screen with info/ads
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters		
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services	(✓)	Mum and Baby App
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	 ✓ ✓ ✓	 Dads' course Mindful Mums

Orpington Hospital: Antenatal Clinic

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	✓ ✓	 High Blood Pressure, Tommy's Hub, Kicks Count Anxiety/OCD wall display
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction** Staff are very concerned about the vulnerability in emergency situations – that they would not see if a woman collapsed in the waiting area or in the toilet, and that they don't have access to a crash trolley/grab bag as these are elsewhere. The antenatal clinic was moved to Orpington during pandemic, to reduce footfall at main hospital. Expected to be temporary, but not clear there are plans to move back to the hospital.		

PRUH: Triage/MAU

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	N/O	
Are reception staff welcoming and kind?	✓	Did not observe dedicated reception staff – rather Midwife also covering other tasks
Does the space feel welcoming?	✓	Thank you cards on wall help to make the area welcoming.
Is the atmosphere calm and peaceful?	✓	Feels chaotic and busy, with equipment in MAU corridor
Are there enough seats? Are they comfortable	✓✓	In main hospital corridor outside locked door
Do appointments seem to be on time?	N/O	
Is water available to drink?	✓✓	
Safety		
Does the area feel safe? (Why/ why not?)	✓	
Is hand gel/hand washing available?	N/O	
Are masks available?	✓	If you ask
Staff		
Are staff calm and friendly in general?	✓	
Are staff calm and friendly when calling someone for an appointment?	N/O	
Do staff introduce themselves?	N/O	
Do staff seem caring of each other?	✓✓	
Are staff kind (to service users and each other)?	✓	
Is there information about who the staff in the area are?	?????	
Do staff communicate waiting times etc?	N/O	
Cleanliness & accessibility		
Is the area clean?	✓✓	
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?	✓	
Is there access to translation/ interpretation services?	✓	
Are cultural needs taken into account or acknowledged?	N/O	
Are the toilets clean?	✓✓	
Are the toilets accessible?	✓✓✓	
Toilets for partners/support people too?	✓✓	Use the same
Are baby change facilities available?	0	

PRUH: Triage/MAU

Element	Observed?	Notes
Information		
Is the signage clear and well placed?		Signage in main hospital corridor confusing as has MAU, but Triage not on main signs but laminated A4 sheet, with maps out of date.
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)		Not much observed in waiting area in main corridor. Walls felt cluttered, but also unlikely to be space that women will stand and look at information. Baby Loss Awareness Week posters
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters		
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP		

PRUH: Triage/MAU

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	✓	Information on Anxiety and Postnatal Depression in toilet Women's Aid poster in shared toilet
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction** Was quiet on the visit day, but staff explained that it can get very busy and they have to wait for doctors, unless the woman is clearly in labour. There is a plan to reorganise the space, by making the very large toilet and shower room into an office, and making the current office space the waiting area. This will be better than leaving women and birthing people in the hospital corridor outside the area, although this will leave the area with only a single toilet.		

PRUH: antenatal/postnatal ward

Element	Observed?	Notes
Welcome		
How long did I have to wait to enter?	N/O	(We came directly from triage/MAU)
Are reception staff welcoming and kind?	✓	
Does the space feel welcoming?	✓✓	
Is the atmosphere calm and peaceful?	✓	Corridor is busy with staff and equipment
Are there enough seats? Are they comfortable	✓✓	All bays/rooms have recliner seats
Do appointments seem to be on time?	N/A	
Is water available to drink?	✓✓	Drinks trolley for tea/coffee as well
Safety		
Does the area feel safe? (Why/ why not?)	✓	
Is hand gel/hand washing available?	✓✓	Outside visitors' entrance
Are masks available?	✓✓	Outside visitors' entrance
Staff		
Are staff calm and friendly in general?	✓✓	
Are staff calm and friendly when calling someone for an appointment?	N/A	
Do staff introduce themselves?	N/O	
Do staff seem caring of each other?	✓✓	
Are staff kind (to service users and each other)?	✓✓	
Is there information about who the staff in the area are?	✓✓✓	Midwife name on each door. Uniform colours
Do staff communicate waiting times etc?	N/A	
Cleanliness & accessibility		
Is the area clean?	✓✓	
How accessible is the area for people with varying needs eg physical, mental or learning disabilities?		
Is there access to translation/ interpretation services?	✓✓	Available but no signs letting service users know.
Are cultural needs taken into account or acknowledged?		
Are the toilets clean?	✓	
Are the toilets accessible?	✓✓	
Toilets for partners/support people too?	✓	
Are baby change facilities available?	N/O	

PRUH: antenatal/postnatal ward

Element	Observed?	Notes
Information		
Is the signage clear and well placed?		
How useful are noticeboards, posters (visual information)? Including • in places where service users can read them? • Well laid out • Up to date • Inclusive of different groups (eg ethnicities, LGBTQ, people with disabilities etc)	sometimes (✓) (✓) (✓)	Information is displayed on the windows of the bays, often with lots of bits of information crowded together, and some noticeboards being empty. It's unlikely that anyone would stand in the corridor and read it all, but some of it is not available on badgernet, or anywhere else. "What to expect" and Welcome information is helpful.
Does the information available encourage/ support choice? Specifically choice about: • place of birth • different ways of giving birth (mode of birth) • coping strategies • personalising birth space • infant feeding • birth supporters	✓	
Is there information available about personalised care? For example: • using personalised care & support plans • use of birth preferences/plans • postnatal care plans • birth reflections services		
Is there information about: • visiting times/policies • classes • staff • Trust values • Support • Birth reflections/afterthoughts service • How to give feedback (including PALS for complaints) • MVP	✓	

PRUH: antenatal/postnatal ward

Element	Observed? (see key)	Notes
Information		
Is there safety information? For example: • who to contact if you need help • covid restrictions • domestic violence • safe sleep information • skin to skin time with baby	 ✓	 Also Bladder Care, Sepsis, Baby Lifeline, Screen test information.
ANY OTHER OBSERVATIONS? **NB Ockenden themes: Safety, information, personalised care & decision making, feedback, coproduction** The room labelled "nursery" is a store for baby equipment. The Milk Kitchen is locked so women and birthing people have to ask staff to access it. Consider how to provide the information in a format/place that is useful eg QR codes (could also lead to information in other languages) especially information that isn't on Badgernet. And some hard copies for those who don't have digital access.		

Ockenden Assurance - Action Plan

V1

23/11/2022

Number	Workstream (IEA)	Themes	Description of concerns	Action Owner	Action Required	Target Date	Status	RAG
1	**(4) Managing complex pregnancy**	Q27 – SBLCBv2 - Compliance with all five elements of the Saving Babies' Lives care bundle Version 2	The service is not offering Co monitoring at 36 weeks gestation to all women/birthing people, and the lack of smoking cessation services in Bromley hampering expectant women/birthing peoples' ability to receive support from a trained stop smoking specialist service.	EP, MV	We currently have stop smoking champions in place in each area to raised profile of Co-monitoring. Continued with monthly audit monitored compliance. All team to receive information about using the national stop smoking helpline.	28.02.2023	Open	
2	**(5) risk assessment throughout pregnancy**	Q30 – Risk assessment - All women must be formally risk assessed at every antenatal contact so that they have continued access	Risk assessment is not being undertaken at each antenatal contact.	HOMs RG & AN	Continue with quarterly compliance audit and trouble shoot any gaps in risk assessment with individual clinicians. Raised awareness of the importance of risk assessment at each appointment via the communication midwives.	Ongoing.	Open	
		Q32 – SBLCBv2 - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway.	The Maternity Assessment Unit (MAU) at Denmark Hill is located outside the hospital site in the Harris Birthright building.	E Pullinger	This currently being review for relocation. It is currently in the business planning phase.	30.04.2023.	Open	
			Suboptimal care - At The PRUH the MAU, has no designated waiting area. reviewed.	CB, E Pullinger	Working on a proposal to repurpose an underutilised bathroom in order to create a self contained and safer MAU space. Awaiting quote from estate.	30.04.2023	Open	
			A review of the pathway for women attending the Fetal Medicine institute (Harris Birthright) building from PRUH site for review by the medical team with input from the MVP.	EB	The pathway needs to be reviewed collaboratively and amended as needed.	30.04.2023	Open	
			There is no dedicated telephone line or a ward clerk and inadequate midwifery resources to meet the demand.	CB & FB	This is a PRUH specific concern. There is a consultation underway for creation of a 24 hr receptionist service. There is now a labour line on the birth centre and plans are in place to create a cross site telephone assessment line	28.02.2023	Open	

			Urgent improvement needed regarding estate at Orpington Hospital - no toilet within the clinic area means anyone could collapse in the waiting room or toilet and staff would not be aware.	CB	Awaiting confirmation of a date to start works. Funds have been secured	30.04.2023	Open	
3	**IEA 6 - Monitoring fetal wellbeing**		No central monitoring at the PRUH site	CB	The Wi-Fi boxes required to create the portal have not been approved for installation at the PRUH; this has been escalated to estate.	28.02.2023	Open	
	IEA 7: Informed consent	Q39 – Accessible Information, Place of Birth - All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended	Choice of place of birth and how to ask for a caesarean not on the Trust website amongst other pathway. Leaflet about induction of labour not on the PRUH website.	C C-T	These will be updated by the Communication Midwife.	28.02.2023	Open	
			Visibility of translated material and interpretation not available at the PRUH.	C C-T	To Create a translation portal using a QR-code working in collaboration with the trust communication team.	28.02.2023	Open	
		Q40 – Accessible Information, All Care - All Trusts must ensure women have ready access to accurate	PRUH website does not include a translation facility while the Kings website does. Little information displayed in other languages at the PRUH.	C C-T	To Create a translation portal using a QR-code working in collaboration with the trust communication team. Also working with the MVP to look at the most common languages and ensure leaflet are translated into those.	28.02.2023	Open	
4	**Workforce planning and guidelines**	Q46 – Midwifery Workforce Planning - Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway	Student midwives expressed a mixed view on their intention to seek employment at the Trust. While they reported good continuity of mentors across both sites, they described that the lack of midwifery staffing has limited their learning opportunities. They also cited an observed lack of preceptorship support for newly qualified midwives and inappropriate culture in the labour ward at the Denmark Hill site as contributing factors to their decision.	FB	Listen events lead by the matrons for all students midwives on both sites. Clinical practice CPF role created using Ockenden funding. 1.2 WTE now in post and clinically visible at DH. 0.6 WTE in post at PRUH. Issues with BEAST have delayed further recruitment. Retention midwives now in role on both sites and funded. Plans to have more focussed recruitment and support. Plans for senior team to commit to mentoring 2-4 NQMs a year.	ongoing	Open	

			Whilst staff felt able to escalate safety concerns, they expressed a desire for timely feedback to help them understand that their insight has been considered as part of the service improvement process. The lack of or delay in feedback has left some staff feeling "invisible" and disengaged. It was acknowledged that the CQC feedback sessions had good staff engagement, but staff reported an imbalance in the feedback as there was little focus on the PRUH site. Overall, the Trust's new initiatives to improve engagement and feedback mechanisms are welcomed by the staff but need monitoring to ensure information reaches all clinicians.	FB/CB/TM	Listening event will continue on a bimonthly basis led by the senior team. Monthly senior team update at MMT. Band and professional category specific FTSUG and NED led events to occur over next 6 weeks. Clinical visibility of senior team in the clinical areas.	ongoing	Open	
			The Trust has implemented several initiatives to reduce the midwifery vacancy rate and has recruited 48.76 wte additional midwives who are joining the service between now and early 2023. However, the Trust is not funded to meet the recommended midwifery establishment based on their last Birthrate plus report; as such question 46 has been downgraded to amber, until the Trust is able to demonstrate that it can fulfil all the criteria	CW, JL	The Trust board is asked to consider this funding as per this recommendation	30.04.2023	Open	
			Midwives and maternity support workers expressed a desire for more senior leadership visibility, including HoM, DoM, consultant midwives and the risk team.	TM, Senior Team	Continue with Senior ward round. Senior team will commit to ensuring there present are effective in the clinical areas.	Ongoing	Open	
			The consultant workforce at the Denmark Hill site described an increasing complexity of their population, with half a day caesarean section list insufficient to cover the workload.	LL, AH, SW	Caesarean section list capacity currently under review and in collaboration with the surgeon.	30.04.2023	Open	

5	Guidelines	**Q49** **Guidelines**	89% of the maternity guidelines are up to date. The remaining seven guidelines are currently under review and expected to be completed in October 2022; the maternity service has not been able to submit the evidence demonstrating full compliance due to workforce issues. Therefore, question 49 remains amber until the audit is submitted to demonstrate full compliance with the guidelines	MV	This is on the audit annual plan going forward and will be monitored.	30.04.2023	Open	

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8th December 2022
Report title:	Maternity staffing report	Item:	8.2
Author:	Tracey MacCormack – Director of Midwifery and Gynaecology and Helen Odell – Midwifery Consultant	Enclosure:	
Executive sponsor:	Clare Williams-ActingChief Nurse and Executive Director of Midwifery, Julie Lowe – site Chief executive		
Report history:	Reviewed at Women's Health Board on 7/11/22		

Purpose of the report

Safety action 5 of the Maternity Incentive Scheme Year 4 (CNST), requires evidence of an effective system of midwifery workforce planning to the required standard. This report demonstrates current and future for midwifery workforce. This is required to be presented to Trust board every 6 months within the reporting period (6 May 2022 - 5 December 2022). This is the second 6 monthly report in relation to midwifery staffing and includes information from May 2022-October 2022.

This report outlines progress being made to address midwifery shortages in line with national guidance
The Committee is asked to note this report and support next steps

Board/ Committee action required (please tick)

Decision/ Approval	✓	**Discussion**	✓	**Assurance**	✓	**Information**	✓

Executive summary

This is a follow up to the midwifery staffing paper presented in May 2022.This report summarises the current progress in ensuring safe midwifery staffing levels at King's College Hospital NHS Foundation Trust. The recommendations within this document are modelled using the nationally recognised tool Birthrate Plus this is the only recognised maternity-specific workforce planning tool which has been endorsed by NICE (2016), A full Birthrate Plus review was undertaken December 2020- January 2021 and presented to the Trust in May 2021. Highlights from this report are outlined in this paper. The Birthrate Plus 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. The Birthrate Plus app is completed in the inpatient areas daily and allows the department to review and plan staffing across all areas. The red flags drawn from the data collected are shown in this paper and demonstrate ongoing staffing challenges across both maternity departments within this reporting period.

This paper provides update on.

- The recruitment of additional workforce and the actions being taken to maintain safe services whilst there is an existing shortfall during recruitment of additional staff
- Compliance with supernumerary status and the coordinator
- Compliance 1:1 care in labour

Recommendations
The Board of Directors is asked to note:

- The progress on recruitment of midwives
- The team will continue to monitor the provision of 1:1 care in labour and the supernumerary status of the labour ward coordinators
- Midwifery staffing levels will continue to be reviewed bi-annually as recommended
- Plans to Fully recruit to all band 5/6/7 vacancies
- Plans to review additional specialist roles e.g., Professional Midwifery Advocate, midwifery research posts, patient safety manager role and submit business case
- Plans to complete businesses cases requesting additional midwives

King's College Hospital NHS Foundation Trust

Strategy					
Link to the Trust's BOLD strategy (Tick as appropriate)				**Link to Well-Led criteria** (Tick as appropriate)	
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			✓	**Leadership, capacity and capability**
				✓	**Vision and strategy**
✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*			✓	**Culture of high quality, sustainable care**
				✓	**Clear responsibilities, roles and accountability**
	Leaders in Research, Innovation and Education: *We continue to develop and deliver world-class research, innovation and education*			✓	**Effective processes, managing risk and performance**
				✓	**Accurate data/ information**
✓	**Diversity, Equality and Inclusion at the heart of everything we do:** *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*			✓	**Engagement of public, staff, external partners**
				✓	**Robust systems for learning, continuous improvement and innovation**
✓	**Person- centred**	**Sustainability**			
	Digitally- enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	Risk related to achieving 10 safety actions in CNST year 4 BAF risk 1: Recruitment and Retention BAF risk 7: High Quality Care
Legal/ regulatory compliance	Nil
Quality impact	Staffing levels have implications for the quality of care being provided
Equality impact	
Financial	There is a financial ask within this paper in line with CNST and Ockenden recommendations
Comms & Engagement	The midwifery department will be regularly updated on the staffing pipeline
Committee that will provide relevant oversight CNST assurance and oversight committee, WHB & QPPC	

King's College Hospital NHS Foundation Trust

1. Introduction

The NHS Resolution Maternity Incentive Scheme requires a bi-annual midwifery staffing establishment report is submitted to the Board – Safety action 5:

Required standard

a) A systematic, evidence-based process to calculate midwifery staffing establishment is completed
b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above
c) 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
d) All women in active labour receive one-to-one midwifery care
e) 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.

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

A systematic midwifery workforce review was completed in January 2021using the Birthrate Plus tool and endorsed by NICE guidance.

The Birthrate Plus 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.

The current midwife to birth ratio as set out in the Birthrate Plus report is 1:24 at DH and 1:26 at PRUH. (Appendix 1)

Birthrate Plus findings noted that the complexity at Kings College 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 has impacted on the staffing required to safely provide care within both departments and has changed significantly since 2015.

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*

The Birthrate Plus report summary of staffing based on a total of 8852 births

KCHFT	Birthrate Plus recommended WTE bands 3-8	Funded Bands 3-8	Variance
8852 Births Dec/Jan 2021	478.59wte	457.32 wte	21.27wte

Action

A detailed systematic workforce review has commenced to support future workforce planning

b) Trust Board to evidence midwifery staffing budget reflects establishment as calculated in a) above

KCHFT	Birthrate Plus recommended WTE bands 3-8	Funded Bands 3-8	Variance
8852 Births Dec/Jan 2021	478.59wte	457.32 wte	21.27wte
October 2021		11.1 wte Ockenden award additional funding	10.17 wte
November 2022			
			Currently recruiting 16.76 B6 10.47 B7

The national Ockenden Maternity award bid was successful with an increase of 11.1 wte in October 2021 which was added to the budgets for ongoing recruitment

Recruitment plans

There is ongoing central recruitment and all the vacant Band 5 & 6 midwifery posts have been filled. Band 7 vacancies being recruited to by individual matrons.

Cross site Band 6 rolling recruitment is successfully established with an open advert with shortlisting taking place once sufficient candidates have applied. This is a new initiative which so far has shown the same rate of applicants, but eliminates any delays associated with adverts going live.

A successful host student recruitment was held in June with plans to repeat this in 2023 to fall in line with university cohort completion dates. A Band 5 & 6 recruitment fair was held in July 2022, with plans to

continue these quarterly. The Trust has bid for 9 further Internationally Educated Midwives to arrive by December 2023 as part of the NHSE Go Further bid.

Current pipeline

- 24.45 WTE with start dates from Nov 2022 – January 2023
- Capital Midwife consortium – international recruitment – 4 currently in post with 7 in the pipeline, 9 further confirmed with Go Further bid

Midwifery turnover

The midwifery turnover remains significantly high across both sites. The workforce plan describes steps being taken to improve retention.

Month 2022	Sept	Oct	Nov	Dec	Jan	Feb	Mar	April	May	June	July	Aug	Sept
Women's Health	10.43	10.6	10.58	10.76	11.77	10.94	11.32	11.29	11.46	11.61	12.8	12.57	12.56

c) 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

Midwifery coordinators are band 7 clinical midwives who have an oversight of all women being cared for on the labour ward. The coordinators are rostered to be supernumerary to enable them to support more junior staff, work closely with obstetricians and have oversight of all women's progress.

Midwifery staffing is entered into Birthrate Plus staffing App, this is a nationally recognised tool used across many maternity services. As well as looking at staffing levels the supernumerary status of the coordinator is also recorded.

The number of red flags for this reporting period

	Number of red flags	**Highest number of red flags**	**2nd highest of red flags**
PRUH	42	Delay between admission for induction and beginning of process (76%) (4/42)	Delayed or cancelled time critical activity (10%) Coordinator not able to maintain supernumerary / supervision status (10%)

DH	155	Coordinator not able to maintain supernumerary / supervision status (50%) (78/155)	Delay between admission for induction and beginning of process (28%)

There are occasions where the coordinator is not supernumerary due to high activity / shortage of staff. Each shift has a second senior midwife – flow and patient safety role who maintains the helicopter view across each maternity unit.

Action

Continue to monitor supernumerary coordinator's role

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

Midwifery staffing is entered into Birthrate Plus staffing App.

The inpatient activity is focused on 1:1 care in labour and produces red flags and issues raised. 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 woman's need and compares them with the staff hours available on that shift.

The following tables highlight the recorded staffing requirements based on the clinical and social needs of the women on the unit from – 01/05/22 – 31/10/22.

	% Staffing was a factor	% Staffing was NOT a factor
PRUH	463 (51%)	453 (49%)
DH	658 (70%	285 (30%)

The records from the staffing App reflect that staffing is a significant concern on the DH site.

Staffing levels are coordinated through:

- Daily review of staffing levels at 8.30 am and 4.30 pm led by the Flow / Patient safety lead midwives with the matrons/Heads of Midwifery
- Matrons/ Heads of Midwifery continue a 7-day rota supporting staffing with presence /on call

The following steps are also undertaken to address staffing issues.

- Utilisation of bank and agency staff
- Incentive payments for bank staff
- Registered nurses to support maternity areas
- Redeployment of specialist staff and staff from other areas within maternity
- Senior management team working clinically
- 24/7 on call support

- Suspension of maternity services (this is only undertaken in line with the escalation policy and with senior management)

One-to-one care in labour

Month 2022	May	June	July	August	Sept	Oct
PRUH	100	100	100	100	100	99.5
DH	100	100	100	100	99.7	100

One to one care in labour was achieved an average of 99% of the time within the timeframe, this rate demonstrates appropriate use of escalation processes within the department to maintain safe staffing.

e) 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

This paper is the midwifery oversight report, last submission May 2022.

Next steps

- Confirm support / submit business case for additional 10.17 wte midwives
- Undertake a full detailed staffing review including all positions, all midwifery bandings and specialist roles, midwifery templates, e roster and budgets to ensure alignment.
- Fully recruit to all band 5/6/7 vacancies
- Review additional specialist roles e.g., Professional Midwifery Advocate, midwifery research posts, patient safety manager role and submit business case
- Complete businesses cases requesting additional midwives
-

Recommendations

- To note the progress on recruitment of midwives
- Continue to monitor the provision of 1:1 care in labour and the supernumerary status of the labour ward coordinators
- Midwifery staffing levels will continue to be reviewed bi-annually as recommended

Appendix

Birthrate Plus report
Workforce action plan

King's College Hospital NHS
NHS Foundation Trust

3 Monthly Safer Staffing Report for Nursing and Midwifery

Aug 2022 – Oct 2022

Trust Board November 2022

Clare Williams
Chief Nurse

KING'S HEALTH PARTNERS

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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 October 2022, the most recent data currently available on BIU.

% 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
84%	87%	88%	101%	6.6	3.1	9.6

- Total CHPPD at 9.6 is reasonable, although it does represent a minor decrease from the previous report (9.9). Lower RN/Midwives fill rates are noted due to some clinical areas not achieving planned staffing levels due to vacancies/sickness (traditionally raised in winter months) and significant raised levels of maternity leave. Staffing levels are maintained through relocation of staff, use of bank staff and where necessary agency staff to ensure safety. Finally not fully reflected in these figures (inc CHPPD) has been the informal redeployment/support of CNS, managerial and Education registered staff supporting clinical areas in particular Paediatrics to maintain safe and effective care for our patients
- 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. has seen a significant drop .

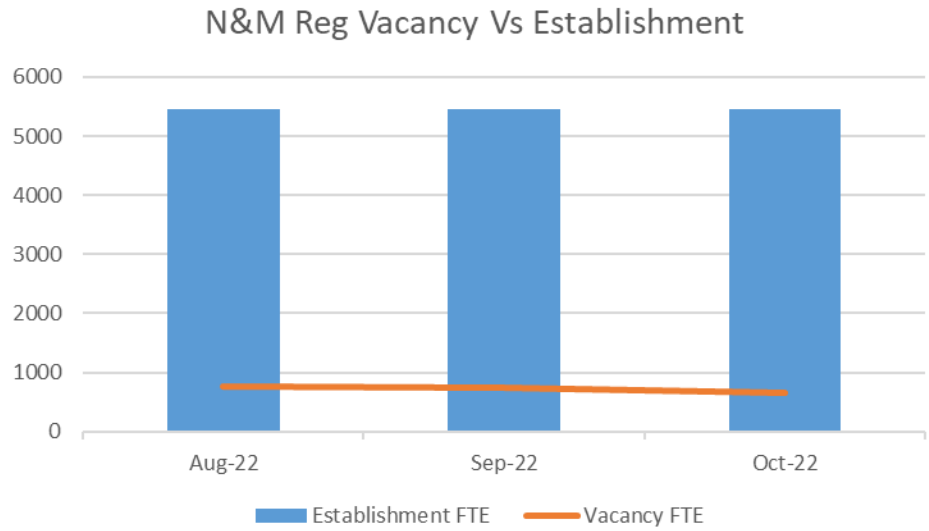
Please note: CHPPD is a metric which reflects the number of hours of total nursing support staff and registered staff versus the number of inpatients at 23:59 (aggregated for the month.) This metric is widely used as a benchmarking tool across the NHS.

Registered N&M Vacancies

King's College Hospital NHS Foundation Trust

- The current vacancy for October 2022 is 12.11% (661.72 FTE) for registered Nursing and Midwifery staff a significant decrease from 14.58% in July 2022 (795.12) despite an increase in FTE establishment.

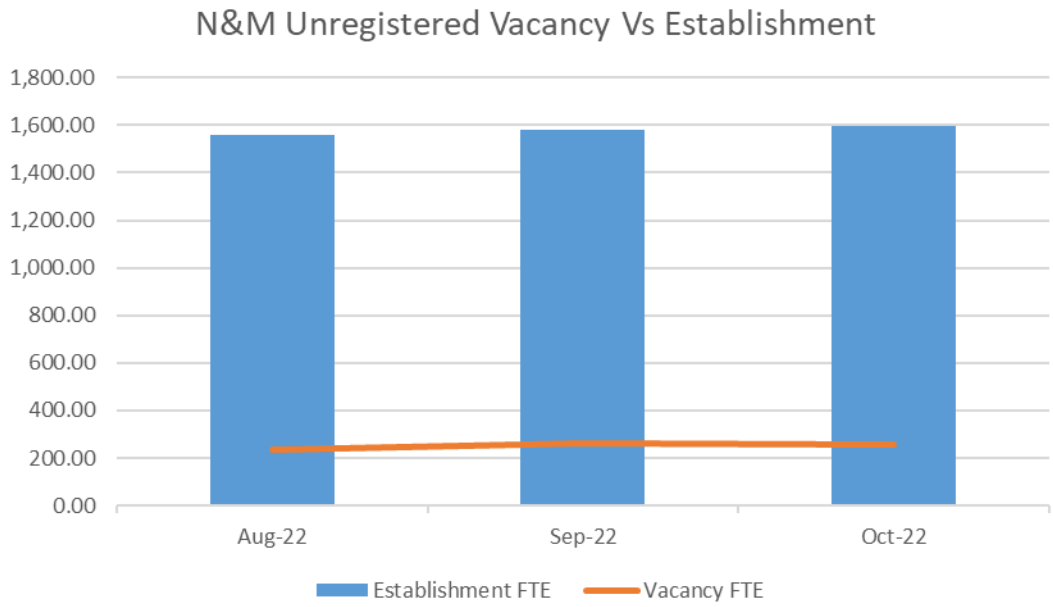
- **Registered vacancies have decreased between Aug-22 – Oct-22:**
  - This drop in vacancy represents 304 registered staff joining the organization over 3 month period.
  - 149 Adult NQN's (96 Host trust students and 53 external) and 59 Paediatric NQN's (34 Host trust students and 25 external) will be joining our teams in Q3/Q4 2022/23; of these, 29 Paediatric and 51 Adult RN's having commenced between September – October 2022.
  - The Trust's In person IEN recruitment has recommended the current pipeline of 189 having passed the IELTS/OET and 425 pending results. The most recent deployment on 25th November consisted of 44 IEN's with the next deployment scheduled for the 6th of January with 40-45 IENs (Visas pending). These cohort sizes are returning to our pre-covid figures with a 3 month average (Aug – Oct) of 40; significantly higher than the previous rolling 13 month average of 28, representing a more robust pipeline moving forwards.
  - It is also important to note registered N&M establishment has increased by **162.92 WTE since Oct 2021**. This represents the CCU expansion and an increase in posts within non-core areas.



Unregistered N&M Vacancies

King's College Hospital NHS Foundation Trust

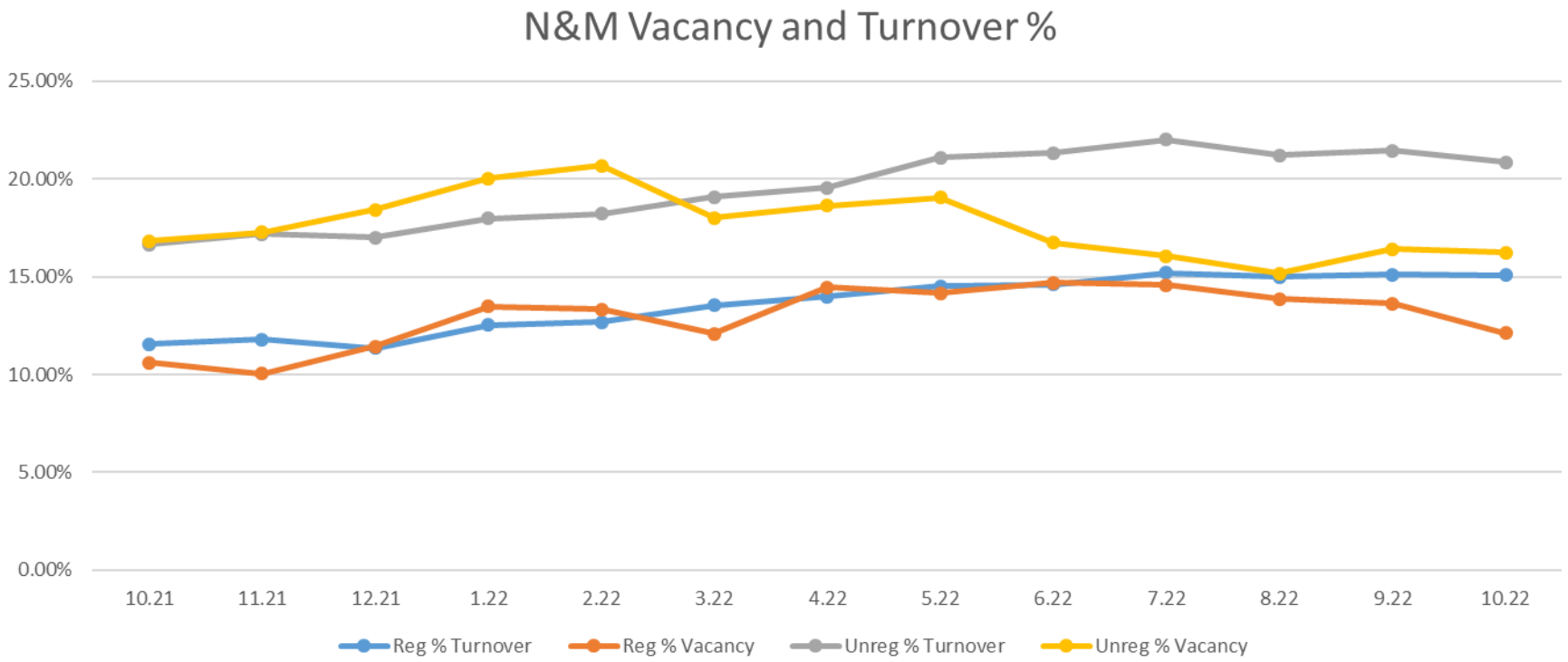
- The current vacancy for October 2022 is 16.24% (259.07 FTE) for unregistered Nursing and Midwifery staff.
- **Unregistered vacancies have remained relatively static between Aug – Oct:**
  - HCA advertising, recruitment centers and widening participation work has been increased in line with the national drive to tackle Health Care Support Worker vacancies with support from NHSE/I.
  - HCA Recruitment event at the Oval on 12th November saw 84 attendees, 68 on the day interviews and 38 job offers. This has allowed us to maintain a strong pipeline of 93 candidates going through employment checks W/C 21/11 and a cohort of 21 with induction dates through Dec-Jan. Not reflected within these figures are the candidates recruited at the PRUH HCA open day which occurred 26th November. Despite the rail strikes there were 90 attendees on the day, 66 interviews on the day, 39 offers to date and 20 virtual interviews scheduled in the coming weeks.
  - It is also important to note this data is not reflectively of purely HCSW it also includes many non-clinical administrative roles. The actual HSCW unregistered vacancy is 203.77 - 14.17% (55.3 WTE difference). Additionally unregistered N&M establishment has increased by 58.86 WTE since October 2021.



Nursing and Midwifery Vacancy and Turnover

King's College Hospital NHS Foundation Trust

As of October 2022, the voluntary turnover currently for registered nursing and midwifery staff is 15.09% and 20.852% 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%.



	10.21	11.21	12.21	1.22	2.22	3.22	4.22	5.22	6.22	7.22	8.22	9.22	10.22
Reg % Turnover	11.57%	11.79%	11.35%	12.55%	12.67%	13.54%	14.00%	14.53%	14.60%	15.22%	15.00%	15.11%	15.09%
Reg % Vacancy	10.62%	10.04%	11.44%	13.48%	13.33%	12.09%	14.46%	14.18%	14.70%	14.58%	13.88%	13.62%	12.11%
Unreg % Turnover	16.66%	17.18%	17.03%	17.98%	18.24%	19.08%	19.57%	21.09%	21.32%	22.02%	21.23%	21.46%	20.85%
Unreg % Vacancy	16.83%	17.27%	18.44%	20.04%	20.68%	18.02%	18.63%	19.05%	16.74%	16.05%	15.19%	16.43%	16.24%

Recruitment Hotspot & Next Steps

King's College Hospital NHS Foundation Trust

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.

Due to some recruitment challenges during the national and international response and recovery 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:** Adult ED Nurses (29.71%)
- **DH:** Paediatric ED Nurses (20.90%)
- **DH:** CCU Sam Oram Ward (22.38%)
- **DH:** NICU (25.13%)
- **DH:** Rays of Sunshine (25.81%)
- **DH:** Kinnier Wilson HDU (20.74%)
- **PRUH:** Paeds Inpatient (PRUH) (27.88%)
- **PRUH:** LNU (Prev S.C.B.U) (28.45%)
- **PRUH:** Medical Units 1 (27.95%)
- **PRUH:** Darwin 2 (22.12%)
- **PRUH:** Farnborough Ward (23.54%)
- **PRUH:** ED PRUH Nursing (20.98%)
- **PRUH:** Chartwell CDU (23.41%)
- **PRUH:** Surgical Ward 8 (24.79%)

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.

Recruitment & Retention Next Steps

King's College Hospital NHS
NHS Foundation Trust

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

Target - 10% vacancy RN and 0 WTE HCA vacancies by the end of 2022

Recruitment:

- Undertaking the NHSI/E HCSW direct support programme to support the accelerated recruitment of HCSW into our vacancies
- Workforce transformation: NA programme relaunched in September with 16 TNA candidates, recruitment for January 2023 cohort was successful in October with 20 candidates offered TNA positions; further cohort dates are being planned into 2023.
- Following the band 2-4 establishment reviews the business case has successfully been approved with consultation commencing in December. A task and finish group has been leading on the development of interview and management resources with the aim of recruiting and embedding the revised establishments in line with the commencement of the 2023/24 fiscal year.
- International nurse recruitment: In person international recruitment has recommenced with an additional 4 trips scheduled through to March 2023 providing us a pipeline to date of 614 candidates
- Our first 2 KCH Maternity IEM's have successfully completed their OSCE and attained their NMC registrations in partnership with Capital Midwife representing a significant new Maternity pipeline for recruitment
- Our most recent IEN cohort to undertake the OSCE exam (Oct 22) had an initial 35% pass rate. While this number is lower than expected, it is both reflective of the national picture, due to the volume of additional OSCE stations, and higher than our regional neighbors including GSTT. >95% of our IEN's are successful on their second sittings.
- Recruitment events & widening participation
- HR and N&M teams continue to attend in-person events with attendance at 12 national recruitment events scheduled for 2023
- Widening participation work remains ongoing in the local community with organized visits to Sixth Form Colleges & Job Centres
- The trust was represented at the first 'Princes Trust', widening access to healthcare event, at Stratford stadium and are partnering with 'Generation' to support people in accessing careers in healthcare
- The first RN open house was trialed at PRUH, offering on the day interviews and the opportunity to meet participating clinical teams on site. The morning received positive feedback from clinical teams and 15 candidates were offered positions on the day. Following the success of this event we are looking to replicate this more widely on other clinical sites.
- Following their move in-house King's Bank has attended our two HCSW Open dates in November garnering strong interest from candidates and allowing us to provide an enhanced flexible working offer alongside our substantive positions
- We are in the process of planning our Adult and Paeds HTS recruitment events in Feb 2023 to embed the NQN pipeline into our recruitment planning and working with Maternity to mirror the same offer for our maternity students

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 taster evenings are planned 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: Feedback from the Pilot IEN Preceptorship programme which launched on 15th September has been extremely positive and further cohorts are planned in 2023 with the goal of offering the programme to all our international recruits
- Education and training: A revised KAM model is being used to ensure improved dialogue with academic partner institutions. A variety of WBL programmes are being developed with the support of our internal PD teams and progress on the academy continues with a soft launch target of Q1 2023
- IEN's The IEN graduation on the November 25th 2022 was attended by over 125 IENs and clinical colleagues with extremely positive feedback, further dates are planned for 2023
- There are scheduled changes to the IELTs requirements for IEN's who currently work within the NHS in 2023, our IEN and Band 2-3 team will continue to work together to identifying and supporting eligible staff interested in the process
- HCSW's Our Band 2-3 team has expanded with an additional B6 Clinical Practice facilitator to help support our new HCSW in clinical practice and improve retention with a focus on those new to care. In line with the teams expansion dedicated HCSW inductions will increase to twice monthly, which should significantly impact our on boarding figures.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8th December 2022
Report title:	Standing Financial Instructions	Item:	10
Author:	Mairi Bell, Director of Financial Operations	Enclosure:	
Executive sponsor:	Lorcan Woods, Chief Financial Officer		
Report history:	Risk and Governance Committee and Audit Committee		

Purpose of the report

This report presents the updated Standing Financial Instructions and Scheme of Delegation for review and approval. These have been updated to reflect changes in Trust structure, procurement regulation and to address identified gaps in previous versions. The cover report summarises the key changes made with the full document attached as an Appendix. These SFIs have been presented to Risk & Governance Committee and Audit Committee in September 2022.

Board/ Committee action required (please tick)

Decision/ Approval	✓	**Discussion**		**Assurance**		**Information**	

The Board of Directors is asked to approve the SFIs.

Executive summary

The Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) have been subject to full review, with the main changes made outlined in this cover report.

The SFIs were last reviewed and updated in 2020, when the main change was to delegated approval limits, with these changes made to align to the implementation of the new finance system. A full review scheduled for this time was delayed due to the Covid-19 Pandemic and temporary introduction of a financial governance regime specific to these circumstances. This full review has now been completed with the proposed revised SFIs presented here in Appendix 1. These draft SFIs have been presented to and discussed by Risk & Governance Committee and Audit Committee, with suggested changes incorporated in the version attached.

Key Changes to Current SFIs and SOD

Organisational Structure and Group Requirements
Specific additional detail confirming the status of King's College Hospital NHS Foundation Trust as a Group with consolidating subsidiaries has been included. This updates includes in particular the extent to which these SFIs are applicable to the subsidiary organisations, and the requirements placed upon these subsidiary organisations by the Board to ensure that they each have their own documented financial procedures in place.

Limits of Delegated Authority
Additional changes to approval limits are made, particularly to reflect the thresholds of delegated approval, where requests must be referred back to Board (or Board Committee) for approval. This is proposed at £5m, with approvals below that level covered by the executive scheme of delegation. The absence of this defined limit within the previous SFIs was identified to be a gap which is addressed in the draft presented.

Responsibilities of Specific Roles
This version of the SFIs also looks to reduce reference to specific roles with the exception of the Chief Executive Officer (CEO) and Chief Financial Officer (CFO) who continue to hold a number of specific delegated responsibilities. In recognition of the diversity of the capital portfolio,

accountability for capital projects is assigned to Executive Directors, with a requirement that each programme of works must be the responsibility of an Executive Director.

Procurement Updates
The document is updated to reflect changes to the procurement regulatory regime and legislation. Following Brexit this includes removal of references to EU procurement thresholds, replacing these with updated UK specific limits.

Strategy					
Link to the Trust's BOLD strategy (Tick as appropriate)				**Link to Well-Led criteria** (Tick as appropriate)	
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			✓	**Leadership, capacity and capability**
	Outstanding Care: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*				**Vision and strategy**
					Culture of high quality, sustainable care
				✓	**Clear responsibilities, roles and accountability**
	Leaders in Research, Innovation and Education: *We continue to develop and deliver world-class research, innovation and education*			✓	**Effective processes, managing risk and performance**
					Accurate data/ information
	Diversity, Equality and Inclusion at the heart of everything we do: *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*				**Engagement of public, staff, external partners**
					Robust systems for learning, continuous improvement and innovation
	Person- centred	**Sustainability**			
	Digitally- enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	Financial Sustainability
Legal/ regulatory compliance	
Quality impact	
Equality impact	
Financial	Robust and up to date Standing Financial Instructions are central to delivering effective financial governance at the Trust.
Comms & Engagement	
Committee that will provide relevant oversight Audit Committee	

STANDING FINANCIAL INSTRUCTIONS

King's College Hospital NHS
NHS Foundation Trust

Standing Financial Instructions

September 2022

Main Document Information	
Version:	2.0
Publication Date:	TBC
Approval Body:	Audit Committee
Approval Date:	September 2022
Document Author:	Director of Financial Operations
Responsible Executive Director:	Chief Financial Officer
Review Date:	March 2024
Policy Category:	Trust-wide
Document Change from Previous:	Standing Financial Instructions August 2019
Related Documents:	Trust Standing orders, Standards of Business Conduct Policy
Readership (Target Audience):	All Staff
Relevant External Requirements (CQC / NHSLA / HSE / IGT etc.)**:**	NHS Model Standing Financial Instructions DHSC Group Accounting Manual

King's College Hospital NHS
NHS Foundation Trust

STANDING FINANCIAL INSTRUCTIONS

Document Authors	
Document Owner:	Director of Financial Operations
Other Contributing Authors:	Not applicable

Consultation Distribution		
Sent To		**Date**
Group:	King's Executive	August 2019

Version Control History				
Version		**Date**	**Summary of Changes**	**Author**

Dissemination Schedule (Following Ratification)				
Target Audience	**Method of Distribution**	**Person Responsible**	**Confirmation Receipt Required?**	**Method of Replacement for Previous Version**
All staff	Kingsdocs	Finance Dept.	N/A	N/A

King's College Hospital NHS
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STANDING FINANCIAL INSTRUCTIONS

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STANDING FINANCIAL INSTRUCTIONS

Introduction

1.1. Purpose

1.1.1. These Standing Financial Instructions (Instructions) are issued for the regulation of the conduct of the Trust, its Directors, officers, employees and agents in relation to all financial matters. The Instructions will also apply to the Trust's consolidating subsidiaries when acting on behalf of the Trust. The Board expects Trust subsidiaries to have their own documented financial governance arrangements in place for use when conducting their own business.

1.1.2. These Instructions explain the financial responsibilities, policies and procedures to be adopted by the Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law, Government policy and best practice in order to achieve probity, accuracy, economy, efficiency and effectiveness in the way in which the Trust manages public resources.

1.1.3. They identify the financial responsibilities which apply to everyone working for, and on behalf of,the Trust. They do not provide detailed procedural guidance. These statements should therefore be read in conjunction with the detailed departmental and financial policies and procedure notes. All financial policies and procedures must be approved by the Chief Financial Officer.

1.1.4. These instructions should be read in conjunction with the Finance pages on the Trust's Intranet which contain guidance for Trust officers on financial matters.

1.2. Authority and Compliance

1.2.1. These Standing Financial Instructions have been compiled under the authority of the Board of Directors of the Trust. These have been reviewed and approved by the Trust's Audit Committee and by the Board of Directors.

1.2.2. These Standing Financial Instructions apply to all staff, including those within hosted organisations, interim appointments and temporary contractors. The Instructions will also apply to the Trust's subsidiaries when acting on behalf of the Trust. Failure to comply may result in disciplinary action, up to and including dismissal, for Trust employees and immediate termination, without notice, of engagement for contractors.

1.2.3. Management must ensure that all employees are aware of and understand their individual financial responsibilities and the rules contained within these instructions. All employees are required to seek clarification from management where they are unsure as to the most appropriate course of action and should do so in advance of making any financial commitment on behalf of the Trust.

1.2.4. Where existing departmental rules and procedures appear to offer conflicting advice to that contained in these Instructions, it is expected that these Instructions will take precedence. However, staff are urged to bring such conflicts to the attention of the Chief Financial Officer.

1.3. Terminology

1.3.1. Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts, shall have the same meaning in these instructions; and

1.3.2. "Trust" means the King's College Hospital NHS Foundation Trust;

1.3.3. "Board" means the Board of Directors of the Trust and/or relevant Board Committees. :

1.3.4. "Budget" means a resource, expressed in financial terms, approved by the Trust for the purpose of carrying out, for a specific period, any or all of the functions of the Trust;

1.3.5. "Chief Executive" means the most senior executive with overall responsibility for the Trust's activities and is accountable to the Board of Directors;

1.3.6. "Chief Financial Officer" means the senior executive responsible for managing the financial actions of the Trust;

1.3.7. "Funds held on trust" shall mean monies held by the Trust, received on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.90 of the NHS Act 1977, as amended. Such funds may or may not be charitable.

1.3.8. "Group" means King's College Hospital NHS Foundation Trust and its subsidiaries including King's Interventional Facilities Management LLP (KFM)M, King's Commercial Services Ltd (KCS) and King's College Hospital Management Ltd (KCH Ltd).

1.3.9. "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

1.3.10. **"**NHS England and NHS Improvement (NHSE&I) is an arm of the Department of Health which oversees the financial performance of NHS Trusts and Foundation Trusts.

1.3.11. Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other director or employees who have been duly authorised to represent them.

1.3.12. Wherever the term "employee" is used, and where the context permits, it shall be deemed to refer to all staff of the Trust including nursing and medical staff, consultants practising upon Trust premises as well as employees of third parties contracted to the Trust when acting on behalf of the Trust (i.e. temporary or contract workers). This will include KFM, when applying the Trust's procurement policy.

2. Powers of Authority and Delegation

2.1. Principles of delegated powers of authority and Schemes of Delegation

2.1.1. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation Document adopted by the Trust. The Board of Directors have determined that they shall reserve, for their sole approval, certain financial transactions based around types or values as set out in the Scheme of Delegation. Those aside, all executive powers are invested in the Chief Executive, who in turn will provide delegated powers to relevant officers. The Chief Executive and Chief Financial Officer may, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

2.1.2. The Scheme of Delegation is a collection of schedules setting out various powers of authority by post holder. The first schedule sets out Board of Directors powers and the extent to which

they are delegated to the Chief Executive and members of the King's Executive. Separate schedules are to be retained by each member of the King's Executive setting out the powers they have themselves delegated to identified post holders within their own organisational control.

2.1.3. The Trust Executive Directors shall be responsible for ensuring that Schemes of Delegation are kept current. A full record of each Scheme of Delegation must be retained within each Executive Directorate with evidence of proper authorisation and acceptance. Copies, including amendments, must be given to the Chief Financial Officer to enable him/her to keep a record of all Schemes of Delegation for each Directorate within the Trust.

2.1.4. No officer nor employee of the Trust may delegate to anyone who is outside their organisational control.

2.2. Board of Directors

2.2.1. The Board of Directors have retained sole rights to approve all financial transactions with a value in excess of the level specified in the Scheme of Delegation (appendix 1 of this document), subject to any exclusions covered by specific delegated authority. This applies to individual transactions and to term contracts for the provision of goods, proposals to spend or generate income, procurement decisions and issuing of contracts for services or capital works over a period of time (unless the contract is such that the Trust may terminate it without financial penalty after the first year).

2.2.2. There are no exceptions to this instruction other than through the exercise of the Chairman of the Board of Directors' action. This may occur where the Chairman instructs the Chief Executive to approve such transactions where time is a critical factor in the interest of the Trust and it is not possible to consult all members of the Board of Directors. In such circumstances, the Chief Executive must provide a full report to the Board of Directors at the next available opportunity.

2.3. Chief Executive

2.3.1. The Chief Executive is the accounting officer for the Trust. This means they are accountable to Parliament for the funds administered by the Trust. The Chief Executive has overall executive responsibility for the Trust's activities and is responsible to the Board of Directors for ensuring that its financial obligations and targets are met. Further, the Chief Executive is recognised by Statute as the Accountable Officer of the Trust and as such is accountable to Parliament for all actions undertaken by the Trust.

2.3.2. Save for the requirements under Board of Directors powers, the Chief Executive is provided with full operational powers to approve financial transactions within the Trust and to delegate such powers to individual members of the Trust Management Executive as per the Scheme of Delegation.

2.3.3. It is the duty of the Chief Executive to ensure that existing members of the Board of Directors, officers, and all new appointees are notified of, and put in a position to understand, their responsibilities within these Instructions. The Chief Executive's duty encompasses both financial and non-financial roles.

2.4. King's Executive

2.4.1. Individual members of the King's Executive are identified as Executive Directors for the purposes of these Instructions and the associated Schemes of Delegation. The Chief Executive delegates powers to them in accordance with the relevant Scheme of Delegation to enable the efficient management of individual directorates.

2.4.2. Each budget holder must produce, update, formally approve and retain their own Schemes of Delegation for officers within their organisational control. . The list of approvers will be identified through this document and retained in Oracle, the Trust's financial system for purchasing and payment approvals.

2.5. Chief Financial Officer

2.5.1. The Chief Executive delegates powers to the Chief Financial Officer in his/her role as a Executive Director responsible for the Finance Directorate. In addition to these, the Chief Financial Officer is provided with further powers to manage the approval of financial transactions initiated by other directorates across the Trust.

2.5.2. The Chief Financial Officer is required to implement the Trust's financial policies, ensure that detailed financial procedures and systems are established and ensure that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose the financial position of the Trust at any time.

2.5.3. The Chief Financial Officer shall prepare, document and maintain detailed financial procedures and systems incorporating the principles of separation of duties and internal checks to supplement these instructions. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

2.5.4. The Chief Financial Officer shall ensure that such systems and procedures are implemented so as to protect the Trust's assets from fraud.

3. Corporate Responsibilities of all Trust employees

3.1.1. All directors and employees, severally and collectively, are responsible for:

- the security of the property of the Trust;
- avoiding loss;
- exercising economy and efficiency in the use of resources; and
- conforming with the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

3.2. Compliance with principles of Public Sector Values

3.2.1. All employees, including directors and senior management, of the Trust must be committed

to the highest standards of corporate and personal conduct in all aspects of their work within the Trust, based on a recognition of public service values. These cannot be ignored.

3.2.2. The crucial public service values which must be understood, accepted and applied are:

- **Accountability -** everything done by those who work in the Trust must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.
- **Probity -** there should be an absolute standard of honesty in dealing with the assets of the Trust. Integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of Trust duties.
- **Openness -** there should be sufficient transparency about Trust activities to promote confidence between the Trust, its staff, patients and the public.
- **Selflessness** - Holders of public office should act solely in terms of the public interest.
- **Objectivity** - Holders of public office must act and take decisions impartially, fairly and on merit, using the best evidence and without discrimination or bias.
- **Leadership** - Holders of public office should exhibit these principles in their own behaviour. They should actively promote and robustly support the principles and be willing to challenge poor behaviour wherever it occurs.

3.2.3. All employees, but particularly the Board of Directors, King's Executive and senior management, have a constant duty to ensure that public funds are properly safeguarded and Trust business is conducted as efficiently and effectively as possible.

3.2.4. Proper stewardship of public monies requires Value for Money to be achieved. The Board of Directors and employees must strive for this at all times.

3.2.5. Accounting, tendering and employment practices within the Trust must reflect the highest professional standards.

3.3. Compliance with rules on Gifts and Hospitality

3.3.1. Employees are required to exercise caution in all matters relating to the offering and receipt of gifts and hospitality to and from third parties. Employees must be aware of the potential risks and the public perception, however unjustified, that may arise in such circumstances.

3.3.2. The Trust's Conflict of Interest Policy and Section *8.1* of these Instructions set out the Trust's policies regarding gifts and hospitality. It is vital that employees of the Trust fully understand these policies and reflect them in their conduct at all times. It is essential that gifts and hospitality must not be offered or received in any situation or manner which may be prejudicial to the interests or reputation of the Trust.

3.3.3. Where an employee is uncertain as to the most appropriate course of action involving a gift or hospitality, the matter should be referred to the immediate line manager for guidance, consideration or approval before taking any further action. If this is not possible, there should be a refusal to make or accept any offer of a gift or hospitality which cannot be fully justified.

A material breach of these instructions will be regarded as a significant disciplinary offence.

3.3.4. All staff must comply with the Trust's Anti-Bribery Policy.

3.4. Compliance with rules of delegated powers of authority

3.4.1. While the Board of Directors retain absolute authority for the conduct of the financial affairs of the Trust, it is necessary to establish a system of delegated powers to enable appropriate officers of the Trust to manage the day to day activities. This system of delegated powers is referred to throughout these Instructions as Schemes of Delegation. The high level Scheme of Delegation is included as APPENDIX A – SCHEME OF DELEGATION to these Instructions. The lower level Schemes of Delegation must be maintained by each Site/Department and copies provided to the Chief Financial Officer after each amendment.

3.4.2. It is critical that employees of the Trust understand these fundamental principles and apply them at all times. These are:

- Financial or approval powers cannot be delegated to a subordinate officer(s) in excess of the powers as set out in the Scheme of Delegation for the delegating officer.
- Powers may only be delegated to officer(s) within the organisational control of the delegating officer; in circumstances where there is no practicable alternative, the term 'officers' in this context may include individuals who are not directly employed by the Trust, such as temporary contractors.
- All powers of delegation must be provided in writing, duly authorised by the delegating officer and accepted by the receiving officer. Any variations to such delegated powers must also be in writing.
- All applications for short term powers of delegation, such as holiday cover, which are not intended to be permanent must be provided in writing by the delegating officer, with start and end dates prior to the period for which approval is sought. In the event of an anticipated event such as long-term illness or an extended period away from the office, the maximum time limit for temporary delegation is 6 months.
- Any officer wishing to approve a transaction outside their written delegated powers must in all cases refer the matter to the relevant line manager with adequate delegated powers, before any financial commitment(s) is made in respect of that transaction.
- Powers may be onwardly delegated unless this is specifically prohibited by the delegator.
- Conditions or restrictions on delegated powers, e.g. not allowing onward delegation of those powers, should be reasonable in the circumstances and stated in writing.

3.4.3. Failure to comply with these principles, or a material breach thereof, will be recognised as a disciplinary offence. Where such a breach results in clear financial loss, the employee may be personally liable to compensate the Trust.

3.5. Compliance with Trust policies and procedures

3.5.1. Employees are reminded that absolute authority governing all actions within the Trust rests with the Board of Directors and that this authority is exercised through Schemes of Delegation.

All employees are bound through their contracts of employment to follow the instructions of the Board of Directors and to comply with the policies and procedures that are developed and authorised by the Trust.

3.5.2. These Standing Financial Instructions set out specific Trust policies and procedures across a number of areas. Employees must comply with these requirements at all times. Where exceptions are deemed necessary, prior approval from the relevant Executive Director must be obtained, as set out in these Instructions. Compliance will be monitored through systems controls, management review, and by audit processes. It is the responsibility of management to ensure that all employees are aware of and understand their individual responsibilities deriving from these Instructions.

3.5.3. It is neither possible nor desirable to govern all the financial affairs of the entire Trust through a single set of instructions. Therefore, these Instructions make reference in a number of areas where it is considered appropriate for the Chief Executive or the Chief Financial Officer to develop a series of detailed policies and procedures. In these instances, it is the responsibility of all employees of the Trust to ensure they understand fully the existence, contents and requirements of such policies and procedures and to comply with them on the basis that they have received full authority from the Board of Directors.

3.5.4. Guidance on the existence and relevance of policies and procedures to specific situations are available from either the Chief Executive, Chief Financial Officer. All employees are required to consult with one of these Executive Directors in situations where they are unsure as to the most appropriate course of action. Such consultation must be sought in advance of making any financial commitment on behalf of the Trust. The Board of Directors will expect all employees of the Trust to comply with these requirements and will regard a material breach as a disciplinary offence.

3.6. Safeguarding Trust resources

3.6.1. Employees of the Trust have an individual and collective responsibility for safeguarding the interests of the Trust at all times. Section *3.2* and *3.3* of these Instructions explain the general requirement for all staff to protect the reputation of the Trust as a public service organisation. This section is intended to remind Trust employees of the requirement to safeguard the financial resources of the Trust. These resources may take the obvious tangible form of fixed assets, cash or negotiable instruments, as well as less clear, or possibly intangible items such as lost or foregone income through failure to notify income sources or opportunities to earn or recover income due to the Trust.

3.6.2. Employees are directed to section *5.2* of these Instructions, which describe the responsibilities of the Chief Financial Officer with regard to income management. Employees are expected to comply with these Instructions and report all income sources promptly to the Chief Financial Officer.

3.6.3. The Chief Executive, in consultation with the Chief Financial Officer and Security personnel, will develop, maintain and monitor detailed policies, procedures and instructions covering all aspects of the security of money, assets and other Trust resources. Employees of the Trust are expected to comply fully with these requirements and to take any and all corrective action as necessary or instructed by appropriate officers of the Trust.

3.6.4. Further to this requirement, each employee has an individual and collective responsibility for the security of property and other resources of the Trust. All issues of concern or potential risk

must be reported immediately to the Security department, including any concerns employees have where existing practices may represent a risk to the assets or other resources of the Trust.

3.6.5. Any damage, beyond ordinary business, to the Trust's premises, assets, supplies or other resources must be reported immediately in accordance with the procedures for Losses and Special Payments, which shall be established by the Chief Financial Officer. These procedures must comply with guidance set out in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the Treasury's Managing Public Money guidelines. Any employee discovering or suspecting a loss of any kind must either immediately inform their Director, who must immediately inform the Chief Executive and the Chief Financial Officer.

3.6.6. In the case of suspected fraud, it must be reported to the Local Counter Fraud Specialist. This officer will then appropriately inform the Chief Financial Officer and/or Chief Executive. The Chief Financial Officer must also ensure that procedures are in place that specify the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it. (These are set out in the Local Counter Fraud and Corruption policy.)

3.6.7. Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft (not involving deception) or arson is involved. For losses apparently caused by theft (not involving deception), arson, neglect of duty or gross carelessness, except if trivial, the Chief Financial Officer must notify the Board of Directors and the External Auditor.

3.6.8. The Board of Directors recognise that in extreme cases financial loss may be the result of fraud (i.e. intentional deception to secure unlawful advantage) or corruption. While the Board of Directors has every confidence in the integrity of Trust employees, it has a duty to put in place controls to minimise the opportunity for illegal appropriation of Trust resources. Accordingly, the Chief Financial Officer shall ensure that appropriate counter-fraud measures are in place, which are referred to in section 5.14 of these instructions.

3.6.9. All employees of the Trust are required to ensure they fully understand the Trust's Local Counter Fraud and Corruption Policy and the procedures for reporting suspicions or matters of possible concern. (This policy can be found on the intranet).

3.7. Patients Property

3.7.1. The Trust has a responsibility to provide safe custody for money and other personal property handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

3.7.2. Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

4. Responsibilities of the Chief Executive

4.1. Business Plans and Estimates

STANDING FINANCIAL INSTRUCTIONS

4.1.1. The Chief Executive, with the assistance of the Chief Financial Officer, shall compile and submit to the Board of Directors, the Integrated Care System and NHSE&I strategic plans and operational plans in accordance with the guidance issued about timing and Trust financial duties. The operational plan shall be reconcilable to an annual update of the financial pro-formas, which the Chief Financial Officer will prepare and submit to the Board of Directors and NHSE&I. The plan will contain:

- a statement of the significant assumptions on which it is based;
- details of major changes in workload, delivery of services or resources required to achieve the plan.
- Prior to the start of the financial year the Chief Executive will require the Chief Financial Officer to prepare and submit financial estimates and forecasts, on both revenue and capital account, for approval by the Board. As a consequence, the Chief Financial Officer shall have right of access to all budget holders on budgetary related matters. Such budgets will be:
- in accordance with the aims and objectives set out in the service development strategy and annual business plan;
- in accordance with workload and manpower plans;
- produced following discussion with appropriate budget holders;
- prepared within the limits of available funds; and
- identify potential risks.

4.1.2. All budget holders must provide the Chief Financial Officer with all financial, statistical and other relevant information as necessary for the compilation of such business plans, estimates and forecasts.

4.1.3. The Chief Executive shall require the Chief Financial Officer to report to the Board of Directors any significant in-year variance from the business plan and to advise the Board of Directors on action to be taken.

4.1.4. The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them to manage their budgets successfully.

4.1.5. The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

- the amount of the budget;
- the purpose(s) of each budget heading;
- individual and group responsibilities;
- authority to exercise virement;

- achievement of planned levels of service; and
- the provision of regular reports.

4.1.6. The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

4.1.7. Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

4.1.8. Non-recurring budgets should not be used against annual recurring finance expenditure without the written authority of the Chief Financial Officer.

4.2. Budgets

4.2.1. The Chief Financial Officer shall, on behalf of the Chief Executive, and in advance of the financial year to which they refer, prepare and submit budgets within the forecast limits of available resources and planning policies to the Board of Directors for approval. Budgets will be in accordance with the aims and objectives set out in the Trust's service strategy and business plan.

4.2.2. The Chief Executive shall require the Chief Financial Officer to devise and maintain systems of budgetary control. All officers whom the Board of Directors may empower to engage staff, to otherwise incur expenditure, or to collect or generate income, shall comply with the requirements of those systems. The systems of budgetary control shall incorporate the reporting of, and investigation into, financial, activity or workforce variances from budget. The Chief Financial Officer shall be responsible for providing budgetary information and advice to enable the Chief Executive and other officers to carry out their budgetary responsibilities.

4.2.3. The Chief Executive may delegate management of a budget or part of a budget to officers to permit the performance of defined activities. The Schemes of Delegation shall include a clear definition of individual and group responsibilities for control of expenditure, exercise of virement, achievement of planned levels of services and the provision of regular reports upon the discharge of those delegated functions to the Chief Executive.

4.2.4. The Chief Executive shall not exceed the budgetary or virement limits set by the Board of Directors, and officers shall not exceed the budgetary limits set for them by the Chief Executive. The Chief Executive may vary the budgetary limit of an officer within the Chief Executive's own budgetary limit.

4.2.5. Except where otherwise approved by the Chief Executive, taking account of advice of the Chief Financial Officer, budgets shall be used only for the purpose for which they were provided and any budgeted funds not required for their designated purpose shall revert to the immediate control of the Chief Executive, unless covered by delegated powers of virement.

4.2.6. Expenditure for which no provision has been made in an approved budget and which is not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive or Board of Directors, as appropriate.

4.2.7. The Chief Financial Officer shall keep the Chief Executive and the Board of Directors informed of the financial consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the financial and economic aspects of future plans and

projects.

4.2.8. The Investment Committee, made up of members of King's Executive, will be the forum to agree business cases for investments and increases to operating budgets. The Investment Committee will see Board approval for business cases that are beyond the CEO/CFO authority level.

4.3. Contracts for the provision of Healthcare Services

4.3.1. The Board of Directors will approve standard terms and conditions for legally binding contracts, on the basis of which the Trust will provide healthcare services. Any variations to the standard terms and conditions will be approved in accordance with the Scheme of Delegation. The Chief Executive is responsible for negotiating contracts for the provision of services to patients in accordance with the Business Plan. In carrying out these functions, the Chief Executive should take into account the advice of the Chief Financial Officer regarding:

- costing and pricing of services;
- payment terms and conditions;
- amendments to NHS service agreements and out of area arrangements.

4.3.2. NHS service agreements should be devised to minimise risk whilst maximising the Trust's opportunity to generate income, achieve activity and performance targets. The Trust will utilise the National Tariff and, subject to approval from NHSE&I, will engage with commissioners to agree a tariff for any services in respect of which the Trust believes that a local tariff should apply.

4.3.3. The Chief Financial Officer shall ensure that a summary of the Trust's contracts is reported annually to the Board of Directors. The Chief Financial Officer shall also produce regular reports detailing actual and forecast contract income with a detailed assessment of the impact of the variable elements of income.

4.3.4. Any pricing of non NHS Tariff services should be undertaken by the Chief Financial Officer in accordance with a policy and the tariff reported to the Board of Directors. In respect of non-NHS tariff income the Council of Governors will be asked to satisfy itself that the services from which such income is derived do not interfere with the Trust's fulfilment of its principal purpose.

4.4. Capital Expenditure

4.4.1. The Chief Executive is ultimately responsible for all capital expenditure of the Trust, including expenditure on assets under construction. To discharge this duty, the Chief Executive will issue Schemes of Delegation for approval of capital commitments, and will arrange for the development of detailed policies and procedures covering all aspects of capital investment management, including scheme appraisals, contract awarding, contract management and financial control.

4.4.2. The Chief Executive shall provide executive delegation to a named Senior Responsible

Officer, who must be an Executive Director to manage programmes for capital works expenditure, including assets under construction, within the restrictions of the Schemes of Delegation. The Executive Director should not be the Chief Finance Officer, in order to maintain appropriate separation of duties.

4.4.3. All expenditure on capital assets will be authorised in line with Schemes of Delegation. Any commitment in excess of the limits currently specified shall be referred firstly to the Chief Executive and then to the Board of Directors, dependent on approval required, before such commitment is made.

4.5. Tendering and Contracting

4.5.1. The Chief Executive has overall responsibility to ensure that the Trust applies the principles of Value for Money in the procurement of goods, services and capital programmes. The Chief Executive shall liaise with the Chief Financial Officer and the Director of Finance and Commercial (KFM) to develop procedures for competitive selection wherever possible in procurement exercises. The Chief Executive shall ensure that these procedures are open and clearly demonstrate fair and adequate competition wherever possible. In particular, the procedures will incorporate NHS and Trust requirements for disclosure of any commercial sponsorship offered by or received from actual or potential suppliers to the Trust.

4.5.2. The Chief Executive has delegated procedures covering the receipt, safe custody and formal opening of tenders received and appropriate records to be maintained in connection with the full tender exercise to the Chief Financial Officer and the Director of Finance and Commercial KFM. These are set out in the Procurement Policy.

4.6. Risk Management and Insurance

4.6.1. The Chief Executive shall ensure that the Trust has a programme of risk management which will be approved and monitored by the Board of Directors.

4.6.2. The programme of risk management shall include:

- a process for identifying and quantifying risks and potential liabilities;
- engendering among all levels of staff a positive attitude towards the control of risk;
- management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;
- contingency plans to offset the impact of adverse events;
- audit arrangements including internal audit, clinical audit and health and safety review;
- arrangements to review the risk management programme.

4.6.3. The existence, integration and evaluation of the above elements will provide a basis to make

statements on the effectiveness of internal control within the Annual Report and Accounts.

4.6.4. The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme, and that documented procedures cover these arrangements.

4.7. Retention of Documents (Corporate and Financial)

4.7.1. The Chief Executive shall be responsible for maintaining archives for all documents required to be retained in accordance with the NHS Code of Practice on Records Management. Annex D2 to the Code of Practice sets out the retention periods for Business and Corporate (Non-Health) Records. APPENDIX B summarises the retention periods for key documents and records.

4.7.2. The documents held in archives shall be capable of retrieval by authorised persons.

4.7.3. Documents held under Annex in accordance with the procedures set out in the Code of Practice and at the express instigation of the Chief Executive. Records shall be maintained of documents so destroyed.

4.7.4. The Chief Financial Officer shall provide advice on the retention of financial records.

4.8. Patients' Property

4.8.1. The Chief Executive shall ensure that there are procedures in place for informing patients or their guardians, as appropriate, before or at admission, that the Trust will not accept responsibility or liability for patients' property brought into the Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.2. The Trust has a responsibility to provide safe custody for money and other personal items (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

4.8.3. The Chief Executive is responsible for ensuring that patients or their guardians, where appropriate, are informed before or at admission by:

- notices and information booklets,
- hospital admission documentation and property records,
- the oral advice of administrative and nursing staff responsible for admissions,

that the Trust will not accept responsibility or liability for patients' property brought into Trust premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

4.8.4. The Chief Executive shall require the Chief Financial Officer, in conjunction with the Chief Nurse and Site Chief Executives, to provide detailed written instructions on the collection,

custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of a patient's money in order to maximise the benefits to the patient.

4.8.5. In cases where the property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965), the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is £5,000 or less, forms of indemnity shall be obtained.

4.8.6. Where patients' property or income is received for specific purposes and held for safekeeping, the property or income shall be used only for that purpose unless any variation is approved by the donor or patient in writing.

4.9. Annual Report and Accounts

4.9.1. The Chief Executive will prepare and certify annual accounts, submit together with any report of the auditor to NHSE&I and for laying before Parliament.

5. Responsibilities of the Chief Financial Officer

5.1. General

5.1.1. The Chief Financial Officer is responsible for:

- implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;
- maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;
- ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time;
- the design, implementation and supervision of systems of internal financial control; and
- the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties.

All such arrangements shall comply with the NHS Provider Licence and all other relevant statutory requirements.

5.1.2. The Chief Financial Officer is responsible to ensure that any contractor or employee of a

contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income are covered by these instructions.

5.1.3. The Chief Financial Officer shall require in relation to any officer who carries out a financial function, that the form in which the records are kept and the manner in which the officer discharges his/her duties shall be to the satisfaction of the Chief Financial Officer.

5.1.4. The Chief Financial Officer shall ensure appropriate arrangements are in place to pay and recover tax, and shall be responsible for seeking professional advice in this regard as necessary.

5.2. Income

5.2.1. General

5.2.1.1. The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due, including from other NHS bodies. All such arrangements shall comply with the NHS Provider Licence. Systems should be in place to ensure the prompt banking of all monies received.

5.2.2. Fees and charges

5.2.2.1. The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges in line with Section 10.1 of the Scheme of Delegation other than those determined by the NHS Executive or by Statute. Independent professional advice on matters of valuation shall be taken as necessary.

5.2.2.2. All employees must inform the Chief Financial Officer promptly of monies due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

5.2.3. Debt recovery

5.2.3.1. The Chief Financial Officer is responsible for ensuring an effective credit control policy is in place across the Trust, incorporating consistent procedures for recovery of all outstanding debts due to the Trust.

5.2.3.2. Income not received and which is irrecoverable should be dealt with in accordance with write off procedures.

5.2.3.3. Procedures should be in place to minimise overpayments, but where these do occur recovery action should be initiated, subject to such action being cost effective.

5.2.4. Security of cash, cheques and other negotiable instruments

5.2.4.1. The Chief Financial Officer is responsible for:

- approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;
- ordering and securely controlling any such accountable stationery;
- providing adequate facilities, procedures and systems for employees whose duties include collecting and holding cash by making available safes or lockable cash boxes, dealing with keys and coin operated machines;
- prescribing systems and procedures for handling cash and negotiable securities on behalf of the Trust. The opening of incoming post shall be performed by staff other than those responsible for cash or bank reconciliations, and financial instruments received through the post shall be entered immediately in an approved register. All cheques shall be crossed immediately and passed to the cashier, from whom a signature shall be obtained.

5.2.4.2. Trust monies shall not under any circumstances be used for the encashment of private cheques or IOU notes.

5.2.4.3. All cheques, postal orders, cash etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Chief Financial Officer.

5.2.4.4. The holders of safe keys shall not accept unofficial funds for depositing in Trust safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

5.3. Annual Accounts and Reports

5.3.1. The Chief Financial Officer, on behalf of the Trust, will prepare financial returns in accordance with the requirements of NHSE&I and the Treasury, the Trust's accounting policies and generally accepted accounting principles.

5.3.2. The Chief Financial Officer, *as delegated by the Chief Executive* on behalf of the Trust, will prepare and certify annual accounts and submit them together with any report from the auditor for laying before Parliament and submission to NHSE&I.

5.3.3. The Trust's annual accounts must be audited by an auditor appointed by the Council of Governors in accordance with the appointment process as set out in the Audit Code for NHS Foundation Trusts issued by NHSE&I.

5.3.4. The Trust will publish an Annual Report, in accordance with guidelines issued by NHSE&I. This will be presented to the Council of Governors at a general meeting and (by at least one member of the Board of Directors) to the members at the annual members' meeting. The

document will include inter alia, the Audited Annual Accounts of the Trust. The annual report and audited accounts will be sent to NHSE&I.

5.4. Bank and Government Banking Services (GBS) Accounts

5.4.1. The Chief Financial Officer is responsible for managing the Trust's banking arrangements in accordance with the policy approved by the Board of Directors and for advising the Trust on the provision of banking services and operation of accounts. This advice will reflect any guidance and directions issued from time to time by NHSE&I.

5.4.2. The Chief Financial Officer is responsible for all bank and GBS accounts and for establishing separate bank accounts for the Trust's non-exchequer funds.

5.4.3. The Chief Financial Officer is responsible for:

- ensuring payments made from a bank or GBS account do not exceed the credit balance on that individual account except where prior arrangements have been made;
- applying solely for an overdraft subject to another employee acting on his/her behalf within the Scheme of Delegation;
- reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn.

5.5. Banking Procedures

5.5.1. The Chief Financial Officer will prepare detailed instructions on the operation of bank and GBS accounts which must include:

- conditions under which each bank and GBS account is to be operated;
- the limit to be applied to any overdraft; and
- those authorised to sign cheques or other orders drawn on the Trust's bank accounts

5.5.2. The Chief Financial Officer must advise the Trust's bankers in writing of the conditions under which each account will be operated.

5.5.3. The Chief Financial Officer will review the banking arrangements of the Trust at regular intervals not exceeding 5 years to ensure they reflect best practice and represent best value for money. Following such reviews, the Chief Financial Officer shall determine whether or not to seek competitive tenders for the Trust's banking business.

5.5.4. Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors.

5.6. External Investments, including Joint Ventures

5.6.1. The Chief Financial Officer will produce an investment policy, in accordance with any guidance received from NHSE&I, for approval by the Board of Directors. The investment may include investment of cash in approved institutions, by forming or participating in forming bodies corporate and/or otherwise acquiring membership of bodies corporate. All new external investment will require approval by the Board of Directors.

5.6.2. The policy will set out the Chief Financial Officer's responsibilities for advising the Board of Directors on investments and reporting periodically to the Board of Directors concerning the performance of investments held. It should also confirm, how the Trust will protect its interests when forming and/or acquiring membership of bodies corporate.

5.6.3. The Chief Financial Officer will prepare detailed procedural instructions on the operation of investment accounts and the records to be maintained.

5.7. External Borrowing and Public Dividend Capital (PDC)

5.7.1. The Chief Financial Officer will advise the Board of Directors of the Trust's ability to pay interest on, the repayment of the Public Dividend Capital and any commercial borrowing within the limits set by the Trust's NHS Provider Licence and reviewed annually by NHSE&I. The Chief Financial Officer is also responsible for reporting periodically to the Board of Directors on the Public Dividend Capital and all loans and overdrafts.

5.7.2. Any application for a loan or overdraft will only be made by the Chief Financial Officer or by an employee acting on his/her behalf, and in accordance with the Scheme of Delegation, as appropriate. All loans and overdrafts excluding PDC will require the approval of the Board of Directors,.

5.7.3. The Chief Financial Officer must prepare detailed procedural instructions concerning applications for loans and overdrafts.

5.7.4. All short-term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position. Any short term borrowing requirement in excess of one month must be authorised by the Chief Financial Officer.

5.7.5. All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

5.7.6. Assets protected under the NHS Provider Licence with NHSE&I shall not be used as collateral for borrowing. Non-protected assets will be eligible as security for a loan.

5.8. Capital Expenditure

5.8.1. The Chief Financial Officer, in conjunction with other directors as appropriate, shall be responsible for preparing detailed procedural guides for the financial management and control of expenditure on capital assets, including the maintenance of an asset register in accordance with the minimum data set as specified in the Department of Health and Social Care Group Accounting Manual (DHSC GAM) and the requirements of the NHS Provider Licence.

5.8.2. The Chief Financial Officer, shall implement procedures to comply with guidance on valuation contained within theDHSC GAM, including rules on indexation, depreciation and revaluation.

5.8.3. The Chief Financial Officer shall establish procedures covering the identification and recording of capital additions. The financial cost of capital additions, including expenditure on assets under construction, must be clearly identified to the appropriate budget holder and be validated by reference to appropriate supporting documentation. The Chief Financial Officer shall also develop procedures covering the physical verification of assets on a periodic basis.

5.8.4. The Chief Financial Officer, in conjunction with other directors as appropriate, shall develop policies and procedures for the management and documentation of asset disposals, whether by sale, part exchange, scrap, theft or other loss. Such procedures shall include the rules on evidence and supporting documentation, the application of sales proceeds and the amendment of financial records including the asset register.

5.9. Payment of Accounts

5.9.1. The Chief Financial Officer shall be responsible for the proper payment of all accounts and claims. The Chief Financial Officer shall establish and communicate procedures to ensure that all officers provide prompt notification of all monies payable by the Trust arising from transactions which are initiated including contracts, leases, tenancy agreements and other duly authorised processes.

5.9.2. The Chief Financial Officer shall establish detailed procedures covering the approval of accounts for payment. These shall include rules on verification of invoices including confirmation of prior receipt of goods or service delivery and confirmation of prices charged and discounts offered. Where required, these procedures shall include rules for proper approval from budget holders where goods or services are obtained outside the normal ordering procedures.

5.9.3. The Chief Financial Officer shall develop procedures for the prompt payment of accounts once verified for settlement. Such procedures will include the taking of settlement discounts where offered, and rules covering independent check and security of payment transactions.

5.9.4. The Chief Financial Officer will implement procedures to retain approval of all payments made in advance of receipt of the related goods or services.

5.10. Purchasing

5.10.1. The Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with current rules on public procurement. These shall be set out within Schemes of Delegation.

5.10.2. The Chief Financial Officer shall prepare procedural instructions on the obtaining of goods, services and works, incorporating the thresholds set by the Trust. This function is delegated to KFM.

5.10.3. The Chief Financial Officer shall determine that no goods, services or works, other than works and services executed in accordance with a contract and purchases from petty cash, shall be ordered except by the use of the Trust's agreed requisitioning and ordering procedures, including online procedures

5.10.4. Suppliers/contractors shall be notified that orders should not be accepted unless on an official form with an authorised unique reference number (a purchase order number (PO Number)) or by agreed electronic means where this has been established. The unique reference number should be quoted on all invoices and correspondence with the Trust.

5.10.5. Official orders shall be consecutively numbered, in a form approved by the Chief Financial Officer and include such information as to description, quantity, prices or costs as may be required. The order shall incorporate the standard NHS terms and conditions.

5.10.6. Order requisitions shall be authorised only by officers with the appropriate delegated authority as set out in the Schemes of Delegation. Lists of authorised officers shall be maintained with a copy of such lists to be supplied to the Chief Financial Officer.

5.10.7. The Chief Financial Officer shall ensure that no order shall be issued for any item or items for which there is no budget provision, unless authorised by the Chief Financial Officer on behalf of the Chief Executive.

5.10.8. Goods and services for which Trust contracts are in place should be purchased within those contracts. Any purchasing request outside of such contracts must be referred in the first instance to the Director of Finance and Commercial (KFM) for approval. Requests above an agreed threshold, as laid out in Appendix 1, should be reported to the Audit Committee.

5.11. Tendering and Contracting – Goods and Services

5.11.1. The instructions in this section concern purchasing decisions for goods and services required where the Trust needs to enter into formal tendering and contractual arrangements.

5.11.2. This section does not cover instructions in connection with capital expenditure on works programmes, which are subject to separate instructions.

5.11.3. As with Purchasing, the Chief Financial Officer shall advise the Board of Directors regarding the setting of thresholds above which quotations or formal tenders must be obtained. This will take into account legal requirements to comply with current rules on public procurement. These shall be set out within the Schemes of Delegation.

5.11.4. The Chief Financial Officer shall be responsible for establishing appropriate procedures to ensure that competitive tenders are invited for the supply of goods and services under contractual arrangements wherever possible. These shall include the procedures to be followed in the event of competitive tendering of in-house services. In such circumstances it must be ensured that no member of the in-house tender group participates in the evaluation of the tender. The Chief Financial Officer will ensure that tenders are evaluated by panels appropriate to the scale and nature of the tender, supplemented by external and independent advice when appropriate.

5.11.5. Where the purchasing service is delivered at arm's length it shall comply with the procedures as set out by the Chief Financial Officer.

5.11.6. Tenders and quotations shall be invited only from financially sound and technically competent firms. In this regard, the Chief Financial Officer shall be responsible for establishing procedures to carry out financial appraisals and shall instruct the appropriate requisitioning

directorate to provide evidence of technical competence.

5.11.7. The Chief Financial Officer shall advise the Board of Directors of circumstances where it would be appropriate for goods or services to be obtained under contract from sources that have not been subject to competitive selection. The grounds where such single quote actions may be authorised are as follows, although approval is not to be regarded as automatic, each case shall be treated on its own merit:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. Exemption from competition will only be allowed on the grounds of compatibility where the award to the provider can be shown to be absolutely essential, i.e. there is only one supplier.

- Where in the opinion of the Chief Financial Officer or the Chief Executive, according to the financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where time is a critical factor for the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

- Where the estimated expenditure or income would not warrant formal tendering procedures or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in the Schemes of Delegation.

5.11.8. Separate authorisation arrangements, as set out in the Schemes of Delegation, shall apply to maintenance or other support contracts for existing goods or assets where the Trust is contractually tied to specific companies. Details of such contracts shall be recorded in a register by the authorising officer.

5.11.9. The extent to which relevant officers can exercise these powers is set out in the Schemes of Delegation. All officers of the Trust must be aware that single quote actions are to be the exception to the preferred procedures of competitive selection. In each case a full explanation is required. Records shall be maintained to enable the use of single quote and other non-competitive actions to be monitored and reported to the Audit Committee at least annually.

5.12. Stores

5.12.1. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of stores maintained at a departmental level shall be the responsibility of the respective Executive or Clinical Director. The day-to-day responsibility may be further delegated to departmental employees and stores managers/ keepers, subject to such delegation being authorised and recorded with a copy sent to the Chief Financial Officer. The control of Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

5.12.2. The Director of Supply Chain and Clinical Procurement (KFM) shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, returns to stores, and losses, these procedures and systems to be approved by the Chief Financial Officer.

5.12.3. Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items, wherever held (e.g. ward or departmental cabinets) at least once a year. The Chief Financial Officer shall establish procedures for the management and control of stores held in ward and departmental cabinets, including procedures for an annual stocktake. This includes stock areas controlled by the Trust's subsidiary, KFM.

5.12.4. Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

5.12.5. The responsible Director/Pharmaceutical Officer shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. These officers shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

5.12.6. For goods supplied via the NHS Supply Chain, the Chief Executive shall identify those authorised to requisition and accept goods from the distribution centre. Procedures should be in place for the Chief Financial Officer to gain assurance that the goods have been received before accepting the recharge.

5.12.7. Subject to the responsibility of the Chief Financial Officer for approving the systems of control, the management and control of goods received at and distributed from the loading bays shall be the responsibility of the Director of Supply Chain and Clinical Procurement.

5.13. Information Technology

5.13.1. The Chief Financial Officer shall be responsible for the accuracy and security of the computerised financial data of the Trust. The Chief Financial Officer shall devise and implement any necessary procedures to ensure appropriate protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act 1998.

5.13.2. In terms of the Trust's financial systems, the Chief Financial Officer shall ensure that:

- appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

- adequate controls exist such that the computer operation is separated from development, maintenance and amendment.

- adequate management (audit) trail exists through the computerised system and that computer audit reviews are carried out as considered necessary.

5.13.3. The Chief Financial Officer shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained prior to implementation.

5.13.4. The Chief Financial Officer shall ensure that contracts for computer services for financial applications with another health organisation or other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

5.13.5. Where another health organisation or other agency provides a computer service for financial applications, the Chief Financial Officer shall periodically seek assurances that adequate controls are in operation.

5.13.6. Where computer systems have an impact on corporate financial systems the Chief Financial Officer shall be satisfied that:

- systems acquisition, development and maintenance are in line with corporate policies including the Trust's Information Technology Strategy;
- data produced for use with the financial systems is adequate, accurate, complete and timely, and that there is a management (audit) trail;
- Chief Financial Officer's staff have access to such data;
- computer audit reviews are carried out as considered necessary.

5.14. Audit and Counter Fraud

5.14.1. Audit Committee

5.14.1.1. The Board of Directors shall establish an Audit Committee of Non-Executive Directors which will provide an independent and objective view of internal control by overseeing Internal and External Audit services, counter fraud services, reviewing financial systems, ensuring compliance with Standing Orders and Standing Financial Instructions, and making recommendations to the Board of Directors. The Audit Committee will have appropriate terms of reference as advised by regulators, statute and good practice.

5.14.1.2. The Board of Directors shall satisfy itself that at least one member of the Audit Committee has recent and relevant financial experience.

5.14.1.3. Where the Audit Committee is of the opinion that there is evidence of ultra vires transactions, improper acts or if there are other important matters which the Committee wish to raise, the Chairman of the Audit Committee should do so at a full meeting of the Board of Directors. Such matters may also need to be reported to the Council of Governors and, exceptionally, to NHSE&I.

5.14.2. External Audit

5.14.2.1. An external auditor will be appointed and operate in accordance with current audit

regulations and has the right:

- Of access at all reasonable times to every document relating to the NHS foundation trust which appears to them necessary for the purposes of their functions.
- To require a person holding, or accountable for, any such document to give them such information and explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the person to attend before them in person to give the information or explanation or to produce the document.
- To require any director or officer of the NHS foundation trust to give them such information or explanation as they think necessary for the purposes of their functions. If they think it necessary, they may also require the director or officer to attend before them in person to give the information or explanation.
- To examine documents held by a contractor in respect of contracts with the Trust for the purposes of examination and certification of Trust accounts.
- In respect of services contracted out by the NHS foundation trust to third parties, all contracts between the NHS foundation trust and third parties shall include a clause whereby the third party shall grant access to the auditor for the purpose of audit and certification of the NHS foundation trust accounts. The said clause shall be in the following or similar terms.

5.14.2.2. The Audit Committee shall assess annually the quality of the external audit work and the level of fees and make a recommendation to the Council of Governors about the auditors' re-appointment.

5.14.3. Internal Audit

5.14.3.1. The Chief Financial Officer will ensure that there is an adequate and effective internal audit of the Trust's systems and controls in accordance with the requirements of NHSE&I, including the provision of an annual opinion on the effectiveness of internal controls as set out in the current public sector internal audit regulation and guidance.

5.14.3.2. The terms of reference for the Internal Audit function will be approved by the Audit Committee and its operation will be in accordance with t current public sector internal audit regulation and guidance.

5.14.3.3. A representative of the Internal Audit service provider will normally attend Audit Committee meetings and has a right of access to all Audit Committee Members, the Chairman and Chief Executive of the Trust.

5.14.3.4. The Chief Financial Officer is responsible for:

- ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function;
- ensuring that the internal audit is adequate and meets the Public Sector Internal Audit Standards;

5.14.4. Counter Fraud

5.14.4.1. The Chief Executive and Chief Financial Officer shall ensure that effective counter fraud arrangements are in place.

5.14.4.2. The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as set out in the NHS standard contract requirements and NHS Counter Fraud Authority standards for providers.

5.14.4.3. The Local Counter Fraud Specialist shall report to the Chief Financial Officer and shall work as appropriate with staff in the NHS Counter Fraud Authority.

5.14.4.4. The Chief Financial Officer is responsible for:

- deciding at what stage to involve the police in cases of misappropriation and other irregularities (subject to sections *3.6.5* and *3.5.7* of these Instructions);
- ensuring that an annual audit report is prepared for the consideration of the Audit Committee and the Board of Directors.

5.14.4.5. The report must cover:

- progress against plan for the previous year,
- all major internal financial control weaknesses discovered,
- progress on the implementation of internal audit recommendations,
- strategic audit plan covering the coming three years,
- a detailed plan for the coming year.

5.14.4.6. The Chief Financial Officer, designated auditors and counter fraud staff are entitled, without necessarily giving prior notice, to require and receive:

- access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;
- access at all reasonable times to any land, premises or employee of the Trust;
- the production of any cash, stores or other property of the Trust under an employee's control;
- explanations concerning any matter under investigation.

5.14.4.7. Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

5.15. Joint Finance Arrangements with Local Authorities

5.15.1. Payments to and arrangements with local authorities made under the powers of section 75f the NHS Act 2006 shall comply with procedures laid down by the Chief Financial Officer which shall be in accordance with the Act.

5.16. New Business Enterprise Activities and Other Significant Transactions

5.16.1. In the case of any new business enterprise activities, including significant capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, loans to external organisations, mergers and alliances, reference should be made to the guidance issued by NHSE&I, including but not limited to the Risk Evaluation of Investment Decisions.

5.16.2. The Chief Financial Officer shall ensure that the approval of the Board of Directors is obtained where required.

5.16.3. The Board Secretary shall ensure that NHSE&I is notified and that approval is obtained as required in the guidance NHSE&I shall issue from time to time.

6. Responsibilities of Executive Directors Regarding Capital Programmes

6.1. Control of Capital

6.1.1. The Chief Executive delegates authority to the Executive Directors to control all works capital programmes, including ad hoc purchases and capital schemes over extended periods of time. These powers and the associated financial restrictions are set out in the Schemes of Delegation.

6.1.2. All capital schemes, including estates, IT and equipment, will be subject to the procedures as set out in the Capital Investment Manual governing control of capital programmes in the NHS. Where appropriate, alternative measures of control deemed may be adopted by the Trust on the advice of the Chief Finance Officer, following discussion with the Chief Executive. Where material, these will be brought to the attention of the Board of Directors.

6.2. Tendering and Contracting (Capital Works)

6.2.1. In respect of Capital Works, the Executive Directors are required to manage capital programmes under the general procurement rules (sections *4.4*, *4.5*, *5.8* & *5.11*) contained in

these instructions. Specifically, the selection of contractors shall be in accordance with the rules on competitive selection set out in these instructions and in accordance with the financial powers set out in the Schemes of Delegation. In order to achieve this, the Executive Directors shall liaise with the Head of Procurement (KFM) to agree and plan procurement in advance insofar as possible.

6.2.2. Within these specific powers of authority, the Executive Directors must comply with general requirements under these Instructions in all regards. All policies, procedures and systems established to manage capital expenditure programmes, including procurement decisions and financial transactions, must be to the satisfaction of the Chief Financial Officer who is accountable to the Chief Executive and the Board of Directors for all financial systems, records and procedures.

6.2.3. The Chief Finance Officer, in liaison with the Head of Procurement (KFM), shall establish and maintain a list of approved suppliers, from which contractors will be selected for invitation to tender. The selection from the list of a reasonable proportion of the contractors to be invited to tender should be by rotation. Additions to this list shall be under the authorisation of the Director of Finance KFM and shall only be included after receipt of evidence as to the contractors' financial and technical competence. The Chief Financial Officer shall be consulted as regards financial competence and a suitable officer within the Finance Directorate will provide advice on financial status and recommended contract limits. The appropriate requisitioning directorate will provide evidence of technical competence. Where the value of works is to exceed £25,000, contracts must be awarded subsequent to a further completion to identify the most economically advantageous tender. The audit trail and rationale for selecting the contractor must be retained in the Trust's e-sourcing system, and the awarded contract must be stored in the Trust's contract repository; further to an award notice being published on Contracts Finder.

6.2.4. Where the approved supplier list does not contain any or an insufficient number of suitable contractors, the financial and technical competence of any additional contractors must be confirmed before inclusion on the approved list and an invitation to tender.

6.2.5. The Executive Director must demonstrate effective and efficient use of resources in awarding contracts, ideally through the use of competitive selection.

6.2.6. Where by exception the Executive Director considers competitive selection to be inappropriate, undesirable or not possible, the Executive Director may seek approval for single quote exercises in accordance with financial limits set out under the Schemes of Delegation. These powers are provided by the Chief Executive and it is expected that they shall be exercised in exceptional cases only. Each case shall be treated on its own merits but examples where single quote rules may be appropriate include:

- Where the requirement is ordered under existing contracts which themselves were sourced under competitive selection.

- Where the estimated expenditure or income would not warrant formal tendering procedures, or competition would not be practicable taking into account all the circumstances. The limits for such single quote exemptions are set out in Schemes of Delegation.

- For the supply of proprietary goods or services for which it is not possible or desirable to obtain competitive quotations. This shall include maintenance or other support contracts

for existing goods or assets where the Trust is contractually tied to specific companies.

- Where in the opinion of the Chief Financial Officer, or the Chief Executive, if in excess of financial limits set out in the Schemes of Delegation, it is considered against the interest of the Trust to enter into open competitive selection procedures. This may include procurement exercises where in the opinion of the Executive Director time is a critical factor in the interest of the Trust. It is acknowledged that in emergency situations, the authority for such single tender action will be obtained retrospectively.

6.2.7. In all cases the Chief Financial Officer shall keep appropriate records of single quote actions including a full justification of the reasons why competitive selection procedures were not adopted. The Chief Executive shall require the Chief Financial Officer to monitor the use of single quote actions in the awarding of contracts and to report to the Audit Committee on the extent of the use of single quote and other non-competitive actions.

7. Responsibilities of the Chief People Officer

7.1. Payment of Staff

7.1.1. The Chief People Officer shall make arrangements for the provision of payroll services to the Trust, to ensure the accurate determination of pay entitlement and to enable prompt and accurate payment to employees.

7.1.2. The Chief People Officer is responsible for ensuring that the Trust meets all its obligations to HMRC in respect of income tax, national insurance and other deductions when employing individuals directly or those who may be considered as employees.

7.1.3. All pay and conditions are determined by the NHS national terms and conditions. Managers are not permitted to deviate from these conditions, including but not limited to pay rates, enhancements or allowances otherwise than in accordance with national agreements unless the approval of the Chief Executive or Chief People Officer has been given.

7.1.4. The Chief People Officer shall be responsible for establishing procedures covering advice to managers on the prompt and accurate submission of payroll data to support the determination of pay including, where appropriate, timetables and specifications for submission of properly authorised notification of new employees, amendments to standing pay data and terminations.

7.1.5. Managers are responsible for the accuracy, completeness and timeliness of manpower or e-roster returns to the Workforce directorate. As soon as a manager becomes aware of the effective date of an employee leaving or a change in circumstances affecting pay, they must notify payroll of details immediately.

7.1.6. Recruitment must be undertaken in accordance with the Trust's recruitment policy and no positions may be filled unless there is adequate budgetary provision. Provisions for the grading of posts are set out within the relevant HR policies and must be complied with.

7.1.7. Where contractors, agency or other form of interim staff are engaged, the booking must be made using the staff bank recording system. No payment shall be made directly to an individual for services without first ensuring that their self-employment status has been verified

and evidence of the check retained.

7.1.8. For individuals providing direct services through their own limited companies, known as personal service companies, the engaging manager must liaise with the Workforce Directorate to ensure that the relevant tax compliance checks have been undertaken prior to engagement.

7.1.9. The Chief Financial Officer will issue detailed procedures covering payments to staff including rules on handling and security of bank credit payments.

7.2. Staff Expenses

7.2.1. The Chief People Officer shall be responsible for establishing procedures for the management of expense claims submitted by Trust employees. The Chief People Officer shall arrange in most cases for duly approved expense claims to be processed through the Trust payroll system, having made appropriate journal entries to the relevant budget holder cost centres. Expense claims shall be authorised in accordance with the Trust's Expenses Policy and the Trust's Scheme of Delegation.

7.2.2. Expenditure on business travel and subsistence will be managed in accordance with the Trust's Expenses Policy.

7.2.3. The Chief People Officer shall refer to the Trust's general policies on staff expenses and may reject expense claims, in whole or in part, where there are material breaches of Trust policies. In this regard, the Chief People Officer shall liaise with the Chief Executive where appropriate.

8. Specific areas of concern

8.1. Hospitality

8.1.1. The Trust's Board of Directors recognise the integrity of all Trust employees in the manner in which they carry out their duties on behalf of the Trust. The Trust policy on Hospitality, which forms part of the Conflict of Interest Policy, should be referred to.

8.1.2. These notes cover instances where employees of the Trust wish to offer *hospitality to third parties* and cases where Trust employees are offered *hospitality by third parties*.

8.1.3. All Trust employees are reminded that they are responsible for public funds. Where hospitality is offered to third parties, this shall be approved in accordance with the Schemes of Delegation having given due regard to materiality and intention. In all cases offers of hospitality to third parties must be *incidental* to bona fide meetings or seminars and must be capable of justification from critical reviews. The Chief Executive shall be responsible for ensuring all Executive Directors and Trust Management retain full records of hospitality provided, with clear explanations of the hospitality offered, the names of all Trust employees and third parties involved and the financial costs incurred by the Trust. Where the costs exceed limits set out in the Conflict of Interest Policy, the record shall also provide a justification of hospitality offered and an assessment of the benefits accruing to the Trust.

8.1.4. English Law prohibits staff from soliciting or receiving any gift, hospitality or consideration of any kind from contractors or their agents, from any organisation, firm or individual as an inducement or reward for doing or refraining from doing something in their official capacity, or showing favour or disfavour to any person in their official capacity. It shall be understood that a breach of these requirements renders employees liable not only to dismissal but to prosecution under English Law.

8.1.5. All employees must be aware of the potential risks in accepting hospitality even when in good faith. Generally, all offers of hospitality should be reported to senior management.

8.1.6. Prior approval must be obtained from a relevant line manager in accordance with Schemes of Delegation where third parties will incur travel and related costs for Trust personnel to visit their premises or attend any third party organised event.

8.1.7. In general, Executive Directors are responsible for approving applications from employees under their organisational control and in turn individual Executive Directors must obtain prior approval from the Chief Executive. In both instances, these records are maintained by the Trust Secretary and Head of Corporate Governance.

8.1.8. The Chief Executive is accountable to the Board of Directors for any applications on his/her own behalf.

8.1.9. The Chief Executive shall be responsible for maintaining comprehensive records of all offers of hospitality, both accepted and rejected. The record shall be in a form designed by the Trust Secretary and Head of Corporate Governance. Completed records shall be available for inspection by the Chief Financial Officer, or designated auditors, at all reasonable times.

8.2. Credit Finance arrangements including leasing commitments

8.2.1. There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Chief Financial Officer.

8.2.2. The Board of Directors has provided the Chief Financial Officer with sole authority to enter into such commitments, although these powers can be delegated to appropriate officers under his/her organisational control. Any credit finance arrangements including lease commitments above the threshold laid out in appendix 1, must be reported to the Board.

8.2.3. This Instruction applies to leasing agreements and hire purchase undertakings which must be sent to the Chief Financial Officer for prior approval. No officer of the Trust outside the organisational control of the Chief Financial Officer has any powers to approve such commitments. Failure to comply with this instruction shall be a prima facie breach of an officer's contract of employment.

8.3. Bank Accounts

8.3.1. The Chief Financial Officer has sole authority to open, operate and close accounts with banks, building societies, Paypal (or any similar organisation) and the Government Banking Service

where Trust funds are received or expended. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to create or operate any such account.

8.3.2. Where officers of the Trust wish to manage non Trust funds such as ward funds or funds from donated sources, they are required to liaise with the King's College Hospital Charity who will operate the accounts on their behalf. It is not appropriate for any officer of the Trust to hold any such account in their own names as it creates a lack of openness in the handling of such funds and may allow that officer's integrity to be called into question, however unjustified that may be.

8.3.3. The only exception to the above will be where the Chief Financial Officer has authorised officers to maintain accounts which have been deemed acceptable, such as accounts for social or sports clubs. The Chief Financial Officer will maintain a register of such accounts.

8.4. Credit Cards

8.4.1. The Chief Financial Officer has sole authority to open, operate and close credit cards held in the Trust's name. It shall be a disciplinary offence for any officer of the Trust outside the organisational control of the Chief Financial Officer to operate any such account.

8.4.2. The Chief Financial Officer shall maintain a register of authorised credit card users.

8.4.3. The Chief Financial Officer shall put in place measures to ensure any spend on Trust credit cards has appropriate authorisation and is accurately recorded.

8.5. Financial commitments to third parties

8.5.1. These Instructions set out the rules on general purchasing and contract tendering. The above also notes the requirements with regard to credit finance commitments. The Board of Directors require that all such commitments and transactions are managed under the authority of the Chief Financial Officer for all expenditure.. Within these rules are clear requirements to ensure the Trust obtains value for money and to ensure that legal commitments are properly authorised.

8.5.2. In principle, the Trust will not allow officers to operate outside these delegated powers and commit the Trust to financial obligations with third parties. Applications to do so must be passed to relevant officers as set out in the Schemes of Delegation prior to any commitment being offered to any third party.

8.6. Direct Ordering

8.6.1. In general, no officer of the Trust can order goods or services directly from suppliers. These Instructions provide clear guidance on purchasing and contract tendering which must be followed. Where officers of the Trust wish to deal directly with suppliers for the procurement

of goods and services, the prior approval of the Chief Financial Officer must be obtained on a case by case basis.

8.6.2. In exceptional circumstances, where senior officers of the Trust wish to operate direct ordering procedures, the approval of the Chief Executive must be gained. This shall include procurement of goods and services where there are legal requirements for specialist approval outside the Finance Directorate, for example the procurement of certain pharmaceutical products. All applications must be made to the Chief Financial Officer who shall pass approved applications to the Chief Executive for ratification.

8.7. Non mainstream contracts with individuals

8.7.1. Where activity is undertaken in the Trust that does not fall within mainstream responsibilities, it may be necessary to contract with individuals for these services to be supplied. In order to ensure that the correct form of contractual relationship is established, the type of contract (i.e. payable gross or subject to statutory deduction through PAYE) must be considered. This requires that the type of activity, reporting responsibilities, place of work and ability to substitute another individual to perform the duties, should all be reviewed prior to engaging or contracting for services to be delivered.

8.7.2. Hence, the contractual arrangements and the estimated expenditure must be authorised in advance at an appropriate level, in accordance with the Scheme of Delegation.

8.7.3. The Chief Financial Officer shall be responsible for establishing detailed procedures, specifying the form of contractual arrangements which will apply, covering the terms and conditions, rates of pay, and method of payment, and the monitoring and reporting arrangements.

9. Research and Development

9.1 The principles and rules contained in this document (together with other relevant polices such as those concerning gifts and hospitality) apply equally to all research and development activity at, or administered by, the Trust.

9.2 Financial probity and compliance with external requirements for the use of public funds are as applicable to R&D activities as to any other activities being undertaken within the Trust.

9.3 There are two types of R&D activity as follows; both of which are covered by this document.

(a) "Commercial R&D" - where R&D is primarily conducted for commercial purposes and funded by an external company, for example a drug trial prior to licensing

(b) "Non – Commercial R&D" – where R&D is funded by a charitable organisations, a Research Council, the Department of Health and Social Care or other government agencies.

9.4 All research and development activities within the Trust shall be notified to the relevant Medical Director. The Chief Financial Officer shall ensure that procedures are put in place to ensure that all such activities are properly accounted for and that funding is utilised appropriately.

9.5 With regards to commercial research, all dealings with industry must be authorised by the Trust's R&D Office. Under no circumstances should an individual employee enter into a contract with industry in a personal capacity to undertake research involving NHS patients. Only protocols registered with the R&D Office will be covered by the NHS indemnity arrangements. The Trust will not accept liability for any activity that has not been properly registered and managerially approved.

9.6 Researchers, supported by finance managers, should ensure that any commercial partner is financially stable, (particularly if the company is small or new) and thus in a position to fulfil their financial obligations; all contracts should include termination clauses unless specifically agreed by the relevant Medical Director.

9.7 Trust employees must follow the agreed current Trust procedures for the financial management of all applications for research funding. No application should be submitted without having been properly costed and being subject to these processes. Standard Trust processes for capital investment and business case approval should also be followed, comprehensively assessing the likely resources required (including other areas of the Trust impacted by the proposed project, such as clinical support or corporate services). These must not wholly rely upon partner organisation estimates of costs. It is important that any commitment to R&D expenditure has a funding source, and that recurrent commitments are matched with recurrent funding. This applies to all expenditure including depreciation on R&D assets that are owned by the Trust.

9.8 For commercially funded R&D, at least the full cost of the activity must be recovered for research in which the intellectual property rests entirely with the company). Where intellectual property is shared, the level of cost recovery can be reduced in line with the potential benefits, subject to the general principles within the SFIs and SoD. For commercial clinical trials the sponsoring company is expected to supply free of charge the medicine that is the subject of the trial

9.9 All proposed R&D applications must be approved in line with the normal management arrangements within the Trust.

10. USE OF FUNDING GAINED THROUGH R&D ACTIVITIES

10.1.1. Researchers do not have the authority to use the funding for other purposes other than that specifically authorised. The use of any surpluses that occur must comply with the contractual terms of the research grant/contract.

10.1.2. In some cases if the research activity is not fully delivered, under the contractual obligations, an element of the funding will need to be returned to the external funding body and will not be retained by the Trust. Researchers must ensure that this risk is appropriately understood, underwritten and authorised by the relevant Director in the Trust before entering into the contract.

10.1.3. Payments to employees for research activities must be in line with Trust payroll procedures and no arrangements to avoid taxation liabilities should be entered into.

10.1.4. Research leads supported by finance managers must ensure that there is ongoing monitoring and control of income and costs for a grant/contract and should any income not be forthcoming, appropriate action taken.

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APPENDIX A – SCHEME OF DELEGATION

RESERVATION OF POWERS TO THE BOARD OF DIRECTORS AND DELEGATION OF POWERS

INTRODUCTION

This document sets out the powers reserved to the Board of Directors and the Scheme of Delegation, together with tables of financial limits and approval thresholds. However, the Board of Directors remains accountable for all of its functions, including those which have been delegated, and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

All powers of the Trust which have not been retained as reserved by the Board of Directors or delegated to a Board Committee shall be exercised on behalf of the Board of Directors by the Chief Executive. The Scheme of Delegation identifies any functions which the Chief Executive shall perform personally and those delegated to other directors or officers. All powers delegated by the Chief Executive can be re-assumed should the need arise.

The Scheme of Delegation shows only the 'top level' of delegation within the Trust. The Scheme of Delegation is to be used in conjunction with the system of budgetary control and other established procedures within the Trust.

Nothing in this Scheme shall allow the delegation of the powers of the Board of Directors where not permitted by Statute.

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POWERS RESERVED FOR THE BOARD OF DIRECTORS

1. General Enabling Provision

1.1 The Board of Directors may determine any matter it wishes in full session within its standing orders and statutory powers.

2. Regulation and Control

2.1 Approval, suspension, variation or amendment of Standing Orders, Standing Financial Instructions, Schedule of Matters reserved to the Board of Directors, Scheme of Delegation of powers from the Board of Directors to officers, and other arrangements relating to standards of business conduct.

2.2 Specification of financial and performance reporting arrangements.

2.3 Approval of the Group's Investment and Treasury Management Policies and authorisation of institutions with which temporary cash surpluses may be held and investments made.

2.4 Requiring and receiving the declaration of Directors' Interests which may conflict with those of the Trust and determining the extent to which that Director may remain involved with the matter under consideration.

3. Appointments

Subject to the Foundation Trust Constitution:

3.1 The appointment and agreement of the terms of reference of Board Committees.

3.2 The appointment of the Deputy Chair.

3.3 Through its Remuneration Committee, the appointment, appraisal, disciplining and dismissal of Executive Directors.

4. Policy Determination

4.1 The approval of personnel policies providing for the appointment, removal and remuneration of staff, including arrangements relating to standards of business conduct (specifically, disclosure of interests, hospitality, gifts and expenses). The approval of all other policies is delegated to King's Executive.

5. Direct Operational Decisions

5.1 The approval of the acquisition, disposal or change of use of land and/or buildings (subject to NHSE&I approval in the event that NHSE&I invokes the relevant provisions in the NHS Provider Licence, and any other statutory restrictions). This includes entering into leases with a capital impact above £5m (i.e. above the level delegated to the Chief Executive Officer).

5.2 The approval of transactions with a value in excess of that currently specified in the table of financial limits as requiring Board of Directors approval, and which are not covered by any specific delegated authority. Such transactions may be subject to notification and approval

from NHSE&I.

5.3 The approval of loans with repayment periods in excess of one year.

5.4 The agreement of action on litigation on behalf of the Trust and against the Trust, except that the authorisation of clinical negligence payments is delegated to the Chief Financial Officer.

6. Financial and Performance Planning and Reporting Arrangements

6.1 The approval of strategy, business plans and budgets.

6.2 The approval of the Trust's Annual Plan prior to submission to the Integrated Care System and NHSE&I.

6.3 Continuous appraisal of the affairs of the Trust by means of the receipt of reports as it sees fit from directors, committees and officers of the Trust.

6.4 Approval of the Trust's Annual Report, including the annual accounts, prior to submission to NHSE&I and the Council of Governors.

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Table 1: Scheme of Delegation of Powers from the Board of Directors to Officers of the Trust

REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
1	**CAPITAL PROJECTS AND ASSETS**		
1.1	Approval of capital and revenue business cases and PFI schemes, including approval of variations, (subject to recommendation by Investment Board):	Executive Directors (sponsorship of bids) Chief Financial Officer Chief Executive (and external as appropriate) Board above £5m NHSI – as per regulatory thresholds	This includes bids to the Charitable Foundation. These powers may not be further delegated; in the absence of the appropriate officer authorisation must be obtained from the level above. The external referral limit will depend on the regulations currently in force.
1.2	Management of capital expenditure and assets under construction	Executive Director (SRO)	**All 3rd party expenditure to be managed in liaison with the Head of Procurement (KFM)**
1.3	Maintenance of the asset register	Chief Financial Officer	Maintained by Director of Financial Operations CFO will require assurance from 3rd Parties (inc Group Subsidiaries) that asset registers are maintained
1.4	Approval of asset disposals: All Land and buildings disposals and other asset sales with book value > £100k	Authorisation retained by Board of Directors – No Delegation	Finance must always be informed to enable the asset register to be updated
	Other assets– book value < £100k	Chief Financial Officer	
2	**PROCUREMENT & CONTRACTS**		

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.1	**Procurement Procedures and Thresholds** (Total Contract Value, inclusive of VAT)	**Procurement Procedure:** **All procurement activity must comply with the Procurement Manual, Trust Standing Financial Instructions and Scheme of Delegation**	**Other essential requirements:** All financial limits quoted are the total for the life of the contract. For recurring services, where the Trust are likely to require the service for at least 4 consecutive years, the 'value' shall be based on a 4-year period, multiplying the baseline spend by 4 in order to calculate this value The Total Contract Value will include the total amount payable, inclusive of VAT. All Procurement Thresholds quoted are inclusive of VAT.
2.1.1	**Goods, Services and Works** **Under £10,000**	A minimum of one written quote representing best value for money, in line with Table 2 Authorisation limits	(Any capital expenditure greater than £5,000 must have the appropriate Sub Investment Board or Investment Board Approval)
2.1.2	**Goods, Services and Works** **Greater than £10,000 and up to £138,760**	Procurement Service KFM to support sourcing requirement. Minimum of three written quotes or Light Touch Tender process	Opportunities to be advertised on Contracts Finder, Find a Tender Service, and on the Trust Procurement System by the procurement team (KFM).
2.1.3	**Goods and Services and Works** **Greater than £138,760**	Procurement Service KFM to support sourcing requirement. Tenders to be managed in line with Public Contract Regulations	Opportunities to be advertised on Contracts Finder, Find a Tender Service, and on the Trust Procurement System by the procurement team (KFM).
2.2	**Authorisation of less than the requisite number of tenders / quotes (Insufficient market response):**		
2.2.1	For contracts up to Public Procurement Threshold Capital projects / Works	Executive Director **and** Chief Financial Officer	See Table 3 for details of required numbers
2.2.2	Goods and Services	Chief Financial Officer **and** KFM Director of Finance and Commercial (above FTS Threshold) Head of Procurement (beneath FTS Threshold)	With endorsement from the Head of Procurement (KFM)
2.3	**Procurement Procedures**		Procurement procedures delegated to KFM as the Trust Procurement Service.

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.3.1	Receipt of tenders	All quotes and tenders (with the exception of pharmacy goods and services) greater than £10,000, to be received electronically via the Procurement Service (KFM)	
2.3.2	Opening of tenders	All tenders, with the exception of pharmacy goods and services, to be received electronically via the Procurement Service (KFM)	
2.3.4	Permission to consider late tenders	Head of Procurement (KFM)	
2.4	**Decision to award or terminate a contract, including authorisation of actions to conclude commercial terms or mitigate commercial risk:**	Endorsement from Head of Procurement (KFM)	The ratification and award to be subject to recommendation of the procurement lead and budget holder. Decision to include all potential extensions as part of the total contract value For all tendering activity, relevant advice to be sought from the Director of Finance and Commercial (KFM), further delegated to the Head of Procurement
2.4.1	**For contracts up to the Public Procurement Threshold:** Capital projects / Works	Both: Associate Director –Construction and Director of Finance Strategy, Planning and Investment	
2.4.2	Goods and Services	KFM Head of Procurement and appropriate Trust Officer.	
2.4.3	**For contracts over the Public Procurement Threshold**: Greater than £5,336,937 Capital projects / Works	Executive Director and Chief Financial Officer	Prior Board approval is required at £5m
2.4.4	Greater than £138,760 Goods and Services	KFM Director of Finance and Commercial and Chief Financial Officer	
2.4.5	For contracts over £1,000,000:	Chief Executive	

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.4.6	**Signing of contracts (including letters of intent)** For Clinical Services and Capital Works:	For Clinical Services and Capital Works: £25,000 and above, but less than £100,000, Directors of Operations, Directors/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance; £100,000 and above, but less than £250,000 Executive Directors; £250,000 and above, but less than £1,000,000 Chief Financial Officer; £1,000,000 and above, but less than £2,500,000 Chief Executive; £2,500,000 and above Chief Executive on direction of the Board of Directors. For Goods and Services (provided via KFM): £10,000 - £50,000 Deputy Head of Procurement / Contracts (KFM); £50,000 – £100,000 Head of Procurement (KFM); £100,000-£500,000 Director of Finance and Commercial (KFM); £500,000 to £1,000,000 Managing Director KFM; £1,000,000+ Managing Director (KFM) & Chief Executive (KCH)	All Trust contracts of £5m and above must be sealed or executed as a deed, where, in the reasonable view of the Chief Financial Officer, there is a potential long-term liability to remain with the contractor. Subject to budget holder authorisation; subject to tender ratification and award being completed (see 2.4).
2.5	**Waivers and Authorisation of single tender / single quote action:**		
2.5.1	For contracts up to the Public Procurement Threshold: Capital projects / Works	KFM Director of Finance and Commercial **and** Chief Financial Officer	All waivers subject to procurement approval that waiver rationale is objective, and exceptions in Public Contract Regulations
2.5.2	Goods and Services	KFM Director of Finance and Commercial **and** Chief Financial Officer	

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.5.3	For contracts over the Public Procurement Threshold For Waivres over £1m	Chief Financial Officer **and** Chief Executive Board of Directors	apply (Reg 32). Waivers greater than £10,000 may require advertisement for a minimum of 10 days, on Contracts Finder or Find a Tender Service prior to being approved, if not already advertised.
2.5.4	Monitoring of the use of all waivers for single tender / single quote action in 2.2, 2.3 and 2.4	Audit Committee on behalf of Board of Directors	Appropriate records to be maintained by the KFM Director of Finance and Commercial as the basis for reporting. Reports to be taken to Audit Committee at least every 6 months.
2.7	**Supplier and Contract Management**		All contracts and suppliers to have performance reviews on a regular basis to ensure value for money and quality of service standards are achieved
2.7.1	Maintenance of list of approved contracted suppliers: Works contracts	Chief Finance Officer	Maintained by the KFM Director of Finance and Commercial, and delegated to Head of Procurement
2.7.2	Goods and services contracts	Chief Financial Officer	Maintained by the KFM Director of Finance and Commercial, and delegated to Head of Procurement
2.8	**Approval of variations or extensions to contract:**		
2.8.1	For contracts less than £10,000: Capital projects / Works	Executive Director and KFM Head of Procurement	Where the value of the variation or extension is less than one year's value of the whole contract. Advice should be sought from KFM Head of Procurement/Contracts before entering into any variation or extension agreement.
2.8.2	Goods and Services	Director of Operations and KFM Head of Procurement	
2.8.3	For contracts up to the Public Procurement Threshold: Capital projects / Works	Executive Director, Chief Financial Officer, KFM Head of Procurement	
2.8.4	Goods and Services	Executive Director and KFM Director of Procurement	
2.8.5	For contracts over the Public Procurement Threshold up to £1m: Capital projects / Works	Director of Finance and Commercial (KFM) and Chief Financial Officer	
2.8.6 2.8.7	Goods and Services	KFM Director of Procurement and Chief Financial Officer	
	For contracts over £1,000,000:	Chief Executive	
	For contracts over £2,500,000	Trust Board	This may be delegated to FCC.

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
2.8.8	Contract variations with KCH subsidiaries	Director of Financial Strategy, Planning and Investment	Where business cases are approved by in line with the SoD, authority is delegated to the Director of Commercial and Contracting and the Chair of the Contract Management Committee for KFM to sign off the relevant contract changes with KCH subsidiaries
2.8.9	Sealing of documents	Chairman (or Deputy Chairman in the absence of the Chairman) and one Director	Subsidiary pages of Works contracts to be signed in accordance with Power of Appointment procedure

3	SERVICE AGREEMENTS FOR THE PROVISION OF HEALTHCARE		
3.1	Approval of healthcare contracts Less than £250,000 £250 to £1m £1m and above	 Chief Finance Officer Chief Executive Trust Board	
3.2	Approval of variations to healthcare contracts: Less than £250,000	Chief Financial Officer	Where the value of the variation is less than one year's value of the whole contract.
	£250,000 to £1m	Chief Executive	
	£1m and above	Trust Board	
3.3	Authorisation of credit notes relating to healthcare contracts: Less than £250,000	Chief Financial Officer, delegated to the Deputy CFO	
	£250,000 and above	Chief Executive	
	£1m and above	Trust Board	

4	PURCHASING AND PAYMENTS (INCLUDING PAYROLL)		
4.1	Authorisation of internal requisitions: Less than £25,000	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	Directorates will determine appropriate values for further delegation, which will be notified to and agreed by the Director of Financial

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	£25,000 and above, but less than £100,000	/Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance	Operations(for the Chief Financial Officer) and recorded on the "Authorised Signatory List"
	£100,000 and above, but less than £250,000	Executive Directors	
	£250,000 and above, but less than £1,000,000	Chief Financial Officer	
	£1,000,000 and above, but less than £2,500,000	Chief Executive	
	£2,500,000 and above	Chief Executive on direction of the Board of Directors	
4.2	Authorisation of official orders	Authorised list maintained by the Director of Financial Operations (for the Chief Financial Officer)	Authorised list: "List of Trust officers permitted to authorise official orders"
4.3	Authorisation of **INVOICES** due for payment where it has not been possible to follow the normal requisitioning process: Less than £25,000	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	See 4.1 above Authorised List: "Authorised Signatory List"
	£25,000 and above, but less than £100,000	Directors of Operations /Medical Directors/Directors of Nursing/Deputy CFO/Directors of Finance	
	£100,000 and above, but less than £250,000	Executive Directors	
	£250,000 and above, but less than £1,000,000	Chief Financial Officer	
	£1,000,000 and above, but less than £2,500,000	Chief Executive	
	£2,500,000 and above	Chief Executive on direction of the Board of Directors	
	Approval of invoices paid through national procurement process and underwritten by NHS England	Director of Commercial and Contracting	Where NHS Supply Chain invoices include products ordered through the national procurement, these invoices can be paid without the formal checking process, on the basis that the risk of non-receipt will be underwritten by NHS England
4.4	Authorisation of petty cash payments	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis(for the Chief Financial Officer).	The authorising officer must be the claimant's line manager or above Authorised List: "Authorised Signatory List"

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
4.5	Authorisation of employee expenses claims	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	The authorising officer must be the claimant's line manager or above. Any expenses claimed by the Chairman shall be authorised by the Chief Executive, or by the Chief Financial Officer if payments relating to the Chief Executive are included within the claim.
4.6	Authorisation of manpower returns	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	The authorising officer must not be included on the return and must be senior to all staff listed on the return
4.7	Authorisation of timesheets	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer). Authorised List: "Payroll Authorised Signatory List"	
4.8	Authorisation of agency timesheets and payments	Executive and Directors of Operations / General Managers, who will determine the extent of further delegation, which will be notified to and agreed by the Director of Financial Management Information and Analysis (for the Chief Financial Officer). Authorised List: "Integra Authorised Signatory List"	**The authorising officer must be an authorised signatory of the Trust and must have knowledge of the agreed rate and therefore the value of the timesheet being signed.**

	PHARMACY ORDERS

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REF	RESPONSIBILITY	DELEGATION ARRANGEMENTS	FURTHER INFORMATION
	Pharmacy Orders • Up to £20,000 • Up to £100,000 • Up to £500,000 • Over £500,000	 Pharmacy Stores Manager Deputy Chief Pharmacist Chief Pharmacist Chief Executive	**Pharmacy orders are processed on ASCRIBE Pharmacy system**

5	INCOME AND DEBT WRITE-OFF		
5.1	Authorisation of invoice requests	Executive Directors, Directors of Operations and Deputy Director of Operations, who will determine the extent of further delegation. These will be notified to and agreed by the Director of Financial Operations (for the Chief Financial Officer).	Authorised List: "Oracle Authorised Signatory List"
5.2	Authorisation of credit notes (non-healthcare income)	Authorised list maintained by the Director of Financial Operations	Authorised list: "List of Trust officers permitted to approve credit notes"
5.3	Authorisation of discounts	Authorised list maintained by the Director of Financial Operations	Authorised list: "List of Trust officers permitted to authorise discounts on invoices"
5.4	Authorisation to refer debts to debt collection agency	Chief Financial Officer	Process operated by Director of Financial Operations
5.5	Authorisation of debt write-off:		Threshold refers to debtor account balance proposed for write-off, not individual invoice value
	Less than £25,000	Deputy CFO or Director of Financial Operations	
	£25,000 and above but less than £50,000	Chief Financial Officer	
	£50,000 and above but less than £150,000	Chief Executive	
	£150,000 and above	Board of Directors	

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5.6	Monitoring of Debt Write-off	Audit Committee on behalf of the Board of Directors	A report must be submitted every 6 months to the Audit Committee by the Director of Financial Operations

6	**LOSSES AND SPECIAL PAYMENTS**		
6.1	Authorisation of losses and special payments, including ex-gratia payments:		
	Less than £5,000	Financial Controller	
	Above £5,000 but less than £25,000	Deputy CFO/Director of Financial Operations	
	Above £25,000 but less than £50,000	Chief Financial Officer	
	£50,000 and above	Board of Directors	
6.2	Authorisation of clinical negligence payments	Chief Financial Officer	
6.3	Monitoring of losses and special payments	Audit Committee	A report must be submitted annually to the Audit Committee by the Director of Financial Operations
6.4	Authorisation of early retirement, redundancy and other termination payments to staff:		All payments should be checked with HR with respect to regulations of these payments by HM Treasury and the NHS regulator. The Board must be notified of any payment requiring external approval.
	Less than £20,000	Directors of Operations	
	£20,000 and above, but less than £50,000	Chief Financial Officer	
	£50,000 and above,	Chief Executive	

7	**BUDGETARY CONTROL**		
7.1	Delegation of budgets	Chief Executive and Chief Financial Officer	
7.2	Approval of virements (budget transfers): - Within a budget and within a budget type (pay, non-pay or income) - Between pay and non-pay authorised control totals	Budget holder and Director of Financial Management Information and Analysis Site Chief Executives, Chief Financial Officer and Chief People Officer	

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7.3	Approval of transfers from reserves	Chief Financial Officer	Managed by Deputy CFO/Director of Financial Management Information and Analysis

8	**STORES**		
8.1	Management and control of stores: - Warehouse, Receipt & Distribution - Pharmacy - Other Stores	- King's IFM Director of Supply Chain and Clinical Procurement - Chief Pharmacist - Director of Operations or Executive Director	

9	**BANK ACCOUNTS AND PAYMENT METHODS**		
9.1	Opening of bank accounts	Chief Financial Officer	Managed by Director of Financial Operations
9.2	Signing of cheques for cash, signing of other cheques, and authorisation of CHAPs payments & BACs payment schedules	Authorised signatory list: "Authorisation of Payments from Trust Bank Accounts"	Lists to be maintained by the Director of Financial Operations and approved by the Chief Financial Officer

10	**FEES AND CHARGES**		
10.1	Approval of fees and charges		

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	Setting Fees, Charges and agreeing patient service contracts Private Patient, Overseas Visitors, Income Generation, Trust sponsorship and other patient related services • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO / Director of Financial Strategy, Planning and Investment Chief Financial Officer	
	Price of NHS Contracts • Setting fees and charges for contracts up to £100,000 per annum • Setting fees and charges for contracts over £100,000 per annum	Deputy CFO / Director of Financial Strategy, Planning and Investment Chief Financial Officer	

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	Rental Agreements • Where annual charge does not exceed £10,000 and/or term does not exceed five years; • Where annual charge exceeds £10,000 and/or term exceeds 5 years • Where annual charge exceeds £100,000 and/or term exceeds 10 years • Where annual charge exceeds £250,000 and/or term exceeds 15 years •	Deputy CFO Chief Financial Officer Chief Executive Board of Directors	

11	**STANDARDS OF BUSINESS CONDUCT**		
11.1	Maintenance of the register of interests:		Maintained by the Foundation Trust Office
	Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Site Directors of Operations	
11.2	Maintenance of gifts and hospitality registers:		Maintained by the Foundation Trust Office
	Executive Board of Directors and Trust Management	Chief Executive	
	Other Staff	Executive Directors / Site Directors of Operations	
11.3	Monitoring of gifts and hospitality registers	Audit Committee on behalf of the Board	To report annually to the Audit Committee

12	**INSURANCE**		
12.1	Insurance arrangements	Chief Financial Officer	Managed by Director of Financial Strategy, Planning and Investment

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13	FRAUD AND IRREGULARITY		
13.1	Counter fraud and corruption work in accordance with the NHS standard contract and NHS Counter Fraud Authority standards for providers.	Chief Financial Officer (Delegated to Director of Financial Operations)	In liaison with Local Counter Fraud Specialist and the NHS Counter Fraud Authority as appropriate
13.2	Investigation of suspected cases of irregularity not related to fraud or corruption	Chief Finance Officer	Process operated by Head of Security

14	INVESTMENTS		
14.1	Approval of Treasury Management Policy	Board of Directors	
14.2	Investment decisions	Board of Directors	Process operated by Director of Financial Operations (related to cash investments)

15	BORROWING		
15.1	Approval of loans:		
	Loans with repayment periods of over one year	Board of Directors	
	Loans with repayment periods of less than one year	Chief Executive	Managed by Director of Financial Operations

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Table 2: Oracle Authorisation Matrix – Delegation Limits

Level	Staff Group	Max Approval Level
Level 3	General Manager / Clinical Director / Head of Nursing / Deputy Director of Operations	£25,000
Level 2	Director of Operations / Medical Director / Director of Nursing / Deputy CFO / Director of Financial Operations / Director of Capital, Estates & Facilities	£100,000
Level 1	Executive Directors	£250,000
Level 0	Chief Financial Officer	£1,000,000
Level 0	Chief Executive	None*

* this relates to payment of invoices and raising POs, not the decision to spend.
** Any orders above £5m requires Board approval prior to sign-off.

Note that all new investment decisions need to be approved via the Investment process.

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Table 3: Required Number of Quotes and Tenders

All financial limits quoted are the total for the life of the contract. For recurring services, where the Trust are likely to require the service for at least 4 consecutive years, the 'value' shall be based on a 4 year period, multiplying the baseline spend by 4 in order to calculate this value,

Limits	Staff Group
Under £10,000	Manager's discretion, in line with Table 2 Authorisation limits
Above £10,000 and up to £138,760	Opportunities to be advertised on Contracts Finder, or sourced via framework contracts by the procurement team (KFM).
Above £138,760	Opportunities to be advertised on Contracts Finder & Find a Tender Service, or sourced via framework contracts by the procurement team (KFM).

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APPENDIX B

Summary of Minimum retention periods for records

(For full details see Annex D2 of the NHS Records Management Code of Practice. The following table is subject to the provisions of the NHS Records Management Code of Practice, as may be amended from time to time.)

No.	Class of Document	Retention Period
	FINANCIAL	
1.	Salaries and Wages Records	10 Years after the end of the financial year to which they relate.
2.	Pay sheets and records of unpaid salaries and wages.	6 years after the end of the financial year to which they relate.
3.	Copies of forms SD55 (ADP) and SD55J	10 Years after the end of the financial year to which they relate.
4.	Principal ledger records including cashbook, ledgers and journals.	6 Years after the end of the financial year to which they relate.
5.	Bills, Receipts and Cleared Cheques.	6 Years after the end of the financial year to which they relate.
6.	Debtors Records.	2 years after the end of the financial year in which they are paid or are written off, but at least 6 years in respect of any unpaid account which has not yet been written off.
7.	Creditor Payments Records	3 Years after the end of the financial year to which they relate.
8.	Requisitions	1.5 years after the end of the financial year to which they relate.
9.	Minor accounting records; pass-books, bank statements, deposit slips, cheques; petty cash expenditure accounts, travel and subsistence records, minor vouchers, duplicate receipt books etc.	2 years after the end of the financial year to which they relate.
10.	Cost accounts prepared in accordance with the directions of the Secretary Of State or at the request of the department.	3 years after the end of the financial year to which they relate.
11.	Tax Forms	6 years after the end of the financial year to which they relate.
12.	V.A.T Records	6 years after the end of the financial year to which they relate.
13.	Budgets	2 years from the completion of the audit.
14.	Major establishment records including personal files, letters or appointments, contract references and related correspondence and records of leave.	6 years after the officer leaves the services of the hospital or on the date on which the officer would reach the age of 70, whichever is the later. Provided that if an adequate summary of the personal and health record is kept for this period, the main records may be destroyed after the officer leaves the hospital's service.
15.	Minor establishment records e.g. leave records, timesheets	2 years from the completion of the audit.
16.	Stores Records - Major (Stores Ledger Etc.)	6 years after the end of the financial year to which they relate.

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17.	Stores Records – Minor (requisitions, issue notes, transfer vouchers, goods received books, delivery notes etc)	1.5 years after the end of the financial year to which they relate.
18.	Audit Reports.	2 years after the formal clearance by the appointed auditor.
19.	Accounts – Annual (Final - One set only)	Permanent
20.	Accounts – Working Papers	3 years after the end of the financial year to which they relate.
21.	Documents other than those of permanent relevance in relation to trust funds and the terms of any trusts administered by health authorities.	6 years after the financial year in which the trust monies are finally spent or the gift in kind was accepted.

	NON-FINANCIAL	
22.	Property Acquisitions / Disposal Records	Permanent
23.	Buildings and engineering works, inclusive of projects abandoned or deferred - key records (e.g. final accounts, surveys, site plans, bills of quantities)	Permanent
24.	Contracts – non sealed (other) on termination	6 years after the expiry date of the contract.
25.	Contracts – sealed and associated records	15 years after the expiry date of the contract. .
26.	Tenders - Unsuccessful	6 years after the end of the financial year to which they relate.
27.	Inventories (not in current use) of items having a life of less than 5 years	1.5 years after the end of the financial year to which they relate
28.	Records of custody and transfer of keys.	1.5 years after the end of the financial year to which they relate.
29.	Patient activity data	3 years after the end of the financial year to which they relate.

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Meeting:	Board of Directors	Date of meeting:	8 December 2022
Report title:	Board Assurance Framework – Q3 Update	Item:	11
Author:	Siobhan Coldwell	Enclosure:	
Executive sponsor:	Prof Clive Kay, Chief Executive		
Report history:	Risk and Goverance Committee/relevant Committees		

Purpose of the report

To provide the committee with an update on the relevant aspects of the Board Assurance Framework and proposed actions.

Board/ Committee action required (please tick)

Decision/ Approval		**Discussion**		**Assurance**	✓	**Information**	

Recommendation

The Committee is asked to note the updates to the BAF over the last quarter and consider whether any further updates are needed before submission to relevant committees and Board.

Executive summary

The Trust's revised Board Assurance Framework (BAF) was approved by the Board in March 2022.

There are currently 10 strategic risks included on the BAF. Five of the 10 risks are rated 'Red' with a score of 20 or 16 including:

- Recruitment and Retention (BAF 1)
- Financial Sustainability (BAF 3)
- Maintenance and development of the Trust's estate (BAF 4)
- High Quality Care (BAF 7);and
- Demand and Capacity (BAF 9).

Since the Board considered the BAF in September, all of the risks have been reviewed and the BAF has been updated to reflect any additional controls and/or mitigations and sources of assurance. The actions to address any identified gaps in controls and/or assurance have also been updated where relevant. The High Quality Care rating has been increased to reflect potential weaknesses in the current quality assurance framework. This was agreed at Quality People and Performance Committee on 24/012022. The IT systems risk target score has been increased, in recognition of the increased threat of cyber attacks. Additional mitigations have been put in place.

A summary of the updates is presented in **Table 1**.

King's College Hospital NHS Foundation Trust

Strategy					
Link to the Trust's BOLD strategy				**Link to Well-Led criteria**	
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*			✓	**Leadership, capacity and capability**
				✓	**Vision and strategy**
✓	**Outstanding Care**: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*				**Culture of high quality, sustainable care**
				✓	**Clear responsibilities, roles and accountability**
✓	**Leaders in Research, Innovation and Education:** *We continue to develop and deliver world-class research, innovation and education*				**Effective processes, managing risk and performance**
				✓	**Accurate data/ information**
✓	**Diversity, Equality and Inclusion at the heart of everything we do:** *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*				**Engagement of public, staff, external partners**
					Robust systems for learning, continuous improvement and innovation
	Person- centred	**Sustainability**			
	Digitally- enabled	**Team King's**			

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Table 1: Summary of key changes from Q2

BAF Risk	Key updates
7. High Quality Care	**Score** **16 – increased from 12.** **Controls and mitigations** • Policy and clinical guidelines Framework • MEG audit process • Integrated Quality Report **Assurance** • CQC Inspection – Orpington – Safe domain downgraded to inadequate, overall rating downgraded to requires improvement • CQC Maternity action plan in place • Internal Audit reports 202/23 – Data Quality (partial assurance with improvements required) • CQC Well-Led Inspection (Nov 2022) • CQC Core inspections of Adult Medicine and Paediatrics (Oct 2022 – outcomes as yet unknown) **Actions Planned** • Executive-led Quality Assurance Group • Strong Roots, Quality Care
9. Demand and Capacity	**Actions Planned** • Review of arrangements for services e.g. ENT and cancer pathways underway. • Action plans to address ambulance handover at both sites
10. IT systems	**Controls and Mitigations** • New monthly joint meeting in place to test readiness for a cyber-attack, Membership includes key 3rd parties including Viapath and KFM,

King's College Hospital NHS Foundation Trust

Board Assurance Framework

Summary – Q3 2022/23

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	**16 (4 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	**20 (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	**16 (4 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)**	↔	8

- **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

King's College Hospital NHS

BAF 1				16
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 2022/23	

Strategy and Risk Register						
Link to Strategy	Brilliant People	✓	Person- centred		Link to BAF & CRR	SR2 – Culture & Values 3866- Staffing Vacancies
	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 (2022/23)	Q2 (2022/23)	Q3 (2022/23)	Q4 (2021/22)	Change from previous quarter	Gross risk	Target risk*
Likelihood	**4**	4	4	4	↔	5	12
Consequence	**4**	4	4	4		5	
Risk Score	**16**	16	16	16		25	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• King's People & Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions • Dedicated recruitment campaigns for specific 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 supply groups • Engagement in King's Health Partners (KHP) – training and development opportunities • King's Kaleidoscope launched to support learning and development opportunities • Recruitment Inclusivity Audit – to identify opportunities where King's can further develop recruitment processes	• Safer staffing reporting to QPPC 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	

Actions planned			
Action	**Lead**	**Due date**	**Progress update**
People & Culture Plan	CPO	June 2022	The People and Culture Plan (2022-2026), was formally launched in June 2022.
Roadmap to Inclusion	Director of EDI	June 2022	The Roadmap to Inclusion (2022-2024) was formally launched in June 2022.
Brilliant People Week	CPO	June 2022	To celebrate the launch of the People and Culture Plan and the Roadmap to Inclusion, we held our second Brilliant People week
Review and refresh of appraisal	CPO	Q1/Q2 2022/23	Revised appraisal process launched for 2022/23
Establishment Review	CPO	Q1/Q2 2022/23	Undertaking a Trust wide review of vacancies to understand enablers to fill posts
Development of leadership development programme and leadership coaching offer	CPO	Q1/Q2 2022/23	First cohort of managers commencing 'Essentials' programme in July 2022
Establish a training academy for KCH nursing and midwifery staff	CNO/CFO	Q4 2022/23	A business case to establish a training academy has been approved
Refresh workforce policies and procedures to reflect King's Values e.g. Values-based recruitment (See BAF 2)	CPO	Q1-Q4 2022/23	Continue to embed the Trust values in our policies and procedures to ensure we are a clinically led, values driven organisation

King's College Hospital NHS Foundation Trust

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 2022/23	

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 (2022/23)	Q2	Q3 (2022/23)	Q4 (2021/22)	Change	Gross risk	Target risk*
Likelihood	**3**	3	3	3	↔	4	9
Consequence	**4**	4	4	4		4	
Risk Score	**12**	12	12	12		16	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• EDI Roadmap 2022-24 - to align activity planning and our longer term strategic ambitions • King's People & Culture Plan – to support delivery of the BOLD vision and 'Brilliant People' ambitions • EDI training programmes e.g. Active Bystander, Trans awareness • 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 • Violence and aggression reduction programme	• EDI quarterly progress reporting to QPPC • People & Culture Plan updates to SRP and QPPC • EDI Roadmap updates 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	
• Health & Wellbeing Framework • Review and refresh of workforce policies to embed our new values (See BAF 1)	• Composite culture measure • Reporting dashboard • EDI Dashboard

Actions/ Activities planned			
Action	**Lead**	**Due date**	**Update**
Roadmap to Inclusion	Director of EDI	Q2 2022/23	The Roadmap to Inclusion (2022-2024) was formally launched in June 2022.
People & Culture Plan	CPO	June 2022	The People and Culture Plan (2022-2026), was formally launched in June 2022.
Brilliant People Week	CPO	June 2022	To celebrate the launch of the People and Culture Plan and the Roadmap to Inclusion, we held our second Brilliant People week
People and Culture Committee	CPO/ Director of EDI	Q1 2022/23	First meeting of the new committee was held in May 2022, and subsequent meetings are scheduled bi-monthly
King's People Priorities	CPO	Q1/Q2/Q3 2022/23	Following the publication of the 2021 National Staff Survey results, all Care Groups and Corporate Teams have agreed three People Priorities to address the issues highlighted in the national staff survey
Develop an EDI reporting dashboard	Director of EDI	Q3 2022/23	EDI Dashboard now developed and information from this is being used to develop appropriate interventions. Further development is ongoing.
Develop a framework to better measure our culture and staffs' sense of belonging	Director of EDI	TBC	

King's College Hospital NHS Foundation Trust

BAF 3				20
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	Oversight Committee	Finance and Commercial Committee	
Executive Group	King's Executive	Latest review date	Q3 2022/23	

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 (22/23)	Q2 (22/23)	Q3 (22/23)	Q4 (21/22)	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	5	5	4	↔	5	8
Consequence	4	4	4	4		4	
Risk Score	16	20	20	16		20	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative & Planned)**
• Annual integrated activity financial plan • Capital prioritisation process – 2022/23 • Key financial system controls framework • Investment Board review and challenge of revenue and capital business cases. Board committee 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 and ongoing progress discussions with NHSE/I • Transformation programmes in place to support improvements in efficiency and productivity • Budget holder training • Engagement with APC and ICS partners & Finance Leads to support SEL system financial planning • Long term energy contracts in place	• Unqualified (Clean) External Audit accounts and VFM opinion – 2021/22 • Financial performance reporting (22/23 plan) – KE, FCC & Board • Achievement of 2021/22 plan • SOF 4 Exit Plan progress updates to Audit and FCC • Internal audit reports 2020/21, including COVID-19 Financial Governance (*Significant assurance with minor improvement opportunities*) • Internal audit reports 2021/22 - Financial planning/ budgetary responsibility (*Significant assurance with minor improvement opportunities*)
	• NHS System Oversight segmentation – SOF4 • Financial performance reporting - Underlying deficit 22/23 • Unfunded pay award (2022/23)

Gaps in controls & assurances	
• Review of Scheme of Delegation and Standing Financial Instructions (SFIs) (Control) • 2022/23 CIP delivery oversight (Assurance) • Balance sheet risk (Trust in-year financial performance is in line with other Trusts, but impact greater due to lack of flexibility in Trust finances).	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Review and refresh of Scheme of Delegation and SFIs	CFO/ DCA	Q32021/22	The review of the SFIs is complete and the updated document was approved by Audit Committee in in October 2022. It will go to Board in Dec 2022 for ratification.
Review current arrangements to support the delivery and oversight of the 22/23 CIP plan	CFO	Sept 2022	Reporting and PMO arrangements put in place to monitor 22/23 plan. Plans are being reviewed, but progress has been slow in some areas. By end Aug 2022, £20m schemes had been assessed as 'Green' (i.e. deliverable). This is well short of the requirement and impacts on the forecast moving forward.
COVID-19 Impact to be described and impact assessed.	D/CFO	Sept 2022	M4 Forecast presented to FCC in Sept

King's College Hospital NHS Foundation Trust

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 2022/23	

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	4	4	4	↔	5	8
Consequence	4	4	4	4		5	
Risk Score	16	16	16	16		25	

Controls and Assurance	
Key controls & mitigations	**Assurances (positive, neutral, negative)**
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 22/23 • 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 QPPC • H&S training compliance • IPC BAF • Internal audit 21/22 – Infection, Prevention & Control • Quarterly capital programme progress updates reported to Major Projects Committee • Internal Audit 2021/22 - Major Estates Projects – amber/green rated. • Estate (site) compliance report • Internal audit review 20/21 – Estate safety and compliance • Backlog maintenance log – funding requirement
Gaps in controls & assurances	
• Future capital and estate planning - capital funding allocation now confirmed for 22/23, supported by a capital plan. No funding allocation post 2022/23 at this stage. • Impact of inflation on capital programme presents an increasing risk to delivery.	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Implementation of external review recommendations	CFO	Multiple	Progress periodically reported to Risk and Governance and Audit Committees
Delivery of 2022/23 capital & estates plan	CFO	31/3/2022	Progress to be monitored via MPC
Delivery of the (5-10 yr) Trust Estates plan	CFO	31/3/2023	

King's College Hospital NHS Foundation Trust

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	Q4 2021/22	

Strategy and Risk Register

Link to Strategy					Link to BAF & CRR
	Brilliant People		Person- centred		
	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	3	3	3	↔	4	9
Consequence	4	4	4	4		4	
Risk Score	**12**	**12**	**12**	**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 • Final Board approval of the FBC following Joint Investment Committee approval • Project plan – key milestones identified • Programme Governance arrangements in place e.g. Apollo Programme Board • Joint Apollo Oversight Committee • 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	
• Benefits realisation plan	

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

King's College Hospital NHS Foundation Trust

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 2022/23	

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 (22/23)	Q2 (22/23)	Q3 (21/22)	Q4 (21/22)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	6
Consequence	3	3	3	3		3	
Risk Score	**9**	**9**	**9**	**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 • 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	Update
Develop plans to increase the Trust's accredited research capacity at the PRUH	CMO	Ongoing	A research nurse has been appointed, but space constraints continue to be a concern.
Launch an Innovation Steering Group to set the direction for innovation across the Trust	Director of Strategy	December 2022	Delayed

King's College Hospital NHS Foundation Trust

BAF 7				16
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 2022/23	

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 (2022/23)	Q2 (2022/23)	Q3 (2022/23)	Q4 (2021/22)	Change from previous quarter	Gross risk	Target risk*
Likelihood	**3**	3	4	3	↑	5	6
Consequence	**4**	4	4	4		4	
Risk Score	**12**	12	16	12		20	

Controls and Assurance	
Key controls & mitigations	**Assurances (Positive, Negative, Planned)**
• 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 • Datix IQ implementation to support the identification of quality trends • Thematic review process developed for 'amber' incidents • Outstanding care programme	• CQC patient survey reports • Quality performance reporting to KE, QPPC and Board • Safe Nurse & Maternity 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*) • Internal Audit reports 2021/22 – Risk management (*Significant assurance with minor improvement opportunities*) • Internal Audit reports 2021/22 – Adult safeguarding (*Significant assurance with minor improvement opportunities*) • GGI Quality Governance Programme Report • Incident reporting backlog • Outstanding complaints backlog • External service reviews (ad hoc)

King's College Hospital NHS Foundation Trust

• Policy and clinical guidelines framework • MEG Audit Process • Integrated Quality Report	• CQC ED reports (DH and PRUH)– 2021 and action plan progress updates • CQC Inspection – Orpington – Safe domain downgraded to inadequate, overall rating downgraded to requires improvement • CQC Maternity action plan in place • Internal Audit reports 202/23 – Data Quality (partial assurance with improvements required)
	• CQC Well-Led (Nov 2022) • CQC DH Inspections – Medicine/Paediatrics (Oct 2022)

Gaps in controls & assurances

• Implementation of external review actions • Quality improvement assurance • Safer medical staffing metrics	

Actions Planned

Action	Lead	Due date	Update
Complete a review of the Trust's quality governance framework	Director of Quality Governance	Q2 2022/23	Review is ongoing, supported by Deloitte
Complete thematic review programme (Amber incidents)	Chief Nurse	Q3 2022/23	Reviews are ongoing.
Strong Roots, Quality Care	Chief Executive	Q3 2022/23	Programme developed and being implemented across the Trust.
Executive-led Quality Assurance Group established	Chief Executive	Q3 2022/23	Meetings in place. Initial focus is on CQC response.

King's College Hospital NHS Foundation Trust

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 2022/23

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	3	3	3	↔	4	9
Consequence	3	3	3	3		4	
Risk Score	9	9	9	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) • Trust's Anchor Programme	• 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 – Progress updates 21/22
Gaps in controls & assurances	
• APC governance and decision-making arrangements are in development • Partnership mapping (community & voluntary) • Oversight – improvements in equality of access, experience and outcomes • System planning arrangements – 2022/23	

Actions planned			
Action	**Lead**	**Due date**	**Update**
SEL APC governance framework to be developed and agreed	CEO	March 2022	The revised APC Committee-in-Common met on 28/3/22. The governance proposals have been agreed by all APC partners. Work is underway to progress the actions identified in the proposals to implement the model.
Establish a 'Trust Anchors' programme to align with the ICS Anchors initiative and coordinate current 'anchor institution activities	Director of Strategy	September 2022	An overview of the Trust's Anchors programme was presented to the Trust's Strategy, Research & Partnerships Committee
Review and map existing community and voluntary group partnerships to support diversification of community engagement	Director of EDI	December 2022	
Develop an improvement plan to address key health inequalities	Director of EDI	Q4 2022/23	

King's College Hospital NHS Foundation Trust

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	Q2 2022/23	

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 2022/23	Q2	Q3 2022/23	Q4 2021/22	Change from previous quarter	Gross risk	Target risk*
Likelihood	4	4	4	4	↔	5	9
Consequence	4	4	4	4		5	
Risk Score	**16**	**16**	**16**	**16**		25	

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) • Engagement with APC/ ICS partners to develop and progress further plans to maximise use of system resources • DH Emergency Care Standard improvement plan	• 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, diagnostics • Patient Outcomes report – quarterly presented to QPP • SEL APC elective recovery performance • Internal Audit Review 21/22 – Site Governance (*Significant assurance with minor improvement opportunities*) • Modernising Medicine programme updates reported to Major Projects Committee – oversight of delivery and review of KPIs • PRUH & SS site and service development updates reported to Major Projects Committee • Internal Audit Review 21/22 – PRUH Discharge • IPR - performance metrics are routinely reported to KE, QPPC and Trust Board e.g. ECS

Gaps in controls & assurances	
• Additional site and workforce capacity	

Actions/Activities planned			
Action	**Lead**	**Due date**	**Update**
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. Modernising Medicine Programme ongoing. See BAF Risk 4 (Estate maintenance and development) Valmar options appraisal ongoing.
Workforce planning and recruitment activities to support increased workforce capacity	CPO	Multiple – See BAF 1	See BAF Risk 1 – Recruitment & Retention
Review of arrangements for services e.g. ENT and cancer pathways underway.	Site CEOs	By end Q3	
Action plans to address ambulance handover at both sites	Site CEOs	By mid-October	Action complete.

King's College Hospital NHS Foundation Trust

BAF 10				12
If tiThe 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 2022/23	

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 (22/23)	Q2 (22/23)	Q3 (21/22)	Q4 (21/22)	Change from previous quarter	Gross risk	Target risk*
Likelihood	3	3	3	3	↔	4	8
Consequence	4	4	4	4		5	
Risk Score	12	12	12	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 • New monthly joint meeting in place to test readiness for a cyber-attack, Membership includes key 3rd parties including Viapath and KFM,	• Information governance reports to Audit Committee • Data security and protection training compliance • 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* • Improving cyber security resilience report
Gaps in controls & assurances	

Actions planned			
Action	**Lead**	**Due date**	**Update**
Implementation of internal audit recommendations	CDIO	Q1 2022/23	Progress reviewed by RGC. Progress in line with expectation.

King's College Hospital NHS Foundation Trust

Meeting:	Board of Directors	Date of meeting:	8 December 2022
Report title:	CQC Statement of Purpose	Item:	12
Author:	Kudzai Mika	Enclosure:	
Executive sponsor:	Clare Williams, Acting Chief Nurse and Executive Director of Midwifery		
Report history:	n/a		

Purpose of the report

The Statement of Purpose has been updated and should be approved by the Board of Directors prior to submission to the CQC.

Board/ Committee action required (please tick)

Decision/ Approval	✓	Discussion		Assurance		Information	

The Board of Directors is asked to approve the Statement of Purpose.

Executive summary

The Statement of Purpose is a legally required document that includes a standard set of information about a provider's service. Statements must describe:

- The provider's aims and objectives in providing the service.
- Details of the services provided including the service types (for example, hospice services) and the service user bands (for example, adults aged 65+).
- The health or care needs the service sets out to meet.
- The provider's and any registered managers' full name(s), business address(es), telephone number(s) and (where available) email address(es).
- Details about the legal status of the provider (for example, whether they are an individual, company, charity, or partnership).
- The address CQC must use to send formal documents to registered providers and managers. Formal documents include legally required notices and inspection reports. ('Addresses for service' can be email addresses where a provider or manager consents to receiving documents in this way)
- All of the locations where regulated activities are actually provided, or where they are provided from (listed as 'locations' on your certificate of registration together with any service branches not listed as locations).

It must be kept up to date. The attached document has been updated to reflect the opening of Willowfield, and the change of Registered Manager (now Clare Williams).

Strategy

Link to the Trust's BOLD strategy		Link to Well-Led criteria	
✓	**Brilliant People:** *We attract, retain and develop passionate and talented people, creating an environment where they can thrive*	✓	**Leadership, capacity and capability**
			Vision and strategy
	Outstanding Care: *We deliver excellent health outcomes for our patients and they always feel safe, care for and listened to*		**Culture of high quality, sustainable care**
			Clear responsibilities, roles and accountability
	Leaders in Research, Innovation and Education: *We continue to develop and*		**Effective processes, managing risk and performance**

	deliver world-class research, innovation and education				**Accurate data/ information**
	Diversity, Equality and Inclusion at the heart of everything we do: *We proudly champion diversity and inclusion, and act decisively to deliver more equitable experience and outcomes for patients and our people*				**Engagement of public, staff, external partners**
					Robust systems for learning, continuous improvement and innovation
	Person- centred	**Sustainability**			
	Digitally- enabled	**Team King's**			

Key implications	
Strategic risk - Link to Board Assurance Framework	High Quality Care
Legal/ regulatory compliance	Up to date statement of purpose is a legal requirement.
Quality impact	
Equality impact	
Financial	
Comms & Engagement	
Committee that will provide relevant oversight QPPC	

King's College Hospital
NHS Foundation Trust

Statement of purpose

Health and Social Care Act 2008

Part 1

King's College Hospital NHS Foundation Trust
Legal status: Organisation

King's College Hospital
Denmark Hill
London
SE5 9RS

020 3299 5252
www.kch.nhs.uk

Statement of purpose, Part 1

Health and Social Care Act 2008, Regulation 12, schedule 3

The provider's business contact details, including address for service of notices and other documents, in accordance with Sections 93 and 94 of the Health and Social Care Act 2008

1. Provider's name and legal status							
Full name[1]	King's College Hospital NHS Foundation Trust						
CQC provider ID	RJZ						
Legal status[1]	Individual	☐	Partnership	☐	Organisation	☒	

2. Provider's address, including for service of notices and other documents	
Business address[2]	King's College Hospital Denmark Hill London, SE5 9RS
Town/city	London
County	Greater London
Post code	SE5 9RS
Business telephone	020 3299 5252
Electronic mail (email)[3]	clare.williams38@nhs.net; clive.kay@nhs.net

By submitting this statement of purpose you are confirming your willingness for CQC to use the **email address** supplied at Section 2 above for service of documents and for sending all other correspondence to you. Email ensures fast and efficient delivery of important information. If you do not want to receive documents by email please check or tick the box below. We will not share this email address with anyone else.

I/we do **NOT** wish to receive notices and other documents from CQC by email	☐

Part 2

King's College Hospital NHS Foundation Trust

Aims and objectives

Aims and objectives *What are your aims and objectives in providing the regulated activities and locations shown in part 3 of this statement of purpose*
King's College Hospital NHS Foundation Trust (King's) is one of the biggest and busiest Trusts in the country, primarily serving the London Boroughs of Southwark, Lambeth, and Bromley, with a population of 1 million people and acting as a tertiary referral centre for millions more. We provide services from the following registered locations: 1. King's College Hospital (KCH), Denmark Hill; 2. Princess Royal University Hospital (PRUH); 3. Orpington Hospital; 4. Tessa Jowell Health Centre; 5. Coldharbour Works; 6. Beckenham Beacon; 7. Queen Mary's Hospital, Sidcup; 8. The Havens: 8.1. Camberwell 8.2. Paddington 8.3. Whitechapel. We also provide service from the following location registered with the CQC as satellite location or services branches of King's: 9. Satellite Dialysis Units: 9.1. Bromley 9.2. Dartford 9.3. Sydenham 9.4. Thamesmead 9.5. Woolwich (Queen Elizabeth Hospital, King's @Woolwich); 10. Dental Clinics, 15 across South East London; 11. Fetal Medicine Research Institute; 12. Maternity Community Clinics; In support of the COVID-19 pandemic national response, the Trust provides COVID-19 vaccination services via the following two satellite locations: 13. One Bromley Health Hub, The Glades COVID-19 Vaccination Centre (managed by the registered location PRUH) 14. Weston Education Centre COVID-19 Vaccination Centre (managed by the registered location KCH). As an NHS Foundation Trust who provide regulated services from multiple sites, our registered Trust headquarters for all correspondence is the King's College Hospital, Denmark Hill. We provide community services across South East London, which are registered with the CQC as satellite clinics under the Trust headquarters, King's

College Hospital. This includes the following community services with the various locations listed in Part 3 under the location King's College Hospital:

- Satellite Dialysis Units;
- Dental Clinics;
- Maternity Antenatal Community Clinics;
- The Havens, Sexual Assault Referral Centres
- Fetal Medicine Research Institute.

We are proud to provide excellent local services to the people of South East London. People from throughout the UK and beyond also come to us for our world renowned specialist services such as liver, neurosciences, haematology and fetal medicine. We are a world-class teaching and research centre and we are a home to a set of highly specialised diagnostic and emergency care services including one of London's leading trauma centres, a high-volume heart attack centre, and two hyper-acute stroke units.

King's is a pioneer in medical research, with an outstanding record of innovation. We are a founding member of King's Health Partners (KHP) – one of eight accredited Academic Health Science Centres in the UK, committed to delivering better health for all through high impact innovation. And, we are a member of the Shelford Group - a group of the top 10 teaching and research-active NHS Trusts.

King's is home to a number of leading clinical units and research centres, such as the Clinical Age Research Unit, the HIV Research Centre, the Cicely Saunders Institute, the Tessa Jowell Health Centre and the Harris Birthright Centre.

Our 13,500 exceptionally talented and motivated staff are working hard to build a clinically-led organisation that delivers some of the best clinical outcomes in the country.

We work together as Team King's – delivering our best for our patients.

Our five year strategy, 2021 to 2026 is **Strong Roots, Global Reach**; and our vision is to be bold:
Brilliant people
Outstanding care
Leaders in research, innovation and education
Diversity, equality and inclusion at the heart of everything we do

Our Trust values, a Kind, Respectful Team, underpin how we care for each other and our patients. Our values runs through everything we do.

- **Kind**. We show compassion and understanding and bring a positive attitude to our work
- **Respectful**. We promote equality, are inclusive and honest, speaking up when needed.
- **Team**. We support each other, communicate openly, and put patients at the centre.

King's is a partner in Our Healthier South East London (OHSEL), the Integrated Care System that covers the London boroughs of Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark. This comprises Commissioners, local authorities, acute provider Trusts, primary and community care providers.

In partnership with Lewisham and Greenwich NHS Trust, and Guy's and St Thomas' NHS Foundation Trust, King's established an Acute Provider Collaborative (APC). The initial focus of the APC has been to develop a system wide response to the backlog of patients waiting for treatment in a number of high volume, low complexity areas. Overseen by a Committee-in Common, the APC is working to establish specialty-based hubs across South East London, to ensure that all capacity in the system is utilised as far as possible.

We work closely with our contractors to ensure that they adhere to King's Governance processes and structures, and where there are deviations, we ensure that the contractors are registered separately with the CQC as providers of regulatory services at King's.

Part 3

Locations, and

- the people who use our services
- the service types
- the regulated activities

The information below is for location no.:	1	of a total of:	8	locations

Name of location	King's College Hospital
Address	King's College Hospital Denmark Hill London
Postcode	SE5 9RS
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

King's College Hospital, Denmark Hill, is the Trust headquarters for King's College Hospital NHS Foundation Trust. We are one of London's largest and busiest teaching hospitals, with a strong profile of local services primarily serving the boroughs of Lambeth, Southwark, Lewisham and Bromley. Our specialist services are available to patients across a wider catchment area, providing nationally and internationally recognised work in liver disease and transplantation, neurosciences, haemato-oncology and foetal medicine.

The following satellite locations are also registered with the CQC under the King's College Hospital, Denmark Hill, registered location:

Name	Address	Regulated activity
Dental Clinics		
Akerman Road Health Centre	2nd floor, 60 Patmos Road, Brixton, London SW9 6AF	
Balham Health Centre	120 -124 Bedford Hill, Balham, London SW12 9HS	
Brocklebank Health Centre	249 Garratt Lane, Wandsworth, London SW18 4DU	

Edridge Road	Impact House, 2 Edridge Road, Croydon, CR9 1PJ	Treatment of disease, disorder and injury Diagnostic and Screening procedures Surgical procedures
Green Wrythe Lane Clinic	1st Floor, Green Wrythe Lane, Carshalton, Surrey SM5 1JL	
Jenner Health Centre	14 St Germans Rd, Forest Hill, London SE23 1RJ	
Jubilee Clinic	1st Floor, Shotfield, Wallington, Surrey SM6 0HY	
Kingston Hospital NHS Trust (wed only)	Galsworthy Road, Kingston-upon-Thames KT2 7QB	
Lister Primary Care Centre	1st Floor, 101 Peckham Road, Peckham, London SE15 5LJ	
Morden Road Clinic	254 Morden Road, London SW19 3DA	
Surbiton Health Centre	1st Floor, Ewell Road, Surbiton, KT6 6EZ	
Teddington Health & Social Care Centre	18 Queens Road, Teddington, TW11 0LR	
Thornton Heath Health Centre	1st Floor, 61A Gillett Road, Thornton Heath, London CR7 8RL	
Waldron Health Centre	2nd Floor, Suite 6, Amersham Vale, New Cross, London SE14 6LD	
Westmoor Community Clinic	Westmoor Community Clinic, 248 Roehampton Lane, London SW15 4AA	
West Norwood Health Centre	2nd Floor, 25 Devane Way, London SE27 0DF	
Mobile Dental Unit	Sited on King's Business Park c/o 245A Coldharbour Work SW9 8RR	
Fetal Medicine		
Fetal Medicine Research Institute	16-20 Windsor Walk, London, SE5 8BB	Treatment of disease, disorder and injury Maternity and midwifery services Termination of pregnancies
Maternity Community Clinics		
Midwives House	65 Coldharbour Lane, London, SE5 9NS	Maternity and midwifery services
Community Midwives Centre	45-47 Caldecott Road, London, SE5 9RL	
Stork on the Hill	Blanchedowne, London, SE5 8HL	
20 Windsor Walk	20 Windsor Walk, London, SE5 8BB	
Ann Bernadt Children's Centre	29 Chandler Way, London, SE15 6DT	
Jubilee Children's Centre	Jubilee Children's Centre, Tulse Hill, SW2 2JE	
Rye Oak Children's Centre	Whorlton Road, London, SE15 3PD	
Kingswood Children Centre	18 Benton's Lane, Norwood, SE27 9UD	
Crawford Children's Centre	Crawford Road, London, SE5 9NF	
The Grove Children Centre	Tower Mill Rd, London SE15 6BP	
Community Vision children's centre	Woodbine Grove, London SE20 8UX	
Blenheim Children's Centre	Blenheim Road, Orpington BR6 9BH	
North Cray Children's centre	North Cray Neighbourhood Centre, Bedens Road, Sidcup, DA14 5JQ	
Danson Children's centre	Danson Youth & Community Centre, Brampton Road, Welling, Kent, DA7 4EZ.	
Biggin Hill children's centre	Sunningvale Ave, Biggin Hill, Westerham, TN16 3TN	

COVID-19 Vaccination Centre		
Weston Education Centre (WEC) COVID-19 Vaccination Centre	Cutcombe Road, London SE5 9RJ	Treatment of disease, disorder or injury

The Denmark Hill site consists of:

- The Emergency Department with Urgent Care Centre provided by Greenbrook
- Critical Care Centre
- General, acute and specialist medicine
- Specialist and Day Surgery
- Major Trauma
- Rehabilitation Services
- Outpatient clinics, including the Willowfield building
- Variety Children's Hospital
- Maternity, Obstetrics and Gynaecology
- Discharge lounge
- Dental Institute
- Caldecot Sexual Health Clinic
- The Haven Camberwell, specialist sexual assault referral centre
- Community Midwifery services
- Mental health services in partnership with South London and Maudsley NHS Foundation Trust.

We also provide services at the Denmark Hill in association with King's College London at the following service branches under the registered location King's College Hospital:

- Academic Neurosciences Centre
- Fetal Medicine Research Institute, which also houses the Harris Birthright Centre and King's Fertility.

The WEC COVID-19 vaccination centre is managed by the KCH registered location in accordance with NHS England and Improvement (NHSE/I) programme as specified by the Joint Committee for Vaccination and Immunisation (JCVI).

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).					
Adults aged 18-65	☐	Adults aged 65+		☐	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☒	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☒
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☒
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☐
Dental service (DEN)	☒
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☒

Regulated activity(ies) carried on at this location		
Personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Nominated Individual(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Surgical procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Diagnostic and screening procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Management of supply of blood and blood derived products etc	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Transport services, triage and medical advice provided remotely	☐	
Nominated Individual(s) for this regulated activity:		
Maternity and midwifery services	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Termination of pregnancies	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Services in slimming clinics	☐	
Nominated Individual(s) for this regulated activity:		
Nursing care	☐	
Nominated Individual(s) for this regulated activity:		
Family planning service	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		

The information below is for location no.:	2	of a total of:	8	locations

Name of location	Princess Royal University Hospital
Address	Princess Royal University Hospital Farnborough Common Kent
Postcode	BR6 8ND
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location

(The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)

Princess Royal University Hospital (PRUH) cares for patients in the boroughs of Bromley and Bexley in addition to Lambeth, Southwark and Lewisham. Many of our services, such as Trauma and Neurosurgery, are delivered on a regional basis, whilst people from throughout the UK and beyond come to us for our world renowned specialist services such as Liver and Fetal Medicine. We will deliver this as part of a joined-up and well-managed healthcare system, built in partnership with GPs, commissioners and other healthcare providers.

The PRUH is the registered location which the following satellite locations are registered with the CQC:

Name	Address	Regulated activity
Bromley Satellite Dialysis Unit	1-3 Ringers Road, Bromley, Kent, BR1 1HX	Treatment of disease, disorder and injury
Dartford Satellite Dialysis Unit	Darenth Wood Road, Dartford, Kent, DA2 8DA	
Sydenham Satellite Dialysis Unit	Worsley Bridge Road, Sydenham, London, SE26 5BN	
Thamesmead Kidney Treatment Centre, Satellite Dialysis Unit	133 Nathan Way, London, SE28 0AB	
Woolwich Satellite Unit (King's @ Woolwich)	Stadium Road. Woolwich. London. SE18 4QH	
COVID-19 Vaccination Centre		
One Bromley Health, The Glades COVID-19 Vaccination Centre	One Bromley Health Hub Unit 260, The Glades High Street, Bromley, BR1 1DN	Treatment of disease, disorder or injury

The PRUH and South Sites consists of:

- The Emergency Department with Urgent Care Centre provided by Greenbrook
- Intensive Care Unit
- General and acute medicine
- Specialist and Day Surgery
- Rehabilitation Services
- Outpatient clinics
- Variety Children’s Hospital
- Maternity, Obstetrics and Gynaecology
- Discharge lounge
- Community Midwifery services
- Mental health services in partnership with Oxleas NHS Foundation Trust.

The Bromley COVID-19 vaccination centre is managed by the PRUH registered location in accordance with NHS England and Improvement (NHSE/I) programme as specified by the Joint Committee for Vaccination and Immunisation (JCVI).

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).						
Adults aged 18-65	☐	Adults aged 65+			☐	
Mental health	☐	Sensory impairment			☐	
Physical disability	☐	People detained under the Mental Health Act			☐	
Dementia	☐	People who misuse drugs or alcohol			☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder			☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)			☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☒
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☒
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☒
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Nominated Individual(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Surgical procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Diagnostic and screening procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Management of supply of blood and blood derived products etc	☐	
Nominated Individual(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Nominated Individual(s) for this regulated activity:		
Maternity and midwifery services	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Termination of pregnancies	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Services in slimming clinics	☐	
Nominated Individual(s) for this regulated activity:		
Nursing care	☐	
Nominated Individual(s) for this regulated activity:		
Family planning service	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		

The information below is for location no.:	3	of a total of:	8	locations

Name of location	Orpington Hospital
Address	Orpington Hospital Sevenoaks Road Orpington Kent
Postcode	BR6 9JU
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)
Orpington Hospital is a registered location that is part of the PRUH and South Sites. Orpington Hospital provides local health care and rehabilitation services to the population living in the London Borough of Bromley. We also provide specialist orthopaedic care at King's Elective Orthopaedic Centre at Orpington Hospital. The purpose-built centre has state-of-the-art operating theatres and a dedicated team of surgeons, anaesthetists, theatre and ward nurses, and therapists, providing the very best of care. Orpington Hospital consists of: • General and acute medicine • Specialist and Day Surgery • Rehabilitation Services • Outpatient clinics • Community Midwifery services.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).					
Adults aged 18-65	☐	Adults aged 65+		☐	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☒	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☒
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☒
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Nominated Individual(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Surgical procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Diagnostic and screening procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Management of supply of blood and blood derived products etc	☐	
Nominated Individual(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Nominated Individual(s) for this regulated activity:		
Maternity and midwifery services	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Termination of pregnancies	☐	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Services in slimming clinics	☐	
Nominated Individual(s) for this regulated activity:		
Nursing care	☐	
Nominated Individual(s) for this regulated activity:		
Family planning service	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		

The information below is for location no.:	4	of a total of:	8	locations

Name of location	Queen Mary's Hospital
Address	Queen Mary's Hospital Frognal Avenue Sidcup, Kent
Postcode	DA14 6LT
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)
Queen Mary's Hospital, Sidcup, is owned by Oxleas NHS Foundation Trust and comprises of several NHS organisations working together with social care to ensure the hospital has a bright future. Queen Mary's is a registered location part of the PRUH and South Sites. Oxleas NHS Foundation Trust have responsibility of the estate. King's services at Orpington Hospital consists of: • General and acute medicine • Specialist and Day Surgery • Dental Services • Outpatient clinics • Community Midwifery services.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).						
Adults aged 18-65	☐	Adults aged 65+	☐			
Mental health	☐	Sensory impairment	☐			
Physical disability	☐	People detained under the Mental Health Act	☐			
Dementia	☐	People who misuse drugs or alcohol	☐			
People with an eating disorder	☐	Learning difficulties or autistic disorder	☐			
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)	☐			

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☒
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☐
Dental service (DEN)	☒
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Nominated Individual(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Surgical procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Diagnostic and screening procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Management of supply of blood and blood derived products etc	☐	
Nominated Individual(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Nominated Individual(s) for this regulated activity:		
Maternity and midwifery services	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Termination of pregnancies	☐	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Services in slimming clinics	☐	
Nominated Individual(s) for this regulated activity:		
Nursing care	☐	
Nominated Individual(s) for this regulated activity:		
Family planning service	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		

The information below is for location no.:	5	of a total of:	8	locations

Name of location	Beckenham Beacon
Address	Beckenham Beacon 395 Croydon Road Beckenham, Kent
Postcode	BR3 3QL
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)
Beckenham Beacon is a community healthcare service part of the PRUH and South Sites. King's services at Beckenham Beacon consists of: • General and acute medicine • Day Surgery • Dental Services • Outpatient clinics • Community Midwifery services.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).					
Adults aged 18-65	☐	Adults aged 65+		☐	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☒	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☐
Dental service (DEN)	☒
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location		
Personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require nursing or personal care	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation for persons who require treatment for substance abuse	☐	
Nominated Individual(s) for this regulated activity:		
Accommodation and nursing or personal care in the further education sector	☐	
Nominated Individual(s) for this regulated activity:		
Treatment of disease, disorder or injury	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Assessment or medical treatment for persons detained under the Mental Health Act	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Surgical procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Diagnostic and screening procedures	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Management of supply of blood and blood derived products etc	☐	
Nominated Individual(s) for this regulated activity:		
Transport services, triage and medical advice provided remotely	☐	
Nominated Individual(s) for this regulated activity:		
Maternity and midwifery services	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Termination of pregnancies	☐	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		
Services in slimming clinics	☐	
Nominated Individual(s) for this regulated activity:		
Nursing care	☐	
Nominated Individual(s) for this regulated activity:		
Family planning service	☒	
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams		

The information below is for location no.:	6	of a total of:	8	locations

Name of location	Tessa Jowell Health Centre
Address	Tessa Jowell Health Centre 72H East Dulwich Grove London
Postcode	SE22 8EY
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)
Tessa Jowell Health Centre is a registered location part of King's, providing outpatients clinics for our patients.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).						
Adults aged 18-65	☐	Adults aged 65+	☐			
Mental health	☐	Sensory impairment	☐			
Physical disability	☐	People detained under the Mental Health Act	☐			
Dementia	☐	People who misuse drugs or alcohol	☐			
People with an eating disorder	☐	Learning difficulties or autistic disorder	☐			
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐	
The whole population	☒	Other (please specify below)	☐			

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☒
Doctors treatment service (DTS)	☒
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☒
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location	
Personal care	☐
Nominated Individual(s) for this regulated activity:	
Accommodation for persons who require nursing or personal care	☐
Nominated Individual(s) for this regulated activity:	
Accommodation for persons who require treatment for substance abuse	☐
Nominated Individual(s) for this regulated activity:	
Accommodation and nursing or personal care in the further education sector	☐
Nominated Individual(s) for this regulated activity:	
Treatment of disease, disorder or injury	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Assessment or medical treatment for persons detained under the Mental Health Act	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Surgical procedures	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Diagnostic and screening procedures	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Management of supply of blood and blood derived products etc	☐
Nominated Individual(s) for this regulated activity:	
Transport services, triage and medical advice provided remotely	☐
Nominated Individual(s) for this regulated activity:	
Maternity and midwifery services	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Termination of pregnancies	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Services in slimming clinics	☐
Nominated Individual(s) for this regulated activity:	
Nursing care	☐
Nominated Individual(s) for this regulated activity:	
Family planning service	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	

The information below is for location no.:	7	of a total of:	8	locations

Name of location	Coldharbour Works
Address	Coldharbour Works 245a Coldharbour Lane Brixton
Postcode	SW9 8RR
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)
Coldharbour works is an outpatients centre where King's provides physiotherapy and outpatient occupational therapy clinics.

No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).							
Adults aged 18-65	☐	Adults aged 65+	☐				
Mental health	☐	Sensory impairment	☐				
Physical disability	☐	People detained under the Mental Health Act	☐				
Dementia	☐	People who misuse drugs or alcohol	☐				
People with an eating disorder	☐	Learning difficulties or autistic disorder	☐				
Children aged 0 – 3 years	☐	Children aged 4-12	☐	Children aged 13-18	☐		
The whole population	☒	Other (please specify below)	☐				

The CQC service type(s) provided at this location	
Acute services (ACS)	☒
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☒
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☐
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☐
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location	
Personal care	☐
Nominated Individual(s) for this regulated activity:	
Accommodation for persons who require nursing or personal care	☐
Nominated Individual(s) for this regulated activity:	
Accommodation for persons who require treatment for substance abuse	☐
Nominated Individual(s) for this regulated activity:	
Accommodation and nursing or personal care in the further education sector	☐
Nominated Individual(s) for this regulated activity:	
Treatment of disease, disorder or injury	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Assessment or medical treatment for persons detained under the Mental Health Act	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Surgical procedures	☐
Nominated Individual(s) for this regulated activity:	
Diagnostic and screening procedures	☐
Nominated Individual(s) for this regulated activity:	
Management of supply of blood and blood derived products etc	☐
Nominated Individual(s) for this regulated activity:	
Transport services, triage and medical advice provided remotely	☐
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Maternity and midwifery services	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Termination of pregnancies	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Services in slimming clinics	☐
Nominated Individual(s) for this regulated activity:	
Nursing care	☐
Nominated Individual(s) for this regulated activity:	
Family planning service	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	

The information below is for location no.:	8	of a total of:	8	locations

Name of location	The Havens
Address	Camberwell Haven in south London, 15-22 Caldecot Rd, London SE5 9RS Paddington Haven in west London, Western Pavillion, St Charles Centre for Health and Wellbeing, Exmoor St, London W10 6DZ Whitechapel Haven in east London, 9 Brady St, London E1 5DG
Postcode	SE5 9RS
Telephone	0203 299 5252
Email	clare.williams38@nhs.net

Description of the location (The premises and the area around them, access, adaptations, equipment, facilities, suitability for relevant special needs, staffing & qualifications etc)	
The Havens are a network of specialist sexual assault referral centres (SARCs) located across London and open 24/7. Our three centres work closely together to ensure that the same level of service is provided wherever a victim of sexual assault presents. We are centres of excellence and our work is internationally recognised as gold standard in the field. The Havens are managed by King's College Hospital NHS Foundation Trust. The service is commissioned and jointly funded by NHS England and the Metropolitan Police Service.	
No of approved places / overnight beds (not NHS)	

CQC service user bands The people that will use this location ('The whole population' means everyone).					
Adults aged 18-65	☐	Adults aged 65+		☐	
Mental health	☐	Sensory impairment		☐	
Physical disability	☐	People detained under the Mental Health Act		☐	
Dementia	☐	People who misuse drugs or alcohol		☐	
People with an eating disorder	☐	Learning difficulties or autistic disorder		☐	
Children aged 0 – 3 years	☐	Children aged 4-12	☐ Children aged 13-18	☐	
The whole population	☒	Other (please specify below)		☐	

The CQC service type(s) provided at this location	
Acute services (ACS)	☐
Prison healthcare services (PHS)	☐
Hospital services for people with mental health needs, learning disabilities, and problems with substance misuse (MLS)	☐
Hospice services (HPS)	☐
Rehabilitation services (RHS)	☐
Long-term conditions services (LTC)	☐
Residential substance misuse treatment and/or rehabilitation service (RSM)	☐
Hyperbaric chamber (HBC)	☐
Community healthcare service (CHC)	☒
Community-based services for people with mental health needs (MHC)	☒
Community-based services for people with a learning disability (LDC)	☒
Community-based services for people who misuse substances (SMC)	☐
Urgent care services (UCS)	☐
Doctors consultation service (DCS)	☐
Doctors treatment service (DTS)	☐
Mobile doctor service (MBS)	☐
Dental service (DEN)	☐
Diagnostic and or screening service (DSS)	☐
Care home service without nursing (CHS)	☐
Care home service with nursing (CHN)	☐
Specialist college service (SPC)	☐
Domiciliary care service (DCC)	☐
Supported living service (SLS)	☐
Shared Lives (SHL)	☐
Extra Care housing services (EXC)	☐
Ambulance service (AMB)	☐
Remote clinical advice service (RCA)	☐
Blood and Transplant service (BTS)	☐

Regulated activity(ies) carried on at this location	
Personal care	☐
Nominated Individual(s) for this regulated activity:	
Accommodation for persons who require nursing or personal care	☐
Nominated Individual(s) for this regulated activity:	
Accommodation for persons who require treatment for substance abuse	☐
Nominated Individual(s) for this regulated activity:	
Accommodation and nursing or personal care in the further education sector	☐
Nominated Individual(s) for this regulated activity:	
Treatment of disease, disorder or injury	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
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Surgical procedures	☐
Nominated Individual(s) for this regulated activity:	
Diagnostic and screening procedures	☐
Nominated Individual(s) for this regulated activity:	
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Maternity and midwifery services	☐
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Termination of pregnancies	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	
Services in slimming clinics	☐
Nominated Individual(s) for this regulated activity:	
Nursing care	☐
Nominated Individual(s) for this regulated activity:	
Family planning service	☒
Nominated Individual(s) for this regulated activity: Mrs. Clare Williams	

Date first published: 31/03/2010
Major review: 26/06/2022
Approved by: CQC Executive Operational Committee, 26/06/2022
Minor update: 13/09/2022
Version: 29.1

Committee Highlight Report for Trust Board			
Committee Chair	Akhter Mateen	Date of Meeting	3 October 2022
Committee:	Audit Committee		

Agenda ref	Item	Link to BAF
3.1	**Procurement Waivers** The Committee considered the half yearly update on the use of procurement waivers. The use of waivers is declining and additional controls have been put in place.	BAF 3 Financial Sustainability
3.2	**Standing Financial Instructions (SFIs)** The Committee considered the revised standing financial instructions. A number of changes have been made including updates to reflect new management structures and changes to procurement rules following the UK's exit from the European Union. The Committee agreed to recommend the SFIs to the Board of Directors for approval, pending confirmation of benchmarking data in relation to the levels of delegation at similar sized Trusts.	BAF 3 Financial Sustainability
4.1	**Information Governance and Management** The Committee considered the annual report from the Chief Digital Information Officer outlining the Trust's approach to information governance and management and the key issues arising during the year in relation to information management, data protection, cyber security, health records and interaction with regulators e.g. the Office of the Information Commissioner. The Committee was assured that appropriate management and controls are in place, but requested an update on cyber security in 6 months, given the increased risk.	BAF 5 Apollo Implementation BAF 10 IT systems
4.2	**Board Assurance Framework** The Associate Director, Corporate Governance provided updates to the BAF over the last quarter including a change to BAF risk 10, IT Risk. The BAF has been updated to reflect any additional controls and/or mitigations and sources of assurance. The actions to address any identified gaps in controls and/or assurance have also been updated as needed. The committee agreed the changes to BAF risk 10.	n/a
4.3	**Corporate Risk** The Director Quality Governance provided key updates on Corporate Risk Register. There are 33 risks on the current corporate risk register following the changes agreed at the Risk and Governance Committee on 20/09/2022. The Committee noted that two risks had been escalated: risk of harm due to long waits in ED and delayed ambulance transfers, and risks to financial recovery.	BAF 3 Financial Sustainability BAF 7 High Quality Care BAF 9 Demand and Capacity

Agenda ref	Item	Link to BAF
5.1.1	**Internal Audit – Progress Update** An update was given on the delivery of the internal audit plan for 2022/23. The Quality Governance review has been deferred to next financial year (2023/24). The review of Risk Management is core to the Head of Internal Audit Opinion and will take place in Q4. The Patient Experience and Child Safeguarding reviews are at risk unless timings can be agreed and committed to.	N/A
5.1.2	**Data Quality Report** The committee received the internal audit of data quality. The overall assessment had received rating of 'partial assurance with improvements required' (amber red). The audit reviewed three indicators: • **RTT 78+ week waits**: received rating of 'significant assurance' (green). • **Core skills training: Resuscitation**: 'partial assurance with improvements required' (amber-red). • **Hand hygiene audits**: 'partial assurance with improvements required' (amber-red). The Committee noted the report and sought assurance on the prioritisation of resuscitation training.	BAF 1 Recruitment and Retention, BAF 7 High Quality Care. BAF9 Demand and Capacity
5.2.1	**Counter Fraud** The committee considered the progress being made to deliver the counter-fraud programme. There have been a number of significant and high value referrals which indicates good awareness of the counter fraud service within the Trust.	BAF 3 Financial Sustainability
5.2.2	**Sickness Absence Management Report** KPMG presented the internal audit review of how sickness absence management is managed at the Trust. A number of recommendations have been agreed and implementation is underway.	BAF 1 Recruitment and Retention BAF 3 Financial Sustainability
5.3	**External Audit Fee proposal – 22/23** The report detailing proposed external audit fees for 2022/23 was presented. The external auditors also provided GT's transparency report and an update recent regulatory changes. This will result in more detailed audit of systems and control and this is reflected in the revised audit fee.	BAF 3 Financial Sustainability
6.1	**Policies** **Counter Fraud and Bribery Policy** Key updates on counter fraud and bribery policy were presented. The policy was approved.	BAF 3 Financial Sustainability
6.2	**Conflict of Interest Policy** A summary of updates on the conflict of interest policy were noted and approved. The Trust's management of the conflict of interest policy was reviewed as part of the 2021/22 Local Counter-Fraud Review and a number of recommendations were made.	BAF 3 Financial Sustainability

Committee Highlight Report for Trust Board			
Committee Chair	Steve Weiner	Date of Meeting	17 November 2022
Committee:	Finance and Commercial Committee		

Agenda ref	Item	Link to BAF
2.1	**Finance Report - M7** At M7, the year to date deficit is £19.8m. The estimated impact of unplanned COVID-19 is c £12m. The Trust is also under-delivering on the cost improvement programme (CIP) (although this was not unexpected). The committee agreed that there is good cost control in place but more focus is need on delivering savings. The committee discussed plans for delivering the CIP noting a pipeline is in place, although further work is needed, including reinforcing the narrative on waste reduction, good housekeeping and effective stock management. The committee noted that governance in this area is being strengthened. The committee noted the cash position. As yet the Trust has not had to draw down additional funding.	
2.2	**KCH Group 2022/23 Capital Financial Position – M7** The Trust noted the M7 capital position. It is anticipated the programme will be delivered by year end. The committee discussed the ICS role in capital allocation moving forward and the implications for the Trust's priorities. In respect of the 2023/4 plan, there is an anticipated £20m overspend, so further work is needed to refine the plan. The committee discussed Apollo and whether any additional costs were anticipated. At this point, it is thought all potential issues have been addressed within agreed budgets.	
2.3	**SOF 4 Update** The Committee noted that the Trust has met the exit criteria it agreed with the NHSI Recovery Support Programme and has met with regional and national NHS representatives to present the case for exit. The committee thanked the CFO and Deputy CFO for the work they had done to ensure the Trust met the exit criteria.	
3.1	**BAF risk 3 – Financial Sustainability** The committee noted the risk and the action plans in place.	
4.1	**Sustainability Progress Update** A number of new appointments have been made to strengthen the team and a plan is in place to deliver improvements in a number of areas including waste management. The new Willowfield building has solar panels on its roof. The committee noted that the team are working through the recommendations in the Internal Audit review and are working with KFM to manage down the carbon impact of the Trust's supply chain. The Trust is leading the way in nitrous oxide reduction.	

Committee Highlight Report for Trust Board			
Committee Chair	Prof Jon Cohen	Date of Meeting	24 November 2022
Committee:	Quality, People & Performance Committee		

Agenda ref	Item	Link to BAF
2.1	**Integrated Performance Report** Performance against the Emergency Care Standard remains challenged at both sites, both in relation to the 4 hour target and the 'decision to admit' target. Ambulance handover delays are higher than they should be but mitigations are in place. In relation to cancer performance standards, the Trust is doing well with the 2 week standard but has struggled on the 62-day target. The diagnostic position had improved, though CT scanning at the PRUH had been challenging recently. The Trust had made good progress with the referral to treatment standards target and compares well both nationally and regionally. The Committee noted that much of London was under enormous pressure and situation was very difficult in the emergency department (ED), with approximately 400-500 patients being seen, many of which were GP referrals. The Committee noted that it is likely that the national cancer targets will be updated, as directed by NHSE. Local discussions are underway to ensure that the right targets are in place across the system to monitor the time to diagnosis and first definitive treatment targets.	BAF 7 – High Quality Care BAF 8 – Demand and Capacity
2.2	**Ambulance Handover** The Committee noted that both sites are monitoring ambulance handovers and further data including trends and detailing any waits over 60 minutes would be provided to the Committee. The Committee noted that there is a national emphasis on moving towards the North Bristol model or a similar continuous flow model, which involves moving patients to wards, regardless of whether a bed was available. The PRUH is subject to enhanced monitoring by NHS London.	BAF 7 – High Quality
2.3	**Child and Adolescent Mental Health** The Committee noted the report which highlighted the objectives and progress which had been made in ensuring children and adolescents with mental health issues received timely and appropriate treatment. The Committee noted the ongoing discussions at the ICB in relation to resourcing to support the service, given the challenges with capacity in the community sector. The safeguarding team works closely with both EDs and the safeguarding team is now working extended hours to ensure availability out of hours and at weekends.	BAF 7 – High Quality
2.4	**Winter Plans** The Committee received the Trust's Winter Plan which outlined how the Trust will respond to winter pressures including COVID-19, influenza, industrial action and power outages.	BAF 7 – High Quality Care

Agenda ref	Item	Link to BAF
3.1	**Workforce Metrics** The Committee considered the Workforce Metrics. Key points of note included: ▪ 90% compliance for non-doctor appraisals. ▪ The first group of Project Search had graduated and were now employed by the Trust. ▪ Vacancy rates had stabilised since last reported with a reduction of 13.51% at the end of October 2022, and nursing and midwifery vacancy rates reduced to 13.85%, was 16% in July. ▪ Medical and dental vacancy rates reduced below 10% in October. ▪ International recruitment is on deliver on track. ▪ Turnover was approximately 15%. One area of concern was staff leaving within 12 months or less at the Trust, and work was underway to review the reasoning behind that. ▪ Sickness was below 4% and vaccination campaigns are underway.	BAF 1 – Recruitment and Retention
3.2	**Kaleidoscope Leadership Training** The Committee was provided with an update on the King's Kaleidoscope, the Trust's learning and organisational development offer following its launch in June 2022. The Kaleidoscope and Talent Management programme had centralised personal, professional and career development for staff working across the Trust. The programme would help develop succession planning and talent management using the NHSE growth model.	BAF 1 – King's Recruitment & Retention BAF 2 – King's Culture and Values
3.3	**Industrial Action** The Committee was provided with an update on the potential industrial action over the next few months. In line with national expectations the Trust was taking a pro-active approach to preparing for potential industrial action in order to minimise the risk to patient care. The Trust Action Industrial Contingency Plan had been updated taking into consideration various modelling. The Trust was working collaboratively with GSTT to ensure patient care and safety was paramount.	BAF 2 – King's Culture and Values BAF 7 – High Quality Care
3.4	**Equality, Diversity and Inclusion Update** The Committee was provided with an update on the performance for September and October 2022. The report also outlined progress against projects and milestones set out in the Roadmap to Inclusion 2022-2024. There had been good traction with the progress against projects with delivery expected in H1 and H2. Work had begun in the local community by engaging with more young people about career opportunities and marketing.. The Committee noted the good progress achieved and acknowledged the support from the Executive.	BAF 2 – King's Culture and Values
3.5	**WRES / WDES Action Plans** The Committee was provided with an update on the WRES report which recorded improvements in 7 of the 9 indicators. The Model Employer scheme was established in 2018 and supports the national Implementing the NHS Workforce Race Equality Standard (WRES) leadership strategy by setting targets for senior leadership representation by 2028. An action plan was developed based the Race Equality Standard and aligned to the King's Roadmap to Inclusion 2022-2024. The dashboard had been	BAF 1 – King's Recruitment & Retention BAF 2 – King's Culture and Values

Agenda ref	Item	Link to BAF
	reviewed regularly as a source of measurement and to ensure the Trust was on track in its delivery. The Committee approved the WRES and WDES action plans.	
4.1	**QPCC Red Risks** The Committee received the report which outlined the red risks in the corporate register aligned to the Committee. All risks were regularly reviewed through the Trust governance processes and the Risk and Governance Committee. The Committee noted the number of overdue quality alerts from primary care. There was a backlog, which was being cleared with dedicated resourcing now allocated. The ICB had complete oversight of the overdue quality alerts. The committee considered the Trust approach to quality compliance and associated risks in detail.	BAF 7 – High Quality Care
4.2	**Board Assurance Framework – QPPC Risks** The strategic risks have been reviewed and in line with discussions at the September meeting it was proposed that the risk score on High Quality Care was increased to 16, in light of concerns raised about the robustness of the Trust's quality assurance framework. The Committee noted that a number of actions were in place to strengthen this. The Committee agreed to raise the score, and to keep it under review.	BAF 7 High Quality Care
	Care Quality Commission Update The Committee considered a summary of CQC activity in the Trust over the Autumn. The CQC carried several inspections including services for Children and Young People and Medical Care in late October and a Corporate Well-Led Inspection in November. The Trust has received the draft report of the PRUH medical wards inspection, which is due to be published in November. The CQC have received 31 enquiries, of which five were whistleblowing enquires.	
22/105	**Patient Safety and Duty of Candour Report - Q2** The Committee received the report which outlined the Trust's performance with Duty of Candour, patient safety incident management and performance. It also provided an overview of the current patient safety initiatives including implementation on the NHS Patient Safety Incident Response Framework (PSIRF). The Committee noted performance improvements seen in Q1 had been sustained in Q2. Measures were in place to ensure the performance continued.	BAF 7 – High Quality Care
22/106	**Patient Outcomes Report – Q2** The Committee received the report that included performance information against the Trust's Outstanding Care objective: Putting Patients First. Key points of note included: ▪ The Committee noted the 2 red Indicators related to the Sentinel Stroke National Programme at both sites. ▪ 3 red Indicators related to high-risk admissions from the ward and high-risk sepsis from the ward. ▪ 80% of the indicators for the Trust was rated as green.	BAF 7 – High Quality Care

Agenda ref	Item	Link to BAF
22/107	**Patient Experience Report** The Committee received the report which highlighted key achievements on patient experience function alongside performance metrics for the period between July 2022 and September 2022. The Committee noted there were no complaints over 6 months, with sustained improvements in FFT. 62 Volunteers had completed their training to help patients at meal times, which would make a big difference to patient experience.	BAF 7 – High Quality Care
22/108	**Quality Account Priorities Progress Report** The Committee received the report which highlighted progress made in quarter 2 in delivering the Trust's quality account priorities. The priority supporting positive behaviour to increase staff and patient safety had a successful event with the launch of the Two Lives film.	BAF 7 – High Quality Care
22/109	**Safeguarding Adults Annual Report 2021/22** The Committee received the report which highlighted the safeguarding adults activity for 2021/22. This included compliance with safeguarding requirements outlined in the Care Act 2014. The safeguarding service was now 7 days a week operating an excellent service for its patients. The Committee noted the responsibility for a number of safeguarding decisions is being transferred from Local Authorities to Trusts.	BAF 7 – High Quality Care

Committee Highlight Report for Trust Board			
Committee Chair	Charles Alexander	Date of Meeting	1 December 2022
Committee:	Strategy, Research and Partnerships		

Agenda ref	Item	Link to BAF
2.1	**King's Role as an Anchor Organisation** The committee considered a presentation on the Anchors Programme, which is a key strand within the Trust Strategy. The presentation outlined the core strands of the programme and the governance structure as well as wider links with other Trust strategies including quality and sustainability.	BAF 8 Partnership Working
2.2	**Health Inequalities Programme Update** The committee considered an update on the health inequalities programme. It outlined activity under the BOLD headings and how the programme will be taken forward.	BAF 7 High Quality Care BAF 8 Partnership Working
3.1	**Specialised Commissioning – next steps 'joint arrangements plus'** There have been discussions with NHSE in relation to the devolvement of specialist commissioning to Integrated Care Boards. South London (SE &SW) has engaged proactively in this programme, with the anticipation it would be implemented in April 2023. This will now not happen nationally due to concerns about financial risk and readiness. In light of this, and so that momentum is not lost, it is being proposed that a pathfinder model is implemented and this has been supported by NHSE. The committee considered how it will be delivered in South London, and reviewed the assessment of the financial challenges and the risks to Trusts in progressing at this stage.	BAF 3 Financial Sustainability BAF 7 High Quality Care BAF 8 Partnership Working
3.2-3.4	**Partnerships** The Committee received updates from a number of partnerships including the South East London Integrated Care Board, the SEL Integrated Care Partnership, the Acute Provider Collaborative and King's Health Partners.	BAF 8 Partnership Working
4	**Board Assurance Framework** The committee considered the two BAF risks and associated action plans.	BAF 6 Research and Innovation. BAF 8 Partnership Working